* Indicates written testimony submitted prior to the public hearing in accordance with the Legislature's guidelines on ADA testimony.

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 County, and I serve as Chair of the 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: Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

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

RIEPE: I'm Merve Riepe. I represent District 12, which is southwest Omaha and the good folks of Ralston

HANSEN: And that's Senator Hardin.

HARDIN: Senator Hardin from District 48, Banner, Kimball, Scotts Bluff County.

HANSEN: Also assisting the committee is our research analyst, Bryson Bartels, our committee clerk, Christina Campbell, and our page for this afternoon is Delanie. A few notes about our policy and procedures. Testimony will be down to 30 seconds for each person. I'm just joking. [LAUGHTER]

WALZ: Oh. I was like, wow, holy quick.

HANSEN: I want to get home before dark, but I'm not that desperate. Please turn off or silence your cell phones. We will be hearing four bills this afternoon. 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 when you come to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but 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 Legislatures policy is that all comments for the record must be received by the committee by noon the day prior to the hearing, but that will, we're altering that a little bit because of the weather and I'll explain at the end of 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 are using a light system for testifying. Each testifier will have five minutes to testify. If we do have a bill that has a large number of testifiers, we may limit that down to three, so. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask 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 name. 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 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 policy in the committee. So with that, we'll begin today's hearing with LB422, and welcome, Senator Kauth. Welcome back.

KAUTH: Thank you. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Kathleen Kauth, spelled K-a-t-h-l-e-e-n K-a-u-t-h, and I represent District 31 in Millard and southwest Omaha. Thank you for hearing LB422, medical freedom. I believe you've all been handed an amendment to it. The last several years have been enlightening for members of the medical community who had differing opinions on medical treatments. Those medical practitioners around the country who advocated treatments that differed from the general medical consensus, for example, with COVID, found that they were penalized and in some cases threatened with their licenses. In response to this issue, Attorney General Peterson issued an opinion for medical practitioners regarding the use and prescription of hydroxychloroquine and ivermectin. That was issued October 13, 2021. By October 14, 2021, I've been contacted by numerous doctors throughout the country who were so grateful that Nebraska made a commitment to its medical professionals in that manner. That opinion piece is limited to two specific medications for a specific ailment. The goal of LB422 is to establish a common practice that medical practitioners’ First Amendment rights to express differing medical opinions will be upheld and that their licenses will not be subject to or threatened with any disciplinary measure as a result of merely expressing an opinion in a public or professional forum. The amendment, AM414, restates the original draft to clearly express the intent of this bill. I'm so grateful to DHHS Director of Legislative Services, Nicole Barrett; DHHS General Counsel, Bo Botelho; Assistant AG, Mandy Lester, and Maureen Larsen with the Policy Research Office for assisting me in developing the legal language needed to make my intent clear. I'm open for questions.

HANSEN: All right. Thank you for that. Are there any questions from the committee? All right. Seeing none, we'll see you at close. If I can, can I get a show of hands for how many people are testifying today on LB422? Oh, I like it. Good. OK, So with that, we'll take our first testifier in support of LB422. Is there anybody coming in to testify in support?

JEANNE GREISEN: Hello. My name is Jeanne Greisen, J-e-a-n-n-e, last name G-r-e-i-s-e-n, and I am here representing myself in support of this bill. However, I don't think this bill goes far enough. This is only the first drop of getting back freedom in the medical community. And what I mean by that is prescribers need to have the option to treat patients how they want versus this herd mentality. And so you can't get away from that until you get away from doing protocols. And can prescribers get away from doing protocol is really the question and the answer to that would be no, because they're rated on health grades and giving a score if they follow these particular protocols. So if they veer off of that, they're going to get a bad score and then that's get posted for every patient to see. So that takes away individual medicate, individual practice to treat a person as an individual. So that's one part of it. But then it also goes into data harvesting. So part of that is the data harvesting for prescribers. So with that is also the electronic health records, but then it also goes into PDMP. So people probably don't realize that their records for prescriptions and things that are written by their prescribers, and maybe you all know this, I don't know, but it's not just between the pharmacist and the patient. It goes into the state for the, like for PDMP. They collect all that information. It used to only be under controlled substances, but now it's all prescriptions, even prescriptions for your dog. It all has to get reported. So who needs that information? Maybe if you get checked into a hospital, maybe, but it's really Big Brother. It's Big Brother being over health care for every person. And that is not right. People need to have only access to their medication and their history and their relationship with their doctor. It doesn't need to be Big Brother collecting data. So it seems like the theme in this legislative session is obviously about children, but then it's also about data harvesting. It's about collecting everybody's data. Big Brother is collecting everybody's data, and that's not right. This bill is the first, like just a drop in the bucket of things that need to happen in this state of getting control back to the people where it belongs. And that's all I have.

HANSEN: All right. Thank you for your testimony. Are there any questions from the committee? All right, seeing none, thank you. Is there anybody else wishing to testify in support? All right. Seeing none, is there anybody who wishes to testify in opposition to LB422? All right. Seeing none, is there anybody who wishes to testify in a neutral capacity? Hello.

PAUL HENDERSON: Good afternoon.

HANSEN: You're on this side now.

PAUL HENDERSON: I know it's my first time, so go easy on me. [LAUGHTER] I will remember to spell my name, P-a-u-l H-e-n-d-e-r-s-o-n, Paul Henderson with Nebraska Medical Association. I speak in a neutral capacity on this bill. Originally, we were opposed to the green copy of the bill and still are opposed to the green copy. Our members had strong concerns that it would make it difficult to ensure the high quality and high standards of care that Nebraskans expect from physicians. We did have a chance to speak with Senator Kauth this morning and to review the amendment. It's our understanding that the amendment would still allow for discipline in cases where a physician has acted incompetently or with gross negligence or if there's been some kind of unprofessional conduct. So that brings us to a neutral position today. But we did just want to state those concerns for the record and we appreciate Senator Kauth bringing the amendment. And that's all I have.

HANSEN: Thank you. Are there any extremely difficult questions from the committee? First time. OK. All right. Seeing none, thank you..

PAUL HENDERSON: Thank you.

HANSEN: Is there anybody else who wishes to testify in opposition or in a neutral capacity to LB422? All right. Seeing none, we will welcome up Senator Kauth to close. And with that, we did have some letters for the record. We did have 6 opposed to LB422 and 48 in support of LB422.

KAUTH: Well, thank you. I think that's probably the fastest I've ever been in and out of this committee so I appreciate everyone hearing this with no opposition, and again, I'm so grateful for the, we have access to amazingly smart people in this building. And so, so grateful for that for helping me rewrite it the way it should be. So I appreciate it. Hope you move this to General File.

HANSEN: Thank you. Any questions? All right. You're good to go. Thank you. And with that, that will close our hearing for LB422. And on a side note, with those letters for the record, due to inclement weather and a temporary extension of the deadline for online position comments, there may be additional comments added to today's hearing record as an exhibit. I say that for the record. All right, so now we'll move on to LB592, and welcome, Senator Hardin.

HARDIN: Thank you, Chairman Hansen, and good afternoon, fellow senators of the Health and Human Services Committee, also known as the finest committee in the building, I am Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n, and I represent the Banner, Kimball and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. I'm here to introduce LB592, known as the Social Care Information Privacy Act. In recent years, there's been a growing interest in addressing health-related social needs as a strategy for improving overall health and well-being. As a part of this movement, social care networks have become an important part of delivering the services that address these needs. These are groups of publicly and privately-funded organizations that share data and make referrals to each other to help provide care across the range of social needs. Social care information is information about the most vulnerable moments of a person's life. People who are experiencing homelessness, food insecurity or threats to their physical safety often want to keep this information private. This information deserves a thoughtful and deliberate governance structure that will ensure the privacy of people going through difficult times. Because it's relatively new, there is currently no regulation of the social care information space. Social care information is a different set of data than protected health information, PHI. Although they may have some overlaps, social care information includes data that may never be accessed by a health care entity and is not subject to HIPAA. Everyone benefits from creating some standard regulation around the exchange and privacy of social care information. People who need social services, social service providers and others all benefit from having a clearly-defined set of best practices and rules governing how social care information is protected and accessed. This bill creates a consumer-directed privacy consent model. It gives people the power to decide who they want to share their information with and when. The bill requires pre-referral consent, meaning, I'm sorry, per-referral consent meaning that people seeking social care must consent to their data being shared on every instance of a referral. This ensures individuals always know every organization that can see their private information, and it also ensures those service providers always have access to the data they need to deliver services. This bill also requires permission-based access to referral information, meaning an organization or an individual can only see social care information they have specifically been granted access to. This differs from other models like HIPAA. With health care, if a person shows up to an emergency room unconscious, they want the ER doctor to be able to look up their medical condition. With non-healthcare social care information, a person should have the ability to actively consent to sharing their information at every step of the process. It's important to let you know this bill does not affect care coordination in the health care space because it does not affect health care entities or protected health information at all. The bill deliberately and explicitly steers clear of protected health information and how it's handled under HIPAA. HIPAA-covered entities that are providing health care and social care referrals to individuals will continue to use their existing processes and follow HIPAA regulations for PHI. Thanks for your time and consideration today. I'm happy to answer any of your questions. I do have testifiers following me that are likely better at answering any more technical questions you may have. On a personal note, I have learned just this morning that there are dimensions to this bill that I did not know existed before this time. I literally thought about pulling this bill this morning. I did not. Let me tell you why I chose not to. It's because I think this privacy discussion needs to happen here on camera. And I think it needs to go on the record because I think that's how high this rises as a priority for people. And so there are some really talented and brilliant people following me, much smarter than me on all sides of this issue, and I think it's going to be a lively debate today. And so for those at home, I encourage you to get out the popcorn and watch along, because I think this should be a meaningful interaction today. And I look forward to the close.

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

M. CAVANAUGH: Thank you. Thank you, Senator Hardin. So when I go, take my kids to the pediatrician, I sign a consent.

HARDIN: You can.

M. CAVANAUGH: And I'm assuming this is something along those lines, but--

HARDIN: My understanding of it, Senator Cavanaugh, is that there are consents that already take place. There seems to be some confusion sometimes in that, that consent that you sign at the pediatrician's office might get handed around in the PHI realm--

M. CAVANAUGH: Mm hmm.

HARDIN: --where, for example, others labs and others that may be servicing the needs of that provider may actually have that shared so you don't have to sign a separate HIPAA form for every piece of that.

M. CAVANAUGH: Right.

HARDIN: In this case, there seems to be some confusion that happens on the recipients of the social care. For example, I may go to a food bank somewhere and I may check a box or I may click a radial dial on a computer screen, and then I start getting contacted by lots of entities, not realizing what may be coming my way from many different dimensions. Those of us who have been through the ringer in life and maybe have found ourselves in situations where we feel very compromised, hurt emotionally, in other ways, kind of the, the bottom end of our barrel. I've been. I'm sure many of us have. Sometimes in those most vulnerable times, we can be taken advantage of. And I think that's part of the concern is that because this is a somewhat new strata of communication and cooperation, that's sometimes a lot of information gets shared and with other organizations that you may not want to share it with. And that's why we're kind of introducing this privacy conversation at this time.

M. CAVANAUGH: So is this, and I love privacy conversations, but is this more of a consumer protection?

HARDIN: I think there's certainly a dimension to that.

M. CAVANAUGH: OK.

HARDIN: Part of what ends up happening and some concerns is that it can become a slippery slope, the bottom of the slope essentially being that someone it's, ends up introduced to social programs like welfare, like Medicaid that they were not intending to get into, and they kind of wake up and go, I'm not sure how I got here. When did I sign something? And then I signed something else, and then I talk to someone and I'm not sure how I got where I am. And so sometimes there is that kind of scenario that evidently takes place.

M. CAVANAUGH: So how would this impact when we have like, navigators? So if you go somewhere and you, you need services and then you meet with a navigator that can help connect you with additional services that you need.

HARDIN: It would be a situation, as I understand it, in the bill. And let me also say I'm, I'm probably somewhat agnostic to this bill. I'm somewhat more interested in covering the basis of the privacy conversation than I am the vendors who seem to be jockeying for positions to win some contracts in the IT world related to this bill.

M. CAVANAUGH: OK.

HARDIN: And so, but I think it's an important conversation to have. And what's being considered here is to do it on a per-share basis or per-need basis so that certainly a navigator, I believe, could still be involved. They would just have to make sure that they understand the fine print before they would help them with that segment of life. I guess I look at it, Machaela, and just say, when was the last time any of us actually sat down and read our auto policy or whatever else that's fine print. And so sometimes people kind of get washed up into these scenarios, not having read all of the fine print.

M. CAVANAUGH: Thank you.

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

BALLARD: Thank you, Mr. Chairman. Can you address the $4 million fiscal note? The way, the way I read it, it almost seems like the department has to change a vendor.

HARDIN: Yes.

BALLARD: I'm not saying that's the case, but can you just address it, kind of you're reading, your inter--

HARDIN: Right. And I also asked the same question. It means we have to change a vendor? And so I get it. There's a lot of information being gathered by the Department of Health and Human Services. They currently keep track of all of that and there are organizations that are interested in taking that process over. And so the change of vendors seems to invoke the need for new processes, new systems, new software, new training, so on and so forth. And I believe that's where the $4 million comes from. Again, I'm not real sure that we need to make the change. It does seem to me that we need to have the conversation about what happens with this privacy. As important as $4 million is, I think it's even, it's trumped, if you will, by the need to have this discussion about this layer of privacy. And it's a vastly growing strata of information.

BALLARD: Thank you.

HANSEN: Seeing no other questions. Thank you for opening. We'll see you at the close. And how many are here testifying on behalf of LB592, total? Can you raise your hands, please? OK, thanks. OK, good. So we'll take the first testifier in support of LB592. Welcome.

JUSTIN HAGE: Good morning. Good afternoon. I'm sorry. Good afternoon, Chairman Hansen and members of the committee. My name is Justin Hage, J-u-s-t-i-n H-a-g-e. I'm here testifying in support of LB592. I'm here representing Findhelp. We are the largest closed loop referral system network in the United States with over 20 million users to date and over 100,000 here in Nebraska. We're a public benefit corporation based in Austin, Texas, and we're proud to have won the trust of over 500 clients in the Health and Human Services space, government space and many businesses that do business right here in Nebraska, including Nebraska Total Care, Healthy Blue, Nebraska Health Network and the

Nebraska Investment Finance Authority. At Findhelp, our mission is to connect all people in need and the programs that serve them with dignity and ease. We believe that privacy is a very important part of that dignity. We also believe Nebraska is on the right track in considering individual privacy, related to closed referral systems. In considering this bill, Nebraska is one of the leading states in a national movement to address this regulatory gap around privacy in social care. This bill is in line with legislation being considered by nearly a dozen states in 2023 and tracks closely with the first in the nation, Privacy Protection Law for social care information, Senate Bill 423, which was passed in New Hampshire last year. As was discussed, we all know about the protections that are provided for HIPAA as it relates to medical information, but people do not always necessarily realize that social service information often exists in a gray area where federal and state privacy protections do not apply. Most social service providers are small community-based organizations. Think of a church with a food pantry, perhaps on Tuesdays and Thursdays, that aren't necessarily covered entities under HIPAA, and therefore do not, HIPAA does not apply. Thus, there is a gray area where we need to really find privacy protections that guide social care. This bill addresses that area and provides privacy protections for social services. In a social secure setting there is a stigma that exists around accessing in needing services. It's important we recognize this stigma exists and that every person has a right to privacy in their time of need. Many people needing services are the newly unemployed, those who have experienced trauma, those who are ex-offenders trying to reenter society, or perhaps a parent helping a child with substance abuse, and we do not want widespread access to that information. There also could be instances where someone doesn't want wide access to, excuse me, wide access to the fact that someone needs food or housing. People expect this information to be protected, and this information is housed in systems like ours, and it, well, needs to be visible to those who the individual trusts. If they won't trust the system, they are less likely to ask for help, and that leads to avoidable outcomes such as going to the emergency room because you didn't have transportation to a doctor's appointment. And referrals for social services used to only be really transmitted by word of mouth, and now they're being digitized for the first time, as Senator Hardin mentioned. Individuals can still walk into a church or a local nonprofit and seek help, but now that information is being shared with a large number of people, a large number of organizations who are part of social service networks that used closed with referral systems. This digitization is very important and it helps and brings tremendous benefits for people in terms of their health and well-being. But at the same time, it presents some very real privacy concerns that this bill addresses. Specifically, this bill is about preventing broad access to very sensitive information related to social care and ensuring that individuals provide informed-consent about where social care information is shared. Additionally, this bill explicitly prohibits the sale of social care data to third parties. Finally, social care, excuse me, peripheral consent model, really is the best practice when it comes to care coordination. Allowing individuals to provide consent on every instance of referral provides the highest level of transparency about who has access to their information. We've not found in working with over 100 health plans and 180 health systems that this really hinders care, nor is it onerous. It actually is a important factor that has some systems really decide to work with us and some nonprofits think this is important for the folks we serve. So in closing, I want to very briefly address the fiscal note. We've been in conversation with the department about how some of the referrals referenced and the systems referenced may not be actually part of the closed referral systems, and therefore this bill wouldn't necessarily apply. And we look forward to having continuous, continued conversation and dialogue with them. With that, I would say thank you very much to the committee for the opportunity to present today. Thank you to Senator Hardin for introducing this important legislation and happy to take the questions.

HANSEN: All right. Thank you. Are there any questions from the committee? Senator Walz.

WALZ: Thank you. Thank you for coming today. I just have a couple curiosity questions. First of all, a public benefit corporation, what is that?

JUSTIN HAGE: Thanks for the question, Senator. So, public benefit corporation, we are a for-profit company, but we also have a public mission. So as part of our public mission, we offer what's called Findhelp.org, which essentially is our social service search engine that's available. Anyone can go to it today, type in a zip code, look for services, that's available to the public. And so we think that's a very important part of our mission. And also part of our mission is the, the dignity in the use of looking for services. So again, we've got a, a for-profit mission, but we also are, have this public benefit mission which really is focused on providing those social services and access to them for free to the public.

WALZ: OK. And I think that this legislation is being seen in other states. So just out of curiosity, are you, are you bringing the legislation? Was it you, your organization that brought the legislation here?

JUSTIN HAGE: We're very supportive of this, of this model and think that this privacy is very important because it hasn't been regulated to date. So to the other states that I referenced, we are definitely in support of having this model be regulated and be instituted in other states, yes.

WALZ: OK. All right. I think that's all the curiosity questions I have.

HANSEN: All right. OK. Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here. On your testimony, you said social services are now being digitized for the first time.

JUSTIN HAGE: Yes.

BALLARD: Provide me an example of what that means.

JUSTIN HAGE: So, again, in the example I provided earlier, if someone were to actually walk up to a food pantry and actually receive food, there's not actually going to be necessarily a digital record of it. There's not going to be people who put, improperly perhaps have access to that information or be able to broadly access that information. But now, if a referral is made to say from a, someone goes to a community center or a different type of entity and then is referred to that food pantry, there's going to be a digital record of it. So there's going to be essentially the ability for other people to have access to it. So use of the word of mouth used to be a phone call to say, hey, you know what? I'm going to send a social worker helping someone who says, I'm going to send Mr. Jones to this food pantry and they show up. There's really no digital record of it. Now, part of these closed referral systems, there is a digital record of that person being referred and what their needs are, what their name is, that sort of thing.

BALLARD: And then you said there's a possibility that that could be sold to third parties.

JUSTIN HAGE: Yes. I mean, there's, within these networks, there's always the opportunity for whether it's a for-profit entity or otherwise, for whoever is running the network, whether it's homegrown or whatever the vendor may be, that there is the possibility for the sale of data by third parties.

BALLARD: Thank you.

JUSTIN HAGE: Thank you.

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

RIEPE: Thank you. Can you explain to me what your relationship would be with the Department of Health, DHHS?

JUSTIN HAGE: Do you mean our company?

RIEPE: In state government.

JUSTIN HAGE: Today?

RIEPE: Yeah. Would you be a contractor?

JUSTIN HAGE: We have the potential to be. We are not now, but we do, we cannot have any relationship with the state at this time.

RIEPE: OK. Thank you.

HANSEN: Any other questions? Seeing none. Thank you.

JUSTIN HAGE: Thank you very much.

HANSEN: We'll take our next testifier in support of LB592. Welcome.

ANGELA GREENE: Thank you. Good afternoon, Chairperson Hansen and committee members. Thank you for having me here today. My name is Angela Greene, A-n-g-e-l-a G-r-e-e-n-e. I'm the chief of staff at CyncHealth, which is the organization designated in Nebraska statute as the statewide health information exchange and administrator of the Prescription Drug Monitoring Program. We also partner to administer a social care referral network, and I'm here to testify in support of LB592. CyncHealth has been supporting implementation of social care technology since 2020, and our organization stood up when network across the state of Nebraska enabling us to become intricately aware of the landscape of social care, referral processes, consent management and information sharing. It has also highlighted the unique needs of Nebraskans and the dedicated community organizations and health care providers who are serving them, all of which are utilizing several kinds of referral networks to support the goal of full person care for Nebraskans. CyncHealth supports the primary aim of this bill, which is to ensure that an individual's privacy is protected, especially for information that you've heard previously, is particularly of a sensitive and often private nature. However, we would like to bring a few things to the committee's attention regarding this bill. First, the bill would only apply to a small portion of the data that it truly aims to cover. It focuses solely on closed loop peripheral technology when there are other types of social care technology and non-technology solutions operating within the state. By limiting the perspective to a single vendor perhaps in the marketplace, this shifts the burden to the patient to have to know what technology their vendor provider is utilizing and base their consents upon that knowledge. Today, in health care, for example, we don't ask patients to know whether their provider is utilizing Epic or Cerner, for instance, for their electronic health record. We trust that once the patient has consented, the data can be shared and by placing the language to a close, closed-loop referral system only, the goal of achieving data privacy and patient control of their data is unfortunately only part of the problem. Next, Nebraska has in place already a body tasked with overseeing the sharing of electronic health information. The Health Information Technology Board or the HIT Board. This board is responsible for establishing criteria for data collection and disbursement by the Health Information Exchange and PDMP through CyncHealth, and for providing the governance oversight necessary to ensure that any health information may be accessed, used or disclosed only in accordance with privacy and security protections afford it, afforded under HIPAA and other applicable laws. This board is subject to the Open Meetings Act and provides for the level of transparency and oversight patient data collection requires. As a neutral arbiter, the HIT Board ensures consistency and appropriateness of the access, use or disclosure of all health data. Finally, because federal standards, standards for health information sharing now include many elements related to social care data, this type of information is already moving through the statewide health information exchange and is available as part of a longitudinal health record. CyncHealth is well-suited to taking this data and apply our stringent data governance, patient matching and consent management processes like we already do all day, every day with the health information in our network. We appreciate Senator Hardin bringing this issue forward and beginning the dialogue on this very important topic. And we're happy to work with the Senator on any clarifying language which is required. Thank you for your time today and I'm happy to answer any questions you may have.

HANSEN: Thank you. Are there any questions from committee? You get off scot-free. Oh, see-- missed anything.

ANGELA GREENE: Almost, so close.

HANSEN: Senator Riepe.

RIEPE: Right under the line, huh? My question would be, is trying to learn here. CyncHealth, does this act create a product development or a contract opportunity for your organization?

ANGELA GREENE: No, it doesn't. I think, you know, from the CyncHealth perspective, we obviously do have a vendor that we work with for our network that we have stood up currently. But I think from, from our lens, there are a number of use cases which the different types of platforms available today meet. So I think we're, I would consider vendor agnostic in that way for utilization of, of a particular platform depending on use case.

RIEPE: Does the existing, existence of an act then build a wall to protect you from other vendors?

ANGELA GREENE: No, I wouldn't say that, that it, it builds a wall to protect us from other vendors. I think it was really in line with how we protect our health data in general. So this act is really an extension of that to include social care data and addition health care data. So I think that's really where I see that moving.

RIEPE: OK. I was just trying to understand a little bit more you're being a proponent of the particular bill. Thank you, Mr. Chairman.

HANSEN: Any other questions? All right. Seeing none. Thank you. Anybody else wishing to testify in support of LB592? All right. Seeing none. Is there anybody who wishes to testify in opposition to LB592? Welcome.

KEVIN BAGLEY: Hello again, this beautiful, snowy day. Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the director for the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here today to testify in opposition to LB592, which places restrictions on closed loop systems collecting social care information. I would first like to thank Senator Hardin for the opportunity to meet with him and discuss the bill and some of the department's concerns. As written, LB592 requires explicit consent for information to be added to a closed loop referral system in order for referrals to be made. This bill would impact multiple eligibility and enrollment systems and other databases within DHHS. The legislation could impact everything from child support enforcement referrals to Medicaid managed care plan enrollment. The department utilizes a number of systems throughout the enterprise such as N-FOCUS for program eligibility and enrollment. Behavioral Health Central Database System. A child support enforcement system known as children have a right to support or CHARTS. The MMIS for Medicaid claims payment and managed care enrollment, just to name a few. These systems are not currently configured to require consent in order to refer data from one system to the other. Under this legislation, the department systems would require significant updates to build new functionality necessary to obtain consent for referrals throughout the enterprise. As an example, when an individual is currently made eligible for Medicaid in the unfocused system, when appropriate, a child support referral is made through N-FOCUS to CHARTS. The unfocused system also communicates within the MMIS system, which triggers the managed care enrollment with our vendor, automated health systems. The managed care enrollment also triggers an assignment of a primary care provider. Currently, an application the individual filed allows for these processes to happen without additional consent. As you can imagine, waiting for explicit consent for each of these referrals could put significant delays in ensuring individuals reach a health care provider or start the process to receive child support. For context, it's my understanding that the bill was brought by a former DHHS employee who has previously attempted to work with us on purchasing their product. We're concerned the bill would be tantamount to creating a legislative need for a product the agency does not currently contract for. We believe LB592 may ultimately create a legislative problem tailor-made to the solution at a price of the vendor's choosing. We believe in order to provide the highest level of service to citizens, we should ensure that government systems work together to minimize the red tape required for Nebraskans to access the services they're eligible for. Nebraskans shouldn't have to fill out two different applications with almost identical questions in order to enroll in Medicaid and SNAP. By requiring explicit consent to share data between these programs, we may ultimately be adding to the barriers and red tape that citizens experience. Citizens absolutely have a right to privacy. Citizens have a right to choose whether or not they participate in assistance programs like Medicaid or SNAP for which they may be eligible. We support those rights. Creating additional barriers to efficiency in delivering those services does not further those rights. It only diminishes the quality of the services we're able to provide. Finally, I'd like to address the fiscal note. I'll point out that the costs reflected in that estimate only reflect the known costs. As additional context, an analysis is done on existing systems when likely to identify significant additional costs. If some existing systems need to be replaced or new vendors procured in order to come into compliance, these replacements could cost hundreds of millions of dollars and take potentially years to complete. To ensure we aren't adding significant costs to future state budgets, we should be thoughtful about how this legislation impacts state administered programs and systems. I appreciate the opportunity to come and testify today. I'm happy to answer any questions.

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

RIEPE: Thank you, Senator Hansen. Thank you for being here, Mr. Bagley, or Dr. Bagley.

KEVIN BAGLEY: Thank you.

RIEPE: My question is just for mind clarification. I notice, in about your fourth paragraph, it talks about and I'm assuming, correct me where I'm wrong here, that it, that these proposed system are in the proposed act and in and of itself competes where-- with DHHS's automated health system. So you're saying, we have one too many people on the dance floor kind of an analogy.

KEVIN BAGLEY: So I would, I would say today we have a lot of disparate systems.

RIEPE: OK.

KEVIN BAGLEY: Some of which are, we'll say kindly past the end of their technological life. And so to make these kind of updates that would allow for this level of consent between them would be significant and in some cases would likely require that they be replaced.

RIEPE: Do you have a specific overall plan? You said that it sounds like a lot of fragmentation. My memory is it's, a lot of it is very, very old.

KEVIN BAGLEY: Yes.

RIEPE: But do you have a plan, a dream plan that says this is what we would like to have, other states are maybe using? Do we at least have that on the drawing board someplace?

KEVIN BAGLEY: We do, Senator. That's a fantastic question. One of the things we are really looking at is how to incrementally and modularly replace elements of our existing systems. Those always do come with a cost. When those costs come up, we plan to work with the Governor's budget office and, and with the Legislature to ensure that those are covered. Our roadmap outlines what some of that looks like. And right now our focus is primarily on the iServe system, which should be released to the public in July, and that, that system is about integrating those applications so that we don't have someone who has to fill out what amounts to almost the same application four or five times in order to get on the programs that, that they need to be on.

RIEPE: It sounds like to me and I'm trying to listen carefully here was--

KEVIN BAGLEY: Sure.

RIEPE: --if you're making some incremental improvements, I'll call them that, or was it, have you considered sort of abandoning the entire system and start anew? I mean, and I don't mean to go out and build a, I'm more of buy off the shelf--

KEVIN BAGLEY: Oh, absolutely.

RIEPE: --for lack of knowledge on my part. But, and I also don't like to be the first that goes through the weed patch. I want to learn on somebody else's mistakes other, you know, all the other 49 states. You know, there must be some really great system. Or is that not true?

KEVIN BAGLEY: I would say as a general rule, there is no silver bullet that solves all of state's problems when it comes to health and human services. I would say, though, there are a lot of best practices out there and a lot of vendors that provide really good off the shelf products. And so for us, in terms of that future planning, it's really been about what is going to provide the largest return on investment for us in replacing pieces of the system. I can say from experience in other states that if you go with that big bang approach, you tend to spend hundreds of millions of dollars over the course of a decade and run the risk of, you know, your system being out of date again by the time it's even released. And so for us, I think what makes the most sense is to identify where those best practices and best opportunities are for us. We joke in Medicaid that if you've seen one Medicaid program, you've seen one Medicaid program. That's generally true of other programs in other states, whether it's SNAP or some of the other programs that we have. But there are a lot of key similarities, and we can learn from a lot of other states. I can tell you that we do that pretty regularly, but it is a thoughtful and deliberative process for us.

RIEPE: Just seems to me, with such dominance from the federal government over Medicaid that there has to be a core similarity about programs. You can provide how they're to be provided. You know, I know that they're supposed to at least delegate to the state to run it, but I think it's probably, he who's got the gold makes the rules. And so my sense is they have a pretty heavy hand in how that's run to, but.

KEVIN BAGLEY: I think that's a, your sense is correct there. I would say part of the struggle for a lot of states is trying to exercise the level of flexibility that we need to tailor the, the programs to the needs of the people in our state, because every state is a little different,

RIEPE: Of course.

KEVIN BAGLEY: And so, it's oftentimes the struggle is trying to help the feds understand what our needs are and how we work within the requirements they have. So that's why I said there's usually no silver bullet that solves it all at the federal level, but there's definitely enough consistency that we can learn a lot from our peers in other states.

RIEPE: OK. Thank you. Thank you, Mr. Chairman.

KEVIN BAGLEY: Thanks, Senator.

HANSEN: It's a lot of programs and a lot of money.

KEVIN BAGLEY: It is, yes.

HANSEN: Can't you use like QuickBooks or Microsoft Excel to go with? [LAUGHTER] Save the taxpayers some money?

KEVIN BAGLEY: Yeah. I--

HANSEN: You don't have to answer that, it's OK. [LAUGHTER]

KEVIN BAGLEY: I would, I would, I would simply say, you will find Excel in use quite a bit. I don't think that solves all of it.

HANSEN: Any other questions? Senator Walz.

WALZ: Thank you. Thank you for being here.

KEVIN BAGLEY: Thanks, Senator.

WALZ: Always a pleasure to see you. I'm just curious, again, has, has privacy protection been a big issue here in Nebraska? I mean, are you hearing a lot of people who are concerned? Is it a--

KEVIN BAGLEY: You know, I think there's always a concern about privacy, particularly when we're talking about the vulnerable populations that we serve in DHHS.

WALZ: Mm hmm.

KEVIN BAGLEY: There's a lot of deeply personal information, whether it's, you know, related to child welfare or Medicaid or SNAP or any of those programs. So I do think privacy is a concern. I would say I've heard a lot more concern about the red tape and inefficiency that people run into in trying to navigate between our systems than I have about privacy concerns. I think we do a pretty good job with privacy. That being said, I want to make sure we're balancing those two things.

WALZ: Sure. Sure. And then the only other question I have is, I mean, it's a pretty cumbersome job, cumbersome job that you already have, you know, trying to approve people for SNAP and Medicaid, and how, how would this impact that process?

KEVIN BAGLEY: So our concern with, with the current bill and then wording that it has is really that we think that our ability to transfer information about an individual between those programs is going to be hindered. If I have to reach out and have explicit permission to share, you know, income data that I've collected on Medicaid with the SNAP folks that need it to be able to make an eligibility determination, well, that's just more red tape for a citizen. To have to say, well, didn't I just send HHS that information? Well, yes, but we need you to tell us that we can now also share it with the folks across the hall in order to make sure that these other benefits to which you're eligible can be provided. Our concern is that this puts more red tape in those at kind of the expense of, of citizens' experience.

WALZ: OK. All right. Thanks a lot.

HANSEN: Any other questions from the committee? All right. Seeing none. Thank you.

KEVIN BAGLEY: Thank you.

HANSEN: Take our next testifier in opposition. Welcome.

PAUL FASSBENDER: Thank you. Chair Hansen, members of the Health and Human Services Committee, thank you for your time today. My name is Paul Fassbender. For the records, P-a-u-l F-a-s-s-b-e-n-d-e-r. I work for a social care coordination company called Unite Us. Unite Us was founded ten years ago by two Iraq War veterans following their return from combat and their subsequent personal mission to help veterans like themselves. The company initially focused on building a coordinated care network to ensure veterans received nonmedical help that they needed. And over the years, the scope has expanded to helping all people within our communities. Those communities now span 44 different states, including here in Nebraska. Our work in the state began in 2021 and has grown to almost 500 accountable network partners, including local community partners such as United Way of the Midwest. We've assisted, our platform has assisted thousands in finding the nonmedical help that they need. We object to the current form of legislation in front of you today. This legislation will place burdensome requirements on numerous organizations that have already, had had already must comply with a myriad of federal and state privacy laws like HIPAA, 42 CFR Part 2, FERPA, VAWA, and VOCA. We do not think that platform specific legislation or regulation promotes coherent policy for, across health care partners, government partners and community organizations. It does the opposite and make it harder for people to access care. As written, the bill would impose unreasonable burdens on individuals seeking care, requiring them to retell their story to each provider they seek services from, even after they've signed a consent to share their information with providers. The bill also creates conflicting obligations for business associates that are already strictly, strictly governed by HIPAA. Unite Us prioritizes privacy and dignity of individuals seeking care at every step of their care journey. We treat all social care data like health care data, employing the same security measures required by HIPAA for all data on our platform, regardless of where it originates. We support quality, coordinated care networks that ease the burden on individuals, streamline delivery of services for organizations in accordance with each individual's expressed consent, and provide people with the temporary help they need. As written, we do not believe that LB592 accomplishes these goals. We have provided language to Senator Hardin, in which I believe each of you have seen, which will address our concerns. We'd also like to thank Senator Hardin and his legislative aide, Michael, for their willingness to discuss this legislation. I appreciate the committee's time, and I'm happy to answer any questions you all may have.

HANSEN: All right. Thank you. Are there any questions from the committee? Senator Ballard.

BALLARD: Thank you for being here. Can you expand on the platform, platform specific regulation? Can you expand on that a little bit, what you mean by that?

PAUL FASSBENDER: Well, I think some of these, some of the language of this bill directly refers to a platform where, software type platform, where consent may come into play. If we are talking strict privacy legislation, which we have no problem with, I believe we need to look at the details of what should maintain private, private. What, what disclosures that consumers should give, consent they need to sign, instead of referring, say, to a closed loop system. Other testifiers today have said the same thing when you only capture a certain part of the universe instead of the holistically, then, well, from your, your chair you may have to go back and change it. There may be new technology you need to trust, whereas privacy legislation, as is seen rarely in other states or as you all have heard about in meetings in other states, addresses the actual privacy of the individual and what needs to be private instead of mentioning the technology.

BALLARD: OK. And one more question. So a previous testifier said there's a possibility of selling data. Can you, can you address that?

PAUL FASSBENDER: We don't sell individuals' data off our platform, so I don't know what that's referencing. We have absolutely no problem with that provision in the bill.

BALLARD: OK. And, you know, are other--

PAUL FASSBENDER: I don't know.

BALLARD: OK. It's just curiosity that--

PAUL FASSBENDER: I can only speak from our company's point of view and I don't, I don't know.

BALLARD: OK. Thank you.

PAUL FASSBENDER: Yeah. Thank you, Senator.

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

RIEPE: Thank you. I'm looking at this, and it's, since you're a vendor, is that right?

PAUL FASSBENDER: Yes, sir.

RIEPE: My question is, how do you get paid?

PAUL FASSBENDER: Our payor in this state is CyncHealth.

RIEPE: OK. OK. That makes the connection there.

PAUL FASSBENDER: Yes.

RIEPE: It almost looks to me, having not long to look at it, it almost looks to me like you're the, quote, unquote, middleman here in the deal. And honestly, you know, as business people, known as legislators, we're always trying to eliminate, whether it's the pharmacy, middleman or if it's any other middlemen. Excuse me for the gender specific reference here, middleman, middle person. And I see you're in the nonmedical. What is--

PAUL FASSBENDER: That's the social care infrastructure, yes, sir.

RIEPE: OK. Well, that would explain why it came to this, this committee. That said who, who, who vets you to-- is that up to the-- who would vet your company to say, you know what they say is what they do?

PAUL FASSBENDER: Oh, it depends. It depends on the partners. You know, when you look at across the United States, we partner with states like the state of Florida, state of Georgia, state of North Carolina. We also partner with large organizations. And here in this state, Charles Drew; CHI Health or to, obviously United Way of Midlands; Together, Incorporated; Saint Vincent de Paul; Tri-City Food Pantry. We, we partner with those organizations. One of the reasons I said earlier in my testimony that we keep at HIPAA standards is because we partner with a lot of large health care organizations that require those standards. So when you look at states, when you look at health care organizations, they require those standards. They pressure test us internally as a organization. We are third-party certified. I get to do the acronym so forgive me if I mess, mess that up, but SOC 2, HITRUST, in this certifying. These are third-party solutions that assess the privacy on your platform to make sure you're up to code and standards. And we also publish everything as far as our privacy standard online.

RIEPE: OK. I heard you talk about the Drew clinic and so where you started us out on medical, you're now--

PAUL FASSBENDER: Well, we connect.

RIEPE: --that was the first chapter of your--

PAUL FASSBENDER: Well, no, and that's, that is true. We do not, obviously we do not have, we do not have the services, medical services on our platform. They can connect to our platform. So classic example, if I, if I'm going into an emergency room, say, and the doctor will always ask, hey, how's things going, other than what you came in for? And, you know, if I say it was an I. I'm having an issue with food stability or I'm afraid my family, we may lose our house. If they're on our network, they can refer out. So they can refer to organizations that may be able to provide food or temporary housing. When you look at before this technology came up, it was a pamphlet. I mean, I used to be a staffer and we'd get calls all the time and have your little list of, of charities that you can refer to, but you never knew if that was answered or not. With our platform, we know, and in Nebraska, within four days, 80 percent of the people referred or helped, answered to help within four days. And if we don't see that, we help close that loop, which is a pretty big stride to getting people help they need and also utilizing the resources that are out there in the community for this sort of thing. Because at the end of the day, it does help bring medical costs down. If you can get people to help they need in the communities where they live, they may not go to the emergency room.

RIEPE: We hear that quite frequently in the wrong, in the long way. In the long term, it's a pay off, but I'm still not convinced how long that long term is, you know, generational or one, wherever it is. But that's a whole another, that's a whole another meeting, which I would have more comments on. But thank you, Mr. Chairman.

HANSEN: Any other questions from the committee? All right. Seeing none. Thank you.

PAUL FASSBENDER: Thank you.

HANSEN: Is there anybody else wishing to testify in opposition to LB592? All right. Seeing none. Is there anybody who wish to testify in a neutral capacity? All right. Seeing none. We will welcome up Senator Hardin to close.

HARDIN: Thank you, Chairman Hansen and the committee. I think like many of the bills that we get to see in this committee, I would say, oh, half of them, this is what I would put into the fixer-upper category, and I think it does need that. I again, I think the debate about this amount of information is important. Ezekiel Emanuel is someone who is known as a venture capitalist. He's heavily involved in this arena. And I think that's an important thing to point out, because his organization testified here today. And I think that there's an enormous financial move to be made about this strata of data. And so the question with LB592 in my mind, given amendments that I think need to be made with it, is if not now, when? Because this pile of data is not going to get smaller, it's going to get larger and it's going to get exponentially larger faster. So states everywhere are going to have to decide how we're going to treat all of this information. It falls under the threshold of PHI, and yet it's still very precious. So it falls to our stewardship to help guide what happens with it. And so I'm very open to everyone that has testified on all sides of this. We would really, I think that there are the brilliant minds in this room, not somewhere else, in this room, who can help bring together the ideas in order to come out with meaningful solutions for this. So I look forward to talking more with those on the pro-side and the con-side and no one was here in the neutral, but I look forward to working with everyone to make, sharpen the pencil and make this as strong as we can make it to protect Nebraskans.

HANSEN: Thank you. Are there any questions from the committee? Are some of those brilliant minds on this side of the table too?

HARDIN: They're mostly out here.

HANSEN: That's OK, but thank you.

HARDIN: Thank you.

HANSEN: All right. Thank you for that. And that will close our hearing for LB592. And now we'll move on to LB680.

LILLIAN BUTLER-HALE: Hi. You may notice I'm not Senator Day.

HANSEN: Yeah, just noticed that. Yeah.

LILLIAN BUTLER-HALE: Yep. So good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Lillian Butler-Hale. That's L-i-l-l-i-a-n B-u-t-l-e-r-H-a-l-e, and I work for Senator Day and I'll be reading her testimony into the record today. I'm here this afternoon to introduce LB680, which would update Nebraska's Parkinson registry in a way that would streamline the registry and utilize modern technology. The Nebraska Parkinson's Disease Registry was established in 1996 and made Nebraska the first state in the nation to create a registry for the purpose of tracking certain Parkinson's patient data for research purposes. Information such as gender, date of birth, current address and address at time of diagnosis, date of diagnosis, the reporting source, and any additional information in the department-- information the department deems necessary is collected to create a picture of Parkinson's disease in Nebraska. Approximately, 700 Nebraskans are diagnosed with Parkinson's disease each year, and since data collection began in 1997, nearly 14,000 patients have been added to the registry. Under current state law, physicians are required to report to DHHS patients with a diagnosis of Parkinson's disease, and pharmacists are required to report any medication on the reportable list of drugs. Individuals diagnosed with Parkinson's disease may also self report. The department also has a Parkinson's Disease Registry advisory committee that meets annually to review the state of the registry, update any medications on the list of reportable drugs, and discuss other related issues. Since 1996, there have not been great improvements to the registry, and in that time, the knowledge of Parkinson's disease has progressed in a way that the information collected is no longer as relevant to current research as it once was. As a result, in working with stakeholders, we learned that although there is great interest in Parkinson's as a field of research, UNMC researchers have not pulled data from the current registry in years. Now, this is not to say that the Parkinson's registry is not an extremely useful tool. With minor tweaks, the registry can keep Nebraska at the forefront of research, helping the nearly 14,000 Nebraskans that are currently in the registry. Fortunately, there has been broad recognition that the registry is a valuable resource for, for doctors, patients, and researchers. And Governor Pillen has requested additional funding beyond LB680 in the budget. While the changes in LB680 would run parallel to the appropriation's request, we believe these changes could enhance the registry and complement the funding in a way that creates the most value for Nebraskans. We wrote LB680 with the idea that we don't need to reinvent the wheel and the bill utilizes our state's current health infrastructure, including the existing state Health Information Exchange and the Prescription Drug Monitoring Program. Allowing use of the state Health Information Exchange makes it easier for doctors to satisfy existing requirements of the registry and should encourage greater participation. The bill also helps to eliminate some duplicative reporting. Those physicians under the Health Information Exchange, already can use that participation to fulfill their registry reporting duties. For those physicians who do not already use the Health Information Exchange, they will continue to report to the registry as usual as the department dictates. Additionally, as part of LB680, pharmacists will no longer be required to separately report prescriptions as all prescription drug information already goes through the Prescription Drug Monitoring Program. In addition to the registry updates, LB680 would create a public website which would post broad summary data of the Parkinson's Registry in Nebraska, allowing the Legislature and general public greater access to trend data. I know that minor tweaks in our state's Parkinson's registry will not be the most dramatic bill brought this session. However, for certain families in the state, this is incredibly important. When a loved one has a condition like this, you want the place they loved to be one where they have access to the best possible care. So much of what we deal with in the Legislature changes things on the margins but when it's a loved one that is sick you're willing to give up everything for even that minor improvement, delayed onset, or better quality of life. So it's my hope that we can look at this really small fiscal note and make these changes that stakeholders tell us will enhance Parkinson's research in Nebraska and keep us as a state where this groundbreaking work is happening. Thank you.

HANSEN: All right. Thank you. And as is customary, we won't be asking you any questions.

LILLIAN BUTLER-HALE: That's OK. I'm fine with that. OK.

HANSEN: We'll have you waive closing, too, then.

LILLIAN BUTLER-HALE: Yes. Thank you.

HANSEN: All right. OK. So with that, we'll take our first testifier. Let me see, can anybody raise their hands who's testifying on this bill? OK. All right. We'll take our first testifier in support of LB680, please.

JULIA PITCHER: Do you mind? This is not a prop.

HANSEN: OK.

JULIA PITCHER: Thank you.

HANSEN: So you're not going to throw it at us or anything?

JULIA PITCHER: Absolutely not. Good afternoon, Mr. Chairman and members of the committee. My name is Julia Pitcher. For the record, that's J-u-l-i-a P-i-t-c-h-e-r, just like in baseball, and I am with the Michael J. Fox Foundation for Parkinson's Research, the director of state government relations. And I almost just want to say thank you very much for having me, because Lillian just did such an incredible job on behalf of Senator Day today. So I hope you got a chance to hear all that because I'm going to change my testimony now because I was going to say the same thing. For those of you before the election in the fall, I was here and had a absolute pleasure to speak before this committee on an interim study on the Parkinson's Registry showing that it has been severely underfunded for many years. It is a legacy registry and we are hoping to make it the exclusive registry that we can see as a model going forward. And when I was here, I had the opportunity to meet with CyncHealth and start to talk about how data is already collected and innovatively done for all patients in Nebraska, as well as other HIEs across the state. Apologies across the country. This led the Michael J. Fox Foundation to have a, what we call, a data summit in November in which the Nebraska Registry directors also attended. We had members of the CDC as well there. And in that registry summit it was so important that we have now just published as of this week-- which I will get you all a copy, it's being bound right now, it's about 42 pages-- of the reason that patient data collection is so important. And you just heard about this, the last two bills of privacy, patient data collection, innovation, this is all related in that. And so the reason that we are here today is because the Nebraska Registry is first in the nation, we would like it to stay first in the nation because this model that we're going forward with in this bill to allow CyncHealth to, or the state's HIE entity, to take the data that is already being collected that is much more robust and comprehensive than what is currently in statute, just based on the pharmacy codes, will be so much more clear for researchers. Because as we go along and update more and bring online more registries in different states, you can see by the handout we are currently active in nine states with legislation that is just like this in this legislative session. And the goal is to then go back to the CDC so that they can, you know, for lack of a better term, flip the switch so that at that point in time the data that is not only going to be helpful and beneficial to the people of Nebraska, it will also be beneficial to researchers across the country. It could be NIH, Johns Hopkins, UCLA, looking for patterns and reasons that we're working towards better therapies and ultimately a cure. And we're also looking at, researchers are looking at things that are called biomarkers. I'm not sure if there's a bill in this session right now, but across the country, we're working closely with the American Cancer Society and other organizations on biomarkers to test for disease states before progression has even started. And the science is moving so quickly, and that is one of the reasons why we wanted to be here today. Just a couple of numbers before I finish, the Michael J. Fox Foundation, as well as the Parkinson's Foundation, co-funded a study that estimates that we are now at 90,000 people per year being diagnosed with Parkinson's in well over 120,000 veterans. This is increasing. We are now the fastest growing neurodegenerative disease and disorder right at-- right behind Alzheimer's and we need to know why. And registries like this will help us look at various patterns in states, including geographic clusters or exposures to environmental exposures. And these registries can give us a real-world view of clinical practice. I'll also like to bolster the goal of feeding the states data that will go into the CDC with thanking the Governor for putting in a significant amount in the budget. We are hoping to preserve that going forward. We think that that's going to take us from paper, as you heard, paper to electronics, and then be able to go further than that in the future. Last, I'm a little bit dismayed that the department put in a fiscal note on this bill as the Michael J. Fox Foundation over the last six months has worked very hard with the department. We have just executed a contract as of February 1, February 1 for $150,000 from the Foundation as a grant to help keep the lights on for the registry. So we are very confused as to why there is even any fiscal note whatsoever. Also, we were not anticipating that the Governor was going to put any money in the budget so we're thrilled for that and we believe that that would negate any fiscal impact that this bill would have other than bringing it into modern day. And with that, I will close and thank you so much for having me and happy to answer any questions.

HANSEN: All right. Thank you. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Senator Hansen. Have, have you found that this is geographically directed? I know there are some literature out there that talks about Parkinson's as a result of Roundup and other kinds of fertilizers?

JULIA PITCHER: We are looking into that, our researchers are studying that now. We do think that there are some neurological connections with exposures to various toxins like Roundup or Paraquat. These types of registries will also let us see if there are clusters like that in the state based on drift or if you've worked in areas and it will also help with clinical studies with patient contact studies. So yes, there are, there are reasons that we're looking into.

RIEPE: You have been, number one, the first one out in 1996, and it took others quite a long time to, to catch onto the idea.

JULIA PITCHER: You bet.

RIEPE: My, my question to that would be is, what contributions have you been able to make as an organization to the body of knowledge since that time to Parkinson's?

JULIA PITCHER: Based on the Nebraska Registry or--

RIEPE: As the-- I think the registries are generally for the benefit of researchers.

JULIA PITCHER: Yes.

RIEPE: Have those researchers used that information that you've collected since 1996?

JULIA PITCHER: Well, as Miss Lillian mentioned earlier, on behalf of Senator Day, the local universities are not pulling the data because it's so outdated and not well collected. One of the reasons Nebraska's data also needs heavy overhaul is because it's coming from pharmacy codes. Not every Parkinson's patient is on a medication targeted for

Parkinson's. You may have some nonmotor Parkinsonisms and you may be on an insomnia medication or something for restless legs, and that would not be captured in its current form. But if you are under the HIE, you're already being collected as a diagnostic code that you have Parkinson's whether or not you're taking that medication or not. Does that make sense? So you're going to get it better.

RIEPE: How can you improve on that or can you? I mean, just so that-- you build a new system that captures yesterday's information, but if it's-- wasn't addressing it yesterday, how's it going to address it into the future, these converging thoughts and directions? It seems like pharmaceuticals and [INAUDIBLE] that are a scatter board.

JULIA PITCHER: I-- I'm not entirely sure what you're asking.

RIEPE: Well, I think you were saying that they-- the way I heard it was they haven't, they haven't made much contribution to the literature because it's different pharmaceutical medications are used and, and so I'm kind of going then, you know, what do you bring to the table that makes it worthy of other than a report?

JULIA PITCHER: Oh, now, I understand. Thank you, Senator. So at the time, the, the Nebraska Registry, much to my dismay, is, is, is pretty much useless. And at this point in time, going forward, using the HIE from the state and taking the data that's already there, collecting it and doing a report for the state will also allow the CDC, as we turn the lights on, so to speak, with Congress and move that data to a full hub which is known as the National Neurological Conditions Surveillance System that already exists for Parkinson's and MS. So the goal is to have multiple states sending their patient data, just like Nebraska will once this bill passes and with the appropriation to change the technology. We're not building a new system. We're going to take the data that's already collected in a more modern way and send it to the department for, for Nebraskans. And then that information from the department will go up to the CDC, as will we in other states so that then researchers can do more. It's--

RIEPE: But if, but if I heard you right, you are contracting with CyncHealth to build a system?

JULIA PITCHER: No, we are not. Michael J. Fox Foundation has given the state of Nebraska Department of Health and Human Services money to give them some technological assistance. CyncHealth is already the state's HIE's system.

RIEPE: Yes, that I am aware of.

JULIA PITCHER: Right. So their data-- we're not contracting--

RIEPE: Also, you're, you're working under an existing agreement with CyncHealth, not a new agreement.

JULIA PITCHER: We don't have an agreement with them, the Fox Foundation. No, no, no. We're just here to support statute to allow whatever state HIE is around for your state to allow that data to flow to the department.

RIEPE: OK.

JULIA PITCHER: Does that make sense?

RIEPE: Yes, it does. Thank you.

JULIA PITCHER: You're welcome. Thank you.

RIEPE: Thank you, Vice Chair.

HARDIN: Very good. Any other questions? Senator Ballard.

BALLARD: Thank you for being here. You mentioned the fiscal note. Why, why would the department require an epidemiologist?

JULIA PITCHER: I cannot answer that question. I said the same thing when I read it earlier. I'm not sure.

BALLARD: Thank you. All right. Appreciate it. Thank you, Vice Chair.

HARDIN: I have a question or two.

JULIA PITCHER: Yes, sir.

HARDIN: And forgive me because you were not privy to this. We were discussing some things in the hallway for my own benefit earlier today. I was wondering if you might share just a big picture some of how this disconnectedness works. There's information available about Parkinson's. It doesn't seem to be gathered anywhere in a meaningful way, not only in our own state, but it sounds like across the country. Can you just speak again for a moment on the need to tie this together so that we can learn about how to fight this disease, battle this disease, and that there is a lot of information just kind of skating around out there that's not being aggregated?

JULIA PITCHER: Thank you. I actually did not plant this question, but this is actually the, the reason why the Michael J. Fox Foundation has actually started an org-- an advocacy shop. We now have a federal and state legislative program. We are the only organization in Parkinson's that is now actively active in Congress, as well as states, doing legislative advocacy. There has not been an increase in federal funding for research on Parkinson's in more than 25 years. NIH only funds about $180 million over the course of the last 22 years since the existence of the Michael J. Fox Foundation. We have funded $1.5 billion globally. In 2024, our estimates are that we are going to fund around $300 million in scientific research grants. So having registries, polling data, streamlining it across states, because states are not going to talk, every state is going to have their own type of registry. We're hoping it's going to be similar. And our model is now this HIE track, which is what we're calling it, so that we can do better research as we go because the government has not spent money on this or has been interested in it in many, many years. One of the other things on a federal plan and one of the reasons why other disease states, and I will use Alzheimer's as an example, has received about $3.7 billion over the last ten years from the federal government is they put into place what's called a national plan to end Alzheimer's. And we are now going to be doing the same thing. We're going to be working with the federal government to pull federal agencies together and say this is the second fastest growing neurodegenerative disorder with no cure in sight, can we please partner as a charitable foundation and the federal government and then states' governments. And what can states do? We can create research funds. We can incentivize universities. A registry like this that is more accessible and with better robust data could allow the local universities to access it for better or, you know, across state lines. I don't know what will be used. I'm not in the, the academic world for that, but that's the idea is to bring more value and awareness to the fact that Parkinson's is growing and we do not know why and we would like more to be done on the local level.

HARDIN: Thank you.

JULIA PITCHER: You're welcome.

HARDIN: Any other questions? Seeing none, thank you.

JULIA PITCHER: Thank you for having me. Appreciate it.

HARDIN: Any other testifiers? Welcome.

MARCIA MUETING: Good afternoon. It's just another day in paradise.

HARDIN: It is a snowy day at that.

MARCIA MUETING: Members of the Health and Human Services Committee, my name is Marcia, M-a-r-c-i-a, Mueting, M-u-e-t-i-n-g, and I submit this testimony as a pharmacist and the CEO for the Nebraska Pharmacists Association. We are in support of LB680. The Nebraska Pharmacists Association has been a partner in the Parkinson's Disease Registry since its inception. Currently, 459 pharmacies across Nebraska submit a report through a very manual process to the registry twice a year. This bill will remove the burden on pharmacies of preparing and sending this report to DHHS and improve efficiencies not only in the pharmacies but at DHHS. Nebraska pharmacies are reporting, at least daily, all dispensed medications to the Prescription Drug Monitoring Program. We're grateful to Senator Day for introducing this bill, which will allow our Prescription Drug Monitoring Program to communicate directly with the Parkinson's Disease Registry and remove the need for pharmacies to submit these reports. The NPA would respectfully request that the committee advance LB680 for further consideration by the full Legislature and I'd be happy to answer any questions.

HARDIN: Thank you. Any questions? Are there any special considerations as a pharmacist that you have to give to these medicines related to this condition compared to others? Any special care, like, for example, bio-injectables and those kinds of things, refrigerants, that kind of thing that takes place for these medicines?

MARCIA MUETING: No, there aren't any medications on the reportable list of drugs. There's a list of drugs which at pharmacies if you have a patient that is on these drugs, then you have to further evaluate. Some of the medications that are on the list, most of them have been taken off. But there, there is a possibility that someone would be taking a medication on the list that is not for Parkinson's. That's where the second step of the registry comes in is confirming the diagnosis with the prescriber.

HARDIN: I see. Very well. Thank you.

MARCIA MUETING: Sure.

HARDIN: No other questions? Thanks so much.

MARCIA MUETING: Thank you.

HARDIN: Any other testifiers as a proponent for LB680? Welcome.

MELANIE SURVER: Hello. Good afternoon, Chairperson Hansen and committee members. My name is Melanie Surver, M-e-l-a-n-i-e, Surver, S-u-r-v-e-r, and I am the chief program officer at CyncHealth, which is the organization designated in the state of Nebraska as a statewide Health Information Exchange and the administrator of the Prescription Drug Monitoring Program known as the PDMP. I'm here today to testify on behalf of CyncHealth in support of LB680. With the incredible developments we've been seeing in health information technology and the ever increasing use of technologies, health information can now move safely, securely, and quickly to where it can be used for those who are authorized to receive it. That is to providers receiving and giving care, to patients participating in their own wellness, and to national and state public health agencies tracking diseases for the health and safety of our communities. We are all well aware of the importance of accurate and timely reporting of public health information, especially following the public health emergency of recent years. However, the current system for collecting and reporting information on individuals with Parkinson's disease is burdensome and prone to error to the way the data is reported. This can introduce-- or excuse me, this can include manual entry, spreadsheets, and in some cases, even still faxing reports. By requiring the registry to source its data from the state's Health Information Exchange, we can ensure that the information is accurate, up to date, and that the public health has access to the information they need to make informed decisions. CyncHealth already offers several public health reporting connections such as electronic lab reporting, immunization reporting, and syndromic surveillance. Once the data feed is set up for the reporting, the provider organization can basically set it and forget it. The necessary reporting data is transmitted in real time and sent to the registry. By using Nebraska's established information sharing network and the reporting functionality that is already in place, this will help to eliminate many of the issues associated with the current system, such as the inaccuracies that can come from manual data entry, the burden of reporting on our providers, and the lack of modern information technology and data systems. There are a few clarifications that we would like to see in this bill. Number one, the Parkinson's Registry should source its data from the Health Information Exchange and PDMP, as opposed to requiring any physician to complete additional forms. This is burdensome, causes delay and accuracy of reporting, and is unnecessary for the information that is already available in the HIE and PDMP that can be leveraged for this purpose. And second, the bill states a data with or without identifier shall be made available to researchers. These data requests would also need to go through the already established data governance process within CyncHealth Nebraska and Nebraska's Health Information Technology Board. This approves and provides the governance and oversight of the data within the HIE and the PDMP. CyncHealth supports this bill and its goal of improving quality of care for individuals with Parkinson's disease and the potential benefit that this data can provide in the Parkinson's research. We strongly recommend amending this bill to require the registry to source the data directly supplied in the Health Information Exchange and PDMP. Thank you for your time today. I'm happy to answer any questions.

HARDIN: Thank you. Any questions? Seeing none, thank you so much.

MELANIE SURVER: Thank you.

HARDIN: Anyone else in favor of LB680? Seeing none of those, anyone in opposition to LB680? No one in opposition. Is there anyone in the neutral for LB680? Welcome again.

PAUL HENDERSON: Thank you. My name is Paul Henderson, P-a-u-l H-e-n-d-e-r-s-o-n, testifying on behalf of the Nebraska Medical Association in a neutral capacity on LB680, but supportive of the goals of increasing the data flowing into the registry and of finding a way to make that less burdensome on physicians. We appreciate that. We're neutral because in reviewing the bill with some of our members, they had some technical questions and concerns about some of the language, and we just appreciate the opportunity to work through those with the proponents of the bill before it advances from committee. And let me just briefly-- like at the bottom of page 3, there are some new fields of data that would be reported, and some of our members expressed concern that it may not be possible to report all of that within the time frame specified by the bill. There are some other provisions, I think, that are getting at that data, facilitating that data flowing into the-- from the HIE into the registry, and they just want to make sure that they understand those and how that would impact their practices. So we have reached out to the proponents and they've expressed that they're very willing to talk with us and work through these questions and we appreciate that. So we will do our best to do that as quickly as possible so we're not holding things up.

HANSEN: All right. Thank you. Again, any extremely difficult questions? Nothing. All right. Thanks.

PAUL HENDERSON: Thank you.

HANSEN: All right. Is there anybody else wishing to testify in support of LB680? I meant neutral. All right, seeing none. Since the primary introducer is not here, we will waive closing. And we do have three letters in support for LB680 and one in the neutral capacity. So with that, we will close the hearing on LB680 and move onto the last one of the day, LB358, and welcome Senator Walz to open.

WALZ: All right, last but not least. Good afternoon, 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. I proudly represent District 15, which is made up of Dodge County and Valley. Today, I'm introducing an incredibly important piece of legislation, LB358, which is a bill to increase Medicaid reimbursement rates by 25 cent-- 25 percent for dental procedures. Over the interim, a, a constituent from my district reached out and shared her story about the difficulties that herself and her child were having finding a dentist that would accept individuals on Medicaid. She described that her daughter needed a dental procedure done and was referred to a dentist in February of last year. She was told that they were not accepting new Medicaid patients until August and that she would have to call back on August 1 because it's a-- it's first come first serve. Oftentimes, my constituents have to go to Omaha or Lincoln to receive treatment. But even still, they have long wait times. Right now, nearly 20 percent of Nebraskans are on Medicaid and one in four children are. The story that was shared with me was just one. There are hundreds, if not thousands of more stories that are almost identical. Dentists right now are not accepting Medicaid patients, and frankly, it's no fault of their own. The estimate that was given to me is that there is typically a 60 to 70 percent overhead when dentists accept Medicaid patients. At the end of the day, dentists are running a business and they need to keep their doors open to help other patients, which is why I believe it's our duty as state senators to step in. One dentist that submitted a public comment said that he's always felt that accepting Medicaid patients was a civic responsibility. At the end of the day, many, many individuals on Medicaid are children. Ironically, this is National Children's Dental Health Month. One of the most common chronic childhood illnesses in the U.S. is tooth decay. Early childhood tooth decay has been connected to impaired development, low educational performance, poor behavior, family stress, diminished quality of life, and can be even lead to disabilities. For adults, poor dental health can cause employment issues, mental health problems, impaired speech, and other health problems like heart attack, stroke, or dementia. People on Medicaid are already struggling to get by day-- to get by day to day, but compounding factors like poor dental health makes life even harder. We need, we need to ensure that people on Medicaid are able to confidently walk into a job interview and that children are able to feel comfortable at school and overall live healthy lives. After introducing this bill, there has been an outpouring of support from our dental community. So many dentists and dental students want to accept Medicaid patients. They truly see this as giving back to the community that they're in. In addition to the dental community, local boards of health, emergency room physicians, local health directors, pediatricians, ESUs, and NACO have all shown their support for this bill. There's been support from all over the state, too, from Gering to Ord to Pender. This support on the bill has really shown how important dental health is to Nebraskans, our children, and our disabled community. I did want to share a story that was sent to me by Ryan Hemsley, a resident dentist specializing in pediatric dentistry that wants to take practice-- that wants to start practice in Fremont. Unfortunately, he was unable to make it today, but shared his testimony with me. Ryan is a Nebraskan through and through. Unfortunately, he had to make the difficult decision to go to the University of Iowa to pursue his degree. A majority of patients that he sees in his residency program are Medicaid patients, which he said he has a waitlist of up to six months. Since he is a student and has two kids, he and his family are on Medicaid, and he shared that he can't imagine the idea of having his child's cavities taking months to treat. Ryan feels that because he has been on Medicaid that he should accept Medicaid patients. But the unfortunate reality is that current reimbursement rates are so low that practices have a hard time justifying accepting too many Medicaid patients. He wanted to end his testimony with this thought, and I think he says it best. As a Nebraska football fan, I've been following the new coaching staff closely. Their current actions have shown an emphasis on keeping the Nebraska talent in Nebraska. Why? I believe this is because for those fortunate enough to call Nebraska home, being able to stay home and give back to the community that made you will always be more rewarding than doing the same things elsewhere, and those individuals are more likely to stay in the long term. Nebraska is my home. I have a passion for treating the children in my community who need the most help. Increasing Medicaid reimbursements would help make it easier to allow individuals such as myself to come back, invest in the community, and stay in Nebraska. And with that, I would be happy to try and answer any questions.

HANSEN: All right. Thank you for that wonderful opening. That was really good.

WALZ: Thank you.

HANSEN: Thank you.

WALZ: No, thank you.

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

RIEPE: Senator Hansen, thank you. When you started talking about the football, I thought he was going to the, the salaries paid to the coaching staff. I'm trying to relate that back to payment to dentists. I think you said in your opening statement, what percentage of Nebraskans are on Medicaid?

WALZ: Oh, hold on a second. Twenty percent of Nebraskans are on Medicaid--

RIEPE: Twenty percent, and is--

WALZ: --and one in four children.

RIEPE: One in four what?

WALZ: Children.

RIEPE: One in four children. OK. OK. Do you know if that's a special program? If someone is eligible for Medicaid, they automatically become eligible for dental? I don't know that. I just--

WALZ: Ask somebody--

RIEPE: We'll ask somebody else. OK. The other question is, when's the last time that they-- do you know the last time they did an increase for the dental fees? OK. And then my question will be-- and maybe this will be something we pass along, too, that--

WALZ: Yeah.

RIEPE: --you know, I'm just kind of curious whether they-- why they landed on the 25 percent increase as opposed to, you know, 30, 50--

WALZ: Right.

RIEPE: --or whatever?

WALZ: Yeah, I think that they will be able to answer that better than I can.

RIEPE: OK. And I also-- the other one, and then I'll ask you if you found your glasses, but-- or did you borrow some?

WALZ: No, they're mine.

RIEPE: Oh, OK. For the crowd, she couldn't find her glasses this morning at no fault of her own. Is dental-- Creighton dental school-- usually dental schools have special programs.

WALZ: Yeah, I'm very aware of that special program.

RIEPE: Do they still get with their budgets backed up and booked up?

WALZ: What?

RIEPE: Do you do if they're backed-- I mean, they're overwhelmed, are they, too?

WALZ: I don't know for sure.

RIEPE: I hear-- see heads going yes.

WALZ: OK.

RIEPE: So I assume that's true if--

WALZ: Yep. I used to go to Creighton--

RIEPE: --[INAUDIBLE] Nebraska.

WALZ: --to get my dental work done when I was little, so I'm pretty aware of the, the program.

RIEPE: OK. Well, thank you.

WALZ: Yeah, thank you.

RIEPE: Thank you, Mr. Chairman.

HANSEN: Any other questions? Yes, Senator Hardin.

HARDIN: Do you know approximately how many dentists out of 10 or out of 100 allow or serve Medicaid dental needs?

WALZ: Oh, I don't know if I have the-- yeah, you're going to have to ask them. I'm sorry. I had a great opening, though.

HARDIN: You did.

HANSEN: It was.

RIEPE: You want a copy of the recording?

HANSEN: I, I have a couple questions that maybe some behind you can, can answer. I was curious to know how we compare to other like states? Like, they're similar size, like the Midwest?

WALZ: Yeah.

HANSEN: Kind of curious to what our rates compare to theirs. And I noticed you didn't have an effective date on your-- in your bill. Do you need to put an effective date on there? Does that matter? Like, starting effective--

WALZ: Immediately. Yeah. OK.

HANSEN: All right.

WALZ: We'll work on that.

HANSEN: OK. All right.

WALZ: Is there anything else?

HANSEN: Seeing none,--

WALZ: OK.

HANSEN: --thank you. All right. We'll take our first tes-- how many people-- if they could put their hands that are testifying on this bill? OK. We will, we'll cut down the amount. We'll go down to four minutes. I know it seems a little unfair, but we have a lot of testifiers so we can kind of get through so it's not too late. So we'll just go down to four minutes. And--

JESSICA MEESKE: Ready?

HANSEN: --ready whenever you are. Yep.

JESSICA MEESKE: All right. I'll talk fast. Good afternoon. My name is Jessica Meeske, spelled J-e-s-s-i-c-a M-e-e-s-k-e, and I currently serve as the Nebraska Dental Association's vice president. I'm a pediatric dentist and I have practices in Hastings, Grand Island, Omaha, and North Platte. And about half of all the kids we serve are on Medicaid. These are primarily the very young, those with severe dental, medical, or behavioral issues. For over 40 years, our practice has been highly engaged in caring for kids with Medicaid. But for the first time, we're having to reconsider our commitment to the program and the families due to the high volume of calls. I never thought we'd be faced with this decision. Our dental Medicaid program is in real crisis. The number of people with Medicaid is going up, and the number of dentists willing to see them is going down, and it creates the perfect storm. While access to dental care for children with Medicaid continues to improve in our state, which is a good thing, the adult situation, and particularly our seniors, it's getting worse. Only 12 percent of adults with Medicaid in 2022 received any dental visit, preventive or emergency. And, yet, we know adults with Medicaid who are able to get in to see a dentist are more likely to take their children to the dentist. Low-income families in Nebraska who rely on Medicaid are unable to get needed dental-- when they're unable to get needed dental care it creates inequities in our state. For example, we know that children with unmet dental needs miss far more school than their peers with private insurance, and children who are black and Hispanic experience more tooth decay than their non-Hispanic white peers. So no matter how you vote on these really important education bills this year, and I'm a former school board president, it doesn't matter what you do if you have kids living in pain, going to school with toothaches, they can't learn. Currently, I serve on the ADA's Medicaid reform task force, and we're looking at innovative ways to help solve the dental Medicaid problems and access. We know you have to balance access, quality, and cost efficiency. It has to work for the patients and it has to work for the dentist. However, the fundamental issue is that you have to be able to cover your costs to provide that care. You have to consider the laws of supply and demand and market forces that can't be ignored. I've also had the pleasure of working closely with the Medicaid Director Kevin Bagley and his team. They're committed as well to improving dental access, and they've made several really great policy changes that have demonstrated the state's willingness to make things better. The request for the fee increase would still make Medicaid our lowest payer, but at least it would allow us to increase our capacity to see those kids, maybe keep more kids out of the operating room who have severe needs. It's been shown in other states that when low-income adults can achieve good oral health, they're more likely to apply for jobs. They're more likely to seek a promotion. And the result over time is more adults with better employment and better wages. Besides going off unemployment, they're going to more likely go off of Medicaid as well as other government programs. Access to dental care empowers Medicaid participants to work and move towards economic self-sufficiency, and we know that some adults will only be able to work part time or not at all due to disability. But they, too, deserve good care. One thing we know is a lot of adults miss work due to dental disease. Therefore, dental Medicaid is a good investment for the state of Nebraska small businesses who may not be offering benefits, but they need workers to fill their jobs. Thank you for considering this important issue.

HANSEN: Thank you for your testimony.

JESSICA MEESKE: Thank you.

HANSEN: Are there any questions from the committee? Senator Hardin.

HARDIN: Same question as earlier. Do you know about how-- what percentage of dentists are honoring Medicaid?

JESSICA MEESKE: I do. So about half of the dentists in the state take Medicaid. But what's really important to know is what percent do they see in their office? So, in other words, if you have a dentist who sees Medicaid and they only saw one Medicaid patient in the last fiscal year they're counted as a provider, where in a lot of practices we see hundreds and hundreds of kids or some practices see hundreds of adults. So the issue becomes for those of us that have made a commitment to do this but we're having to cut it off and make tough decisions, we've already figured out a lot of how to do this and help these patients. And so for those practices, it would increase the capacity. And I think for our new dentists, it would be more enticing for them to try to include Medicaid in their practice. But we know not every dentist is going to change their mind.

HARDIN: OK. If I can follow up?

HANSEN: Yep.

HARDIN: Did you say that about half of your patients are Medicaid?

JESSICA MEESKE: Correct.

HARDIN: OK. What will happen to your practices if this doesn't pass?

JESSICA MEESKE: Yeah. So our practice, what we have already had to do is we've had to triage patients based on very young age, those with the severest dental disease, medical conditions, etcetera. And then what we're doing is we're having to move the older, healthy children out of our practice to see a general dentist so we can just make the spots to see the kids with the worst disease and we can't find anywhere to transfer them to. And it's often 20 phone calls and a parent or a foster parent or a grandparent who's sitting in front of you saying I can't believe this is going to be so hard to find another place for my kids to go. So it's just we're just in dire straits and it's all across the state.

HARDIN: Thank you.

JESSICA MEESKE: Um-hum.

HANSEN: Senator Riepe.

RIEPE: Thank you, Senator Hansen. Welcome back. I, I remember--

JESSICA MEESKE: Nice to see you again.

RIEPE: --you have-- it's been some time, but good to see you--

JESSICA MEESKE: Thank you.

RIEPE: --and I've always admired your commitment to, to Medicaid and to children.

JESSICA MEESKE: Thank you.

RIEPE: My question is this. Do you have an idea what the percentage of commercial health insurance plans provided for children's dental--

JESSICA MEESKE: We do.

RIEPE: --services? Like, behavioral has sometimes been the forgotten orphan, if you will, on health plans.

JESSICA MEESKE: So is your question how does reimbursement for Medicare-- Medicaid compare to commercial?

RIEPE: Well, I'm just curious how many kids have dental? And I don't mean just cleaning and--

JESSICA MEESKE: Yeah.

RIEPE: --because some programs only provide-- and they call it a health/dental plan--

JESSICA MEESKE: Um-hum.

RIEPE: --but it doesn't provide anything very serious. I'm just questioning where commercial is at on this.

JESSICA MEESKE: So what we-- I don't know how many kids in the state have commercial dental insurance. I can tell you in our practice. So about half the kids we see have Medicaid and maybe another 30 to 40 percent have commercial dental plans and then maybe 10 percent are uninsured. I do know this, I know that for all Americans who have a private dental plan, only about half of them use their benefit. So we have a lot that have the benefit and don't use it.

RIEPE: Do you have other pediatric dentists in Hastings?

JESSICA MEESKE: I do. So we have seven in our whole organization. So there's three that cover Hastings and Grand Island right now.

RIEPE: But you're, you're one group, you're not, for lack of a better term, competitors.

JESSICA MEESKE: No. And I'll be honest, pediatric dentists don't see themselves as competitors. There is such an abundance of kids with unmet dental needs. We are just constantly there helping each other out and trying to do everything we can to keep our head above water.

RIEPE: I know one of the challenges in dentistry is, is you have to make educational expenditures or commitment to become a dentist--

JESSICA MEESKE: Um-hum.

RIEPE: --and at that you would get paid X, and so you go on to specialize in pediatrics and you get less X in pediatrics.

JESSICA MEESKE: In the case of Medicaid, that would be true, Senator. But when you go into pediatric dentistry, you are making-- you know going in you're making a commitment to take care of those underserved kids. And out of 51 pediatric dentists in the state, 98 percent of us see Medicaid. And the one that doesn't is the one that, that struggled with the audit challenges.

RIEPE: I think most physicians that specialize get paid more. Not so in pediatric dentistry. Other question-- another one, then I'll, I'll quit, if I may, Chairman? The affordable healthcare plans, the Marketplace plans have grown significantly. How do they pay? How do they compare to Medicaid, they pay about the same or a little bit better or, or--

JESSICA MEESKE: No, because in the Marketplace, if you go out and purchase a private plan, whether or not you get a government subsidy or not, the plan has a certain number of benefits. And there was supposed to be what's called essential benefit-- essential health benefits for kids and those happened on the medical side, but they did not happen on the dental side. So that's something that the American Dental Association is trying to change is when ACA passed and we said we needed a list of essential healthcare benefits, trying to get dentistry included in that is something we're still working on. So we see really robust commercial dental plans and ones that aren't very good at, at all.

RIEPE: Is that the Obamacare ones?

JESSICA MEESKE: Yes, American-- well, there, there are all kinds of commercial plans. So if you pick one through the Marketplace, you still get a choice of which plans. And you either can pick a really good plan or you can pick a plan that doesn't have a lot of benefits.

RIEPE: OK. If you have others, then I'd like to come back.

HANSEN: Does anybody else have any questions? You can keep going.

RIEPE: My only other question would be is I-- because I saw you responding a bit out there in the audience on the why the 25 percent and when was the last time there was an increase? That'd be my last question.

JESSICA MEESKE: Yeah, great question. Thank you for asking that. So our last increase was July 1 of last year and it was 10 percent. But the reason that Director Bagley was able to do that is because of COVID. You had all of this unspent money that was earmarked for dental that would have had to go back to the General Fund. So the dental contractor would to have-- would have to have given it back. And so fortunately, the director said, look, the money's already been earmarked for dentistry, let's make sure it gets out to the, the access to care problems and the dentists that are taking care of it. So when they did that, it maybe took like 30 to 35 cents on the dollar, up to maybe 40 cents on the dollar. And David O'Doherty, our executive director, he'll be presenting more data on the figures for you and he'll be our last testifier.

RIEPE: So over the two years, it would be 25 percent on top of 10 percent, which compounds out to about a 27 percent increase over two years.

JESSICA MEESKE: Um-hum.

RIEPE: Roughly.

JESSICA MEESKE: Right.

RIEPE: OK. At least we know. Thank you.

JESSICA MEESKE: Thank you.

HANSEN: Yes, Senator Cavanaugh.

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

JESSICA MEESKE: Thanks.

M. CAVANAUGH: I'm going to ask a question which is tangentially related to this and I don't know if we have any other dental bills, Medicaid specific this year, so I know you've come here before about our pediatric dentistry reimbursement and challenges that we have had with that with our MCOs and I just wanted to give you the opportunity to maybe update us if you want to, you don't have to. Are, are those ongoing-- are those challenges still ongoing with our MCOs? Are we still having difficulties getting pediatric dentistry for these patients approved, reimbursed?

JESSICA MEESKE: You know, I think that our Managed Care Organization, MCNA, has really done a very good job and we feel like it's been much better since when it was a state-administered dental Medicaid plan. However, change is coming, and with the new Medicaid contract, dental and medical will be integrated with the three medical MCOs. So what we're starting to do is we're starting to meet proactively with the three MCOs and their dental partners, and we're laying out ideas and plans of how the dental community and the Managed Care Organizations can work together. So an example of that would be we would love to see an early childhood dental program to specifically answer your question. This has been done in the states of Texas and Washington. And when you engage more dentists to see children younger for preventive dental visits, which is simple as a dental mirror and a toothbrush, you can identify risk factors, identify early disease, treat it earlier, treat it cheaper, and keep kids out of the operating room. So we have been talking with the department about that.

M. CAVANAUGH: OK. Thank you.

JESSICA MEESKE: Um-hum.

M. CAVANAUGH: On a personal note, I realize that my husband scheduled all three of my children's dental appointments for Monday because it's a recess day for me to take them. Very much looking forward to my youngest throwing a fit on the floor at the dental office, which he did the last time. So this is just a great reminder dental care is important for those kids even--

JESSICA MEESKE: Absolutely.

M. CAVANAUGH: --even if they throw a fit.

JESSICA MEESKE: Yeah. Thanks for making it a priority for your kids.

M. CAVANAUGH: Thank you.

HANSEN: Any other questions from the committee? I-- yes, Senator Ballard.

BALLARD: Go ahead. Oh.

HANSEN: Yeah.

BALLARD: Can you-- thank you. Thank you for being here. Can you address what this means for rural Nebraska, this, this expansion of Medicaid?

JESSICA MEESKE: Yeah, this hits us really hard in rural Nebraska, so it's not uncommon that my patient families will travel from McCook, that they can come from Valentine, because they just maybe only have one dentist in the whole county. So if that dentist isn't participating in Medicaid, or maybe they're not seeing new Medicaid patients, the families have to travel such a long distance. When that happens, those parents miss work. Those kids can miss an entire day of school. And so I think in rural Nebraska, even though this impacts every dentist in the state, it really hits us hard in the rural areas because we don't have enough dentists and we already have access to care problems just for our regular patients to go. So it'll make a real impact.

BALLARD: OK. Thank you.

JESSICA MEESKE: Yep.

HANSEN: I have a couple of questions. Is in your mind, because you kind of, you kind of touched on this a little bit, is this more about a lack of dentists in the-- in this field or in this area? And this you're hoping will help bring more of them to the table to take Medicaid patients or is it more about reimbursement rates or is it kind of both?

JESSICA MEESKE: It's both. But I think the most important thing is it's about access to care for the patients that have Medicaid. So, you know, the question came up when, when you qualify for Medicaid, do you qualify for the whole thing or do you just qualify for dental Medicaid? You qualify for Medicaid, then you are able to access any of the services. And so making sure that people have a place to go as a primary place for preventive care is important. So that part goes out to the 350,000 Nebraskans that have Medicaid, the part of the reimbursement that goes to the dentist, it, it still doesn't make it a big payer. And in fact, it's just creeping up on Ameritas, which is state employee insurance. But what it does is at least when you put a patient in the chair, you don't lose money. You don't make as much, but you don't lose money. So the efforts of dentists like myself and those here today and in the Nebraska Dental Association is we also have to just do a better job of helping dentists understand. We feel we have a moral obligation to take care of all the people in our state. So if you believe in that, then let's help you figure out the math so the business side works for it. So none of us are becoming inherently wealthy taking care of Medicaid, but there's many things you can do to help your peers to understand it better.

HANSEN: OK. Because I know there's going to be, I think, with a declaration of emergency being done here pretty soon, they're going to be resuming eligibility redetermine-- redeterminations. And I think they're probably expecting eligible Medicaid patients to decrease by 10 to 20 percent.

JESSICA MEESKE: That's correct. There's going to be a whole public health unwind of individuals that had qualified for Medicaid because of COVID that now it'll be rolled back. So we're definitely paying attention to that and trying to help families figure out how can we continue to take care of their kids.

HANSEN: Yeah. And then what's, what's a typical cost for, like, a routine checkup for a, a child under the age of three?

JESSICA MEESKE: So if it's OK with you, I'm going to let Mr. O'Doherty handle the questions about the fees, because he's put together a really nice one-page fee comparison schedule and checkup fees and codes would be on there.

HANSEN: Awesome. OK.

JESSICA MEESKE: All right.

HANSEN: Good. Thank you very much.

JESSICA MEESKE: All right.

HANSEN: Appreciate it.

JESSICA MEESKE: Thank you.

HANSEN: Are there-- we'll take the next testifier in support. Welcome.

CORINNE VAN OSDEL: Good afternoon, Senators, committee members. My name is Corinne Van Osdel, C-o-r-i-n-n-e V-a-n O-s-d-e-l. I am here representing my personal views and to testify as a proponent to LB358. The views I am sharing today are my own and do not represent an official position of the University of Nebraska system or the University of Nebraska Medical Center, as a parenthetical there. I am a native Nebraskan and a dentist in Omaha. I primarily serve special needs and medically compromised patients. This includes patients who are preparing for solid organ transplants, unable to communicate, preparing for lifesaving cardiac procedures, or cannot cooperate for any oral examination due to behavioral issues. I see patients of all ages, many of whom live in care facilities and nursing homes. Most of my patients are on Medicaid. Many caregivers travel over three hours with very fragile special needs patients to see me because there is no one in their area that takes Medicaid. Within a three-hour radius of Omaha, there are three dentists, myself and my two colleagues, which take Medicaid special needs adults to the operating room for treatment. This is a crisis because we have a one-year waitlist to examine patients and assess if we can attempt care in a traditional setting or if we need to proceed with care under general anesthesia in the operating room. And then the patients that need care in the OR get placed on our waitlist that is over four years long. There are many dentists in Nebraska that have the training and ability to see patients in the operating room. But as a majority of these patients are in Medicaid, dentists will not see them. Treatment in the operating room adds the expense of care, and dentists cannot cover their costs when seeing Medicaid patients with or without general anesthesia. We do not know how severe a special needs patient's dental disease is until we are able to get them into the operating room and in four years this can become catastrophic. This amount of time in between general dental care and surgeries has led to the worsening of oral disease in an already vulnerable population and, therefore, a more compromised medical state. The special needs patients that require treatment in the operating room are also losing their teeth due to the inability to be seen in a timely manner. And we cannot replace missing teeth for these patients as all tooth replacement options require multiple appointments with a high level of cooperation. It is heartbreaking for me to tell a caregiver or parent that we cannot see their adult child or their dependent for dental care for four years and that when we do their dental disease will have progressed to the point where we will likely need to extract teeth and then be unable to replace them. This life altering situation is entirely preventable. If dentists were able to cover costs when seeing patients on Medicaid, more would be able to care for our medically compromised and special needs Nebraskans and improve their health. I ask the committee to support LB358 and I thank you for your time.

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

RIEPE: I have a question.

HANSEN: Senator Riepe.

RIEPE: I'll try to-- thank you for being here.

CORINNE VAN OSDEL: Um-hum.

RIEPE: My question is, are you trained as a specialist in a select field with-- within dentistry? Maybe you said that, I was [INAUDIBLE].

CORINNE VAN OSDEL: Not necessarily. I'm a general dentist, but I did do a residency program where I was trained in hospital dentistry, but it's not required.

RIEPE: It was hospital dentistry?

CORINNE VAN OSDEL: Yes, but I'm not a specialist.

RIEPE: Oh, OK.

CORINNE VAN OSDEL: Yeah.

RIEPE: That's OK. Thank you.

CORINNE VAN OSDEL: Yeah.

RIEPE: Thank you, Chairman.

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

CORINNE VAN OSDEL: Thank you all.

HANSEN: Take our next testifier in support. Welcome.

MELISSA LAW: Good afternoon. So I am not a dentist. I'm just kidding. I'm a pediatrician. So I thank you for having me and I'm here from Grand Island. I'm also a representative of the Nebraska State [SIC] Chapter of the American Academy of Pediatrics. I am a general pediatrician in Grand Island and we, me, and the American Academy of Pediatrics in the state of Nebraska support LB358. I see about 50 percent of Medicaid patients in my clinic daily making sure they're growing and developing appropriately and I spend a lot of my day discussing reducing risks to have health issues. I discuss ways to keep kids safe and healthy. And at every visit this usually includes some sort of oral health assessment and then the risk for dental problems.

HANSEN: Did you spell your first and last name?

MELISSA LAW: Oh, I didn't. They told me to not forget that. I forgot it. I am Melissa Law, M-e-l-i-s-s-a, Law, L-a-w.

HANSEN: Thank you.

MELISSA LAW: I'm so sorry. So the American Academy of Pediatrics and the American Academy of Pediatric Dentists [SIC] work closely together, we both recommend regular dental visits and then establishing a dental home for children by the age of one. As we know, this reduces the risk of dental caries, and that means dental decay and cavities, as you would call them. So the American Academy of Pediatrics places a large emphasis on oral health and we have developed many ways as pediatricians to try to teach us how to do oral health risk assessments and exams in the clinic. But we need our dentists' help, we can't do everything. They provide more in-depth education for parents, more risk assessments. They can do fluoride treatments and things like sealants to children at high risk for dental problems that we can't. Dental caries is one of the most common chronic childhood diseases. About 23 percent of children will have a cavity by the age of 5 and by age of 6 to 11 this is up to 50 percent, and most of them or a majority of them are lower socioeconomic children. And the nine and half years that I've been serving Grand Island, I have seen children with dental cavities or caries present with tooth or mouth pain. Sometimes they have trouble eating, which leads to weight loss or difficulty gaining weight. Sometimes they have behavioral problems at home or at school or at daycare. They have abscesses or other large infections. I have children who require emergency room visits due to dental pain and/or infection. I also trained in the state of Nebraska and during that time I saw kids who needed heart procedures and they were postponed due to poor dentition. If you have bacteria in your mouth you can seed that in other areas of the body, especially in certain heart conditions and so they had to have their teeth fixed before they could have their heart procedures. Children who require dental procedures, they do spend more time out of school, as we've already seen, and those parents are gone from work as well. And certain children, they need a dental procedure they might need anesthesia to make them calm or even all the way to sleep because they can't cooperate or they have developmental delays or anxiety. With putting them under anesthesia, that adds risk and cost to a procedure. And then with poor dental care, we are continuing a cycle of poor oral health. Studies show that mothers with increased bacteria in their mouth and poor oral health are also associated with young children having dental problems. If you don't improve the oral health now, the cycle will continue. Currently in Grand Island, there is one community health dental center that I send people to that accepts new Medicaid patients. I did have patients that used to drive to Kearney or Lincoln or other areas, but they stopped taking new Medicaid patients if they didn't have an address in their town. So this is a common problem in the entire state. Daily, I must describe to Medicaid patients that there's one person that might see you after you spend some time on a list and they do meet-- try to meet the needs of the more problems first. So I had a three-and-a-half-year-old Hispanic female with regular care with multiple teeth decaying in her mouth. I used a social worker with the Spanish-speaking mother, and we called several places to try to find her a place that would take her as a new Medicaid patient. That was in September 2022, and I haven't seen she has found a dentist yet. A five-year-old Caucasian male came in with an abscess in his front tooth causing it to come out. Parents had called around town already, they couldn't find anywhere to accept him as a new Medicaid patient until he came into our visit for-- our office for a visit and we had to do a direct referral. So instead of one dental visit, he had a doctor's office visit, days of pain, antibiotics, and still needed a dentist to fix the problem. On Monday of this week, a five-year-old Caucasian male came in and had an infection. He also was complaining of tooth pain. They said we have been on a list, it's been three weeks, we're still waiting for our name to come up to see the dental office. So these are people who are seeking regular medical care, but they cannot find regular dental care. So supporting LB358 will increase overall health in my community and the state. With this bill, we regain more dentists filling spots with Medicaid patients. If you have more availability, we have an early dental home. And then we hope we have fewer dental problems, which means less pain, less risk of infection, less procedures to patients. And then that means less time, resources, money, and time away from school and work. So please support LB358. Dental care is healthcare.

HANSEN: All right. Thank you for that. Are there any questions from the committee? Yes.

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

MELISSA LAW: Yeah.

M. CAVANAUGH: When you talk about-- you use the example of a five-year-old who had an abscessed tooth, had to come to you and then go on antibiotics and then get a referral. I guess the problem that we're talking about right now or that you're talking about is the, the amount of time, the wait time trying to find a dentist that will take them. In a situation like that where it's an emergency, really, are you able to find somebody because it's an emergency or do you still have that same issue of, I guess, all of you?

MELISSA LAW: Yes. Thank you for the question. So the answer is I have been there long enough to know the people that I can call--

M. CAVANAUGH: OK.

MELISSA LAW: --and who I know if they're in trouble that they will see them.

M. CAVANAUGH: OK.

MELISSA LAW: But if I called any dental office, a lot of them would probably still say no.

M. CAVANAUGH: And they would see them, but that, that doesn't mean that they would take them on as a full-time patient.

MELISSA LAW: Not necessarily.

M. CAVANAUGH: OK. So that, that-- we still go back to that problem.

MELISSA LAW: Um-hum.

M. CAVANAUGH: OK. Thank you.

HANSEN: Any other questions? All right. Seeing none, thank you for coming. All right, take our next testifier in support of LB358. Welcome.

GARRET SWANSON: Chairman Hansen and members of the Health and Human Services Committee, my name is Garret Swanson, G-a-r-r-e-t S-w-a-n-s-o-n, and I'm here on behalf of Holland Children's Movement in support of LB358. The importance of quality dental care is often overlooked compared to other health services. The cost of lock-- the costs of the lack of proper dental care in the United States is difficult to quantify precisely, but it is significant. According to, to a report by the American Dental Association, in 2019, Americans spent an estimated $124 billion on dental care with approximately 8.5 percent of that being spent on just emergency room dental visits. This is largely due to people not receiving preventative care or waiting until they have a dental emergency to seek treatment. The lack of proper dental care also has indirect costs, such as loss productivity due to dental pain, missed workdays, and decreased quality of life. The National, National Institute of Dental and Craniofacial Research estimates that in 2010, the total economic impact of world diseases, diseases in the United States was $237 billion. Senators, with this legislation, we can chip away at a major problem that is causing a drain on our economy and a quality of life many-- and the quality of life for many Nebraskans. Although, although this bill has a small fiscal impact, the benefits it will provide to our economy, economy in the form of fewer emergency room visits and a higher workforce participation rate make it well worth it. We urge that this bill be voted out of committee. And from my last testimony, I dropped off the multipage research sheet. There's a lot of great information about that in there. And I did have an answer to one of your questions earlier, that from the Nebraska Medicaid annual report 2021, there's 1,885 dentists in state, 215 dentists out of state, 80 dental hygienists in the state and one dental hygienist out of state that accept Medicaid.

HANSEN: All right. Thank you. Are there any questions? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. My question is this, does the Holland Foundation ever make grants for pediatric dentistry for poverty children?

GARRET SWANSON: Not, not the Holland Children's Movement or the Holland Children's Institute. No, not that I know of.

RIEPE: So the Holland Foundation is more of to, what, campaigning to get the state to do it?

GARRET SWANSON: Yes, we, we support, obviously, this legislation. We believe that it's going to help a lot of people. Not just in urban but rural Nebraska. And also not just the people that benefit from it but, as I stated in my speech, all of us indirectly benefit in some way.

RIEPE: My recollection is from having lived in Omaha a long time, that the Holland Foundation is a multimillion dollar foundation.

GARRET SWANSON: So we're-- I'm the Holland Children's Movement, which is a nonprofit.

RIEPE: Isn't that part of the Holland Foundation?

GARRET SWANSON: It's--

RIEPE: It has the name.

GARRET SWANSON: Yeah, it's not directly related, but we have a lot of the same goals and, obviously, Holland goes back to Dick Holland.

RIEPE: Yeah.

GARRET SWANSON: So I'd say cousins.

RIEPE: Oh, it's a cousin thing like, like the Buffetts?

GARRET SWANSON: I'm trying to--

RIEPE: That's OK.

GARRET SWANSON: --think of the best way to describe that relationship.

RIEPE: OK.

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

M. CAVANAUGH: I'll just provide some clarification that there is the Holland Family Foundation that-- and the Holland Children's Movement is funded by the Holland Family Foundation. So you maybe aren't best suited to answer what the Holland Family Foundation funds, but perhaps we can look into that a little bit further to see if they do fund some of those things that Senator Riepe was talking about.

GARRET SWANSON: Yeah, I'm not aware of all grants that the foundation provides, it's definitely something I'll look into, though.

M. CAVANAUGH: Thank you.

RIEPE: Maybe we can guilt them into--

GARRET SWANSON: It's not a bad idea. It's-- I've done a lot of research the last week about this, and I think some of the numbers truly blew me away. I don't think of dental healthcare as the number one thing I think of when I think of healthcare which I now know is wrong.

HANSEN: Any other questions? We just expected a detailed flowchart of all of your charitable organizations that you're a part of.

GARRET SWANSON: I'll see what I can do. Thank you.

HANSEN: All right. Thank you for coming to testify.

GARRET SWANSON: Appreciate it.

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

BETSY MURRAY: Hello. My name is Betsy Murray, B-e-t-s-y M-u-r-r-a-y. I'm a board certified physician anesthesiologist with Associated Anesthesiologist, PC here in Lincoln. We provide anesthesia services to the Bryan Hospital system, along with many of the private surgery centers here in Lincoln. And I'm speaking in favor of the bill. Too few dentists in our community are accepting Medicaid, and the result is too many children are unable to access a dental home. Many end up with severe tooth decay and abscesses and this is all preventable. Thousands of kids every year on Medicaid must receive dental treatment in an operating room under general anesthesia due to the severity of their dental disease. Oftentimes, the disease is so progressive that nearly all their teeth are being treated taking up 60 to 90 minutes of OR time per child. As we all know, medical costs are rising and the cost of OR time is astounding. Anesthesiologists see firsthand the devastation of dental disease, both in children and adults. And most people who require this level of treatment in the operating room are also covered by Medicaid. When Medicaid pays for a patient to have their dental needs treated in the operating room, the cost quadruples due to the added medical costs of anesthesia and the facility costs. Aside from the cost, the greater concern is that while general anesthesia is very safe for most patients, there can be rare but serious complications. And these are sometimes deadly. It is my medical opinion that general anesthesia should be avoided unless necessary for children. Fortunately, most of the severe dental disease is preventable if patients have a dentist that they can follow regularly and someone to address their dental-- their disease before it becomes dire. And this is why this bill is so important. The goal is to widen access to care and capture these patients in an outpatient setting. Hospitals and surgery centers are also fighting labor shortages and rising wages. Many dentists are losing OR block times due to the low reimbursement, as many surgery centers are for profit and cannot afford to take a loss on these dental cases. And I think, as we heard mentioned, sometimes the waits are four years. So if that increases, that's significant. The result in the delayed treatment, which allows dental infections and pain to become worse, and in many cases when a child can't get their disease addressed in the operating room dental treatment sometimes may have to happen in an emergency situation without any anesthesia. This can require restraints, restraints and this, as you can imagine, this is very difficult in a child. Children aren't the only physicians-- only patients that we see. We also treat adults. Many are disabled and require special care from highly trained providers. Some cases require two providers to help administer the treatment safely, straining the resources in the system even more. Many of these other adult patients arrive at our operating rooms via the emergency room due to an acute dental problem and this drastically drives up costs for the entire hospital system which provides obstetric emergency and trauma services to our community as a whole. In the big picture, it is affecting everyone. Even when anesthesiologists are providing anesthesia services for nonmedical treatment, we see horrible tooth decay and gum disease daily. The patients I have had conversations with almost unanimously state that lack of access to a dentist is the reason for their poor dental hygiene. These adults commonly have other comorbidities such as diabetes or heart disease and inflammation and infection caused by dental disease can increase their morbidity and mortality drastically. My dental emergency medicine pediatrician and anesthesiologist colleagues are providing the dental and medical healthcare for these Medicaid patients of Nebraska, basically, out of our own pockets. I speak for myself and most others by saying I went into the medical field with a big heart and morals to care for those in need without an expectation of payment. The children in Nebraska are particularly the most vulnerable. And why we can all volunteer our time, the state of Nebraska cannot continue to expect private businesses and for-profit surgery centers to lose money on these dental cases, as the current reimbursement does not cover the expenses to pay our staff wages and the facility fees. I believe all children and vulnerable individuals in the state of Nebraska deserve the right to receive quality dental and medical care and increase in reimbursement will offer more opportunity and access to the care that we would all want for our own children and loved ones. Thank you.

HANSEN: Thank you for coming to testify. Are there any questions from the committee? Seeing none, thank you.

BETSY MURRAY: All right. Thank you.

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

SOPHIA PANKRATZ: Hello.

HANSEN: Welcome.

SOPHIA PANKRATZ: Good afternoon, Chairman Hansen and committee members. My name is Sophia Pankratz, S-o-p-h-i-a P-a-n-k-r-a-t-z, and I'm a third-year dental student at the University of Nebraska Medical Center College of Dentistry in Lincoln. I'm speaking in favor of this bill. I was raised in Hastings, Nebraska, and attended the public school. Hastings is a town with 13 percent of its population covered by Medicaid as their primary form of insurance. These families were my friends, teammates, coaches, and classmates with whom I grew up with. A key part of dental school education is clinical procedures and having a diverse population of patients to obtain proper training. In fact, I'm currently looking for root canals if any of you want to volunteer. While UNMC does serve as a dental home for patients with Medicaid, the school has limited the number of patients due to the reimbursement fees being unable to cover the costs of care. This not only impacts student opportunities to treat patients and gain valuable experience, but it also limits our ability to care for underserved Nebraskans. Treating patients with Medicaid not only enhances our clinical training, but also teaches us how to support patients with barriers to healthcare. These patients may be children in foster care, people with disabilities, single parents, or seniors who are medically compromised. Understanding their needs extends to their barriers to receiving healthcare, which includes their transportation challenges, language barriers, compliance with care plans, and learning the ins and outs of navigating a complex medical program-- Medicaid program. It's part of educating the whole dental student. A fundamental component of our education is learning and embodying the ethical obligations of becoming a dentist and the principles of serving as a healthcare provider. One of our five principles includes treating people justly and delivering dental care without prejudice, including prejudice due to insurance status or type. As of fall of 2022, approximately 378,000 Nebraska residents received insurance through the Medicaid or CHIP programs, yet dentist participation in the Medicaid program is not meeting the need. When I graduate from dental school, my dream is to complete a residency in pediatric dentistry and go back to rural Nebraska and care for underserved children, including those with special healthcare needs in my community. However, my current educational debt is anticipated to be $300,000, and I want to own my own practice. I'm eager to see patients from my community that have the greatest needs and may not be able to care for themselves. However, with the current reimbursement being at 30 to 40 percent of average dental fees, I'm concerned I will not be able to include them in my practice. A 25 percent increase in reimbursement fees will allow me to obtain valuable clinical experiences during my training in dental school. In addition, it will help young dentists like me choose to stay in Nebraska, own a small business, manage my student loans, and include all members of community in my practice. With your support in this bill, together we can improve access to dental care for Nebraskans. Thank you.

HANSEN: All right. Thank you. Do you have any family that are dentists?

SOPHIA PANKRATZ: One.

HANSEN: OK.

SOPHIA PANKRATZ: We are in a negotiating contract.

HANSEN: OK. All right. Any questions from the committee? Seeing none, good luck with school.

SOPHIA PANKRATZ: Thank you.

HANSEN: Take our next testifier in support.

EDISON McDONALD: Hello.

HANSEN: Welcome.

EDISON McDONALD: My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm here representing the Arc of Nebraska. We are Nebraska's largest membership organization representing people with intellectual and developmental disabilities and their families. We support LB358 to expand access to dental services for people with disabilities. In Nebraska, 41 percent of adults with intellectual and developmental disabilities do not receive regular dental care. This is frequently one of the most difficult services for our members to find for two main reasons: lack of training to support dentists working with people with disabilities and lack of quality reimbursement rates. The hole is particularly evident in rural communities. This year alone, at least 14 states have positively updated their laws regarding dental Medicaid and another three states currently have pending legislation. There's an excellent study this year from the National Council on Disability in 2022 that says: key findings include that in the 12 states that do not currently provide dental benefits, the total estimated cost of providing extensive dental benefits to adults with IDD would be approximately $19.6 million annually with those state governments responsible for approximately $7.3 million of that cost. NCD, the National Consortium [SIC] on Disability estimates that these costs would be more than fully recovered through reductions in emergency department use in hospital admissions and reductions in the cost of treating several chronic diseases, the root cause of which are poor oral health. We estimate federal and state government combined would realize a return on investment of approximately $7.7 million beyond recovering the initial cost annually, and the share of that ROI for those 12 states would total close to $3 million annually. The report also indicates improving rates is a key tool to address the lack of access. We need to make this investment for the health and safety of people with disabilities and to create long-term savings. I urge you to pass LB358. Any questions?

HANSEN: All right. Thank you.

EDISON McDONALD: Yeah.

HANSEN: Are there any questions from the committee? Seeing none, thank you. Take our next testifier. Welcome.

KERRI DITTRICH: Hello. Good afternoon, Senator Hansen and members of the Health and Human Services Committee. My name is Kerri Dittrich, K-e-r-r-i D-i-t-t-r-i-c-h. I'm a public health registered dental hygienist. I'm here today representing Elkhorn Logan Valley Public Health Department and the Nebraska Dental Hygienists' Association. Thank you for allowing me to speak with you today. I'm here to voice my support for LB358 and I would like to thank Senator Walz for introducing this bill. Nebraska is fortunate to have a dental workforce model that includes public health registered dental hygienists who have been providing oral healthcare to underserved populations in our state for over 13 years. These professionals provide crucial oral health services that focus not only on treatment of disease, but also prevention in community settings that largely serve populations who are our most vulnerable Medicaid recipients, children and elderly individuals. In the past year, I have provided preventative dental services to over 1,700 children in school and childcare settings. Forty-six percent of those children indicated that they do not receive regular dental care, oftentimes because they cannot find a dental provider that accepts Medicaid patients. Children are not the only population experiencing the negative impacts of a lack of access to oral healthcare. Elderly populations and those residing in long-term care facilities are especially at risk of adverse health outcomes due to inadequate oral healthcare. According to the U.S. Census Bureau by 2030, all baby boomers will be at least age 65. We must focus on changes that can be made now to plan for the care of this population, many that will outlive their wealth and end up on Medicaid at some point. Providing bedside hygiene services is something that our elders deserve and greatly aids in the aging process with dignity and comfort. Sometimes this is the only point of service that immobile and bedridden elders in long-term care facilities have with Medicaid as a payer source. For those in younger age groups or for elders aging at home offices that do accept Medicaid patients, as we've heard as a resounding theme up here today, have long waiting periods, many weeks to even months, which can lead to dental emergencies presenting to the emergency room as the only option for pain and infection relief. According to Nebraska's most recent State Oral Health Assessment Report from 2003 to 2013, the number of dental related ER visits has risen 81 percent. Poor reimbursement rates is one of the most common reasons that dental clinics disallow Medicaid as a payer source. One way to alleviate this issue is to increase reimbursement rates to amounts that appeal to more providers, potentially driving dental clinics to accept Medicaid as a payer source. The increase proposed by LB358 is a great starting point to support the few dental providers currently accepting Medicaid, to recruit new providers to begin doing so, and to help sustain crucial community-based dental services. Public health registered dental hygienists play an integral role in increasing access to oral healthcare for Nebraskans. The preventative focus of our care not only improves outcomes, but also decreases overall healthcare expenditures. I am proud to support LB358 on behalf of the organizations that I represent. This bill is a step in the right direction to support dental professionals as they provide care to vulnerable populations in our state. And I respectfully ask that you advance this bill out of committee. Thank you for allowing me to testify today and I'd be happy to take any questions.

HANSEN: Thank you for coming to testify from District 16. Which, which county do you live in?

KERRI DITTRICH: Part of, part of your county--

HANSEN: OK.

KERRI DITTRICH: --would be my service area. So our health department serves Burt, Cuming, Stanton, and Madison County so I go into quite a few schools and daycares.

HANSEN: OK, good. Well, we should have gave you extra time then.

KERRI DITTRICH: Yeah.

HANSEN: I got a quick question. You mentioned Medicaid for those over the age of 65. Does Medicare cover den-- does-- any checkups or anything like that?

KERRI DITTRICH: Not that I'm allowed that we could reimburse for it. [INAUDIBLE]

HANSEN: OK, they are shaking their heads behind you, so.

KERRI DITTRICH: Yes. No, I would agree.

HANSEN: OK. I was just kind of curious about that. You brought up a point about that.

KERRI DITTRICH: Um-hum.

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

KERRI DITTRICH: Thank you.

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

NICHOLAS WOODWARD: I don't want to follow you.

HANSEN: Welcome.

NICHOLAS WOODWARD: How you doing? Senator Hansen, thank you very much. I am Nicholas Woodward, N-i-c-h-o-l-a-s W-o-o-d-w-a-r-d. I am a board-certified pediatric dentist. I have offices in Elkhorn, Beatrice, and I am also an adjunct professor at Creighton University School of Dentistry. I am not here speaking on behalf of them, but I, again, I am an adjunct professor there. I'm a native Nebraskan, second-generation dentist from, from here in Nebraska. I've actually had the privilege of, of practicing, or maybe I shouldn't call it a privilege, I've, I've practiced in two other states besides Nebraska in my, in my used to be able to say short career and now it's a little bit longer, but for the last nine years I, I made the choice I, I came back to Nebraska and I practiced here in Nebraska for the last nine years. I'm not going to reiterate what everybody else has said about the amount of calls that I get in a, in a day looking for patients, you know, who, who are looking for a dentist to access Medicaid because everybody in here could, could, could give you stories like that all day. Mostly I just wanted to address Senator Riepe's question from earlier about Creighton University. Yes, there are programs there that we, that we do. Again, I'm an adjunct professor in the, the department of pediatrics there. We do see children, there are after hours programs as well that try to see children. It-- it's definitely a help but it is, I would say, a drop in the bucket within the, the region of Omaha. And a lot of that is just because dental students as they're learning our trade and our craft, and again we were all there, often take a lot longer to see any single patient whereas once you're, you're out in you're kind of doing your thing and you've learned that craft and perfected it or getting closer than you can see a lot more of those children in a lot lesser time. So I just wanted to address that and see if you had questions. I, I will say again, I, I practice in a rural setting as well on a, on a part-time basis and I can tell you just this week that I have talked to at least three of my colleagues who two in Beatrice and one, and one in the Weeping Water area who have said they have started their paperwork to remove themselves from the Medicaid system. I knew that I would be here today and not, not that I had to ask them, but I just said if you give me a one sentence answer, why? All of them say because I'm tired of paying to have these patients in my office. And what they mean is when these patients come in and sit in their office for a half hour or 45 minutes, the reimbursement rates are, are so low that they can't break even, they can't make money. It's costing them money to see these patients. And while I think that all three of these gentlemen are, are very good people and have big hearts, like the others have said there, there comes a point where, where business is business. So that's all I have. I will take any questions if, if you have any. Otherwise, thank you so much for your time and thank you for your consideration.

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

DAVID O'DOHERTY: Good afternoon, Senators. My name is David O'Doherty, D-a-v-i-d O-'-D-o-h-e-r-t-y. I'm the executive director of the Nebraska Dental Association representing 70 percent of the dentists in the state. And who doesn't love a good spreadsheet, which is what you're getting right now. Last year, for my own internal use, I created most of the spreadsheet. On the far left column you'll see our NDA fee survey from 2021, which we do internally for the benefit of our members so I decided to take that data and compare it to DHHS Medicaid fees. At the time, it was before the July 1 increase and then compare those fees to three private insurance companies that are in the state of Nebraska. And as you heard in July, COVID money that wasn't spent for dental Medicaid was increased. So that percentage, which says 39 now used to be 36 percent. So 30 percent-- 39 percent is what Medicaid is paying relative to what dentists are charging in their office. And that's what I would pay since I don't have a dental benefit plan. So when we met with Director Bagley this past summer and handed the sheet out, one of his staff looked at it because I had the names of the insurance companies at the top and the first thing they said is no wonder I can't find a dentist to accept our insurance, which is the same problem with Medicaid. Later that summer, we met with the Attorney General's Office and one of the assistant attorney generals said the same thing almost immediately, well, no wonder I can't find a dentist. These fees are so low they're not taking our insurance. So that's, that's part of the-- I can answer some questions about the fees later, I don't want to mess with my four minutes. So on the second page, this, this data from the ADA, it's this bar chart, the ADA did a survey of dental offices. What, what things are you going to do in 2023? And there are a number of things to choose from, one of those being drop out of some insurance networks. That's private insurance networks. The thing that really stuck out with me was 53 percent of younger dentists are going to be dropping out of private insurance this year, not Medicaid, private insurance. And the number goes down as the age groups go up. But that really stood out to me that, oh, no, they're already dropping some in private insurance and they're doing it for valid reasons. We lost 9 percent of our workforce through COVID. We're, we're projected to lose another 33 percent in the next five years. So we have a serious work shortage-- workforce shortage to deal with. And if they're having trouble making ends meet with private pay and, and, and good insurance plans, they have to make decisions on where to cut and lowest-- the lowest fee schedule is going to be one of them. The last page is a letter from our president, Dr. Papineau, who couldn't be here with us today. But on the bottom of her testimony is just another example of why this doesn't work, the money, the money doesn't work when you're trying to run an office, the overhead, if you're-- as we just heard, if you're losing money by seeing patients that's not a good business move. You don't make it up in volume. And another thing that wasn't discussed, unfortunately, the Medicaid population has barriers to get to offices if they have to travel three hours. So if, if your Medicaid patient doesn't show up, you don't stop paying the hygienist or the assistant. You still pay them and you don't get any reimbursement from Medicaid. We've had four states in the last year who've increased their fees significantly: Connecticut and Virginia increased their fees 25 and 30 percent. The, the column you see in blue, South Dakota, because Senator Walz asked for comparison of our neighboring states, they raised their fees last year and so now they are 60 percent of what our office fees would be. And South Dakota last year raised their fees that got it to 80 percent. So the 25 percent number, that was one of the questions, how do you come up with 25 percent? We tried to get that comparison at least equal to the lowest private insurance that we see here in Nebraska. We're very happy if you went higher than that because, because obviously, well, we know we have a lot of data from the ADA, the ADA. The higher the percentage of reimbursement goes up, the more participation that happens. So if you can't even compete within private insurance, you know, there's no hope, honestly. I'd be happy to answer any questions.

HANSEN: Thank you for your testimony. Thanks for the numbers, actually helps out quite a bit, actually. Any questions from the committee? I have one. Does Medi-- Medicaid patients have a copay?

DAVID O'DOHERTY: I don't believe so.

HANSEN: OK. Now with some services, they might be like $1 or they might be something or, so.

DAVID O'DOHERTY: Yeah. One, one of your other questions about Medicare, you heard no. Yeah, Medicare does not cover dental, only very few select dental procedures but none of these, basically. And there was an early question about the preventative codes: D0120 at the very top is an exam code; D1110 down the middle left column, that's a cleaning for a child; D1120 is a cleaning for an adult. And then D1206 would be a fluoride treatment. So those are preventative codes.

HANSEN: OK. All right. Yes, Senator Riepe.

RIEPE: Thank you. I, I know a number of health plans that will market and some that they have a dental plan. But when you fold back the pages, it's basically, you know, the 120 code, it's, it's for hygiene and prevention without any procedures for any serious dental work.

DAVID O'DOHERTY: Well, a lot of times they'll--

RIEPE: Sort, sort of a little, I consider it a bait and switch kind of idea.

DAVID O'DOHERTY: Well, what, what we were meeting with the Attorney General was about a stat-- insurance statute we modified. Talking about your plans, they, they, they provide a plan, but it's very basic. And people don't want basic, you know, they don't want a big silver crown in their head, like, they want a, a tooth-colored crown. Well, that's a $400 difference, but their plan doesn't cover that. So they'll provide a plan, but it's not what they want. So they're disappointed in the plan?

RIEPE: Yeah, one needs to read carefully.

DAVID O'DOHERTY: True.

RIEPE: Thank you.

HANSEN: All right. Thank you for your testimony. Appreciate it.

DAVID O'DOHERTY: OK. Thank you.

HANSEN: Take our next testifier in support.

HEIDI STARK: I'm going to fill this out as I'm talking real quick. My name is Heidi Stark. I'm a pediatric dentist here in Lincoln. H-e-i-d-i S-t-a-r-k. I just wanted to make one quick comment. As I was sitting here with a lot of my colleagues in the room, one thing that we haven't even talked about and as a pediatric dentist I'm very passionate about is we have lots of children in this community and around the state who absolutely have zero chance of ever paying for any orthodontic care. The orthodontists absolutely do not take Medicaid for the most part. If you look around the room, they probably are all agreeing with me. A 25 percent increase in fees may allow some of these children to get some orthodontic care. And if you also look around the room, everyone in this room can probably smile with a beautiful smile. And so when you talk about the future of children getting into college, getting a job, having confidence, all the Medicaid patients that we see in our practice, and I submitted letters on behalf of our office and we see 9,000 patients on Medicaid in our practice, 39 percent of our patients are on Medicaid, it is so heartbreaking for me to be looking at these children and to their parents and to know that they are probably never going to have a chance to have orthodontic treatment for their children. So anyway, that's all I have to say.

HANSEN: All right. Thank you for your testimony.

HEIDI STARK: You're welcome.

HANSEN: Are there any questions from the committee? Seeing none, we will take our next testifier in support of LB358. Welcome.

KRISTEN LARSEN: Hi. Good afternoon. My name is Kristen Larsen, and that's K-r-i-s-t-e-n L-a-r-s-e-n, and I'm here on behalf of the Nebraska Council on Developmental Disabilities to testify in support of LB358. Just want to share that although the Council is appointed by the Governor and administrated by DHHS, we are-- we operate independently and our comments do not necessarily reflect the views of the Governor's administration or the department. We are a federally mandated independent Council comprised of individuals and families of persons with developmental disabilities, community providers, and agency reps who advocate for system change and quality services. And we take a nonpartisan approach as needed to educate senators on bills that could potentially impact folks with developmental disabilities. So the Council supports this bill, which would increase Medicaid reimbursement rates for dental services by 25 percent. Oral health is essential for general health and the well-being of people throughout life. And for too long, individuals with intellectual and developmental disabilities, or IDD, have experienced healthcare disparities, including having unmet dental needs and many face challenges receiving dental services due to limited access, availability, and accommodations. LB358 has the potential to address this issue by incentivizing dentists to serve all Nebraskans who utilize Medicaid for dental care. We recognize that there are Nebraskans with IDD who might not necessarily be eligible for Medicaid services, but for those who are, this bill may address dental access issues. Prompt dental care has not been readily available for individuals with disabilities, and research indicates that individuals with disabilities experience a higher prevalence of dental problems. In the United States, one in four adults have some form of a disability and are more likely to have poor health, suffer chronic diseases, and face more significant barriers to healthcare. Adults with disabilities are less likely to have visited a dentist within the past year compared to adults without disabilities, and research shows that children with special healthcare needs are at increased risk for inadequate dental services and access. According to the Nebraska State Oral Health Surveillance System Report, 2011 to 2020, in 2012, there were 1,542 practicing dentists who accepted any and all Medicaid patients. In 2019, this number dropped to 785, and in 2020 the number dropped again to 653. That's a 42.3 percent drop in the number of dentists who accept Medicaid patients. The staggering evidence shows that Medicaid patients, especially underserved populations, face a barrier in accessing dental services. The report provided a recommendation to increase the number of Medicaid providers. When access to oral healthcare is deterred for Nebraska's underserved populations, those individuals resort to seeking episodic dental care in the local emergency rooms as you've been hearing in testimony previously. Research demonstrates that many Americans with acute dental pain and chronic oral infections are not accessing treatment at a traditional dental office or dental home and instead they'll seek that urgent care in the local emergency room. Law stipulates that the emergency rooms are required to see the patients even if they can't pay so that results in an inefficient and expensive pathway to provide dental care. And typically, those emergency room patients are only receiving medication, pain "relivers"-- pain relievers, and antibiotics to address their pain without receiving the proper dental care to treat the underlying condition. The Nebraska State Oral Health Hospital Emergency Department Use for Non-Traumatic Dental Conditions Report, 2009-2016, also documents the, the great increase in cost per visit for dental conditions as noted in the handout. And I'm not going to go into the numbers, but they basically gave a recommendation to work with Medicaid programs to increase adult benefits, reimbursement rates, reduce administrative barriers, expand preventative services, and increase dental provider participants. This bill would have an impact. I want to say that challenges related to the access for the IDD population is complex. It cannot be solved simply by the Medicaid reimbursement rates. Patients with IDD were largely unable to obtain dental care because a lot of times dentists don't receive the training that they need. I have some other information in my handout that according to an article published in August of 2019, the Commission on Dental Accreditation voted to require dental schools now to train their students in managing the treatment of patients with IDD. And I also want to reference that we are pleased to learn that the Office of Oral Health was selected to receive a federal HRSA grant, and that grant will provide some structure to support UNMC's College of Dentistry's champions of care clinic at Munroe-Meyer Institute to increase access to high-quality dental care for folks with intellectual and developmental disabilities. There's additional information in my handout that you'll have that just talks about some of the additional barriers that people with IDD face, but definitely increasing Medicaid reimbursement rates is a step in the right direction. Sorry, I ran out of time. I was planning on 5 minutes, but.

HANSEN: You did pretty good. You got a lot in there. All right, well, thank you for testifying.

KRISTEN LARSEN: Thank you.

* Indicates written testimony submitted prior to the public hearing in accordance with the Legislature's guidelines on ADA testimony.

HANSEN: Are there any questions from the committee? All right. Seeing none, thank you for coming. Appreciate it. Is there anybody else wishing to testify in support of LB358? I feel real bad about not flossing now. My dentist said I hit the tooth lottery, so my teeth are pretty good so far. Anybody wishing to testify in opposition to LB358? OK. Is there anybody wishing to testify in the neutral capacity to LB358? OK. All right. So with that, we will welcome Senator Walz back up to close. And just for the record, we did have some letters in support. We had two with the ADA accommodation written testimony in support and we had 80 proponents in support of LB358.

***HENRY BARTENBACH:** Because of my disabilities, my top teeth came in two places to the left with a large overbite. With firsthand experience of having dental reconstruction surgery and the cost without having insurance. Now having Dental Insurance, it still does not come close to paying for the care I need. This dental assistance program is greatly needed for people with extensive dental issues.

***KATHY HOELL:** I am writing to support LB 358. As a person with a disability I know that the number of dentists has decreased because their rate of reimbursement is so low.Because of this it is really difficult to find a dentist for a child or person with a disability. By increasing the reimbursement rate you would increase the number of dentists accepting Medicaid thus improving the health of Medicaid recipients.

WALZ: All right. Well, thank you. You know, as I'm sitting here listening to all the testifiers come up, you really don't think of dental-- or you tend to think of dental care as a service, but you normally don't think of it as a ministry. And after listening to so many of the dentists, I kind of feel it is now. So just wanted to say thank you for those who came to testify today on LB358. I think all the testifiers really identified why this bill is so vital for Nebraskans and especially for the children of Nebraska. I'd like to point out that because we would be increasing rates, this will cause patients to reach their service limit of $750 sooner. So my understanding is that Medicaid will be dropping that cap in 2024 or 2025. And I think to ensure access to care, we should speed that up significantly. So I'd like to kick out this bill out of committee addressing that issue by either increasing the cap limit or removing it altogether. In addition, a lot of Nebraskans are going to the ER for dental care, and that not only doesn't fix the dental problem, but they're also put on narcotics which contribute to the opioid-- I always have a hard time saying that, opioid problem. So why would we increase medical costs and just not fix the dental problem in the first place? This bill is not going to solve all the issues that we have, but I'd like to come back and see what more we can do to increase access to care. Additionally, I would like to see how we can support our providers further that do accept some of our most vulnerable citizens. So with that, I'd be happy to try and answer any other questions.

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

WALZ: All right.

HANSEN: --thank you. And that will close the hearing on LB358, and that will close our hearings for this afternoon.