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

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

DAY: Good afternoon. I'm Senator Jen Day. Represent LD 49 in Sarpy County.

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

HANSEN: Good timing again.

RIEPE: Good timing. I'm Merv Riepe. I represent District 12, which is part of the Omaha metropolitan area.

HANSEN: Also assisting, assisting the committee is our legal coun-- or, research analyst, Bryson Bartels; our committee clerk, Christina Campbell; and our committee pages for today, Maggie and Molly. A few notes about our policy and procedures: please turn off or silence your cell phones. We will be hearing five bills and will 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'll find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are a yellow sign-in sheet at each entrance where you may leave your name and other pertinent information. Also, I would note: if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by 8 a.m. the day of the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We'd ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system for testifying. Each testifier will have three to five minutes to testify, depending on the number of testifiers per bill.

When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony, and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. On a side note, the reading of testimony that is not your own is not allowed unless previously approved. And we do have a strict no-prop policy in this committee. So with that, we'll begin today's hearing with LB933 and welcome Senator Bosn to open. Welcome.

BOSN: Thank you. Thank you, Chairman Hansen. And good afternoon, members of the Health and Human Services Committee. For the record, my name is Carolyn Bosn, C-a-r-o-l-y-n B-o-s-n. I represent District 25, which consists of southeast Lincoln, Lancaster County, and does include Bennet. LB933 changes two distinct pieces of Medicaid coverage: first, adding coverage of continuous glucose monitors, or what I'll refer to as CGMs, for pregnant mothers; and second, specifying that CGMs should be allowed for Medicaid patients on insulin therapy, not just those who are receiving three or more shots of insulin per day, which is the current policy. This small Medicaid policy change would have an important impact on pregnant mothers experiencing gestational diabetes. Gestational diabetes adds further stress and complications for expecting mothers. From the point of diagnosis, mothers must work to control their blood glucose levels more precisely than they otherwise would, as high blood sugars endanger both the mother and the unborn child. A mother diagnosed with gestational diabetes has a higher likelihood to require a cesarean section to give birth, and her baby is more likely to need neonatal intensive care once born. To mitigate these concerns, expecting mothers must frequently monitor their glucose levels. Unfortunately, traditional glucose monitoring methods can be challenging to adhere to. A study of women with gestational diabetes found that 38.5% of women were unable to adhere to their prescribed regimen. Researchers also found that poor adherence was associated with a higher incidence of preeclampsia. The best and most cost-effective way for mothers with gestational diabetes to have complete care is to use a continuous glucose monitor. The use of continuous glucose monitors for moms with

gestational diabetes results in less gestational weight gain, better glycemic control, reduced risk of preeclampsia, among other things. More importantly, though, for the babies and for the taxpayers of our state covering those medical costs, the use of CGMs can mean fewer neonatal intensive care admissions lasting longer than 24 hours, a day shorter length of a hospital stay, and fewer cesarean sections, or C-sections. The second part of this bill will improve coverage for other patients with diabetes. Most of you will remember-- or some of you will remember-- when Senator Mark Kolterman brought the original bill for Medicaid coverage of CGMs. This committee ultimately supported his legislation, and the bill became law just last year, 2023. Unfortunately, when the Medicaid regulations were put in place to implement the use of CGMs, Nebraska missed the mark on how and when these important devices could be used. Current Nebraska regulations state that a continuous glucose monitor will only be covered for a Medicaid recipient if that person is on three or more shots of insulin per day. Current ADA standards of care and guide-- care guidelines and CMS regulations, however, provide coverage for a person on any amount of insulin therapy. I hear from physicians and care providers in our states that many patients with type 2 diabetes are currently unable to get a continuous glucose monitor because of Nebraska's Medicaid regulations but are still at a high risk of dangerous hospitalizations that are very costly to the state. Again, this is about the health of the person, but it is also about the costs to the state and the taxpayers. As a pharmacy benefit and the state utilizing rebates, CGMs cost-- CGM costs approximately $1,300 to $1,600 per year, and this is only approximately $90 more expensive per year than the finger sticks. $90 a year more expensive than the finger sticks. Meanwhile, one trip to the emergency room due to severe low blood sugars or a hospitalization due to diabetic keo-- ketoacidosis from high blood sugars costs thousands of dollars more than the CGM. Studies also show that CGMs decrease diabetes-related hospital admissions by approximately 75%. When tools are available to help both the patient and save money, we should work to take full advantage of that technology. I'm excited to be part of this solution, and I look forward to working with you on this. I want to thank you for your time. And I would be happy to try to answer any questions. Dr. Eiland from Nebraska Medicine will be following me and will be able to answer some of those questions in more detail.

HANSEN: Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Thank you for being here. I think one of the initial questions I have is, does the monitor also require a smartphone to go with it?

BOSN: I don't know the answer to that, but I can find out.

RIEPE: Oh, someone who may have. I, I was just-- and I, I guess another question I'm going to have-- this can come up later too-- is, just how do you get to some assurance of compliance? That's always a problem in the health care business.

BOSN: Assurance of compliance with-- by the patient?

RIEPE: Yes. You know, they have it but they may not dis-- may not, may not use it. That's typical in health care across the board on, on a lot of issues, not just with the Medicaid population but with populations in general. It's a problem physicians have all the time.

BOSN: Sure. I can certainly look into what options we might have to alleviate that concern or the best we can do to address that concern. But I don't have any assurances in the bill as drafted.

RIEPE: Well, that's, that's what's called my hard question, let’s say. Thank you very much for being here. Thank you, Chairman.

HANSEN: Any other questions? Senator Hardin.

HARDIN: Thanks for being here. Can you give us kind of an idea, typically speaking, about how many moms are, are going through and, and end up with gestational diabetes--

BOSN: Sure.

HARDIN: --right now?

BOSN: The specific numbers, I don't have. What I can tell you is that, at any given time-- well, I guess-- certainly, the, the test that you take-- and I'm not trying to dumb this down, but since you're not a female who's had one, the test that you take is typically given to moms at around 20 weeks. You then, if you fail that, have to come back and take a second one. And let me just tell you, the syrup is absolutely terrible.

HARDIN: We've heard about that yesterday [INAUDIBLE].

HANSEN: We've heard it's great, actually.

BOSN: OK. So I would highly recommend you try it. They say it tastes like Hi-C, and that's a lie. So they-- if you then qualify, what happens right now is your, your doctor can apply and try and get you the, the CGM. It's denied. You can apply. So you can follow through with that. Well, here's what happens. You still have a baby at nine months. So if they haven't qualified and time has run out, the baby still is born. And so it's really kind of a time-sensitive-- we don't have time to keep applying, get denied, go through the second round of applications, get denied, go through the third round, and then they say, OK, and it's-- the, the parents are say-- the mom is saying this isn't really worth it at that point. And quite frankly, they're right. Based on that-- 16 to 20 weeks of usage are, are-- is typically what we're looking at. I don't have a number of how-- what the percentage is of moms that are diagnosed with gestational diabetes, but I can find that number out. But even in that number, there are some who would not want the continuous glucose monitor. It wouldn't be a good fit for their lifestyle. So it's not necessarily that everyone who's diagnosed with gestational diabetes would then need or want a continuous glucose monitor, so.

HARDIN: Do you have a sense from a different perspective on it? I'm looking at about $7 million this year, $9 millionish next year for this process. They certainly have some financial numbers in terms of what it does cost given that they're not doing it right now in terms of hospital bills, right, that Medicaid ends up paying. So it's-- we're talking about a, a, a big savings, I'm assuming, for Medicaid if they would take this preventive measure as opposed to the reactive side. Is that kind of where we're going?

BOSN: Correct. So that would-- and-- what is it, an ounce of prevention is worth a pound of cure? So that would be my argument. I was unable to get the, well, what is the cost-benefit analysis of the money you're saving versus the money you would be spending otherwise? We did try to get that. I would point out that the funds from this are somewhat different on the fiscal note. And I don't know if that answers your question, but if you'd like, I'd be happy to explain a little bit about that.

HANSEN: We're, we're used to hearing that, oh, dear. We don't know what that number is. We were hoping maybe you would be the exception and have a number for us on a separate matter, but--

BOSN: Sorry to disappoint.

HARDIN: --we're used to hearing that, so.

BOSN: So what I can tell you right now is that the general funds on your fiscal note at $1.0-- essentially $1.8 million-- I believe is high. And I'm sure you also hear that every time somebody comes in with a note that they don't like. Here's what I can tell you: of the individuals with type 1 diabetes who would qualify for a continuous glucose monitor, what the numbers show is that between 60% and 70% of the total individuals diagnosed with type 1, 60% to 70% actually have a continuous glucose monitor. So there's between 30% and 40% that don't. Of the type 2 individuals who are diagnosed with type 2 diabetes, between 15% and 25% have a continuous glucose monitor, which means there's, if my math is correct, 75% to 85% that don't have one. In this particular case, these numbers are based off of a 75% usage rate. And my position is, based on everything I've read, that's high. That's approximately-- that would mean only 25% of women who are diagnosed with gestational diabetes don't get the monitor. And what the individuals who are going to come after me can do a better job of explaining is that, typically, it's about 30% actually apply. So that estimate is based on a number that I think is not likely to be seen.

HARDIN: Thank you.

HANSEN: I got a question. So-- are we talking about-- so you said in your opening statement that they require multiple shots in order to be eligible for this?

BOSN: You have to have-- be using three shots per day right now to q-- to qualify for a continuous glucose monitor.

HANSEN: And this would not change it or would change it?

BOSN: This would mean that if your doctor says you need it, we'd-- the number of insulin injections that you receive per day is not how we decide whether or not you need it.

HANSEN: All right. Because I see in the fiscal note that there-- expected number of individual patient-- additional patients to be covered will be about 4,086. And so then-- but then we assume that those who are not eligible for it are going to be eligible for it now who had maybe one shot a day versus three?

BOSN: I'm not sure I understand your question. So of the 4,000--

HANSEN: Well, I think that's one of the questions maybe Senator Hardin has, how many people are going to be-- this, this would apply to.

BOSN: OK.

HANSEN: Is that number in the fiscal note? They're saying 4,086.

BOSN: Yes.

HANSEN: Would that probably be the-- an accurate number then?

BOSN: Well, that would be based on the 75% utilization rate instead of what I believe is a 30% utilization rate, approximately.

HANSEN: OK. Thanks. Senator Riepe or Senator Cavanaugh. Which one?

RIEPE: Ladies first.

M. CAVANAUGH: Oh, thank you, sir. So I'm just going to add some clarification on these numbers and the fiscal note. That 4,000 number is the estimated number of people that would be in the pool. The 75% of that is 3,065. 75% is a very high amount. It's my understanding that it would be closer to a 25% utilization. Also, the fiscal note says that it covers for 12 months.

BOSN: I've never been pregnant that long.

M. CAVANAUGH: I haven't either. And--

BOSN: It does feel like it, though.

M. CAVANAUGH: 12 months after the 20 weeks when you get the test done. So that seems long. So let's just assume seven months. It covers you for seven months. At a 25% utilization, the cost to the state will be $759,000. So I just want the committee to keep that in mind that we are talking about approximately 25% of the 4,000 would be covered by your bill at a generous 7 months, not a torturous 12-month coverage. It probably would be more like four or five months. So on the high end, we're looking at $750,000. Does that seem fair?

BOSN: That seems fair.

M. CAVANAUGH: OK.

BOSN: Thank you for the good clarification.

M. CAVANAUGH: I love a good fiscal note. This committee knows that. Also, yesterday, we had a testifier who had gone through her test and she was expecting. And she described the thing as flat orange soda. So she told the Chairman that if he likes the taste of flat orange soda, then he should have the glucose test.

BOSN: It's horrible.

M. CAVANAUGH: Yeah.

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Again-- well, yes, it may be-- it seems to me that once we have authorized something-- and we all understand that a pregnant woman who is also a diabetic is a very, very serious situation and needs to be paid attention to. That said, I would make this assumption-- you can correct me. That's-- I'll try to put this so you can respond, please-- is that once they have the monitor, they're probably not likely to pull it back and reuse it in some other way. They're probably-- if they're a type 1 diabetic and they're young enough to have a baby, they're probably going to be well-served to have that monitor on an ongoing basis, so--

BOSN: Under the type 1 and type 2, yeah.

RIEPE: Yes. So in response to my fiscal conservative neighbor here, that-- her number may not be correct. It may be higher than that. The question that I really wanted to go with was, was on the source of funding because it's such a sensitive issue now. I don't know whether, whether it's general funds of-- or is that out of some health care funds? Or do you have a, a kind of a target? And the on-- the reason I ask you is you probably, being a senator, are probably the only one that would maybe have privy to that.

BOSN: I do not have another source of funds other than general funds--

RIEPE: OK.

BOSN: --to the extent that was your question. If you have suggestions that I might not have thought of, I'd be happy to consider them. But at this point, the ask would be coming from general funds.

RIEPE: My only suggestion was you plead with Senator Clements, who's Chairman of the Appropriations Committee, so.

BOSN: I have. I will continue to do so.

RIEPE: I'm sure you will, and I'm sure you'll do it well. Thank you, Mr. Chairman.

HANSEN: Yep. Any other questions? Seeing none. Are you staying to close?

BOSN: I will, yes.

HANSEN: All right. Well, we were take-- we will take our first testifier in support of LB933. Welcome.

LESLIE EILAND: Hi. Thanks for having me.

HANSEN: Before you begin, how many people here are testifying on LB933? Can you raise your hand for me? OK. Good. So we'll go five-minute testimony now.

LESLIE EILAND: Thank you.

HANSEN: And you can begin whenever you like.

LESLIE EILAND: OK. Good afternoon, Chairperson Hansen and members of the Health and Human Services Committee. Thank you for holding this hearing. And thank you to Senator Bosn for introducing LB933. My name is Dr. Leslie Eiland, L-e-s-l-i-e E-i-l-a-n-d. I'm an endocrinologist at UNMC as well as medical director of digital health and patient experience at Nebraska Medicine. I am testifying in support of LB933 on behalf of the Nebraska Hospital Association. Diabetes is an epidemic in the U.S. as well as Nebraska. 8.8% of adults in Nebraska have a known diagnosis of diabetes. Even more have diabetes but just aren't aware of it. Every year in Nebraska, another 10,000 people are diagnosed with diabetes. Nebraska data also shows that the prevalence of diabetes is higher in people without college degrees, those with lower incomes, and in racial and ethnic minorities. A continuous glucose monitor, or a CGM, is a device that a patient inserts into their skin. A thin metal filament sits just under the skin and detects the glucose levels of your interstitial fluid. Glucose values are collected every few minutes and sent to a receiving device, which can be a smartphone app, which displays your current glucose value as well as the direction that it's trending. Increased research on CGM is leading to standards of care being expanded to cover larger groups of people with diabetes. In general, people who use CGM consistently tend to have better blood glucose control and fewer episodes of low blood

sugar. Low blood sugar is an acute complication of diabetes that can lead to loss of consciousness, seizure, even death, and often results in an EMS call or an emergency room visit. Decades of research prior to CGM show that improved glucose control decreases risk of long-term complications of diabetes. These complications take years, decades to emerge, and by then it's often too late. This includes kidney failure leading to dialysis, lower extremity amputations, loss of vision. All of these are extremely costly to people, payers, and society. The American Diabetes Association, the ADA, updated their standards of care several years ago saying that CGM should be offered to anyone on insulin. Medicare recognized this change and subsequently started covering CGM for people with diabetes on any insulin, including just one shot of long-acting insulin per day. Nebraska Medicaid currently only covers CGM for people on intensive insulin therapy, which is defined as three or more injections per day or an insulin pump. When it comes to treating people with diabetes, a reactive approach is not working. We have historically waited for people's blood sugars to rise to an unacceptable degree, and then we try to knock them down with another medication or more insulin. And guidelines are now shifting to become more proactive, trying to prevent worsening glucose control from occurring in the first place. Unfortunately, current Medicaid coverage for CGM goes against this. We are forced to wait for someone's disease to progress to intensive insulin therapy before they are allowed to receive a CGM. Instead, we should be providing CGM prior to this in hopes that we can slow disease progression and prevent or delay the need for multiple and daily injections of insulin. When I review CGM data with a patient during an appointment, I engage them with their data. I ask questions about trends that I'm seeing. And our visit is so much more efficient and effective. CGM's impact on patient engagement and shared decision-making cannot be undersold here. CGM devices make the invisible visible, and I see my patients on CGM play a much more active role in their care. Their education on their own diabetes is massively accelerated. They see the direct impact of their food and activity choices on their blood glucose values in real time. This is a simple ask: align Nebraska Medicaid's CGM coverage with that of Medicare and the ADA's standards of care. This is not asking to give everyone with diabetes on Medicaid a CGM. The ask us to give people with diabetes on Medicaid on insulin access to CGM. The current policy is such that our Medicaid patients are not receiving standard of care. As a clinician, I always attempt to practice in a payer-agnostic way, but this difference in policies forces me to treat my patients with Medicaid on less intensive insulin therapies differently. Instead of a CGM, they are given a glucose

meter and asked to do periodic finger sticks, which gives me a fraction of the data. It's like I am shown one or two still images of a movie and being told to just figure out the entire plot, adjusting prescriptions based on this tiny amount of information. CGM data is like watching the whole movie from start to finish, allowing for safer, more effective treatment adjustments. My concern is that continuing to deny CGM to our Medicaid patients with diabetes on less aggressive insulin regimens will lead to widening, worsening disparities in diabetes outcomes in this population, and we will look back and regret our lack of proactive approach. Thank you.

HANSEN: Thank you. Any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. As an endocrinologist, you're highly specialized. So I'm assuming you kind of get the worst of the worst, most difficult cases. And it seems that yours is addressing not just mothers, pregnant women, but anyone that's a serious diabetic.

LESLIE EILAND: Correct.

RIEPE: So-- and it also had-- I think it says in here that you talked about invasive procedure. Under the skin makes it invasive.

LESLIE EILAND: OK. Sure.

RIEPE: OK.

LESLIE EILAND: Mm-hmm.

RIEPE: So to me, do you honestly think-- I want your opinion-- that once-- say it is a pregnant woman-- that one could ever then go out and remove the-- and, and discontinue the service?

LESLIE EILAND: Can I ask you a clarification question? So are-- you're asking about somebody with gestational diabetes?

RIEPE: You're not supposed to ask us a question, but I'll try to-- please tell me-- ask me a question.

LESLIE EILAND: Are, are you asking about women on gestational-- who have gestational diabetes who then deliver and are asking to stay on this device?

RIEPE: I guess that would be my question. Or do we-- not only asking because they may not know, but I-- I'm going to speculate here. As an

endocrinologist, you're probably going to say, your diabetes is serious enough that you need to be on this on a routine basis, period, regardless of whether you're pregnant or not pregnant.

LESLIE EILAND: OK. So--

RIEPE: Is that fair?

LESLIE EILAND: In some way, yes. So I, I feel like-- I'm primarily speaking to the second part of the bill that's talking about people with type 2 diabetes--

RIEPE: OK. Yes.

LESLIE EILAND: --who are on one shot of insulin per day, which is not intensive insulin, but there's good evidence and the standard of care is such that CGM is still recommended. Most-- and I want to be clear that, in my clinical practice, I primarily care for women with type 1 and type 2 diabetes prior to pregnancy--

RIEPE: Of course.

LESLIE EILAND: --and gestational diabetes is mainly taken care of by an ob-gyn, so I have less direct clinical experience. But I, I do occasionally care for women with gestational diabetes. So most women with gestational diabetes, you know, do not get diagnosed until halfway through their pregnancy. And they have diabetes-- they have insulin resistance because of a hormone that is made by the placenta. And so as soon as the baby is delivered, placenta is delivered, their insulin resistance plummets, goes back to near normal values, and the majority of women with, with gestational diabetes then do not subsequently, at least in the near future, require medication for diabetes, especially insulin. If they're requiring insulin after gestational diabetes, it's probably because they had preexisting type 2 diabetes and just didn't know it. So the majority of women do not need to continue to monitor their glucose levels intensively after delivering. They go back to normal glycemia, like normal glucose levels. And the guidelines really just suggest periodic screening for diabetes, like with the hemoglobin A1C, once a year maybe with their primary care provider because we know they are at increased risk for type 2 diabetes in the future. But in the near term, there's no reason to continue to monitor glucose levels intensively. And most people are not asking for it because they go back to normal.

RIEPE: That's very informative. I did not know that.

LESLIE EILAND: Sure.

RIEPE: So that would allow them to forego having the monitor.

LESLIE EILAND: They do not need any glucose monitoring device after that if they purely just have gestational diabetes.

RIEPE: That was very helpful.

LESLIE EILAND: Thank you.

RIEPE: You should go to medical school.

LESLIE EILAND: Thank you.

RIEPE: Thank you, Chairman.

HANSEN: Yep. Any other questions? Is the reliability of the glucose monitoring device the same as using the finger prick? Because I think they are testing different-- you know, one's interstitial fluid and the other one's is actually the blood--

LESLIE EILAND: Blood glucose.

HANSEN: Is there much of a difference there?

LESLIE EILAND: Not really. When the glucose levels are stable and you have an arrow that's straight across-- so the FDA several years ago-- now, any, any continuous glucose monitoring device that is approved has an FDA indication to dose insulin off of, meaning the accuracy is the same as a leukometer. The exception to that is when glucose levels are quickly rising and falling, then the finger poke is going to be more accurate in the moment. But within about 30 minutes, things reequilibrate.

HANSEN: OK. And I don't know if you'd be able to answer this, but just-- it's kind of more of a curiosity. Since we are getting more technological with the information here, and always my concern about, you know, privacy and information--

LESLIE EILAND: Sure.

HANSEN: --these are on apps and these are on devices and it is--

LESLIE EILAND: Correct.

HANSEN: --protected information.

LESLIE EILAND: Mm-hmm.

HANSEN: Do you know who has, who has access to this, this information? Like, the people-- like, because the app, I'm assuming, is owned by a, an outside company.

LESLIE EILAND: That's a great question. And that goes along to your smartphone app as well. So all of the devices that are FDA approved do have the ability to be used with a standalone receiver that does not connect to anything. It's just Bluetooth from the sensor transmitter to the receiver device. And then there's no data or cell phone service to send it anywhere. So that's one option. If you're using the cell phone app, then, yes, it would be an app from the company based on the device that you're utilizing. And then the patient has the option for a couple things. They can share their data in real time with, like, a family member or a loved one to get real-time alerts, like if their blood sugar is low and they are not able to-- you know, they're passed out and-- you know. Their loved one could get alerts and come find them and save them from, hopefully, an ER visit. And so you have the ability to share your data in real time with a family member. There's also the idea of, of you get cloud-based data sharing to a health care clinic should you choose. So my patients, if they would like, I can send them an email invite from my clinic, which connects their app-based data to my clinic cloud-based portal, which then all of our providers have to have their own individual username and password, often with two-factor authentication to get the data.

HANSEN: OK. All right. Thanks.

LESLIE EILAND: Yeah.

HANSEN: Seeing no other questions. Thank you for coming.

LESLIE EILAND: OK. Absolutely.

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

MIKAYLA WICKS: Good afternoon. Go ahead? OK.

HANSEN: Yup.

MIKAYLA WICKS: Good afternoon, Chairperson Hansen and members of the Health and Human Services Committee. My name is Mikayla Wicks,

M-i-k-a-y-l-a W-i-c-k-s. And I'm a member of District 30. I'm here today to testify in support of LB933, introduced by Senator Bosn. I was diagnosed with type 1 diabetes in April 2004 at the age of 14. At that time, I was testing my blood sugar with a finger prick before every meal I ate and then two hours after. I used this information to tell me if I needed to take additional insulin or eat or drink something to increase my numbers. As you can imagine, especially for a teenager, compliance is not always 100%. I was supposed to test a minimum of seven times per day. This includes before and after meals and then before going to bed. If at any time during the day I felt my blood sugar was high or low, I would have to test again, which led to additional finger pricking. So for those that are unaware, you are pricking your finger with a lancet or a small needle to retrieve blood to put on a test strip. By the time I started using a CGM, I was on the highest setting for the lancet to puncture my skin, as my fingers were so calloused due to the amount of finger pricks I was doing. It was not until 2014, 2015-ish that I decided to try a continuous glucose meter, or CGM. My husband and I at the time were wanting to expand our family and knew, to have a successful pregnancy, my blood sugar or glucose management was especially important. At the time of collaborating with my endocrinologist to be allowed to utilize a CGM, I was pricking my finger to test my blood sugar up to 12 times per day minimum. Once approved for the CGM, I started wearing the device and immediately saw better results in my A1C. I wore the CGM on my abdomen at that time for seven days between putting on a new one, per the FDA guidelines. Now I can wear my CGM for ten days, which is now in my arm. The CGM allows for a blood sugar update every five minutes. Not only does it show what my blood sugar level is, but it helps determine which direction my blood sugar is going. There are arrows to show that your blood sugar is increasing, decreasing, or holding steady. During both of my pregnancies, I wore the CGM to help control my diabetes. Without the CGM, I believe I would not be sitting here with you today. While pregnant, my blood sugar would drop very quickly, and most often while I was sleeping. The CGM would sound an alarm if I went under a certain number, not only on my phone but also on my husband's. This would allow one or both of us to wake up and correct my low blood sugar. With the company that I use for my CGM, my mom was also able to get my readings and would make phone calls to my husband in the middle of the night to ensure we were treating my lows. As you can imagine, when your body is at a state of panic and trying to survive, you are not always able to be awakened. Throughout my pregnancies, my endocrinologist was able to download my blood sugar readings to be able to make changes between appointments related to dosage to ensure

I was in range as much as possible. To this day, if I must go without my CGM for any reason, I find myself having a more challenging time, not just in my diabetes management but in life. Diabetics have approximately 180 additional decisions to make per day compared to the average person. I'm thankful to have-- also have an insulin pump that works with my CGM to increase and decrease my insulin dose based on my blood sugar level. While my diabetes wasn't just while I was pregnant, I strongly encourage you to vote this bill out of committee as I support any, any individual being able to use the technology of CGMs to manage their diabetes, especially while pregnant, not just for the individual's heals-- health but also for that of their unborn child. Thank you for the opportunity to share my experience with CGMs and pregnancy through testimony today. I've also included for you an article from Beyond Type 1 regarding CGM as a vital tool in healthy pregnancy. I would be happy to answer any questions there may be.

HANSEN: All right. Thank you for your testimony. Any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Thank you for being here, here and sharing your story. My question is currently where I'm wrong here that you receive every five minutes. Do you get any record of that so that you could look at trend lines and say-- I'm, I'm, I'm guessing here-- that, before or after meals, the trend line changes. But there's some advantage to having more than just a, a spot every five minutes that you, you see over some period of time. My other question would be is, I think I heard you talk about-- you said you have an automatically in-- infusion from-- of insulin.

MIKAYLA WICKS: Correct.

RIEPE: Is that in correlation with the five minutes? I mean, this sounds like-- it sounds pretty sophisticated.

MIKAYLA WICKS: It is. Yes. So the-- sorry. I do have an insulin pump and it works, like, in real time with my glucose sensor. As far as seeing trends and things like that, I use the app on my phone. And I can go into the app and I can-- and even on my insulin pump, I can see 1-hour, 3-hour, 6-, 12- or 24-hour graph. It also tells me how long I've been in range for the past 7 days or 14 days. And every week-- mine just happens to be on Sundays-- I get an email that tells me, this week, you were in range 80% of the time. This is an increase or decrease from last week. And so I can see what percentage I was in-- like a very high, high, in range, low, or very low kind of status. But

the-- my specific insulin pump and glucose meter work in real time. So if my glucose meter is saying that my blood sugar is going up very quickly and I don't have, say, any insulin on board-- so I haven't take-- maybe I ate and I forgot to take insulin-- it will start to correct and add in some additional insulin. It also will beep and tell me, hey, your blood sugar's high. It's been high for an extended period of time even with the additional insulin we've given. You need to check into this.

RIEPE: Do you happen to have a Apple Watch as well?

MIKAYLA WICKS: I do. So I can get it on my watch. So it's really easy when I'm at work or in meetings. I can look down to see where I'm at, especially if I'm starting to feel different. I can check my phone or I can check my pump as well.

RIEPE: Good for you.

MIKAYLA WICKS: Thank you.

RIEPE: Good for you. Thank you for being here. Thank you, Chairman.

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

MIKAYLA WICKS: Thank you.

HANSEN: Thank you very much. Take our next testifier in support of LB933. Any-- anybody else wishing to testify in support?

MARION MINER: Good afternoon.

HANSEN: Welcome.

MARION MINER: I'll, I'll be brief. My name is Marion Minor, M-a-r-i-o-n M-i-n-e-r. I'm associate director of pro-life and family policy for the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life through engaging, educating, and empowering public officials, Catholic laity, and the general public. The conference supports LB933's intent to provide continuous glucose monitoring to patient-- to pregnant women with gestational diabetes and who are eligible for Medicaid. The rest of my testimony is very similar to the testimony I gave yesterday in this committee on LB857. So instead of continuing to read that, I'll just wrap up by saying that LB933 fits into a broader effort that the conference supports: to affirm the dignity of human

life at all stages and to express that affirmation in a special way through the preferential option for the poor. So with that, I'll wrap up. And I'll take any questions if you have any.

HANSEN: All right. Thank you. Are there any questions from the committee? I don't see any. Thank you.

MARION MINER: Thank you.

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

ROBERT LASSEN: Welcome. Thank you, Chairman Hansen and members of the Health and Human Services Committee. My name is Robert Lassen, spelled R-o-b-e-r-t L-a-s-s-e-n. And I'm here representing AARP. Thank you for the opportunity to comment on LB933, a bill to require the coverage of continuous glucose monitoring devices under the Medical Assistance Act. I'm here today to discuss the advantages of the continuous glucose monitoring. These devices automatically track blood glucose levels throughout the day and night. This allows diabetics to see their blood glucose levels anytime while allowing medical practitioners and providers the ability to review how glucose levels change with a few hours, days and see trends that may be developing. Seeing glucose levels in real time can assist the diabetics in making informed decisions throughout the day about how to balance their food, physical activity, and medications. Most devices send an alert when glucose levels rise or fall to a certain amount. With this information, changes can be made quickly. Early intervention can prevent highs and lows from running into big problems. With information recorded on the device, us medical providers can then better personalize diabetic care based on what they've seen and learned in these device histories. Finger sticks, as mentioned earlier, are now one of the only options-- or has been-- to measure blood glucose. And again, this provides only one quick look in time. To provide more glucose readings requires more finger sticks. Finger sticks, over time, as mentioned earlier, can cause scarring and numbness in the testing area. As medical costs continue to rise, related to indirect expenses are also rising, such as reduced productivity, inability to work, and absenteeism. Compared to people with commercial insurance, Medicaid beneficiaries have higher rates of suboptimal debi-- diabetes management, worse glycemic control, experience more barriers to care, and have more acute and long-term diabetes-related complications. Studies have shown that the use of the CGMs can lead to a better health outcomes and quality of life. With better outcomes and quality of life, the work absenteeism rate and

diabetic-related hospitalization rates can decrease significantly. One study shows that a patient adopting a CGM for just nine months resulted in health care savings of $4,000 and related expenses. CGMs have shown to be cost-effective at $100,000 per quality adjusted life years by decreasing the experienced diabetic stress, fear of hypoglycemia, reduction or elimination of finger stick testing, and changes in critical A1C markers. Thank you for the opportunity to comment on this important legislation. And thank you to Senator Bosn for introducing it, and the number of cosigners who understand good process equals good results. AARP encourages you to support and advance this bill to the floor. Have any questions now?

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

ROBERT LASSEN: Thank you.

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

WYATT LANIK: Hi. Thank you, Chair Hansen, members of the Health and Human Services Committee. My name is Wyatt Lanik, W-y-a-t-t L-a-n-i-k. I'm a fourth-year medical student at the University of Nebraska College of Medicine and a member of the Nebraska Medical Association, which represents approximately 3,000 physicians, residents, and medical students across Nebraska. My testimony does not represent UNMC. However, I am testifying on behalf of the Nebraska Medical Association. The ANA-- the NMA supports LB933. As an applicant to internal medicine residency and a trainee dedicated and subspecializing in endocrinology after residency, I have a vested interest in providing my future patients with the standard of care expected. Continuous glucose monitoring, CGM, is a necessary medical device for multiple therapeutic interventions beyond the current Department of Health and Human Services regulation, which cites eligible beneficiaries as those, quote, who have diabetes mellitus, use multiple daily doses of insulin, or are on insulin or on an insulin pump, end quote. The strict definition of eligible recipients negates many people that would benefit from a CGM device. Severe hypoglycemia, or low blood sugar, a potentially fatal state, is associated with unwanted comorbidities, mortality, emergency room visits, hospitalizations, and cost of medical therapy. The Endocrine Society and the ADA have edi-- evidence-based medicine guidelines surrounding hypoglycemia and diabetes, and recommend CGM devices be utilized for patients with diabetes on insulin and/or sulfonylureas, another class of diabetes medications separate from insulin, which can

cause low blood sugars as well. Further, insulin does not only come in continuous pumps or multiple daily doses-- dosing regimens, thus the current regulation leaves patients with single daily dosing or basal-only insulin without CGM coverage. The new language in LB933 would closer align the Nebraska Medicaid coverage of CGM devices with new Medicare policy and would align with the original intent of LB698 by providing Medicaid coverage of CGM devices to all eligible recipients with a prescription. Limiting eligible recipients neglects people across our state with different diagnoses that would benefit from CGM. LB933 will allow patients to achieve better clinical outcomes, enjoy a higher quality of life, and cost less to the state. The NMA appreciates Senator Bosn for introducing LB933. And we encourage your support for the bill. Thank you for your time. I'm happy to answer any questions.

HANSEN: All right. Thank you. Is that your first time testifying with the NMA?

WYATT LANIK: Yeah.

HANSEN: OK. Well, we're going to pick everything apart that you said here today.

WYATT LANIK: OK. Sounds good.

HANSEN: No, you did good. Any questions from the committee? See? And you don't even get any questions either. See? That's nice. All right. Thank you for coming. Appreciate it.

WYATT LANIK: Thank you.

HANSEN: All right. Anybody else wishing to testify in support? All right. Seeing none. Is there anybody who wishes to testify in opposition to LB933? Seeing none. Is there anyone who wishes to testify in a neutral capacity? Seeing none. We'll welcome Senator Bosn back up here to close. And for the record, we did have 25 letters in support of LB933 and 1 in the neutral capacity.

BOSN: Thank you. I will be brief because I know I'm the first of several things going today, so I'm just going to recap and try and answer some of the questions that were asked. Really, I think this comes down to removing some of the red tape for moms and individuals with type 1 and type 2. That puts us back into compliance with the intention of previous legislation. I also want to clarify because-- just because a, a mom-- specifically as it relates to gestational

diabetes, just because a mom is diagnosed in one pregnancy doesn't necessarily mean she will be diagnosed with gestational diabetes in future pregnancies. I know this to be true because it was true of my own mother. I don't know how often it's true. The other thing that you had asked about the phone app I think we got answered, but I did get confirmation that you can use a phone app. That doesn't mean you have to. You can also use a receiver. You had asked about compliance-- or, I think Senator Riepe asked about compliance. And the information that I've received is that compliance is at 90%, and that's regardless of age, income, any of the other factors that might carry over. So it's a 90% compliance rate, which I think is important to note. I want to thank those who came to testify in support of this. Give my shout-out to Columbus, because both Dr. Leslie-- worked in Columbus; and also Ms. Wicks, who I worked with when I was with the county attorney's office, she was with HHS. So I'm grateful that they were willing to come and testify. And I hope that you guys will vote this out of committee.

HANSEN: All right. So with that, are there any questions from the committee? There are none. Thank you very much.

BOSN: Thank you guys.

HANSEN: All right. And that'll close our hearing for LB933. And we are going to take a short break. We're going to stay until 2:30 because right now I guess Nebraska public television is down. And so none of the cameras are on and nothing else is working. So we're going to take a short break. We'll see how that goes here for now. Thank you.

[BREAK]

BLOOD: [RECORDER MALFUNCTION]-- risen significantly postpandemic. The demand and shortage of workers is worsens by the-- worsened by the expected high number of social workers and behavioral experts that will be retiring in the near future. The compact will allow telehealth access to a wider pool of qualified social workers for rural Nebraskans. Telehealth is not a pa-- panacea for the social worker shortage, as many rural areas of our state still lack broadband infrastructure. But this is a huge step for patients in our state to have access to more qualified behavioral experts from other states. It also provides continued care for clients relocating to another member compact state with their preferred social worker, preventing disruption of care. For regulators in Nebraska, there are benefits with this compact: cutting bureaucratic tape and enhancing public

safety. The compact reduces the licensure application time to process if a licensed social worker rele-- relocated from a member compact state. Compact member states also share databases on licensed behavioral professionals to keep up-to-date on disciplinary information of licensed individuals and any pending investigations a licensed individual might have. In general, it expands cooperation among compact member states' licensure boards and encourages cooperation on any ongoing disputes or possible violations by a licensed professional moving between compact states. This type of cooperation and shared data between member states enhances public safety in the profession in a way reciprocity or universality programs cannot accomplish. Most importantly, state sovereignty is preserved for member states as this compact, like others, does not change the scope of practice. Also, this compact will be a boon for military member spouses in this profession. With frequent redeployments, the reality for many military spouses and their professions is a disruption in their careers. They face difficulty attempting to get new licenses and maintaining or increasing their previous income. There is no reason military families being restationed in Nebraska should face further hurdles in getting licensed in Nebraska. They should face the easiest possible assimilation within our state. I want to make the committee aware of the amendment we have passed out cooperating with DHHS. We are introducing this amendment so it works in conjunction with LB1214 relating to national criminal background checks. This revised statute will need to be approved formally by the FBI. DHHS will continue to work with State Patrol to receive final approval. We hope the committee considers adding in the amendment. LB822 is a benefit for social workers, behavioral experts, military families stationed in Nebraska with spouses that work in the industry, and underserved patients. Interstate compacts are commonsense legislation that preserves Nebraska's sovereignty over its regulations and scope of practice while enhancing public safety through shared databases and cooperation among member states' regulatory agencies. Since this is a priority for the DOD, I hope the committee votes LB822 and the amendment to the floor expeditiously. And I thank the committee for their time today and can answer any questions that you may have.

HANSEN: Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Thank you for being here. And you seem to be the go-to senator when it comes to compacts.

BLOOD: That, that is my jam.

RIEPE: That is your-- one of your jams. One of your jams. I also understand that you have one coming up on diabetics-- or, dietitians?

BLOOD: On dietitians.

RIEPE: Dietitians. OK. So I don't know-- I don't want to get necessarily into the [INAUDIBLE]. To set up, to set up a, a compact, does it, does it take seven states? Is that the number?

BLOOD: It depends on the compact. I've had compacts that have been ten states. I've had compacts that have been seven states. So each compact is different. The organizations that get together and work with the DOD and the CSG are the ones that make the decision as to what the, the foundation will be when the compact's created.

RIEPE: Because I think you said you had three states now on, on social work.

BLOOD: Two, two states on social work and 24 pending.

RIEPE: OK.

BLOOD: I, I think you'll notice that from the very-- when we first started bringing interstate compacts to this and other committees-- I was just telling someone this-- it used to be-- you know, we'd be like, uh. You know, we don't want to be first. Why would we want to be first-- part of the first seven? You remember that.

WALZ: Mm-hmm.

BLOOD: And now it's like everybody is rushing to do these because they find they are more efficient than reciprocity. Because with reciprocity, not all states are the same. And so-- especially the states that are trying to be number one for the military. Like, you want to be the most military friendly state, you're going to rush to help the DOD with their compacts. So, yeah. It's happening fast because this was literally just dropped. So I-- it was not like this seven years ago, Senator Riepe. Now people are, like, chomping at the bit to get them done.

RIEPE: Put it on the symposium pretty soon.

BLOOD: I have spoke at the Pentagon on this before. It was actually one of the highlights of my life, so.

RIEPE: Well, thank you. Thank you for your cause.

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

BLOOD: I unfortunately cannot stay for close because I have a 3:30 doctor's appointment in, in Omaha and I would get a speeding ticket.

HANSEN: All right. So with that, we will take our first testifier in support of LB822. Welcome.

AMANDA DUFFY RANDALL: Hello. I am Dr. Amanda Duffy Randall, A-m-a-n-d-a D-u-f-f-y R-a-n-d-a-l-l. And I am the retired director of the Grace Abbott School of Social Work at UNO. Among other credentials, I'm a licensed independent social worker in Nebraska and also in the state of Iowa. I currently have a private practice in Omaha, which I've had for over 40 years. And I speak as a licensed clinical social worker in the state of Nebraska. And I'm also representing the National Association of Social Workers Nebraska Chapter on this bill. I heartily endorse the adoption of LB822. The Social Work Compact will allow occupational licensure across compact states. My experience of getting licensed in Iowa-- I practice in Omaha, so I serve clients in the metropolitan area, and I currently maintain two licenses in two states, pay two license fees, continue education requirements for both states, and maintain licensure in order to practice only in Iowa and Nebraska. With telehealth and with mobility, as you know, social work practice has expanded exponentially. And I am somewhat at the end of my career in social work, but this will be a huge benefit to social workers coming up and practicing currently. Licensure is a jurisdictional issue. United States and Canada. I am the past president of the Association of Social Work Boards, which was one of the organizing organizations for this. We have struggled for years with trying to obtain mobility and flexibility for our social work practice. We are a mobile profession. And the largest employer of social workers in the United States is a veterans administration. Those social workers have licensure in every jurisdiction. Their spouses and active duty military spouses do not. So it, it requires every social worker married to an active duty military person to obtain licensure in each jurisdiction. I strongly urge passage of this and-- will benefit social workers in the future. And I hope to be one of the compact members as soon as it is passed.

HANSEN: Thank you. Are there any questions from the committee? Seeing none. Thank you very much. Take our next testifier in support. Welcome.

SUSAN REAY: Hi. Thank you. My name is Dr. Susan Reay, S-u-s-a-n R-e-a-y. I have some copies of testimony. I am the current director at the Grace Abbott School of Social Work and-- at the University of Nebraska at Omaha. I'm here representing myself. And my views do not necessarily represent the, the University of Nebraska system. I also am a licensed independent clinical social worker, and I've been one for the last 25 years. I was a Mental Health Practice Board member for 13 years and was in leadership roles in that capacity for 9 of the 13 years. But mostly what I do in my life is just try to be like Amanda, who you just heard from, my wonderful mentor. And I'm so happy to have her as a colleague. I am so excited about this. I think this is one of the most important pieces in-- of legislation for social work practice in my lifetime. The first one was when we initially got licensing in the '90s, and then back-- and then second was in 2007 with ment-- independent mental health practice, and then this. It's really a game changer. I have two main points that I want to drive home today. One is related to my students, and that is that the students now are very mobile and they are-- grew up with technology. They understand it. They work remotely. They-- during the pandemic, they were remote on their own. And they are-- they want the flexibility to be able to move around, but Nebraska is their home base largely for, for almost all of them, and they want to maintain that connection to Nebraska. So in terms of workforce development and mental health practice and social work, this is a really important piece of legislation where people can maintain that connection but still be involved and around. My second point is related to administrative paperwork and fiscal responsibility. So when students graduate with their master's in social work, they apply for a license as a licensed clinical social worker. You've heard a lot about that with LB932 and in other bills. This application that they complete is 17 pages long. I have a copy of it if you'd like to see it. It is paper. It is something that you can fill in and type in or you can write it in. It includes several attachments. And it's very important that we have transcripts submitted, that we understand background checks, all of those things. However, the way that we're doing it now is not effective. And every hour-- I spend probably three hours with students explaining what licensing is and about public protection and how to complete this application. And I tell them two hours to complete the application, but you can see why, you know, it's taking so long to get people

licensed. If somebody at the Department of Health and Human Services is having to theoretically check all of that and make sure that happens and people are filling this out and it's just a paper system, it's not working. And this compact will help to bring up Nebraska in our methods of submitting and completing licenses. There's a lot of stuff in the works, and I know the department's moving towards an electronic record system, but this legislation will help to move that forward so that we can be compatible with other states. So in that vein, I'm, I'm very excited about this. I'm happy to answer questions, but I do have one more thing. My students and I have been watching this committee, watching your testimony the last couple days, and learning that you're doing Taylor Swift references. And so I had a student request to end with a Taylor Swift reference. Sorry, Senator Hansen. I'm sure you're not excited here, but-- so I just have to--

HANSEN: I love Taylor Swift. Go ahead.

SUSAN REAY: Don't give us another cruel summer of doing this lengthy licensing application. Let's move into a new era of social work practice, so. Thank you very much.

HANSEN: Thank you for your testimony. Maybe people will start doing Elvis references. I like that better. I don't-- I'm old school. All right. Any questions from the committee? All right. Seeing none.

SUSAN REAY: Thank you very much.

HANSEN: Thank you very much. We'll take our next testifier in support, please. Welcome.

SARA BATTER: Thank you. Hi. Good afternoon. My name is Sara Batter, S-a-r-a B-a-t-t-e-r. I am a licensed independent clinical social worker. And I'm here today representing the, the Nebraska Board of Mental Health Practice. I would like to share that the board is in full support of this bill. We are aware that there are significant shortages regarding mental health and social workers nationwide. This bill would allow social workers to meet the client's needs and be able to practice across state lines. This would improve access to much needed mental health services. Additionally, this bill will allow for a continuum of care when clients relocate either permanently or temporarily. For example, if a col-- college student returns to their home state during a break, a social worker in Nebraska would be able to continue therapeutic services in that client's home state. Also, this bill would make it easier for spouses of military personnel to

practice when they locate due to military responsibilities. Many spouses of military personnel are foced-- forced to meet new requirements and face waiting periods when they relocate. Not only is this burdensome for the social worker, it also prevents qualified social workers from practice, thus adding to the shortage. Lastly, through the pandemic, we have learned the value of telehealth services, particular-- particularly in the areas of shortage of social workers and rural areas. This bill would increase social workers' abilities to practice via telehealth across state lines, which would, again, address the shortage issues experienced in many communities. Therefore, the Mental Health Practice Board would like to fully support LB822. Thank you.

HANSEN: Thank you. Are there any questions? There are none.

SARA BATTER: Thank you.

HANSEN: Thank you. Anybody else wishing to testify in support? Welcome.

KRISTEN RODRIGUEZ: Thank you. Good afternoon, Chairman Hansen and committee members of Health and Human Services. Sorry. Can you all hear me? I'm closing enough. So my name is Kristen Rodriguez, K-r-i-s-t-e-n R-o-d-r-i-g-u-e-z. And I did not intentionally-- I am not here-- excuse me. Let me restart. Clearly, I am not prepared for today. I saw-- I was planning on being here this morning and decided that this wasn’t important enough for me to stay for this afternoon. So please bear in mind that I am just going off the cuff here, so. But things that I would like for you to know is I am originally from Massachusetts. I'm a licensed independent clinical social worker. That's where I first got my license. I'm also the vice president of operations at Child Saving Institute. And my husband is an active duty member. And so I am thus here all the way from Massachusetts to overseas to Nebraska courtesy of, of my husband. But I'm really happy to be here. I think what I most want you to know is that, as a military spouse, I had my options as I was looking around at what my license could do here in Nebraska. And honestly, my first look was to work at Offutt because that's where my license from Massachusetts would, would work for here. So from my perspective, I want you to know that that was my first look. And I'm really happy to be an employee serving the community. We plan on staying here. My husband has about 2 years left of his 20. And assuming things continue going well, we're-- we plan on staying. And finding that a lot of people in the military community want to stay here. And I think that this compact will go a

long way to incentivize people to work in the community rather than, than on the base. They already have, have that as an option regardless of where they go. I think pe-- you know, the spouses who are social workers kind of in the military community would really enjoy the opportunity of being able to jump right in and be a part of the community because they're kind of half in the military community and then half in, you know, the local community. If you have kids, you know, your kids go to schools locally. And so sometimes it's this kind of, are you in or are you out? Where do you belong? And so I just really wanted to speak to that. If you want people to be incentivized to live here in Nebraska, this is going to go a long way. And also, you know, in turn, through the services that are provided, be able to elevate the community and all-- in a lot of different ways. As an employee of Child Saving Institute, recruitment and retention of staff is a huge thing. I don't need to go on and on about all of that. You guys hear about that all of the time, I assume. Of course, I'm happy to answer questions. But for me, the big thing that I want you to know from my perspective is that the compact is one very small piece of the bigger pie or puzzle to keep providers standing. Rates are a big part of that. You know, Medicaid-- all, all of the strings attached. This is one piece of the multitude of, of issues that are kind of going on in this space that is going to kind of keep us standing and sustainable and on two feet. So I just really want you to hear that this is a personal thing for me and, and for others and to hear my story in it. But also that, for kind of the provider network, this is really, really important. We're a landlocked community. We are surrounded by other states. And we have great border states next to us. But it would be really great if we could welcome those people into our community for employment as well. I'm happy to answer questions if you have any.

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

WALZ: I don't really have a question, but I, I did not-- first of all, you did a really good job for being off the cuff.

KRISTEN RODRIGUEZ: Thanks.

WALZ: I can't do that very well. I did not realize that you could practice on the base for two year-- or, for as long as you're there, right? Is that what you--

KRISTEN RODRIGUEZ: Yeah. So as-- if you get a GS position, a general schedule, then yes. It-- you know, my Massachusetts license for sure qualified me for those positions.

WALZ: But once you're out of service, then you, you can't practice [INAUDIBLE]--

KRISTEN RODRIGUEZ: Don't believe so. Unless you're grand-- I, I don't know the answer to that. My guess is that, you know, if you're living here and you elect not to get a Nebraska license--

WALZ: Right.

KRISTEN RODRIGUEZ: And so, so say I, I have my Massachusetts license. I don't have my Nebraska license. My only opportunity would be to work on the base.

WALZ: The base. OK. All right.

KRISTEN RODRIGUEZ: But, again, that's, that's a choice.

WALZ: Right.

KRISTEN RODRIGUEZ: But it's a much easier choice to, to get through.

WALZ: Right. Well, we hope you stay in Nebraska.

KRISTEN RODRIGUEZ: Thanks. I'm hoping to.

WALZ: Thanks for coming today.

KRISTEN RODRIGUEZ: Yeah. Thanks for your time.

HANSEN: I got a question.

KRISTEN RODRIGUEZ: Sure.

HANSEN: How long you been in Nebraska then?

KRISTEN RODRIGUEZ: As of April, it's going to be two years.

HANSEN: OK. From Massachusetts or were you overseas?

KRISTEN RODRIGUEZ: I am born and raised Massachusetts. We spent about eight years overseas. And I have two young kids at home. And we wanted

to be closer to family, so we attempted to come back stateside, which landed us here at Offutt, so. Happy to be here.

HANSEN: You sound like you're from Nebraska. From being from Masschusettes, that's great.

KRISTEN RODRIGUEZ: Yeah. Well, you know what? A lot of people tell me that. And there's about-- in Boston, there's about two neighborhoods that have that kind of really, really thick Boston accent. And I haven't lived there in about a decade. So I have-- as a military spouse, one of the things you have to do is you-- part of the resilience of it is that you have to morph and kind of fit into wherever you land. It's not so-- my choice. Again, I'm happy to be here. But, you know, I've had to recreate myself many times.

HANSEN: Well, you sound like you're from Nebraska, so you should stay here.

KRISTEN RODRIGUEZ: Thanks. Happy to, if you'll have me.

HANSEN: All right. Thank you very much. Appreciate it.

KRISTEN RODRIGUEZ: Thank you for your time.

HANSEN: Anybody else wishing to testify in support? All right. Seeing none. Is there anybody who wishes to testify in opposition? Seeing none. Is there anybody who wishes to testify in a neutral capacity? All right. Seeing none. That will close the hearing-- since Senator Blood has waived her closing, that'll close the hearing on LB822. And we will now open it up-- the hearing for LB1320 and welcome Senator Ballard. And before he begins, we did have three record-- rec-- letters for the record on LB822: three of them in support, one in the neutral capacity. And you can begin whenever you're ready.

BALLARD: All right. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Beau Ballard. For the record, that is B-e-a-u B-a-l-l-a-r-d. And I represent District 21 in northwest Lincoln and northern Lancaster County. I'm here today to introduce LB1320. LB1320 requires any EMS that treats and transports individual experiencing a suspected or actual overdose to report the incident to the Department of Health and Humans Services within 72 hours, if possible. Once the department receives the report, they will be required to report this information to the Washington/Baltimore High Intensity Drug Trafficking Area Overdose Mapping and Application Program. According to the WBHITDA, the purpose-- the primary purpose

of the OD mapping includes a-- provide a near real-time surveillance of known or suspected overdose incidents across the United States and its territories; and two, to mobilize safety and public health effort, efforts to collaborate and mobilize immediate response to overdose incidents. The ODMAP is beneficial because multiple different partners, public health and public safety, can see all the information about overdoses and can coordinate responses based on sudden increases to prevent further lives lost. For each incident, the ODMAP reports four pieces of information: one, the date and time of the incident; two, the location of the incident; three, whether the overdose was fatal or nonfatal; and four, whether a first-responder admini-- administers Narcan to the victim. The bill also ex-- explicitly states that the overdose information reported due to the bill cannot be used for any sort of criminal investigation or prosecution. The bill also provides immunity to any EMS that has a good faith reporting. Finally, with the drug epidemic continuing to evolve, this could be the best effort to providing information as fast as possible. This country has transitioned to opioids in the 1990s, heroin in the 2010s, and now fentanyl. Unless we take drastic measures, drug overdoses will continue. I'd be happy to answer any questions that you may have.

HANSEN: Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here, Senator Ballard. My question is, is this a new source of information for us? Would this-- or are we getting information already on an overdose report?

BALLARD: I believe we're getting information already, but this would just be in being real time.

RIEPE: The other question that I had is it said in the piece here, it said Washington/Baltimore High Int-- sounded like a high school to me, but. I assume that's a national--

BALLARD: It is a national-- out of, out of Maryland.

RIEPE: Maryland.

BALLARD: Mm-hmm.

RIEPE: OK. Thank you.

BALLARD: Thank you.

RIEPE: Thank you, Chairman.

HANSEN: All right. Any other questions? Seeing none. See you at close.

BALLARD: Thank you.

HANSEN: All right. We'll take our first testifier in support of LB1320. Welcome.

CHERI IVERS: Hi. Thank you. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Cheri, C-h-e-r-i; Ivers, I-v-e-r-s. And I'm the drug intelligence officer for Nebraska State Patrol. I'm here today on behalf of Nebraska State Patrol in support of LB1320, which would require emergency medical services to report overdose information to the Overdose Detection Mapping Application Program, ODMAP, operated by the Washington/Baltimore High Intensity Drug Trafficking Area. This information submitted to the program would not contain specific details about the patient. Instead, the information gathered would provide valuable data regarding the overdose event. The information would not be used as part of a criminal investigation or for the prosecution of the parties involved but rather to empower law enforcement agencies to act in the interests of public safety and better coordinate with public health to respond to areas designated as having a spike of activity or a cluster of events. The timeliness of a reporting period would also increase the opportunity to better allocate resources in near real time to save lives and prioritize location of future training opportunities. LB1320's overdose reporting requirements would ensure communication regarding overdose and would improve the health and safety of Nebraskan communities. First, there's not an established central repository for the overdose information in the state of Nebraska. Various agencies currently operate ses-- separate systems with different criteria, and these systems include but are not limited to death certificate information, health department community-based epidemic surveillance, the State Unintentional Drug Overdose Reporting System, and police reports. These records are currently compiled to create a comprehensive figure for the overall number of suspected overdoses that occur since no dataset is independently complete. Each contributing agency has specific policies that dictate how the information may be disseminated. This means that there is time required to sanitize documentation for release, which further impedes the timeliness of informed response and the potential for intervention. ODMAP is by far the most inclusive dataset, as submissions may include deliberate,

accidental, survived, and fatal overdose events in one system. Second, ODMAP protects entry information by requiring access approval, and it's not accessible to members of the public. Furthermore, the location of the incident is geocoded so the information cannot be searched or stored as an address. The zoom function is also restricted to further anonymize the site while still permitting improved specificity from other systems that only report per zip code. And third, the entry of data from emergency medical service professionals presents the best possible source of information. These professionals are trained in the medical field to identify the symptoms associated with overdose. This process alleviates the reliance solely based on admissions received or evidence obtained by law enforcement at the scene. Finally, Nebraska State Patrol focuses on matters related to the safety of the public and requires information to understand current threats by relying heavily on partnerships with agencies to address overdose issues in all troop areas. Currently, we know there are regions that are underinformed since hospitals are not required to report survived overdoses and because suspected overdose deaths are not required to be autopsied or have toxicology reviewed. If emergency medical service staff was reporting the number of actual overdoses occurring, the information could assist in supporting areas that have previously not established the need for officer or community safety alerts, substance abuse prevention efforts, or recovery services. In closing, thank you for the opportunity to provide testimony on this important matter. And I would be happy to answer any questions.

HANSEN: Thank you.

CHERI IVERS: Thank you.

HANSEN: Are there any questions from the committee? There are none. Thank you very much.

CHERI IVERS: My pleasure.

HANSEN: Is anybody else wishing to testify in support of LB1320? OK. Oh, we do. OK. Welcome.

MIKE GUINAN: Good afternoon. Afternoon, Senator Hansen and members of the committee. My name is Mike Guinan, M-i-k-e G-u-i-n-a-n. I'm the chief of the criminal bureau at the Nebraska Attorney General's Office. And I'm here on behalf of the Attorney General's Office in support of LB1320. My purpose of being here is just to provide a little bit of background on how we got here or how this bill gets here

before you today. And we do appreciate Senator Ballard for introducing it. Last year, about this time last spring, we had a drug forum with the Nebraska Attorney General's Office, with law enforcement officers from around the state, and this item was noted as a sticking point or a, a problem area where information was not being fed into the systems-- and, and in particular, this particular system-- so that we could-- OD mapping-- so that we could help track and-- ODs or overdoses. And in particular, one of the large pieces that I think-- of the puzzle that's really important that gets tracked through this method would be nonfatal overdoses. So the idea here is that, that the real, real-time tracking, my understanding is the mapping is like a heat mapping so that we can kind of see where the issues are, what types of drugs generally, and where in the state are we seeing that. The idea there would be allow us to surge resources to surge not just maybe law enforcement to be on the lookout for these types of things but also to educate mental health providers, schools, health providers in general in those areas so that we could at least face the problems that we're facing in that knowingly. The other large issue for, for this would be-- the legislation would also hopefully-- at that forum, and, and I've heard many times since, that, anecdotally, we are woefully underreporting overdoses in this state. And hopefully as a result of getting our numbers more in line with where they should be or what the reality is, hopefully we'll be able to maybe find federal funding at a higher level than maybe we do now. Again, I want to thank Senator Ballard for introducing the legislation. I was not involved with the sausage-making on this. We, we met at the beginning of this-- after we had the drug enforcement-- or, drug forum. We met with HHS and Midwest HIDTA at that time and essentially got the ball rolling with them, and they did all the heavy lifting after that to actually put this legislation together, so. We would ask that you advance it. And I would be happy to answer any questions that I'm able to at this time.

HANSEN: All right. Thank you. Are there any questions from the committee? I don't see any. Thank you very much.

MIKE GUINAN: Thank you.

HANSEN: Anybody else wishing to testify in support? All right. Seeing none. Is there anybody who wishes to testify in opposition? All right. Seeing none. Is there anybody wishing to testify in a neutral capacity?

JOHN LINDSAY: Thank you, Senator Hansen, members of the committee. My name is John Lindsay, L-i-n-d-s-a-y. Appearing today as a registered lobbyist on behalf of the Nebraska Association of Trial Attorneys. And given that much, you could probably guess why I'm here. I did hear an earlier testifier mentioned some references to Taylor Swift, and I could see that those might get to Senator Hansen a little bit, but we knew he would shake it off. Not an auspicious start, but.

HANSEN: So it begins.

JOHN LINDSAY: I-- we have no position on the underlying bill. It seems to make sense to me. Our concern is with subsection 5 of Section 3 on page 3, lines 27 to 29. It is an immunity--, an attempted immunity from liability. And this-- we're-- I'm here in a neutral capacity instead of opposition because, frankly, the immunity doesn't do anything. And I think it's a testament to the fact that sometimes we take boilerplate language and stick it in bills. I had the opportunity this morning, because I didn't have to sit on Final Reading with you, to listen a bit to the Supreme Court argument in the, the question of, of Donald Trump's appearance on the ballot and the appeal from the Colorado Supreme Court. And it's always fascinating listening to the Supreme Court arguments. They-- listening to them parse the words of Section 3 of the Fourteenth Amendment to the United States Constitution was fascinating, but it reminded me of something I learned back in law school: words matter. And we have here words that I'm not sure how they matter to the bill. They-- it says that it's the-- any person or any service that makes a good faith to report under this section shall be immune from civil or criminal liability. First, there's also, I, I think, some immunity from criminal liability in the paragraph before. But I would call attention to Section 3. It says the EMS shall report and it shall include certain information-- there goes my chair again-- shall include certain amati-- information and shall make best efforts to submit it within 72 hours and shall report such information using the Washington/Baltimore High Intensity-- et cetera. The point is that how-- there is-- the lawyers on our Legislative Committee could find no way that there's liability for making a report that the Legislature commanded shall be made. So this to me seems like just extra verbiage. And I think the Legislature needs to be careful about just throwing in extra verbiage that has no meaning or is not thought out well enough to know what it applies to. If it's trying to get around liability for maybe a violation of HIPAA, I don't think that's going to work either because I don't think a state legislature can grant immunity for a violation of federal law. So I don't-- I-- we are-- we were struggling to see why and coming to

the conclusion that it just seems that you always put it in because there's a misperception out there. And Senator Hansen, we talked about this a little bit last time that I appeared before you. There's a misperception out there that if there is harm, there is liability. And if that were the case, there'd be a heck of a lot more plaintiffs' attorneys just lining up to collect checks without any work. The fact is someone has to do something wrong, and we can't figure out what an EMS doing a report that the Legislature commands them to make what they've done wrong. So we are in a neutral capacity because there is an immunity provision and we have to comment on it. But we'd suggest you look at-- to see, again, whether all words that you put into a bill necessarily makes sense being there.

HANSEN: All right. Thank you. So in your opinion, removing that, that subsection 5, that is-- is that kind of what you're recommending--

JOHN LINDSAY: Yes.

HANSEN: --the immunity clause part?

JOHN LINDSAY: Yeah. We're not opposing the bill because, if it's in or if it's out, it's-- probably doesn't make a difference except that courts-- and it's pretty settled law in-- certainly in Nebraska construction of statutes. The courts will try to give meaning to each word, each sentence, each clause that the Legislature puts into statute. We'd be concerned if the Supreme Court, looking for why this is in there, had to come up with some reason to try to give it meaning, and that concerns us with what that might possibly be.

HANSEN: OK. And in your opinion, if that was removed, that wouldn't change the intent of the, of the, the bill, would it?

JOHN LINDSAY: No, I don't think so at all.

HANSEN: OK.

JOHN LINDSAY: I think still the EMS-- emergency medical services would have to file that report and they would have to do it in-- following all the conditions that are set forth in the bill. And anybody who doesn't, they're not going to get sued anyway because a lawyer operating on a, a contingency agreement isn't going to waste his or her time filing a lawsuit that isn't going to go anywhere. They don't, they don't like to waste their time when they could be billing somebody for it.

HANSEN: OK. Any questions from the committee? I got another question, John. Sorry.

JOHN LINDSAY: That's all right.

HANSEN: So it's not-- would this-- would, would maybe the intent of that subsection 5 be that if somebody did report that from somebody who had an overdose, that person who had the overdose can't sue them, the person who reported it, can they?

JOHN LINDSAY: Oh, I don't, I don't know how you-- what it would be based on. Typically, it, it would be based on-- most cases that are filed are based in negligence, which is a duty that is imposed, a breach of that duty, and damages, along with some other issues. But in this case, there is no duty owed to the person with the overdose because the only duty imposed would be under HIPAA, which is irrelevant here. The only other duty imposed is imposed on the emergency medical services to make that report. That's the only breach of a duty, I thi-- that we can see under this bill.

HANSEN: OK. That’s what I was wondering. OK. All right.

JOHN LINDSAY: Thank you.

HANSEN: Seeing no other questions. Thank you very much.

JOHN LINDSAY: Sorry about the Taylor Swift pun.

HANSEN: I'm getting used, I'm getting used to it now, so. Maybe. We'll take our next testifier in neutral. Welcome.

NATHANIEL CACY: Welcome. Good afternoon, everyone. My name is Nathaniel Cacy, spelled N-a-t-h-a-n-i-e-l. Last name's spelled C-a-c-y. And I'm the public health analyst for the state of Nebraska under the Overdose Response Strategy, a joint collaboration between the Office of National Drug Control Policy and the HIDTA Program, specifically the Midwest HIDTA and the CDC Foundation. For compliance purposes, I'd just like to state real quick: this presentation is supported by the Centers of Disease Control and Prevention for the U.S. Department of Health and Human Services [INAUDIBLE] financial assistance, awarding $11,600,000 to the capacity building of public health analysts in Overdose Response Strategy, with 100% funded by CDC/HHS. These contents of these authors do not necessarily represent the official views nor endorsement by the CDC/HHS, or the United States government. Under federal guidelines and regulations, I am

actually not allowed to lobby on specific legislation. However, I am permitted to provide technical assistance to legislative bodies and committees given that I provide fair and adequate coverage to the, to the issue at hand. Today, I come before you to speak in favor of model legislation very similar to LB1320, which requires EMS providers and other public health and safety partners to report patient overdose information to the Overdose Detection Mapping Agency Application Program, otherwise known as ODMAP, to the Washington/Baltimore High Intensity Drug Trafficking Area, commonly referred to as HIDTA. ODMAP was developed and managed by the Washington/Baltimore HIDTA, a grant program funded by the Office of National Drug Control Policy. The program started as a pilot in 2016 and was formally launched in 2017. As of February of 2024, nationally, all 50 states, including the District of Columbia and Puerto Rico, are after ap-- individuals using ODMAP. There are over 4,000, close to 5,000 approved agencies and over 3,300 users across the country. 27 states in the country have at least one active statewide API, including South Dakota and Kansas within the Midwest territory. Ten states have passed legislation or have legislative support for ODMAP, and this includes Texas, two in Florida, Maryland, and California. Important to remember: ODMAP is not a HIPAA-covered entity and has received support from four state Attorney Generals, which I can provide with you afterwards. And ODMAP does not collect protected health information or personable identifiable information, PII and PHI. There are other optional fields individuals can fill out within the ODMAP, the recommended data point being the suspected drug type, because it help informs agencies on the drug trends and threats in their areas. Now, I want to also remind you that in the state of Nebraska, we currently only have 45 accounts created for ODMAP. All the entry is currently voluntary, and we currently only have 15 active volunteers submitting data within the state. Most of those data points for clarification do come from the Omaha-Lincoln metro areas. As you all know, there are 93 counties in the state, so we are woefully inadequate on our own voluntary submi-- submission of data within the state. This, in turn, can be used to inform strategies and resource allocation. ODMAP is not meant for the public, and all agency request forms are vetted and approved or rejected by the Washington/Baltimore HIDTA. The data submitted to ODMAP is not owned by the Washington/Baltimore Dat-- HIDTA, and dataship-- ownership is retained by the states and the data-contributing agency. In 2023, using data from the National Vital Statistics, it's estimated that 1,000-- 100,795 [SIC] people will have died of overdose in the United States that year. One American dies from a drug overdose nearly every five minutes around the clock,

according to Rhaul Gupta, director of the Office of National Drug Control Policy. To further emphasize the importance of the community information sharing and evidence-based practices occurring within the state of Nebraska, I'd like to remind the committee of another statistic: 46.3 million people at the ages of 12 or older meet the criteria for a substance use diagnosis, yet only 6% receive treatment for it. Without coordinated structures that link both public health and public safety together, it is difficult to ascertain why Nebraska's rankings for overdose are considerably lower than the national average. Compared to peer states, Nebraska ranks last among 30 states and territories in the age-adjusted rate per deaths per 100,000 for all drugs, at 9.4, for 175 deaths in the 2022 period, according to the CDC's State Unintentional Drug Overdose Reporting System, otherwise known as SUDORS. While ODMAP would not be the magic bullet to addressing the national crisis of drug overdoses around the United States and in Nebraska, implementing model legislation similar to LB1320 would allow for data and overdose occurrences to be shared quickly and all involved parties to be able to share what they are seeing in real time. I'd like to thank the committee for allowing me to speak. And I'd be an-- available to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? I have a quick question. How tedious is it for, like, a volunteer to enter information into this if we're going to force them to do it now?

NATHANIEL CACY: That's, that's a, that's a good question. I will say that it largely depends upon the demand in the area and the, the amount of overdoses we're seeing. For larger cities, it's-- there's typically somewhat more of a requirement for those people to enter that data. So it's a lot of time and man-hours. I can personally attest to my partner and I helping or-- coordinate data going into ODMAP. I mean, we'd have years of backlog of data to get that done. So a statewide API or a mandated report to the state where they can then report that into it would ease the burden and the administrative burden that many of the professionals we see in public health, public safety experience in that.

HANSEN: OK. Because you said right now it's voluntary, so-- [INAUDIBLE] see is in Omaha and Lincoln.

NATHANIEL CACY: Yes, sir.

HANSEN: So we got-- now we're going to start mandating that, you know, EMS out in western Nebraska to do this who have maybe have never done

it before. Is there a cost when they do it at all since they haven't done it before? Or, like, is it going to take them, like, an hour--

NATHANIEL CACY: So this--

HANSEN: [INAUDIBLE] to do one of these, or--

NATHANIEL CACY: Yes. So this data's currently being captured already. It's just not being entered into ODMAP. And it's not being centralized into a central repository. So the, the biggest issue within the state of Nebraska is there's a lot of silos for different areas of medical information and health information and public safety information and the-- none of that's coordinated. What this application would do is would-- it'll allow for all those coordinated efforts to kind of come in and kind of seamlessly integrate together so we could see that. A lot of the times, APIs have already been created or they can be created for very little cost that can help make that easier.

HANSEN: OK. And I wouldn't imagine they have that many out--

NATHANIEL CACY: You would be surprised, sir.

HANSEN: OK. Well, I-- are we doing the best out of 30 states, though?

NATHANIEL CACY: If you want to think of that in the best, yes. We have the lowest reported death rate, but that doesn't mean, necessarily, more deaths aren't occurring. That simply means we aren't ca-- catching more of those deaths.

HANSEN: All right. Any questions? Seeing none. Thank you very much.

NATHANIEL CACY: Thank you.

HANSEN: Anybody else wishing to testify in neutral capacity? All right. Seeing none. We will welcome Senator Ballard back up here to close. And for the record, we did have two letters in support of LB1320 and one letter in the neutral capacity.

BALLARD: Thank you, Chair. First, I'd like to thank the committee and all the testifiers that came out today. I think Nathaniel, the previous testifier, said it best. This is, this is not the silver bullet to solve our, our epidemic in this country. It is just a, a piece in the puzzle that helps, that helps save lives and help prevents future overdoses. I'd like to thank the trial attorneys for coming in and giving me a heads-up about the, the Section-- subsection

5 of the bill. Willing to work with the committee and the trial attorneys on that piece. But I look forward to continuing conversations and moving this to General File.

HANSEN: Any questions from the committee? I do have one more. So is funding for this contingent upon LB1108 from Senator Dorn [INAUDIBLE] Transportation?

BALLARD: That-- I'll follow up on that. That, I do not know for sure.

HANSEN: [INAUDIBLE] I'd be kind of curious about that, so. All right. Thank you.

BALLARD: Thank you.

HANSEN: All right. Senator Cavanaugh.

M. CAVANAUGH: Is Senator De-- Dorn's bill in Transportation the one about EMS?

BALLARD: I believe--

HANSEN: Yeah. It had-- I think it-- it has-- I don't know if I can answer it. I think it has to do with motor vehicle assessment tax. Is that-- right? Saving, saving one life fee.

M. CAVANAUGH: Yes.

HANSEN: I think they're increasing it from $0.50 to $1.00.

M. CAVANAUGH: We'll talk.

BALLARD: We'll talk. Yeah, I don't know that all too well, so I will--

M. CAVANAUGH: Yeah. We'll, we'll talk after this.

BALLARD: [INAUDIBLE].

HANSEN: All right. All right. Thank you. And that closes our hearing for LB1320. And we will open up LB1054 and welcome Senator Walz to open.

WALZ: Thank you, Chairman Hansen and members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z. And I represent District 15. In Nebraska, school systems are typically notified by law enforcement of nearby incidents that may have

implications for the safety and security of children and staff. However, it is far less common for Nebraska child care providers to receive these same notifications. LB1054 is designed to align child care programs to Nebraska school systems by mirroring the emergency response protocols in place for schools. This i-- issue was first brought to my attention last year when a child care center director in my district informed me of an incident involving active police presence in close proximity to a local child care program. While this incident put those providers on high alert, they did not receive any inform-- any emergency notifications or guidance on how to respond to that situation. Fortunately, the event turned out to be a police training exercise. But other incidents involving potential threats to child's-- child-- to children's safety serve as a reminder that emergency preparation, real-time notification, and response procedures are potentially lifesaving measures for our youngest children and those who care for them. My constituent is here today to share her story, as well as other testifiers who will share their own experiences and explain how emergency prep-- prepared-- preparedness procedures operate in a child care setting. You will also hear from Lincoln Littles, a nonprofit organization that supports child care providers here in our capital city. Lincoln Littles began leading local efforts to coordinate emergency response procedures after child care providers drew attention to incidents similar to the one I just explained. The work of Lincoln Littles can be made replica elsewhere in our state, which is why it served as the model for LB1054. LB1054 appropriates 300-- $300,000 from the Cash Reserve Fund in fiscal year 2024-2025 to create the Child Care Safety and Security Fund. This fund will be administered by the Nebraska Department of Education to award competitive grants that facilitate community partnerships for emergency response procedures involving child care providers. The bill requires three designees to coordinate these efforts effectively. The first designee to operate in a-- in emergency response notification system to notify providers of local emergencies; two, a designee to coordinate age-appropriate safety and reunification training; and three, a designee to provide safety and reunification materials. LB1054 allows local partnerships to develop and standardize their own notification, safety, and reunification efforts. The bill is designed to avoid putting any additional expense on child care programs or the parents they serve. And participation is entirely volunteer on parts of the pro-- providers. Finally, the bill requires NDE to submit an annual report to the Legislature on how the fund was used and the number of children that they served. I'll try to answer any questions.

But if you have technical questions, there are people behind me who can answer that.

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

WALZ: Thank you.

HANSEN: See you at the close. All right. We'll take our first testifier in support of LB1054.

GENNA FAULKNER: Chairman Hansen and members of the Health and Human Services Committee. My name is Genna Faulkner, G-e-n-n-a F-a-u-l-k-n-e-r. And I'm here to testify in support of LB1054. I am currently the director of Bergen Catholic Ele-- Early Childhood Education Center in Fremont, Nebraska, and I have previous experience working for the Fremont Family Coalition, supporting early childhood efforts, and a former 911 dispatcher for the city of Memphis, Tennessee. Thank you, Senator Walz, for introducing this bill and bringing attention to the safety of young children in child care settings across the state. A couple of years ago, I received a text message from my sister, who was a deputy sheriff at the time. She advised me not to bring my kids to daycare until she let me know that it was safe due to an active shooter situation happening near the center. After my initial concern for my own children, I thought, well, what about the kids at the center who had already been dropped off? Are they outside playing while someone is close by putting them in danger? Luckily, my sister had called the center and alerted them to not allow any child in or out and to go into lockdown. Without her making that call, that center would never have known that there was a threat to children's safety in the immediate area. There is no standard procedure for deputies to alert child care providers. Her personal connection with the center prompted her to make the call. Our society is rightly concerned about school safety, but unfortunately the safety of young children in child care is often left out of this conversation. In Fremont alone, there are roughly 30 early care and education providers, including in-home centers and Head Start programs. Currently, there is not a standardized procedure in place to notify those providers in a timely manner if something is a threat to the children in their care. With an in-home program or center near every elementary, middle, and high school, there is a gap in notification for providers when schools are undergoing safety protocols. At approximately 1:15 today at Fremont Middle School, they had an incident which prompted them to contact Bergen Elementary,

which is about a mile from them, that there was a situation occurring and that they should go into secure status, which means they continue to teach with shades drawn and no outside recess. Growing Hearts Child Care Center is directly across the street from middle-- Fremont Middle School, and they were never notified. They didn't have any idea that it was happening. This goes way beyond active shooters. Fremont has had its fair share of natural man-made disasters. The flood of 2019 is a good example. A provider on the south side of Fremont had to leave her home for days due to the water. Luckily, she didn't have kids in her home when it got bad, but it certainly could have been worse. There are other potential risks to children's safety if there's a gas leak or environmental disaster at one of the manufacturing plants in Dodge County. Currently, in-home providers in the area don't have a way to consistently receive notification or have procedures to follow. LB1054 will be a much needed support for communities like Fremont to participate in their own emergency systems and training, like the Lincoln Littles model. Given my previous experience as a dispatcher, I know the Lincoln Littles model could work in other communities with the right support. The Lincoln Littles model noti-- not only includes the notification system but also valuable training for child care providers on emergency response. Lincoln Littles has proven the notification can work and given us a highway to follow, but what this bill does is provide the on-ramps for each community in Nebraska. In my previous role at Fremont Family Coalition, I had conversations with law enforcement, 911 communications, emergency management, and the public school security and safety coordinator about this very issue and how to implement it in our community. Ultimately, those conversations did not end up in a notification system for Dodge County. While Fremont Family Coalition was interested in hosting the system for as long as I remained in my position, if I were to ever leave, it would disappear. LB1054 would provide permanency to these efforts by establishing agreements for the notification system to not rely on a single individual but have a structured management of the system. LB1054 would enable child care programs to align with the systems in place for school districts. The Standard Response Protocol's in use by a large number of school districts across the state. This protocol transfers to early childhood settings very well. Having a common language when it comes to emergencies is crucial when time is of the essence. Child care providers knowing the vocabulary and important information that dispatchers will use can be lifesaving. Giving communities a way to notify child care providers of safety concerns in a timely manner is paramount not only to child safety but also allowing parents to see that we as a society are taking care of

the well-being of children even before they reach kindergarten. Thank you for allowing me to testify today. I would urge you to advance LB1054 to General File. And happy to answer any questions you may have.

HANSEN: Thank you. Are there any questions from the committee? Seeing none. Thank you very much for coming to testify. Anybody else wishing to testify in support of LB1054? Welcome.

SUZANNE SCHNEIDER: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Suzanne Schneider, S-u-z-a-n-n-e S-c-h-n-e-i-d-e-r. And I represent Lincoln Littles, a nonprofit organization which supports early care and education in Lincoln. For many years, child care directors in Lincoln felt concerned and frustrated by a lack of notification during safety incidents in their area. In 2020, Officer Mario Herrera was tragically killed in the line of duty. There were two child care centers in close proximity with children on playgrounds while the officers responded to this incident. Those children are our youngest residents: infants to five-year-olds. Getting a group of six or ten toddlers to move quickly and safely in an emergency situation as this without emergency notification and standardized procedures to follow proved incredibly difficult for these providers. Ensuring the safety of children in child care, especially during emergencies, is paramount. Other incidents as well in Lincoln highlighted the need for immediate notification to child care, especially when children are in close proximity to potential danger. In such instances, timely alerts allowed child care programs to take swift action, securing their facilities and safeguarding children. To address this vital need, Lincoln Littles is championing the implementation of the Standard Response Protocol, SRP-- which is one of the many models for safety and reunification procedures-- and an emergency notification system for child care centers in Lincoln. This work is planned and implemented by a team that includes the Lincoln Public Schools, Lincoln Lancaster County Health Department Emergency Management, Belmont Community Center, and UNL Children's Center. We are trailblazing a system that seems to be the first in the nation. The initiative includes emergency notification alerts, regular communication alerts, drill reminders, emergency materials, and training. We have completed five training sessions, with two more scheduled this year. We average 40 participants out of the 115 child care centers in Lincoln. We are partnering with key organizations and we're utilizing established systems to implement the program effectively. Aligning with Lincoln Public Schools to ensure children

and parents are receiving consistency in systems and messaging is essential. We are implementing the Standard Response Protocol, which is developed by the I Love You Guys Foundation and utilized in 80% of the schools in Nebraska. We implemented a text alert system. The cost for us to start up was $500, and the ongoing cost is $200 a year. That covers all of Lincoln. We utilize the Nebraska Child Care Referral Network, which is an online database of all licensed child care in Nebraska and can be used to locate the child care centers. We rely upon partnerships, and ours include Lincoln Police Department, Lincoln Public Schools, the Health Department, Belmont Community Center, and UNL Children's Center. We're providing online resources for providers to gain access to materials, and we are issuing quality improvement grants so pri-- providers can purchase security-related items. By implementing these systems and supporting child care providers in Lincoln to now have notification and training, we have a better ability to keep our youngest residents safe. Please consider how important this is for children all across the state. Lincoln strong-- Lincoln Littles strongly supports LB1054 as a way to enable other communities across Nebraska to model our successful efforts in Lincoln. In closing, I would like to thank Senator, Senator Waltz for bringing this bill forward. And I'm happy to take any questions.

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

SUZANNE SCHNEIDER: Thank you.

HANSEN: Take our next testifier in support.

TINA ROCKENBACH: Good afternoon. I'm Tina Rockenbach, T-i-n-a R-o-c-k-e-n-b-a-c-h. I'm the executive director for Community Action of Nebraska. We're the state association representing all nine of Nebraska's community action agencies serving all 93 counties here in support of LB1054 on behalf of the network. You've got my testimony there. I'm not going to read it here word for word. I just want to highlight a few things. I've also included-- some of you I know have seen this through other committees-- just a map of our agency areas for your reference. First of all, I want to ditto everything that's already been said as far as the logistics and the ability to keep children safe that this bill is addressing. It's, again-- just for a second, my, my prior life, I was an early childhood center owner and I can testify to everything they said is accurate as far as the frustration. Currently, our agencies ser-- eight of our nine agencies have early Head Start or Head Start centers, and we serve a little

over 2,300 children in the state currently. That's not counting children on our waiting lists. Omaha out of our agencies is the only one that does not have Head Start. That's through a different grantee. And nationwide, as part of our national network, Community Action is the largest national grantee for Head Start. So just a little background there for you on that. Head Start is very well-known for its, its large standards of excellence and requirements and organizational components, evidence-based practices. What we have is-- yes, we definitely have the ability because we're required to make those plans and have those in place and walk through the logistics of those in the drills and the staff training. But what this bill also is really bringing together is that final connection on that communication piece. And as you can see by our map, we serve a variety of different types of areas of Nebraska. The way our Head Start centers in Lincoln operate on these types of procedures is completely different than our centers out in Chadron and everything in between. Coming from a small town and having owned a child care center back in the day, very similar to the Chadron setup right now, where-- we took it upon ourselves, connected with the local police chief, had personal connection, and figured out our own communication as far as from law enforcement to the center. That does not take into account the ability to have consistent and accurate and confidential communication to the parents for reunification purposes. As you can imagine, when things like this happen, often you go into panic mode. Now, think about if you're there and you're in close proximity to your child. That panic goes to a level you've never known. And so you want to kind of take matters in your own, own hands and try to get to where your child is; you're not sure where they are. And if you're not getting communication from your center, that can be alarming. And then if you're in a small town, then you have other people calling other people and, and it just becomes kind of mass chaos. The other thing I want to elevate here for our Head Start centers is this is absolutely something we are on board with. The financial component to this also is important to discuss because that assistance is critical not just for the independent providers but also for the Head Start. Right now, Head Start federally, there's a lot happening. There are a lot of increased rule changes that are being proposed, including changes to re-- to reduce certain types of enrollments. There's also being proposed funding cuts and reductions yet also wanting to increase some spending and not fund those. And so it becomes this priority battle of, well, this is what we have to do now, so I guess the mass comps for this is going to take a back seat. And so I would love to see the state partner in this 100% strictly for the safety of everything that

every child care provider is trying to do. It would, it would just be a tragedy if something happened because somebody was caught in a crossfire of any kind of emergency when this could have been prevented. So with that, I'm happy to answer any questions if I can.

HANSEN: Thank you. Are there any questions from the committee? There are none. Thank you very much.

TINA ROCKENBACH: You bet.

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

MITCHELL CLARK: Chairman Hansen and members of the Health and Human Services Committee. Thank you for allowing me to be here today. My name is Mitchell Clark, M-i-t-c-h-e-l-l C-l-a-r-k. And I am a policy advisor with First Five Nebraska, a statewide public policy organization invested in the care, early learning, and well-being of Nebraska's youngest children. I'm here today to testify in support of LB1054 and would like to thank Senator Walz for her leadership in advocating for the safety and security of children in child care programs. As you heard firsthand from Lincoln Littles and the other testifiers, this is-- the Lincoln area effort is a successful method for standard emergency preparedness for child care providers, and it's effective being the model for LB1054. This work requires effective coordination, as you've already heard, amongst various partners at the community level. While it does not necessarily need to look like that Lincoln area effort, that is one way in which it could be implemented. LB1054 is a unique model to address the needs of standardizing the approach to emergency preparedness and response for child care providers. As you've also heard, this participation is entirely voluntary. It provides the opportunity for communities to establish their own pro-- procedures for emergency preparedness. And also, as, as Tina spoke to as well, there are other emergency preparedness plans in place under various licensed programs, including Head Start. Also as you've heard, the missing component to that would be that emergency response notification system and these, and these standardized approaches. That is the link, as, as Tina just hit on earlier. So that key benefit is-- in these emergency notification systems is geolocation components, so-- such as what Lincoln Littles does. If there's an incident in an area, they can locate that just to those providers in that area. It does not necessarily need to go to all of those which are subscribed to the system. I'll just close by saying the safety and security of children under the care of child care providers warrants the need for this emergency preparedness and

response in the same manner that exists in the K-12 school system. This LB1054 provides that crucial link. Thank you, Chairman Hansen and members of the committee for your time and attention today. I urge you to advance LB1054 to General File. I am happy to answer any questions that you may have.

HANSEN: Thank you. Are there any questions from the committee? I might have one question. And this-- either-- if you can't answer this, maybe Senator Walz can. So we're appropriating $300,000 in the Cash Reserve Fund to create this Child Care Safety and Security Fund. And it seems like the purpose of this bill is to use it for, I, I'm assuming, exclusively emergency response notification systems. Can this money be used for anything else besides that?

MITCHELL CLARK: Yes. So there are two other components there. That would be the training for those providers and also for the materials such as signage and training materials.

HANSEN: For the emergency--

MITCHELL CLARK: Yep. For the emergency preparedness.

HANSEN: OK. I-- [INAUDIBLE] look at the bill. I'm curious if it's exclusively mentioned in the bill it could be used for that because it says just for training purposes. Sometimes people then can use this money for all kinds of stuff, you know what I mean? And not--

MITCHELL CLARK: Yeah.

HANSEN: --for the intent of what we want it to. You know, this is a honeypot. People seem to somehow--

MITCHELL CLARK: Indeed.

HANSEN: --do what they want out of it, so.

MITCHELL CLARK: Yep. Indeed. So the bill actually does stipulate in order for these funds to be distributed, an ESU actually applies to the Department of Education. Now, the ESU has three designees which have to be kind of under their banner, if you will. So these three designees have to be-- all three of these have to be fulfilled in order for these funds to be distributed. So say, for example, an ESU has a designee-- we'll just say a Lincoln Littles, for example, that's going to have that emergency response notification system. And then say a school system wants to coordinate the training. And then it

could be a health department wants to distribute those materials. All three of those have to be under that grant in order for it to be distributed. So you can't just go to the fund and try to get some money just for--

HANSEN: OK.

MITCHELL CLARK: --some vague training process.

HANSEN: And the most is $1,000 per--

MITCHELL CLARK: Yep.

HANSEN: OK-- designee? OK. OK. All right. Any other questions? All right. Thank you.

MITCHELL CLARK: Yep.

HANSEN: Anybody else wishing to testify in support of LB1054? Anybody wishing to testify in opposition to LB1054? And is there anybody wishing to testify in a neutral capacity to LB1054? Seeing none. We'll welcome Senator Walz back up to close. And for the record, we did have one letter in support and two in the neutral capacity for LB1054.

WALZ: Thank you. I thought for a minute Benson was going to come up and give some testimony in support. Thank you to our testifiers. I think we had a really great team. Gave a lot of good information. And I would entrust my kids with them, so thank you. Every day, thousands of Nebraska parents entrust their education, care, and safety of their youngest children to hardworking child care professionals so they can participate in the workforce and provide for their families. Those parents deserve to go to their workplaces, as we all know, and be productive at their jobs knowing that they can rely on child care providers to take good care of their kids. In turn, providers deserve to be included in well-designed standardized notification, safety, and reunification procedures so they can live up to the heavy responsibilities that we always place on them. LB10-- LB1054 is a first-of-its-kind solution that addresses a need in our communities and provides for the safety and security of Nebraska's youngest children, their families, and the child care professional workforce. Thank you for your time and attention today. And I'd be happy to answer any questions.

HANSEN: Thank you. Are there any questions? Nope.

WALZ: All right.

HANSEN: All right. Thank you.

WALZ: Thank you.

HANSEN: That'll close the hearing for LB1054. And now we will open the hearing for LB903. And it looks like Senator DeBoer is not here.

BRIAN MURRAY: That is correct. I am in my introducer era--

HANSEN: All right.

BRIAN MURRAY: --in keeping with the Taylor Swift theme.

HANSEN: Man. I didn't even know that one, so that's-- all right. Well, you are ready to open whenever you're ready.

BRIAN MURRAY: All right. Hello, Chair Hansen and members of the Health and Human Services Committee. My name is Brian Murray, Brian, B-r-i-a-n; Murray, M-u-r-r-a-y. And I'm the legislative aide for Senator Wendy DeBoer. Senator Wendy DeBoer represents LD 10 in northwest Omaha and regrets that she can't be here but is caught up in the Judiciary Committee with Senator Hardin's bill, actually, right now. I'm here to introduce LB903 on her behalf. LB903 makes changes to the Alheim-- Alzheimer's Disease and Other Dementia Support Act. Senator DeBoer introduced the act in 2021. That was LB374. And it passed in 2022 as part of LB752. The act created the Alzheimer's Disease and Other Dementia Council. The council is to meet, compile a report, and focus its efforts on (a) the needs of individuals living with Alzheimer's disease and other dementias; (b) the services available in the state for those individuals and their family caregivers; and (c) the ability of health care providers and facilities to meet the current and future needs of such individuals. LB903 makes two changes to the act. First, it adjusts the terms of the members of the councils. Currently, the terms of all of the members on the council would expire at the same time. With the changes of this bill, members will have their terms expire on a staggered basis to ensure continuity of the council. The second change is to adjust the statutory deadline for the first report. Due to circumstances beyond the council's control, they were unable to have their first meeting until December of 2023, which was the same month their first report was to be due. Seemed problematic. LB903 moves the deadline for the first report to December of this year. That way, they have more time to compile a report that's actually going to be useful to the

Legislature. This is a super simple cleanup bill, and I want to make sure the committee is aware that the department submitted a comment in support of this bill, as well as the fiscal note has the three magic words of "no fiscal impact." I'm here to answer any questions and thank the committee for their time.

HANSEN: If anybody has any technical questions they'd like to ask.

RIEPE: He had the magic words: no fiscal impact.

HANSEN: Yep. All right. Thank you.

BRIAN MURRAY: Thank you.

HANSEN: And we'll take our first testifier in support of LB903.

NICK FAUSTMAN: Good afternoon. I'm Nick Faustman, N-i-c-k F-a-u-s-t-m-a-n. I'm the director of public policy and advocacy for the Alzheimer's Association Nebraska Chapter. The Alzheimer's Association is the leading volunteer health organization on Alzheimer's care, support, and research. Our vision is a world without Alzheimer's and all other dementia. We requested Senator DeBoer introduce LB903, which would update the statutes governing the Alzheimer's Disease and Other Dementia Advisory Council. And the bill does two things, as Brian mentioned. First, it pushes back the statutory deadline for the advisory council to compile its initial recommendations by one year. And this is necessary because the advisory council's first meeting is not called until more than a year later than required by statute. And because of that, the group was unable to fulfill its statutory duties. The advisory council is currently operating under the timeline proposed by LB903, but the statute should be changed to reflect this. Second, the bill provides a method by which the terms of the members can be staggered, preventing a situation in which all members would term out at the same time. This change helps preserve the longevity of the important work that the council does. And it would also prevent a situation where the Governor would have to empoint-- would have to appoint 12 members all at one time-- 12 new members all at one time. This portion of the bill was modeled after how terms are handled for the Women's Health Initiative Advisory Council, which is found in Nebraska Revised Statutes Chapter 71-702. I'm aware that several members of the council, as well, well as various stakeholders, submitted written comments in support of the proposal, and the Alzheimer's Association and joins them in urging the Health and Human Services Committee to advance LB903 to General File.

HANSEN: Excuse me for coughing. Sorry. Got a frog in my throat. Any questions from the committee? I got a question. Have all the positions been filled?

NICK FAUSTMAN: 11 of the 12 have been filled. 11 of the 12 voting positions have been filled. I do know that there are applicants for that, that 12th spot.

HANSEN: OK. All right. Seeing no other-- Senator Ballard.

BALLARD: I do have a question.

NICK FAUSTMAN: Sure.

BALLARD: Thank you for bringing the bill. I appreciate it.

NICK FAUSTMAN: Mm-hmm.

BALLARD: I, I have a question about one of your statistics on the back. It says that Alzheimer's is expected to increase by 14% in-- by 2025. Can you just kind of highlight-- is that just-- highlight why that would-- why that would be [INAUDIBLE] dramatic increase.

NICK FAUSTMAN: Well, I think a, a big part of that is the work that our organization and others are doing to increase early detection and diagnosis. I mean, there's still that stigma out there that, you know, when you see someone with dementia-- grandmother, grandfather-- oh, grandma's just getting old. You know, that's still out there. Of course, the research that's being done on, on an annual basis is so much better than what, what we have seen in the, you know, the decade prior. So we're starting to recognize the disease much more earlier. And we are more, I guess, more familiar with what, what all that entails. So it's, it's a com-- it's a-- it's com-- it's a complicated answer, but I, I would, I would say those two reasons are the biggest.

BALLARD: Thank you for being here. Thank you for your work.

HANSEN: OK. All right. Any other questions? Seeing none. Thank you for coming.

NICK FAUSTMAN: Thank you.

HANSEN: Anybody else wishing to testify in support of LB903? Seeing none. Is there anybody wishing to testify in opposition to LB903? Seeing none. Is there anybody who wishes to testify in the neutral

capacity? All right. Seeing none. Senator DeBoer-- waive closing. And we will close the hearing for LB903. And that--