HOWARD: --Human Services Committee. My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman. Welcome, Senator Murman.

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

ARCH: John Arch from District 14, Papillon, La Vista.

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

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

HOWARD: Also assisting the committee are our legal counsels, plural, Jennifer Carter and T.J. O'Neill back there-- he's new-- and our committee clerk, Sherry Shaffer. And we're hoping to have a committee page later. A few notes about our policies and procedures: Please turn off or silence your cell phones. This morning, we'll be hearing three briefings and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you-- you will find blue testifier sheets. If you're planning on testifying today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the briefing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts, that you please bring ten copies and give them to the page or Sherry and she'll help-- help us get them. Today we have invited testimony only. Testimony is not grouped by supporters or opponents but-- opponents but taken in turn. Unless otherwise agreed, each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. We do have a strict no-prop policy in this committee. And with that, we'll begin today's briefing from the Nebraska Children's Commission

pursuant to Section 43-4207. Welcome, Chris Jones from the Nebraska Children's Commission.

CHRIS JONES: Hi. Good morning. Happy Friday the 13th, full moon and all. All right. OK. My name is Chris Jones and I'm the policy analyst with the Nebraska Children's Commission. It's spelled C-h-r-i-s J-o-n-e-s. And I'm here today, as Senator Howard mentioned, that this is part of our statutory requirement to present our annual report and recommendations to the Health and Human Services Committee of the Legislature annually. In your handouts, you have a copy of a slide deck for this presentation, including a member roster of the Nebraska Children's Commission, recently appointed in September, as well as our 2019 annual report and our recently released Nebraska Bridge to Independence extended foster care evaluation. If you are looking at their slides, I'm moving on to slide 3. The Nebraska Children's Commission was a product of the 2011 LR37 by Senator Kathy Campbell, a comprehensive investigation by the Health and Human Services Committee that identified a number of gaps in the service delivery model for children and families during the child welfare reform that spanned approximately 2008 or 2009 until 2012 and continues, and a partial privatization with the lead contractor agency, St. Francis, in the Eastern Service Area. LR37 led to many important pieces of legislation for child welfare-- child welfare, excuse me, including the creation of the Office of Inspector General of Child Welfare and the Nebraska Children's Commission. In 2012, the Nebraska State Legislature created the commission to provide a leadership forum for the collaboration of child welfare and juvenile justice, and to devise a strategic plan for child welfare and juvenile justice reform at that time. On slide 4, the-- it goes over kind of the composition of the Children's Commission. We have 26 members who are a mix of ex officio, nonvoting members, that are representatives of three branches of government, as well as voting members who-- who are comprised of child welfare, juvenile justice stakeholders, as well as regional community representatives, private, public and community stakeholders and foster care alumni, Like most of the people who are part of the Children's Commission, they have some part-- you know, they're very passionate about their work in child welfare and juvenile justice. Either they work in the field or their family has been directly impacted by child welfare, juvenile justice. So, for example, we have adults who were formerly in foster care, foster and adoptive parents who are members, as well as biological parents who were previously involved in child welfare and have had their parental rights terminated. So it's a

really robust group that has a lot of different perspective. I personally am very fond of the Children's Commission just because I've worked in child welfare in Nebraska for the last ten years. So when LR37 was taking place back in 2011, I took off vacationing time from-- I was a case manager at the time-- to come and watch public hearings. So I personally am a huge fan of the Children's Commission and so, so happy to see what it's been able to do over the years, so hopefully I can convey the enthusiasm for the work that we do to all of you. So there's over 250 stakeholders and community members across the state that have participated in the commission's initiatives over the years, which have led to significant child welfare and juvenile justice policy and legislation. Our office is located within the Foster Care Review Office, just a few blocks from here, just for administrative purposes. We have two full-time employees, including myself, so we are an organization that is pretty much run by the volunteer members in our various groups, and we just have two full-time employees to support the operations. A copy of the member roster is in your handouts. Moving on to slide 5, the Children's Commission is an umbrella commission which provides research and expertise in an adviser-- in an advisory capacity for the implementation of new state and federal child welfare and juvenile justice legislation. It helps to preserve some of that institutional knowledge of child welfare and juvenile justice, which is important for term limits, and executive and judicial branch turnover. When I talk about child welfare, I'm talking about child abuse and neglect, foster care, experiences of reunification, out-of-home placements for juvenile justice; we're talkinga about youth who are involved in juvenile court for reasons of truancy, delinquency or status offenses, who may be experiencing out-of-home placement-- placements in foster care, detention, or the YRTCs. So we are a collaborative expert resource for this committee and the Legislature, and we serve as a legitimate forum for those-- for community involvement and representation, as I talked about. Through those statewide public hearings that took place during LR37 in 2011, it really gave voice to those communities, the foster parents, the families, service providers, and the child welfare workforce impacted by the tides of the reform over the years. Feel free to ask me any questions as I'm going along. On slide 6, some of our key accomplishments included we've given roots to some of the major initiatives you probably hear about today. We were part of the development of the original alternative response regulations. We helped develop the foster care reimbursement rate recommendations that were later passed into legislation and appropriated and funded. So we

also participated in the Young Adult Voluntary Services and Support Act, which is now known as the Bridge to Independence Act, for young adults who are exiting foster care, and the Strengthening Families Act. Something we're very excited about, one of our latest and greatest accomplishments, a real feather in our cap, is that we helped facilitate the extended foster care Bridge to Independence evaluation that's in your handouts. On slide 7, some of our 2018-2019 highlights that are included in our annual report on page 2, Senator Bolz introduced LR451 in 2018, which really was targeted at looking at the work of the Children's Commission and to evaluate the need for the children's continuation and any revisions to its structure and purpose beyond its sunset date. We were previously set to sunset in June of this year, June 30, so much of the focus over the last year, year and a half, has been directed towards continuing looking, you know, what's the role that we serve, how are we-- are we appropriately structured, should we continue, should we not, and that kind of discussions. LB600 was introduced by Senator Walz and amended by Senator Bolz to include the provisions necessary to continue the commission. The legislation was passed and signed into law by Governor Ricketts to continue the commission without a sunset. So we have been continued beyond our sunset three times now. So I think when we were initially created in 2012, we had a two-year sunset, followed by another two-year, followed by a three-year, and so at this point we are ready to stay. So we're very excited about that to continue partner long term with the Legislature. The commission approved the work products of the statutory committees submitted and presented over the last year and advanced them to the Legislature, the Department of Health and Human Services, and the Governor for consideration. The new legislation this year includes developing strategic priorities for child welfare research and policy development. And as part of that process, we took into consideration by statute the results of the federal Child and Family Services review that's conducted of Nebraska's child welfare system, as well as annual reports of the Foster Care Review Office and the Office of Inspector General. Present day, the new commission members began in September of 2019 following their appointment by Governor Ricketts. This is the parent commission to five statutory committees assigned to the commission through legislation. So over the years, we have been tasked with a variety of things through this committee specifically and legislation that was passed through this committee to take on specific issues related to child welfare and juvenile justice. So that is how we currently have our-- our current structure. So on slide 9, it kind of gives an overview of what those

statutory committees are as they exist today. We've had previous statutory committees, such as a lead agency task force, a title IV-E federal funding waiver demonstration project committee, and currently we have the Bridge to Independence advisory committee, our foster care rates committee, juvenile services, psychotropic medications for-- for children in foster care, as well as the Strengthening Families Act committee, along with some other commission-made work groups that have been prioritized. So the Bridge to Independence program provides voluntary services to young adults ages 19 to 21 who have aged out of foster care. The advisory committee was created in 2013 when that legislation was packed to provide-- passed to provide for that program. Committee-- the advisory committee makes recommendations to the Legislature regarding the ongoing implementation of that program, extended guardianship assistance, and extended adoption assistance. So the evaluation that was completed this year, we're very pleased to share the outcomes of that and embark on further technical assistance with Child Trends, who helped us create that. It was a new program in 2013, so the evaluation is really looking at measuring the outcomes of success for the participants in that program, assisted with next steps, determining right-sizing, any technical assistance needed for the program going forward. The Foster Care Reimbursement Rate Committee, I think that that title adequately summarizes what they're about. They look at what our-- what's the appropriate reimbursement rate for foster parents who are providing care for foster children. And that was created in 2011 and it was one of the recommendations from LR37 in 2011. At that time, Nebraska was among the lowest foster care rates in the nation. And so the work that was done to make the recommendations for the rates we have today was-- has been done through that very robust, collaborative, research-driven group. And so juvenile services, they meet jointly with the Nebraska Coalition for Juvenile Justice, and they examine the structure and the responsibility of the Office of Juvenile Services and they make recommendations about the YRTC and a continuum of care. Much of the last year for them, they've spent looking at juvenile suicide prevention and response to at-risk youth. Moving on, on slide 10, these are the members who serve as our committee. They're recently appointed, and they're also recently voted by the members of the Children's Commission. Jeanie Brandner, who is our chair, she's the deputy administrator for the juvenile division of the Administrative Office of Courts and Probation. Lana Temple-Plotz is our vice chair. She is the CEO of Nebraska Children's Home Society. A'Jamal Byndon, who is the racial and ethnic disparities coordinator from Douglas

County, Jim Blue, CEO of CEDARS, and Dr. Richard Hasty, who is the Plattsmouth Schools superintendent and special education director. So I think our executive committee is representative of the different perspectives that come to the table that are all active stakeholders and representatives of the child welfare and juvenile justice committee. On slide 11 is our annual report recommendations. The Bridge to Independence advisory committee, again, they're a volunteer program that provides services and supports to young adults who have aged out of foster care. These recommendations can be found on page 4 of our annual report, if that's what you're looking at. The community uses-- the-- the committee uses data and policy analysis to make recommendations about expanding to similar or at-risk populations. Their recommendations include expanding eligibility for tribal youth and juvenile justice youth, as well as those youth who are eligible for both Bridge to Independence and the Division of Developmental Disabilities, but they're not yet receiving services because they're on the waitlist for funding. So those recommendations are specific to expanding to those young adults who would be considered at risk or in need of services and supports as they enter into adulthood that are not currently captured by the program. Specifically for tribal youth, many of the tribal jurisdictions, the-- the youth are considered adults at age 18. And in the state of Nebraska, the age of majority is age 19. So to be eligible for the Bridge to Independence program, you need to be age 19. And so we really-- this committee really wants there to be legislation to help close that gap and expand eligibility for those tribal youth so that you're not missing out on that year where those-- that support and service could be really beneficial to those young adults. And then establishing a pathway for enrollment for Bridge to Independence for Nebraska's juvenile justice system-involved youth, for a young-- a young person who's in out-of-home placement as they age out of probation on their 19th birthday, prior to aging out, the court must hold a hearing to make a finding such that the placement is necessary because returning to the home would be contrary to the welfare of the child. That's really important for those youth whose parents will not accept them back into the home and they're in the probation-- they're receiving services and supports through probation but not through child welfare. And the-- those youth who are now becoming young adults are in need of services and support, just like their child welfare counterparts. As we know, many of the youth who are served by the probation system have past experience in child welfare, so they would be-- well, the committee wouldn't say as-- as similar at-risk population. On slide 12 is our annual report

recommendations for the Strengthening Families Act committee. They can be found at page 7 of your report. The Strengthening Families Act represents a culture shift to allow children to youth-- and youth to grow and thrive in less restrictive, more family like environments and participate in age- and developmentally appropriate activities. One aspect of the Strengthening Families Act is the requirement for all child-caring institutions, such as group homes and temporary shelters, under contract with the Department of Health and Human Services, are required to submit plans and annual reports on the ways in which the facility takes into consideration the youths' voice, their choice, a need for access to normalcy despite facility placement, so how are they promoting and protecting the ability of children to participate in age- or developmentally appropriate extracurricular activities, enrichment, cultural and social activities? So this Strengthening Families Act committee has a normalcy subcommittee and what they do is they review the normalcy plans and reports that are a part of the statute. All those facilities, like group homes and shelters, under contract with Children and Family Services are required to submit their plans as to how they're going to provide access to normalcy activities for these youth. So this, this group reviews those statutorily required reports and makes recommendations about them. So as it's written today, the requirement is only applied to group homes and shelters but does not include treatment settings where youths are placed to-- so the requirement set out in statute doesn't include all of the levels of care. So, for example, psychiatric residential treatment facilities or treatment group homes, we only have one-- just really one slice of the pie and we-- this committee is making a recommendation that all kids in out-of-home placement deserve access to normalcy, that it's-- it's crucial to their identity and their development and well-being. So normalcy should extend to youth in care in all systems. The committee recommends the statutory requirement for normalcy plans and reports pursuant to 43-4706 be amended to include facilities which provide treatment services as a component of the placement, including treatment group homes and psychiatric residential facilities. On slide 13, the commission has met on three dates since members were appointed this fall in order to orient members and provide the education on key issues and hear from the statutory committees. 43-4204 outlines the provisions which the Children's Commission much identify-- must identify three defined strategic priorities for child welfare research and policy development. We met earlier this-- just like a few days ago to finalize our recommendations for what those strategic priorities will be for the

biennium. We've listed them here for you: a prevention continuum, including a focus on the alternative response program; noncourt voluntary cases, as well as the Family First Prevention and Services Act; placement stability, including disruption for adoption and guardianships; racial and ethnic disparities, as we all know, is-- is a very important issue for our-- for our state in both our juvenile justice and our child welfare systems. Truancy and status offense filings, as well as statutory committee priorities, including the foster care reimbursement rate committee, they have a statutory requirement to provide an update and recommendations to the Legislature and the Governor every four years by statute. Their next report is due this coming July. So the rates that were approved in-- set forth in 2014 have not changed since that time. So this whole last year, the rate committee has been looking at what factors need to be considered in making recommendations for the next four-year period. And so one of our priorities is to uphold and support and promote the work of the rate committee. That's currently underway, as well as preparation for adulthood or another planned permanent living arrangement, and the Bridge to Independence program expansion to those other groups of young adults that we-- that I mentioned earlier. And then on the next slide, on slide 14, we also believe, although it's not a strategic priority for research and policy development, the Nebraska Children's Commission is continuing to monitor and request updates and remain an active stakeholder and participant regarding the Eastern Service Area contract transition from PromiseShip to St. Francis, as well as the Youth Rehabilitation and Treatment Centers. And then we also developed a new legislative work group and this work group would-- would review pending bills, make recommendations to the executive committee for the commission to take action, come forward and show support and weigh in on bills that are being presented as they are presented. So final slide, thank you very much. We look forward to our continued partnership with the Health and Human Services Committee of the Legislature. Our contact information is on there. I'd be happy to answer any questions to the best of my ability.

HOWARD: Thank you.

CHRIS JONES: Yeah.

HOWARD: Thank you for your your briefing today. We appreciate it. And just for the record, Senator Walz is the committee's member for the

Children's Commission. She's our designee from our committee. Senator Arch.

ARCH: Just a question of clarification. How-- what exactly is the role of the Children's Commission to these other committees? Are you simply a coordinator, facilitator to these other committees so that you compile the recommendations as they come from the committees and then communicate that to the Legislature? How would you describe that role?

CHRIS JONES: So we-- our interaction with our statutory committees, one, they're assigned to us through legislation, so they are under kind of our umbrella. We do promote their recommendations. We prioritize them and-- and advance them to the Legislature. And then we also assign work to them. So some of the work that they do is because the commission has assigned it to them.

ARCH: OK. And so-- so when these committees develop recommendations, they are communicating directly to the Legislature; they're communicating through the Children's Commission.

CHRIS JONES: Some.

ARCH: OK.

CHRIS JONES: So the statutory committees, most of them have a statutory obligation to provide an annual report and recommendations to the Children's Commission, the Health and Human Services Committee, the Legislature and the Governor--

ARCH: OK.

CHRIS JONES: --as well as the Department of Health and Human Services in some instances.

ARCH: All right. OK. Thank you.

CHRIS JONES: We report to all.

ARCH: All right. Thank you.

HOWARD: Thank you. Are there other questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you for being here. So we're all on the same page, could you take me through the process of how you are funded as a-- a group and what the dollars are?

CHRIS JONES: Sure. Yes. OK, so we're currently funded through the Health Care Cash Fund. In the past, we've been funded by the Health Care Cash Fund and we have also been funded by General Funds of the past. So because we have previously operated on sunset dates, that's been difficult to submit a budget request through the traditional means to do so. So this last year, we were facing sunset. And so when we had-- LB600 was introduced, there was an appropriation, LB600A, which included the provisions for the Health Care Cash Fund. So this year, this fiscal year, we're funded $179,779 and next year it's $181,437. And so that's-- most of it is-- is PSL, or permanent salary benefits, for the two employees, and then the operational costs for meetings and expense reimbursements for members if they-- if they submit for that.

WILLIAMS: Thank you.

CHRIS JONES: So we operate on a tiny, tiny, tiny drop in the bucket.

HOWARD: Other questions? Seeing none, thank you for briefing us today. We appreciate it.

CHRIS JONES: Yeah. Thanks, all of you.

HOWARD: All right. We're now going to move on to a briefing regarding issues related to optometry. This is invited testimony only and they will only have an hour for this briefing. Our first testifier will not be timed and it's-- I'd like to invite Dr. Chris Wolfe to come tell us a little bit about optometry.

CHRIS WOLFE: Well, thank you so much, Chair-- Chairwoman Howard. And thank you, committee and senators, for everything you're doing and taking time out of your interim session to be here today. What you'll see in the handout is just sort of an overview of the profession. It's-- it's important, I think, for people to kind of have a grasp of what optometry does. Often, it sort of gets characterized into small buckets, and those buckets don't really represent the larger-scale things that we do within the healthcare realm and within our communities. And so that's-- that's kind of how-- how we'll approach this. And so just to give you some historical perspective, that first page that you're seeing there on your handout sort of gives you an

overview of the scope-of-practice changes that have occurred since 1979 with our profession specifically in the state of Nebraska. And-- and as you look through that, I think what's important to know is that, as any limited licensure profession, we're required to educate, you know, obviously through our-- our standard educational systems, through our colleges and schools, but we're also required to educate before any other scope-of-practice changes. And so we have to have common or-- or almost constant adjustments in scope of practice so that our profession can keep up with the knowledge, education, and training of what's occurring at the schools, and as well, what's being delivered through our-- our continuing medical education that occurs outside of the school for-- for our licensure. And so-- so that's what you're seeing kind of represented here. And if we take this in stages, I think what's important is that, you know, 1979, prior to 1979 in Nebraska, optometry was a drugless profession. And so 1979 came around and our ability to utilize medications to diagnose, so mainly to dilate the eye and look inside of the eye for retinal diseases, so things like retinal holes and tears, glaucoma, macular degeneration, that's challenging to do without-- without a fully dilated pupil. Then in 1987, we were granted-- so again, education continues to evolve, training continues to evolve for optometrists, and in 1987, the Legislature granted the authority to prescribe topical medications. And-- and so that would be things like treating eye infections that would be from bacteria, would be from eye inflammation that isn't infectious, so things like topical steroid medications, things like viral infections, so topical antivirals. So I don't know if you're aware, but, you know, you get cold sores on your lips, you can get those same types of lesions on your eyes. So-- so in 1987, that's when the authority was granted by the Legislature to update the scope of practice for optometrists in Nebraska. In 1993-- again, I think it's important to go through this only because to give you some perspective of-- to culminate what-- what I do every day in my practice. In 1983, we were granted the authority for minor sur-- minor procedures that would allow the removal of foreign bodies from the eyelid, the cornea, and the conjunctiva. So Doctor Vandervort will come and talk to you specifically about these, but essentially-- and you'll have-- later in your handout it'll kind of show you some of the images of what we're talking about. But the cornea is the very front surface of the eye. It's where a contact lens sits. The conjunctiva is-- is the covering of the white part of the eye. It's about a-- it's like a grape seed-- grape skin thickness. It's very, you know, very thin. And so that's the conjunctiva. It's where a lot of those blood vessels are-- are--

are coursing through. It's when you have a red eye, that's typically-- there's some deeper inflammation that can occur in the sclera and the episclera. But typically the conjunctiva is where you'll see the-- the redness when somebody presents with the red eye. And so-- so that's-- that was-- that occurred in 1993. And then in 1998, so five years later-- I was still in high school-- we were granted the opportunity to-- and the authority to treat glaucoma. So glaucoma, while we could diagnose it, we could use medications to diagnose it, use technology to diagnose it, we couldn't actually treat it until 1998 from the Legislature. Again, the-- the education and training of the profession had been there for quite some time at that point in 1998, but Nebraska specifically was allowing us to have that authority in 1998. And-- and so glaucoma is a-- is a disease that tends to-- well, it-- in general, it tends to be a slowly progressive, asymptomatic disease until late stage. So imagine you have, you know, oh, I'm closing one eye, but imagine that you have this kind of creep of your vision from the side in. Most patients aren't aware, unless their pressure is significantly high; they don't feel it; they don't feel that that there's damage in their eye, so they have this kind of gradual. And the worst-case scenario is this is-- when they come in, this is all they see. Right? So our goal as primary eye-care providers is to detect that way earlier, so ideally even before or at the very start of vision loss of that visual field, because we can intervene. And so that's what those-- those medications allow us to do, is topical medications that we could use to-- mainly to reduce the pressure so that we didn't get this continued damage of the optic nerve that would lead to vision loss. The-- in 2014, the Legislature approved a bill that-- and passed a bill that allowed us to-- it basically removed all the remaining restrictions on oral medication. So I should have covered this in the 1983 perspective, but in 1993 we also were granted the authority to treat eye diseases with oral medications. There was a few that were excluded at that time and that was kind of codified in 2014. So in 2014, the-- the remaining exclusions on those medications, which were oral steroids, really powerful medications like immunosuppressive medications and-- and oral glaucoma medications, were all authorized in 2014 by the Legislature. And so to kind of give you an understanding of that, the-- I wanted to-- I didn't share this in the packet. Obviously, because of patient information, I've got it all redacted. But to give you kind of a sense of how this impacts my patient base and my patients that seek our care and our practice, I looked over just Wednesday's chart schedule. And if I look back on that, of the-- of the patients, 80 percent of them that I saw were not

coming to me for glasses and contact lens prescriptions. Their main issue was the management of ocular diseases that is granted by the authority that you all over the years have-- have granted us, and so things like glaucoma treatments, things like lacrimal treatments that we use for patients with-- with dry eye, what's commonly called dry eye, things like keratoconjunctivitis sicca, meibomian gland dysfunction. And so those-- of that 80 percent of those patients on my schedule, you know, if-- if this hadn't occurred in the Legislature, then those patients would have had to seek care-- would have had to see me-- they could have chose to see me, but then they would have been forced to see somebody else for that additional care. Now they can choose. If they want to see somebody else for that care, they can, but they have the option to see me and-- and they're choosing to do that. And that's really kind of reflected not just with Chris Wolfe's practice but-- but also practices across the state in Omaha, Lincoln, and then also rural areas across the state. The-- and to give you another perspective, the-- you know, of those 80 percent, about half of them, I wouldn't have been able to treat in 1997 and the-- pretty much the rest of those 80 percent I wouldn't have been able to treat before 1993. So-- so that I think is helpful kind of in understanding the importance of-- of continued ongoing enhancement of the profession so that we can continue to serve the patient population that's in Nebraska. And in regards to that patient population, if you'd flip to page 3 of the-- of your handout, it sort of-- you'll see kind of the distribution of eye-care providers. And the-- if you look on the left-hand side, that distribution map comes from the American Medical Association, so it's based on their registries of doctors within-- of medical doctors, specifically ophthalmology. And if you look, they're distributed largely along I-80 and-- and it makes sense because the type of work that they typically want to do is high-volume surgical procedures that are typically done in an operating room. And so they're going to locate their practices along the populated areas. And-- and optometrists obviously are more spread out throughout the state and can provide more acute and chronic care in those locations where it's not needed for maybe operating room procedures or-- or kind of secondary or even tertiary types of-- of-- of care. If you think about the importance of continuing updates in scope of practice, specifically for optometry, the first one that comes to mind in terms of reasoning for it would be that we have-- we don't have any optometry schools in Nebraska. We have two medical schools, as you know, that are in Omaha. And-- and so when people are trained outside of the state-- and I'm-- I'm one of them. Obviously, every one of us

are trained outside of the state. But in particular, I was trained in Oklahoma. I finished my training 11 years ago, about 11.5 years ago. And-- excuse me, 10.5 years ago. And the things that we're being trained to do, we-- we can't necessarily-- well, we can't do if we come back to a state that has a different scope of practice, and that's really where we're at in Nebraska. And so that's one is the-- is the ability for people to come back to Nebraska and utilize their full training and so that the-- the patients in Nebraska, if they so choose to, can have access to that training and those-- that knowledge, education, and skills that-- that optometrists have when they're being trained in other states. The other thing is that when you look at things to drive the cost curve down of healthcare in general, there's a lot of them, but-- but I think one-- one report that really summarizes this well that's kind of an independent report, and it's sort of a national report, comes from the Health and Human Services. And it was directed at the President when he was looking for ways that healthcare reform can drive that cost care down. And that's on page 4 for you. And this is a 120-page document and there's a citation where you can access that. But-- but this is just one of those pages. But the big-- the big push within that whole document is that we can actually save healthcare dollars, significant healthcare dollars by utilizing, and I've highlighted a couple of points here, but by utilizing non-MD professions to their highest scope and training. And so-- so we know that that allows us to not have to duplicate services for patients, not have to have additional visits, a different, additional travel time, those sorts of things. And then to give you another perspective of, you know, where things are being done, I gave you this map here. And essentially what you're seeing is the states that are colored have a larger scope of practice than Nebraska does to include other types of procedures. So in general, the way that the profession is, is moving, and in terms of our training and our education, is that we are-- are seeking the needs or we're fulfilling the needs of the patients who seek our care by adding different types of procedural things to our-- our skill set. And so, for example, if you-- so if you look at that map, what we're showing you there is that obviously there's different scope of practice in every state. But there's at least 19 other states that allow different procedures that we cannot allow-- we can't offer to our patients in Nebraska. They can't even choose to see us for those procedures. Some of those procedures you'll find on page 6, 7, and 8-- excuse me, 6 through-- through 13. And the reason that I wanted to show you this is-- is to do a couple things. First is to show you that we're not

talking about operating-room procedures. We're really talking about procedures that-- that-- so we can-- right now we can-- we are trained and we are licensed in Nebraska to manage these procedures-- or, excuse me, to manage these conditions. So we just can't use a procedure to manage them with. So, for example, one of the patients that I was referencing, she's a glaucoma patient, also had a little-- what's called a sudoriferous cyst on her upper eyelid, which is a sweat gland cyst. There's a gland of Moll, which is a-- lots of sweat glands along our eyelids. And those can sort of become obstructed with epithelial cells and-- and then they sort of back up and they leave this really hard ball. And if they're superficial enough, we can express them, right? We can basically squeeze them. The-- the challenge is if they're really deep and you start squeezing those things, they'll-- they can lead to deeper infections so we don't do it. But what you're seeing here on-- on some of the-- on page 7 in particular, all you're doing in terms of-- of performing those procedures is taking a sterile needle, a single-use needle, and you--- and you basically lance that, that lesion, and then you squeeze kind of the cheesy material that comes out. Other types of cysts that we're talking about don't even need a whole lot of squeezing. Sometimes you can just kind rupture the-- the membrane over the top of it and it flows out. Probably the most-- the goriest, although it's-- it is, you know, something that we're doing all the time, but if you watch the videos-- in fact, I don't know-- I-- we can't use them here today, but we have a whole suite of videos so you can see kind of what it looks like to do the procedures that optometrists are currently authorized to do today, which Dr. Vandervort will talk about behind me, but also how that relates to the technical skill involved with these procedures. So one of the things I think is really challenging is when you look at these procedures, which I was trained ten years ago to do, I've done well over 50 of these types of procedures in my training when I was in Oklahoma, the-- it's hard for a layperson to wrap their mind around, well, I'm not going to-- I'm not going to do that. That's-- how's-- how's that going to be easy for us to kind of-- how-- easy to learn? But it's important to know that the techniques, the skill that we use to work around the eye every single day within our current procedures, and just our normal examination and evaluation of patients is sort of that base, and we're not talking about this huge jump in terms of these procedures. We're talking about a step in using the same techniques that we use day to day to implement on these procedures. But that's called the chalazion removal and that typically involves an injection around actually. So if-- I talked about this a

few years ago, but there's really two pathways that can happen when we get chalazions. The common thing for people to know is that you've got about 25 glands in your lower and upper eyelids. They're oil glands and those oil glands prevent-- they-- they secrete oil every time we blink. And those oil glands actually push oil out on the surface of the tear film and what they do is they're responsible for preventing the fluid of the eye, the watery component of the tears, from evaporating off the surface of the eye. And so those glands commonly get obstructed and they get obstructed with biofilms from microorganisms that live along our eyelids and lashes, from makeup, from lack of blinking, actually, when we use near-- you know, when we do a lot of near work, digital device use, we don't blink as completely or as often, so those glands don't get as expressed as easily. Well, two things can happen once that-- once that gets kind of clogged up. The first thing is-- that is way more common is that those glands will try to pump to restore the surface of the tear film, but then the gland sort of dies off gradually and it's asymptomatic. Patients don't feel it, but it's something that we screen for in our-- in our general practice. The other thing that can happen, which is much more commonly recognized by the public, is that gland will swell, become inflamed, and that's what's called a stye. So those styes, we tend not to-- we tend to leave those alone. We sometimes will treat them with oral antibiotics, which we're authorized to do, to try to help the resolution or prevent what we call preseptal or orbital cellulitis, which is where that infection moves to the entire lid and then to behind the-- the protection of the eyelid behind the eye. But most of time, they'll just resolve on their own. But sometimes, they'll-- they'll leave kind of this hard mass, this lump in the eyelid, and those lumps then, again, we-- we try with warm compresses; we try with longer-term, kind of lower-dose medications that we use for-- to treat in-- inflammation come-- similar to like medications you can use for like rosacea, so like doxycycline is a commonly used medication that you can use for a longer period of time safely in specific situations that we already do. But sometimes these-- these just need to be lanced, essentially, so you basically flip the eyelid, you create a small kind of incision along that gland, and you go in and kind of-- you know, it's called a curette, but you-- it's almost like an ice cream scoop. You just sort of scoop all that cheesy material out. I'm sorry that I'm being graphic, but I think it's important to know. And-- and then it-- it sort of-- the-- the vast majority of the time doesn't need anything else other than just a topical antibiotic and it-- it heals on its own. So the reason, again,

the reason I go through that is not-- I see people wincing and those sorts of things. But-- but the reality is, is that this is-- the-- like, you know, this is the Legislature's-- you have to make these decisions. And so it's hard because you don't understand. You know, on the one hand, when you hear these things come up, you have one group of experts that are telling you one thing and one group of experts that may-- may say something else. And-- and then if you look at it pictures or listen to the way it's descriptive-- described, it's hard to-- to kind of grasp or to want to even look away because it's not something that you do every day. It's easy to get queasy. But I think it's important that I share that with you so that you can kind of understand the types of procedural things related to the profession of optometry that are being taught and have been being taught-- have been taught for years and-- and how that impacts our day-to-day care. So that patient that I was describing to you from Wednesday, my glaucoma patient, she said, well, can you just take this off, can you just-- can you just get rid of that, can you help me get rid of that? And I said, I can't, I have to-- I'm going to have to make a small incision and I can't do that. Well, why not? Well, I was trained to do it, but I can't do it because the-- the Legislature doesn't allow me do it. But I can send you to this surgeon over here and-- and they can take care of it. And most of the time they'll-- they'll go. In some cases what they say, and in fact in a lot of cases, even in Omaha, what they'll say is, is there anything else I can do to try to not have to go see somebody else? I mean, it's a reality. I'd love to say that it wasn't. But, you know, I'm a mile from the surgeons that we use most of the time. And what they'll say, I think that for some of these things, is, can I try warm compresses for a while, can I-- you know, and so they sort of go with-- with the care that they're-- because they don't-- not because they don't trust them. It's because they they just don't want to establish another relationship with somebody else if they don't have to. And so they'll try other things first, even though they're-- even if they've tried them, or they'll try them for longer, those sorts of things. So-- so with that, I-- I'd be happy to sort of open up for any questions you have about just the general history of optometry. We will have Dr. Ternus and Dr. Vandervort. Dr. Ternus will talk about specific education related to optometry. And-- and Dr. Vandervort will talk about the procedures currently that we're authorized to perform in this state that we've been performing since 1993.

HOWARD: Are there questions? Before we go to questions, can you talk about your previous 407s or your issue for us?

CHRIS WOLFE: Oh, yeah, absolutely, yeah. Thank you. Yeah. So-- so our-- our last 407 I believe was in 2013 before the bill that passed in 2014. And-- and in that 407 review, the-- all the procedures that I just talked about within this packet were approved by the Board of Health level of the 407. And so the other thing that we did within that after-- after that 407 review was to try to in the future, if-- if legislation is presented that deals specifically with these procedures, the technical review committee wanted to see specific language in that-- in that bill that would outline the education that-- that existing doctors would have to undertake or that students would have to be able to prove that they could-- that they've obtained. And so-- so anything that-- and so instead of just leaving it up to the Board of Optometry, one of the things that we took from that 407 review was let's look at the standard, which the Board of Optometry would have-- have used anyway, but put it in statute. The standard education that has been used in other states to show that-- to ensure that patient safety was occurring, that standard education that's delivered was-- would be put in any-- any future legislation. And we don't have to wonder whether that-- that training is appropriate for the profession of optometry because it's been proven to be appropriate in all these other states. The other thing as far as the 407 is concerned is that if you look at the technical review committee, one of the-- a couple of interesting things is that when you look at their recommendations and from that 407 process, we-- we didn't-- 4-- the technical review committee didn't approve that 407. We failed on a 4-3 vote. But the Board of Health, they-- they did approve it. And so I think there's a couple things. The first thing was that when you look at their-- their outcome or their impressions of why they-- they didn't think it was appropriate, from a technical review committee standpoint, was that they were scared that-- that either some procedures or some of the-- the medications that were in that review were going to put the-- put the public at risk. And one of the interesting things is that-- so in 2014, the technical review committee, some of those outcomes or some of the-- the comments of it was that the medications were too dangerous for optometrists to prescribe safely. And yet here we are five years later and, just like every scope-of-practice enhancement that has occurred, there has been no complaints, not just to the Board of Optometry but no complaints in malpractice, no complaints in-- to the Board of Health that

optometrists have been prescribing those dangerous medications that the technical review committee was so concerned about, or the four people on the technical review committee were so concerned about, that-- that actually hasn't come to fruition. And so-- so-- and those-- so the similar kinds of things of, well, how do we know that the-- that the rigor that's involved in training optometrists to perform these procedures is adequate? That was another common concern that-- that some of the negative votes on the technical review committee kind of voiced. And-- and so they they were concerned about that because during that technical review committee, the opposition created enough-- enough doubt in their minds that it wasn't going to be adequate. But there was never any evidence in any of the other states that I showed you there that that educational program was inadequate to protect the public by nature of the fact that there hadn't been any board actions; there haven't been any laws that had been rescinded by those legislatures; there hadn't-- not even board actions, but even board complaints to their med-- state medical boards or the state optometric boards. And so-- so even in spite of the fact that there is no evidence-- of course-- of course, one of the things that I would be remiss if I-- if I didn't say, but, you know, there's a difference between bad care and bad outcomes. So to say that-- that, you know, optometry does procedures and there's no potential side effects of those procedures, that wouldn't be accurate. But the reality is, is that the evidence shows us that the-- that optometrists performing these types of procedures, the complication rate of optometrists performing these types of procedures is no greater than-- than an ophthalmologist performing these types of procedures. And I think that's what's important to take home from the evidence, is that-- that that educational standard has been used in other states. We don't have to wonder whether it's going to be effective for optometrists in Nebraska because we know the Board of Optometry for all of these years have-- have safely incorporated new scopes of practice and those types of education have been used in other states to do those types of new procedures for the profession. I-- I'm sorry if I went a little longer, but I could go all day on a 407 review. I was, and Dr. Bob was, too, we were intimately involved in that.

HOWARD: Thank you.

CHRIS WOLFE: You're welcome.

HOWARD: Senator Hansen.

B. HANSEN: Thank you. I appreciate your elegant use of the term "cheesy material," especially when my colleague--

CHRIS WOLFE: You're welcome.

B. HANSEN: --Senator Cavanaugh, who I know--

CHRIS WOLFE: I-- I [INAUDIBLE]

B. HANSEN: --looks forward to these conversations and pictures.

CHRIS WOLFE: I know. I know.

B. HANSEN: So I appreciate that. I do have a question though. Out of all these procedures you talked about, and this might be even a question for the following testifiers, out of all the procedures you talked about, do all the colleges that you know of, of optometry, teach those procedures?

CHRIS WOLFE: Yes.

B. HANSEN: So somebody coming from one college versus another, you know, they don't take like extra credit or, you know, get extra training to learn these procedures, so if we happen to expand scope of practice, we don't have to worry about somebody going to one college who doesn't understand how to do something versus somebody else?

CHRIS WOLFE: Yeah. Correct. And if the Board of Optometry also decided that it was important to-- so the short answer to your question is yes.

B. HANSEN: OK.

CHRIS WOLFE: The longer answer is that if-- if the board of optometry decided to implement those types of specific outlines in order to further protect the public in Nebraska to say we want you to do this additional course, they could choose to do that through their regulation if-- if something was to pass in the future. But, yes, they're-- they're also tested at the level of the National Board of Examiners. And so-- so the-- yeah, so they're trained and tested.

B. HANSEN: OK, cool. Thanks.

CHRIS WOLFE: You're welcome.

HOWARD: Other questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. Thank you, Dr. Wolfe, for being here. You mentioned Oklahoma. Where are some other states that have--

CHRIS WOLFE: Yes, sir.

WILLIAMS: --schools of optometry?

CHRIS WOLFE: Close states would be Illinois, they've got two in Chicago, St. Louis, which it-- and then-- so those-- so-- and then Oklahoma, Tahlequah, Oklahoma, which is about an hour east of Tulsa. And then once you get beyond there, then you've got a couple schools in Texas. You have San Antonio, University of Houston. You've got schools on the coasts, so you have a school in Arizona. You've got a school-- three schools in California: Berkeley, Southern California and Western. You have a school in Oregon. And then you have a couple schools in Massachusetts, a school in Michigan, a school in Indiana, which is common, so--

WILLIAMS: Most of our optometrists are from the Midwest?

CHRIS WOLFE: Most of ours are going to be Oklahoma-- yeah, Oklahoma, Chicago, Indiana, St. Louis are kind of the predominate-- Houston-- are going to be kind of the predominant ones to go to.

WILLIAMS: And following up on Senator Hansen's questions, the curriculum at all of those schools would be very similar?

CHRIS WOLFE: Correct. Yeah. So there's always nuances. But, yes, the base curriculum, because they're all-- they all have to be accredited by the ACLE, which is accredited by the Council of Higher Education federally. They all have to follow their-- their-- a specific curricula.

WILLIAMS: Thank you. And as you know, because we've-- we've been over this, there are many of us sit on this committee that have no medical background. And you're right. We hear different versions of these things that can happen to your eye.

CHRIS WOLFE: Yeah.

WILLIAMS: And one of the arguments that continues to be made is we're not allowing you to-- to practice to the scope that you are trained--

CHRIS WOLFE: Yes, sir.

WILLIAMS: --you know that-- and using that as a as an argument here. I have been one, speaking for myself, that has tried to rely on the 407 process because that is a process conducted by independent people that have a medical background. My question is-- it would appear to me that the current legislation that has come before this committee is an attempt to find a different way to change and manage a scope of practice and avoid using the current 407 process to do that. Can you address that question?

CHRIS WOLFE: Yeah, I'd be happy to. I think the first thing is that because-- so if we go back to kind of that scope-expansion sheet, the sheet 1 that I showed you--

WILLIAMS: Yeah.

CHRIS WOLFE: --when it goes through-- when these types of things go through the Legislature, the-- of course, any limited-- limited license profession is going to have to go through a legislature. But when it goes through the Legislature, it winds up delaying that-- that change significantly over time. So to give you some perspective, the National Board of Examiners had tested on all topical and oral medications related to eye disease since 1992. It's called the TMOD. And-- and-- and yet we didn't expand our authority in Nebraska fully, meaning that-- that schools, because you can't practice in any state-- almost any state-- without passage of all three levels of-- of the National Board of Examiners in Optometry. And so the schools had to teach that stuff before 1992 because all of those boards were to rely on the outcome of that in order to give licenses. So the teaching and the testing mechanism in place for optometry for those medications in Nebraska existed in 1992 for all graduates of those optometry schools and everybody licensed in Nebraska. But we didn't fully expand the authority in Nebraska until 2014. So think about that. So if-- Senator Williams, I'm not sure what your profession is, but if you think about how your profession or the types of things you could do evolves with technology, etcetera, etcetera, and you're still trying to catch up to what you were trained 22 years ago, that's-- that's the challenge with the 407. And I-- and I would-- being through the technical review committee-- and I agree. I think it's-- it's a-- it's a way to rely on experts, or who should be experts and independent experts. The Board of Health has a perspective of what technical aspects of-- of professions have to understand. Right/ They-- they-- they're not-- the

Board of Health isn't-- there are lay people on the Board of Health, but the Board of Health has a swath of professionals who understand what it's like for professionals to learn new techniques and procedures. The technical review committee is actually made up of three professionals and four lay members. And so-- so what happens is those lay members, while they're-- they may be swayed because of medicine saying this, optometry saying this, and so what our current bill, LB528 that exists still in this committee, was aiming to do was to say basically the only way that we can change our scope of practice in-- in Nebraska for optometry would be that the Board of Optometry says, yeah, there's education and training to make sure the public is safe, but then the Board of Health would have to evaluate that as well and-- and ensure that it's safe. So it's not just the Board of Optometry anymore. That's what LB528 would do. Our intention may be that-- that if-- if this committee obviously isn't-- isn't comfortable with that, isn't uncomfortable not relying on the 407 process, then-- then we may, you know, in the future have to take, you know, the role of the 407 for-- for additional procedures, you kind of rely on the 407 again. But the intent of that bill was to say we don't-- you know, we understand that when senators need to make decisions and we say "cheesy material" or this is going to be gross, like there's sort of this discomfort to kind of wrap your mind around what it is we're talking about, because it-- because we're not used to seeing those things as lay-- as lay people, and put that onus on the people who really understand, one, what the profession does, Board of Optometry, and, too, overseeing the Board of Optometry will be the Board of Health, to be able to say we know what professions do, and we can oversee that the Board of Optometry isn't going to say go rogue, which they've never done in the past because their sole purpose is to protect the public and not to protect the profession.

WILLIAMS: Thank you.

CHRIS WOLFE: You're welcome.

HOWARD: Senator Cavanaugh. That was your question. All right. Any other questions from the committee? Seeing none--

CHRIS WOLFE: Thank you very much.

HOWARD: --thank you for briefing us.

CHRIS WOLFE: Appreciate it. Thanks for everything you guys do.

HOWARD: All right. Our next testifier will be Dr. Turness in five minutes.

[BREAK]

HOLLY TERNUS: Thank you, Senator Howard.

HOWARD: Morning.

HOLLY TERNUS: Hello, Senators. My name is Holly Ternus, H-o-l-l-y T-e-r-n-u-s, and I'm an optometrist that practices in Omaha. Thank you for this opportunity to speak with you today about our profession and the advances in the education for optometrists. And I know Dr. Wolfe kind of touched on all of that already, but a lot of people think of optometrists as eyeglass doctors. However, the training and education we receive currently is far more advanced than 40 to 50 years ago. If you look at our curriculum and education, and in the handout there's a red tab and it's not the first page on that red tab, it's the second page, you can see that there's a curriculum comparison between optometry and medical doctors, and you can see that about 80 to 90 percent of our training is based solely on diseases of the eye. Currently, we're trained to treat and manage glaucoma, macular degeneration, eye infections. We remove foreign bodies from the cornea and treat injuries such as corneal abrasions. And we provide pre- and postoperative care for patients before and after eye surgeries. And we're trained to detect systemic disease such as diabetes, high blood pressure, autoimmune diseases, multiple sclerosis, and brain lesions solely from a comprehensive eye exam. This is far more extensive than just eyeglass and contact lens doctors that some of the public may perceive us to be and the way ophthalmology portrays us to you, largely because most ophthalmologists and medical doctors don't know or understand our training or the range of medical eye care that's already part of our current scope of practice in Nebraska, because the vast majority of them have never been to an optometry school or never set foot in one, so they're not aware of what we do there. If you look at that handout, on page 15, many of the core classes between optometry and medical school are the same. These common core classes are the same between optometry and medical school. In addition to postgraduate courses on ocular anatomy and physiology, we take core classes on infectious disease, cardiovascular systems, microbiology, pathology, dermatology. And then moving into year three, we continue to advance our knowledge on the eye and visual system and apply it clinically to our patients. And if you look there during year three,

we learn how to perform injections and minor surgical procedures, which in year one and two we take human anatomy and dissect cadavers, just to build on that anatomy knowledge so we're comfortable performing these minor surgical procedures. And then we continue to gain clinical experience in injections and procedures into your four, when we do externship rotations. In contrast, if you look at medical doctors, they receive little to no training on the eye in medical school. If you look at the handout, they might get a two to four weeks in a specialty such as ophthalmology in their year-four preresidency program. And it's important to know, even though these medical doctors receive very little training on the eye, they're allowed to perform all the minor surgical procedures we have previously asked the Legislature to authorize for optometry in Nebraska. In addition, nurse practitioners and physicians' assistants are also allowed to perform these procedures with little to no training on the eye. Opponents focus on comparing our education and training to that of ophthalmologists, but it's important to note that there are providers in Nebraska who are authorized to provide medical eye care beyond our current scope of authority with far less training on the eye than we have. Optometry schools, and Doctor Wolfe talked about this, we're all accredited with similar curriculum to train optometrists extensively on ocular disease, the visual system, and the ocular adnexa, which is around the eye and the lids. The National Board of Examiners of Optometry tests every graduate on our skills to ensure the safety of the public and make sure that every student is trained proficiently. There are also established training and education courses for previous graduates to become more comfortable with these procedures and become certified to perform them. The courses are already implemented in states that allow optometrists to perform minor procedures. And as Dr. Wofle stated, we know that these specific training courses are enough to ensure the safety of the public because they're already implemented in these other states and have been proven to be effective. Also, we are all required to continue to take at least 22 hours of continuing education per year to stay current on our knowledge and skills, just like all healthcare providers. This is essential in all professions, as you know, due to the continuously evolving and developing advancements in healthcare. We need to continue to progress and advance in every profession to provide the best available techniques and treatments for our patients. And it's important to remember that in addition-- additional training or education relative to any specific new authority or care would simply be building on our training, knowledge, and clinical experience we already have, just the

same as is for MDs or any other licensed healthcare professionals. And I think you'll see from Dr. Vandervort's presentation that the extension of the authority we're seeking is not a significant departure from what we're already doing. Starting in 1981, at least ten states have permitted optometry to perform all the minor surgical procedures we are seeking for our patients in Nebraska. All of the evidence shows that these procedures are being performed in a safe and highly competent manner. These procedures are safe for optometrists to perform because this is part of what we do for our patients every day and it's what we're trained to do already. Thank you again for this opportunity, and I will be happy to answer any questions you may have.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Thank you. You may have mentioned it, but what is your-- what's your postschool requirements for training, residency, that-- that type of thing?

HOLLY TERNUS: Residencies are optional if you prefer to specialize, but the-- those would be a year long. And a lot of people's trainings say I worked for an ophthalmologist after school and-- and received training there as well.

ARCH: For-- for licensure then, do you have certain number of hours required postschool?

HOLLY TERNUS: Yes. It's-- it varies a little by state. Here in Nebraska, it's 22 hours per year.

ARCH: For continuing education.

HOLLY TERNUS: Yes.

ARCH: But as far as experience postschool, do you have to-- do you have to do certain number of hours within an optometry-supervised area or you-- you-- you're able to practice upon graduation?

HOLLY TERNUS: Correct.

ARCH: OK. All right. Thank you.

HOLLY TERNUS: Yes. Thank you.

HOWARD: Any other questions? Seeing none, thank you--

HOLLY TERNUS: Thank you.

HOWARD: --for visiting with us today. Our next invited testimony is Dr. Robert Vandervort. He gets five minutes, Sherry.

ROBERT VANDERVORT: Good morning. Thank you again for this opportunity. My name is Robert Vandervort, R-o-b-e-r-t, Vandervort, V-a-n-d-e-r-v-o-r-t. I'm an optometrist and practice in Omaha, and I am currently the chair of the continuing education committee for the Nebraska Optometric Association, have been for quite a few years. I also participated in every single 407 process for optometry since the 407 process was created. I'm also on the Board of Optometry, but I'm not here to represent the Board of Optometry, although if you have questions on how the board might look at a scope of practice bill or the scope of practice, I would be happy to answer those questions. My purpose here today is to just talk about what we do, day in and day out, as doctors of optometry across the state. I've referenced page 17 to start. I tried to make these pictures so that-- I don't think they're too graphic. But our opponents, when we-- when we bring scope-of-practice legislation, they like to characterize what we are going to try to do in this legislation as a great leap forward in our skills, and that is simply inaccurate. What we are asking to do when we change scope of practice is to extend a natural extension of what we're already trained to do. The procedures that I'm showing you today have been around for, in many cases, since I was in optometry school, which is 40-plus years ago, and that I was taught. The first one here on page 17 is punctal dilation. It also follows up with nasolacrimal irrigation on page 18. This procedure is used on patients who have blocked tear duct where they have chronic tearing and their tears are going down their cheek. It's very annoying and very disruptive to patients. The goal here is to open that drainage channel up. There's a-- there's a little hole in your lower lid and a hole in your upper lip and your tears drain out those holes and then drain down into your nose, and that's why, when we cry, we have to blow our nose. But if that duct gets blocked and a person has normal tear production, their tears don't have anywhere to go and they start going down your cheek. So the goal is to open that up. Punctal dilation, you take a relatively sharp instrument-- I did bring them today if you want to see how-- what they look like up close-- and you gently insert that into the little hole in the lid called the punctum and you gently slide it down, the little tube called the canaliculus, to open that up and expand it. Then on page 18, you then take a device called the lacrimal cannula and you slide that into that little hole and down

into the-- to the canaliculus, and then you inject saline solution or some sort of irrigating solution to try to force fluid through that channel to open up that drainage mechanism. Again, I was taught that over four years ago. Now it's important to understand this is not done behind a microscope. These pictures were taken behind a low-magnification microscope. But you have to have proper technique when you do this. You could injure a patient. You've got to have the patient properly seated, properly positioned. The instrument is inserted into relatively delicate tissue. It is sharp. And if the patient lurches, jerks, or does anything, you could injure the patient. We are taught how to anticipate that, how to mitigate that, that problem. There's ways you hold the instrument. There's ways you help rest your hand on the patient's head so if there's any kind of funny movement, everything just moves with the patient and you don't-- you don't cause damage. The same kind of procedures that Dr. Wolfe was talking about, same concept, you know, when we're doing those procedures, we already have those skills in place to mitigate those risks that-- that ophthalmology might say we-- we don't know how to handle. Page 19 and-- is we have two procedures. One is called meibomian gland debridement. This is actually relatively new. It isn't-- it wasn't commonly done until five to ten years ago. Dr. Wolfe mentioned the meibomian glands. They're large oil glands in our eyelids. The openings to those glands get blocked and this procedure, you just scrape along with a relatively sharp device called a spud and you-- you take debris off of the openings to allow those-- that oil to excrete into the tear film for dry-eye management types of problems. Concretions are little sand-like material that develop, that builds up underneath the eyelid that-- and they can start poking through that skin layer that Dr. Wolfe mentioned, the conjunctiva, and every time the patient blinks, they rub against the eye. You have to evert the lid and scrape those off. And again, that's done with a needle or a spud or other sharp instrument. I'm going to skip over corneal abrasion and denudement. It's basically the same as corneal foreign body removal. Corneal foreign body removal was approved by the Legislature in the early '90s, as Dr. Wolfe said. I was not trained on corneal foreign body removal in optometry school in the 1970s, so this is a perfect example of something that I learned after graduation to-- to implement. I will put my skills in removing a corneal foreign body against anybody of any profession. It-- it was simply an extension of what I was already taught in optometry school. In this procedure, you're-- you're going on the cornea. Now, in any future legislation that you're going to be looking at in the near future, it's on the

eyelid. The cornea is that front surface of the eye. You lift a foreign body off the cornea and if there's residual rust, you take a little burr and you-- you get it out. If you mess up, you can permanently damage a person's vision. There have been no complaints, no malpractice cases against an optometrist that I'm aware of for this procedure anywhere that I know of, certainly not Nebraska. So I would close with we're doctors. If there's one thing to please keep in mind when you're assessing scope of practice for optometry, we are doctors. We have nothing to gain and everything to lose if we harm a patient. No one wants to harm a patient. No doctor is going to do a procedure, even if they're certified to do it, unless they feel comfortable on that particular patient to do it. It's not going to happen otherwise. If there is a rogue optometrist out there, we have the state board to go after them. So please take that into consideration. I appreciate your time. Happy to answer any questions.

HOWARD: Thank you. Are there questions?

ROBERT VANDERVORT: Yes.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Chairman Howard, and thank you, Dr. Vandervort. And I just want to walk through this so that I give you the opportunity to have me understand this ongoing training.

ROBERT VANDERVORT: Right.

WILLIAMS: And you took your original training 40 years ago--

ROBERT VANDERVORT: Right.

WILLIAMS: --so there's been a number of things happened.

ROBERT VANDERVORT: Right.

WILLIAMS: If you have a change like that on something that an optometrist has not been trained on, where do they go for the training? How is it certified that they have that training? And how does the Board of Optometry oversee that?

ROBERT VANDERVORT: Let's just take the corneal foreign body removal, since that was the one that-- it would be the most-- one of the most obvious. That bill passed the Legislature in '92, '93. The-- I'd have

to review the Legislature. They may have-- the Legislature maybe even had some specific number of hours of continued education required. It wouldn't really matter. The-- what the Board of Optometry would do is they would ask schools of optometry to submit a curriculum to review that they think they could submit to-- for continuing education purposes, to training optometrists. And that would include didactic training. It would include laboratory training, clinical type of training where you're-- you're in a-- you're actually practicing these things. In 1986, there was even-- we had a preceptorship where optometrists were required to actually go into another doctor's office, they're typically ophthalmology offices, and-- and spend a week with them. That was pretty dramatic and-- but with the foreign body one, you did it in the lab and-- and then you were-- the instructors would look over your shoulder; they'd instruct in the technique. Again, I may not have been trained to do a foreign--

WILLIAMS: You were going back to the school of optometry for that training?

ROBERT VANDERVORT: It was-- the-- the-- you didn't have to physically have to go to Pennsylvania. Pennsylvania-- in this case, it was the Pennsylvania College of Optometry. They came to Nebraska and taught the course. And then they would review. Their instructors would-- would review. They'd look over the shoulders; they'd see your technique. But again, keep in mind, I was doing punct-- all these other things before. I mean, to actually do foreign body, it was a very straightforward process. It's-- you know, I'd been managing foreign bodies my whole career to that point. I just hadn't taken a spud and actually lifted one off a cornea and--

WILLIAMS: Yeah.

ROBERT VANDERVORT: And so it was a very, very straightforward training and-- and easy to do. And it's-- if you have the skills and you have the training, which we do, learning the new procedure is actually fairly straightforward.

WILLIAMS: Thank you.

ROBERT VANDERVORT: And the board-- but the board has to certify, which, by the way, the question was asked about how do-- how do-- how do the-- how the schools do-- is it taught in all the schools? If a new procedure or new medicine or whatever is-- comes up and the Board

of Optometry is-- will survey a school and say, OK, do you teach this, do you certify in writing that you teach this to your students? The Board of Optometry will then review that. So if a student graduates from some school and they're not certifying that, I mean, there could be a problem for that-- for that particular student.

WILLIAMS: Thank you.

HOWARD: Any other questions? Seeing none, thank you, Dr. Vandervort.

ROBERT VANDERVORT: Thank you very much, appreciate your service.

HOWARD: This will conclude our briefing on issues related to optometry. And we're going to take a brief break and see if we can get things to quiet down outside a little bit. We'll reconvene at 10:35.

[BREAK]

HOWARD: Good morning and welcome to the Health and Human Services Committee. I'm Senator Sara Howard. We won't redo introductions because we're doing briefings today. Next we'll be hearing a briefing on issues related to the Medicaid audit of dentists. There will be one hour allotted for this briefing and it's invited testimony only that we've received already from Mueller-Robak. So we'll start with Dr. Scott Morrison, who will get a five-minute clock, Sherry.

DAVID O'DOHERTY: Good morning, Senators. I am not Dr. Scott Morrison. He couldn't be with us today. My name is David O'Doherty, O-'-D-o-h-e-r-t-y. I'm the executive director of the Nebraska Dental Association, which represents over 70 percent of the dentists in the state. Just a brief history of why-- why we're here. Five years ago, the dentists received a RAC audit in 2014. Over 300 dentists received a letter, involved cleanings. After a little bit of research, we found out that the-- the State Auditor was not following Nebraska regulations. It took a long time to get that resolved, but with the help of this committee and, at the time, Senator Campbell, the Chair, we had meetings with the department and that-- that audit was corrected and deficiencies were resolved. But as a result of that audit, we, with the help of Senator Howard, filed and passed LB315 in 2015, which set parameters on future Medicaid audits on how they should be performed. The reason I tell you that is because when this current UPIC audit reached our ears, we were wondering, why are they not following the audit bill we passed in 2015? So CMS uses a lot of alphabet soup letters on their audits, but it's all under the umbrella

of program integrity. At the time, this was a RAC audit. I found this document for CMS in their program Integrity and they were transitioning in 2015 to a UPIC audit, Uniform [SIC] Program Integrity Contractor. That's the current audit we're talking about today. But the question still remained, why are they not following our-- our Medicaid statute, until I found not too long ago a CMS publication entitled Medicaid Program Integrity Manual, which tasks the program contractor, in this case, AdvanceMed, and the state Medicaid agency, DHHS, to do a number of things. They research state policy, state statutes, state regulations, all with the goal of how they perform an audit. So the state and the Auditor should have been doing a lot of work finding out what the state law regarding Medicaid audits is and follow that. Specifically, in our case, these audits were going back to 20-- 2014. In section 1.7.4., it says the UPIC, which is the contractor, shall defer to the state's look-back period for purposes of conducting an audit, so that point alone should shut these current audits down because they're violating Nebraska state law that says this-- the look-back period is two years. They're going back four to five years right there. You're going to hear some testimony about who is doing the audit. One of the things that is in LB315 is that the audit will be conducted by a dentist who has training in the same area of the person being audited. The person involved in this first audit was a nurse, not really qualified to examine dental records. So they weren't even following the state law that we passed in 2014, so that's why we're here. There's a number of things, other things that they're not following, but the fact that they've gone back more than two years automatically should shut this down. In fact, they're not using people who are trained in the same specialty that they're auditing. You'll hear testimony that they weren't even following the same guidelines, the same peer-reviewed guidelines that pediatric dentists follow for standards of care. If they followed what Medicaid wanted them to do, they would be violating their standard of care, which puts them in a very difficult ethical situation. So that's just a brief summary. The last-- the last item is just a cover sheet that the UPIC auditor in Nebraska, whose name is AdvanceMed, AdvanceMed has a national class action filed against them in Chicago for poor auditing practices, so we're not the only one who has a problem with AdvanceMed. They're-- it's involving home healthcare. But there's-- there's clearly a document issued by CMS on how UPIC audits should be governed, and they're not being followed. So we're here to ask your help-- oops, yellow-- ask your help with this audit like we did back in 2014, because in 2014, after that first audit, I had at least 20 dentists

call me apologizing that they were quitting Medicaid because they couldn't take it anymore. They-- they-- I mean, they have great hearts, but they said, I just-- we can't put up with this anymore. That happened five years ago. I know that's happening now. We need to get this stopped before it happens anymore. I'd be happy to answer any questions you might have.

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

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Dr. O'Doherty.

DAVID O'DOHERTY: I wish.

CAVANAUGH: No, wait. I'm sorry. You said you were not Dr. O'Doherty.

DAVID O'DOHERTY: Juris doctorate. No, Dr. Morrison is not here.

CAVANAUGH: Dr. Morrison. You are?

DAVID O'DOHERTY: David O'Doherty.

CAVANAUGH: David O'Doherty.

DAVID O'DOHERTY: Not a--

CAVANAUGH: I apologize. You were talking about Medicaid and in addition to the audit not following our statute that was passed in 2015, it-- did I hear correctly that we are not following Medicaid's regulations on this as well?

DAVID O'DOHERTY: Well, it's-- there isn't a Medicaid regulation on the audits--

CAVANAUGH: OK.

DAVID O'DOHERTY: --that's as detailed as the state law.

CAVANAUGH: OK.

DAVID O'DOHERTY: The department could have issued regulations having more detail. We have quite a bit of detail in our state law--

CAVANAUGH: OK.

DAVID O'DOHERTY: --specifically the two-year look back requiring auditors to be in the same profession as those being audited. There's

another provision there that talks about even if the audit finds the claim was improperly filed-- we're not talking about fraud here, this is-- these things were actually performed-- that the claim could be reissued, because right now they're asking for every dime back, even though all of those services were performed. That's also in the statute. They weren't following that.

CAVANAUGH: OK. Thank you.

HOWARD: Any other questions? Thank you.

DAVID O'DOHERTY: Thank you very much.

HOWARD: Our next testifier will be Dr. Marty Killeen, who will not be timed. Good morning.

MARTY KILLEEN: Good morning. My name is Marty Killeen, M-a-r-t-y K-i-l-l-e-e-n. I'm a pediatric dentist here in Lincoln and I'm the first pediatric deaths in the state to go through one of these CMS UPIC audits and the only one to be done with the audit process. I work in my private office four days a week and up until very recently, I've worked at the Lincoln-Lancaster County Health Department every Friday. Before the audit, I was a Medicaid provider of both locations. As a pediatric dentist in private practice who saw Medicaid patients, I was an outlet for general dentists who do not feel comfortable treating young children. Some of the Medicaid patients referred to me was driving from as far away as Norfolk and Falls City. The Health Department, though, is where my heart really is and where this Medicaid audit has been so devastating. Its dental clinic serves as a safety net for children who need a dental home but are unable to find one anywhere else. The Health Department does not turn away anyone with Medicaid. The Health Department-- excuse me. So for 13 years, my Fridays were very busy treating children. Being the only pediatric dentist employed by the Health Department, I was booked out over three months. The routine was that if a general dentist at the Health Department wasn't able to treat a child due to advanced dental decay or difficult behavior, the child was rescheduled with me. So my Fridays were reserved for the most challenging kids in the clinic. Many of these children on Medicaid have severe decay at a very young age, known as severe early childhood caries. Children have 20 teeth and every day I was seeing kids with cavities on at least eight teeth, some on all 20. Many of these kids were in pain, unable to chew their food, thus their diets were affected. Many of them needed teeth

extracted due to infection. My desire is to do what is best for my patients and treat them the same way I would treat one of my own kids. To do that, I follow and I've always followed the American Academy of Pediatric Dentistry's treatment guidelines. When the AAPD's guidelines change due to evidence-based research, I change how I practice. For pediatric dentists, the guidelines are considered the Bible of pediatric dentistry. With every appointment, I want to be effective, efficient, and focus on my patient while providing the highest-quality treatment. By following the AAPD guidelines, I know that I'm practicing to the gold standard of my specialty and that my treatment decisions are based in evidence and good clinical practice. That is why for the past 18 months it has been so heartbreaking for me. I have undergone a Medicaid audit and been forced to defend my treatment decisions that followed the AAPD guidelines. The audit recommended that instead of following the AAPD guidelines, I should have treated my severe early childhood caries patients with a less-expensive treatment option, a treatment that is not effective, not efficient, and did not focus on my patients' needs. Now, a few words about my audit experience. As David said, the audit was not initiated by CMS-- or, I'm sorry, the audit was initiated by CMS in May of 2018. But as David said, actually, CMS didn't do the audit and they outsourced this to a UPIC. In my case, the company was AdvanceMed. AdvanceMed requested the dental records for 40 of my patients who I treated from 2014 to 2016. All the patients that were audited had severe early childhood caries with a minimum of ten cavities. All were young. In fact, the average age was four years old. And I treated almost all of them in the operating room under general anesthesia. In September of 2018, I received my initial findings report from AdvanceMed. In the report, they denied 74 dental codes. The majority of these denials were because the least-costly dental restoration wasn't chosen. The auditor felt that a filling could have been placed on these severely decayed teeth instead of a crown. AdvanceMed asked for my response and any additional information that would justify my treatment choice. I painstakingly defended each restored tooth in all 40 of those cases in a 12-page provider rebuttal. My provider rebuttal was a detailed description of why services were provided. I described the standard of care for pediatric dentists set forth by the AAPD's clinical guidelines. I explained what our guidelines state, what the research has shown, and what I was taught in residency. I described how a pediatric dentist has to evaluate the whole patient and make wise treatment decisions when restoring the cavities so as to prevent more cavities from developing. In December of 2018, I received my final

findings report from AdvanceMed and a request for a large overpayment. Two things made my jaw drop that day. First, the provider rebuttal that I sent in October was largely ignored. Two clerical issues were addressed and the dental work in question was not reviewed. In fact, I found out after the fact that my provider rebuttal was not reviewed by a dentist but by a nurse outside of Nebraska. Secondly, AdvanceMed had taken the initial 40 audited patients and extrapolated the overpayment to now include 568 patients. My overpayment now skyrocketed and was due in 30 days. I was given the option to appeal the findings report and I did on June 13, 2019, with a daylong appeal hearing for my Medicaid audit. In the morning session of the appeal hearing, it was revealed that the dentist who performed the audit was a general dentist with no additional training in pediatric dental care. The auditing dentist currently does not treat children in the hospital setting, nor did she have the specialized training to do so. Additionally, when questioned about the definition of severe early child caries and the AAPD standards of-- standards of care for its treatment, the auditing dentist was unable to describe the disease or its recommended treatment. The biggest shock for me was when the auditing general dentist stated that, had she been allowed to review my 12-page provider rebuttal, she would have reversed her audit decision. AdvanceMed didn't even give her the chance to look at it. I felt that I was playing by the rules while the auditing firm was making it up as they went along. In the afternoon session, I was given a chance to defend myself case by case. I began by showing x-rays and describing why treatment decisions were made-- were made. Halfway through my defense, it was realized that the state distributed different evidence to my legal team and the hearing officer. Everyone in the room was looking at different x-rays and different patient information, all labeled as the same. My defense came to a screeching halt while both sides tried to figure out the best course of action moving forward. Eventually, the hearing officer stated that there simply wasn't any way for us to proceed because there was no way to know what we were looking at was the correct evidence. She said, I've seen a lot of weird stuff, this one is the first in my 17 years. My hope that a final decision could have been reached based on this hearing was dashed by the state's incompetence. We stopped the appeal hearing that day and set up two more meetings. The first meeting was intended to figure out the correct evidence. The second meeting was a redo of the botched hearing. Heading home that evening, I was forced to look at the big picture. After eval-- after evaluating the legal costs I had in my audit defense, I quickly came to the realization

that I shouldn't proceed. The legal costs had already skyrocketed and were about to get even worse if we were to have two more meetings with the hearing officer. The next day, I asked my legal team to please get me out of the audit as quickly as possible. I was done. Between the settlement costs and the legal fees, I spent more on this Medicaid audit than I had all of dental school. Bottom line, without protections in place for dentists, I feel that there's too much liability being a Medicaid provider. The day I signed the Medicaid settlement agreement, I also quit being a part of the Medicaid provider network. In my final findings report, it was stated that the AAPD guidelines had no effect on the denial decisions. Medicaid is choosing to ignore the well-established and evidence-based AAPD guidelines for standards of care for children. Instead, Medicaid's policies only allow for the least-costly restorations possible in high-risk children, even when that treatment is not recommended by the AAPD guidelines. I was told to treat Medicaid patients to a lower standard than other children. My ethics, morals, and logic lead me to refuse the misguided directive. Sadly, after 13 years, I had to turn to the Health Department and tell them I was done there as well. This has left many of my young patients without a pediatric dentist. Some of them will have to leave the Health Department and find specialized care elsewhere. This is already a difficult task and will only be harder as more pediatric dentists think twice about being in the Medicaid network. Now, on a very positive note, I would like to introduce you to one of my favorite patients. I had the privilege of caring for Ibrahim at the Health Department, and his family is now looking for a new pediatric dentist since I've left the Medicaid network. When I first met Ibrahim three years ago, he had severe dental decay and treatment was challenging due to Ibrahim being autistic, blind, and deaf. Ibrahim's father reported that he was in pain and kept pointing to his teeth. Ibrahim has the most caring and wonderful parents. Following questions, you will have the opportunity to hear from his mother, Shatha. Any questions?

HOWARD: Are there questions for Dr. Killeen? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you so much for being here today and for outlining this process that you went through. I-- I do have several questions, but we'll skip to the end of my questions. You talked about Medicaid's policies only allow the least-costly rest-- restorations possible in high-risk children. This, just for clarification, this is

not the federal regulation; this is the state's Medicaid. No, you're correct. That was the state's-- state's findings.

CAVANAUGH: So it's Nebraska's decision, Nebraska's Medicaid office that has decided--

MARTY KILLEEN: Yes.

CAVANAUGH: --that we will go with the least costly as opposed to the accurate-- the recommended from the American Academy of Pediatric Dentistry.

MARTY KILLEEN: Yeah. Frankly, it's-- it's a little-- a little confusing with how many players are-- are-- are-- are part of this. I mean, you've got the UPIC that came, which put the words in writing and said you must pick the least-costly restoration, we feel that you didn't do so by picking the filling over a crown. Now, where that came from, kind of combination of-- from states, but then they also said it was-- you know, it was the state statutes, but it was initiated by CMS, so kind of all three players involved. So Medicaid-- federal Medicaid would allow.

MARTY KILLEEN: In this case, it came from the state--

CAVANAUGH: OK.

MARTY KILLEEN: --the UPIC qualifications for the audit.

CAVANAUGH: OK, so there isn't-- there isn't a higher federal rate.

MARTY KILLEEN: Not that I'm aware of.

CAVANAUGH: OK. Well, because you also stated that children are now seeking this care elsewhere, so that would imply that Medicaid patients in other states could, perhaps. But maybe somebody after you will be able to address that, so--

MARTY KILLEEN: Yeah.

CAVANAUGH: --we'll leave that for them. At the beginning of your testimony, you talked about the AAPD, the American Academy of Pediatric Dentistry's recommendations and guidelines, and you said you had undergone the Medicaid audit and been forced to defend your treatment decisions that followed the guidelines. Was there a reason

that they-- that they gave, beyond just the cost, that you shouldn't follow the recommendations of the AAPD?

MARTY KILLEEN: No, they didn't give a reason I think is was strictly cost, it was cost savings--

CAVANAUGH: OK.

MARTY KILLEEN: --because then in AdvanceMed's, you know, report to me, they said, we didn't take into account the AAPD guidelines at all. They were focused on just what was in the state statute, which basically says you've got to treat to the standard of care. But then when you look at the CMS, you know, guidelines and recommendations, they-- they're pulled from the AAPD guidelines. So it's a little kind of a circle there. But, no, my-- my understanding is, is that they were just going for cost.

CAVANAUGH: Sorry, I have two more questions.

MARTY KILLEEN: Yeah.

CAVANAUGH: I don't know--

HOWARD: Sure.

CAVANAUGH: OK. So you also said that the auditor mentioned that if she had been able to review the 12-page provider rebuttal, that she would have reversed her decision. Did any one state the reason for her not being allowed to review the rebuttal?

MARTY KILLEEN: Not that I'm aware of.

CAVANAUGH: OK.

MARTY KILLEEN: You know, she did the initial review, I wrote the rebuttal, and then a nurse reviewed it, read through the rebuttal. And there were, like I said, a couple of clerical issues, but the meat and potatoes of that saying, hey, look at what I did, why I did it, looking at the guidelines, you know, take a peek. She didn't even have the opportunity to-- to review my defense. But it was-- that was just-- it was-- it was such a shocking moment in that hearing, you know, testimony. It was early in the morning. Right away, she said, yeah, had I been given the opportunity read that, I would have changed the decision. When we were talking about the suit, she said, yeah, I

don't think I would have-- I would-- I would reverse that now; now that I'm looking at what you wrote, I would change my mind. And I just-- I couldn't believe it. I mean, you talk about-- I thought, well, I don't know much about the legal system, but we should be done, like this is-- this is kind of a like mistrial or-- but it's a hearing, and so it's kind of-- kind of like the Wild West. There's a lot of stuff that can-- can go on in that. And then we just-- the ball keeps rolling.

CAVANAUGH: And my last question is, if you were to have done the less-expensive options, would that have been in the short term less expensive and in the long term more expensive? Or maybe you could talk through the-- the two different--

MARTY KILLEEN: Yeah, fan-- and that's a fantastic question. That's-- and I think Dr. Wallen will-- will talk about it from the academic standpoint and the research. But just from a finan-- a financial standpoint, the difference there is a $75 dollar restoration versus a $116 stainless steel crown. You know, that-- that's the crux of this. They're saying, well, instead of doing this crown that costs $116, you could have done a filling that was $75 and saved a lot of money. But you've got to look at it not just from one single tooth. You've got to look at the whole patient. Quite literally, when I've got a three-year-old that's asleep under general anesthesia, and I-- and this is-- this is an example of one of the patients. I did 18 crowns on a three-year-old and they looked at 17 of them and said, yeah, we're A-OK with those 17, but that 18th crown, we think we could have done a filling. Now here's the problem with the filling on a three-year-old. Some of those teeth are in there until the child is 12 and a filling, especially a high-risk individual like that, that has that disease I mentioned, severe early childhood decay, or just think of it-- a lot of decay at a really, really young age. These kids are going to get more cavities. So we try to be really efficient with how we treat. We want to do a good job, take care of it once. And I don't want to have to go back to a hospital and use general anesthesia and my nice anesthesiologist and redo a whole surgery because I'm having to redo a white filling in the search of saving, you know, $35, $40. So that little decision, I mean, you could say, well, that's really aggressive for that one tooth. But when you look at all 18 teeth, it-- or the whole patient in general on a three-year-old, you know, and the parents aren't necessarily changing their habits at home, I mean, I'm trying to counsel against drinking Mountain Dew at night right before bed, encouraging parents to brush their kids' teeth with fluoride

toothpaste, I mean, just going through some of these habits that a lot of us have down, but these parents just need some education on it, but the things don't change. And so these are really high-risk individuals for catching more decay. So short sight, short term, yeah, that filling might suffice for a little while. But boy, in the big picture, if you've got to-- looking at the life of that tooth, it's got to stay in there until the child is 11 or 12, that crown is the best bet. So the research is there. It's what's taught in residency and it's what's indicated in those guidelines. So, yeah, it ends up being a dollars-and-cents decision. You know, it's-- in the end, I mean, gosh, the parents would probably like a little white filling. It looks better. But let's go for function; let's go for what's going to last the best, and-- and sometimes a little silver crown on that back molar is going to hold up the best.

CAVANAUGH: Thank you.

HOWARD: Other questions? Seeing none, thank you for visiting with us today.

MARTY KILLEEN: OK. Thank you.

HOWARD: Our next testifier. Shatha? Good morning.

SHATHA AL-TAMEEMI: Good morning. My name is Shatha Al-Tameemi, S-h-a-t-h-a A-l-T-a-m-e-e-m-i. My family and I are from Iraq. We came to the United States eight years ago. We came here on asylum after my husband's father was killed in the street and our lives were threat-- threatened. We-- when we came to Lincoln, we had trouble finding a dentist for my seven-year-old son, Ibrahim. No dentist would-- would take him because of his special need. He is-- he-- he is-- he have autistic, deaf, and blind. We called many place, but the Health Department is the only place that would see him. This is where we meet Dr. Marty. Ibrahim was having a lot of pain from his teeth. He was having pain from eating and he wasn't asleep at night. He keep pointing at his teeth. We found out that Ibrahim had 11 cavities. He need many crowns and even root canal. Dr. Marty was able to fix his 11 cavities in the dentist clinic with my husband's help. Now Ibrahim is out of the pain and we go to the health department every six month for his checkup. He is happy and he love go to school. We were sad to hear Dr. Marty will not be at the Health Department, who has seen Ibrahim for years and we trust him with Ibrahim's care. There is no one else in the clinic that can care for Ibrahim because his special need. He

needs a pediatric dentist. Even with my son have Medicaid as his insurance, we will have hard time finding a new dentist. We-- we have been told to find a new dentist, but it is not easy. He now-- he knows-- he knows Dr. Marty and it will be difficult for-- for him to find-- to change doctor. We know Dr. Marty and we trust him. We are not happy that we will have to find a new pediatric dentist. I want you know that we are thankful for Medicaid and the Health Department giving Ibrahim good care, but it will be struggle to find a new dentist. Please help pediatric dentists like Dr. Marty provide good care for kids like Ibrahim. Thank you.

HOWARD: Thank you. Are there questions? How long have you been in Lincoln?

SHATHA AL-TAMEEMI: Three years.

HOWARD: Three years?

SHATHA AL-TAMEEMI: Yes.

HOWARD: And what school does Ibrahim go to?

SHATHA AL-TAMEEMI: Meadowlane.

HOWARD: Oh, that's wonderful. And he likes it?

SHATHA AL-TAMEEMI: Yes, like it.

HOWARD: That's wonderful.

SHATHA AL-TAMEEMI: Yes.

HOWARD: Well, hopefully we can fix this problem for you.

SHATHA AL-TAMEEMI: OK. Thank you so much.

HOWARD: Thank you for visiting with us. All right, Dr. Wallen, five minutes.

JILLIAN WALLEN: Good morning.

HOWARD: Good morning.

JILLIAN WALLEN: My name is Jill Wallen, J-i-l-l-i-a-n W-a-l-l-e-n, and I currently serve as the chair of the department of growth and

development and as assistant dean for extramural activities and outreach of UNMC College of Dentistry. My views today do not necessarily represent those of the university. Rather, I'm speaking to you as an individual who is a faculty member with expertise in this area. The mission of the college is to continually improve the oral health of the people of Nebraska and beyond through a humanistic approach to education, extraordinary patient care, and innovative research. Our values speak to our strong sense of community and demand that we demonstrate integrity, accountability, and intellectual curiosity. The college has provided advanced specialty education and certificates in pediatric dentistry to residents since the 1960s and has graduated over 250 pediatric dentists. It's fully accredited at this time by the Commission on Dental Accreditation. Our residents, faculty, and alumni from our program provide important oral healthcare services to many of the state's vulnerable children. As pediatric dental specialists, we care for the underserved, not only in our clinics at Children's Hospital and Medical Center and at the college, but in schools, federally qualified health centers, rural hospitals, and private practices across the state. Our clinics provide over 2,000 patient visits a year and we are, as such, the state's largest provider of dental Medicaid services. Recently, our state and our specialty have been highlighted as a result of these Medicaid audits. There are 47 practicing pediatric dentists in the state making up a large portion of the dental safety net that exists for Nebraska's children. The majority of the providers involved in this audit and the RAC audit of 2014 are UNMC graduates, many receiving both their DDS certificate and their certificate in pediatric dentistry from the college. We're proud of our graduates and the services that they provide for the children in their communities. According to the Department of Health and Human Services Office of Oral Health, of the 93 counties in Nebraska, 85 percent are state-designated shortage areas for pediatric dentistry and 57 percent for general dentistry. In short, we have an access-to-care issue that persists across our state. In an oral health survey completed by the department's Office of Oral Health in 2016, Nebraska children in rural areas were reported to have caries experience on average 10 percent higher than the national average. A resident educated in our program or at any other program in the nation is required to prepare comprehensive oral health treatment plants for their patients based on a number of factors. These include current and future risk of developing cavities, restoration longevity behavior, access-to-care issues such as language barriers, finances, transportation, family oral health literacy, risk of general

anesthesia, risk of repeat general anesthesia, among other factors. Treatment of children under general anesthesia is very common in our specialty but a responsibility that we take incredibly seriously. Research shows that over 50 percent of children who are treated in the operating room are likely to require a second visit. Our treatment plans reflect our responsibility to reduce that risk of repeat surgery, thus the restoration of an individual cavity not treated in isolation without assessing the comprehensive risk factors. It's our understanding that the audit primarily involves the least-costly service and the treatment of dental caries not being provided. The cost differential at current Medicaid rates is a difference of $75 for a two-surface filling, $87 for a three-surface, and $116 for a stainless steel crown. For pediatric dentists, this audit finds us faced with an ethical, inhumane challenge. Do we choose the least-expensive restoration knowing that 50 percent of these kids will come back and that a multisurface filling has a three-year lifespan versus a greater-than-seven-year lifespan for a crown? Do we provide treatment that we know will cost the state of Nebraska needless expense for repeat general anesthesia and individual tooth treatment over the course of the primary dentition? Our pediatric dental residency program achieved approval without reporting requirements at a site visit in 2014. We will undergo another site visit in 2021. As a part of this ongoing commission-appointed, peer-reviewed evaluation and assessment process, all programs must demonstrate compliance with an approved set of standards. Standard 4-3 states that the program must provide the opportunity to extend to students and residents diagnostic ability beyond that-- and critical judgment beyond that provided to the general dentist. Over the course of the two years of the certificate program, [INAUDIBLE] residents receive in-depth training in caries risk assessment, evidence-based treatment planning, ethics, among many other subjects. Pediatric dental residency programs across the nation, including our program, utilize these guidelines that are established by the American Academy of Pediatric Dentistry as accepted teaching norms. These are continuously reviewed and updated every three years by national and international experts in pediatric dentistry and formulated using the highest scientific evidence. It's incomprehensible that the auditor in this finding finds these clinical recommendations to be irrelevant. The ADA article also suggests that the audit places the state's dental educators, such as myself and my faculty, in a difficult position. Realistically, it places us in an impossible situation, along with the Board of Dentistry who utilize these guidelines to set acceptable standards of oral healthcare for

children. We are concerned that the processes and outcomes as a result of these audits will discourage pediatric dentists and other oral healthcare providers from becoming Medicaid providers. Decimation of the Medicaid provider network as a result of this audit is concerning for the underserved population in Nebraska, and the cascade has already begun. Audited dentists may stop seeing Medicaid children, depleting the small pool of willing providers. Other unaudited dentists may drop out, cut back on accepting new patients, or greatly reduce their participation. New pediatric dentists may not enlist. Families, pediatricians, school nurses, and the general dental community scramble to find care resources and cannot. Children in pain and with serious tooth-related infection end up, after hours of travel, at training programs such as ours or local emergency rooms over and over with no continued source of care and no dental home. Simply put, our safety net falls apart. We support the recommendation put forth that future Medicaid audits be conducted by auditors who have the same educational specialty training as the practice-- practitioners they are reviewing, that the auditing dentist be licensed within our state, and that they are current providers of Medicaid services. With such peer-review policies in place, we feel confident that our alumni and graduates will continue to serve as Medicaid providers and that the safety net for dental services in this state will remain in place. Thank you for giving me the opportunity to testify before you today. I'm happy to answer any questions you may have.

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

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Dr. Wallen, for being here today and sharing your perspective from the academic and training background. So is there concern that shifting the way that you train students to-- to fall in line with what the audit seems to find acceptable will challenge your accreditation?

JILLIAN WALLEN: Yes, it will absolutely challenge our accreditation. We're-- it's worth noting that we're also responsible for predoctoral education in pediatric dentistry, so my faculty within my department teach the dental students and dental hygiene students, but worthy noting that we teach them to these standards.

CAVANAUGH: OK.

JILLIAN WALLEN: So-- and I-- I brought a copy, thanks to one of my colleagues this morning, of these guidelines that we speak of. As you can see, it's-- it's not a magazine. It's a weighty document. There is a significant amount of thought, detail, and scientific evidence goes into these. If we are asked to discard those, as an educator, I wouldn't know what to teach. OK, we-- we're taught the evidence of dentistry. We teach evidence-based dentistry. And if that is not considered in these findings or others, then, yeah, that would be a significant challenge for us as dental educators.

CAVANAUGH: Just a follow-up.

HOWARD: Sure.

CAVANAUGH: What would happen if you lost your accreditation?

JILLIAN WALLEN: Accreditation cycle is every seven years. It is very rare that a dental school or a medical college would lose accreditation standards. Most likely we would be given an opportunity to have recommendations with a very short turnaround of how to remedy the deficiencies that they see during a CODA site visit. Those visits are multiple days. They visit with every faculty member, with the dentists, and they take a comprehensive look at our didactic curriculum as well as our clinical curriculum. It is devastating for a dental school to not pass accreditation on a site visit. It would have a major impact in this state.

CAVANAUGH: Thank you.

JILLIAN WALLEN: Yeah.

HOWARD: Senator Arch.

ARCH: Thank you. A quick question on your-- in your testimony, you-- you identify three recommendations, correct?

JILLIAN WALLEN: Yes.

ARCH: Future Medicaid audit be conducted by auditors and-- and so forth. What's not in here is-- is that they-- that the audits follow the AAPD guidelines.

JILLIAN WALLEN: I think my assumption in the first recommendation that we are reviewed by someone within our own specialty makes the

assumption that a person graduates from a program such as ours that follows these guidelines and is fully accredited by-- by the Commission on Dental Accreditation.

ARCH: OK. All right.

JILLIAN WALLEN: So I can certainly bring that forward as a recommendation but--

ARCH: It's covered with that recommendation.

JILLIAN WALLEN: Yes, sir.

ARCH: Thank you.

JILLIAN WALLEN: Thank you for your question.

HOWARD: Other questions?

JILLIAN WALLEN: Great. Thank you very much.

HOWARD: Seeing none, thank you for visiting with us today.

JILLIAN WALLEN: Yeah.

HOWARD: And our last testifier is Dr. Meeske.

JESSICA MEESKE: My testimony is about seven. Is that OK?

HOWARD: That's all right. You're fine.

JESSICA MEESKE: OK. Good morning. My name is Jessica Meeske. It's spelled J-e-s-s-i-c-a M-e-e-s-k-e, and I'm a pediatric dentist with practices in Hastings, Grand Island, North Platte, and Omaha. And we are also one of the largest private-practice providers for dental services for children in Nebraska that rely on Medicaid. You've heard testifiers today talk about the UPIC audit and our concern about its fairness. I want you to know we've made every effort to work through the proper channels to get resolved to this before we came to you today. We've talked to Nebraska State Program Integrity staff as well as CMS Program Integrity staff about our concerns. I want to note I appreciate Jeremy Brunssen, deputy director of Medicaid and Program Integrity, for meeting with us twice in the past year. In addition, I've personally participated in meetings with the ADA, the AAPD, and CMS Program Integrity Office to try to get some resolve to this.

However, despite our concerns that the audits haven't been conducted by appropriately trained dentists and credentialed auditors, and they also did not adhere to the nationally recognized clinical standards we're required to follow, these audits are still continuing and there's no end in sight. This continued practice could jeopardize our state's dental provider network serving kids and adults all across the state. It's interesting when we speak with other dental and medical organizations, both in Nebraska, NMA, the state pediatric medicine chapter, the ADA. No one else is going through these dental UPIC audits, only Nebraska pediatric dentists. And all of us in the room today, we're really proud to be Medicaid providers to kids. In fact, every pediatric dentist in this state steps up and takes care of these kids. And I think very few specialties are able to say that. When we see a kid with Medicaid, we pay attention to making sure we're compliant with the program, that the quality of care is there. And we do choose the lowest-cost treatment that's appropriate for that child and that child's condition, taking into consideration the life of the tooth and the life of the child. It is not a one-stop-shop, what's the cheapest thing at this point in time. It's looking at the whole situation and what is going to be most cost-effective over the course of the life of those baby teeth and the mouth and the child. These audits feel like a punch in the gut. We have dentists who have been Medicaid providers for more than a decade, as you've heard, now leaving the program because they've either suffered through one of these audits or they're hearing about it from another colleague. We even have our dental students and our residents saying, I don't know if I want to set up practice in Nebraska, I'm committed to seeing these kids, but if this is what I'm going to have to go through, I'm not sure I want to set up my dental practice here. Instead of us relieving pain and suffering from severe tooth decay or trauma in this population of kids on Medicaid, we're going to have to potentially look at spending our time doing other things, cosmetic dentistry, Invisalign. I don't want to do those things. I have general dentist colleagues and orthodontists that can do it. But if I'm not going to be allowed to see Medicaid kids and take good care of them following Medicaid policies and guidelines that the states put forth, you've left me with no choice. The state and children need us to provide critical dental care and we want to provide that care. But you're giving us reasons to now leave the Medicaid program. So I myself, I've been through Medicaid audits, and other than the RAC audit several years ago that David mentioned, most of them are spot-checking charts: send us ten charts in, we're spot-checking on those procedures. It's

not a big deal. It's not burdensome. These UPIC audits have been beyond burdensome. You heard Dr. Killeen testify his cost has been more than his entire four years of dental school. This isn't how it's supposed to work. We understand and appreciate that reasonable government oversight and accountability is necessary. But what we don't under-- don't understand is how we came to the point of these aggressive, overpoliced audits that rifled through our charts. And someone says we-- that even know this is a covered Medicaid service, we think you should have done it differently. There seems like a better way to have that discussion. The Medicaid Office claims that their hands are tied by CMS on these audits, and yet when we talk to CMS, they give the state the latitude on how to conduct the audits. So essentially, we have finger-pointing coming from the feds and the state how this is supposed to be done and the dentists and the patients are caught in the middle. But in a program whose goal it is to provide oral healthcare for children most in need, it makes absolutely no sense to audit us to death and drive our dentists out of the program. Even our dental Medicaid contractor, MCNA, does fair audits. And they've audited me and it's been very reasonable and I've provided them the information they've had. And when they need to give me feedback to do something differently, I'm happy to have that feedback. But they don't ask me to pay 100 percent of the fee I collected from Medicaid back when I did the appropriate treatment and the kid was correct-- was treated correctly. So how do we solve this? By assuring dental Medicaid audits are fair and reasonable. You can direct Program Integrity to stop the current audits and require them to follow CMS's Program Integrity guidelines, as well as the current state law that was passed five years ago in LB315. In that law it says they can only look back two years. That didn't occur in this case. They have to use an appropriately credentialed person. Same specialist, licensed in Nebraska, is only allowed to review same specialist with similar training, and any improper payments that are identified by the new audit can be resubmitted and adjusted. We have dentists willing to see Nebraskans with Medicaid, but reviews of restorative treatment choices that we make should be vetted more fairly and in a different sort of process. Senators, we are literally "quabbling" over how to treat baby tooth on a child who had such severe decay we had to put him to sleep in the operating room. There was no question whether these teeth had decay and no dentist was questioned was this a case that deemed necessary for the child to go to the OR. Everybody agreed on those things, but then they were quibbling over, well, how should the individual tooth have been

treated once they got there? Let me tell you how I'm going to treat a kid when I take him to the OR. I'm going to give them the best possible care I can within the parameters that Medicaid outlines in my provider manual. I know the rules, but what I want to do is make sure that whatever I do, I am going to minimize every risk for bringing that child back to the OR, because every time I bring the kid back to the OR, it's not only medically risky for that child, you're spending more dollars in taking that child back to the OR with the $2,000 just to walk through the door to put them to sleep. You're spending it on the medical side and not the dental side. When children receive appropriate dental restorative treatment at the appropriate time and treatment is in accordance with national guidelines and it's a covered Medicaid benefit, the treating pediatric dentist should not be responsible to pay back all of those fees to the state. There's a right way to conduct audits and we welcome-- we welcome them, but we need the legislators-- Legislature's help in assuring these audits are conducted fairly. In closing, the Governor's vision to grow Nebraska and his mission to create opportunity through more effective, more efficient and customer-focused state government is not reflected in these current UPIC dental audit processes. There are several customers and stakeholders who are affected by this. Government, dentists, parents, we all share responsibility in ensuring the Nebraska dental Medicaid program is there to help Nebraskans, and predominantly our children, so they can be healthy, free of pain, be able to eat their food and be able to learn in school and grow up to be productive, working adults. Medicaid audit systems that are inefficient and overly burdensome, they drive dentists out of the program. We would leave patients without dental care and Nebraska's most precious asset, our kids, to not be able to grow up to their full potential. Thank you.

HOWARD: Thank you. All right. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairman Howard. Thank you, Dr. Mees-- Misky?

JESSICA MEESKE: Meeske.

CAVANAUGH: Meeske, sorry, apologize. You mentioned your Medicaid provider manual that you-- when you are in the OR, you conduct yourself with that in mind. So your Medicaid provider manual would allow for the treatment that we're talking about here. Every single dental treatment that was provided in the current audit that doctor

Killeen talked about was a covered Medicaid benefit in our provider manual.

CAVANAUGH: OK, it just was deemed not the most cost efficient.

JESSICA MEESKE: So the auditor deemed-- when they looked at the treatment provided, they looked at the point of service and said this crown was more expensive than this filling, and what they did not take into consideration is the high risk for retreatment of that child having to either have that tooth retreated in the office-- which if you saw this little boy over here, there is no way we can safely treat that child in the office. You can't numb him up safely and expect a good dental visit. But it is far more expensive to undertreat a child and then to have to go back and retreat them again.

CAVANAUGH: Sure. I have additional questions but I can--

HOWARD: Are there any other questions?

CAVANAUGH: OK. So we are talking about children, population of children, and I feel like it's worth reflecting on what those children look like. This committee has heard a lot from Medicaid parents whose children were on the aged and disabled waiver and we've had some issues with that. And so when we're talking about children, this population of children that you're treating, could you tell us a little bit about what some of these kids are like? I mean, we-- we saw one of the-- the young man who's autistic, blind, and deaf. But when we were dealing with the A&D waiver, the aged and disabled waiver, we heard from parents saying how difficult it was to even have their child eat. So the importance of dentistry, if you could maybe just tell us a little bit about that?

JESSICA MEESKE: Absolutely. So there is a very strong connection between the health of a child's mouth or their dental health and their overall health. And tooth decay, surprisingly, is one of the most common chronic childhood illnesses. It's five times more common than asthma. And we have so many kids in this state that either get to a dentist too late and tooth decay has already set in or they aren't able to get into a dentist at all. And so what happens is because the nature of tooth decay, and particularly the kind that Dr. Killeen talked about, this severe form of early childhood tooth decay, it's very progressive. It happens very rapidly. And a lot of times, we don't get to these kids until they already have a toothache. Their

face is swollen, their eye may be swollen shut, and now we have a medical emergency that we have to get them in, get them out of pain and stop this before they could get really sick. And so anything we can do to prevent that from happening by treating the child right the first time eliminates not only the need of putting the child through those procedures again, but it also saves the Medicaid program money because we did it right the first time, we didn't undertreat the child.

CAVANAUGH: Thank you.

HOWARD: Any other questions? Senator Walz.

WALZ: One quick question. Thank you. Thanks for coming today. I'm just curious, do you have any idea how much money has been required to give back statewide, like--

JESSICA MEESKE: You mean in the audits?

WALZ: Yes.

JESSICA MEESKE: So what we know is there are four pediatric dentists currently under audit. Dr. Killeen's audit is completely done. I believe that was about in the-- $50,000?

MARTY KILLEEN: Seven number-- was 50--

JESSICA MEESKE: Seventy-- $57,000?

MARTY KILLEEN: Yeah, I'll be honest. I mean, the original overpayment was $88,000. They were asking an overpayment of $88,000.

WALZ: OK.

HOWARD: Dr. Meeske, can you restate that for the transcript?

JESSICA MEESKE: Sure. So what Dr. Killeen was clarifying is that $87,000 was asked to be paid back to the state for the treatment he provided. And so with the second and third pediatric dentists who are under audit, they are in their appeal right now. I believe those two people are in the room and I don't know the amounts they've been asked. And then the fourth pediatric dentist, to my understanding, has not received her final letter saying what she owes back. But it-- it's going to be thousands and thousands of dollars. And it's not only the amount they're being asked to pay back; it's the fact that their legal

fees to properly and appropriately defend themselves make it impossible for them to try to do the right thing and defend what they did.

WALZ: Can I ask one more question, just because I really-- I don't know. So the UPIC company, or whatever they are, they're under contract with the state of Nebraska?

JESSICA MEESKE: With CMS--

WALZ: With CMS.

JESSICA MEESKE: --the federal government.

WALZ: OK, is there a contract? Is that public?

JESSICA MEESKE: It should be, um-hum.

WALZ: OK. Thank you.

JESSICA MEESKE: Thank you.

WALZ: That's all I needed.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Just a quick follow-up to Senator Walz's question. So the amount that's being asked to be repaid, that's the full amount. It's not the $41 difference between what they would approve--

JESSICA MEESKE: Correct.

CAVANAUGH: --and what was done.

JESSICA MEESKE: That's correct, and I appreciate you clarifying that. So if he was paid $116 for a stainless steel crown, the state is asking to pay that back.

CAVANAUGH: Not the $41--

JESSICA MEESKE: Not the difference.

CAVANAUGH: --overage?

JESSICA MEESKE: Correct.

CAVANAUGH: Thank you.

HOWARD: This--

JESSICA MEESKE: Thank you.

HOWARD: Thank you for visiting with us today. All right. This will conclude-- conclude our briefing on issues related to the Medicaid audit of dentists and it concludes our briefings for the day. Thank you for visiting with us.