HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, District 48, and I serve as chair of the committee. The committee will take up the bills in the order posted. The public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify today, please fill out one of the green testifier sheets that are in the little rooms off to either side. Be sure to print clearly and fill it out completely. Please move to the front row to be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name, and spell your first and last name to ensure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, finally, by anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer, if they wish to give one. We'll be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining, and the red light indicates your time is finished. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard; it's just part of the process here, as senators may have other bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Please note that thumb drives, CDs, DVDs, oversized documents, books, lists of signatures and similar items will not be accepted as exhibits for the record. Props, charts, and other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn your cell phones off. Verbal outbursts or applause are not permitted in the hearing room; such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8:00 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at legislature.nebraska.gov. Written position letters will be included in the official hearing

record, but only those testifying in person before the committee will be included on the committee statement. You may submit a position comment for the record or testify in person, not both. I will now have the committee members with us today introduce themselves, starting with Senator Riepe.

RIEPE: Thank you, Chairman, and welcome. I'm Merv Riepe. I represent District 12, which is Omaha, Millard, and the fine little town of Ralston.

HANSEN: Senator Ben Hansen, District 16, which is Washington, Burt, Cuming, and parts of Stanton Counties.

FREDRICKSON: Good afternoon. John Fredrickson. I represent District 20, which is in central west Omaha.

G. MEYER: District 17, Glen Meyer. It's Dakota, Thurston, Wayne, and the southern part of Dixon County.

QUICK: Dan Quick, District 35: Grand Island.

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

HARDIN: Our legal counsel, John Duggar, will be here shortly, and Barb Dorn is our committee clerk. Ladies?

SYDNEY COCHRAN: Hi, I'm Sydney, and I'm a sophomore studying history at UNL.

DEMET GEDIK: Hi, my name is Demet. I also go to UNL, and I study political science.

HARDIN: With that, Senator Hansen. How, how did you get 1-2-3-4? That was pretty special.

HANSEN: I specifically waited.

HARDIN: Nice. That took some timing.

HANSEN: Yeah.

HARDIN: OK. We're ready when you're ready.

HANSEN: All right, thank you. All right. Good afternoon, Chairman Hardin, and members of the HHS Committee. My name is Ben Hansen, that's B-e-n H-a-n-s-e-n, and I represent Legislative District 16. Today, I am bringing LB1234 with AM2051, a bill that creates licensure for freestanding birth centers under the Health Care Facility Licensure Act. The Healthcare Facility Licensure Act includes 65 different statutes that regulate safety, fees, inspections, consumer protection, and standards that healthcare facilities in Nebraska are held to. Currently, birth centers are overseen by regulation in Nebraska. However, the way they are set up and who can staff them is-- seems to be so unworkable that all birth centers have shut down in the state. LB1234 writes them into statute, establishes an accreditation requirement, and, with AM2051, allows there to be a workforce that is unable to staff them. I worked very closely with the American Association of Birth Centers, or AABC, who are the national entity for birth center standards across the states. This bill is in response to an interim hearing Senator Spivey and Storer introduced last year-- some of us might remember that one. The AABC testified in length with eye-opening testimony that showed Nebraska is behind when it comes to birth options in the country. While there are over 400 birth centers across the United States, Nebraska has successfully abandoned this option for mothers who desire birth outside of the hospital setting. You can see in my handout that ACOG, the American Council of Gynecologists-- oh, I got that right-- the-- that ACOG and the Society for Maternal-Fetal Medicine's level of maternity care consensus refers to the AABC as a standard for birth centers. This is the reason I've worked with the AABC primarily to write LB1234. The American Association of Birth Centers has been around for 40 years promoting state regulations and establishing national standards for birth centers. They conduct major research projects and provide a national data set that informs their-- that informs their support of evidence-based practice. The midwifery-led birth center model of care has been proven to support physiological birth. Women choosing births outside of the hospital setting and celebrating physiological birth increased significantly between the years 2004 and 2019, with a 130 percent increase in women having birth center births. During that time, Nebraska remained stagnant, while other states made movement towards providing midwifery care for the women. Psychological-- or, physiological or natural birth is the process of labor and delivery that unfolds according to the body's natural rhythm; it is characterized by spontaneous onset and progression of labor. There isn't routine medical

interventions like epidurals, pitocin, or cesarean sections. Women, women desire this type of labor because it emphasizes trusting their body's ability to labor. It provides maximum mobility and prioritizes hormonal support for both the baby and mother. While hospital births have increased in use of-- increased in use of interventions and C-sections, mothers are looking for opportunities to birth their babies in a setting that celebrates womanhood and childbirth. The AABC explained during Senator Spivey's LR245 hearing that when creating statute for birth centers, it is important to make it in such a way that allows them to operate. In some other states, compromises were made to appease the medical associations that made it impossible for a birth center to be sustainable. As a result, AABC has combined best practices and formats for birth centers, and provided the language for LB1234. Included in the recommendation was for birth centers to be accredited. Accreditation through the commission for the accreditation of birth centers is a standard that requires excellence in birth centers across the country. In LB1234, freestanding birth centers would not only have to adhere to the Health Care Facility Act, but they would be required to be accredited through the CABC as well. These standard standards focus on safety and consistency in practice. In an unlikely event of an emergency need for a higher level of care, collaboration between birth centers, EMS, and hospitals are key. This is, this is modeled differently in each state. For instance, a birth center in Iowa partners with local EMS and the university for joint training to provide for more familiarity and smoother transitions. In Washington, one of the friendliest and most successful states in community births-- birth actually has their health department join forces and providing resources for transfer of care. This is why LB1234-- this is why in LB1234 we require a transfer plan to be implemented. Birth center practices are to, are to continually assess the risk criteria during prenatal care and throughout labor. When indications of a potential risk arise, birth center transfer-- birth centers transfer the care of a patient to the hospital. Included in national recommendations was to change Nebraska's laws around the birth center-- birth experts who provide care at freestanding birth centers. Staffing shortages have been one of the two leading causes for birth centers to close. Nebraska's will-- Nebraska will need to recognize certified nurse midwives, certified professional midwives and doulas as people capable of working at our centers. This is why I brought AM2051. 61 percent of birth centers are owned, partially or in full, by certified professional midwives, and 73 percent of birth centers have CPMs on staff. 39 other states license CPMs, with Massachusetts being

the most recent; in fact, they are licensed to practice starting this year. Medicaid reimburses CPMs as well in certain states. To allow for freestanding birth centers and not allow for CPMs is to create a structure that won't be staffed correctly. AM2051 license CBMs and authorizes them to work in freestanding birth centers. To keep in line with other licenses provided by the state, the details for CPM licensure are found within the language, but will be subject to the rules and regulations under DHHS and the Uniform Credentialing Act. Certified nurse midwives are also key to birth center success. CNMs have run birth centers in Nebraska before, but the practice agreement with a physician has closed down all centers and limited women's birthing rights. Nebraska is the only state that limits CNMs so rigorously. Physicians are unable to or don't want to sign the agreements, so CNMs are unable to run birth centers. AM2051 removes the practice agreement. Doulas are well-known in reducing the need for interventions in childbirth. The continuous care significantly enhances hormonal response, and result in positive birth outcomes. I kept the CNMs, CPMs, and doulas in the loop while putting this language together. The interim hearing was December 3, so I relied heavily on the AABC. CNMs and CPMs have, have things they would have liked to see included, but since this bill isn't addressing home birth or hospital birth, I limited the language to birth center focused birth only. Some of the more technical aspects of LB1234 are found within the Health Care Facility Act, but LB1234 does outline certain requirements that are important to note. Birth centers will be required to have a certified nurse midwife as the clinical director; standards are to be set for transfer protocols; restrictions against certain anesthesia, C-sections, and epidurals are specified, as well as vacuum and forceps use; the rights of patients and equality are prioritized; and confidentiality, data collections, and informed consent are defined. Also, including this requirement to establish low-risk criteria factors that preclude the patient from being seen. This seems like something new, but it isn't. These same exact standards found in LB1234 and AM2051 have been, have been implemented in states for years. On behalf of women, it's time let Nebraska-- let "Lebraska"-- let them give birth in a way they desire. We trust women to make decisions for their children, we trust them to make decisions with their own health, we trust to choose their health care provider; we need to join the rest of the country and let them birth in birth centers and midwives and doulas they desire. With that, please support LB1234 and AM2051, and I'm willing to answer any questions the best that I can. Thank you.

HARDIN: Thank you. Questions? Senator Riepe?

RIEPE: Thank you, Chairman. Thank you for being here, Senator. So, it appears this is both for licensed nursed midwives and doulas. My question would be, on the doulas is, you know, this has to be-- and, and I'll ask you to-- is this an expansion of Medicaid, and with that, a corresponding new cost to Medicaid?

HANSEN: I'd have to look that up just to make sure I answer that, answer that correctly, because I believe no, the way it is written. So, they would be able to be reimbursed through Medicaid, but there's a-- I think a proponent of that that does not increase the cost of Medicaid. I have to look and see, just to make sure I answered that right.

RIEPE: OK, because if they're providing a service, unless they're a volunteer, I would assume that they expect to get reimbursed, and the only vehicle-- I don't think private commercial is there yet. The other question that I have is-- I have in front of me, and maybe other members do too-- I have a list of 27 rural-- and I assume that we're trying to do this to enhance rural opportunity or resources--

HANSEN: That's one of the goals, yes.

RIEPE: And yet, I have a letter here from 27 rural health care facilities who are in opposition. Do you want to respond?

HANSEN: No, but that's a great question. And I'm sure they will be behind me to answer that question, which I'm hoping that they will respond to. Again, this bill-- I'm, I'm willing to work with all involved with this bill, because I think this is important. Like you mentioned, in those rural areas in Nebraska, we are seeing very limited use-- or, OBGYNs to be able to birth these children, and I think this is a reasonable solution that many states have moved towards.

HARDIN: Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Hansen, for bringing the bill. So, I, I, I-- you were referencing kind of the interim study hearing, and I, I recall that hearing over the summer. And I, I, I seem to recall one of the primary issues, or, like, sort of the themes that I was hearing, at least, in that, were things related to-- I think it there was,

like, accreditation concerns, Medicaid reimbursement concern was another one that seemed to kind of--

HANSEN: Mm-hmm.

FREDRICKSON: --come up quite a bit, and, like, the independent practice piece. And so, I'm just kind of curious to hear how--

HANSEN: Yeah, so I can touch on the accreditation piece, and this is what ACOG has mentioned that I handed out there, too. It is by the American Association of Birth Centers, standards for four birth centers, and those are the same accreditation process that we went through with this bill, and I'm pretty sure that's pretty much what every state and every birth center has followed is the AABC standards. Which, from my understanding, I think they were concerned about accreditation and making sure that there was some kind of oversight here, and that is what we have in the bill with the AABC that we modeled it after. If my understanding, DHHS also has the ability to monitor these facilities, inspect them as they will. And you referenced a couple other things about, like--

FREDRICKSON: Like independent practice,--

HANSEN: Yes. Yeah.

FREDRICKSON: And also the reimbursements--

HANSEN: Yeah, it's--

FREDRICKSON: --the Medicaid reimbursement.

HANSEN: Medicaid, I'm going to-- I'm going to follow up on that a little more, maybe in my closing, too.

FREDRICKSON: OK.

HANSEN: But one of the two biggest hurdles we had, like I mentioned at my opening, was the practice agreement with a, with a medical doctor, and, and that's one of the reasons why we don't have any anymore, because A, they-- they're unable to, or they're just not signing off on them.

FREDRICKSON: Mm-hmm.

HANSEN: And so, we're trusting that CNMs have the ability to open these birthing centers independently.

FREDRICKSON: Mm-hmm.

HANSEN: And so, that was one of the big hurdles I think we had to kind of get over, and so that's why I kind of have the language in the bill that says CNMs have to be the clinic director of these facilities. And then, you have to staff them.

FREDRICKSON: Mm-hmm.

HANSEN: You know what I mean? And so, like I mentioned before, over 70 percent of them are staffed by CPMs, so we're trying to find a way to staff these as well because we're talking about rural areas of Nebraska. We got to make sure that there's people there, otherwise they won't even be open. So, that's why I incorporated the CPM and the doula portion as well.

FREDRICKSON: Mm-hmm.

HANSEN: In line with, maybe, what a lot of other states in the country do as well. So, we're not trying to go outside, I think, what is the normal in the, in the rest of the country, the other 400 freestanding birth centers or, or, or birth centers in the country.

FREDRICKSON: Thank you.

HANSEN: Mm-hmm.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. Could you clarify a little bit on the, like, the C-sections and use of forceps and-- yeah, I know you mentioned it in your opening, but I, I think I might have missed part of what you were talking about there, as far-- they aren't able to do those things, those procedures, correct? Or--

HANSEN: They're-- according, again, to the American Association of Birth Centers, they have that all laid out about what they can and cannot do, and they have to be certain criteria, and if there's a certain criteria that are not met, they are now then required to refer them to a hospital. And some of that has to do

with make-- they become a certain point to a higher risk, or the use of certain procedures, then they're referred to a-- send them to hospital--

QUICK: Yeah.

HANSEN: --all based on those standards that almost all of the other birth centers in Nebras-- or, in the country follow.

QUICK: OK. I know just from-- you know, of course we've had this discussion before. My wife was a labor and delivery nurse, and there are times when it's not just time to transfer, it's like seconds to be able to, you know--

HANSEN: Oh yeah.

QUICK: --or within minutes to be able to do those things, and transfers, just making sure those patients are safe and--

HANSEN: Yep. And if you remember, during the interim study, they-- I think they sent out a big study by the March of Dimes showing, like, the success that a lot of these birth centers have had throughout the country with lower risk of C-sections. You know, the collaboration they have with the hospitals and, and OBGYNs to make sure that they, like we kind of all talk about, we want to make sure that we can kind of collaborate for Nebraskans. I think all that is set out right here [INAUDIBLE].

QUICK: OK. [INAUDIBLE]

HANSEN: And again, I know some people have some recommendations maybe behind me, and that-- we're willing to listen to all that kind of stuff.

QUICK: OK. And then, just one last question on the inspection piece, because, you know, I know with other-- you know, I-- we visited some of the nursing homes, the mental health facilities here a few years back, and inspections was one of the big issues. I don't know how it works for hospitals, or how DHHS-- because DHHS would be doing the inspections, is that right?

HANSEN: Yeah, I think it-- there-- because these facilities are going to be under the, the facility, facility act. I can't-- I don't [INAUDIBLE] top of my head. I mentioned that in my opening.

QUICK: OK. OK.

HANSEN: The Health Care Facility Licensure Act.

QUICK: OK, OK. Because I know even with my bill on that, and this-- tattoo artists have nothing to do with it, but when I had the words "shall inspect," I had to change it to "may" because they said they'd have to hire more inspectors.

HANSEN: Yep, and if we need to do that, I'm totally open to that. You know what I mean? Because we do want the ability for the department to monitor or inspect as, as needed and make sure that everybody's following kind of-- just like we do for every other facility. And if you want to amend your tattoo bill into mine, that's fine too.

QUICK: No, I'm not going to-- I'm not going to do that. I just know I, I had the issue working with DHHS on, you know-- they said they'd have to hire more inspectors, so.

HANSEN: And, and, and that's a good point. And I think DHHS maybe has a couple, maybe, recommendations for this bill that they may testify on. I don't really know.

QUICK: OK. Yeah, all right. Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you, Senator Hansen. Sorry if I missed it in your opening. Can you talk a little bit about the liability concerns? Do you address that? I know that was an issue last year.

HANSEN: Yes. Yeah. Well, either it was concerns, or it was maybe some confusion about the liability. And so, from my understanding, currently in Nebraska, if it is the fault of the birth center that, that results in liability, they would still be held liable for that, even if they drop them off at a hospital. I think the second you walk into a hospital, all the liability isn't on the hospital or the medical doctors there. It's all based on, I think, who was at fault. I know I will have some people behind me who, who might have some clarifying language for that, that they're willing to maybe put in the bill that I'm open to, to kind of further clarify the liability aspect.

BALLARD: OK, so it's not the intention that the attending physician gets liability when receiving a--

HANSEN: No, no, unless, unless they are at fault, but you mean-- but if we're talking about the birth center or the, or the midwives are at fault, then that should be where the liability is at.

BALLARD: OK. And then, at the very end of this amendment, it talk a lot-- it talks a lot about informed consent for-- can you explain kind of the, the reasoning behind that?

HANSEN: Well, informed consent is good, and the [INAUDIBLE]--

BALLARD: It's good. Yes, of course. Of course. Especially in the birth, the birth centers.

HANSEN: Yes. And I think we have it also in the amendment, but it's also under the AABC standards of care. It's like they-- there has to be informed consent about, OK, here's your risks, here's what we need to do, here is the plan we have in place, that kind of stuff. And that's already all according to the regulation that we're putting in place. And that-- from my understanding, that's typically how we do most things here. We don't put a lot of regulation in statute; we rely on the accrediting agencies or the, or the regulation itself to set the standard for-- of care for most healthcare facilities.

BALLARD: OK, I appreciate it. I'm just trying to run my head around this whole liability. So, I appreciate it.

HANSEN: Yep, yep.

BALLARD: Thanks, Senator Hansen.

HARDIN: Senator Quick.

QUICK: I just thought of one other question. Thank you, Chairman. But-- so, you know, with the-- we're doing these Medicaid, you know, work requirements, and we've had loss of marketplace insurance. I, I know it's going to be upon the facilities to hire people to know to, you know, if they're going to have to file insurance or if they're going to do all of that. But I don't know if you want to talk about any of that.

HANSEN: I would, I would assume they would. You know what I mean?

QUICK: Yeah.

HANSEN: And that's more of kind of an operating question.

QUICK: Yeah.

HANSEN: But-- you know what I mean? If they-- if, if that's the route they want to go with, you know, how they're going to get revenue or take care of patients, I'm assuming they would have somebody to help clarify all that kind of stuff.

QUICK: Because it's going to become more complicated, I think, as we go along, especially with some of the things coming down from--

HANSEN: It could possibly be that way, yeah. And so, I'm assuming also a lot of these births are, are-- people will self-pay for, as well. You know what I mean? And so, we saw some of that in March of Dimes, like how much cheaper it is, so.

QUICK: Thank you.

HARDIN: Seeing no other questions, will you stick around?

HANSEN: Yes, I will definitely stick around.

HARDIN: Wonderful. First proponent, LB1234. Welcome.

JOY KATHURIMA: Thank you. Good afternoon, members of the Health and Human Services Committee, and Chair Hardin. My name is Joy Kathurima, J-o-y K-a-t-h-u-r-i-m-a, and I am legal and policy counsel at I Be Black Girl. IBBG has a strong track record in maternal and child health work, supporting underrepresented communities and improving birth outcomes, specifically for black women. I'm here in support of LB1234. LB1234 would allow for freestanding birth centers to be better regulated in Nebraska, ensuring that bureaucratic red tape does not stop women from having the type of care they want and deserve. Freestanding birth centers allow for a person to give birth in a home-like environment, providing a more comfortable environment for those with low-risk pregnancies and who also want care from a midwife. According to a Journal of Perinatal Education article entitled

free birthing-- Freestanding Birth Center and Evidence-Based Option for Birth from January of 2022, the number of births in birth centers have doubled over the past decade to almost 20,000 births per year, and people who participate in birth center care experience lower rates of pre-term birth, lower rates of low birth weight births, and lower rates of cesarean birth. We know that in Nebraska, our pre-term birth rate is 11.1%, one of the highest in the nations. And women that deliver at freestanding birth centers see higher rates of breastfeeding when compared to people who have similar risk profiles who receive typical prenatal care. In 2023, IBBG hosted a statewide summit where Jennie Joseph, a prominent thought leader, practitioner, midwife, and CEO of Common Sense Childbear-- Childbirth Easy Access Clinic in Winter Garden, Florida, graced the main stage of the event to share the impact of midwifery and freestanding birth centers. Through her work, Ms. Joseph has found an outsized positive impact on underserved and underrepresented communities. Her easy access prenatal care clinics offer quality maternal care for all, regardless of their choice of delivery site or ability to pay, and it has successfully reduced both maternal and infant morbidity and mortality in central Florida. We appreciate Senator Hansen for bringing this bill in hopes to put Nebraska in better alignment with other states that have demonstrated the positive impacts of freestanding birth centers, combined with midwifery care for underserved communities. We do understand some of the opposition and concern, as we work with these same partners specifically surrounding timely access to emergency care should complications arise during labor or after delivery. We also know that currently, for underserved and underrepresented populations, that hospitals are also not safe for us. Freestanding birth centers create an option for lower-risk clients to choose for their prenatal care and birth in an environment where they feel safe, listened to, and cared for. We appreciate and thank this committee for its collaboration and consideration, and we look forward to working with Senator Hansen and this committee to advance this legislation. Thank you, and I'm happy to answer any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. My concern, and maybe you can answer this, is in a home birth delivery, oftentimes-- and I'm not a physician, but a C-section becomes needed. If a-- if you're doing a homebirth, you're in an awful predicament. How did-- how is that handled?

JOY KATHURIMA: So, with a freestanding birth center, it's still not a home birth. It still wouldn't be a home birth in your own home.

RIEPE: But it's an independent center.

JOY KATHURIMA: Yes, and I understand what you're saying. So, the goal with the freestanding birth centers as written out in the bill is that these are for low-risk pregnancies that should not be having the need for a cesarean. Ideally, these people will have already met the criteria, have been meeting with their doctor. As, you know, Senator Ballard said in the informed consent, these are patients who have-- understand the risks of what could happen if something were to change during their labor and they would need a cesarean. They're making an informed consent decision of, like, OK, well, how far away am I from services to provide that? So, I think that part of that is trying to balance the care that people are wanting to receive for the type of birth that they want to have while also balancing the ability to receive emergency care services if needed.

RIEPE: Along in there someplace, you said "should be." that's the problem. It's an unpredictable. C-sections are not always predictable, and then-- yet you do not have a time for transfer, and you have to act on it immediately, or you're likely to end up with a child maybe that has a umbilical cord that's wrapped around his neck. That's-- it's critical. You've got to get after it really quickly, and I don't see that as happening in a remote independent center or home birth, either way.

JOY KATHURIMA: And, and I understand that.

RIEPE: And it's rare. Hopefully it's very rare. But it can happen.

JOY KATHURIMA: It can, and, and we're not saying it, it, it can't happen. But again, we're trying to fit-- find a balance for folks to have choice about how they give birth and understanding, yes, that those emergencies can happen.

RIEPE: OK. I have no further questions, Chairman.

HARDIN: Other questions? So, how can someone pay for this? Is it from, from major medical to private pay? Kind of talk us through the types of options that are available for someone to engage.

JOY KATHURIMA: Ideally, that would be, would be the goal, is that private pay could happen with private health insurance. We're happy to work with Senator Hansen to figure out ways that folks would be able to access this type of care, whether-- you know, I've previously heard recommendations about, like, Medicaid reimbursement. So, there's obviously lots of options. I think it's trying to figure out what would work best for our state and for Nebraskans across the state, including realizing that rural situations might be a little different than urban situations as well.

HARDIN: Can you kind of give us a range of what you think it does cost, could cost, ought to cost, that sort of thing?

JOY KATHURIMA: Yeah. So, from-- and I'm happy to send the, the article that I found from the Center for Medicare and Medicaid Services. They estimated around $2,200 for birth center births. But again, that-- I'm happy to follow up with the committee with that report, but I think that there could be certainly a wide range, depending on the services that are being provided.

HARDIN: OK. Can you kind of-- and I can ask this of some other folks as well so as not to take up all of your time, but I'll just also, I guess, ask. Tell us about the positions, the people inside. What do they do, what do they have for training, that kind of thing. Can you kind of talk us through that world, in terms of the--

JOY KATHURIMA: I could try my best. I am a lawyer, not a doctor, so there might be folks who are coming behind me who might be more--

HARDIN: Oh, and, and we can certainly-- we can certainly save [INAUDIBLE]

JOY KATHURIMA: Yeah, more-- better, better situated to describe that.

HARDIN: So, that's fine. Any other questions? Thank you. Appreciate you being here.

JOY KATHURIMA: Yeah. Thank you so much. And I will follow up with that, with those information about costs.

HARDIN: OK. Very good.

JOY KATHURIMA: Thank you.

HARDIN: LB1234. Welcome.

ABIGAIL CADA: Thank you. Good afternoon. My name is Abigail Cada, A-b-i-g-a-i-l C-a-d-a. Thank you for taking the time to hear my testimony today. I'm a mother of six from Columbus, and a certified professional midwife licensed in Iowa. Though I'm sure you have heard many times over the past year, I would like to outline again what a certified professional midwife is. We are healthcare professionals who are licensed in 38 states and on staff at 73 percent of U.S. birth centers. In order to obtain the CPM credential, we must either graduate from a MEAC-accredited program or pass through the portfolio evaluation process, which is an intensive apprenticeship overseen by an approved preceptor. Both pathways require verification of competence in over 800 skills, and passing a 300 question exam. We are trusted to assist approximately 30,000 U.S. mothers each year as they bring new life into the world. We are sought out by these mothers because of our unique model of care, which is built on respect, informed choice, individualized care, continuous hands-on assistance, minimized interventions, and close monitoring of the well-being of the whole person. CPMs value evidence-based practice and participate in continuing education and peer review to ensure our standards are high and the level of care we deliver is excellent. Keeping these midwives from serving mothers while the healthcare system experiences huge shortages is negligent. I am grateful to have been able to work at an amazing birth center during my training. We were able to provide prenatal, labor, birth, postpartum, newborn, and well-women care. Because of the high level of integration, we easily consulted with OBGYNs and pediatricians, and transferred to the hospital when the need arose. Though continuity of care was not always available, women were familiar and comfortable with the midwives, and knew each of them would skillfully support their low-risk physiological birth while closely monitoring for any problem which may arise. The midwives and other staff worked together seamlessly as a team to provide outstanding care. Working as a doula here in Nebraska, I have supported mothers who chose to travel hours to Lincoln to give

birth at the former Good Life Birth Place. It offered a calm, home-like environment, which in turn put the mother at ease and facilitated a smooth delivery. Though it is not ideal to have to travel so far from home, families were willing to do so to receive a model of care that was important to them. Unfortunately, that birth center is now closed, and the options for Nebraska's mothers are few. Currently in our state, hospital-based providers have a monopoly on birth and refuse to let that go. The assertion is that we must keep birth in hospitals for safety reasons, however, we know Nebraska was given a D-grade in maternal and infant health, and the U.S. ranked 55th in the world for maternal mortality, behind every other developed nation. Unsurprisingly, the states which-- with some of the highest grades, such as Oregon, California, Vermont, New Hampshire, and Massachusetts, also have some of best midwifery integration, with around 20 percent of their births assisted by a midwife. The Commonwealth Fund, the World Health Organization, and the March of Dimes have all stated that integration of midwives into the healthcare system is key in reducing maternal mortality and preventing adverse outcomes for newborns. This is far from a fringe idea; it is an accepted fact. Birth is a normal physiological process that is safe for low-risk women. Licensing freestanding birth centers and integrating CPMs into the health, health care system would be a significant step in the right direction for Nebraska. That is why I ask that you pass LB1234 with AM2051 through the committee. Thank you for your time and consideration.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. So now, are you both a doula and a licensed nurse-- maternal infant--

ABIGAIL CADA: I'm a certified professional midwife. I'm licensed in Iowa.

RIEPE: You're a certified nurse midwife?

ABIGAIL CADA: Certified professional midwife, CPM, not a CNM.

RIEPE: OK.

ABIGAIL CADA: And then, I'm working as a doula because you can't really do much as a midwife in this state right now, as a CPM.

RIEPE: OK.

ABIGAIL CADA: So, just to support mothers in that way.

RIEPE: Is, is-- and do you practice beyond doulas? Do you practice-- when-- in Iowa, did you say?

ABIGAIL CADA: I got my license in--

RIEPE: I know we're, we're not in Iowa. [INAUDIBLE]

ABIGAIL CADA: Right. I got my license in Iowa, and I have attended.

RIEPE: Do you know in Nebraska anyone that's practicing or doing home deliveries? Are they doing that alone? Solo?

ABIGAIL CADA: Do you mean the mothers, or?

RIEPE: Well, if someone's, if someone's delivering someone at home in Nebraska--

ABIGAIL CADA: So, when--

RIEPE: --are they doing that---

ABIGAIL CADA: This, this-- OK.

RIEPE: My concern here is you almost need two people. You need somebody to hold the baby, catch the baby--

ABIGAIL CADA: Right.

RIEPE: --at the same time, when you're maybe finishing up with mom.

ABIGAIL CADA: Right. So, this bill is mostly--

RIEPE: I don't know. Do you work in teams, or solo?

ABIGAIL CADA: --only about, about birth centers, but if you were to do a home delivery, you would need at least two providers.

RIEPE: That's my sense.

ABIGAIL CADA: Yeah, there-- it would be very unwise to go to a birth alone, ever, any-- at any location.

RIEPE: Yes. The other question would be, is, is there a formalized training, or is most of this sort of on-the-job training?

ABIGAIL CADA: For a CPM?

RIEPE: Is there for-- formal schooling, if you will? Or--

ABIGAIL CADA: For certified professional midwives?

RIEPE: Yeah. I'm not concerned with the doulas. Oh, well I am, but we-- that's a different subject.

ABIGAIL CADA: Right. Yeah. So, for CPMs, there are MEAC-accredited programs, which is the Midwifery Education Accreditation Council, I believe. And so, that's just a college program that you go through, and then there's also your apprenticeship that you do alongside with that, so there's--

RIEPE: When you say it's a college program, does mean it's held on a college campus? Or is it a degree program? [INAUDIBLE]

ABIGAIL CADA: Some are held on a college campus, others are more distance-learning, I guess. Mine was through the National College of Midwifery, so I had a preceptor who taught our class. Basically, there were-- it wasn't on a college campus; it was at the clinic that I worked at, and--

RIEPE: How long was your program? In months, or years, or-- how long was it?

ABIGAIL CADA: Three years.

RIEPE: Three years.

ABIGAIL CADA: Mm-hmm.

RIEPE: OK, that's helpful.

ABIGAIL CADA: Yeah. And so, there's multiple ways to go about it. Everyone kind of has a different path, but that was the way that I did it.

RIEPE: Does everyone have a variance in the terms of level of training?

ABIGAIL CADA: No.

RIEPE: OK.

ABIGAIL CADA: No, the level of training is the same for everyone, and the exam you have to pass and the skills that you have verify at the end are all the same.

RIEPE: OK. Thank you for being here. Appreciate it.

ABIGAIL CADA: Yeah. Thank you.

RIEPE: Thank you, Chairman.

HARDIN: So, you practice in Iowa?

ABIGAIL CADA: I'm licensed in Iowa.

HARDIN: Licensed in Iowa.

ABIGAIL CADA: Yeah. Mm-hmm.

HARDIN: So, does Iowa have birth centers?

ABIGAIL CADA: I believe so.

HARDIN: OK. Very good.

ABIGAIL CADA: I don't-- I haven't done it a lot. I just recently was-- I-- licensed a few months ago, so.

HARDIN: OK. Very well. Thanks. I mean, that helps me out. Other questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Could you kind of walk us through the process? I see prenatal, labor, birth, postpartum, newborn, and well-woman care. What-- when does a-- when would a woman come to a, a, a midwife or a birthing center? Is that very early in their pregnancy? I see prenatal, but, you know, I think for me, up till birth is prenatal [INAUDIBLE].

ABIGAIL CADA: Yes. Right.

G. MEYER: So, so, what, what, what does the process-- what's that generally look like?

ABIGAIL CADA: So ideally, they would come at the very beginning of their pregnancy, because that will result in the best outcomes, right, towards the end if we're able to counsel with them and monitor their pregnancy throughout. But some may come later on, may have switched providers, or just didn't find out they were pregnant until later on. But the ideal would be, you know, early in the first trimester, six to nine weeks that you would set up your first visit and come to a birth center for care.

G. MEYER: And so, you work with them with vitamins, nutrition--

ABIGAIL CADA: Right, exactly. Education--

G. MEYER: --exercise, things of that nature?

ABIGAIL CADA: Yep. All of that.

G. MEYER: OK. OK, thank you.

HARDIN: Other questions? Senator Quick.

QUICK: Yeah, thank you Chairman. So, as far as, you know, if you're seeing these-- the patients for prenatal care, are you able to diagnose or use ultrasound, or anything that if you were-- because I know, like, when they go to the-- to some of the doctor's offices for, for provider services, they're using an ultrasound to make sure the baby is healthy and that it's growing properly. Are you able to use those type of-- those type of practices?

ABIGAIL CADA: So, I'm just speaking for a CPM: no, that's not part of our training. We would refer out for an ultrasound, or a birth center may have an ultrasound tech on staff, but typically that wouldn't be part of a CPM's role.

QUICK: OK. All right. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. A follow-up question. Do you do a history and physical on, on the patient so that you-- oh, you

do. OK. So that you have some idea-- I'm just concerned about diabetic moms or high-risk moms and the risks, then, to the baby, and that's-- that would be a concern of mine, so.

ABIGAIL CADA: Yes, that would be part of the first appointment, is a complete medical history.

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

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

ABIGAIL CADA: Thank you.

HARDIN: Proponents, LB1234. Welcome.

HOPE LINDSTROM: My name is Hope Lindstrom, H-o-p-e L-i-n-d-s-t-r-o-m. I am the mother currently suing the state for its egregious overreach as it pertains to certified nurse midwife birthing options in the state of Nebraska. I come before you today as a mother, a daughter, and a granddaughter, titles that every person in this room share with someone that they love, and yet, in Nebraska, all these women are radically and frankly barbarically underserved. Nebraska stands alone, stained as the only state in the nation denying certified nurse midwives the ability to practice in the full scope of their training. And, as a result, 51.6 percent of our counties are maternal care deserts. Women are driving 30 to 90 minutes to receive care, even in labor. This is not new information to you, and you've been presented with these facts repeatedly; the only thing that's been missing is your action. I have personally received certified nurse midwife care in a freestanding birth center in Oregon. I can attest to the safety, the outcomes, and the intentional evidence-based care that these professionals provide. The data supports it, and the rest of the country already trusts CNMs with their mothers and their babies. Last summer, when LB676 did not advance, many mothers went home defeated. Not because they disappeared, because we were told once again to politely sit down and wait. But something shifted these mothers did not disappear; they stood up, quietly at first, painfully, but together, and what began as a ripple has grown into a tidal wave. That wave is made up of women united across party lines, rural and urban, conservative and progressive, religious and secular, who agree on one simple truth: that mothers and babies deserve access to safe and qualified care, the same care that's standard and accessible in

all other 49 states. I stand here today as only one drop of that wave. This wave is not angry, but it is resolute; it is informed, it is organized, and it will not recede. We are no longer pleading, and we are moving forward. History will record whether Nebraska met this moment or stood in the way of it again. I ask you to step outside of the bureaucracy to silence the noise of the lobbies, to hear the reality of the families that you represent. Allow certified nurse midwives to practice fully in this state, and let Nebraska choose care, access, and dignity for its mothers before the rave-- the wave reaches the shore without you. Thank you.

HARDIN: Thank you. Questions? Thank you. Proponents, LB1234. If I can, how many more proponents do we have? I might have you move towards the front, if you're not already in the first couple of rows. So, thank you. Welcome.

GLORIA WISSMANN: Hi, thank you. It's an honor to be able to share a testimony with y'all. My name is Gloria Wissmann, G-l-o-r-i-a W-i-s-s-m-a-n-n, and I'm here as a mom, and I just have great thanks for Senator Hansen bringing this bill up again-- this issue up again through this bill. My husband and I have been married 45 years, and the Lord has blessed us with 13 children; 10 were born outside of the hospital, 3 were born in the hospital, so I have both experiences. And now, our children live in six different states, and of our 34 grandchildren, more than half have been born in-- outside of hospital options, and so we have experienced both of their also. And we have one daughter that's a doula and one daughter-in-law that's doula. So, I just want to share that to echo what Senator Hansen said, that-- the-- outside of hospital experiences for women, return the respect and honor for the decision-making to go to train either nurse midwife, which some of our daughters have done that, or certified professional midwives, which, some of my daughters have done that. And I-- as a woman, I cannot explain to you the blessings of having a birth where there's another woman attending, and I've learned so much more from the midwives that we've had. And I've had good teaching in the hospitals, too, don't, don't get me wrong. Our first two were born in the hospital, and we had great teaching there. But I was blown away with how much more the midwifes taught me about my own body and about birth, and about the baby itself, and that's been our experience. And so, I would just like to share that from our-- my perspective. And having family in Falls City, Nebraska and Kimball, Nebraska, it's been called to our attention lately that

the new hospitals that were born-- or were, were built in those two cities just within the last maybe 20 years or so don't offer birthing facilities for women, and we were shocked when we found that out. But they said that birth is too dangerous, and they don't want it. And so, women in those cities have to go to either St. Joe, Denver, outside of the state or outside of their communities; at least Lincoln, Omaha, perhaps. Sometimes up to a two-hour drive to find a legal assistance for birth in Nebraska. And knowing how, you know, sometimes that doesn't really-- it's-- it just puts a woman in a very difficult situation. And even in Seward, my understanding lately is that they only allow one birthing mother at a time.

HARDIN: I've, I've got you in the red here.

GLORIA WISSMANN: OK.

But no one in this room probably can tell us what you can tell us. And so, did you ever have any emergencies in those situations? Just-- because, big picture, and for lots of people who will testify here, that's probably the biggest concern--

GLORIA WISSMANN: Right.

HARDIN: --for everybody sitting here, is what do you do if there is an emergency? And yes, we've, we've heard, well, you go-- you, you, you figure that out ahead of time so you don't have one. I, I get it. Sometimes, life doesn't work quite that way. In your experiences, did you ever anything that made the, the nurse wife go "wow" as you were going through it, and in your experience?

GLORIA WISSMANN: Right. Well, in my experience, we, we consider that God made birth and he provides for it. And our daughter just had a baby-- she's 43, and she just had her fifth baby. In a different state, not in Nebraska, but at a birthing center out-- apart from the hospital. And--

HARDIN: You have 34, you said, from your kids. Grandkids?

GLORIA WISSMANN: We have 34 grandchildren, right.

HARDIN: OK.

GLORIA WISSMANN: And the knot was-- the, the cord was knotted three times. And part of that comes-- like the certified professional midwife said, part of this is with nutrition, because with good nutrition, God designed the cord so that it can't tie tight.

HARDIN: I see.

GLORIA WISSMANN: And so, even though it's maybe around the neck, or it's, you know-- I don't know how deep to go, but, but there's-- we have many friends that have had births outside the hospital that have had the cord wrapped around the neck, but the Norse-- the professional midwives are trained to not panic and to know how to change the situation, so. And I know that there have been, you know, difficult situations at home.

HARDIN: Were, were you ever in a birthing center? Obviously, we don't have them in Nebraska, but were-- did you ever deliver in a birthing center somewhere else?

GLORIA WISSMANN: I personally did not. I had the privilege of giving birth to some children before the Nebraska Attorney General sent out those cease and desist letters.

HARDIN: Gotcha. OK.

GLORIA WISSMANN: And so-- but I have, yeah, many daughters that have given birth in birthing centers in other states--

HARDIN: OK.

GLORIA WISSMANN: --with wonderful outcomes.

HARDIN: OK. Wonderful. Thank you. Other questions? Seeing none. Thank you.

GLORIA WISSMANN: Thank you.

HARDIN: LB1234. Welcome.

BETHANY VANDERHART: Bethany VanDerHart, V-a-n-D-e-r-H-a-r-t. Hello senators, thank you for your time. I am here as a proponent for LB1234, specifically with AM2051.

HARDIN: Excuse me, did you say you're a proponent or an opponent?

BETHANY VANDERHART: Yes, proponent.

HARDIN: OK, great.

BETHANY VANDERHART: I am a Iowa-licensed midwife. I live here in Nebraska, but I live close enough to the Iowa border that I can practice there in Iowa. I am certified professional midwife, and I trained in Wisconsin and Indiana, and I worked in birth centers in both of those states. In fact, my first birth that I attended was at La Farge Birth Center in Wisconsin. Birth centers, as you heard, are a great middle-of-the-road option, providing a home-like environment to low-risk women who desire that experience when they do not need the specialized care in a hospital. Birth centers are staffed by trained, licensed midwives. As you've heard, there's about 400 birth centers across 40 states, and CPMs staff about 73 percent of them, according to the American Association of Birth Centers. They offer a safe place and an option that the women of Nebraska currently do not have. Why are you not supporting and protecting the women of this state? You are forcing them to choose between two very hard options: to give birth alone, unassisted at home, or birth in a hospital, where their wishes are often ignored and they are forced into procedures that sometimes can have lifelong complications, procedures that often have no medical reasons just done through hospital policy. I ask you, if America has a high C-section rate and over 90 percent of the births that occur there in a hospital, all in the name of health and reducing the risks and dangers of childbirth, then why is our maternal mortality rate sitting at between 55 and 65 worldwide? That means countries like Egypt, Hungary, Ireland, and so many others have better birth outcomes than we do. Maybe we should start thinking outside the box and give women the benefit of the doubt. If Nebraska is considered a conservative state and we support family values and personal freedoms, then why on earth are you so focused on forcing the wives and daughters of Nebraska to give birth where you want them to, instead of where they want to? They're telling you where and with whom they would like to give birth. How about we listen to them? Birth choice freedom is a human right. Thank you.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman, thank you for being here. Can you always predict that this baby will not come breech?

BETHANY VANDERHART: Can you predict that when you go into your car and drive down the road, that you will not get into an accident?

RIEPE: Well--

BETHANY VANDERHART: There's risk with everything we do.

RIEPE: You don't get to ask questions, but the question gets to be, is what do you-- would you do if you were put in a situation where the baby does come breech?

BETHANY VANDERHART: There's training for the midwives, both CPMs and nurse midwives have training that give you the information of different moves and procedures to facilitate a better breech birth. And that's what prenatal care is for, so that you have time and opportunity, either through an ultrasound or through hands-on palpation where you find out what position the baby is in before labor starts, and that can better assist you in what the best place and location for that birth to proceed in.

RIEPE: That's a good general answer, but the fact is sometimes babies make a decision at the last moment and end up coming breech.

BETHANY VANDERHART: Sometimes. It's--

RIEPE: And it's something that-- the question then gets to be, is, is your procedure to try to turn that baby around?

BETHANY VANDERHART: The procedure is usually to put mom in the best position so that the baby can work its way through the pelvis. And when women are allowed to birth naturally without an epidural, and they have the ability to move themselves and to move their bodies where they can use gravity and other sources, then breech birth has been shown in other countries that allow training to happen, for breech birth to happen, have a better outcome than--

RIEPE: So, you would allow the mother to deliver breech if, if, if that's what works, and-- but she's not going to be in the position to make that call.

BETHANY VANDERHART: I'm sorry, what was that?

RIEPE: You're-- you can hardly allow the mother to make the decision about that she wants to deliver the baby breech, because time is such an instant important thing at that moment.

BETHANY VANDERHART: I guess I'm not really following what you're having to say.

RIEPE: OK. OK. Thank you, Chairman.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. One of the comments you made, you talk about low-risk women. How's that determination made?

BETHANY VANDERHART: I believe that low-risk is women who follow the criteria of good health. And so, prenatal care through a physical, we do blood pressure checks, and, you know, make sure that, you know, nutrition is optimal. And other parameters, blood checks, all of that, to decide for whether or not this mom-- and as well as the baby, checking on the baby. Each prenatal visit is a way to see if the woman is staying within that parameter of low risk.

G. MEYER: In the process of the prenatal visits and all that, if, if you see some red flags, determine that maybe there's going to be some complications, what's your process and, and how do you handle that?

BETHANY VANDERHART: So usually, if-- it really depends on what it is that's risking them out. But, say, if they are experiencing high blood pressure and it's something that you try at different-- through nutrition or supplementation, or something that's not working, then you would refer them to a doctor and see if a doctor is able to prescribe them blood pressure medication or so, and at that point, then they would probably risk out of, you know, the birth center birth, if their blood pressure is reaching a point where it's not safe for them to be in that low-risk environment.

G. MEYER: If, if you make a determination of someone that is potentially high-risk, or is high-risk, what kind of reception do you get from the, the local doctors? Are they welcoming to, to provide services for that individual? Or does it vary between

doctors? What-- you know, what is the process? What is the acceptance? What does that look like? If, if-- are you in contact early? Do you have people that you refer to as part of the normal course of business for you?

BETHANY VANDERHART: Mm-hmm. Obviously, here in Nebraska, there is no communication between health providers, but in other states, depending on what state and how comfortable that a doctor is, there are some midwives that work hand-in-hand, and they have a hospital or a medical doctor that is willing to prescribe them things, to see their clients. Other doctors and midwives in other states that the client would proceed to go to the doctor herself and just facilitate care independently of the care that she is receiving from the midwife.

G. MEYER: OK. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, yeah. Thank you, Chairman. So, I, I know that a lot of-- there could be a lot of low-risk births that, that, that have good outcomes. But every once in a while, there's that one that comes in-- and my wife experienced that as a labor and delivery nurse, where all of a sudden, the baby's heart rate is dropping. You only have seconds to make sure that that-- maybe you're going to have to do an emergency c-section or something like that, and there's not going to be that time to get that baby and that mom to the hospital unless you do that C-section right now. What-- how do you address those? Because they come in as a low-risk birth, and now, all of a sudden you're in this situation.

BETHANY VANDERHART: Through my experience, I have seen very, very little births that start out low-risk, physiologic births that would get to the point where they're not giving warning signs with enough time that you can change course of actions, and that is why the women who are choosing midwives are choosing the care given, to have frequent checks and things like that. And, and there's risk factors no matter where you go. So, the women who are choosing this care are understanding, potentially, that there is the risk factor that you have stated, and through informed consent, they're fine to make that decision for themselves.

QUICK: OK. So, with that, do you have to carry a malpractice insurance, or how would that work?

BETHANY VANDERHART: No, there is no malpractice insurance that I know of within-- as-- and I, I, I haven't worked on a-- in a board setting of a nurse-- of a birth center, so I don't know about birth centers that way. But usually, individual midwives do not carry malpractice insurance.

QUICK: OK. So, how would that work with-- because I know, like, my wife being a delivery nurse, she's either had to testify maybe only twice in her 44-year career, and actually, at one point, she was part of the lawsuit. So, they sued the hospital, the doctor, and the nurses. And the, the, the baby-- you know, the, the child had, had a disability after, after the birth. So, what would you do in a-- I mean, I mean, a lawsuit-- I mean, what's that going to do to your, to your, to your clinic? I mean, is that-- are you going to have to hire lawyers, or are-- because they're going to sue you, right? If something-- if there's a bad outcome.

BETHANY VANDERHART: Midwives established relationships with their clients, and there is not liability as the same way as there are in hospitals.

QUICK: So, they have to sign-- they sign a consent that says that they won't sue you, then.

BETHANY VANDERHART: Usually. Or something along that lines. And we provide time and opportunity to get to know each other on a personal level, and I have not heard of clients suing their prior midwives.

QUICK: OK.

HARDIN: Senator Meyer.

G. MEYER: That, that essentially was my question, also. I was just curious whether you sign a-- the consent form.

BETHANY VANDERHART: Yes, there's usually some consent form, you know, talking about the experience of the midwife and, you know, the policies that she--

G. MEYER: The expectations of outcome--

BETHANY VANDERHART: --feels comfortable with and, you know, what's, what's a dangerous-- you know, what, what, what the parameters of being low-risk and high-risk are, and being able-- the clients make the decisions for themselves, because this is their health that they are deciding on. And, and then, yeah, then they-- through that, being able to, you know, agree that, that they are making this decision with the information that has been given to them.

G. MEYER: Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. And I guess this is kind of of his too, because I'm just thinking-- I know hospitals have you sign a, sign a consent too. Every time you go to the doctor, you're consenting. And-- but that has not stopped people from, you know, from them suing. So, I don't know how you get around that without-- if someone really feels that they've been wronged, or that maybe you-- the-- it didn't come out like they thought it should, and didn't feel like the-- a midwife had performed the way she should. I just don't see how you're going to stop them from suing you. So, I don't know--

BETHANY VANDERHART: I mean, I've never had to cross that bridge, so I don't really know how to best answer that.

QUICK: OK. [INAUDIBLE].

HARDIN: Seeing no other questions. Thank you.

BETHANY VANDERHART: Thank you.

HARDIN: Proponents, LB1234. Welcome.

CHANDRA STEWART: Thank you. Hello, Senator Hardin, and members of the committee. My name is Chandra Stewart, C-h-a-n-d-r-a S-t-e-w-a-r-t. I'm a certified professional midwife and a licensed midwife in the state of Iowa. I'm here before you again today to speak in support of LB1234 with Senator Hansen's AM2051. As you already know, Nebraska is severely lacking in birth options. Though there are over 400 freestanding birth centers in the United States, Nebraska does not have a single one. What you may not know is that Nebraska is also the most expensive state in the entire country to give birth in. These two statements are

directly related. Midwifery care and out-of-hospital birth reduce costs for families and for Medicaid, reduce unnecessary interventions for women, and reduce NICU stays for newborns. We need freestanding birth centers in Nebraska. That said, passing this bill without AM2051 would be a grave mistake. You must license certified professional midwives. Over 70 percent of those 400 birth centers nationwide are staffed by certified professional midwives, and 61 percent are owned by CPMs. Certified professional midwifes like myself will not be able to work in birth centers in Nebraska without licensure. It simply does not make sense to pass a birth center bill without allowing for the majority of their workforce. Additionally, the requirement for CNMs only to direct freestanding birth centers would further limit the scope of certified professional midwives. We respectfully ask that you amend the bill to remove that requirement and allow CPMs to work within their scope. The Nebraska Medical Association and their friends are probably going to stand up here and tell you that CPMs are not safe, not educated, and should not be included in this bill. They are wrong on all counts. In safety studies, birth centers led by certified professional midwives had the same good outcomes as birth centers lead by certified nurse midwives. In fact, certified professional midwives are the experts in out-of-hospital birth. CPMs spend years training prior to their national certification and board exam, and they are the only type of maternity care provider that is required to train in out-of-hospital birth. I won't go into all of that now; I know you've been presented with all that information before, and you know we're always happy to meet with any of you to discuss our education and certification further. For now, I will say that the Nebraska hospitals have an absolute monopoly on birth in Nebraska. Nebraska has the lowest rate of CPM-attended births in the country. The lowest rate of CPM-attended births. CPMs and out-of-hospital birth are clearly not the problem with maternity care in our state. Instead of asking yourselves if certified professional midwives are safe, you should be asking yourselves, if the hospitals are doing such a good job with birth in Nebraska, why do we have such a poor rating for maternity care from the March of Dimes, who gave us a D? If hospitals are doing such great job, then why are so many women having unnecessary C-sections, and so many babies needing care in the NICU? If CPMs aren't safe, educated, trained, and capable, then why do 38 other states license them? Why is Nebraska one of the few states that refuse to recognize this profession? A woman in Nebraska can currently choose to end the life of her unborn baby, but she cannot choose where to give birth to that baby. The only options

Nebraska offers her are to go to the hospital where she has little control over the birth she receives, or to give birth unattended at home. The women of Nebraska need access to safe out-of-hospital birth options, and their midwives need to be able to practice to the full extent of their scope. Nebraska's families need options that are not controlled by doctors, nurses, and hospitals. It's time to end the monopoly on birth. Please vote yes to LB1234 with AM2051.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. My first question is this. You're both a certified professional midwife and a licensed midwife. Why both?

CHANDRA STEWART: Because most states-- it's the same way for nurses or doctors. You, you need to be licensed in the state that you work in. Nebraska does not offer a license for certified professional midwives. So, if, if Nebraska offered licensure, I would be licensed here too. The certification is a national standard of education and training.

RIEPE: But a certification doesn't supersede a license.

CHANDRA STEWART: No. Well, it does. In most cases, yes, you would have to be-- to be licensed as, as a CPM, you would also have to also be certified as a CPM, yes.

RIEPE: OK.

CHANDRA STEWART: Because that's the standard of education, making sure that you have this minimum level of education and training.

RIEPE: OK. And being familiar with some other states like New York, I'm, I'm, I guess, taken aback by your statement that says Nebraska, and I quote, "is also the most expensive state in the entire country to give birth in."

CHANDRA STEWART: It is. And I realize that I did not add that to my sources, but I'd be happy to email that to you, if you'd like. That, that just came out a couple weeks ago.

RIEPE: If you say it, I, I can research it myself. But I'm a little bit surprised.

CHANDRA STEWART: Yeah, I was too.

RIEPE: OK. Thank you, Chairman.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair. As you travel state to state, if, if you were to travel, that-- I'm not trying to push you out of Nebraska here. Is your license recognized-- are you recognized to practice in other states? Is there reciprocity?

CHANDRA STEWART: Yes. Yeah. I've done births-- yeah, in Iowa-- I could go to South Dakota, I could go Colorado, I could go to Wyoming, I could go to Missouri, and I could be licensed in any of those states and practice within my full scope.

G. MEYER: Do you have to test when you go in, or [INAUDIBLE]

CHANDRA STEWART: You have to test to get your certification in the first place. There's a board exam that you have to pass, yes.

G. MEYER: But not in each state, as you--

CHANDRA STEWART: No, they use, they use the NARM's CPM certification as their standard for licensure.

G. MEYER: OK. Thank you.

HARDIN: Other questions? Seeing none, thank you.

CHANDRA STEWART: Thank you.

HARDIN: Proponents, LB1234. Welcome.

EMILY AMIN: Hi. Sorry. Hi, sorry. Getting over a cold. Members of the committee, thank you so much for the opportunity to testify today. My name is Emily Amin, that's E-m-i-l-y A-m-i-n, and I serve as state policy counsel at Pacific Legal Foundation. PLF is a non-profit public interest law firm that defends individuals' liberties when they're threatened by government overreach and abuse. As part of this mission, we represent a Nebraska mother who spoke earlier today who is fighting for the freedom to choose how and where to give birth. We've also represented a Nebraska midwife that fought to provide care to

her patients. Right now, Nebraska has some of the most restrictive home birth laws in the country, permitting only licensed physicians to attend home births. But at the same time, more than half of Nebraska counties are designated maternity care deserts without hospital services. This has resulted in many Nebraskan women giving birth on the drive to hospitals that are hours away from their homes. This combination of heavy restriction and limited supply leaves families with fewer options and higher barriers to care. LB1234 would allow Nebraska mothers an additional and safeguarded choice as to how and where to give birth. Research summarized in one of our policy briefs on birth centers show that the 400 licensed birth centers in over 40 states are associated with lower costs and positive outcomes for both mother and baby. These facilities expand access without compromising on safety. It is also worth emphasizing that this bill is not meant to eliminate hospital births; it merely offers another option for expectant mothers. It authorizes licensed birth centers to provide care for low-risk pregnancies and newborns for stays generally under 24 hours, and it permits insurance policies to provide coverage for services that are rendered by these licensed providers at these centers. This gives Nebraskan women more certainty as to where they will be giving birth, and how much it will cost. At its core, this bill is about removing an unnecessary regulatory barrier that restricts both providers and families. As a brief aside regarding the recent amendment to this bill, while we support the representation of those disproportionately impacted by poor birth outcomes on these working groups, we believe that the use of the word "color" creates a constitutional issue as a racial preference, and would urge the deletion of just that word from the amendment as a potential legal issue. With that note in mind, we respectfully urge you to advance this bill.

HARDIN: Thank you. Questions? So, tell me about-- not very many states are like Nebraska, have this situation where we don't have birthing centers. You're legally representing some people in this room. I don't know to what degree you have freedom to talk about that, but I, I guess I'm-- what does it look like? Does it, does it look like-- do we look like other states, or are we very unique in Nebraska in this, in this legal path?

EMILY AMIN: Right. So, Nebraska is the most restrictive. I don't have all of the data in front of me, but I-- we have published numerous policy briefs on this issue, and I would be happy to forward those to you.

HARDIN: OK. Thank you. Senator Riepe.

RIEPE: I have a question. Are you an attorney?

EMILY AMIN: I have graduated law school, but I am not barred.

RIEPE: Oh, well, I'll take your opinion anyway. My understanding is that one cannot sign away any negligence in any situation. If there's negligence, you can have waivers or any other thing, but you can't, you can't sign it off and say, well, we're not liable if you're, if you're negligent in practice.

EMILY AMIN: That is my understanding as well, but again, I'm not a barred attorney.

RIEPE: Well, as long as you would say that as well, so that's good enough for me. Thank you. Thank you, Chairman.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair. I, I, I probably was remiss not asking one of our other testifiers. Perhaps someone behind you can answer this. But previous hearings that we've had regarding this, if memory serves, the certified nurse midwives, certified professional midwives, the home births seem to have a lower instance of C-sections based on the relaxed birth atmosphere of, of, of a home birth, or, or even a birth center attended birth. Do you think we're a little too quick to go to the C-section, if we're in a clinical setting?

EMILY AMIN: My personal opinion is yes, but again, I would probably not be the best person to answer that question. I think there's a lot more qualified people in this room.

G. MEYER: But, but with your law background, I thought maybe you would offer, offer a more succinct opinion. I'm just kidding you. Thank you.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Chair. Thank-- good to see you again, Emily. So, we, we talk a lot about birth outcomes. Can you talk a little bit about around the country? States that have birth centers, states that have certified midwives, do they have different birthing outcomes just based on the data?

EMILY AMIN: I don't have that data in front of me, but my understanding from the data that I have read previously is that they do have better outcomes.

BALLARD: Positive? Better outcomes?

EMILY AMIN: Positive, better, yes. Positive and better outcomes.

BALLARD: OK. Interesting. Thank you.

HARDIN: Other questions? Thank you. LB1234, proponents.

BENJAMIN STACHURA: My name is Ben-- Benjamin Stachura. B-e-n-j-a-m-i-n, last name S-t-a-c-h-u-r-a. Thank you, HS-- HHS Committee, for your time and attention to this bill. I come to you today as a dad and a father and a husband, and one thing I wanted to attest to was my experience with a midwife. Me and my wife were going to have a, a home birth with our firstborn a couple years ago, when home birth was legal, and that ended up being a hospital birth. We were in the process-- she was in-- or she-- through the birthing process-- not birthing, sorry. Through the pregnancy process, close to our birth, my risk-- or, my wife started having risk of a high-risk birth. Her blood pressure was high, and she started to have protein in her urine, which ended up being a sign for preeclampsia. So then, our midwife told us that we were at a high-risk of a home birth, and she recommended that we did not do a home birth. So, at that stage, we went to the hospital and we ended up having a hospital birth, and it went well. She did have preeclampsia, and so-- but we were able to have a safe birth there. And so, with that, I know you guys had questions, too, about the process, of red flags, or what do midwives look for. We experienced that in our home birth-- or, well, not home birth; it ended up being a hospital birth. But they referred us to the hospital and we were able to have a safe birth there. She was able to see the signs and see the red flags and was able refer us then. My, my plea to you guys today is that now, our option to have home birth, or any option outside of the hospital is being taken away. Me and my wife, we would like to see this bill passed, LB1234, because we would like to have options outside of just a home birth-- or, outside of the-- a hospital birth. This bill would enable us to have an option. This bill not only gives parents another option for home birth, or, or for birth, but it gives back a little-- the little freedom that the state has taken away from the parents' birthing rights. Hospitals have a monopoly on the

market of, of birth. Birth is not a market, it's a right, and I'm still confused as to why Nebraska does not recognize that, as a majority of states do. I don't understand if people-- or, the state does not understand that parents are able to make informed decisions or not. And so, I would ask that the committee would think about what the parents want and not the establishment. Thank you for your time.

HARDIN: Thank you. Senator Meyer?

G. MEYER: Thank you, Chair. Thank you for coming today. So evidently, having experienced complications initially with the first birth, you have no qualms whatsoever about considering a home birth or a birthing center birth now.

BENJAMIN STACHURA: No, not at all. My experience with our midwife was really good in the sense of-- we had, we had monthly checkups with her, prenatal checkups, and she kept a close eye on my wife. She wasn't showing signs of preeclampsia in the early stages, but she was having high blood pressure, which was one little sign that our midwife had recognized, and so she kept a close eye on that. And closer to the due date, she started to have protein in her urine, with is-- which is another sign. And because of that, she analyzed that it was a high-risk birth. And so, I have no qualms. I'm very grateful for our midwife and the knowledge and training that she had to be able to recognize those things.

G. MEYER: Would you say your experience gave you more confidence?

BENJAMIN STACHURA: Yeah, 100 percent. Yup. Yeah.

G. MEYER: Thank you.

HARDIN: Any more kids, Ben?

BENJAMIN STACHURA: Yes, sir. Another one.

HARDIN: How many do you have?

BENJAMIN STACHURA: Two.

HARDIN: Two? OK.

BENJAMIN STACHURA: Yep.

HARDIN: Well, congratulations.

BENJAMIN STACHURA: Thank you.

HARDIN: All right. Any other questions? Thank you. Proponents, LB1234.

FREDRICKSON: Welcome.

JUSTIN CHERRY: Hi, Senators. Thanks for allowing me to be here. My name is Justin Cherry, that's J-u-s-t-i-n C-h-e-r-r-y, like the fruit. And really, I don't-- you know, before this I really didn't think I had a dog in this fight until about last year sometime, when my wife had dropped on me that she feels that she was led to have a home birth. And between the two of us and our blended family, we're six kids, and, and-- now six kids, and five of them have been hospital births. And she decided that she wanted to have a home birth, and when-- I didn't really know much about it, you know, and kind of prayed over it and thought that would be a good direction, but obviously paying attention to what's going on. And we were pushed in the initial direction of, of just going to her OBGYN and doing the appointments that they normally do, but when we talk about informed consent, I think that's one of her big concerns that she would tell you if she was here, is that when you go do to the hospital births and you start meeting with the, the doctors, I mean really, they, they push you through so much that is, quite frankly, that I learned is unnecessary; that really, the patients don't have an option to say no to this stuff, right? And that was one of the things that through five, five children she birthed that she was really adamant about: we want to do this as natural as we can because God made the human body, and he made the human body in such a way for, for pushing out a baby and for having a baby, right? And quite frankly, some of the things that I hear in this, in this committee meeting, the questions that are, that are, that are said here-- you know, in my humble opinion, and I'm not a medical expert by trade, but it seems to me that everybody has an impression that a hospital birth is the normal thing to do. But for thousands of years, nobody's done a hospital birth. Like, we weren't doing hospital births. When I go around the country, and I've been around the county and the world, and I talk to other people, like, a lot of people have done births through birthing centers and not having to, having

to sit in a hospital environment. But especially other countries, the midwife is such a-- it's almost a sacred thing, to have a relationship with a midwife, and a midwife to come in and help the mother through the whole entire pregnancy process, right? Even up till birth and having the baby, that-- it's-- that is the normal environment in this case, in my humble opinion; it's not actually going to the hospital and giving birth there. Another thing too-- so, that was about informed consent, but we try to get a, a, a-- the, the midwife avenue going, but we quickly realized that Nebraska has very stringent laws, or no laws, really, in place to regulate that, unlike other states. And so, by the grace of God, we went forward with just having our own birth at the house. And, and you might not like this, but I learned through a lot of ChatGPT, talking to the midwife that we were going with, and, and had a lot of stuff planned out. And, you know, two months ago to this day I delivered-- you wouldn't think so, but I delivered a beautiful baby girl right inside my basement, and it was the most wonderful experience I had ever gone through. It was beautiful watching her be delivered right in my hands. And literally, I went down a checklist, nothing that [INAUDIBLE]-- ChatGPT said and other people said about the scenario that could have happened happened, and it was a beautiful experience. But I would have liked to had a midwife there with us, a pair of midwives there with us. So, I'm not quite understanding, you know, a lot of the pushback for this, and, quite frankly, like, it's, it's-- you know, if you haven't spoken to midwives outside of this meeting, I would encourage all of you to do that. I mean, it, it seems like maybe some of you have maybe spoken to lobbyists, right? Maybe they're taking campaign donations from the Nebraska Medical Association or other lobbyists. But I would courage you to actually talk to midwives outside this committee meeting and get your-- get their expert opinion.

FREDRICKSON: Mr. Cherry, you're in the red, so if you can wrap up your thoughts, we'll see if if you have-- if there's any questions from the committee, though.

JUSTIN CHERRY: Yeah, no problem. I, I support the bill, and support the Hansen amendment. And if you guys have any questions, I'd be happy to answer your questions.

FREDRICKSON: Great. Any questions from the committee? Senator Meyer.

G. MEYER: You probably can't answer this, because I'm pretty sure I can't. Is that illegal, to deliver your own baby?

JUSTIN CHERRY: I don't think so. I don't know.

G. MEYER: Wouldn't think so.

JUSTIN CHERRY: I don't know.

G. MEYER: Yeah. Well, congratulations.

JUSTIN CHERRY: Thank you. It was an amazing process.

FREDRICKSON: All right. Are there other questions from the committee? Seeing none. Thank you for being here.

JUSTIN CHERRY: Thank you. Appreciate it.

FREDRICKSON: Next proponent for LB1234.

DANA WOCKENFUSS: I'm Dana Wockenfuss, D-a-n-a W-o-c-k-e-n-f-u-s-s. Hello, Chairman Harding [SIC], and members of the committee. I traveled to Lincoln from-- today from Norfolk, just as I did twice for last year's midwifery hearings, because the message has not changed. Nebraskans deserve real options in who provides our maternity care and where we give birth. Last year, the midwifery hearings were packed. Families and advocates from across the state showed up in overwhelming numbers. We heard from people of faith, rural Nebraskans who traveled from those maternity care deserts, queer families, transplants from other states, birth workers, health professionals, elders, and young women. Some pregnant, several holding babies, and some breastfeeding as they waited to testify. That wide range of constituent support is proof that this issue impacts all of us, and that Nebraskans are ready for a change. Access to birth options is not only about autonomy; it's fiscally responsible. We have heard about the brain drain happening in Nebraska. And within this issue, highly-trained women's health providers are leaving because they are not allowed to practice here. My own family has seriously considered leaving. My number one reason that-- is because Nebraska restricts my reproductive health care during pregnancy, and limits my birth choices, I do not feel safe. And as a mother, I know the easiest way I can ensure my daughter never experiences that is by moving. So-- and the, the harder choice is staying and continuing to show up here and

demand we do better. So I'll ask, what is Nebraska doing to support young and growing families? Let's just say I want to have another child. Forget the worries about clean air, drinkable water, healthy soil, or the rate of pediatric cancer in Nebraska. Forget about inflation and the cost to raise a child. Forget about the lack of guaranteed parental leave. Forget about the-- our childcare system that's on the brink. Forget about the restrictive reproductive health laws that could jeopardize my life during pregnancy. If, despite all of that, I choose to grow my family, Nebraska still limits which providers I can see and where I can give birth. That does not reflect family-centered policy, it does not reflect a free market. A free market requires both providers and consumers who have choices. When the state limits which prop-- qualified providers can practice and forces families into the most expensive setting, regardless of the medical need, that's not a free market; that's a regulated bottleneck. Birth centers and professional certified providers cost less, reduce strain on hospitals, and allow care to match the risk level of a pregnancy, especially as rural hospitals struggle and close. This bill and its amendment offer a practical solution to workforce shortages, access gaps, and rising costs. When women are supported through pregnancy, birth, postpartum, all outcomes improve. There's less trauma, fewer and unnecessary interventions, lower long-term health costs, a stronger parent-child bond, and those bonds shape a child's emotional and social development. It reduces downstream impacts--

FREDRICKSON: And we have you in the red, so if you don't mind just wrapping up your final thoughts.

DANA WOCKENFUSS: Sure. It reduces downstream impacts on childcare systems, public schools, behavioral health services, and even our justice system. If the Unicameral does not act, Nebraska will lose families, providers, and opportunities. Advancing LB123 [SIC] with AM2051 is a meaningful step towards a healthier outcome for our society.

FREDRICKSON: Thank you for your testimony. Are there any questions from the committee? Seeing none. Thank you for being here. Next proponent.

SUZANNE GOODDING: Hello. Thank you for having me. Thank you your time. My name is Suzanne Goodding. Spelled S-u-z-a-n-n-e G-o-o-d-d-i-n-g. I'm from District 21. I was here last year and spoke;

my husband spoke at another hearing. I've given birth to eight children. Three of them were at freestanding birth center in Bellevue. One of them was born at the birth center inside of Immanuel Hospital, and the other four were born at hospitals due to not having-- well, three of them, due to there not being birth centers at the time, and one of them because I risked out of it because my baby was breech. I gave birth to a vaginal breech birth at the hospital. My midwife bent over backwards to find me a doctor who would allow me to do that. He came, and his hands-- he had hands off, and I was able to birth my baby. We-- when you give birth naturally and you haven't had medication or anything pumped into your body, you can still make sound decisions for yourself. It isn't your job to limit or to eliminate all risk. I actually think one of the most dangerous things about giving birth in Nebraska is this battle between there only being hospital birth options currently. You either birth on your own, unassisted, or you burn within the hospital. I'd welcome some questions if you have-- I have more things to say, but if you had questions-- having given birth at several birth centers. I've also had a baby with an-- the cord wrapped around the neck. If you are-- if you have good nutrition, if you have good fluids, just because a cord is wrapped around a neck doesn't mean a bad outcome. The baby was perfectly fine. Midwife unwrapped her neck-- unwrapped his neck. He was perfect-- perfectly healthy. Is that ideal? No. But does it happen? Yes. God made that cord to protect them. It's an embarrassment to live in Nebraska and to talk to my friends who live other places, and they have many more freedoms in the options for giving birth. This bill specifically, LB1234, is about birth centers, and I believe that we should have options outside of the hospital system. So, my last pregnancy, I was planning to deliver at the Lincoln birth center. However, they closed, and so the hospital says you can receive the same services if you move over to the hospital. I received similar services, but do you know how much more my bill was? I'm self-paying. They billed $25,000. My portion, $12,000 dollars. Do you what the self-play portion at a birth center is-- the birth center would have been? $4,000. So, I had $8,000 more dollars because I was forced to birth in the hospital rather than the birth center. So, the current medical system in Nebraska has proven that they care more about themselves and about the choices in the finance, finance-- than the finances of their patients. Standalone birth centers are essential to give parents an affordable option to birth in the environment of our choosing. I support LB1234 with the AM2051. And again, I, I welcome questions about what it's like to make a decision to birth in a birth center. I actually

think that you have more informed consent because you have to take charge of your own health, your own decisions, educate yourself, and not just rely on other people. And moms who lose a baby, they don't always sue. If a mom [INAUDIBLE] the baby, it doesn't mean that they're going to sue. I think that we take the risk; we want to make an informed, informed decision. I think that I have had better risk assessment from midwives on what the right choice for me is. Like, the vaginal breech birth. I risked--

FREDRICKSON: And we're in the red here, so if we can wrap up final thoughts, we'll see if there's questions as well, from the committee.

SUZANNE GOODDING: OK. The vaginal breech birth, they risked me out of birthing at the birth center, that's fine. We found someone else who was able to deliver my baby, and then with my eighth, like I said, I was going to go back to that birth center, but it unfortunately closed, and we don't really have another option. You either birth on your own or you birth in a hospital, and even if you don't want any services, I worked out things that we had left the hospital nine hours after birth--

FREDRICKSON: OK. Let's see if we have some questions from the committee.

SUZANNE GOODDING: --usually it's 24--

FREDRICKSON: We're in the red, so we'll see what questions there are.

SUZANNE GOODDING: OK.

FREDRICKSON: Senator Meyer.

G. MEYER: Thank you, Vice Chair. Thank you for coming today.

SUZANNE GOODDING: Yeah.

G. MEYER: You said that you were in a-- you were in a hospital setting and that they were allowing you to have a natural birth.

SUZANNE GOODDING: Mm-hmm.

G. MEYER: But you were breech?

SUZANNE GOODDING: Yup, baby was breech.

G. MEYER: And so, the-- they found someone that would allow you to continue a natural birth. At what point-- was there a point when you would have said, OK, we-- we've, we've got to-- we've got to do a C-section? Or was it vaginal birth, come heck or high water? Where were you at?

SUZANNE GOODDING: No, this was baby number seven for me. So, I'd given birth to babies. Most of my babies are around eight and a half pounds; my last one had been nine and a half. So, I had a proven pelvis, right? This was baby number seven. They actually did maneuvers to transition baby head down once before labor, twice in labor, and then they couldn't move-- baby, baby kept moving, right? And so, finding a doctor who was OK me giving birth-- the baby wanted to come bottom first, then it was a bottom-first situation. Usually, babies want to come head first, or ideally the baby would come head first. But finding a doctor who would allow me to do what my body knows how to do, is to birth a baby.

G. MEYER: And so, your testimony was he was hands-off, but he actually helped you deliver. Is that correct?

SUZANNE GOODDING: He was there, yes. So, he came in the room just as I was ready to push the baby out, and came and had checked things to see how things were going. And then he left, and my midwife supported me, and then he was back in for the delivery. But there was not any maneuvers or anything that were needed for to deliver the baby.

G. MEYER: OK. Thank you.

FREDRICKSON: Senator Ballard.

BALLARD: Thank you, Senator Fredrickson. Good to see you again.

SUZANNE GOODDING: Thank you.

BALLARD: Can you talk a little about-- you mentioned at the risk assessment you did [INAUDIBLE].

SUZANNE GOODDING: Yeah.

BALLARD: Can you talk a little more about that?

SUZANNE GOODDING: So, there's usually criteria you have to meet to be-- in order to be considered low-risk, in order to birth at a birth center. So, whether you have high blood pressure, you have-- [INAUDIBLE] could probably give you a list of all the different things. But they're taking assessments of you regularly to see if you're going to risk out. So, I-- my fifth baby, I risked out of doing the Lincoln birth center at that time, and I went to the birth center that's inside of Immanuel Hospital for that baby, because I would meet their requirements. It was because-- just because I was having baby number five, and the physician that was overseeing the midwives were not allowing at that time. They changed that, and that's why I went back to the Lincoln birth center and attempted to do it there. But they're regularly checking, you know, we're-- they want you to take charge of your own health and make sure that you are informed. They're checking for any indicators that might risk you out. Something like a breech birth-- if they know the baby's breech, then I was sent over to the hospital and knowing that that's where I was going to give birth, whether it was vaginally or a cesarean would have been needed.

BALLARD: OK. Thank you.

FREDRICKSON: Other questions? Senator Riepe?

RIEPE: Yeah, thank you, Chairman. I want to follow up a little bit. You said that you had gone to the Lincoln birthing center, is that correct?

SUZANNE GOODDING: Yes.

RIEPE: What, what was it, if you can share, what, what was it that forced them out of business, if you will? Was there not enough demand for, for-- I'm just curious.

SUZANNE GOODDING: So, I never gave birth in the actual Lincoln birth center. I gave birth--

RIEPE: Yes.

SUZANNE GOODDING: --to three in the Bellevue, one inside of Immanuel Hospital birth center. The Lincoln one, I was pregnant with my last.

RIEPE: OK.

SUZANNE GOODDING: My opinions on it is that it wasn't generating enough money. I think that--

RIEPE: Not enough demand?

SUZANNE GOODDING: I think there are patients that want to deliver there. I think that the criteria was pretty restrictive on who could give birth there. There are less-- it's less restrictive in other birth centers and other states. And then, I know that Medicaid reimbursement is not very high for birth center, birth center births. So, if there were patients that would be on Medicaid versus me who would be self-pay-- I'm going to pay out-of-pocket for that-- they're not making as much money. But they said that it would be the same services moved over to the hospital, and like I said, my portion would have been $4,000 at the birth center--

RIEPE: Yeah.

SUZANNE GOODDING: --and it was $12,000. And that was me fighting to leave early. You know, I did extra things to be able to leave at nine hours after birth. I was in the hospital for a total of 12 hours.

RIEPE: Sounds to me like, though, there wasn't sufficient request, demand, if you will, for the service to keep them--

SUZANNE GOODDING: I think--

RIEPE: --financially viable. And I think that on Medicaid reimbursement, it's the same whether it's in center or whether it's in the hospital.

SUZANNE GOODDING: The numbers were not going down from the birth-- my understanding, the births that were happening at the birth center. And like I said, their criteria for what they would consider the risk assessment, that wasn't the certified nurse midwives deciding what that situation was; it'd be the-- you know, they would have to have a physician over them. So, there can be different criteria for what would risk you out, and there are other birth centers that their criteria would not be as strict.

RIEPE: My guess is it was payer mix, that they didn't-- they had too many Medicaid and not enough non-Medicaid,--

SUZANNE GOODDING: But does the--

RIEPE: --which is what every provider deals with in the healthcare arena [INAUDIBLE]

SUZANNE GOODDING: But does that mean that the rest of us shouldn't have, shouldn't have an option for an out-of-hospital birth?

RIEPE: OK. Thank you, Chairman.

FREDRICKSON: Thank you. Other questions? I have just one. So, so you've had a, a diversity of experiences,--

SUZANNE GOODDING: Mm-hmm.

FREDRICKSON: --as you mentioned, with the, with the-- all of your children. So, when you were working with midwives, were you working with CNMs or CPMs, or both?

SUZANNE GOODDING: I was working in-- I was living in Nebraska for all of those, so I worked with certified nurse midwives for those births.

FREDRICKSON: OK, great. Thank you. Other questions? Seeing none. Thank you.

SUZANNE GOODDING: Thank you.

FREDRICKSON: Next proponent for LB1234. Welcome.

SCOTT THOMAS: Good afternoon, HHS committee. My name is Scott Thomas, S-c-o-t-t T-h-o-m-a-s. I'm with Village in Progress and USIDHR. That was amazing, Senator. Those, those weren't invited testifiers, huh? I didn't hear anybody getting called up by name. So, it's just a very popular bill. And we support the bill in alignment with Article III, the right to life in the 1948 Universal Declaration of Human Rights, and then Article 29-- 28 or 29, whichever one the best practices article is. It basically says that the government is required to provide the optimal standard of living available to the general public. So, if it's available in all of the states, and this is an outlier and exception, then probably to move towards uniformity on that. That's all I really have on it, just a human-rights-related issue. And we, we support women having every choice but abortion

where I'm from, so. You know, I like to give them a lot of options if we can in law. We could try and do that, and move towards that. And just for the record-- I know this is going to sound petty, but I just want to get it on the record real quick while I'm here, because I was, I was interrupted last week across the hall at committee hearing, asked to remove my hat. Now, there are gentlemen who have hats in committee hearings sometimes; they don't have the president's name on them, they don't have the flag on them, but I just want to point it out so that that's on the record as well. Any questions for the senators?

FREDRICKSON: Thank you for your testimony.

SCOTT THOMAS: I apologize, Senator.

FREDRICKSON: Are there questions from the committee? Seeing none. Thank you for being here.

SCOTT THOMAS: Appreciate you.

FREDRICKSON: Next proponent for LB1234. Seeing none, we'll move on to opponents for LB1234.

TIMOTHY TESMER: Good afternoon, Vice Chair Fredrickson, and members of the Health and Human Services Committee. My name is Dr. Timothy Tesmer, T-i-m-o-t-h-y T-e-s-m-e-r, and I'm the Chief Medical Officer of the Division of Public Health in the Department of Health and Human Services, DHHS. I'm here to testify in opposition to LB1234. DHHS currently regulates health care facilities and services under the Health Care Facility Licensure Act. Health clinics that provide labor and delivery services are included within this act. These standards include requirements for initial licensure, renewal, disciplinary action, reporting, and fees. Consistent standards create values in the provision of health care and enable the regulation of health care facilities and services in a coherent manner. If LB1234 is passed as written, freestanding birth centers would be excluded from the Health Care Facility Licensure Act and would not be covered by the existing framework and provisions therein. DHHS would not be able to create new regulations for freestanding birth centers because the Act does not grant DHHS the authority to promulgate regulations. Therefore, freestanding birth centers would only be regulated by the text of this Act. LB1234 requires DHHS to license a freestanding birth center if

it is accredited by the Commission for Accreditation of Birth Centers, CABC, or to be in the process of obtaining accreditation within six months of the date of the application for licensure. The CABC is not an entity DHHS has previously worked with for accreditation, and DHHS has no control over its accreditation requirements. In essence, the bill would divest the state of licensing authority and surrender this authority to a third-party commission. LB1234 does not address protocols for the freestanding birth center to ensure the safe and proper transfer of patients to higher-level care facilities and emergencies. While the freestanding birth center is intended solely for low-risk deliveries, emergency situations requiring transfer may occur. Furthermore, the bill does not require a collaborative agreement with another facility for emergency transfers, which poses definite patient risks. LB1234 defines a licensed provider to include, but not be limited to, certified nurse midwives, certified midwives, or licensed midwives. Currently, Nebraska licenses certified nurse midwives as a type of advanced practice registered nurse; they must hold a current registered nurse license, be certified by an approved body, and have practice agreement with a physician whose practice includes obstetrics. Nebraska currently does not regulate certified midwives or licensed midwives. The bill does not require a physician to be involved with a freestanding birth center at all. Fees for initial licensure, renewal licensures, and change of ownership are specified in this bill at $250; there is no indication that $250 will cover the cost of creating this new license type, which has a completely different licensure system from that of other health care facilities and services regulated by DHHS. For these regulatory, licensure, and patient-safety issues, we respectfully request that the committee not advance the bill to General File. Thank you for your time. I would be happy to answer any questions on this bill.

FREDRICKSON: Thank you, Dr. Tesmer. Questions from the committee? Senator Meyer.

G. MEYER: Thank you, Vice Chair. If we address the regulatory, licensure, and patient safety issues, would you be in support?

TIMOTHY TESMER: I'm sorry?

G. MEYER: If we address the regulatory, the licensure, and patient safety issues, would you be in support of this bill?

TIMOTHY TESMER: I--

G. MEYER: Seems to be what--

TIMOTHY TESMER: Senator, let me answer.

G. MEYER: It seems to be what's causing you pause, so if those were addressed, evidently, there wouldn't be any pushback, would there?

TIMOTHY TESMER: I believe that-- I, I, I can answer that, that, that would certainly be reasonable grounds to, to consider all of that, yes.

G. MEYER: OK. Thank you.

FREDRICKSON: Further questions? Senator Ballard.

BALLARD: Thank you, Senator Fredrickson. Good to see you, Dr. Tesmer. So, at the end, you talk about patient safety issues, but I'm, I'm-- can you expand on that a little more? Because I understand the licensing point, but patient safety issues-- is that-- does the licensing of-- are those connected, or is the patient safety outside? Because most of your testimony was about licensing, and at the very end, you were talking about patient safety issues. Can you expand on the patient safety a little bit more?

TIMOTHY TESMER: Well, I think from a patient-- well, I mean-- I'll answer it-- try to answer it this way. The, the goals for delivery, I mean, for optimal pregnancy outcomes, basically deal with making things best for moms and babies, and the safest provider to help or attend a birth is one that's the best trained and the best experienced. Now, there are statistics that state neonatal mortality rates different in birth center facility, home birth, or hospital settings. There are those differences in neonatal mortality rates out there. So, I, I-- I'm not-- I'm, I'm happy to answer more of whatever you're--

BALLARD: I'm just trying to understand the, the risk. We hear, we hear from proponents that there's no risk-- minimal risk. I shouldn't say there's no risk. It is health care; there's, there always risk in health care. But then, I'm assuming we're going to hear about the risk in that opposition. So, I'm trying to wrap my head around no risk-- minimal risk, excessive risk.

TIMOTHY TESMER: OK.

BALLARD: And so, what's the middle ground?

TIMOTHY TESMER: The, the-- there are-- again, there's statistical data that says that in home births and births at birthing centers, there is about a 10-15 percent transfer to the hospital rate. Now, those transfers certainly could be for non-emergent issues; those could include lack of progression of labor, the need for more pain medication for mom, mom's becoming too exhausted to proceed with the, the process. True emergency transfers from home or birthing center facilities probably range in about 2-3 percent of the time. Now, those true emergencies could include really quick, sudden fetal change, change in the fetal status, or bleeding, hemorrhaging. So, those are some of the safety issues, I think.

BALLARD: OK. I appreciate it. Thank you, doctor.

FREDRICKSON: Senator Meyer.

G. MEYER: Thank you, Vice Chair. Just to follow up a little bit on what Senator Ballard had. You seem to be concerned about the complications that could occur, justifiably so, in a home birth or, or a birth being attended by a certified professional midwife or a certified nurse midwife. But if there's no one there in the rural community, in our underserved community, in our maternity desert, aren't they going to show up in the emergency room anyway? How do you-- how do you mitigate risk? Because they're going to show up in the, in the maternity-- or, in your emergency room anyway. Wouldn't it be better to have a certified nurse midwife, a certified professional midwife pre-screening, working with the prenatal, and, and identifying when you have an opportunity for, for risk, greater risk, to be able to refer to a doctor? Because your liability exposure, in my opinion, and from strict logic, is much greater without a certified nurse midwife or a certified professional midwife attending these people that are pregnant. They're going to be in your hospital anyway.

TIMOTHY TESMER: If-- certainly, if you're talking about-- I mean, the whole concept of maternity deserts, there are a, a-- there's a significant number of factors involved in what's considered a maternity desert. Workforce issues, being able to train more physicians in obstetrical care, being able to have

strong collaborative agreements between physicians and midwives--

G. MEYER: We know what we-- we know what we need, but it's not happening. So, what's our next option? There is no other option, other than, as I proposed previously, a year ago in a previous bill, we should just absolutely, as the Legislature, ban anyone getting pregnant west of Highway 81 in Nebraska. I don't think that's a viable option.

TIMOTHY TESMER: True.

G. MEYER: And so, once again, the Legislature or-- no one can mitigate, legislate, regulate risk. We have people with informed consent. This is what they want. And you're saying, you can't have it.

TIMOTHY TESMER: I'm sorry, Senator. I don't know that I'm saying you can't have that, I'm just speaking on--

G. MEYER: Because I, I, I kind of got it off of here. I-- you know, that's exactly what, what the position is. If you don't license it, if, if, if you don't-- if you don't regulate it, it can't happen. That's, that's what this says. For regulatory licensure and patient safety issues, you don´t want this to come out. That's pretty plain.

TIMOTHY TESMER: I realize-- OK. We were made-- the department was made aware of amendment language to LB1234 just as it was dropped yesterday. The department is in the process of reviewing that amendment language and its effect, potential effect on the department, and what our next steps and processes would be. So, I think that it would be something that would be worth further discussion. Does that make sense?

G. MEYER: So, so it's a work in progress, and, and, and I appreciate that. If, if it was a very short window of opportunity to have a discussion, I appreciate that. And, and perhaps I'm being a bit harsh. But what kind of timeline do you think you would have to have that discussion, and perhaps advance it yet this year during this legislative session?

TIMOTHY TESMER: Probably-- it would be honestly very premature for me to, to give a timeline to you right now.

G. MEYER: You know, we had a run at it a year ago, and it doesn't appear that we got-- made any progress with, with Senator Hansen's previous bill, so. Got to-- next year? Year after?

TIMOTHY TESMER: I don't-- I, I, I, I don't-- I, I don't-- honestly, sir, I don't think I can give you a timeline--

G. MEYER: OK. I'm, I'm probably--

TIMOTHY TESMER: --but I know that's something that the department is, is reviewing right now.

G. MEYER: I'm, I'm probably being too, too harsh with you, and I apologize if I put you in a bad spot. But I, I appreciate your time. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. Can you talk a little bit about, like, what you-- like, for the hospitals. So, they have to go through the same process, right? Of having DHHS oversee or, or making sure that they're under the certain requirements to meet patient care, right? I mean--

TIMOTHY TESMER: I mean, you're talking about the Health Care Facility Licensure Act?

QUICK: Yeah. Yes. So, I mean, DHHS oversees that, is that correct?

TIMOTHY TESMER: Yeah, I mean as far as the licensing and renewals, and, and it shouldn't be--

QUICK: Yeah. So how does it work for, like, a hospital that has, like, a labor delivery or a birthing center in their hospital? What's the process like for that, for a hospital? They have to have-- do an application, or how does that work for them? Or how, how does work for you to oversee the-- what kind of patient care is done in a hospital setting?

TIMOTHY TESMER: Well, the, the whole health care license-- our, our whole health care licensure act has been created with standardized protocols to ensure, primarily ensure, patient safety. Now, those protocols work very, very well, and every

health care facility-- I mean, basically every health care facility is governed or is, is run under those guidelines, under that-- under the Health Care Facilities Licensure Act. So, it, it would just seem natural that birth centers-- which, again, speaking on LB1234-- it'd be natural that birth centers be under that Health Care Facility Licensure Act, which is not necessarily in the original LB1234 language.

QUICK: OK.

TIMOTHY TESMER: And again, this testimony that I give was finalized and submitted before this amendment came out.

QUICK: So, so it's basically-- it's patient care, consumer-- patient protections, right?

TIMOTHY TESMER: Mm-hmm.

QUICK: So-- and it's the same way-- it'd be hospitals, physicians, clinics, any type of, of medical clinic then, right?

TIMOTHY TESMER: Mm-hmm.

QUICK: Do the, do the veterans hospitals, do they fall underneath that too? Or are they federal? That's all federal.

TIMOTHY TESMER: I, I wouldn't know. My guess would be they may be federal, but I don't know for sure.

QUICK: Not that that would have anything to do with this bill, but--

TIMOTHY TESMER: Yeah.

QUICK: All right. All right. Thank you.

TIMOTHY TESMER: Mm-hmm.

HARDIN: Can I ask a piecemeal question? Would-- if not everything is here that needs to be here in order for the department to be involved, is there an advantage, or can we amend it in some way to get the department involved, even with this rendition? Can we amend this and move forward? Sometimes, we build bills and we build laws and we built concepts a piece at a time, I guess is my, my question.

TIMOTHY TESMER: Mm-hmm, mm-hmm.

HARDIN: Is that a possibility? Could we start with what we have and, and build onto it? We can do that from a legislative side, but, I mean, are there other types of things that, to your memory-- I understand you've, you've been with us for now, how long? Two years?

TIMOTHY TESMER: Almost three. Almost three.

HARDIN: Almost three. OK. But I'm looking at it saying, how do we build the bridge from "it's not here at all, but it's in most states"-- how do we become more like most states?

TIMOTHY TESMER: Mm-hmm.

HARDIN: Is it best to do it in one fell swoop and, and get everything in place all at once? That would perhaps be ideal, so that the department could regulate it and we could have everything up to snuff in one fell swoop. I also understand we've got to have somebody inside those birthing centers, if we do that. And so, we have those pieces to do as well. So, I guess the question is, if we were to pass this, and it-- there it sits. Kind of doesn't do much on its own. We kind of need help from the department.

TIMOTHY TESMER: Mm-hmm.

HARDIN: So, we might come back in another year and try and take another step in that direction to see if we can fully and finally, in a couple of years or something, if that's how long it takes to get it going. Are you familiar with that type of process, either in our state or other states, where it takes a while to get up to ramming speed?

TIMOTHY TESMER: Well, I'm sure that happens quite a bit of the time, I would imagine, with, with certain bills or certain legislation.

HARDIN: Right.

TIMOTHY TESMER: I--

HARDIN: Would we be in any danger because-- if we were to pass this and we didn't have the regulatory piece in place, for

example, is there any great danger to it sitting there percolating and doing nothing for a year until we did something more with it?

TIMOTHY TESMER: I don't understand how you would-- if you passed LB1234--

HARDIN: Uh-huh.

TIMOTHY TESMER: And again, I can't really speak to the amendments that just were dropped, but if you passed LB1234, there would be-- there, there-- I don't know if that would embolden or emblazon someone to go-- to, to go out and start setting something up without the regulatory background--

HARDIN: Framework?

TIMOTHY TESMER: --and framework, I don't know how that would work.

HARDIN: OK. We will chat with Senator Hansen about the content of the amendments a bit more before the day is over. So, I just wanted to get your thoughts on that. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thanks for being here. So, this is-- so, the bill, as written, this is for freestanding birth centers. Are-- do we-- so, I, I know we, we-- from what I'm-- I'm just kind of putting this together. We, we used to have one in Lincoln, from when I understand.

TIMOTHY TESMER: Mm-hmm.

FREDRICKSON: So, are we currently prohib-- are-- is the-- are people currently prohibited from licensing a freestanding birth center, currently?

TIMOTHY TESMER: Well--

FREDRICKSON: Like, in other words, like, if, if someone wanted to start a freestanding birth center in the state of Nebraska, could they get a license to do that?

TIMOTHY TESMER: Currently, no. My understanding, currently not. I mean, there are, there are birth-- birthing centers in the state, as was mentioned, mentioned by one of the testifiers

earlier. CHI Immanuel has a birthing center, and there's one associated with Nebraska Med, UNMC. Both of those centers are driven primarily by midwives.

FREDRICKSON: Right.

TIMOTHY TESMER: Certified nurse midwives or whatever.

FREDRICKSON: But what, but what we're hearing from a lot of the proponents of the legislation is they're, they're looking for freestanding, right? So, they, they, they don't necessarily want to have something that's-- from what I'm understanding, and if I'm misunderstanding this, I'm willing to be corrected. But from what I'm understanding, they're looking for something that's separate from, like, the kind of the traditional hospital,--

TIMOTHY TESMER: Mm-hmm.

FREDRICKSON: --traditional hospital setting. And so, I guess I, I-- my understanding was there used to be one of these in Lincoln, Nebraska.

TIMOTHY TESMER: I believe so.

FREDRICKSON: And so, I, I would think-- and, and again-- but I would think they would-- they were licensed. I would think that they were able to be licensed. I'm seeing some people nodding in the back, so I don't know if that's-- but I guess what I was trying to piece together is what-- and, and maybe this is something that we can-- I can find out from other testifiers, but the-- what might be limiting, like, a freestanding birth center itself from opening up, right? I mean, we're, we're-- the amendment that was dropped, of course, is like the CPM amendment. That's a whole other conversation. But the original bill as written-- just trying to piece it, like, separately, like the idea of just, like, a freestanding birth center, which is what I'm, I'm hearing there's the-- a desire for it a lot of ways, so. Yeah.

TIMOTHY TESMER: Senator, I don't know that I can speak to what the regulatory framework may have been some time ago--

FREDRICKSON: OK.

TIMOTHY TESMER: --which allowed the, the freestanding birth center here in Lincoln to operate, versus what it is now. I don't know. I mean, I'm happy to look into that and research that.

FREDRICKSON: OK. All right. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. And I'd, I'd asked Senator Hansen this earlier, but, you know, as far as, like-- so, for-- if, if, if they did become part of the Act or the, you know, the-- or like hospitals and everything else, and they've qualified for that. If that-- if that-- if it was amended, could there be a fiscal note that would be added for the-- would it become a more of a burden on the department? Would you have to have more-- and you may not be able to answer this, because I know some of my bills have come up and then they-- the department would say well, it's going to cost us much more to actually facilitate that.

TIMOTHY TESMER: I, I, I think I can speak to the fact that if you're adding a facility-- if a facility would be added into the Health Care Facility Licensure Act, that would be-- that would be-- manpower would have to be dedicated for that, as far as all the certification and the licensure and all, and all of that. There would have to be manpower dedicated to investigations, should there be a complaint. So, I guess there, there could very well be some fiscal note to it, but I don't know what that would be. I wouldn't have an idea of what it would be, necessarily.

QUICK: Yeah. And that'd probably all be, be determined by how many freestanding clinics would be built here.

TIMOTHY TESMER: Yeah.

QUICK: OK. All right. Thank you.

HARDIN: Other questions? Thank you.

TIMOTHY TESMER: Thank you.

HARDIN: Opposition, LB1234. Welcome.

BLAKE SMITH: Thank you. Good afternoon, Chairman Hardin, and the members of the Health and Human Services Committee. My name is Blake Smith, spelled B-l-a-k-e S-m-i-t-h, and I'm a registered nurse and currently serve as the president of the Nebraska Nurses Association. And I'm here today testifying on behalf of our legislative advocacy and representation committee, known as LARC, in opposition to this bill, LB1234, as it is written today. Nebraska Nurses Association represents approximately 30,000 registered nurses across Nebraska, including many who practice maternal and newborn health. We recognizes the-- we recognize the challenges that our state faces in maternity care access, particular in rural communities, and we appreciate the intent behind LB1234. Our concern with LB1234 is not the concept of freestanding birthing centers; it is the sequencing. The bill creates a bill-- a birth center infrastructure before Nebraska has clearly resolved provider authority, scope of practice, and accountability, particularly with certified nurse midwives. Under current statute, CNMs do not yet practice, practice to the full extent of their education and training. Establishing new care settings without first addressing those scope limitations places infrastructure ahead of professional authority. Last session, our Legislature encountered similar concerns when differing midwifery proposals were combined. These-- those discussions underscored the importance of clearly defined roles, licensure, and accountability, issues that remain unsettled today. From a practical standpoint, providers and communities are unlikely to invest in birth centers while scope and liability remain unclear. In rural Nebraska, where we know emergency transport and specialty access can be limited, statutory clarity and integration are essential for patient safety. I want to acknowledge the amendment, AM2051, filed yesterday, which attempts to address some of our listed concerns. But is-- but-- but it significantly expands this bill. It creates a new licensure framework, it modifies multiple practice acts, it revises certified nurse midwife statutory language, and adds additional policy changes. Legislation of this scope warrants careful and deliberate review. Given the limited time to access its full impact on scope, governance, and integration, we believe advancing a facility licensure bill with the amendments in their current form would be premature. For these reasons, the Nebraska Nurses Association respectfully opposes LB1234, including the proposed amendments at this time, and urges the committee not to advance the bill in its current form. We remain open to dialogue on thoughtful solutions that expand access to safe, high-quality maternal care in Nebraska, and continue discussions around this bill itself.

HARDIN: Thank you. Questions? Senator Quick?

QUICK: Yeah, thank you, Chairman Hardin. So, what-- so, there-- are there some nurse midwives actually can, can practice now right? In the state of Nebraska?

BLAKE SMITH: Yes.

QUICK: Yeah. And do they have to work-- I can't remember if we passed the bill. Did they-- can they practice on their own, or do they still have to be with a doctor, with an OBGYN?

BLAKE SMITH: I would, I would defer to my certified nurse midwife colleagues to, to explain the exact, you know, supervisory pieces of that. But I, I do believe that there's still some restrictions that have been going back and forth and, and having those discussions with the Nebraska Medical Association and other entities that I cannot speak on, because I was not part of those conversations.

QUICK: OK. And then, are there any-- there's-- are there's clinics for nurse midwives in Nebraska that would-- say they're associated with a doctor, but do they have a, a birthing center that-- just with nurse midwifes then, in Nebraska?

BLAKE SMITH: I'm personally not aware of any, but again, I can defer to my certified nurse midwife colleagues who are-- I'm, I'm sure may or may not come up and, and speak on their behalf, and would have that information for you.

QUICK: OK. All right. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. You're a nurse, right?

BLAKE SMITH: I am.

RIEPE: And you're opposed to this particular LB1234?

BLAKE SMITH: As it is presented today, yes.

RIEPE: Maybe I can share with you that I do have correspondence from the president of the Nebraska affiliation of American College of Nurse Midwives. And she says the certified nurse--

and I quote, certified nurse midwives do not support the legislation. They were-- we were not included in the draft of this legislation, and we especially do not support the amendment which allows for anyone of any sort of cultural practice or religious conviction to provide birth care. Can you respond to that? Why, why their own organization would take exception or be in opposition?

BLAKE SMITH: I can't speak on behalf of, of, of our colleague organization. They're speaking on their own behalf. But what I will say is we're here today to, to support our certified nurse midwives colleagues to be able to practice to the full extent of their licensure in Nebraska, and how it impacts this bill specifically.

RIEPE: OK. I just thought maybe nurse-to-nurse--

BLAKE SMITH: Yeah. We are aware that they're in opposition, and we do have conversations with them, but I do believe the best and appropriate individuals to speak on behalf of them would be themselves.

RIEPE: OK. I don't, I don't know whether there's anyone here to represent them.

BLAKE SMITH: Yeah.

RIEPE: I just thought nurse-to-nurse, I thought maybe it was an opportunity.

BLAKE SMITH: Yeah, I appreciate that. Yeah.

RIEPE: But you would know more about it than I.

BLAKE SMITH: Yeah, and I can follow up with them as well.

RIEPE: That's OK, I can as well.

BLAKE SMITH: OK.

RIEPE: So, thank you. Thank you, Chair.

HARDIN: Seeing no other questions. Thank you.

BLAKE SMITH: Perfect. Thank you, everyone.

HARDIN: Those in opposition, LB1234. Welcome.

TROY BRUNTZ: They didn't lie about how you set this up. OK. Do I wait for the light?

HARDIN: You are good to go.

TROY BRUNTZ: All right. Chairman Hardin, members of the Health and Human Services Committee, my name is Troy Bruntz, T-r-o-y B-r-u-n-t-z. I am the CEO of Community Hospital, a 25-bed independent critical-access hospital in McCook, Nebraska. We are equipped to care for more than 30,000 people who live in our referral area, and I'm here today to testify in opposition to LB1234 and AM2051. There are a number of factors that determine whether or not a rural hospital is able to support labor and delivery services. Most important is the number of deliveries annually, which provides the necessary provider experience and patient volume to do so safely. In McCook, we are fortunate to have two labor and delivery rooms, and staff with the expertise to handle routine deliveries and provide the best available care in the event of complication. In rural communities, FBCs are not a solution to maternal-- maternity care deserts, as they do not address the fundamental challenges of low numbers of births. Freestanding birth centers in rural communities will not see enough deliveries to develop the expertise required to meet the standard of care, nor will they see enough patient volume to be financially viable. For rural hospitals with an already fragile financial picture, FBCs will compete for scarce patients and workforce, destabilizing existing [INAUDIBLE]-- obstetric units and exacerbating the maternal care deserts in rural Nebraska. Additionally, I remain in staunch opposition to the licensure of professional midwives in this situation. The education and training of this category of professional midlife [SIC] is simply inadequate to provide the standard of care necessary in a complicated labor and delivery situation, especially in a desert. Every rural hospital that delivers babies has experienced the reality of routine delivery that turns into an emergency. Literally just happened a couple days ago. Adequate training and access to emergency care are essential when minutes can mean the difference between life and death for the baby and mother. When a labor and delivery attended by an inadequately-trained licensed professional midwife at a freestanding birth center encounters complications, rural hospital emergency departments bear the burden. Depending on the location of the FBC and the availability of transport, the closest ER for-- with

OB-trained staff could be hours away by ambulance. To note, transport crews are also not trained in OB. For hospitals that do have OB staff like McCook, and there-- that do not have OB staff like McCook, and they are plenty, this combination clearly presents an unacceptable safety risk for the baby and the mother. So, I encourage you to oppose LB1234 and AM2051, and I'm happy to answer any questions you may have.

HARDIN: Thank you. So, emergency staff is also not trained to be able to help out.

TROY BRUNTZ: No, usually not. I mean, like in Benkelman-- I'm in McCook; Benkelman's 60 miles away, Imperial's 60 miles away. They don't have a soul that has OB training. They, they don't have that.

HARDIN: You need to conduct a clinic. How do you guys have two, basically, places to have a baby?

TROY BRUNTZ: We only have one.

HARDIN: Oh, you only have one.

TROY BRUNTZ: We have we have two labor and delivery suites in our hospital.

HARDIN: Two labor and delivery suites in the same facility.

TROY BRUNTZ: Yeah, yeah.

HARDIN: OK, gotcha. All right. Very good. Senator Quick?

QUICK: Yeah, thank you Chairman. How many deliveries would you say that you have per year? Or do you know?

TROY BRUNTZ: Good question. We were doing 140 births a year, pretty much, for many years until about three years ago; it started to go down. Birth rates are low, less people are having children, less-- more people are having fewer children. And so, we're down to about 90 births ourselves, and that's with five physicians that are delivering babies. They're FPOBs, so you spread that out, and we're looking at less than 20 births per physician per year. It's-- if it gets too much lower than that, then you need to probably reduce the number of docs that are doing it, but eventually you get to the point like Grant did a

couple years ago where the-- it's just-- it's not smart. Common sense would tell you it's not smart to have, you know-- you-- you'll run out of doctors. You have one person on call forever, which doesn't work, or, or they're doing too few, too few cases, so.

QUICK: And then, do you have, like, any OBGYNs, or you have-- [INAUDIBLE] family practice doctors, or what do you have?

TROY BRUNTZ: Visiting. So, we talk about low-risk, by the way, that's no-- that's not no-risk, that is low-risk. Higher-risk pregnancies use-- we have a specialist out of North Platte that comes down each month, maybe a couple times a month. Pankratz comes in from-- Dr. Pankratz comes in from Hastings a couple times a month. And those high-risk pregnancies, even in our case, they see them, but when it comes time to deliver, they, they drive. They'll drive two hours to Hastings. A couple days, you know, they'll spend a week there, maybe, waiting to deliver. But generally, it's family practice docs that are OB-trained, is what we, we use.

QUICK: OK. All right. Thank you.

HARDIN: Thank you for being here.

TROY BRUNTZ: Yeah.

HARDIN: Driving all the way out.

TROY BRUNTZ: Yes, three and a half hours. But my daughter lives here, so we'll see her tonight.

HARDIN: Thanks.

TROY BRUNTZ: Thanks.

HARDIN: Opposition to LB1234. How many more do I have in opposition? Can I see some hands? OK, don't be shy. Crowd up to the front. Jump right up when you can. How are you?

ROBERT WERGIN: Good, good. Chair Hardin and members of the committee, I am Robert Wergin, R-o-b-e-r-t, Wergin, W-e-r-g-i-n. I'm a family physician and the current president of the Nebraska Medical Association. I am testifying today on behalf of the NMA in opposition to LB1234 and AM2051 because of the significant

patient risk that they create for Nebraska, Nebraska mothers and infants. The NMA is not opposed to freestanding birth centers, which can already operate under Nebraska law, but we are opposed to LB1234. LB1234 recognizes licensed professional midwives, also known as certified professional midwifes; the Legislature rejected this approach last year. CPMs have no formal medical training, and their standards fall far short of what is required to provide safe maternity care, especially in obstetrical emergencies. Introducing CPMs into a birth center model does not mitigate the underlying safety concerns. When complications arise, and they do, patients need care from clinicians such as APRN-certified nurse midwives who are well trained and who can identify these complications early, and arrange for a higher level of care, if needed. LB1234 lacks essential safety guardrails. The bill does not set defined exclusion criteria, such as prior cesarean delivery, multiple gestation, or fetal malpresentation, meaning these higher-risk deliveries would occur in settings unequipped to respond to complications. Equally troubling, LB1234 does not require freestanding birth centers to be located within a safe proximity to a hospital-- to a hospital that provides 24/7 labor and delivery services, surgical capability, blood banking, and neonatal care. In obstetrics, minutes matter. Delays in transport can mean the difference between recovery and tragedy. Conditions such as postpartum hemorrhage, shoulder dystocia, fetal distress in labor are not uncommon. Most of these scenarios occur in what was previously been a normal pregnancy or normal labor, and these complications become-- can become life-threatening emergencies in moments. A system that does not require timely access to emergency care places mothers and newborns at unnecessary risk. AM2051 compounds these risks. The amendment would expressly license certified professional midwives or licensed professional midwifes and grant them expansive independent authority, including management of high-risk pregnancies and home deliveries, with no meaningful oversight. This is the same unsafe proposal the Legislature regretted-- rejected in 2025 due to unacceptable safety concerns. Granting independent authority to individuals without medical training significantly increases the likelihood of delayed recognition of complications, delayed transfer, and preventable harm. The NMA and Nebraska's healthcare community continues to support expanding access to maternity care with APRN-certified nurse midwives. CNMs are highly-trained clinicians who practice within integrated medical systems and collaboratively closely with physicians and hospitals. That model protects patients while expanding access. As Nebraska already has 98 licensed CNMNs

[SIC] across the state, LB1234 and AM2051 do not provide the same safeguards. For the safety of Nebraska mother and infants, the NMA urges you to oppose LB1234 and AM2051. And I'll take questions.

HARDIN: You are from Seward.

ROBERT WERGIN: Yes.

HARDIN: So, you're kind of rural,--

ROBERT WERGIN: Yes.

HARDIN: --because you're kind of close here, too.

ROBERT WERGIN: Right.

HARDIN: Help me understand. How do we help cool down this desert? I ask you that about Seward just because, well, you kind of get what it's like to live where you can still see the stars at night. How, how in your opinion do we do this? How does, how does the NMA look at rural Nebraska, which sort of has a lot in common with North Korea, with satellites at night, across much of the area, like where I live?

ROBERT WERGIN: Yes.

HARDIN: But there's a lot of areas that aren't nearly as in good of shape as where I live, because we have a level-two trauma hospital where I am, in Scottsbluff.

ROBERT WERGIN: Yeah.

HARDIN: What do we do? How do we close this gap? It's just you and me talking over the fence, here. I'm curious. How, how do we do this?

ROBERT WERGIN: Well, in the Rural Transformation Act, part of the Big Beautiful Bill, we proposed OB crash cards, OB emergency care training for ERs at hospitals that don't do OB. It was very well accepted, and I think it'll be part of our bill. And also, predetermined transport. The other issues, even with Seward, is we do get emergencies that arise in the course of labor and delivery, and we do have to transport those people to Lincoln. And we also, in family medicine, have tried to identify high-

risk pregnancies before you get in those situations. I have a close relationship with Dr. Kenney and the maternal fetal program here in Lincoln, and, and sometimes refer them on early on. But we, we-- even with physician oversight we will transfer people, or have them consulted and deliver in, in a, a higher level of care, that's the key to having good maternal-fetal outcomes. Also--

HARDIN: So, your hope is the RHTP funds will be able to help bolster some of that.

ROBERT WERGIN: Yes. And, and we also were pushing for an increase in expansion of maternity. I was a former faculty at a family medicine residency, and we worked hard at training family physicians to go to rural areas and identify things early. And, and part of that proposal was to expand the rural workforce, particularly as it pertains to family medicine and, and-- along with this transport system as well. And even in operative obstetrics, I, I have to do operative obstetrics because of the emergency situations that arise. There isn't even time for me to transport those individuals. So, it, it is a problem. Southern Georgia, you look at them, they-- they are-- have-- many states have these rural OB deserts, and--

HARDIN: Right.

ROBERT WERGIN: --there won't be easy answers. But we, we want to work forward with HHS to solve this issue.

HARDIN: OK. Senator Riepe.

RIEPE: Thank you, Chairman. And welcome. Good to see you again. Have you ever delivered a baby?

ROBERT WERGIN: Yes, I've delivered about 1,000 babies in my lifetime. I delivered someone I delivered. That's continuity of care.

RIEPE: Both of them, I'm sure, quite young.

ROBERT WERGIN: They both--

RIEPE: Did you run into emergencies in those thousands that surprised you as they went along?

ROBERT WERGIN: Multiple times over-- I hope my face doesn't show it. Multiple times. Things can turn rapidly emergent and require quick action. One example, I had a person develop HELLP syndrome, low platelets, hypertension, kind of a preeclampsia, headed towards eclampsia, and identified it early enough to get her down to-- and she had a very complicated course, but we had a good outcome. So, over my lifetime, fortunately, it's not all that frequent, but it, it does occur. And we-- that's the-- even for family medicines for physicians, in my situation, or, or malpresentation, breech deliveries, which have a four-time increase of mortality, even in multiparous patients, we-- they come in, and as you said, they can turn, and suddenly a person whose vertex is suddenly breech when they show up in labor, and so we proceed to operative delivery with them.

RIEPE: OK. Thank you. Good to see you again.

ROBERT WERGIN: Good seeing you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. So, you know, when you're, like, diag-- you know, you have your patients come in for prenatal care,--

ROBERT WERGIN: Yes.

QUICK: --and you have a lot of resources that you're, that you're-- that, you know, like, you have that right at hand. I'm just curious if-- and, and I guess I should ask them that, but what kind-- I don't know what they would have to diagnose, like, someone who's going to have-- maybe, maybe it's going to be a low-risk birth, maybe there's going to be some, some complication. I know my wife, being a labor and delivery nurse,--

ROBERT WERGIN: Yes.

QUICK: --she talked a lot about, you know, the fetal growth, you know, and making sure the baby's growing as it's growing. I don't know if professional midwives would have that kind of resources, or--

ROBERT WERGIN: I, I, I think certified nurse midwives understand ultrasound, particularly as it relates to fetal presentation.

Having trained family docs, we-- part of our training was to train them in OB ultrasound, fetal growth. And, and, and slow fetal grow is an indication to get help for those, because they'll be small for gestational age babies, which can have adverse outcomes. And, and perhaps early intervention, to try to minimize risk factors related to that. But yeah, the-- as a physician in family medicine, we train our, our residents to do obstetrical ultrasound, and understand if you do it, even if you have someone else do it, you understand the connotation of intrauterine fetal growth.

QUICK: OK. And just-- my wife was a labor and delivery nurse for 44 years, so she had the --

ROBERT WERGIN: She's--

QUICK: --opportunity to be, you know-- had helped with the delivery of a, of a, of a baby, and that-- she eventually had her own baby, and my wife got to be part of that process as well, so.

ROBERT WERGIN: She, she obviously saw many things turn bad quickly, and one of the other challenges in rural areas is workforce, getting competent labor in delivery. And the other issue, being a non-urban hospital, is low-volume, high-cost care is not a good business formula, so it's hard to train people who do labor and delivery, who work in the ER. Our nurses have to work-- they just don't work in labor delivery, so. But we work hard at maintaining that, and then, they have ongoing continuing training, as your wife probably did.

QUICK: Yeah, yeah. And then also, like in the hospital setting, you had the, the nurse, the labor and delivery nurse, but then you also had a, a nurse for the baby itself as well, so.

ROBERT WERGIN: Yes. Yes. We worked as a team, and that's a critical point of, of rural health care, and-- because after you have the baby, now all of a sudden, I have two lives to take care of, and--

QUICK: Yeah, yeah. All right. All right. Thank you.

HARDIN: Not seeing any other questions. Thank you.

ROBERT WERGIN: Thank you.

HARDIN: Opposition, LB1234. Welcome.

AMY PINKALL: Thank you, Chair Hardin, and committee. My name is Amy Pinkall, A-m-y P-i-n-k-a-l-l. I'm a physician testifying in opposition on behalf of the Nebraska chapter of the American Academy of Pediatrics. I'm a physician board-certified in pediatrics and pediatric hospital medicine, and I provide medical care for newborns. So, freestanding birth centers are already permitted to operate in Nebraska under existing health care facility licensure laws, and several have done so within the current regulatory framework. This bill would provide an additional licensure structure for freestanding birth centers that would include care by certified professional midwives. There are opportunities for policy to support the viability of freestanding birth centers, however, this bill does not fill that gap; it actually creates additional licensure structure that lowers the standards of cares and increases the risk. And, as we've heard, rural areas are particularly at risk with this bill. This bill would recognize certified professional midwives under the title "licensed midwives." And in 2025, the Legislature already rejected the approach of CPMs. CPMs do not have the adequate medical education, training, or clinical experience to allow them to provide safe care for newborn babies. Nebraska law recognizes advanced practice registered nurse certified nurse midwives, CNMs, who have completed graduate-level education and extensive clinical training. Placing CPMs at birth centers under nominal CNM supervision does not address the fundamental gaps in training, education, and clinical judgment that pose risks to babies and their mothers. The American Academy of Pediatrics' policy dictates two care providers should be present at each delivery; at least one should have the primary responsibility for the newborn and appropriate training skills and equipment to perform full resuscitation of the infant, according to the neonatal resuscitating program. Approximately 10 percent of deliveries of full-term infants require some level of resuscitation. Having trained skilled providers that are able to assess the infant and intervene immediately when necessary is of the utmost importance. This bill does not ensure the CPM would have the necessary skillset to resuscitate a newborn. The AAP guidelines also recommend the observation of newborns in a facility for 48 hours following a vaginal delivery. They do allow for earlier discharge after 24 hours, if appropriate clinical situation applies. But this bill does not provide for that safety net, with babies often discharging from freestanding birth centers after periods of six hours. Additionally, this early discharge

could negatively impact state-mandated newborn blood spot screening, which must be done after 24 hours of age. Other important newborn screening, including that for congenital heart defects, could also be negatively impacted. Our newborn infants and their mothers deserve safe, well-trained care. Please ensure the smallest of our Nebraskans get the safe care they deserve. Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chairman Hardin. Welcome.

AMY PINKALL: Thank you.

G. MEYER: I'm glad you came today. Should only OBGYNs and doctors that specialize in pediatrics or, or obstetrics, should they be the only ones that deliver babies?

AMY PINKALL: No.

G. MEYER: Do most general practitioners, they come out of med school, they do their residency, so they got five years training. How many babies do they generally have an opportunity to, to deliver? One? Ten? Two?

AMY PINKALL: Well, like you were talking about, it-- family medicine training, which I am not an expert at because I'm a pediatrician, but, you know, there are family medicine programs that do OB training so they can be prepared, and there are programs that actually don't do that and don't prepare those, those providers to go out into areas like that.

G. MEYER: We've had testimony in the past that's-- many doctors deliver one baby in training and then probably never see another baby.

AMY PINKALL: Mm-hmm. And those aren't the people you want delivering your baby?

Wouldn't, wouldn't, wouldn't you be better off with a trained certified professional midwife delivering a baby, rather than a doctor that doesn't really know what he's doing?

AMY PINKALL: Well, you-- a certified nurse midwife that's an advanced practice registered nurse that does have the training and the experience to deliver a baby, yes.

G. MEYER: [INAUDIBLE] many cases--

AMY PINKALL: Which is different than the CPM.

G. MEYER: In other states, in many cases, it's the certified professional midwives teaching the certified nurse midwives. That's been testimony in the past, and no one's refuted that, so.

AMY PINKALL: Well, I don't have any knowledge of that, so I can't--

G. MEYER: Evidently, they're qualified to deliver babies also.

AMY PINKALL: I can't support or deny that.

G. MEYER: OK. Thank you.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you. Do you ever experience any confusion from the consuming public between the registered nurse-- registered certified nurse, which is a CPNM, and a CPM?

AMY PINKALL: Yes.

RIEPE: I would think so.

AMY PINKALL: Yeah. I think this-- that's part of the problem here, is it's really confusing wording for people. And in this bill, you know, it's talking about licensed midwives, but certified professional midwives are currently not licensed midwifes in Nebraska, but they would largely be the ones providing the care to patients in, in this version of the freestanding birth center. And the-- they're not the more highly-trained advanced practice registered nurse certified nurse midwives, CNMs, who do have that experience and training.

RIEPE: I think there's a risk in the untrained eye here, about--

AMY PINKALL: Very much so. Very much so.

RIEPE: OK. Thank you for clarifying that. Thank you. Thank you, Chairman.

HARDIN: Seeing no other questions. Thank you.

AMY PINKALL: Yep. Thank you.

HARDIN: Opposition, LB1234. Welcome.

MARGARET WOEPPEL: Thank you. Good afternoon, the members of the Health and Human Services Committee. My name is Margaret Woeppel, M-a-r-g-a-r-e-t W-o-e-p-p-e-l. I am the Chief Nursing and Informatics Officer at the Nebraska Hospital Association. I am here to testify in opposition of LB1234 on behalf of the NHA. Nebraska hospitals are deeply committed to ensuring mothers and infants receive safe, high-quality care. As a nurse who spent decades in the emergency room witnessing the worst unimaginable outcomes, and now working in quality, hospital quality, my goal is to ensure mothers and babies receive safe, high- quality care. Hospitals are working hard to improve maternal health outcomes, so much so that we tied our state-directed payment program quality metrics to maternal care. Another way we do this is by offering extensive training for existing staff, including hospitals who don't regularly deliver babies. Nebraska hospitals are committed to expanding access to patient-centered childbirth options, including recruitment and retention of rural obstetric physicians. LB1234, in its current form, presents concerns with the proposed licensure and regulatory framework for certified professional midwives. Our concerns are centered on patient safety, consistency in clinical standards, and the need for strong integration across Nebraska's healthcare delivery system. Obstetric emergencies happen unexpectedly, and are heartbreaking. Hospitals are required to operate in a manner in which they can safely and immediately treat emergencies. Hospitals are required to have surgical capacity, anesthesia, blood products, neonatal resuscitation supplies. These rules are in place to ensure moms and babies receive the highest quality of care, especially in unexpected emergencies. Nebraska hospitals routinely receive patients transferred from out-of-hospital settings when complications arise. LB1234 lacks sufficient detail regarding mandatory collaboration agreements, real-time communication requirements, and standardized transfer protocols. Strong integration between birth centers and hospitals is essential to protect outcomes. Hospitals participate in robust quality improvement initiatives and

transparent reporting systems designed to improve outcomes statewide. Any expansion of freestanding birth centers should include clear requirements for standard data reporting, participation in statewide maternal quality initiatives, and accountability measures that ensure consistent policies across all birth settings, setting. I'm happy to take any questions.

HARDIN: Thank you. Questions? Seeing none, thank you. Opposition, LB1234. Welcome.

JENI JACOBITZ: Thank you. Chairman Hardin and members of the committee, thank you for the opportunity to speak. My name is Jeni Jacobitz, J-e-n-i J-a-c-o-b-i-t-z. I'm a rural and central Nebraska nurse midwife student graduating in May, kind of focused on the status in Nebraska. I focused my capstone work that we're still working on, on comparing outcomes of out-of-hospital and hospital births for low-risk women under the lens of integration. So, meaning, how does a state like Nebraska compare to one who has embraced integration? We use the midwifery integration scoring system, which evaluates the scope of practice, autonomy, governance, prescriptive authorities, regulatory barriers. For our study, a score above 50 indicated an integrated system; Nebraska scores 23. Our research showed-- we looked through 3,700 articles within the last five years, and found 22 that met our criteria across-- and in the results across all integration settings, out-of-hospital birth shows greater autonomy, less mistreatment, stronger relationships with providers, longer visits, and more partner involvement. The difference, when you compare to an integrated versus unintegrated, is the integrated system shows respect. Integrated systems consistently show better outcomes, fewer interventions than hospital deliveries, more intact perineums, lower postpartum hemorrhage, fewer neonatal resuscitations, and more normal birth weights. The one exception that showed negative outcomes was coming from an unintegrated system which was coming out of Hawaii, but they did show higher rates of hypoxic ischemic encephalopathy, lower Apgar scores, more neonatal seizures, higher neonatal mortality. This data was pulled at a time when Hawaii's score was still two points higher than what Nebraska sits at. So, a lot of this data shows the safety of out-of-hospital birth, but the, the problem is that I feel like Nebraska and Hawaii compare quite a bit, and that our out-of-hospital births are happening not by-- in the same way, that it's not with the same training or, like, they did not have CPMs or CMs certified, and then their-- they didn't have a lot of

regulation for the rest of deliveries. I do believe Nebraska needs to move in the direction of licensing CPMs as well as expanding the practice of CNMs, I just-- on the original bill, I felt neutral, but with the amendments that threw in that nurse midwives were not allowed to attend home deliveries and some of the other pieces of that puzzle gave me the feeling that this wanted to create its own island so that it could practice separate from medicine, and give it all of the tools within that toolbox. And I can close.

HARDIN: Thank you.

JENI JACOBITZ: Yeah.

HARDIN: Senator Quick.

QUICK: Yeah, yeah. Thank you, Chairman. Can I ask about-- so you had to practice so long as a nurse, right? Before you could go to nurse midwifery school, right?

JENI JACOBITZ: There's no big requirement, maybe a year, but I did practice 17 years labor and delivery in Hastings, at the hospital.

QUICK: OK. That was at Mary Lanning then?

JENI JACOBITZ: Yep, Mary Lanning.

QUICK: OK. And so then-- and maybe you mentioned where you're going to school right now--

JENI JACOBITZ: I didn't mention, but Bethel University, which is online in Minnesota.

QUICK: OK, OK. Because I know when my wife looked into that-- and this has been, I don't know, it's been-- it was a long time ago when she looked to be-- she wanted to be a nurse midwife. She was either going to have to go to Kentucky or go to Colorado to receive her training.

JENI JACOBITZ: Yeah.

QUICK: And she'd probably at that time been already a labor and delivery nurse for over 20 years at that time, so.

JENI JACOBITZ: Yeah.

QUICK: OK. All right. Thank you.

HARDIN: Seeing no other questions, thank you.

JENI JACOBITZ: Thank you.

HARDIN: Opposition, LB1234. Welcome.

HEATHER SWANSON: Hi. Chairperson Hardin and committee members, my name is Heather Swanson, H-e-a-t-h-e-r S-w-a-n-s-o-n. I'm here to testify on my own behalf in opposition to this bill. For the past 23 years, I've been involved with multiple efforts to remove CNM practice restrictions and to license CPMs. This is my-- the first time my testimony has been in opposition. I'm clearly not skilled enough at legislative strategy since we've had-- since we have very outdated CNM statutes, but including the different types of midwives, doulas, a bona fide church denominations, and one amendment to a birth center bill, I think is too much. I've been a CNM for nearly 24 years, practicing in clinics and hospitals, as well as in Texas, where I was the director and lead midwife at a birth-center practice that also did home births. My most recent CNM position was at Rosebud, South Dakota at the IHS facility, where the OR and OB unit were closed. Any deliveries occurring there were in the ER, if unable to get women transferred. I'm not opposed to birth centers, home births, or pregnant women living in rural locations and choosing to stay in their communities to deliver, if risks are assessed appropriately and they have the right provider. What I'm opposed to is pretending that the introduction of LB1234 was needed and that Nebraska doesn't already have a mechanism to license birth centers. I draw your attention to the written testimony submitted by Elizabeth Mollard on behalf of the Nebraska ACNM and Heather Ramsey. They both worked in birth centers in Nebraska that have closed. My first CNM job was in Norfolk, where I watched a physician and CNM build a birth center, ready it for opening, and then have to sell the building because they were unable to get it open due to local professional pressures. I don't think this bill fixes the barriers we currently have. Yes, the amendment introduced yesterday removes the required collaborative agreement and physician supervision for CNM practice, which is a step forward for CNMs. But it does not address our inability to be included in the excess liability fund unless we're employed by a physician. I love birth centers,

and my work at one was thus far the pinnacle of my career. But after watching these three birth center buildings be repurposed, I have little interest in starting one. My other reasons for opposition are related to the amendments, and my concerns about what's currently going on with some planned home births in Nebraska. I've heard about too many poorly-managed care situations by people calling themselves midwives without formal midwifery training that meets ICM and U.S. MERA standards, or who are simply doulas. The subsequent bad outcomes, in my opinion, are inexcusable, and misrepresent the quality of care that can be provided by out-of-hospital-- that can provided out-of-hospital by CNMs and CPMs. It leaves in the restriction on CNM-attended home birth, while allowing just about anyone else to, to attend them. Those not requiring licensure include those with cultural or indigenous traditions in accordance with the tenets of practices or a bona fide church or religious denomination, or sincerely-held belief practices or observance. Nebraska ACNM asked for that provision to be removed, and instead it was left in and the line prohibiting CNM-attended homework was unstruck. Seems like anyone now, and with this amendment, can be a primary birth attendant, but since I'm a nurse midwife, it's still a felony for me. I also very much like doulas, but they can already work here. In some states, doulas are getting paid more from Medicaid for attending a birth and a birth provider. There's more I'd like to say, but I think LB1234 isn't needed, and the two midwifery professions and doula bill-- bills should be considered individually. CPMs have LB374 in committee, and LB676 on Select File would grant CNMs full practice authority. Thank you.

HARDIN: Thank you. Questions? Seeing none. Thank you.

HEATHER SWANSON: Alright. I had notes for responses to things, but alright. Thank you.

HARDIN: Thanks. Opposition, LB1234.

KORBY GILBERTSON: Good afternoon, Chairman Hardin, members of the committee. My name is Korby Gilbertson, it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n, appearing today on behalf of the Nebraska section of the American College of Obstetricians and Gynecologists, otherwise known as ACOG. We want to begin by expressing our appreciation for the intent of LB1234; establishing licensure and requiring accreditation for freestanding birth centers is a meaningful step towards ensuring

that all Nebraska families receive high-quality, safe maternity care. However, while we recognize the goal, we have significant concerns with the bill as currently drafted. Our opposition is grounded in evidence-based guidance that emphasizes the safety of pregnant patients across all birth settings. One of our primary concerns is that the bill does not include mandatory written and mutually agreed-upon transfer protocols between birth senators-- birth centers, hospitals, and emergency medical services. Safe and timely transfer is essential, as 10 to 25 percent of planned out-of-hospital births involve interpartum or postpartum transfer. Additionally, the bill delegates the creation of risk-screening criteria to each individual center. ACOG has consistently emphasized that safe out-of-hospital birth requires clear and uniform standards for determining which patients are appropriate candidates. For example, ACOG has identified fetal malpresentation, multiple gestation, and prior cesarean delivery as an absolute contraindication to birth outside a hospital. Without clear statutory guidelines, Nebraska risks inconsistent practices that may expose patients and infants to avoidable harm. We are also concerned with AM2051, which would permit licensed professional midwives to manage pregnancy and labor without limits on conditions they may attend. The absence of exclusions for conditions ACOG identifies as absolute contraindications creates a framework in which licensed professional midwives could legally provide care in situations that are unsafe. ACOG continues to support licensure frameworks for certified professional midwifes that promote accountability, transparency, and patient safety. Finally, the bill's approach to data reporting and quality improvement does not go far enough. ACOG recommends robust system-wide quality review, including transfer case evaluation, standardized metrics, and participation in statewide maternal health quality collaborations. For these reasons, ACOG cannot support LB1234 in its, in its current form, however, we are committed to working with Senator Hansen and Senator Spivey on the legislation. Thank you for your attention. I'd be happy to take any questions.

HARDIN: Thank you. Any questions? Seeing none. Thanks.

KORBY GILBERTSON: Thank you.

HARDIN: LB1234, those in opposition. Those in the neutral. Those who are named Senator Hansen.

HANSEN: That's me.

HARDIN: Online, we did have 123 proponents, 23 opponents, 8 in the neutral.

HANSEN: All right. Thank you, Chair. I appreciate everyone testifying. Actually, this, this helps us wrap our heads around this, and then maybe get some ideas about how we can move this forward. I do have to give Dr. Tesmer a hard time, again, because the three states that he previously "pracked" in-- practiced in all have freestanding birth centers in their states. Kentucky, though, it's not illegal, but they actually just introduced legislation, I think, a year or two years ago, to change that [INAUDIBLE] make them more-- make them more available, I guess. Senator Fredrickson, I know you had a couple of questions about-- and I think it was a good question. I could tell you were contemplating on how to ask it. But what's limiting our ability to-- why, why don't we have these freestanding birth centers? I think-- and it kind of goes back a little bit to my opening, which is mainly because of that collaborative agreement. They're-- they can't get anyone to sign off on a, a medical doctor. And staffing issues, as well, so-- which is what we're trying to hope-- kind of fix with this bill. The CEO of the community hospitals-- sorry, I forgot his name, but he mentioned that he has a concern that there may not be enough patients for this, and that's fine. If there's not, they won't open. It's a market-driven, you know, business, just like a hospital is, just like anything else is. And so, if there's no enough patients there, they won't be open, and then we won't have any. And he also had a concern about some of the safety risk that-- you know, I would address-- first of all, the safety risks was kind of addressed by our-- brought up by a few people here, and I just wanted to mention here real quick that the-- I've got to get this on the right spot. Sorry. Should have had this ready. So, mainly, the reason why standing-- freestanding birth centers have typically a lower risk of incidence and actually are more safe to have a child in is typically because they're dealing with low-risk pregnancies. And so, in the bill, and according to the regulations that they have to follow, if there is-- starts to become a high-risk pregnancy, they, they need to refer them out, and which they should, and which is what we heard from a previous testifier. And actually, according to some statistics here, they do have-- birth centers are generally associated with better maternal outcomes, significantly lower C-section rates, fewer interventions, higher rates of spontaneous vaginal birth, breastfeeding initiation, and patient satisfaction, lower pre-term birth, and low birth weight. So, this idea that we're making people more unsafe by having

freestanding birth centers is not true. 40 other states have these. And I'm assuming if they had higher risk, they would be closing down, but they continue, and actually, they're growing. So, I think we just have to-- that whole notion, because I've heard that multiple times from multiple people about the idea that this is just unsafe, and we're making people really unsafe, and that's just-- the statistics just do not bear that out at all. I understand maybe they have a personal concern with it, which is fine. Dr. Wergin with the NMA, again, brought up the idea that it's unsafe, and he did bring up a, a good point that they're trying-- with the Rural Transformation Act, that they're trying to actually encourage more training with-- for EMS and "obstetristics," or, you know, how to handle an emergency situation with a birth. And that ties in very well with what we're trying accomplish here, because that was a concern that they mentioned, is, like, what happens if there is an issue, an emergency? And they're trying to address it on their, their end, when somebody has to come maybe transfer somebody, in the very rare instance that there is. The NHA, I think, made some good points; they want some mandatory reporting, and I think there's some things we can kind of work on. You know, I'm not terribly opposed to that. Consistent regulation, I think I heard that from a couple people. And that's the whole idea that they-- of the regulation that they'll follow from the American-- the, the, the birth center association that all the other birth centers follow in the country. So, that provides that consistent regulation among birth centers. Ms. Jacobitz and Swanson, they both sounded like proponents for my bill, but they had, they had a concern about the CNM home birth part. I think one of my goals with this bill was to not touch home birth. I didn't want to expand it, I didn't want to contract it, I didn't want to, you know, I didn't want to add any amendments to that that has to do anything with home birth. But I know it's a concern with them, that they would like to see that part stricken. And I'm not opposed to working with them on that, for CNMs. And so, I'd be willing to talk with them about this. I just got to see what the, what the appetite is among the body and the committee here, too, to move something forward with that. So, that's something I would have to work with them, and then also the, the committee on. And she also said there was an issue with the liability fund, that they want to be included in the liability funds, Ms. Swanson did, and that was probably one of the biggest issues that the NMA had, and the hospital association, was including CNMs on the liability fund. So, in the essence of kind of, not everybody's going to get what they want kind of thing, I-- that was the one thing I couldn't include in here. And also, striking

the, the part about indigenous and religious birth policy-- I'm not going to be the person up here to tell the Amish how to birth their children, or religious groups. And so, I was kind of staying away from that. And ACOG again, I, I, I appreciate them coming to the table and, and willing to work with us here, too, and some of the stuff they even mentioned either A, is in the amendment, or B, I'm, I'm willing to work with them on and see what we can put in the bill. Something that had to do with data reporting and transfer protocols as well. So, I want to bring up Dr. Tesmer and his testimony, and I appreciate him for coming and, and sharing his opinion and some of his concerns. And actually, a lot of the stuff that he mentioned, I, I was, I was chomping at the bit in my seat. Like, I wanted to get up and, and say something there, but pretty much everything that he had mentioned that he would like to see in this bill is included in the amendment. And I understand it was only introduced a day-and-a-half ago, but they, they were concerned about safe and proper transfer; the amendment fixes that. Health care facility act, under the amendment, they are included under the health care facility act, which is a big one I know some people are concerned about, requiring, then, the department to have regulation. Requiring licensure when the birth center is accredited, that is something we can fix, and is, I think, part of the health care licensure act. So, a lot of the stuff that he did mention-- you know what I mean? And that's something we kind of communicate on further, after maybe they read it, and, and then see if there's anything else they would like to be included, so. Let's not forget also that the patient has the ability to only be seen by a CNM in a birth center. If there's CNMs and CPMs working there, the patient can go there and say "I only want the CNM seeing me. I only want them taking care of me. I only want them delivering my child." They can still do that. They don't have to be seen by a CPM. We're just giving the CNMs the ability to hire them. And again, this bill is definitely not something new to the country, it's just new to Nebraska. And I know we sometimes have a difficult time with introducing something new in Nebraska, but just to give some people some relief that this is pretty popular around the whole country. And I think somebody brought up the idea that this seems like a, a good middle-of-the-road option, and I think that was a pretty good way of saying it. We're not talking about home birth; we got home birth on this end, and we have only-hospitals on this end. I feel like this is a good way that we can compromise and come to an agreement, and say, hey, look, we're having a well-regulated facility with all of the-- I was going to touch, touch on something Senator Quick said-- all of the facilities there,

all the equipment there to maintain and take care of gals who are having babies, and also to address if there's some emergency concerns in there as well. This seems like a good middle of the road, and I think we really do need something to help the healthcare deserts, maternity deserts in this count-- in this state. And I'm assuming a lot of these facilities will have liability insurance; I can't imagine opening one without one, but-- I think that was mainly all it was. Yep. I think. Yep, that's all I had, so. Thank you.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Hansen, for being here. So, I just want to make sure [INAUDIBLE]. So, so you-- I think you said in your close that this is sort of like that middle ground, like, it's not home births, it's sort of not hospitals, it's kind of like that between area, the freestanding birth center. Am, am I reading the amendment incorrectly? I, I believe your amendment allows CPMs to do home delivery. Is that correct?

HARDIN: No, I didn't touch on that at all. It shouldn't be in there.

FREDRICKSON: OK. We might be reading it a little bit differently, but we can follow up on that afterwards.

HANSEN: Yes.

FREDRICKSON: OK. Yep. Thank you.

HANSEN: And to, to try-- if I can, to touch on some-- Senator Quick, he had a couple of questions about fees. If they're under the Health Care Licensure Act, fees are included as part of-- that's part of the Act. Licensure activities under the Health Care Facility Licensure Act shall be funded by licensing fees, so it'll be a fee structure included with that. And then, I know you had a concern about, are these facilities able to take care of an, like, an emergency situation? And that's included in the American Association of Birth Center Standards that we included, talking about the facilities and all the stuff that has to be in there. Oxygen, provide care during birth, including repair of lacerations, oxygen, all that kind of stuff. Screening. That's all laid out in the regulations that they would have to follow. Sorry.

HARDIN: Well, I just AI'd you, and you're right, no one, no one of those 40 states-- this actually says 41-- have retracted any of their legislation or posture on that, and it only seems to be growing.

HANSEN: Yep. And like I said, the March of Dimes that we had the interim study on talked, talked in length about the safety of these birth centers.

HARDIN: OK. Is data reporting system reporting included in the amendment? Do you know?

HANSEN: I don't know if we have mandatory reporting. It might be recommended reporting, but that's something, like I said, we can look at.

HARDIN: OK.

HANSEN: Definitely.

HARDIN: How about transfer protocols from-- let's say something does go unfortunately, and we go from the birth center-- transfer protocols back to the hospital.

HANSEN: Yep. I believe that's right here in the regulations from the American Association of Birth Centers. They're, they're going to have a lot of that.

HARDIN: OK.

HANSEN: And it includes some of the informed consent stuff, too.

HARDIN: OK. Do you have any sense why the CNMs don't support? Is it just because of the other baggage we've already talked about?

HANSEN: It was some of the stuff that I mentioned. It was maybe the liability fund part--

HARDIN: OK.

HANSEN: --and then also, the-- they would-- I think would like to see the part struck about CNM home birth. They would like to-- you know, we'd just have that out of statute.

HARDIN: I see. OK. Any other questions? Seeing none. Thank you.

HANSEN: Thank you.

HARDIN: This concludes LB1234. We will be moving on to LB1211 and Senator Riepe.

RIEPE: Sir, a quick piece of information. "1234" is the license plate of Donald Duck.

HARDIN: Of Donald Duck?

RIEPE: Yes. I thought that was important information to share.

HARDIN: And how long has Mr. Duck had this license plate?

RIEPE: Quite a long time.

HARDIN: A long time? It pays to know people, doesn't it?

RIEPE: And he's never placed any, any-- he hasn't updated his monthly or annual ticket on it either, hasn't been paying taxes on it.

HARDIN: Wow.

RIEPE: Yeah. Nobody's going to be turning him in, but--

HARDIN: Good to know.

RIEPE: These Donalds can get away with stuff, you know.

HARDIN: You have to be a Donald. I think all of the moving about is done, Senator Riepe, so we are ready when you are ready.

RIEPE: Thank you, Chairman Hardin, and members of the committee. For the record, my name is Merv Riepe, it's M-e-r-v R-i-e-p-e, and I appear for-- appear before you today to introduce LB1211 and to speak to the white copy amendment, AM1988, which is a pharmaceutical bill and a structural change, and doesn't impact the substance of the underlying bill. Both LB1212 and AM1988 were written with assistance from the Nebraska Pharmacists Association. LB1212 updates the Automated Medication Systems Act to expressly authorize and regulate the use of automated pickup kiosks by Nebraska pharmacies with the goal of improving patient access to routine prescription medications while preserving pharmacists' oversight, safety, and accountability. To paint a,

a clearer picture, imagine this. You have medications you need to pick up; the pharmacy closes at 6:00 p.m., but your work-- you work until 8:00 p.m. How do you pick up your prescription without slipping out of work early? Or, you have a prescription at a pharmacy 60 miles or minutes away, and you may not be able to get there until the weekend. Mail order medicines help in some cases, but many Nebraskans still prefer to pick up their prescriptions to maintain a relationship with the pharmacist, and they pick those prescriptions up in person. And, the grocery and retail pharmacies hosting these kiosks will appreciate the foot traffic. Automated pick-up kiosks give pharmacists and pharmacies a secure, regulated way to bridge that gap by allowing patients to retrieve prescriptions after hours while keeping a Nebraska-licensed pharmacist and pharmacists responsible for the medication and the patient relationship. In other states, where similar systems are already in use, the process includes robust safeguards. The system verifies a patient's identity, counseling is offered and can be provided in real time by telephone or other remote means, and all transactions occur under pharmacist supervision. The technology to do this already exists; it is simply not permitted under Nebraska law. Under LB1211, LB1211, with the amendment, an automated pickup kiosk is a secure device operated by a licensed pharmacist that releases prescription medications other than controlled substances to a patient or caregiver, and it may only be located on property owned or leased by that pharmacy, either inside the building or attached to its exterior. So, this is a-- is not a freestanding vending machine out in the community. The best way to conceptualize this, I found, is that it's similar to those of you who can remember the, the RedBox movie rental system or the Amazon pickup kiosk you might find in your community. A bill also clarifies that kiosks are distinct from the automated systems used inside hospitals and long-term care facilities, such as the machines nurses use to pull medications for administration, which remain governed by existing law. LB1211 as amended requires any hospital, long-term care facility, or pharmacy that uses an automated medication system or automated pick-up kiosk to maintain written policies and procedures developed with the pharmacist responsible for the pharmacist-- pharmacistic care, addressing how the device is used, which is responsible for how its medications are loaded, verified, and released, and how security, confidentiality, and quality assurance are maintained. The amendment also creates a specific licensure framework. The pharmacist is charged-- in charge must obtain a separate license for each kiosk location from the Division of Public Health, pays a modest fee not to

exceed $50, and allows inspection before and during operation. To protect patients, the pharmacist-in-charge may designate a pharmacist responsible for kiosk oversight, ensuring compliance with existing storage, record-keeping, and labeling laws, and require pharmacist verification and review of each prescription before it is loaded or released, with pharmacist care offered to the patient or the caregiver. The bill requires any outdoor, outdoor kiosks meet environmental and physical security standards, and, importantly, prohibits kiosk from storing or dispensing controlled substances. We need-- we did hear concerns about whether the criminal activity affecting outdoor kiosks. I share those concerns, but also trust that innovators will secure or figure out how to do this securely. So, the bill allows the Board of Pharmacy to decide when an outdoor kiosk is sufficiently secure and temperature-regulated, rather than locking us into a statutory ban on blanket permission. We have also been contacted by the hospital association, which has expressed interest in future language to clarify that controlled substances do not contain within similar systems or when they are operated within the confines of a medical facility. For example, a hospital lobby. Their goal is to better facilitate the dispensing of discharge medications when a patient leaves the hospital, and I believe the security infrastructure at these facilities is conducive to successfully dispensing these medications without undue concern over theft or damage. I think this could be a relatively quick tweet, and I would ask the committee to consider that concept as we move forward. For the average commercial pharmacy, we think it is best to preclude controlled substances, and inside a hospital where security is robust, and I believe such a system would be appropriate. I believe an individual with the pharmacist association much more familiar with the specifics of these systems will be testifying after me. I would like to say, too, this was originated with the idea that we would be able to maybe support some of the smaller pharmacies in rural communities that are, are-- some are no longer being able to sustain and to meet the needs of the patients that they serve because of access and hours that they have to keep, and the distance that patients may have to travel to get to that pharmacy. We saw this as a viable alternative. With that, I yield my time, and I will do my best to answer questions.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Riepe. This is certainly-- seems like an innovative idea. I, I was kind of just looking these machines up and looking at them. Do, do you know how much these things typically cost? Or what the-- that might be a question for behind you as well. OK, someone behind you raised--

RIEPE: No, I do not know.

FREDRICKSON: OK.

RIEPE: And, and quite frankly, I don't know-- you know, when I think about it, I think about, like, mailboxes.

FREDRICKSON: Yeah.

RIEPE: I don't think of RedBoxes because they're tin. I like something that looks like a U.S. Postal box, it looks like it's made of steel. And maybe it's because it's gray like a Navy ship, it looks secure.

FREDRICKSON: I guess my other que--

RIEPE: But I don't know the price.

FREDRICKSON: OK. And my other question is that-- I'm assuming that these would be paid for by, like, the pharmacy. Like, they, they-- it's not like a state would be supplementing the cost of these. It would be a--

RIEPE: Yeah, absolute-- and it's totally voluntary.

FREDRICKSON: Yep. Yep.

RIEPE: If it doesn't work for a business, don't do it.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. And you may not be able to answer this question. Maybe I'll have to ask someone behind you. But would you have to, like, request that, but ahead of time? Like, right now, I can get mine filled by-- with my app. We go through a Hy-Vee pharmacy, so they'll tell me when my

prescription is ready, but would I have to request that that be put in the kiosk, then? Is that how that would work?

RIEPE: Well, I, I-- my assume is-- assumption would be, is that you would say, you know, what time do you close? Say we close at 5. And I think I-- I, I think can get there at 5, but it might be 5:30, or you have car trouble. And so, you could-- they could say, well, why don't we play it safe, and we'll put it in it and give you the code. And you can-- when you get there, you punch the code, take out your prescription, and go home.

QUICK: And I can ask you too, but I'll probably ask them, but, you know, I know sometimes when we go to pay for it, they'll check whether it's-- we use GoodRx or whether we use our, you know, Part D or whatever. But maybe that's a question for them too, but--

RIEPE: Well, it would depend upon your insurance plan, and they would work that out too, but they could-- I'm sure that they could-- over the phone, they could take a, a credit card to pay for it.

QUICK: Yeah.

RIEPE: They'll get your money one way or the other.

QUICK: Oh yeah. All right. Thank you.

HARDIN: Will you stick around?

RIEPE: Yes, sir.

HARDIN: All right. Proponents, LB1211. Welcome.

ALLISON DERING ANDERSON: Thank you. Good afternoon, Chairman Hardin, Vice Chairman Fredrickson, members of the committee. My name is Allison, A-l-l-i-s-o-n, Dering Anderson, D-e-r-i-n-g A-n-d-e-r-s-o-n. I am a pharmacist, I am the mother of a pharmacist, and I am daughter of a pharmacist. I am also a faculty member at the University of Nebraska College of Pharmacy. I appear today to speak to you on behalf of the Nebraska Pharmacists Association in support of LB1211. I am not representing my employer, nor am I representing the Board of Regents. The concepts in this bill are really simple. Sometimes, patients need to pick up prescriptions when the pharmacy is

closed. My dad owned a community pharmacy in Crete, Nebraska for nearly 50 years. I remember clearly when the phone would ring and he'd have to leave supper because somebody just got to town and the pharmacy was closed. I also remember my very first chance to drive a golf cart was when dad was golfing and somebody needed a prescription, clearly before cell phones, but I got to drive the golf cart to go pick him up to help someone else who couldn't get their prescription any other way. I worked the vampire shift at Walgreens for 10 years. I went to work at 10:00 at night, and I got off at 8:00 in the morning. I helped so many patients whose pharmacies were closed. It was one of the things I liked best about the overnight shift. Senator Riepe clearly understands the need for patients to be able to pick up prescriptions when the pharmacy is closed. This bill will allow for secure access lockers or kiosks, for lack of a better description; these are storage lockers accessible only by the patient or someone acting on their behalf with the code to make it open. Those who argue that a locker cannot counsel a patient ignore the fact that we use mail order and we deliver. And when the patient places the order, they are offered the opportunity at counseling right then, so the machine doesn't need to talk to them. If a patient asks for a drug to be placed in a locker, we say, do you want to talk to a pharmacist? Pharmacists are not in the business of hurting people; we are in the business of finding creative and safe ways to help our patients. This bill is a creative and safe way to expand coverage to patients who cannot get to the pharmacy during store hours. I appreciate that Senator Riepe would offer this bill and the supporting amendment, and I am happy to answer any questions that you may have.

HARDIN: Questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman. So, I know you heard me ask the questions of Senator Riepe about-- so, you'd have to request it. So, is there a certain time, maybe, you would have to do it, before the pharmacy closed? [INAUDIBLE]

ALLISON DERING ANDERSON: Oh, I think there are a variety of issues. The first one is, am I putting it in a locker in-- like, at Hy-Vee, where the store is open, but the pharmacy is closed? I can probably do that quickly. If I need to make sure that I am in the anteroom or wherever it is at my pharmacy, if the whole business is closing, I, I need a little more time and, and, and prep with that. But, yeah, I, I think that you can either ask

right now-- "Look, I go to work at 10:00 at night. I want to pick it up at 9:30 on my way." I know that. I can ask right now. Or, "I didn't pay attention to the weather and the snow is going to be a problem. Sorry, I didn't plan for that. Could you please?" I think those are both completely viable, and maybe some little girl would get to have supper with her dad the pharmacist. And we talk about rural health shortages. One, one of the reasons for those is that my dad didn't get to have supper with us because he had to run back to the pharmacy to pick things up. I graduated three times. My dad got to stay for the whole ceremony once.

HARDIN: Other questions? Thank you.

ALLISON DERING ANDERSON: Thank you.

HARDIN: Proponents, LB1211. Welcome.

AMY McMURTRY: Good afternoon, Chairman Harbin [SIC] and members of the Health and Human Services Committee. My name is Amy McMurtry, and I serve as the Vice President of Operations for Pharmacy and Lab Services at Nebraska Medicine-- excuse me-- as well as Vice Chair for Clinical Relations between Nebraska Medicine and the UNMC College of Pharmacy. I'm here today in support of LB1211 on behalf of Nebraska Medicine, the Nebraska Hospital Association, and the Nebraska Pharmacy Association. We want to thank Senator Riepe for introducing this bill and working with us on amendment AM1988. Automated prescription kiosks offer a safe, secure, and convenient method for patients to receive medications that have already been filled, verified, and dispensed by a licensed pharmacy. These systems are used across the country to improve access to care, support medication adherence, reduce diversion risk, and preserve the pharmacist-patient relationship by ensuring required counseling occurs prior to pickup. LB1211 addresses ongoing health care workforce shortages affecting hospitals, community pharmacies, and patients across Nebraska. By allowing pharmacies to extend services through automated kiosks, this legislation enables more efficient use of limited pharmacy workforce while maintaining high standards of patient care. Pharmacists can focus their time where it is most needed while patients retain reliable access to medications and pharmacy services. Hospitals rely heavily on community pharmacies to support safe discharges, medicated-- medication reconciliation, and treatment adherence. Staffing shortages can delay prescriptions, create access barriers, and

"increasc"-- increase the risk of non-adherence, potentially leading to preventable complications and hospital readmissions. Automated pickup kiosks help alleviate these pressures and support continuity of care as patients transition from the hospital to their home. Recruiting and retaining pharmacy professionals remains challenging in many Nebraska communities. LB1211 supports the sustainability of community pharmacies by providing modern tools that help maintain services despite workforce constraints, strengthening the broader health care system, and ensuring continued local access to essential care. Additionally, we would like to ask the committee to consider allowing controlled substances to be placed in these machines, specifically those operated within a medical facility, as this will support the many use cases for kiosks and convenience for patients. For these reasons, we support LB1211 as amended by AM1988, and ask the committee to advance the legislation to ensure Nebraska patients have access to safe, secure, and modern prescription pickup options that improve medication access across our communities. Thank you for the opportunity to testify. I'm happy to answer some questions you might have.

HARDIN: Thank you. Questions? A question that I have--

AMY McMURTRY: Yeah.

HARDIN: Is there any difference, in terms of safety considerations or indoor versus outdoor, as far as the Board of Pharmacy might be concerned?

AMY McMURTRY: So, I'm not-- I, I am on the Board of-- this is-- I am on the Board of Pharmacy, but I'm not speaking on their behalf.

HARDIN: Sure.

AMY McMURTRY: There-- to my knowledge, there is not any kiosks today that are suited for outdoor use.

HARDIN: OK.

AMY McMURTRY: I appreciate that this legislation is introduced in a way that leaves that open, in case in the future there is the ability to utilize completely external-facing kiosks.

HARDIN: OK, OK.

AMY McMURTRY: But to my knowledge there is not any.

HARDIN: So, predominantly, like, if there happens to be a large enough entryway or that sort of thing in, in a--

AMY McMURTRY: Yeah. A temperature control.

HARDIN: --freestanding drug store or inside of a grocery store type of thing.

AMY McMURTRY: Typically, they're in a temperature-controlled environment.

HARDIN: OK. Very well. Other questions? Will I get robbed when I do this? What does, what does that look like elsewhere around the country?

AMY McMURTRY: Yeah. So, as of today, Asteres ScriptCenter is the biggest vendor of these kiosks, these pickup kiosks; they have over a thousand machines in 38 different states.

HARDIN: OK.

AMY McMURTRY: So, it's very widespread. There is security measures in place. It's the responsibility of the pharmacy that is, that is putting this kiosk out there to have security measures in place whether it's, you know, visual or--

HARDIN: It's well-lit, and so forth. OK. Very good. Senator Quick now has a question, because now he's concerned about the getting robbed thing.

AMY McMURTRY: I said too much. I spurred questions.

QUICK: No, but I, I was going to ask again, because I asked about-- you know, maybe is there going to be, like, a, a time frame when you have to, you know, before that pharmacy would close, to pick up your prescription? That you'd have to have it put in a, in a box like-- a kiosk?

AMY McMURTRY: Yeah. I think it depends on the type of pharmacy and the, the way the legislation is written really leaves it open to the pharmacy to be able to make that determination. But yes, an employee of the pharmacy would have to put it into that

kiosk, so it would have be, you know, before the pharmacy was closed.

QUICK: And I know, like, I use the app to-- when I fill and everything, so it probably would give the option for that [INAUDIBLE]

AMY McMURTRY: Yep. Would probably be another pick-up option. Yep. Mm-hmm. Yep.

QUICK: OK. All right, all right. Thank you.

HARDIN: Seeing no other questions, thank you.

AMY McMURTRY: Yeah.

HARDIN: I think we've exhausted the room, so, Dusty, unless you would like to come up in opposition-- OK. There's no one in the neutral. Senator Riepe. While he is coming, online, we had 1 proponent, 0 opponents, 1 in neutral.

RIEPE: Thank you, Mr. Chairman. I'd like to thank the committee, and I'd like to thank all of those that testified. I'd also like to point out that there is no cost in this proposal to the state. And also, I would also say that we will not-- all of the codes will be 1234.

HARDIN: OK.

RIEPE: And we would also be suggesting security on these, and the question was, was brought up by our friendly pharmacist, a representative who talked about controlled substances. And we do not intend to overmanage this, particularly if it's inside of a hospital where there's security, then that would be up to the organization. We don't need to regulate this, because if we regulate it, we have to place it. It's not in our interest. With that, I have no other comments.

HARDIN: Any questions? Seeing none, thank you.

RIEPE: Thank you.

HARDIN: This concludes LB1211 and our hearings for today.