MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-sixth Session
February 14, 2011

The Senate Committee on Health and Human Services was called to order by Chair Allison Copening at 3:30 p.m. on Monday, February 14, 2011, in Room 2149 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Allison Copening, Chair
Senator Valerie Wiener, Vice Chair
Senator Sheila Leslie
Senator Ruben J. Kihuen
Senator Joseph (Joe) P. Hardy
Senator Ben Kieckhefer
Senator Greg Brower

GUEST LEGISLATORS PRESENT:

Senator Mo Denis, Clark County Senatorial District No. 2

STAFF MEMBERS PRESENT:

Risa Lang, Counsel
Marsheilah Lyons, Policy Analyst
Stephanie Robbins, Committee Assistant
Annette Ramirez, Committee Secretary

OTHERS PRESENT:

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Rose M. Park Yuhos, Interim Executive Director, Great Basin Primary Care Association
John L. Sasser, Esq., Washoe Legal Services; Legal Aid Center of Southern Nevada; Washoe County Senior Law Project
Donna Marie Shibovich, National Alliance on Mental Illness

Joe Tyler, President, National Alliance on Mental Illness
Carolyn J. Cramer, General Counsel, State Board of Pharmacy
Elizabeth Conboy, Chief, Investigation Division, Department of Public Safety
Liz MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Bill Bradley, Attorney, Nevada Justice Association

CHAIR COPENING:
Please note Senate Bill (S.B.) 105 was pulled at the sponsor's request earlier today. We will open the hearing with Charles Duarte's presentation on the overview of Nevada Medicaid.

SENATE BILL 105: Revises provisions governing the possession and administration of controlled substances and dangerous drugs. (BDR 40-759)

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
I present the budget proposal for the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS) for fiscal years (FY) 2012 and 2013. Page 1a (Exhibit C) illustrates Medicaid Medical and Administrative Expenditures. Essentially, 5.5 percent of our budget is associated with administrative costs. These costs are mostly for vendor services rendered by private-sector partners. Page 2 shows Medicaid expenditures by service. Pages 3 and 4 provide an overview of the DHHS budget. On page 3, the important thing to note is we are requesting approximately $1,065,371,950 in General Fund monies over the biennium and a total amount of spending of $3,890,198,458 in General Fund monies and federal funds.

Now I will talk about what we are not cutting. There is confusion associated with the original agency request proposal published in the fall about items that were on that list and are no longer on the Governor's recommended budget. Page 7 lists what we have added back for the Medicaid budget. There are two services being proposed for elimination in the Medicaid budget right now and include eyeglasses for individuals 21 years and older and nonemergency transportation for children in the Nevada Check Up program (NCU).

On page 8, Exhibit C, there are four key issues explained in terms of their financial impacts. Obviously, budget reductions are a key issue for us. You can

see we have almost $139 million in General Fund reductions over the biennium. We are requesting $236 million associated with caseload and inflation. We have about $9.2 million associated with health-care reform activities. Those savings are associated with fraud, waste and abuse-detection efforts. We need to replace approximately $162 million in lost American Recovery and Reinvestment Act of 2009 funds. Finally, we have a technology-information request. This request is for a federally required information systems change associated with billing, and requires about $1 million over the next fiscal biennium to support that initiative. We are continuing several budget-reduction initiatives discussed during the 26th Special Session as shown on page 10, Exhibit C. One of the more important initiatives for cost savings is our program-integrity recoveries which we believe will yield almost $8 million.

Page 11 shows programs to support our public hospitals. These primarily benefit the University Medical Center (UMC). There is a State net benefit associated with this of approximately $5.9 million in the General Fund over the biennium.

Page 12 describes one of the more controversial reductions included in the Governor's Medicaid proposals about how we share costs with counties. This is one of those proposals on the director's list of county shifts associated with "County Match Program." Under current *Nevada Revised Statutes* (NRS), the counties are responsible for paying the State's share of Medicaid costs for institutionalized individuals with incomes at or above 156 percent of the federal benefit rate for Supplemental Security Income, and it could be up to 300 percent of the federal benefit rate. That means individuals with incomes between $1,051 and $2,012 will be included. We are proposing to change that in FY 2012 to 132 percent. This will make counties responsible for a larger share of the Medicaid program, lowering the threshold from 156 percent of the federal benefit rate to 132 percent, and then in FY 2013 lower it to 124 percent. There is a complicated technical explanation why we picked these numbers. It has to do with the provisions of the Affordable Care Act and some of the caps imposed in that legislation preventing large-scale shifting of Medicaid costs to the counties.

Page 14, Exhibit C, highlights specific reductions proposed in reimbursements for services. There are some protections for rural hospitals, designated as critical-access hospitals, since they are paid differently and on a cost basis. I would like to point out the add-backs. Essentially, we have replaced the elimination of services with the reduction of reimbursements.

Obviously, there are a host of issues to be considered by the Legislature, but there are also federal issues. There has been litigation about reducing rates, particularly in the Ninth Judicial Circuit. The federal government centers for Medicare and Medicaid services are complicating the issues more by stating there will be new guidelines and proposed rules sometime in April. These rules will define what states need to do when they try to reduce rates. Since we do not know what those rules will entail, it is difficult to say whether we will have to do something differently at that time. The final rules will not be released until sometime in the summer, and this Legislative Session will presumably be over. The rules may change our ability to implement some of these things, so I am requesting flexibility in what we are reducing. There may be changes to implement administratively when these final rules come out.

One of our major issues is caseload increases projected for Medicaid in FY 2013 as shown on page 23. We are projecting coverage of approximately 312,000 Medicaid recipients by the end of FY 2013. Towards the end of the biennium, we are projecting caseloads will slow down, but not necessarily decline. A big part of this budget is associated with covering the costs of additional caseloads projected right now. I will talk about caseload relative to expenditures. The biggest expenditure is associated with the aged and disabled, although they represent a relatively small share of the overall caseload. In the next fiscal biennium, we will spend more on low-income children and families than we will on the aged and disabled. That is a dynamic we have not seen in the past. This is primarily because of who is coming into the program. A lot of that is associated with reductions in employment in the State. As people lose their unemployment benefits, they become eligible, and families are coming onboard to Medicaid.

SENATOR HARDY:
When reviewing page 12, did I hear you say Clark County would require more than $54 million?

MR. DUARTE:
If you are talking about the total shift that is occurring, then I believe that is correct.

SENATOR HARDY:
Is $54 million what the State is otherwise going to pay? Clark County has a higher salary base, would they have a higher amount they would be paying? Is the higher salary taken into account?

MR. DUARTE:
County employee salaries do not have an effect. We send the counties a bill right now, and they pay the State share of medical costs for recipients for whom they are responsible. There is no salary effect associated with this proposal.

SENATOR HARDY:
Are you saying there would not be an advantage to having the federal match increase at the same time, because you would not effectively be doing that?

MR. DUARTE:
Correct.

SENATOR KIECKHEFER:
Are there other programs that Medicaid operates where we rely on the local government to pick up a portion of the State's share? In the pie charts separating the split between the mapped population and the mothers and children, is it economically impossible to put the mapped population into a managed-care program?

MR. DUARTE:
With respect to other services, there are a host of services where we use county and local government funds. School districts and hospitals are good examples. You mentioned upper payment-limit programs. Right now we have an operating program to supplement payments to public hospitals. The State matching funds come from counties. We have services rendered by county child-welfare agencies and juvenile justice agencies, where there are matching funds in their budgets and we draw in federal funds. There are many programs where we use county monies as match.

In respect to the issue of managed care for the aged, blind and disabled; the DHCFP has been an advocate for managing patient care for the aged and disabled for some time. There are three issues associated with implementing a full-risk program for the aged and disabled. The first issue creates a hurdle for

the State to realize a positive return on investment from implementing the managed-care plan for the aged and disabled. This issue is with financing and our fee-for-service claims. These are fees we pay for service claims while we continue to pay managed-care plans, prospectively, for managing services for the aged and disabled. It creates a double-financing issue for up to six months.

Issue number two is that we have implemented a lot of these programs, which support public hospitals, by providing subsidy payments. Those payments are only for fee-for-service hospital claims. We pay admissions for people moved into full-risk, managed-care programs, such as UMC. These people would no longer be counted and UMC could not get paid for them. We also have a State benefit that we accrue from this program. The county gives a little more State matching funds than what is necessary, to match the federal drawdown to pay the hospital. That goes into our intergovernmental transfer account and is used to help support the Medicaid program. We would lose those State matching funds, and that creates another financing hurdle.

The third issue is that most of the aged are on Medicare. If I spend a lot of money managing patient care, essentially any savings goes to the Federal Medicare Program (FMP). The FMP pays for hospital services, Part A; physician services and other ancillary services, Part B; and drug services, Part D. Most of the acute medical savings accrue to the Medicare programs that may change in 2012. The federal government will start "savings sharing" with states for managing the aged and disabled populations. We are researching the possibility of medical homes for patients with multiple chronic conditions in the next two years if we can make a fiscal case for it.

CHAIR COPENING:
On page 13, the eliminated nonmedical vision services for over age 21, are these eyeglasses we are talking about?

MR. DUARTE:
Yes, just the eyeglasses, medical vision services continue.

CHAIR COPENING:
In the graph on page 28, the actual numbers of NCU clients appear to have dramatically decreased from 2007 to 2011. To what was that attributed?

MR. DUARTE:
There are a couple of reasons. We do not have definitive information. One fact we do know is that more children are becoming eligible for Medicaid. For the most part, children are coming into our medical programs from households with little or no income, so they are qualifying for Medicaid rather than NCU. The second thing is that there has probably been a demographic shift in people who have traditionally used NCU.

SENATOR WIENER:
Do you have data on how many have shifted from NCU to Medicaid?

MR. DUARTE:
I do not. The new applicants are going right into Medicaid. It is not so much a shift from NCU to Medicaid, just more people directly becoming eligible into the Medicaid program.

ROSE M. PARK YUHOS (Interim Executive Director, Great Basin Primary Care Association):
I will address the status of the uninsured in Nevada. I have written testimony I will read (Exhibit D). In conclusion, as we look at the unemployment rate as it impacts our economy and financial status, we are going to see the rate of uninsured in Nevada continue to increase.

JOHN L. SASSER, ESQ. (Washoe Legal Services, Legal Aid Center of Southern Nevada, Washoe County Senior Law Project):
If health care reform goes forward as planned after the year 2014, there will no longer be any uninsured in our State. All households with incomes under 133 percent of the federal poverty level will be eligible for Medicaid. Everyone who has an income above 133 percent of the federal poverty level will either receive insurance through their employer or they will be required to purchase health insurance on their own. If they cannot afford health insurance and their income falls between 133 to 200 percent of federal poverty levels, then they will qualify for a federal subsidy to help buy insurance. The only people who will be uninsured will be those choosing not to participate and a small number of people who will not qualify due to immigration status.

Having uninsured individuals is a bad thing for a number of reasons. If people do not have insurance, they tend not to deal with their medical issues until they become critical, and they end up in the emergency room at a hospital. At that

time, their condition, disease or injury is much more expensive to treat. If they do not have insurance, who pays for that? All of us do in a number of different ways. Those of us who pay through our private health insurance have our premiums increased to cover the costs of these individuals. A couple of years ago, 11 percent to 12 percent of everyone's health insurance premium in Nevada was due to the cost of uncompensated health care. Another way uncompensated care is paid for is the hospital writes it off.

Why has Nevada had high rates of uninsured? During the 2005-2007 interim, EP&P Consulting, Inc., performed an environmental scan for the Legislative Committee on Health Care. At that time, private employers insured a little higher than the national average of their employees. Where we fell below the national average was with a number of individuals achieving their insurance through our public programs, through Medicaid and NCU. At that time, the national average for adults between 19 and 24 years of age receiving Medicaid was 8 percent, and in Nevada it was only 4 percent. Over the last few years, only 5 percent of Nevadans received their health insurance from Medicaid, which is half the national average of 10 percent. If we had achieved the national average of Medicaid coverage, then only 24 states would have had lower uninsured rates.

In my testimony (Exhibit E) on page 3, I have tried to look back at the statistics we found four years ago after that interim study, and where we are today. One difficulty is that there is almost no data available after the year 2009. We will have to guesstimate past the year 2009. The last Great Basin study done in that period of time showed Nevada had about 450,000 uninsured individuals. According to the latest 2009 data, about 550,000 individuals are uninsured and 25 percent of our adults are uninsured. Nevada is forty-ninth for uninsured children.

In Nevada today, we have slipped to number 50 with 10 percent of our population covered by Medicaid compared to the national average of 19 percent. Also, 47 percent of non-elderly Nevadans whose incomes fall below the poverty level are uninsured, which ranks worst in the United States.

Despite recent caseload growth, Nevada continues to under-spend on Medicaid. According to the last available data, Nevada is number 50 in Medicaid enrollment as percentage of total population. One reason is that individuals are unable to qualify for Medicaid. An unemployed individual in Nevada who is not disabled, not a senior, and has no children does not qualify for Medicaid. They

also will not qualify if they have children and have very little income. In order for children to qualify for NCU, the family needs to be 200 percent below the national poverty level. In Nevada, for a family to qualify for Medicaid, the net income for a family of three must fall below $384 a month. In California, the maximum payments for a family of three are considerably higher at $647 to $679 per month. The number of people on NCU is dramatically dropping.

Why, despite the fact that Nevada has the highest uninsured rate for children in the United States, does the caseload in this program drop? First, Nevada spends no General Fund dollars on outreach for these programs. The Covering Kids & Families Coalition has utilized grants from the Robert Wood Johnson Foundation matched with federal funds. Starting in FY 2008, the State has ceased matching local funds with federal funds. The State failed to support covering children's applications for a federal outreach grant last year. The State felt it could not support the applications because they have no money in the budget for that extra child beyond our caseload. Second, Nevada has resisted making changes to the eligibility process which would make it eligible for federal performance bonuses. There is a new round of outreach money that has been announced. We have until March to decide whether Nevada is going to try to achieve the outreach fund. There is $40 million available nationally, and we received none last time.

I participated in three Nevada health-care reform studies. We spent a lot of time on uncompensated care, the cost of which is passed along to the insured in the form of rate increases. Nevada employers, both large and small, provided insurance at roughly the national average; however, our Medicaid program covered nearly 50 percent of the average in other states. The "low hanging fruit" was expanding Medicaid coverage and enrolling those currently eligible.

We never conceived of the federal government covering 80,000 additional Nevadans on Medicaid, while paying 100 percent of the cost initially and scaling down to 90 percent of the cost over time. We never conceived of adding over 70,000 current eligible individuals to the Medicaid roles. As the Governor mentioned in his State of the State speech, increased Medicaid spending from 2014 to 2019 is roughly $550 million from the State General Fund. The Governor failed to mention, the State would receive a $1,750,000,000 Medicaid match from the federal government and another $4.2 billion in subsidies for individuals not able to afford their health insurance.

For our $550 million we get a return of $5,950,000,000. That is a nearly 11- to-1 return on our money.

Any cost-benefit analysis should include the cost of doing nothing. Last year, an example that came up was the uncompensated costs in Nevada's hospitals exceeded $1 billion in 2009, while the percentage of patients with insurance, to which these costs were shifted, dropped to 30 percent. The current trend of rising insurance premiums, employers dropping coverage and lack of access to preventive care is simply unsustainable.

SENATOR KIECKHEFER:
The State has traditionally had a significantly lower penetration rate for public assistance programs across the board. Part of that is consistent throughout the Intermountain West and part of that is Nevada-specific. I have looked at projections for what is going to happen when health-care reform takes effect. The DHHS has called it the "woodwork effect." It occurs when people are eligible for Medicaid but are not enrolled. Do you have any way to estimate what percentage of Nevada's currently uninsured would be eligible if they applied?

MR. SASSER:
In my written testimony Exhibit E, on page 21, you will find the analysis Mr. Duarte completed of the impact of health-care reform. In that analysis, there are approximately 70,000 individuals who would come onto Medicaid in a 5 year period of time and would be on the program by 2019. We do pay our traditional share, whether it is 50-50 or 52-48. For individuals newly eligible, the federal government pays 100 percent for a number of years and 90 percent after that.

SENATOR WIENER:
What do we do with the provider community? We have shortages. What do we do when this rolls out as quickly as it does, for the health-care-provider shortage?

MR. SASSER:
You are right. It does no good to expand eligibility and provide everyone a Medicaid card if providers will not accept those cards, or we have no providers. Those are challenges in Nevada. In the Governor's proposed budget, there is a 5 percent cut in hospital rates. That creates more uncompensated care that is

passed along. In the proposed budget, there are $20-per-day cuts for nursing homes. There are cuts to physician rates. The health-care reform bill does take care of primary-care physicians' rates for a short period of time. The problem is not solved by federal legislation. In Nevada, we still need to provide our share for those rates. We need more professionals in our State. We need to create the kind of state and education system to which they will want to be a part.

CHAIR COPENING:
We will now open our hearing on S.B. 97.

SENATE BILL 97: Removes the prospective expiration of certain provisions governing the list of preferred prescription drugs to be used for the Medicaid program. (BDR S-940)

SENATOR VALERIE WIENER (Clark County Senatorial District No. 3):
For several Legislative Sessions, there have been efforts to expand opportunities for the Medicaid Preferred Drugs List (PDL). The subject was brought before this body, in S.B. No. 4 of the 26th Special Session, for some additional consideration of the PDL. We were able to pass that measure which dealt with particular types of drugs. That bill passed with a sunset.

This measure before you, S.B. 97, addresses the concern of the Legislature's need to prove there are savings. My concern is to ensure we maintain public safety, and that physicians have an opportunity to obtain a waiver, if they choose not to use drugs listed on the PDL. In the interim, we had a committee that did base-budget review. One of the considerations was to allow us to move forward and remove the sunset. Based on information Mr. Duarte and I have gathered, our cost savings projected when we were in the 26th Special Session have exceeded our expectations. I urge the Committee's support to pass S.B. 97.

MR. DUARTE:
We had a budget bill draft request that we had proposed, associated with our budget, which included eliminating the sunset clause. Instead of moving our bill forward, we are glad to support Senator Wiener's bill. An issue we were specifically confronted with during the 26th Special Session was related to managing certain classes of drugs. We have safely run a preferred drug list for

many critical medications since 2005. For years, we have been seeking the ability to manage some higher-cost drug classes, specifically antipsychotic medications. Through S.B. No. 4 of the 26th Special Session, we were able to get permission to put these on a PDL.

A PDL is not comparable, in the Medicaid program, to a commercial PDL. In commercial plans, you have a formulary. If the drug is on it, you can get it. If it is not on it, you cannot get it, and it will not be paid for. With Medicaid, federal law requires to offer all U.S. Food and Drug Administration approved drugs for the indications that are approved. But, we can manage the drugs. The 2003 Legislature approved the establishment of the Pharmacy and Therapeutics Committee (P&TC). This is a professional committee of practicing pharmacists and physicians, licensed in Nevada, who make decisions as to which drugs are preferred without consideration of cost savings to the State. By State law, DHCFP is required to abide by their decisions. Even if a drug is not preferred, a physician can get that drug. If a non-preferred drug is preferable, because the patient has failed on a prior preferred drug, the physician can request a prior approval of a non-preferred drug indicating the clinical reason why.

During the 26th Special Session, the DHCFP was asked to include provisions for individuals receiving a non-preferred drug now, to continue on that drug. We have grandfathering clauses to allow individuals to continue to receive the medications they need. We also have provisions for physicians to request a clinical override of approval to get a non-preferred product.

Senator Wiener spoke about a report that we sent out (Exhibit F). We were late in providing it. We received the information after January, and I failed to communicate in a timely manner to this Committee and the Legislative Counsel Bureau. I have given you my written testimony (Exhibit G). The report indicates that between October 1, 2010 and December 31, 2010, DHCFP had clinical requests to the clinical call center for 307 prescriptions. We approved 229 prescriptions and had zero denials. We have savings for the first two quarters of this program of approximately $342,000. If savings continue at this rate, we are projecting we will save $1.1 million in total savings. If S.B. 97 does not pass, we will have issues. Passage of this bill is necessary for the DHCFP to realize an estimated General Fund savings for the 2012-2013 biennium of $1.7 million.

SENATOR WIENER:
A concern in the 26th Special Session was with brand-named drugs and generic drugs. The concern was that individuals would receive inferior drugs. How many drugs would be under a brand name, and how many would be a generic drug?

MR. DUARTE:
The Nevada Medicaid program maintains that approximately 74 percent of prescription-drug payments are for generic medications. That figure increased from last year's figure of 70 percent. The DHCFP have been consistently high in terms of generic substitution and generic prescriptions. The P&TC does not consider if a drug is a brand-name drug or a generic drug. In some instances, they prefer a generic drug and other instances a brand-name drug. They are making decisions on the clinical nature of drugs in that class. The P&TC only reviews therapeutic equivalents in a specific class.

SENATOR KIECKHEFER:
If the P&TC does not have any consideration for cost, could they prefer the most expensive drug on the market? Where do the savings come from? Is it from rebates from preferred manufacturers? Where do we achieve the $1.7 million in State General Fund savings?

MR. DUARTE:
We have clinical and fiscal staff that presents information to the P&TC. The DHCFP makes recommendations to them as to which drugs we prefer. We make those determinations internally based on what we believe are savings. We do not present those savings numbers to the P&TC. If we present something to them and they make a different decision, they have the ability to do that. Savings occur in two areas. We have sidebar agreements with pharmaceutical manufacturers, and we receive additional rebates. That is actually a very small area of savings. Secondly, we really realize a savings when we establish a lower net price for a drug and there is a market shift. If we prefer certain products, there can be a market shift to those preferred products. It amplifies the savings to the State because we receive a lower net price for the products. It is called volume purchasing.

SENATOR LESLIE:
Have there been any special issues pertaining to use of these drugs with youths? Do you have a way to address those issues?

MR. DUARTE:
We do have a separate way to manage prescription medications for these classes of drugs for children. It is not handled through the PDL or the P&TC. Instead, there is a federally required body called the Drug Utilization Review Board made up of pharmacists and physicians who practice in Nevada. They review our policies for all prescription medications. They have taken a close look at issues affecting children and the use of mental-health drugs.

SENATOR LESLIE:
Does this bill cover that?

MR. DUARTE:
This bill does not deal with that.

SENATOR LESLIE:
That is what I thought, so I do not want to take up the Committee's time.

DONNA MARIE SHIBOVICH (National Alliance on Mental Illness):
I am submitting my written testimony (Exhibit H). Please correct, my testimony where I mentioned "assemblywomen and assemblymen" and change it to "Senators". Also, make a correction in paragraph 2, where it says "I stated," it should be "I started."

JOE TYLER (President, National Alliance on Mental Illness):
"I am paid in a very minimal way, not paid, but some of the funds that I used for our NAMI Nevada ... less than 10 percent are used ... are put to use for our programs from the pharmaceutical companies."

I hope that Mike Willden, DHHS, has made the statement that prior authorizations are easily done. I am aware that U.S. Senator Reid's office in Washington, D.C., indicated Nevada could get psychiatric residency for advanced-practice nurse practitioners for psychiatry. This means we could save money by having advanced-practice nurses supervised by psychiatrists. I am submitting written testimony (Exhibit I). I would like to add, therapeutic equivalents are not equivalents. Every one of those atypical anti-psychotics work differently. They are not therapeutically equivalent.

CHAIR COPENING:
We will close the hearing on S.B. 97 and open the hearing on S.B. 114.

SENATE BILL 114: Revises provisions relating to controlled substances. (BDR 40-190)

SENATOR VALERIE WIENER (Clark County Senatorial District No. 3):
During the interim, Senator Hardy brought a measure before the interim Legislative Committee on Health Care. This was one of seven measures brought to this legislative body as approved by the members of the Legislative Committee on Health Care. This is a product moved forward by Senator Denis during the last Legislative Session.

SENATOR MO DENIS (Clark County Senatorial District No. 2):
Several sessions ago, I received a telephone call from a mother whose daughter had died from an overdose due to prescription narcotic abuse. I started a process of working on some bills to help address those issues. This last Legislative Session, a bill passed to do a study to put together a group to meet during the interim. This group was to return with suggestions. What you see before you has survived that process. You will hear from several organizations that were part of that process. If you are not familiar with the database, they can talk about that.

Two things are accomplished by S.B. 114. It allows for the Nevada Prescription Controlled Substance Abuse Prevention Task Force (CSAPTF) to share information with other prescription monitoring programs. It provides legal immunity for pharmacists, pharmacy, or other dispensers that make a report in good faith to the Nevada Prescription Drug Monitoring Program (PDMP) database. Approximately 34 states have PDMPs. The implementation of the first recommendation would assist in promoting the interoperability of PDMPs across state lines. In addition, the inclusion of the proposed language enhances the State's effort to continue to be eligible to receive grants from the federal government in further development of Nevada's PDMP.

The second provision relates to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996, and potential legal ramifications for providing information to a database. Currently, many states having a PDMP provide immunity to persons who have access to that information, and share that information part of participating in the PDMP. This recommendation adds

Nevada to the states providing such protection. One statistic you may not be aware of, more people die from prescription narcotic drug abuse in Nevada than from car accidents.

CAROLYN J. CRAMER (General Counsel, State Board of Pharmacy):
I will read and submit my written testimony (Exhibit J).

ELIZABETH CONBOY (Chief, Investigation Division, Nevada Department of Public Safety):
The Investigation Division receives its authority through NRS chapter 480, which includes our authority to enforce the provisions of NRS 453, also known as the Uniform Controlled Substance Act. The Division also derives some authority in NRS 639 which authorizes our investigators to enter pharmacies and request records from the pharmacy concerning prescription records of certain controlled substances.

The Division currently has 71 full-time employees, 48 are sworn employees, and 23 are non-sworn employees. Among our other missions, we manage 6 rural narcotic task forces across the state that service 13 of the 17 counties. We also participate in the Drug Enforcement Administration's Tactical Diversion Unit in Las Vegas. The *Executive Budget* is proposing the elimination of 15 sworn full-time employees and 3 non-sworn full-time employees over the next biennium.

Historically, the Division has conducted proactive investigations regarding crimes that involve the diversion of prescription controlled substances and often initiates those investigations upon referral from information we receive from the State Board of Pharmacy.

The Division is a member of the CSAPTF. We have direct access to, and often utilize, information from the PDMP in the furtherance of our criminal investigation.

I am not objecting to any language in S.B. 114, but I would like to get some clarification on a portion of it.

Nevada Revised Statute 453.154, originally passed in 1991, states the Investigation Division shall report annually to the Governor and biennially to the presiding officer of each House of the Legislature on the outcome of the

program with respect to its effect on distribution and abuse of controlled substances. My Division is not providing that report. Part of my reason here today is to obtain some clarification from this Committee on what my Division can contribute to a report. We have made contact with the Pharmacy Board and they are willing to participate in preparation of a report to this Committee if S.B. 114 is passed.

The Investigation Division utilizes information differently than the Pharmacy Board. Our inquiry into the PDMP is in furtherance of criminal investigations that the Investigation Division conducts concerning the diversion of controlled prescriptions. The Pharmacy Board uses information they receive from data more from the intervention and prevention standpoint. I am asking for clarification from the Committee of what the Division can provide for the future in preparing a report.

CHAIR COPENING:
Do you see, the section of the bill where it asks for a report, or is that a different area?

ELIZABETH CONBOY:
It is in section 1, subsection 4.

SENATOR WIENER:
Were these some of your considerations when you were meeting as a group?

MS. CRAMER:
No, it was not. I am sure we can make their regulatory visions come true.

SENATOR WIENER:
You are at different places on the spectrum of need and engagement. This means you have had some conversation about what information you would be providing. We have heard this bill at least three times, and this was not discussed in this Committee. Keep on collaborating and make that the information—and again if it enriches what you are doing with your collaboration with the other states providing information—then you are going to know what will enhance it.

CHAIR COPENING:
The program stated in statute is an antiquated program. During our interim, we thought there was a report being generated. One concern is the ability to put together a report. We are looking for the numbers to be able to track how we are doing. Work at that and figure out what information is needed.

LIZ MACMENAMIN (Vice President, Government Affairs, Retail Association of Nevada):
The Retail Association of Nevada (RAN) has been involved in bringing forward the PDMP. We were the first state to come forward with a PDMP. The Retail Chain Drug Council and RAN were concerned about the abuses with prescription drugs. At that time, there were no thoughts about this information being used incorrectly. As these programs have been implemented in other states, they have given immunity from liability for only the information the pharmacies are providing. If the pharmacist makes a mistake filling the prescription, their liability is still there. They are being given immunity from providing this information to a third-party provider. The doctors already have immunity from liability. The State has immunity from liability with this program. The most important piece that provides information is the pharmacist and pharmacies. We put immunity from liability language in section 2, subsection 8 of this bill. We ask the Legislature to consider this.

BILL BRADLEY, ATTORNEY (Nevada Justice Association):
We do not believe that giving someone immunity for an erroneous communication furthers the goal of improving the quality of health care. We are not here to stop this program. There needs to be personal responsibility for somebody communicating critical sensitive information to a database. There needs to be personal responsibility and accountability for damage done when someone, through negligence, transmits incorrect information resulting in an erroneous admission into a program and an investigation is done for possible criminal violations.

If, through negligence, a patient requiring pain medication is placed into this database and on "watch" in terms of a criminal intent, how does that person continue to get their medication? What do they do when they show up at the pharmacy and find out that they have been put on a watch list? They cannot get their medications because a clerk was in a hurry transmitting this information. We do see errors in pharmacies where best standards are not followed. Just to say "we are sorry, we are immune," goes contrary to the

ideals of personal accountability and personal responsibility. That is why we would like to work with Senators Denis and Wiener to identify how we can promote this program. But, if there is negligence, make sure there is accountability.

The term "good faith" is in this bill. I have 30 years of experience and tell you I do not know what "good faith" means. There is no definition. If "good faith" means, I did not mean to hurt this person, then that is a different definition than negligence. If good faith means, nonnegligently, then we are good with that. If there is negligence involved that harms a patient, or a provider, they could have damages. In that case, we do not believe there should be immunity.

SENATOR BROWER:
The good-faith issue is a good one. We need to work through that. This is an outstanding and successful program. The way section 2, subsection 8 is drafted, is awkward. It is makes it hard to track.

CHAIR COPENING:
Ms. MacMenamin referred to doctors and an organization that already have immunity, but it was the pharmacist that did not have it. What language is used that protects them?

MR. BRADLEY:
That is an excellent question. We believe in the standard of reasonable care. If a person uses reasonable care in transmitting this information, then that says it all. That says they have done it in a nonnegligent fashion. In place of "good faith," I would look at "reasonable care." I do need to look at the immunity that has been granted to the other arms of this health-care system. I will do that and get back to you and the members of the Committee.

CHAIR COPENING:
I close the hearing on S.B. 114. There being no further business to come before the Senate Committee on Health and Human Services, the meeting is adjourned at 5:24 p.m.

RESPECTFULLY SUBMITTED:

Annette Ramirez,
Committee Secretary

APPROVED BY:

Senator Allison Copening, Chair

DATE:

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 14, 2011 Time of Meeting: 3:30 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Charles Duarte	Division of Health & Human Services "Biennial Budget"
	D	Rose M. Park Yuhos	The Uninsured in Nevada
	E	Jon L. Sasser, Esq.	Testimony Re: Uninsured
S.B. 97	F	Charles Duarte	Letter to Lorne J. Malkiewich and report on status of regulations.
S.B. 97	G	Charles Duarte	Written testimony
S.B. 97	H	Donna Shibovich	Testimony
S.B. 97	I	Joe Tyler	Testimony
S.B. 114	J	Carolyn J. Cramer	Testimony