# MINUTES OF THE
# SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

## Seventy-ninth Session
## March 20, 2017

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 3:56 p.m. on Monday, March 20, 2017, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, 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 Pat Spearman, Chair
Senator Julia Ratti, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

**STAFF MEMBERS PRESENT:**

Megan Comlossy, Policy Analyst
Martha Barnes, Committee Secretary

**OTHERS PRESENT:**

Brett Kandt, Chief Deputy Attorney General, Boards and Open Government Division, Office of the Attorney General
J. David Wuest, R.Ph., Deputy Secretary, Nevada State Board of Pharmacy
Chuck Callaway, Las Vegas Metropolitan Police Department
Eric Spratley, Washoe County Sheriff's Office
Robert Roshak, Executive Director, Nevada Sheriffs' and Chiefs' Association
Michael Hackett, Nevada Primary Care Association; Nevada Public Health Association
Colleen C. Lyons, M.D., Family Physician, Nevada Academy of Family Physicians
Joanna Jacob, Dignity Health-St. Rose Dominican Hospital
John Vellardita, Clark County Education Association
Tom McCoy, American Cancer Society

Sara Hunt, Ph.D., Director, University of Nevada, Las Vegas Mental and Behavioral Health Coalition
Melissa Lewis, Chief, Fiscal Services, Division of Health Care Financing and Policy, Department of Health and Human Services
Keith L. Lee, Nevada Association of Health Plans

CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 59.

**SENATE BILL 59**: Requires the reporting of certain information to the database of the program to monitor prescriptions for certain controlled substances. (BDR 40-386)

BRETT KANDT (Chief Deputy Attorney General, Boards and Open Government Division, Office of the Attorney General):
I have provided the Committee with a letter of support and the introduction of proposed amended language for S.B. 59 (Exhibit C). Nevada, like all states, has experienced a surge in prescription drug abuse, addiction, overdoses and deaths. We have seen firsthand the devastating effects of prescription drug abuse on the public health and safety of our communities.

According to the Centers for Disease Control and Prevention, drug overdoses now surpass automobile accidents as the leading cause of injury-related deaths for Americans between the ages of 25 and 64. More than 100 Americans die as a result of an overdose in this Country every day, more than half of them caused by opioids, other prescription drugs or heroin. In Nevada, physicians write 94 prescriptions for every 100 residents.

This epidemic requires a multifaceted response that involves pharmacists, other health professionals, public health entities and law enforcement working in collaboration to support the legitimate medical use of controlled substances while limiting abuse and diversion.

Nevada's Prescription Monitoring Program (PMP) was instituted in 1997 to track the prescription and dispensation of controlled substances to prevent diversion, abuse and overdose. However, some critical data is not currently entered into the PMP, including data on controlled substance violations of law, prescription drug-related overdoses or deaths and reports of stolen prescription drugs.

Senate Bill 59 implements certain recommendations of the Substance Abuse Working Group, which is chaired by the Attorney General, to fix this deficiency and enable Nevada to more effectively combat prescription drug abuse.

As I walk you through the bill, please refer to the amended language (Exhibit D) in order to avoid confusion. The amended language revises section 1 of the bill into four separate sections that better effectuate the goals to ensure law enforcement agencies, coroners and medical examiners can effectively report controlled substance violations, prescription drug overdoses and deaths, and reports of stolen prescription drugs to the PMP.

We worked with law enforcement to balance obtaining this critical information to combat prescription drug abuse without weighing them down with onerous reporting requirements. Similar reporting requirements have been enacted in other states.

Amendments 1 through 4 propose to maintain a reporting requirement for law enforcement agencies, and add a new section of reporting for coroners and medical examiners when, during the course of an autopsy or investigation, they determine the death was a result of an overdose.

Amendment No. 3 indicates what the law enforcement agency, coroner or medical examiner must report to the PMP to gather critical data not currently being captured.

Amendment No. 4 will create a new section; a corresponding amendment to the prior proposed amendments providing a mechanism by which the coroner and medical examiner are authorized to report to the PMP.

Amendments 5 through 8 would expand the provisions relative to the PMP to include schedule V drugs since abuse may lead to limited physical dependence or psychological dependence. This reflects the practice of a majority of states that include schedule V drugs in their prescription monitoring programs. These amendments will also clarify the law to indicate the PMP can release confidential reports only to a patient or his or her attorney on the patient's behalf, unless the requester has a court order. This piece is important to ensure protection of the privacy of individuals. Without this data, we are unable to formulate an effective response to this ongoing epidemic.

J. DAVID WUEST, R.PH. (Deputy Secretary, Nevada State Board of Pharmacy):
Amendments 5 through 8 require schedule V drugs to be reported as schedule II, III and IV are reported now. Schedule Vs are controlled substances available by prescription. These prescriptions contain such things as promethazine with codeine or Tylenol with codeine. Codeine by itself would be a schedule II drug, but when added to another agent it changes the schedule. We have seen people take enough codeine to get high, but these drugs are not as highly abused as others. Some pharmacies already report the schedule V drugs, but the amendment will mandate the reporting of these drugs.

MR. KANDT:
There is an amendment posted for S.B. 59 from the U.S. Pain Foundation, (Exhibit E). We do not consider this a friendly amendment as it was not discussed with us.

CHUCK CALLAWAY (Las Vegas Metropolitan Police Department):
We support S.B. 59 utilizing the proposed amendments submitted by the Substance Abuse Working Group from the Office of the Attorney General. We had discussions regarding the original language relative to some logistical concerns, and this amendment addresses our concerns.

ERIC SPRATLEY (Washoe County Sheriff's Office):
We support S.B. 59.

ROBERT ROSHAK (Executive Director, Sheriffs' and Chiefs' Association):
We support S.B. 59 with the proposed amendments from the Substance Abuse Working Group from the Office of the Attorney General.

CHAIR SPEARMAN:
I will close the hearing on S.B. 59 and open the hearing on S.B. 139.

**SENATE BILL 139**: Makes various changes to provisions relating to patient-centered medical homes. (BDR 40-679)

SENATOR JOSEPH P. HARDY (Senatorial District No. 12):
Senate Bill 139 deals with patient-centered medical homes (PCMH). The PCMH is better at keeping people healthy, out of hospitals and saves money for Nevada. The PCMH is challenged because it requires a larger team to perform

the work and it costs more money. There is a proposed amendment to S.B. 139 (Exhibit F), which may allow the language to be more permissive than mandatory.

MICHAEL HACKETT (Nevada Primary Care Association; Nevada Public Health Association):
Both the Nevada Primary Care Association and the Nevada Public Health Association support S.B. 139. Senate Bill No. 6 of the 78th Session established the PCMH in statute. Senate Bill 139 seeks to address a key component as to whether the patient-centered medical home model in Nevada is sustainable and can realize its goal, which is payment reform. Developing a reimbursement model that is value-based or outcome-based is essential. Although many states have enacted PCMH legislation before Nevada, enacting payment reform with commercial carriers and Medicaid can take time.

The proposed amendment, Exhibit F, is a mandate to adopt regulations, establish payment methods and establish incentive standards for insurance health plans. It is also a mandate for Medicaid to pay the non-federal share of incurred expenses.

The first proposed change in section 6 removes the Commissioner of Insurance from the authority of developing regulations and standards pursuant to S.B. 139. Instead, that authority will be held by the Director of the Department of Health and Human Services (DHHS). Another change noted in section 6 is to change the word "shall" to the word "may" and "must" to the word "may" throughout the section.

The second change in the amendment is in section 11 where the language is changed from a mandate to permissive regarding the requirement for Medicaid to pursue a similar payment methodology. The proposed change adds language regarding the Director of DHHS approving the State Plan, contingent upon approval from the Centers for Medicare and Medicaid Services (CMS). The amendment changes the language from "shall" to "may."

As amended, this bill keeps the PCMH issue moving forward and provides guidance and direct engagement for the PCMH Subcommittee when assessing this issue. Establishing a common set of quality measures as uniform payment methodology provides the best chance of success for the PCMH model by increasing consistency in reporting across health plans and primary care

services. It also fits the overall narrative of health care system reform from a sick-based system to one that emphasizes wellness, prevention, outcomes and provides incentives.

The CMS goal is that 80 percent of claims will be reimbursed by 2020. Patients that are in PCMH receive a better delivery of primary care. We will continue to work with stakeholders to address any concerns there may be with S.B. 139 and the amendment. We want the amended version of the bill to match the intent.

COLLEEN C. LYONS, M.D. (Family Physician, Nevada Academy of Family Physicians):
I am Dr. Colleen Lyons, a family physician since 1988, practicing in Nevada since 1992. I am a proud fourth generation native Nevadan. Born and raised in Reno, I attended the University of Nevada School of Medicine, graduating in 1985, and completed my residency in Family Medicine with the U.S. Army at Fort Ord, California, in 1988.

I could speak to the historical background and/or the economic benefits of medical homes, but will today provide my personal perspective and experience as a practicing family physician in western Nevada for the last 24 years.

After completing my military obligation and without debt for my medical education, I was able to establish a solo family medical practice in Carson City in 1992. I have always provided a medical home for my patients, utilizing a licensed registered nurse in the office to help coordinate care, provide additional patient education and to direct patients to appropriate social services. I dare say, the majority of primary care physicians utilize a licensed practical nurse at best, and more commonly, a medical assistant—the majority of whom would be hard-pressed to provide the level of care of a registered nurse. Extenuating circumstances in 2003 resulted in my practice being the first in Carson City to be fully computerized and in 2004 included billing, scheduling and medical records within the same software program.

With the advent of PCMH certification, I was glad to be recognized by the National Committee for Quality Assurance as a PCMH, one of the first two in Nevada. Approximately seven years ago, Physician Select Management was working with the Nevada Health Care Coalition, to identify high performing primary care practices and push the insurance carriers to compensate

appropriately for the savings generated by the provision of coordinated quality care. Unfortunately, those efforts did not bear fruit for local employers due to the lack of a strong independent assessment tool that could be easily implemented to grade individual primary care providers. I know that Nevada employers are eager to see their employees, if not themselves, cared for in medical homes.

With the mandate of meaningful use of computers in medical offices looming on the horizon and persistent diminished reimbursement, I elected to close my practice and join the Veterans Affairs (VA) at the Carson Valley Community-Based Outpatient Clinic (CBOC) in 2012. The requirements of electronic prescribing and computer reporting would have dictated the purchase and conversion to a new computer program/software vendor at an estimated expense of $50,000. The VA had moved to Patient Aligned Care Teams (PACT), their acronym for medical homes, in early 2011, and I was eager to participate in a truly coordinated system of medical care with a highly skilled team of ancillary providers. Each PACT team includes a physician, registered nurse, licensed practical nurse and medical staff administrative assistant providing medical care to 1,180 veterans. Additionally, the CBOC has a full-time psychiatrist, licensed clinical social worker, a pharmacist with a Ph.D. and a highly skilled nurse manager. Contrary to popular media reports, the VA provides medical care that meets or exceeds the private sector in quality at considerably less expense.

Shortly after my departure from private practice, numerous primary care physicians joined hospitals both in Carson City and Reno. In Carson City, this resulted in an increased cost to patients without commensurate increased quality of care. Currently, northern Nevada hospitals are not incentivized to provide medical homes, as these homes have consistently resulted in fewer hospitalizations and emergency room visits, thus cutting into the hospital's revenue stream.

Since 2014, in Carson City two primary care physicians elected to change to hybrid concierge practices decreasing their patient populations from approximately 2,000 to 600 patients each. These types of practices only exacerbate the primary care physician shortage and place a larger financial burden on patients, though they do provide excellent primary care. Just this past weekend, I spoke with a woman who indicated her friends felt compelled

to continue with their current physicians in spite of the increased expense due to the fear of being unable to find a new physician who would take Medicare.

Other physicians in Carson City and Reno have chosen to supplement their practice income with ancillary services such as cosmetic procedures and alternative medicine therapies, all in attempts to remain financially viable. These ancillary services take time away from much needed primary care but certainly pay the bills. The math calculation being, it is better to be in practice than not.

Note as well, the medical insurance industry is minimally incentivized to foster medical homes. Again, the associated cost savings do not justify increased premiums. The insurance companies profit from a percentage of premium dollars.

In conclusion, many have postulated the U.S. suffers from a lack of primary care physicians, an ailment manifested by the highest per capita healthcare costs in the world where health outcomes fall far below any other developed nation. Perverse and chronic poor compensation for primary care physicians and services has resulted in a mere 30 percent of U.S. physicians trained in primary care. Every other country in the world has a minimum of 50 percent primary care physicians and some as many as 70 percent. We cannot hope to see a cure for this ailment without improvement in our meager compensation for primary care. Without considerable improvement in the financial viability of primary care, we shall only suffer more as U.S. citizens. Thus, I unequivocally support S.B. 139, a start to improving compensation for primary care.

There is no stronger medicine, for Nevada or America, than primary care. Health is primary.

JOANNA JACOB (Dignity Health-St. Rose Dominican Hospital):
Dignity Health-St. Rose Dominican Hospital is one of three acute care hospitals located in southern Nevada. We support S.B. 139. We also have the St. Rose Quality Care Network which is a network of 750 physicians in southern Nevada. We are participating in a pilot program with a Medicare-shared savings program that became effective January 1, 2017, to look at models of care across the system of care. We are looking at outcomes based on population, health and quality of care.

JOHN VELLARDITA (Clark County Education Association):
We support S.B. 139. The Clark County Education Association represents 18,000 licensed professionals and has a nonprofit, self-funded health plan that covers the lives of 40,000 people, educators and their dependents. About a year ago, we transitioned to the PCMH model because there has been a change in the industry. Particularly with the Affordable Care Act (ACA), there were millions of people without insurance getting insurance for the first time. This has created a great deal of change within the industry.

We had a preferred provider organization (PPO) plan, but it could not sustain itself. We looked into other models and settled on the PCMH model. There is a correlation with the outcome of care and the compensation for performance on the part of a provider. We transitioned to the PCMH option. Given the nature of our transition, we know the transition can be done quickly. We also support the amendments as this is a work in progress.

Section 16 highlights the Medicaid issue in the State and attempts to reform Medicaid reimbursement to move from a fee-for-service payment to one that is based on performance outcomes. We think this is critical and folks who have not been insured for many, many years come with a number of issues concerning their health. Anything short of trying to manage outcomes around a patient receiving care falls short of trying to provide quality health care.

Where the language cites members of the advisory council, we would suggest a member of the advisory council be from a self-funded, nonprofit plan in order to provide a different perspective regarding the industry.

TOM MCCOY (American Cancer Society):
We support S.B. 139. I am the Chair of the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease which is the home of the subcommittee that is the advisory group for PCMH. We formed the subcommittee and part of this effort is in progress.

SARA HUNT, Ph.D. (Director, University of Nevada, Las Vegas Mental and Behavioral Health Coalition):
We work primarily on issues related to workforce development. We are neutral regarding S.B. 139 but want to encourage the Advisory Council to consider how behavioral health will be impacted. We are in full support of integrated care models. We are trying to increase training for our students in behavioral health.

This is a growing model and fits well within the PCMH. Representation from the field of behavioral health would be appreciated in any decision making going forward.

CHAIR SPEARMAN:
If we do not take mental health into consideration with this particular model, will there be unintended consequences?

MS. HUNT:
There are no negative unintended consequences, but we are always in support of making sure behavioral health is included in the discussion.

MELISSA LEWIS (Chief, Fiscal Services, Division of Health Care Financing and Policy, Department of Health and Human Services):
Respecting my prepared testimony (Exhibit G), S.B. 139 revises provisions for PCMHs by establishing an advisory council to study the delivery of health care. The amended language also requests the Director of the DHHS to adopt regulations regarding payments and incentives to drive health outcomes. If the language is changed to permissive for funding and implementation, the Division is neutral and there would be no identified fiscal impact.

Based upon the uncertainty of how an ACA repeal and replace plan would play out, permissive language is important so the State does not commit to funding should federal funding opportunities be limited or unavailable. Any change in payment methodology or delivery model must be approved by the CMS via a Medicaid State Plan amendment. Mandating them in statute does not guarantee federal match which is why the language needs to be permissive.

KEITH L. LEE (Nevada Association of Health Plans):
We are a consortium of the largest health insurers in Nevada. We were involved in the initiation of legislation resulting in creation of the advisory council. Several of our members already have PCMH in their portfolios. Incentives and disincentives have been developed. The idea is to provide comprehensive care of the patient in a single or small identified segment. We are offering incentives for good health outcomes. The better the health outcomes, the better the payments are going to be for that circumstance.

If there are disincentives for poor outcomes, that also results in better outcomes. It is important as we go forward with this legislation, the Department

of Health and Human Services considers disincentives when they develop their regulations.

Several of our members have developed plans and business models that are working now. The purpose of this legislation is to encourage those third-party payers that do not already see the successful method of treatment used by a PCMH as worthwhile, to consider this model. The idea of permissive regulations is to develop an outline. At the same time, we do not want to discourage our companies as they continue to develop programs and learn along the way.

We only represent about 35 percent to 40 percent of the insureds in the State. The changes made here do not really apply to the balance because the rest of the plans are self-funded. It is important for S.B. 139 to move forward.

SENATOR HARDY:
We already have about 58 qualified patient-centered medical homes. It is a work in progress but it is progressing. As we roll the model out, the State and others will find better health and save money.

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CHAIR SPEARMAN:
I will close the hearing on S.B. 139. As there is nothing further to come before the Committee, we are adjourned at 4:37 p.m.

RESPECTFULLY SUBMITTED:

Martha Barnes,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

| EXHIBIT SUMMARY | | | | |
|---|---|---|---|---|
| **Bill** | **Exhibit / # of pages** | | **Witness / Entity** | **Description** |
| | A | 1 | | Agenda |
| | B | 5 | | Attendance Roster |
| S.B. 59 | C | 2 | Brett Kandt Office of the Attorney General | Prescription Monitoring Program letter of support |
| S.B. 59 | D | 9 | Brett Kandt Office of the Attorney General | Proposed Amendment |
| S.B. 59 | E | 3 | U.S. Pain Foundation | Integrative Pain Management Proposed Amendment |
| S.B. 139 | F | 1 | Michael Hackett / Nevada Primary Care Association | Proposed Amendment |
| S.B. 139 | G | 1 | Melissa Lewis / Division of Health Care Financing and Policy | Written testimony |