MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eightieth Session
April 10, 2019

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 4:19 p.m. on Wednesday, April 10, 2019, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E 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 Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

GUEST LEGISLATORS PRESENT:

Senator Yvanna D. Cancela, Senatorial District No. 10
Senator Ben Kieckhefer, Senatorial District No. 16
Senator James A. Settelmeyer, Senatorial District No. 17

STAFF MEMBERS PRESENT:

Megan Comlossy, Committee Policy Analyst
Eric Robbins, Committee Counsel
Vickie Polzien, Committee Secretary

OTHERS PRESENT:

Beth Slamowitz, Senior Policy Advisor on Pharmacy, Department of Health and Human Services
Vivian Leal
Connor Cain, Carrera Group LLC; Pharmaceutical Research and Manufacturers of America
Asher Lisec, Pharmaceutical Research and Manufacturers of America

Liz MacMenamin, Retail Association of Nevada
Dave Wuest, Deputy Secretary, Nevada State Board of Pharmacy
Elisa Cafferata, Biotechnology Innovation Organization; Planned Parenthood Votes Nevada
Jeanette K. Belz, Nevada Psychiatric Association
Betty VanDeusen, Executive Director, Nevada Chapter of the National Hemophilia Foundation
Sarah Adler, President, National Alliance on Mental Illness Western Nevada
Catherine O'Mara, Nevada State Medical Association
Dan Musgrove, Nevada Donor Network
Warren Hardy, Life Science Anatomical
Jessica Vela, Community Relations Specialist, Sierra Donor Service of Nevada
Tyre Gray
McClure Cronin, Donor Network West
Ted Nagle
Eric Spratley, Executive Director, Nevada Sheriffs' and Chief's' Association
Joelle Gutman, Washoe County Health District
A.J. Delap, Las Vegas Metropolitan Police Department
Connie McMullen, Personal Care Association of Nevada
Steve Fisher, Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Kirsten Coulombe, Social Services chief, Long Term Services and Support, Division of Health Care Financing and Policy, Department of Health and Human Services
Dena Schmidt, Administrator, Division of Aging and Disability Services, Department of Health and Human Services
Marlene Lockard, Nevada Chiropractic Association
David Rovetti, D.C., Northern Nevada Director, Nevada Chiropractic Association
Cyrus Hojjaty
Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Julia Peek, Deputy Director, Programs, Department of Health and Human Services
Damon Haycock, Executive Officer, Public Employees' Benefits Program

CHAIR RATTI:
I will open the hearing on Senate Bill (S.B.) 283.

SENATE BILL 283: Revises provisions relating to prescription drugs. (BDR 38-114)

SENATOR YVANNA D. CANCELA (Senatorial District No. 10):
I am here today to present S.B. 283 for your consideration.

Senate Bill 283 revises statutory language related to the list of preferred prescription drugs used by the Medicaid Program. Federal law requires Medicaid to cover all prescription drugs approved by the United Stated Food and Drug Administration. This bill gives the Department of Health and Human Services (DHHS) more flexibility in developing Medicaid's list of preferred prescription drugs and in negotiating favorable rates for the State and its taxpayers.

Since 2010, the Legislature has been passing short-term fixes that sunset every two years. This bill aims to address this issue for the long term. Senate Bill 283 will increase access to certain drugs and allow Medicaid to consider not only the clinical efficacy and safety of certain prescription drugs but also their cost effectiveness.

Should *Nevada Revised Statutes* (NRS) 422.4025 sunset on June 30, 2019, we will revert to pre-2010 requirements. This will tie the hands of the State Medicaid agency to negotiate the prices it pays for certain drugs. Given the exponential increases in the cost of prescription drugs in recent years, this is not a good situation for Medicaid beneficiaries or taxpayers. The changes outlined in S.B. 283 will enable Medicaid to reduce costs, better serve recipients and spend taxpayer dollars more efficiently.

This bill expands the scope of the existing Prescription Monitoring Program (PMP) which currently tracks prescriptions for controlled substances listed in Schedules II, III, IV and V. They are filled by a registered pharmacy or dispensed by a registered practitioner to track every prescription regardless of whether the drug prescribed is a controlled substance.

This bill is important for Nevadans who receive health insurance coverage through Medicaid. It will expand their access to prescription drugs and improve the bottom line as the State purchases these drugs with taxpayer dollars.

I have submitted a conceptual amendment (Exhibit C) which will be reviewed by Ms. Beth Slamowitz.

BETH SLAMOWITZ (Senior Policy Advisor on Pharmacy, Department of Health and Human Services):

I am a Doctor of Pharmacy serving as Senior Advisor on Pharmacy in the DHHS and will read from my written testimony (Exhibit D).

CHAIR RATTI:

What is the impact on patients if their drug is not on the preferred list?

MS. SLAMOWITZ:

If the drug is on the preferred list, it requires no preauthorization process to receive the medication. If the drug is on the nonpreferred list, it would require the prior authorization process and require the individual to show whether or not they have a drug interaction, an allergy or have tried other products. If it is a continuity of care issue and the patient has been on the medication for a period of time, the physician can show medical necessity in order for the patient to receive the drug.

CHAIR RATTI:

The easier path is to have the drug on the preferred list. If a patient needs to continue to take a medication on the nonpreferred list, they will require a prior authorization and the physician will have to prove the reason for continuity of care. Is there any difference in price to the consumer?

MS. SLAMOWITZ:

That is correct; there is no cost difference to the consumer.

CHAIR RATTI:

The way NRS is written there is a list of drugs mandatorily on a preferred list.

MS. SLAMOWITZ:

That is correct. Through June 30, 2019, the current NRS states there are certain classes of medications that need to be excluded from the preferred drug list. There are three classes: human immunodeficiency virus medications, anti-hemophilia medications and the anti-rejection medications. Medications that had been approved by Medicaid prior to June 30, 2010, are to be excluded from the preferred drug list.

CHAIR RATTI:
Medicaid is going through a process of negotiating with pharmaceutical companies to bring a higher level of rebates which brings down the cost of a drug. If that drug is protected by NRS, we have no negotiating power as a State.

MS. SLAMOWITZ:
That is correct.

CHAIR RATTI:
This bill seeks to provide the State with better negotiating power by saying we cannot have a conversation about these pharmaceuticals.

MS. SLAMOWITZ:
That is correct. To continue what we have been doing since 2010, we are addressing the medications on the preferred drug list with the exception of the three I mentioned previously. Based on the sunset language, as of July 1, 2019, that would change. This bill would allow us to continue the flexibility to manage the benefit as we have been.

CHAIR RATTI:
We have been dealing with this for some time and continue to extend for two years, we need to act on it. If we do nothing, the bill does not pass and we do not address the sunset issue. Where does that leave us?

MS. SLAMOWITZ:
As NRS states, as of July 1, 2019, the three excluded classes, along with anticonvulsants, antipsychotics and antidiabetics, would all be excluded from the preferred drug list. We would not be able to address those from a clinical or cost standpoint.

CHAIR RATTI:
Why does this need to happen in a closed meeting?

MS. SLAMOWITZ:
There is federal statute that those negotiations with federal manufacturers are proprietary, requiring the closed door session.

CHAIR RATTI:
If we are not able to have these negotiations, we have tied our hands. We are spending more State dollars on our pharmaceuticals than we should be; therefore, we cannot afford to do other things.

MS. SLAMOWITZ:
That is correct.

VIVIAN LEAL:
I am a multiple sclerosis (MS) patient, advocate and lead person for Indivisible Northern Nevada. We understand the need for this bill to avoid a disaster. We want costs to go down. We understand certain procedures need to come into effect when we have duplication of cost categories. However, we are concerned for MS patients on Medicaid.

There are many new drugs being released, but the side effect profiles are different and something every person is struggling to work out with their physicians in terms of which drug to take. It is often trial and error. We can stabilize a patient if a drug is not on the formulary. To move the patient to a new drug opens an immune system window. Immune system diseases are not the same as other diseases. A person who is walking one day can be back in a wheelchair within three months.

I have provided a graph (Exhibit E) so you can see the prices we are talking about. In recent years, we had a new generic drug available. The lowest price for that generic is now $23,775 per year for 2019. Medications I was started on in 1999 are at $90,000 per year for 2019. You can see how the MS patient would be frightened of cost corrections and how long the preauthorization process would take in terms of continuity of care. Time is mobility for MS patients.

We understand the need for this bill. There is no rationality for the cost basis of these medications. Congress has done a study on this and I will submit it for your review. A lot of the rebates are a racket that, unfortunately, we must accept.

CONNOR CAIN (Carrara Group LLC; Pharmaceutical Research and Manufacturers of America):
Pharmaceutical Research and Manufacturers of America is opposed to S.B. 283.

ASHER LISEC (Pharmaceutical Research and Manufacturers of America):
Currently, Pharmaceutical Research and Manufacturers of America is opposed to S.B. 283. We have had an opportunity with the author's office and the Division of Health Care Financing and Policy (DHCFP) to better understand the intent of the bill. We appreciate how conceptual amendment 1 allows the DHHS discretion when it comes to the protected classes.

We will be asking for an additional amendment to clarify the closed door piece so the Pharmacy and Therapeutics Committee would only include discussions about the proprietary negotiations. Our concern is making sure patients, providers and others in the community have the opportunity to speak their voice and ensure the rationale for making decisions about how formulary placement is made transparent to the public. With this additional amendment, we would be neutral on the bill.

LIZ MACMENAMIN (Retail Association of Nevada):
The Retail Association of Nevada has mixed feelings on S.B. 283. I feel an ownership to the piece on the protected classes and the Pharmacy and Therapeutics Committee. In the past, the Retail Association of Nevada worked with Assemblywomen McClain and Koivisto to bring help with respect to cost savings. We accepted the protected classes at that point and negotiated with the manufacturers because of the concern with the protected classes. We do support this portion of the bill.

The sunset has been going on each year since 2010, and we have looked at a sunset each session since then. The Retail Association of Nevada has stayed out of that.

We do oppose the piece on the PMP. The Retail Association of Nevada was not made aware of this until two hours ago. Until today, we were not given an opportunity to discuss our concerns with the individuals bringing the bill forward. I am working on information for the Committee to help you understand what the cost to the pharmacy will be. We have concerns about security breaches and what is to be done with the information. This is protected health information.

I was told, that currently, they would not be able to accept an amendment. I do want to state the Nevada PMP, another thing the Retail Association of Nevada was instrumental in implementing, is a database regarding information for controlled substances. We would hate to dilute the information in that database.

CHAIR RATTI:
We do have a database for opioids or controlled substances, correct? We have gotten valuable data to understand purchasing patterns and policy level decision making information. What is the challenge with expanding that to other pharmaceuticals?

MS. MACMENAMIN:
I am gathering the information to find out what the cost would be to the pharmacy. There will be a cost to implement this on the grand scale. Walgreens spends more than the U. S. Department of Defense on electronic privacy and issues with technology to ensure their databases are safe.

My concern would be the safety of the patient information, the cost incurred by the member and what it would cost to implement. There was a cost involved in other states and in initially setting up the PMP. Dave Wuest with the Nevada State Board of Pharmacy may have more information on the State side. There will be a big expense incurred on the stakeholder's side.

There has been a breach in the past where the State was sued. Would the State be able to offer unlimited liability for incorrect information?

SENATOR SPEARMAN:
The Commerce and Labor Committee just passed S.B. 21 related to cybersecurity. Once it gets through the Assembly, I believe it will address, if not all, 98 percent of your concerns. It will tighten security for personal information as well as health information.

SENATE BILL 21: Enacts the Insurance Data Security Law. (BDR 57-221)

SENATOR HARDY:
Are we talking about putting all medications under the PMP?

MS. MACMENAMIN:
That is my understanding. They want to collect all data.

SENATOR HARDY:
As a physician, will I have to enter all of this information in to the PMP?

MS. MACMENAMIN:
I do not believe you would have to enter the information yourself. The pharmacies will be the ones to enter the information in to the database for everything that is prescribed.

SENATOR HARDY:
Logistically, as I check the PMP periodically, will I see everything?

CHAIR RATI:
Mr. Wuest, will you be able to help us with this information?

DAVE WUEST (Deputy Secretary, Nevada State Board of Pharmacy):
I am neutral on this bill. The PMP is co-administered between the Nevada Investigation Division (NID) and the Nevada Board of Pharmacy. The NID handles law enforcement of the proper use of the PMP. We have had no issues in the 25 years the PMP has been used in Nevada. This does not mean we will not have an issue.

The State Board has been sued three times since the inception of the PMP. We were found not guilty in each case. We recently had a case linked to a doctor who used it inappropriately. These things do come up, and we address them appropriately.

Senator Hardy, regarding your question about entering information into the PMP, if this moves forward, we would have the capability of not showing you the data unless you chose to see it.

The long-term goal of the DHHS is not only to do surveillance that is required on such things as antibiotic and cardiac events but to do medication reconciliation. If, through integration, we were able to migrate this data to the prescriber, you would be able to see what the medication prescribed for the patient looks like.

This would be an opt-in situation not a mandate. There is no mandate in this bill you would need to review before prescribing a medication. In the hospitals, medication reconciliation is a challenge, and this data would potentially help them.

SENATOR HARDY:
Is this working seamlessly elsewhere, and are all doctors happy with it?

MR. WUEST:
There are always issues with technology. As far as I know, Nebraska is collecting the data without issue. We spoke with our vendor, and we can handle the data. There will be an expense on both sides, and we have placed a fiscal note with an amount yet to be determined. The goal would be to potentially use grants to fund the program.

ELISA CAFFERATA (Biotechnology Innovation Organization; Planned Parenthood Votes Nevada):
I am representing two companies today, the first being Biotechnology Innovation Organization, which is the trade organization for biopharmaceutical drugs. We do have our comments on the record dealing with protected classes. The issue is the negotiations around protected classes do not just affect negotiating the price. They impact how patients can access those drugs and whether they have to go through the preauthorization and step therapy processes. One of the reasons these drugs have ended up in a protected class is so when patients find something that works for them they can keep it consistent.

Today, I am also representing Planned Parenthood Votes Nevada. We are concerned. I have raised this concern with the sponsors about a database where people can go and, out of curiosity, look people up. We are more concerned about the people having access to these databases randomly looking up information on family or friends than a massive data breach. Those are the kinds of breaches we see along with the Health Insurance Portability and Accountability Act violations. They are much more personal and individual. While we understand those things are against the law, it does create serious problems for our patients.

JEANETTE K. BELZ (Nevada Psychiatric Association):
Prior to 2010, the DHHS was required to exclude drugs such as atypical and typical antipsychotics from any restrictions on their list. Financially, in 2010, they were looking for ways to add money to the budget. They came to the Legislature and convinced them, for a period of time, to exclude atypical and typical antipsychotics from the restricted drug list. They would allow restrictions on these drugs and collect rebates. At the time, it was approximately $1 million

dollars; that number has come down. Every other year they would come back and permanently attempt to remove those restrictions as it is being written into S.B. 21. We were opposed and would convince them to extend it another two years.

There is a sunset on this as of July 1, 2019. To my understanding, there are budget consequences in the $600,000 range. We asked the DHHS if we could work with them in the Interim to see if there was something else we could come up with to address our concerns.

The best thing that could happen for Medicaid folks with mental illness is for a prescription to be filled with no prior requirements. We understand that will no longer happen.

I have provided a flyer (Exhibit F) showing how Medicaid patients are currently receiving medications. In the Fee for Service category a formulary is developed through the Drug Utilization Review Board (DUR) and Pharmacy and Therapeutics (P&T) Committee which is a public process. There are limitations that will be put on this public process. I have seen the DUR and P&T Committee take public input and make changes based on what they intended to do.

The Managed Care Plan category formularies are developed in private. These plans can be different, simple and complicated. You may have to scroll down 30 pages to get the information on what the restrictions might be. We have patients that can be in one of four of these categories. We asked the DHHS how we could make this easier for the patient. It should not matter which one of these categories you are in to know which drugs you will be able to access. That is the way it is currently working. We asked the DHHS whether these three drug classes, atypical and typical antipsychotics, anticonvulsants and antidepressants could be executed through the public and fee for service systems carving out these three drug classes for mental health drugs.

We appreciate that amendment 2 would include these drugs. If this cannot be done, we would request these drugs get carved out as it should not matter what category you fall in. Most patients and patient advocates with mental health issues are afraid of being in the managed care system. About 70 percent of our patients with Medicaid are in the managed care system.

I am in opposition as ideally it would be great for protected classes to go on indefinitely. We have not been a protected class since 2010. You can continue to delay this for another two years, but that is unproductive. If we could get past the point of continuing to delay this for another two years, we would support this bill.

BETTY VANDEUSEN (Executive Director, Nevada Chapter of the National Hemophilia Foundation):
We are in opposition to S.B. 283. I have submitted written testimony from the National Hemophilia Foundation (Exhibit G) and will read from my written testimony (Exhibit H).

SARAH ADLER (President, National Alliance on Mental Illness Western Nevada):
The National Alliance on Mental Illness (NAMI) is hopeful for the world that was described by Senator Cancela and Ms. Slamowitz; however, at this time we are in opposition. We urge the Committee to ensure open access to all atypical and typical antipsychotics and to continue to exclude antipsychotic medications from a list of preferred prescription drugs in the State Medicaid Program.

We are concerned S.B. 283 would remove the presently existing exclusion. We would like for the sun not to set. It is incredibly difficult for severely mentally ill people to achieve stability. We are succeeding with the current access to antipsychotic medications. When individuals with mental health conditions are unable to access the most appropriate clinically indicated psychiatric medications, they experience higher rates of emergency room visits, hospitalizations and other health services.

A study in general hospital psychiatry by Joyce West, Ph.D., analyzed Medicaid data from ten states. The study found psychiatric patients who reported access problems with their medication visited the emergency department 74 percent more than those who had no difficulties accessing their medications. I have submitted a statement (Exhibit I) from Robin Reedy, NAMI State Director, explaining more on this data.

CATHERINE O'MARA (Nevada State Medical Association):
We are neutral on the section related to the expansion of the PMP although it could be a beneficial tool for physicians. We have issues where patients state they are taking a blue pill and some kind of red pill, or they do not remember what their other doctor has prescribed. It would be helpful to be able to look at

the PMP and see what medications are listed in order to help these patients. I have gone through a demonstration on the PMP, and there are ways to organize it so you can sort by controlled and non-controlled substances and find the data you need.

My father is elderly and has seven doctors. We keep a binder of all his medications to share with his primary care doctor when we go for visits. His primary care doctor would be able to access his medication information on the PMP rather than us providing our binder at each visit.

We do get paranoid when we talk about the DHHS collecting and studying data. We reached out to them and asked them how they would be using this data. If it is for studying public health, we are on board.

We went through a controlled substance bill last Session, and we have another one this Session. We would oppose any pathway of mandated prescriber guidelines on other drugs. We understand that is not the intent behind the bill, and the DHHS is not going in that direction.

CHAIR RATTI:
I recognize this is a complicated issue and there are competing factors we are attempting to address. This is a serious and significant issue. We want to ensure we have protected classes so care is not disrupted by preauthorization or the need for step therapy. At the same time, it is a challenging notion that we will tie the hands of our own purchasers to negotiate pricing in order to bring down prices for the system. We can afford to do more for patients.

Continuing to sunset is not good policy making. We need to figure out a long-term solution to have a balanced approach to meeting the needs of the patients of Nevada, as well as manage costs and figure out how to solve this permanently.

I will close the hearing on S.B. 283 and open the hearing on S.B. 387.

SENATE BILL 387: Revises provisions relating to organ donation. (BDR 40-882)

SENATOR BEN KIECKHEFER (Senatorial District No. 16):
I am here to present S.B. 387 for your consideration.

This is the fourth organ donor bill I have sponsored in the Legislature. This bill relates less to transplant and more to donation of bodies and tissues for research purposes. The idea is when individuals decide to make a gift of themselves to further the purposes of research that the gift is honored in the same way other gifts for transplant are honored.

The amendment (Exhibit J) ensures organizations collecting donations made for nontransplantation follow certain standards put forth by the American Association of Tissue Banks and the Eye Bank Association of America as outlined by regulations to be developed by the DHHS. The goal is to ensure the organizations in these donation processes are following high standards adopted and established at the national level and are encouraging more people to participate in the process and donation in general.

DAN MUSGROVE (Nevada Donor Network):
Nevada Donor Network supports S.B. 387. The number of people waiting for a lifesaving transplant today is 114,000. Another name is added to the list every ten minutes. We have 600 Nevadans waiting for a lifesaving available organ for transplantation. Sadly, we have 20 people die each day for lack of an organ donation. Anything that might chill organ donation is something we want to work to counteract.

In 2015, we had a situation in Las Vegas where bodies donated by those who thought they were donating their loved one for research were not treated with the dignity they deserved. The only thing the DHHS could do was charge the company for pollution.

This bill focuses on nontransplant body donation. The three organ procurement organizations in Nevada are highly regulated at the federal level. The federal government has not been able to put together legislation to regulate these nontransplant organizations. There is a bill in Congress that is a placeholder; there is no language in the bill. We have about ten states that have begun to attempt regulating this industry. Nevada could be one of the first to set a standard.

Senate Bill 387 has devised a new definition for what we call nontransplant body donation organization. When the bill was crafted they brought in procurement organizations, something we do not need to do as they are now highly regulated. We want to focus on a nontransplant body donation organization. Those are folks engaged in the disposition of human bodies and human body parts donated or transferred for educational research or for the advancement of medical, dental or mortuary science and not for use in human transplantation.

We have created a mechanism for the DHHS to regulate this, and they did make a suggestion to ensure the actual Department of Public and Behavioral Health is the one establishing the regulations. It would be the DHHS that enforces the regulations according to national standards and ensures these folks are treated with dignity.

This is language that comes from other regulations set for regulation disregard. Few, if any, rules mean there are few consequences when bodies are mistreated. We want to ensure there are consequences if our loved ones are treated in an inappropriate way.

WARREN HARDY (Life Science Anatomical):
Life Science Anatomical is a nontransplant donor who follows the national standard and is in support of S.B. 387. We are concerned there is nothing in State law or regulation that provides a framework for how this should be done. We look forward to working with the sponsors of the bill in the regulatory process.

JESSICA VELA (Community Relations Specialist, Sierra Donor Service of Nevada):
I will read from my written testimony (Exhibit K) in support of S.B. 387.

TYRE GRAY:
As a private citizen, I support S.B. 387. September 12, 2012, I received a kidney transplant that helped to save my life. I support anything that helps to assist and encourage people to donate.

MCCLURE CRONIN (Donor Network West):
Donor Network West supports S.B. 387. This is something that is necessary to protect Nevadans. The data and information sharing provisions will be important going forward to help educate our legislators, our government and individuals throughout the State.

SENATOR KIECKHEFER:
This is an effort to ensure nothing is on our books that allows a process that creates a chilling effect on people's desire to donate and save lives.

CHAIR RATTI:
I will close the hearing on S.B. 387 and open the hearing on S.B. 446.

SENATE BILL 446: Revises provisions relating to Medicaid. (BDR 38-974)

SENATOR JAMES A. SETTELMEYER (Senatorial District No. 17):
I am here to present S.B. 446 for your consideration. This bill is a result of concerns from a constituent who reached out to me. He is self-sufficient, has a job and would love the idea of using his own money to help supplement the reimbursement to caregivers. This is not allowed under current Nevada law. We are attempting to correct this.

We have a very successful economy in northern Nevada that has had some unintended consequences. Individuals with disabilities are unable to find people to help care for them. Medicare reimburses approximately $24 per hour, and in reality, the reimbursement to caregivers is about $9 per hour. At that rate, it is difficult for individuals to find caregivers.

This bill seeks to create a supported personal care concept similar to what Kansas currently has. I was fortunate when I brought forth this language to be directed to the DHHS where I worked with an individual who actually came from Kansas. She was familiar with the process but could not speak for or against, as she works for the DHHS, but she was able to provide us with information on the subject.

The first part of the bill would allow for Medicaid individuals to directly receive reimbursement as they do in Kansas. That would then allow them to allocate the money to individuals rather than dealing with a service contract. Under the same portion of the bill it would allow them to use other sources of money including their own. It would also allow a relative of a Medicaid recipient with the proper training to receive reimbursement for personal care services covered by Medicaid that are provided pursuant to NRS.

Section 1, subsection 3 of the bill states:

> An agency to provide personal care services in the home that enters into a contract with Medicaid must agree to pay its employees who provide personal care services at least 75 percent of the reimbursements paid to the agency under Medicaid for personal care services.

If they are paying $20 per hour, the goal would be to pay $15 per hour to the Medicaid recipient. This may cause concern with the service agencies and may need to be discussed further. We are not attempting to get rid of these agencies. We want to open up more opportunities for individuals to care for themselves, especially those such as my constituent who are more than mentally capable of caring for themselves and directing some of their own care.

This bill has the opportunity for those who are wheelchair-bound or those with autism or any other disability where there is an issue with paying the appropriate wage, to interest individuals in becoming caregivers.

TED NAGLE:
I am 60 years old, owned a home and ran a business in Gardnerville for the past 23 years. The last ten months I have lived at Gardnerville Health and Rehabilitation Center as I have no caregiver in my home. I was born with a birth defect called arthrogryposis, which has left me needing to rely on others for my personal needs such as dressing, bathing, cooking and cleaning, among other things.

Life has had challenges, but I have made the best of what God has given me. I was born in the San Fernando Valley of California, the youngest of eight children. I was raised to look for ways to do things rather than complaining that I was not able to. I was taught Christian values I hold close to my heart and to be grateful for what I have, not complaining that life is unfair.

Most of my youth was spent in special schools for the disabled, as at the time they were not yet mainstreaming the disabled into the regular school system. After eleventh grade, I told my parents I wanted to go to regular school for my senior year or not go to school. They instilled in me the "go get 'em" attitude, and thanks to my parents' activism, I was the first wheelchair-bound student to graduate from Chatsworth High School in Los Angeles County in 1976. I graduated with a 3.5 grade point average in the top 5 percent of my class, to date the largest graduating class in the Los Angeles City Schools history.

Because of my love for learning, I went on to study at five different colleges over the years. Though I did not receive a degree, due to the misdirection of career counselors, I excelled in several areas helping me to become the man I am today. I continue to learn new things daily through self-study and life lessons.

Shortly after graduating high school, I decided it was time to move out on my own as my other siblings had done. Reluctantly, my parents helped me get settled into an apartment, and like other kids my age, I was free. This would not have been possible without caregivers and family members. The first year was challenging and a bit scary, to say the least, but I did it. I am a stubborn person and have rarely found a challenge I could not overcome. At this point, I knew I could survive the real world with the assistance of personal caregivers and help from family and friends. I have successfully integrated into society for better or worse.

Over the 40 years of my adulthood, I have had over 150 caregivers, maybe more, in California, Washington and Nevada. Each state has their pluses and minuses as far as personal care programs are concerned. When I lived in California, their program was a self-managed program allowing me to find my own caregivers who were paid through the in-home supportive services programs. This worked for me.

In Washington, their program was similar in that I could recommend people to the program, or they would provide personal caregivers to you. Whenever possible, I chose the caregiver myself in order to have more control over my life. During the four-and-a-half year period I was in Washington, I had four caregivers, one of who was a relative, which is not allowed in Nevada.

Since I moved to Nevada in 1996, I have been amazed by how convoluted the personal care programs are and how difficult it is to understand the programs. It is almost impossible to get the information for the programs. The counselors and their supervisors seem to know only what is deemed necessary to run their portion of the program. It seems like a guessing game to me, or they are trained to avoid certain aspects of the program.

Living in rural Nevada, which I and many disabled Nevadans choose to do, is a big problem as the workforce is small. Finding agencies who have caregivers living in the area and who accept Medicaid is difficult at best. Many agencies have stopped accepting Medicaid clients because of reimbursement issues. When an agency's only office is in an urban area, they put very little effort into hiring in the rural areas. It is difficult to get their existing caregivers to drive to distant clients like myself for a two or three hour shift and for the pay they receive, which does not include mileage or travel time pay. When they do find a caregiver willing to travel the extra distance, it is short-lived.

What options are there? Many do not know there is a fund available to pay for mileage to and from distant clients such as myself. Why has it taken 20 years of living in rural Nevada to find out about this? I have tried, and it seems to be a very well-kept secret.

Over the years, I have had caregivers lasting two to three years. I have others who have lasted two or three days with an average longevity of two months. I was married ten years ago and the constant change of people coming and going has been a challenge. Because my wife cannot physically take care of me due to her own physical limitations, the need for personal caregivers is less desirable but more necessary. At one point, my week was made up of seven different caregivers just to be able to cover the day. There is no stability in that.

There are several problems arising from the current Medicaid funded care program in Nevada. When you pay someone the same starting wage or less than those of fast-food companies, and the duties are less desirable, people are not going to stay. People living on such menial wages are more likely to steal from the people they are caring for to supplement their wages. This has happened to me to the tune of over $10,000 in personal property and medications. This has happened to almost every disabled person I know. It is hard to trust people, and that is a shame.

When a loved one needs care, and you are the only one willing to take that on, you quit your job and do the honorable thing. Then you find out a spouse cannot be paid to care for the loved one. This causes the family financial despair, and many lose their homes because of it.

Good caregivers come and go quickly because private pay clients pay $20 to $25 per hour for the same services agencies are paying $10 to $12 an hour. When Medicaid recipients, their friends, relatives, churches or strangers want to help supplement the pay of caregivers to make the job more desirable, the law takes the Medicaid coverage away.

Today, to alleviate some of the problems caused by the low-paying Medicaid contracted care agencies, S.B. 446 allows Medicaid recipients to be reimbursed for personal care services paid for by my own means or by the means of other individuals. This bill also allows Medicaid recipients to pay, by their own means or the means of others, supplemental pay for caregivers without affecting their Medicaid eligibility. The bill will not limit relatives from being caregivers and being paid for the services. It will require care agencies to pay at least 75 percent of the monies reimbursed by Medicaid to the individual caregivers who are providing the care.

Does this solve all of the problems? No, but it is a good beginning, and Medicaid recipients will have options to hopefully find and keep quality, reliable caregivers.

SENATOR JOSEPH P. HARDY (Senatorial District No. 12):
When people enter the prison system, they have their Medicaid terminated at a critical time in their life when attempting to overcome addictions or work on substance abuse. It is then reinstated when they are released, which is a process. The suspension of Medicaid is easier to do than terminating the coverage. That is the genesis of the idea around the amendment to S.B. 446 clarifying the bill itself.

The conceptual amendment (Exhibit L) explains the revisions to be made to S.B. 446.

We will be able to save lives as soon as people are released from incarceration as they go back to the same dose they used prior to incarceration and overdose. We have hope we can help people and save their livelihood.

CHAIR RATTI:
We have two distinct concepts brought to us today. The ability to ensure personal care assistance where needed and making sure we have continuity of care for individuals who are departing jail or the prison system.

ERIC SPRATLEY (Executive Director, Nevada Sheriffs' and Chiefs' Association):
Nevada Sheriffs' and Chiefs' Association supports S.B. 446. We, along with the Washoe County Sheriffs' Office and stakeholders, have been a part of several meetings on the incarceration part of this bill. We are at a place where the

mechanics of the bill seem to be doable for the Sheriffs and the jails, and we look forward to the implementation in the future.

JOELLE GUTMAN (Washoe County Health District):
The Washoe County Health District Supports S.B. 446 specifically for the suspension versus termination piece in the conceptual amendment. We provide family planning services and sexually transmitted disease testing to the Washoe County Sheriffs' Office. As we have a captive audience, we can encourage them to access additional resources on release; however, a lot of those resources are dependent on being signed up for entitlement programs. By having Medicaid reinstated, it eliminates barriers to access and will help some of our communities' most vulnerable stay covered. Staying covered means staying medicated if necessary. It also keeps people out of unnecessary hospital visits and hopefully the prevention of reoffending.

A.J. DELAP (Las Vegas Metropolitan Police Department):
The Las Vegas Metropolitan Police Department supports S.B. 446. It is my understanding our Information Technology (IT) Department believes it can be accomplished given the time provided by the measure. We think this will be fruitful for our inmates as they are released back into the community.

CONNIE MCMULLEN (Personal Care Association of Nevada):
The Personal Care Association of Nevada opposes S.B. 446. I will read from my written testimony (Exhibit M).

Mr. Nagle is one of the best concepts of what the Olmstead Decision stood for in 1999. Keeping people who are physically disabled in the least restrictive setting in a place they make home, of their own choice, not in a nursing home. I commend him for his lifelong effort in doing so. I recently served as an Olmstead Co-chair to update their annual report, so I understand his dilemma. I also think his efforts to find caregivers and the rate at which Medicaid pays points to the problems we have been talking about for the past two Sessions.

The underlying concern is in trying to better serve the clients in rural Nevada. Casual caregivers, a neighbor, a relative, a sister or brother is where Medicaid clients are going to be forced to go. This is not a good incentive for professionals to service the rural communities. It will be a disincentive.

STEVE FISHER (Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services):

The suspension of the Medicaid portion of the bill is very important, and the Division of Welfare and Supportive Services is always looking for ways to make our process more efficient. We currently have eligibility workers in both the Clark and Washoe County Detention Centers doing eligibility as individuals are leaving these facilities. However, electronically doing this would be the next step as suspending eligibility would be more efficient. The piece that is missing for stakeholders and detention centers is knowing when someone enters a facility and when they are leaving. If we can electronically get this information, we can suspend and then reinstate their eligibility more efficiently. The Division supports S.B. 446.

DUANE YOUNG (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):

We wanted to speak to the self-directed piece referred to today. This is a 1915(j) Self-Directed Personal Assistance Services State Plan option that can be operated under the 1915(c) Home and Community-Based Services Waiver that serves the physically disabled population. This would look at our highest acuity clients within this waiver allowing them to work through a self-directed model referenced here many times.

This is something the DHCFP has looked at over the years and were hoping to look at and implement in future sessions. We have placed a moderate fiscal note on this. The cost would be in terms of staffing and the different pieces Ms. McMullen referred to is the administrative cost. That is taken care of through a program called Cash and Counseling. Agencies are paid a capitated rate per member per month for those in the program to oversee the administrative functions, and the rest goes to the person performing the services.

SENATOR HAMMOND:

Do you feel you could have done this through the regulatory process before needing any kind of legislation, or was this bill presenting the legislation to do something like this?

MR. YOUNG:

It requires budget authority which we have not had to implement a program like this with competing priorities. With this legislation, the opportunity to place a fiscal note on this portion of the bill is the opportunity to possibly see this come to fruition for Nevada.

CHAIR RATTI:
We have a self-directed care model, or are moving toward a self-directed care model and not the 1915(j) waiver, but the Intermediary Service Organization (ISO) programs. Who can speak to what an ISO program is accomplishing now, and how it would differ from what we are currently doing with what the 1915(j) waiver might accomplish?

KIRSTEN COULOMBE (Social Services Chief, Long Term Services and Support, Division of Health Care Financing and Policy, Department of Health and Human Services):
As an option to receive personal care services through Nevada Medicaid, we currently can receive services through a traditional agency model. We also have an ISO model where we have a fiscal agent who receives the funds, bills Medicaid and ensures all of the necessary requirements are completed, such as tuberculosis (TB) testing and training requirements.

The difference with the 1915(j) model is the recipient manages the self-direction they are responsible for and their budget which is different than what they have in the self-directed program. Right now, the self-directed program is more related to the components of meeting work requirements, and recipients do not manage budgets. It is not a Cash and Counseling Program which is within the DHCFP, and it is not currently within the Division of Public and Behavioral Health.

CHAIR RATTI:
If Mr. Nagle, or anyone similarly situated, came to an ISO today and stated they had a friend who would be a great caregiver and would like her to be their caregiver, what would happen?

MS. COULOMBE:
They would first have an assessment for personal care services to see how many hours they would need authorized for those services. They would then tell the ISO entity this would be the caregiver they choose to perform services. They can have family caregivers who do not have a legal relationship with the Medicaid recipient. By terms of legal relationship it means it could not be a spouse or someone who has a legal guardianship over the patient.

We do have family members who provide personal care services, particularly in the rural areas where we do not have a lot of agencies. That is an option as long as there is no legal relationship. The ISO holds the licensure, oversees the time sheets and would currently work to ensure the TB testing and training requirements have been completed.

CHAIR RATTI:
Do they pay the caregivers?

MS. COULOMBE:
There is an administrative fee that is from our current Medicaid rate of $17 an hour for personal care services. They have administrative fees, and they would pay the caregiver.

CHAIR RATTI:
Does the larger portion of the Medicaid rate of $17 an hour end up in the hands of the caregiver in an ISO?

MS. COULOMBE:
No, not through the ISO, but through the 1915(j) State Plan option. It is a Cash and Counseling program, so the recipient would manage that with a budget they could use. We do not currently have a 1915(j) State Plan in Nevada; we are still learning what those options are. They would be able to purchase services and goods with a lot more flexibility than we would have in the ISO option.

MR. YOUNG:
The State would pay the administrative fees through the capitated rate to oversee the Cash and Counseling portion. That would be the difference in the models as more would be passed on through the 1915(j) State Plan. There would not be an agency taking their fees off the top before giving pay to the caregiver.

CHAIR RATTI:
If we were to pursue the 1915(j) waiver, it would take out the middle man of the ISO and get more money directly to the caregiver?

MR. YOUNG:
It allows the State a process to pay for the management outside of the acceptable rate. The State would be paying for the administrative costs outside

of that through the capitation fee, and the rate would be passed on to the caregiver.

SENATOR HAMMOND:
Mr. Nagle mentioned he would like to be able to supplement the caregiver under any one of these two programs mentioned. Does that allow for a participant to supplement a caregiver in order to incentivize others to be caregivers?

MR. YOUNG:
Nevada Medicaid Services Manual Chapter 100 outlines that Medicaid payment must be accepted in full for all providers. There is no way to supplement any payment for any Medicaid services. States that do this usually operate within a waiver in which they have copays. Nevada does not do this.

CHAIR RATTI:
Please explain the co-pay piece.

MR. YOUNG:
There are states that have "skin in the game". They will charge recipients $1 to $2 dollars per Medicaid service. Most states have done this to ensure their attendance rates at appointments. Nevada Medicaid does not do this. It is outlined in our policy and in our State Plan that all Medicaid payments are accepted as final; no provider can charge any fees to a Medicaid recipient. Even if the Medicaid recipient was voluntarily paying it would still be considered a provider accepting fees from the recipient.

CHAIR RATTI:
In Nevada, we prohibit any co-pay, and we are doing that because we are required to by the federal government, as we do not have a waiver to do it differently? Even if we change that in NRS?

MR. YOUNG:
That is correct. We would have to apply for a waiver to do that.

CHAIR RATTI:
Would that waiver we apply for require them to charge a co-pay for Medicaid services?

MR. YOUNG:
It would depend on the design of the waiver. I can get you the correct information, but I believe it would be a Section 1115 demonstration waiver. We would have some flexibility in designing the waiver in terms of services that would and would not allow co-pays.

CHAIR RATTI:
So we are now up to two waivers and need to apply for a third? Is the legal relationship also something we are not allowed to change?

MR. YOUNG:
It can be a family member who is not a legal guardian. It is difficult for a spouse or a parent as I believe they would have to give power of attorney to another individual. If there was another family member who was not legally responsible, they can currently serve as a caregiver through the ISO model. They would be allowed to do that through the 1915(j) waiver as well.

SENATOR HAMMOND:
Would that individual be paid as well?

MR. YOUNG:
That is correct for both the ISO and 1915(j) waiver programs.

SENATOR SPEARMAN:
Who sets the rate, or is this something the agency working with the individual sets?

MR. YOUNG:
We currently set the rate which is $4.28 per 15 minute increment. We have a budget proposal to raise that rate this year within the Governor's recommended budget. We are proposing $17.56 per hour which would be $4.39 per 15 minute increment. That is set through Medicaid and approved by this Committee. Medicaid, as with any rate, is not able to regulate or recommend what is passed on to the caregiver performing the services under the agencies applying for the rate.

SENATOR SPEARMAN:
It would be set by the agency who provides the frontline worker?

MR. YOUNG:
The actual Medicaid rate is set by Medicaid. The rate that is paid to the caregiver would be set by the agency, and Medicaid has no part in that.

SENATOR SPEARMAN:
Mr. Nagle stated there were, at one time, seven caregivers within seven days at his home. We have a difficult time getting caregivers to the rural areas of Nevada. If we do not pass this bill, how easy or difficult would it be to ensure those like Mr. Nagle are serviced in a quality and consistent way?

MR. YOUNG:
We have always had challenges recruiting personal care agencies and participation in personal care agencies particularly in the northern and rural areas. With our health care shortage, this will always be a challenge. Part of the reason in proposing the higher rate was to address this challenge. If there is more passed on to the agency there will be more passed on to the caregiver.

The option of family members and legally responsible adults is always going to be an issue. There are family members currently serving in the ISO. If that is a communication issue, this is something we can help to spread the word that they would be able to work within the existing models. If we explored the 1915(j) State Plan option, this would also help get the word out that family members would be able to serve as caregivers.

I believe the issue of recruitments would remain the same.

DENA SCHMIDT (Administrator, Division of Aging and Disability Services, Department of Health and Human Services):
Our Division does some of the assessments for the individuals on the frail elderly and physically disabled waiver. We refer the individual caregiver and assist with getting them enrolled with an ISO.

This is a State Plan option within our waiver. This would be a voluntary option for those folks on the frail elderly and physically disabled program. This would not replace the ISO. It would give the State an additional option for certain individuals to meet their needs. It provides some flexibility in areas we do not currently have it. It is not a mandate for the individual or the State agency. Because it is an option, we have flexibility in the way it is designed and who can qualify for this model.

CHAIR RATTI:
Can anyone speak to the question regarding mileage or travel time pay?

MS. COULOMBE:
Nevada Medicaid does not currently cover or budget for mileage reimbursement for personal care services, but we are happy to look into this as a standard or best practice in other states.

SENATOR SETTELMEYER:
When we started looking at this issue, somehow none of these discussions came forward. I encourage everyone who states there is an option available, to speak to my constituents so we can exercise these options. We are frustrated as to why we have not applied for additional waivers when it appears they are what we need.

I support Senator Hardy's amendment to the bill. We need to get the reimbursement rates at a fair level. If it is not prohibited, we should pass this bill as it provides more options.

CHAIR RATTI:
This is something we need to provide more time and energy to. There are some things we can do legally and those we cannot. I would encourage working with DHHS to see what can be done before it goes to the Finance Committee as they will have questions. This Body has yet to authorize the budget allocation necessary to get the waiver completed.

SENATOR HARDY:
Realistically, this has been a great opportunity to shed light on things that need to be done that are beneficial for all people.

CHAIR RATTI:
I will close the hearing on S.B. 446 and open the work session on S.B. 262.

SENATE BILL 262: Makes various changes to provide for tracking and reporting of information concerning the pricing of prescription drugs for treating asthma. (BDR 40-55)

MEGAN COMLOSSY (Policy Analyst):
I will read the summary of the bill from the work session document (Exhibit N).

CHAIR RATTI:
I will entertain a motion on S.B. 262.

> SENATOR WOODHOUSE MOVED TO AND DO PASS S.B.262.
>
> SENATOR SPEARMAN SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 293.

SENATE BILL 293: Makes various changes relating to children who are victims of commercial sexual exploitation. (BDR 38-517)

MS. COMLOSSY (Committee Policy Analyst):
I will read the summary of the bill and the amendments from the work session document (Exhibit O).

CHAIR RATTI:
I will entertain a motion on S.B. 293.

> SENATOR HAMOND MOVED TO AMEND AND DO PASS AS AMENDED S.B. 293.
>
> SENATOR SPEARMAN SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 378.

SENATE BILL 378: Revises provisions relating to the pricing of prescription drugs. (BDR 40-574)

MS. COMLOSSY:
I will read the summary of the bill and the amendments from the work session document (Exhibit P).

SENATOR HARDY:
There are issues with S.B. 378. I will be voting no.

SENATOR HAMMOND:
I am in agreement with Senator Hardy. I will be voting no.

CHAIR RATTI:
I will entertain a motion on S.B. 378.

> SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 378.
>
> SENATOR SPEARMAN SECONDED THE MOTION.
>
> THE MOTION CARRIED. (SENATORS HARDY AND HAMMOND VOTED NO.)

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CHAIR RATTI:
I will open the work session on S.B. 390.

SENATE BILL 390: Revises provisions governing the slaughtering of livestock. (BDR 51-258)

MS. COMLOSSY:
I will read the summary of the bill and the amendments from the work session document (Exhibit Q).

SENATOR SPEARMAN:
I am unfamiliar with what S.B. 390 does and have questions. I will be voting no.

CHAIR RATTI:
I did reach out to legal counsel with respect to adding specificity in the bill. This could be done through NRS or through regulation. If this bill passes, I am asking

the Nevada Department of Agriculture to ensure they are reaching out to all parties here during the process to review the NRS to be able to participate after we have gotten through the regulatory process.

I will entertain a motion on S.B. 390.

> SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED S.B. 390.
>
> SENATOR HAMMOND SECONDED THE MOTION.
>
> THE MOTION CARRIED. (SENATOR SPEARMAN VOTED NO.)

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CHAIR RATTI:
I will open the work session on S.B. 430.

SENATE BILL 430: Expanding the definition of "chronic or debilitating medical condition" for certain purposes related to the medical use of marijuana. (BDR 40-1152)

MS. COMLOSSY:
I will read the summary of the bill and the amendments from the work session document (Exhibit R).

I will entertain a motion on S.B. 430.

> SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED S.B. 430.
>
> SENATOR SPEARMAN SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will entertain a motion on S.B. 387.

SENATE BILL 387: Revises provisions relating to organ donation. (BDR 40-882)

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 387.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the hearing on S.B. 484.

SENATE BILL 484: Revises provisions relating to State health care programs. (BDR 38-1133)

SENATOR PAT SPEARMAN (Senatorial District No. 1):
I am here to present S.B. 484 for your consideration. This bill requires Medicaid to cover services provided by chiropractors. I have submitted a conceptual amendment (Exhibit S) which deletes section 2 of the bill, meaning section 1 is the only substantive section of the bill. It specifically requires the Director of the DHHS to include, in the State Plan for Medicaid, a provision authorizing reimbursement under Medicaid for the services of a chiropractor.

The fiscal note submitted by the DHCFP is not as large as some of the other bills requiring Medicaid to cover certain services. This is, in part, because Medicaid currently covers chiropractic services for children. This bill would simply apply that for adults as well.

MARLENE LOCKARD (Nevada Chiropractic Association):
Dr. Robert Rosenbaum recently stated and the Nevada Chiropractic Association agrees health care is today's front page news. It is hotly debated in Washington, D.C. and here at the Legislature.

Whether you are a patient, family member, provider, administrator or payer you care about how this problem is managed. In an age of increasing specialization, decreasing availability of primary care providers and increasing bureaucracy in accessing care, patients need to interact with care providers who can assess and treat their problems.

People on Medicaid in 30 states and everyone on Medicare can access chiropractors for various chronic pain and disability. Missouri was the most recent state to pass this measure. The Director of Missouri's Department of Health and Senior Services recognizes that:

> The importance of alternative therapies in the treatment of chronic pain is a major milestone in our response to preventing substance use disorder which often begins with prescription medications and self-medication for pain management.

When Ohio introduced their bill, representative Scott Lipps stated, "Chiropractic care is widely recognized as one of the safest, drug free, noninvasive treatments for conditions such as back and neck pain."

Chiropractic methods can solve the root cause of pain instead of masking the pain and risking dependency on opioids. Research has found prescription opioid pain medications are ineffective in the treatment of chronic lower back pain. The National Institutes of Health performed a study that found complimentary pain management approaches such as yoga, massage and chiropractic medicine were helpful in managing chronic pain for some patients. Diversifying the kinds of care patients can receive to manage their health is not just good for public health, it is fiscally responsible.

According to the Office of the Inspector General, chiropractic care only comprises a small portion of total State Medicare expenditures. A professor at Saint Louis University, Dr. John McGowan, crunched numbers and found chiropractic care can reduce the total costs of health care spending by substituting invasive medical and pharmaceutical care with less invasive and less expensive chiropractic care. He estimated the State of Missouri would save between $9.8 million and $21 million by allowing Medicaid patients to access chiropractic care in lieu of other more expensive options.

Chiropractic care is an important option that should be available to Nevadans on Medicaid. Please vote to ensure patients have diverse and robust alternative therapies for their chronic pain.

DAVID ROVETTI, D.C. (Northern Nevada Director, Nevada Chiropractic Association):

I am a chiropractor in northwest Reno and the northern Nevada Director for the Nevada Chiropractic Association. On the surface, S.B. 484 may appear to give Medicaid recipients the luxury treatment of chiropractic care for neck and back pain and possibly expensive care. However, there are many offsets the State and federal government would benefit from including it as a benefit for Medicaid patients.

The primary physicians who actually accept Medicaid are few and far between. Going to a chiropractor would decrease the amount of trips to a primary physician's office, the emergency room and associated costs for both. It would decrease the chances for spinal surgery as well, which is between $15,000 and $30,000. Eliminating one or two percent of those surgeries through allowing chiropractic care would pay for the visits to the chiropractor.

There should be an alternative to medication choices. Chiropractic care for neck and back pain would be an excellent alternative to medications.

The study done by Dr. John McGowan was the cost efficiency and effectiveness of including doctors of chiropractic to offer treatment under Missouri Medicaid. His conclusion was by these offsetting factors, Missouri would save $9.8 to $21 million. Our population is half that of Missouri, so we would also expect to save that amount.

With chiropractic care, the fact that we actually touch the patient and we have time to listen to the patient creates a good rapport with the patient and increases their satisfaction. As a parent with a child with a disability, who will probably be into the Medicaid system at one point, it would be nice to know he will be given the opportunity to choose his provider and have increased patient satisfaction.

SENATOR HARDY:

Was the study by Dr. McGowan projecting what would be saved or what actually was saved?

MR. ROVETTI:

It was a projected study done about a year ago. I do not have data on what actually happened once it was put into law.

MS. LOCKARD:
The law in Missouri was just adopted last week.

SENATOR HARDY:
Are there any other states where this is a law?

MS. LOCKARD:
Ohio has also introduced legislation. There are currently 30 additional entities; I can provide a list of those states for you.

CYRUS HOJJATY:
I support S.B. 484.

SUZANNE BIERMAN (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
It was mentioned that Nevada Medicaid currently covers the services for children and qualified Medicare beneficiaries. This bill revolves around the addition of the adult population.

We have been working with the Nevada Chiropractic Association to explore whether there are cost savings, or if this would be cost neutral. We believe expanding these services could lead to reductions in other areas of Medicaid such as emergency room use. We are committed to continuing to work with the Association and others to explore those options. This is also something we could do in the absence of legislation.

CHAIR RATTI:
Are you are saying we could add chiropractic services to the Medicaid State Plan should this bill not pass?

MS. BIERMAN:
That is correct. We do not need specific legislation to necessarily add services if we can demonstrate it would be cost neutral or result in a savings to the Medicaid program.

CHAIR RATTI:
Would that be done as part of the State Plan update?

MS. BIERMAN:
Correct. We would have to provide information on reimbursement rates and ensure it was meeting cost neutral or cost savings purposes as we do not have a decision unit in the current budget for the addition of these services.

CHAIR RATTI:
I will close the hearing on S.B. 484 and open the hearing on S.B. 472.

SENATE BILL 472: Establishes a database of information concerning health insurance claims in this State. (BDR 40-1145)

SENATOR SPEARMAN:
I am here to present S.B. 472 for your consideration. This bill establishes an all-payer claims database (APCD) system in Nevada. The measure makes strides toward our goal of healthier, more informed Nevadans. It provides the means for how we can receive better health care with smarter spending.

Over the past several years, a growing number of states have established a state sponsored APCD system to address the needs of transparency in health care at the state level and support consumers, purchasers and state reform efforts.

An APCD is a large-scale state database that systematically collects medical, pharmacy and dental claims. The purpose of the APCD system is to inform consumers and purchasers about cost containment and quality improvement efforts. The database contains eligibility and claims data and is used to report cost, use and quality information.

The data consists of service level information based on valid claims processed by health payers. Service level information includes charges, payments, clinical diagnoses and procedures codes and patient demographics. To mask the identity of the patients and ensure privacy, data is encrypted and aggregated and patient identifiers are suppressed.

The first statewide APCD system was established in Maine in 2003. Today, there are 26 states with an APCD system, and other states have introduced legislation with such a system.

I would like to present examples of ways an APCD system is used to promote transparency and oversight in health care utilization, quality, and cost. Promoting cost and quality transparency and protecting consumers, the APCD cost website in New Hampshire, Maine and Maryland makes available provider level price and quality information to consumers, health plan enrollees and employers to promote health care comparison shopping.

The Oregon APCD publishes quarterly reports that compare per member per month cost and utilization services by category for commercially insured, public employees and public payers. In Colorado, the information has been analyzed to study price variation for common procedures among health care facilities.

The system in Massachusetts has been used to produce an annual report of trends in health care spending for commercial payers by category of service, type of episode and geographic area.

Rhode Island has released a report of the top 15 clinical complaints and associated costs of potentially avoidable emergency room visits broken down by payer type. In Minnesota, APCD data has been used to analyze prescription drug spending by therapeutic category and setting. They have also released a report estimating the use and cost of low-value services in the state.

Organizations in Virginia and Utah have used APCD data to track opioid prescription claims across geographic areas and patient characteristics to understand and address trends. The researchers at Arkansas Center for Health Improvement are using APCD data to understand the impact of Medicaid expansion efforts.

The important point to remember is that none of these reports would be possible without an APCD system.

The first seven sections of S.B. 472 provide definitions of terms used in the measure.

Section 8 of the bill requires the DHHS to establish an APCD of information relating to health insurance claims resulting from medical, dental or pharmaceutical benefits provided in the State. In establishing the APCD system, the measure requires the DHHS to establish a secure process for uploading the data and ensuring the accuracy and consistency of the records. In addition, the data must not contain any patient identifiers.

In order for the DHHS to carry out the provisions of the bill, section 8 also authorizes the establishment of an advisory committee to consider the maintenance and release of data. The membership of any such committee must include representatives of providers of health care, health facilities, health authorities, health maintenance organizations, private insurers, nonprofit organizations that represent consumers of health care services and each of the two entities that submit data concerning the largest number of claims to the database.

Section 9 of the bill requires any public or private insurer that provides health benefits and is regulated under State law to submit data to the database. Certain insurers regulated under federal law are not required to submit data to the database; however, they are authorized to do so.

Sections 10 and 17 of the bill provide the confidentiality of the data contained in the APCD system. The APCD system will be compiled using the HIPAA requirements currently in effect.

Section 11 requires a person or entity wishing to obtain data from the APCD to submit requests to the DHHS. The request must include certain information including a description of the proposed use of the data, the measures to be taken to ensure the security of the data and the method by which the data will be stored.

Section 12 provides for conditions under which data may be released by the DHHS. The conditions differ depending on the sensitivity of the information requested. This section also provides for the payment of a fee for receipt of the information.

Section 13 relates to reporting requirements. The DHHS is required to publish a report at least annually, concerning the quality, efficiency and cost of health care in Nevada using data from the APCD system. They are also required to post on the internet an annual list of reports that are intended to be published with data from the APCD system.

Sections 14 and 18 of S.B. 472 require the DHHS to submit certain reports to the Legislature and Interim Finance Committee concerning the cost, performance and effectiveness of the APCD system.

Section 15 provides legal protections.

Section 16 requires the DHHS to adopt regulations to carry out the provisions of this program, including those relating to data to be included in the system, fees for obtaining data and accessed penalties.

Section 20 provides the provisions relating to implementing the APCD system are effective on January 1, 2020.

This came to me quite by surprise, when I had a meeting with the Vice Chair of Westrends for the Council of State Governments. We were attempting to discover what we needed to do for the western region in terms of some of the issues we were grappling with. We came to the conclusion that health care is one of the biggest issues each of our legislatures are wrestling with.

Washington Senator Randi Becker stated they instituted this in 2014 under Governor Jay Inslee. They have seen a lot of success since then.

JULIA PEEK (Deputy Director, Programs, Department of Health and Human Services):
The DHHS has prepared a PowerPoint (Exhibit T) which I will present for you.

As part of the bill, and a national lawsuit, the Employee Retirement Income Security Act plans do not have to report to the all-claims payer database. We have spoken to a few of them, and they are willing to possibly take part in the program. This bill is a great compliment to other bills we have heard with regard to transparency, cost, access and utilization.

This data would allow the DHHS is to look at a number of thing, including the type of patient by demographics and the geographic location of not only where they live but where they are accessing services. It also includes the types of diagnoses they have, medical needs and different payers. We would also be able to assess public health trends. Proprietary data would not be shared publicly.

The graph on page 3 of Exhibit T shows the states that have already implemented databases or are in the process of implementation.

Page 4 of Exhibit T refers to the many use cases specifically for the DHHS. We are excited about being able to look at population health in a number of different ways we have not been able to in the past. One of the proxies we use to understand population health is the hospital discharge billing data, which is limited. This would expand to primary care and other types of services we do not have a grasp on yet. It would also provide the opportunity to look at how Medicaid compares to private payers, both related to access and payment.

The graph on page 5 of Exhibit T shows what Arkansas accomplished. They looked at the Medicaid average price for certain services versus a private payer price. This is good information for us to understand health care costs. If there is a large discrepancy in that and/or trends over time, we will be able to dig deeper to see what is taking place.

Some of the APCD successes were covered by Senator Spearman. Page 6 of Exhibit T looks at avoidable emergency room visits by payer type. Page 7 is a great example of how states have used the data system complementing their efforts in looking at prescription information.

One of the challenges in the State related to public health data is chronic disease data. It is not a public reportable condition. This would allow us, as they did in Colorado, to really dive into this. We can also look at the diagnoses and the types of services the patients are receiving. This is a longitudinal data set, so we can look over time at certain services and outcomes that we have data on public health from birth to death.

I understand this is a Policy Committee, but I want to talk about the investment and our fiscal note. States have used a variety of ways to pay for the APCD system. Medicaid's proposal for Nevada would be to do this with a Medicaid match combined with the General Fund appropriation. One of the benefits we have available to us now is the HITECH Act at the federal level which allows a 90/10 match with the federal government for different IT based systems. That match does end on September 30, 2021. If we were to lose the opportunity in this Session there may not be an opportunity to have it in the future.

We also have the option to have ongoing maintenance support at the 75/25 match. The State investment for this is not huge. The federal government does match a good portion of the investment.

We have spoken with other states about what the fiscal impact might look like. We feel this is the best estimate of what it could look like. Several other states have talked about the wealth of data that is available and with that the data requests and research that can be done. We have indicated the level of staffing we believe would be needed to pull those reports and keep the data accurate and also work on compliance with the reporting facilities.

SENATOR SPEARMAN:
Senator Becker said one of the greatest benefits has been to consumers. Whenever they do the enrollment period, most people have no idea which plan will work best for them, especially those at the senior level who have chronic and complicated illnesses. This will allow them to look at the plans, see who is offering what, and compare them side by side. This also helps lead to better health outcomes.

SENATOR HARDY:
Does this take the fiscal note from $6 million to $600,000?

MS. PEEK:
We have provided both the federal match and the State match in the proposal. Yes, the General Fund matches that lower amount.

CHAIR RATTI:
Are we charging a fee? I am trying to figure out where the two-thirds vote comes from.

ERIC ROBBINS (Committee Counsel):
I believe the bill provides for a fee for those who wish to obtain information from the database. That is where the two-thirds vote comes in.

CHAIR RATTI:
Do we know who in other states is requesting any information from the database?

MS. PEEK:
It is not uncommon for us to charge a fee. We charge a fee for some of our other databases such as the cancer registry. Typically, it will be researchers in an academic setting who want to do research and publish on a topic. We will charge for our time to do a review if it will be a complex, time intensive review.

CHAIR RATTI:
There may be some cost in terms of the time they have to put into it to submit the data. We do not charge insurance plans or anyone providing data to help fund the project?

MS. PEEK:
That is a model some states have used where they provide the match through a fee from the providers. That is not what Nevada will do; we propose the use of the General Fund as the match.

SENATOR HARDY:
I looked at the Medicaid reimbursement and thought this may backfire on us as no one can make a living doing that. I may be discouraging people from taking Medicaid.

SENATOR SPEARMAN:
The upside to that would be if there are cost savings in other places to let us know where we can use those cost savings. Last Session we talked about gathering information on insulin. If we gather this demographically and geographically, we would typically know where those types of diseases are prevalent. We would also be able to gather additional information to determine whether there are social factors creating more of a problem or lessening the chronicity of those illnesses.

DAMON HAYCOCK (Executive Officer, Nevada Public Employees Benefits Program):
The Public Employees' Benefits Program (PEBP) is neutral because of the slight cost associated with us providing these payer claims to the DHHS. This is an excellent opportunity for people to obtain good data.

I would like to see what people are paying in other health care plans to help me negotiate the lower cost for our program and to the State. As with any information technology requirement, there is a pitching and catching of the data and formatting that may need to occur, and that formatting comes at a cost. This is not a cost we would bare individually at the PEBP program. Our third-party administrators would have to program it to ensure it would go over in a format that can be absorbed by the payer database. I would think all other plans would have to do something similar, so it would be a potential, additional cost.

CHAIR RATTI:
I will close the hearing on S.B. 472.

I will entertain a motion on S.B. 484.

> SENATOR HAMMOND MOVED TO AMEND AND DO PASS AS AMENDED S.B. 484.
>
> SENATOR HARDY SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

* * * * *

CHAIR RATTI:
We have received testimony in support of S.B. 387 from the Nevada Donor Network (Exhibit U) and Nevadans for the Common Good (Exhibit V).

We have received testimony in opposition to S.B. 283 from Sunovian (Exhibit W), the Epilepsy Foundation (Exhibit X) and the Biotechnology Innovation Organization (Exhibit Y).

We have received testimony in the neutral position to S.B. 283 from Gilead (Exhibit Z and Exhibit AA).

CHAIR RATTI:
Seeing no further business, we are adjourned at 7:11 p.m.

RESPECTFULLY SUBMITTED:

____
Vickie Polzien,
Committee Secretary

APPROVED BY:

____
Senator Julia Ratti, Chair

DATE:___________________________________

EXHIBIT SUMMARY

Bill	Exhibit / # of pages		Witness / Entity	Description
	A	2		Agenda
	B	8		Attendance Roster
S.B. 283	C	1	Senator Yvanna D. Cancela	Proposed Conceptual Amendment
S.B. 283	D	3	Beth Slamowitz / Department of Health and Human Services	Testimony of Support
S.B. 283	E	1	Vivian Leal	Chart Trends in Annual Disease Modifying Therapy Costs
S.B. 283	F	2	Jeanette Belz / Nevada Psychiatric Association	Medicaid PDL Infographic
S.B. 283	G	2	National Hemophilia Foundation	Letter of Opposition
S.B. 283	H	1	Betty VanDeusen / National Hemophilia Foundation	Testimony of Opposition
S.B. 283	I	2	National Alliance on Mental Illness	Letter of Opposition
S.B. 387	J	2	Dan Musgrove / Nevada Donor Network	Proposed Amendment
S.B. 387	K	1	Jessica Vela / Sierra Donor Services of Nevada	Testimony of Support
S.B. 446	L	1	Senator Joseph Hardy	Proposed Conceptual Amendment
S.B. 446	M	1	Connie McMullen / Personal Care Association of Nevada	Letter of Opposition
S.B. 262	N	1	Megan Comlossy	Work Session Document
S.B. 293	O	3	Megan Comlossy	Work Session Document
S.B. 378	P	10	Megan Comlossy	Work Session Document
S.B. 390	Q	10	Megan Comlossy	Work Session Document
S.B. 430	R	1	Megan Comlossy	Work Session Document

S.B. 484	S	1	Senator Pat Spearman	Proposed Conceptual Amendment
S.B. 472	T	10	Julia Peek / Department of Health and Human Services	Presentation
S.B. 387	U	1	Nevada Donor Network	Testimony of Support
S.B. 446	V	1	Nevadans for the Common Good	Testimony of Support
S.B. 283	W	31	Sunovian	Letter of Opposition
S.B. 283	X	2	Epilepsy Foundation	Letter of Opposition
S.B. 283	Y	2	Biotechnology Innovation Organization	Letter of Opposition
S.B. 283	Z	1	Gilead	Letter in Neutral
S.B. 283	AA	22	Gilead	Supplementary Testimony