[LB778 LB1027 LB1093]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, February 18, 2010, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB1093, LB778, and LB1027. Senators present: Tim Gay, Chairperson; Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norman Wallman. Senators absent: Dave Pankonin, Vice Chairperson. []

SENATOR GAY: Welcome to the Health and Human Services Committee. We've got three bills to listen to today. Just going to go over some ground rules. If you're testifying, we have testifier sheets on each side of the room, and there are some at the Speaker's desk. If you could fill that out before you come up and testify, it's helpful. If you want to be on record either as a proponent, opponent, or neutral and don't want to testify, you can still fill that out and just give it to a page or the clerk, and you'll be put into the record on your support or opposition or neutral. We have a time limit here in this committee--five minutes. The introducer gets as long as they want to introduce the bill or...and then any questions that we may have for the introducer. But if you're a testifier, you've got five minutes. Green light will be on until four minutes. At four minutes, the yellow light will come on. When that red light is on, your five minutes is done, and if you could wrap up your statements, we'd appreciate it. Stay around for--if there are any questions from the senators to ask of you; that doesn't count to any time; that can be either very brief or as long as you want on that. This is being broadcast via the Web and also throughout the Capitol on our televised system in the Capitol. When you come up, the clerk...if you could state your name and spell it out, that's very important and wait to be...till she gets that done because these are transcribed usually down the road quite a ways, and it helps them keep everything in order. So that's very helpful if you can spell it out even if it's a simple name. If you spell it out, it's very helpful. So with that, we will get started. As I had mentioned, if you have a cell phone please silence that if you could. That's in the interest of respect for everyone that's testifying. I'm Senator Tim Gay from Papillion-La Vista, chairman of the committee, and then we'll introduce our members and go ahead, Michelle. []

MICHELLE CHAFFEE: I'm Michelle Chaffee, legal counsel to the committee. []

SENATOR GLOOR: Senator Mike Gloor, District 35, Grand Island. []

SENATOR CAMPBELL: Kathy Campbell, District 25, Lincoln. []

SENATOR WALLMAN: Senator Norm Wallman, District 30. []

ERIN MACK: Erin Mack, committee clerk. []

SENATOR GAY: All right. And our pages are here to help you in any way as well. They

do a good job. If you have any handouts and want those distributed or need any assistance, they can help you out with that. We have other members on the committee. Senator Pankonin could not join us today. He had a commitment at something else he couldn't get out of, and then Senator Stuthman and Senator Howard are also members of the committee. They may be joining us momentarily. If people have to get up and go--senators during the committee hearing--don't take offense to that. We're still introducing bills in other committees, and they may have to go introduce a bill or testify in a bill that's in another committee in the Capitol. So with that, Senator Lathrop is here to introduce LB1093. Welcome, Senator Lathrop. Whenever you're ready. []

SENATOR LATHROP: (Exhibit 1) Thank you, Chairman Gay and members of the Health Committee. My name is Steve Lathrop, L-a-t-h-r-o-p. I'm the state senator from District 12, and I'm here today to introduce LB1093. This is a bill that seeks to clarify existing internal Medicaid procedures for newly approved prescription drugs as it relates to Nebraska's preferred drug list. The existing procedure requires any newly approved drug to be restricted in use by prior authorization for six months until reviewed by the drug use board. The Legislature previously passed legislation which required the Department of Health and Human Services to develop a preferred drug list, which is established and maintained by the Medicaid pharmaceutical and therapeutic committee. The six-month new drug prior authorization and the timing of the review by the committee can be in conflict, depending on when the new drug is approved and the schedule of the drug class review by the committee. The committee reviews a drug class only once a year, so timely review of the new drug is critical to the state and the manufacturer for potential rebate negotiations with the manufacturer. LB1093 clarifies that if a newly approved drug is approved in the time frame of six months or less before the next scheduled committee review of that class, then the committee shall review the drug for placement on the preferred drug list. LB1093 does not stop the department's procedure to control new drug utilization through prior authorization unless the drug is part of a preferred drug list class or outside of the review time by the committee. It also makes clear that the committee should not advise the department on economic benefits of the drug. There will be other testifiers today who will provide additional information on the impact of this bill and its attempt to improve the operation of the preferred drug list. I will say this, that LB830 was my bill, the preferred drug bill, and Senator Gay and I worked extensively on that to make that the law. It's something that I'm really pleased about in terms of an accomplishment since I've been down here. Now, the in and out in the committees and what they do and they don't do and how we make that all work is sort of inside ball, it seems to me. And so what you'll hear after I get up from this chair and go over to Judiciary Committee is the people who try to operate and function in that environment. And I'll tell you, here's what our concerns are, and here's why we brought the bill. So I would encourage you to ask them questions, and if you have a really simple one, I'll take a shot at it (laughter). [LB1093]

SENATOR GAY: Are there any simple questions? (Laughter) [LB1093]

SENATOR LATHROP: That's the nature of the subject matter. The answer is no. [LB1093]

SENATOR GAY: (Laugh) Actually, there probably isn't on this issue, that's for sure, but... [LB1093]

SENATOR LATHROP: Right. [LB1093]

SENATOR GAY: ...I got maybe a request. [LB1093]

SENATOR LATHROP: Certainly. [LB1093]

SENATOR GAY: Your statement--if you could get your LA or somebody to make a copy and get it to Erin, it might help us to put in our bill files, or we could do that right now. [LB1093]

SENATOR LATHROP: Okay. I'll just give it to you, and I can have somebody else prepare me a copy of it. [LB1093]

SENATOR GAY: I don't know if it's...if you marked it up or something. But I thought you did a good job explaining what you want to get done, and then we could throw it in our files and... [LB1093]

SENATOR LATHROP: Very good. And I don't know that there would be any purpose served if I stuck around to close. I'm... [LB1093]

SENATOR GAY: No, you got other things... [LB1093]

SENATOR LATHROP: ...I'm going to let these folks come in and tell you kind of how it all works inside the halls of HHS. [LB1093]

SENATOR GAY: I hear you. We'll probably learn a thing or two as well. So. [LB1093]

SENATOR LATHROP: I expect so. Thanks, Senator Gay and... [LB1093]

SENATOR GAY: Is there any questions at all? Nope. Okay, thank you. [LB1093]

SENATOR LATHROP: Okay. [LB1093]

SENATOR GAY: All right. Let's see how many people want to be speaking on this issue just so I can gauge. How many proponents are going to be speaking? About three or four. How many opponents? One. Anyone just neutral? So we don't have too many. All

right. Go ahead, Bill. [LB1093]

BILL MUELLER: (Exhibit 2) Senator Gay, members of the committee, my name is Bill Mueller, M-u-e-l-l-e-r. I appear here today on behalf of the Pharmaceutical Research Manufacturers of America in support of LB1093. The pages are handing out to you a two-page handout that describes one of the...one of the committees that we are here talking about today. And the...first of all, let me say, we're not here saying that Nebraska should not have a preferred drug list. What we're bringing to the committee's attention is that we currently have in the department two processes that both deal with drugs and both deal with drug issues. And the challenge that the pharmaceutical manufacturers are having that ultimately affects patients is: How do these two processes work together? I've handed out to you a two-page flier that the Nebraska Pharmacists Association has produced and handed out, describing what's called the drug use review board, the DUR board. This is a board that is required by federal law, as I understand it. Nebraska has had one of these since 1991. Then, as the committee knows, in 2008 the Legislature adopted LB830, and you put in...and that's the bill that you have before you. Those are the statutes that dictate how this preferred drug list procedure works. The DUR procedure is not in statute. It is in rule and regulation. The PDL process is in statute. The challenge that we're having here is that both of--and each of these entities have either a committee that looks at drugs, but there are not the same members on each committee. And the challenge is that the time lines, particularly for a newly discovered, newly marketed drug, can result in significant delays of that drug being available for Medicaid patients, because not only practically must a drug be reviewed by the PDL committee in order to decide if the state is going to put it on its PDL list, but that drug is also reviewed by the DUR committee that will decide whether the drug will be available for Medicaid patients--whether it will be subject to prior authorization. We've had discussions with the department. To date, we have not been able to satisfactorily resolve the timing of this process. The bill before you addresses two specific problems with the process as we see them. It addresses what is the role of this P&T committee in PDL--don't you love all these acronyms and initials?--what's their role. And this is a committee comprised of healthcare providers. And what we believe the role of this group--it should be determining the appropriate use of medications should a drug be on the state's PDL, should it be available to Medicaid patients. That group shouldn't be looking at the cost of a drug; that, we think, is a role of the Department of Health and their vendor that administers and negotiates on behalf of multiple states' drug costs. That's the first issue addressed in this bill. The second one is: How do we handle newly discovered drugs? How do we get those drugs so that they are available to Medicaid patients in Nebraska? And as I said before, the challenge is we have to go through the DUR and have them review the drug, get their approval before we can ever go to the preferred drug list process, before we can go through the P&T committee. I think we just need to encourage people to sit down and figure out how we make this whole process work. Every state, as I understand it, has a DUR, because that's required by federal law. Most states have a PDL program--so other states have this. They...I'm told from those

who work in these other states, these programs do work together so that patients do have drugs available to them. That, in a nutshell, is why we're here today. We think it's important. We think that, obviously, it's important that Medicaid patients have access to drugs they need; and it's also important to the state, because the state does need to watch its checkbook to see what it's paying for drugs. We, the pharmaceutical companies, want to come to the table with the state and try and get our drugs on the preferred drug list; and now with this multiple process, that's a challenge. I'd be happy to answer questions. There is someone behind me who will give you some practical examples of the problems that we're running into. I'm color-blind, but I'll bet I've gone over my time. I'll be happy to answer any questions you may have (laugh). [LB1093]

SENATOR GAY: You're right on. Senator Howard. [LB1093]

SENATOR HOWARD: Thank you, Chairman Gay. Well, just so I understand how this process works--a new drug comes out, and it has to go through the DUR and... [LB1093]

BILL MUELLER: Yes, correct. [LB1093]

SENATOR HOWARD: ...and am I right--when I listened to you, it sounded like the DUR not only looks at the effectiveness of the medication but also the cost of the medication? [LB1093]

BILL MUELLER: That is not...that is not what the DUR looks at. I don't believe that the DUR looks at cost. That is what the PDL side of this looks at, is cost. The DUR looks at, I would describe--should this drug be available to Medicaid patients? Now, do we think that the cost of that drug goes into what they think? [LB1093]

SENATOR HOWARD: That's what I meant. That's what I'm asking you so I can get an accurate picture. [LB1093]

BILL MUELLER: I think it does. Yes, I think it does. [LB1093]

SENATOR HOWARD: And a part of that would be a new drug--there's no generic drug available for that. [LB1093]

BILL MUELLER: Correct. [LB1093]

SENATOR HOWARD: So they're...if I understand it correctly, they're generally pricier when they initially come out. [LB1093]

BILL MUELLER: I think that if you ask the department, that's what the department's opinion is. What I hear from companies is that may not necessarily be true. The difficulty

is we can't get from the DUR to the PDL to where we can negotiate prices. [LB1093]

SENATOR HOWARD: Okay. Thank you. [LB1093]

BILL MUELLER: And...and if I may add: I think, practically, a newly discovered, a newly released drug--the department basically will say: Before anybody can get that, we're going to prior authorize that for at least six months. Just automatically, they impose this six-month prior authorization requirement. Depending on the timing of when the DUR board meets, it could be longer than six months; and then you have to line up in the PDL process and get on their agenda before you can ever come to the table with the state. [LB1093]

SENATOR HOWARD: So there's not regular, scheduled times when they sit down and discuss this. [LB1093]

BILL MUELLER: Each of these groups, as I understand it, meet quarterly. They may not review...well, they do not review every drug class at each one of these meetings. And there are times when the agenda is full on these meetings, and they don't have time or they've told our companies they don't have time to look at a newly discovered drug; so then that backs it up further. [LB1093]

SENATOR HOWARD: So...and the method that you're suggesting to move these things forward? [LB1093]

BILL MUELLER: In the bill, what we do is we, in effect, require that the P&T committee look at a drug at its next scheduled meeting after...if it's been on the market shorter than the six-month period. At the very least, I think the Legislature needs to decide--and if it's required to put it in statute, so be it--what is the role of the DUR and what is the role of the P&T, and work so that these processes work together. [LB1093]

SENATOR HOWARD: Okay. All right. Thank you. That's helpful. [LB1093]

BILL MUELLER: Thank you. [LB1093]

SENATOR GAY: I've got a question for you. Do you think...I mean, the PDL was fairly new legislation... [LB1093]

BILL MUELLER: It is, yes. [LB1093]

SENATOR GAY: ...so there's a certain point is the fault lie, and I'll take some of the...it is. Was the...could the bill...you know, if you're the department you got to do what you're told under the law. Was the bill written maybe that it just didn't work together, and that's something to fix, then? That's what this is doing, is fixing the PDL in a way? Or do you

think there's...? There obviously is need for improvement. But I guess I'm not going to wait clear to the end, because I know the department is probably going to come in and say: We do what we're told. And that is true, but isn't there some of this probably our own fault, the way we wrote the bill? [LB1093]

BILL MUELLER: Yeah, and I...I don't...I mean, you...I guess we could have addressed these...I mean, we could have attempted to address these issues up-front. As we all know, it's oftentimes difficult to anticipate what the issues would be. I am not aware...I think the department has the discretion now to coordinate these processes. I don't believe that LB830 is an impediment to the department to do that. I don't...I don't...there's no requirement that I've seen that a drug be prior authorized for six months. That's a policy of the department... [LB1093]

SENATOR GAY: And I guess we'll wait till they speak. [LB1093]

BILL MUELLER: Yeah, and it's a little awkward coming in front of the department, but I don't... [LB1093]

SENATOR GAY: I understand. I... [LB1093]

BILL MUELLER: ...I don't think it's a question of--we need to amend this so that the department can administer it a certain way. I don't believe that that's necessary. [LB1093]

SENATOR GAY: Okay. Any other questions? I don't see any. Thanks. [LB1093]

BILL MUELLER: Thank you. [LB1093]

SENATOR GAY: Other proponents? Come on up. Hello. [LB1093]

SHARON BRIGNER: Hello. Good afternoon. Good afternoon, Chairman Gay and distinguished members of the Health and Human Services Committee. My name is Sharon Brigner. That's S-h-a-r-o-n B-r-i-g-n-e-r, and I'm deputy vice president of PHRMA, the Pharmaceutical Research and Manufacturers of America, a trade association of more than 28 member companies devoted to research and development of new medications. In addition to working at PHRMA, I also work as an emergency room nurse in northern Virginia, in my hometown, where I provide direct patient care to emergency room patients two weekends per month. Thank you so much for this opportunity to talk to you about this very important bill, LB1093, which addresses important clarifying language that can affect the Medicaid patients' access to medicines. This bill is not about repealing the preferred drug list. The challenge in Nebraska, as I understand it, is that the bill will address two important things. One is that the two processes that are in place--the drug utilization review and the preferred drug list--are in

conflict and can be in conflict and consequently deny patients access to medications and deprive the state from getting supplemental rebates because we're not able to get it to the table to negotiate. The second aspect that this bill helps to clarify is the role of the pharmaceutical and therapeutic committee, which is called the P&T committee--that they should be using their clinical expertise to address those issues, not to address cost issues. Nebraska already has a vendor that's assigned to look at costs, and that vendor is called Provider Synergies. And the P&T committee has incredible medical experts and others that are not medical economists or insurance actuaries--rather, medical experts with health outcome knowledge and information. We know that chronic disease accounts for 75 cents of the healthcare dollar, or seven out of ten deaths are related to chronic disease. We know costly complications and deaths could be avoided if we had stronger prevention and wellness programs as well as the appropriate use of medications when needed. As a nurse, I see firsthand what happens when medication therapies are interrupted. It results in very expensive hospitalizations and procedures and also interrupts the patient's quality of life. Medicaid patients should have access to the very newest of medicines. Research shows that newer drugs have fewer side effects and they're easier to use. For example, if you only have to take one pill versus four pills a day, it's much easier to use. One interesting example is Zofran, which is a cancer drug that helps prevent patients from having nausea and vomiting. It was approved back in 1991. Well, we all know if we're nauseated, the last thing we want to do is swallow a big old pill, and that wasn't exactly good for some of our patients. Well, eight years later, in 1999, Zofran was approved with a different form, a form that melts on your tongue. It's a pill that just melts on your tongue...you don't have to swallow. So that's an important piece and an example that I want to say, because it's a huge advancement when drugs are approved in different forms. These advances should be available to patients. In addition to having access to new medications, if a patient is currently taking a medication or needs a medicine that is not on the preferred drug list, that PDL, there should be a way for that patient to get the medicine that their doctor feels is necessary. Cost should not be that driving factor; rather, it's what's best for the patient. And I've seen firsthand when cost, for example, becomes the driving factor. One example is a patient that I had recently: 62-year-old retiree with heart history, cardiovascular history, and reflux came into my ER. His employer retiree coverage no longer covered a medicine called Prilosec. It's a medicine that controls the reflux. Well, he came in with extreme epigastric pain, which basically...if you all have ever had reflux, you know it can mimic heart pain--he didn't know if he was having yet another heart attack. So bottom line--three days later, lots of expensive hospital tests on his heart and his stomach to determine that, wow, he needed to go back on that Prilosec. The Zantac, which is an over-the-counter medicine, works great for some people, was not the most effective for him. But can you imagine all the costs that are incurred, the times that he had to spend in the hospital? And if this had been a Medicaid patient, those costs would have been dramatic and also would have, you know, been incurred by the state. Also, no two patients are alike. I have an identical twin in Dallas, Texas. We both have reflux. What works for me doesn't work for her. For example, I take Nexium, and she just

cannot take that. Even the director of the FDA, Janet Woodcock--the former director--said not every patient responds to every drug in the same way. So it's important to have a choice of medicines within class. Also, research and articles and--specifically, the Alimentary Pharmacology Therapeutics Journal even substantiated what my twin sister and I are a pretty good example of. So we know that medicines in the same class may work in the same fundamental way but are not interchangeable. Lastly, when I worked at NIH--National Institutes of Health in Bethesda--I worked on an epilepsy protocol for seizure patients. I remember seeing this very young girl...she was a junior in college, and she came because she had to switch to a different medicine within the class to kind of stave off...she had to switch because of an insurance reason. She never had any seizures for years since she was really 13. All of a sudden, she started seizing several times a day. And anybody that knows when you have a seizure, you're not allowed to drive for about six months until you can show that you've been seizure free. So the poor young girl couldn't work, she couldn't complete her schooling, and this interruption again...and medical costs was traumatic, all because she had to switch to another medicine that was actually less effective and caused a lot of complications for her. Well, the examples can go on and on, but my two main points are that new drugs should be quickly reviewed by the P&T committee so that we have an opportunity to have the patient have the opportunity to have access to those treatments, and the healthcare providers can have that in their arsenal of medications as an option for that patient. LB1093 clarifies this process, that a drug would not be blocked by the DUR process and impede the PDL process since it only meets one time a year. So if a drug comes out in January and the P&T committee meets in March, that effectively means that they may not be able to have that drug reviewed for about 15 months, so this bill clarifies that. The second one is the role of the P&T committee... [LB1093]

SENATOR GAY: I'm going to cut you off pretty soon; there's some questions. [LB1093]

SHARON BRIGNER: Yes, and this is my last sentence. The P&T committee will be clarified with that role to focus more on clinical outcomes since we already have a vendor that's looking at the cost, so they can use their medical expertise. Thank you for your time. [LB1093]

SENATOR GAY: Thank you. Any questions? Senator Stuthman. [LB1093]

SENATOR STUTHMAN: Thank you, Senator Gay. Sharon, thank you for your testimony. I'd like to see your twin sister too. [LB1093]

SHARON BRIGNER: (Laugh) Yes, she's wonderful (laugh). She's a teacher. [LB1093]

SENATOR STUTHMAN: The review on those drugs concerns me--you know, when a new drug comes out and they don't review it and they can't utilize that. What is the

reason why they don't get to reviewing that drug as to, you know, moving it on, moving it to the other list? [LB1093]

SHARON BRIGNER: From what I understand, there's a six-month process; and because the P&T committee only meets one time a year, that it really...it's and they...it's 15 classes are reviewed per meeting, that basically that...the problem is that you have to wait for that next hearing until that drug could be reviewed again. So it's...I don't think that, you know, unfortunately, that's the problem, and this bill instructs that P&T committee to look at that new drug even if there's a six-month waiting period for that. [LB1093]

SENATOR STUTHMAN: Explain to me: What do they do in the review? [LB1093]

SHARON BRIGNER: In the... [LB1093]

SENATOR STUTHMAN: In the review of that new drug, do they test it? Do they...do they break it down? Is...what...what is the process? [LB1093]

SHARON BRIGNER: I think that...and I need to get back to you on more clarification on that or if I may ask my colleague, Bill, to... [LB1093]

SENATOR GAY: Well, it's...we can get it later. [LB1093]

SENATOR STUTHMAN: Yeah, we can get it later. [LB1093]

SHARON BRIGNER: ...later get that? Okay, later. [LB1093]

SENATOR GAY: He knows where to find him. [LB1093]

SHARON BRIGNER: But I do know that this bill is--really clarifies the procedure so that there's no longer a wait for that long waiting period, that it's not stuck and the new drug is not in what they call PA time...a new drug PA--prior authorization time, so it's stuck there. It's... [LB1093]

SENATOR STUTHMAN: So the utilization...with this bill, it will hasten the ability to utilize that new drug, the new technology, at a quicker time. [LB1093]

SHARON BRIGNER: Yes, and so it's not stuck with the DUR process. It's able to move forward for potential review on the PDL for the Preferred Drug List. [LB1093]

SENATOR STUTHMAN: Okay. Thank you. [LB1093]

SHARON BRIGNER: Thank you. [LB1093]

SENATOR GAY: Any other questions? Senator Gloor. [LB1093]

SENATOR GLOOR: Thank you, Chairman Gay. And thank you for making the long trip to visit with us, and don't take it personally if I tell you I never want to see you in your professional capacity in northern Virginia. [LB1093]

SHARON BRIGNER: I know (laugh). I'd take good care of you (laughter). [LB1093]

SENATOR GLOOR: If you work in trauma. Yeah, I'm sure you would do a great job. I'd just as soon, though, not meet you under those circumstances. [LB1093]

SHARON BRIGNER: Yes. [LB1093]

SENATOR GLOOR: Do you have budgetary responsibility in your role in trauma? [LB1093]

SHARON BRIGNER: No, I do not. [LB1093]

SENATOR GLOOR: Do you report to somebody who has budgetary responsibility? [LB1093]

SHARON BRIGNER: I do, yes. [LB1093]

SENATOR GLOOR: Are they also a clinician...he or she? [LB1093]

SHARON BRIGNER: No, actually, not a clinician. No. [LB1093]

SENATOR GLOOR: In your organization, do you have people who are clinicians who also have budget responsibility? [LB1093]

SHARON BRIGNER: Yes, we do. Yes. [LB1093]

SENATOR GLOOR: Trust them to make good decisions on behalf of patient care even if they're armed with dollars and cents, information? [LB1093]

SHARON BRIGNER: We have an incredible chief medical officer that I do...know is...keeps the patient as the absolute focus. [LB1093]

SENATOR GLOOR: Yeah. [LB1093]

SHARON BRIGNER: Of what he does in PHRMA. [LB1093]

SENATOR GLOOR: I think that's part of the challenge with this, is it appears we're trying to keep...it's an argument that we seem to play both ways, that this committee hears both ways. And that is, we can't trust professionals with information related to cost because it will warp their view of it. And then the flip side of that is that, you know, if we give them this information, they're professionals, they have, as professionals, the patients, the clients--whatever professional group we're talking about--first, and the dollars don't enter into or warp their decision-making process. So we hear it both ways, and I've gone through a career hearing that argument made both ways. But most of the times, I think people who are good, true professionals armed with cost information still make the right decision. And so my only comment here is I have a concern about the portion of it--and I put it out there so that somebody behind you can speak to it--of differentiating or keeping separate from these professionals cost information because we think it's going to warp their professional judgment. [LB1093]

SHARON BRIGNER: May I respond to that? [LB1093]

SENATOR GLOOR: Absolutely. [LB1093]

SHARON BRIGNER: I think that's a very interesting and good point. I think that what the intent of this legislation was just to simply utilize the experts that have been put out there on the P&T committee, which was really for their medical expertise. As I understand it, there's eight physicians in different fields, etcetera, that are to really provide their health outcomes data, their knowledge of how it really works in a patient versus what a vendor already has set up. I think a vendor--Preferred Strategies, I believe--is already contracting with the state to provide a lot of cost data; so why not utilize that P&T committee to the best of their talents, which is more of the clinical? Not, certainly, that they couldn't differentiate, because we know they can. I can (laugh)--others...so thank you for that, though. [LB1093]

SENATOR GLOOR: Okay. Thank you. [LB1093]

SHARON BRIGNER: Sure. [LB1093]

SENATOR GAY: Senator Campbell. [LB1093]

SENATOR CAMPBELL: Thank you, Senator Gay. Ms. Brigner, when you travel around the country for your company, for PHRMA, and work with other states, I'm sure...is the situation--the setup in Nebraska more complicated, less complicated? [LB1093]

SHARON BRIGNER: I believe...and, please--and I would like to get back with you with specific examples of states; but from my research on this, states have it in a little bit more simple manner, that some of them will...don't have that six-month barrier. Some immediately review it--the new drugs. Some review them at particular times despite, you

know, that six-month...so I think there are much, kind of, easier procedures and mechanisms in other states. Yes, ma'am. [LB1093]

SENATOR CAMPBELL: I'd be pleased to look at any information you have. [LB1093]

SHARON BRIGNER: I will send you some vignettes, yes. [LB1093]

SENATOR CAMPBELL: Thank you. [LB1093]

SHARON BRIGNER: Thank you. [LB1093]

SENATOR GAY: Any other questions? I've got a...I don't know if it's a question or not but maybe a statement you brought up. You said cost should not be a deciding factor, but I think cost is a major factor or we wouldn't have this, to be honest with you, because...but on the...this whole idea...I mean, I'm all for efficiency and some of those to make it work together and be more...but the PDL was--is there for cost. And every consumer makes those decisions. So we can't just say: Well, unmedicate. We're not going to do that. And I think that's why that was there. In Nebraska, we do have...there's specific exemptions that aren't in the PDL list, because we didn't want to take some drugs from people on the cases you brought up, just FYI. So we do have exemptions in there to control some of those things. But would you say, then...forget that. But this thing, if you could make it work better, is you're available to go find, as a resource, that we could go check and see what other states are doing and maybe enhance what we're doing. Is that the main thing of what you're doing? [LB1093]

SHARON BRIGNER: Absolutely, Chairman. It's my main point to make it easier. [LB1093]

SENATOR GAY: Because I don't want to mislead people and say: Well, you know, this is...cost isn't a factor. Cost is a factor or we wouldn't have this, and...but here in Nebraska we have made some exemptions on that just for those reasons you brought up. So the bill probably needs some work of LB830; but I guess on that, I just wanted to say I think that was pretty resounding. There is no...and even the sponsor of the PDL list put those in for a reason. So. [LB1093]

SHARON BRIGNER: Um-hum. That's right, and I think...I agree that LB1093 is really just clarifying language to make this, I think, move forward a little bit more smoothly. But I definitely will provide you those examples within the next couple of business days. [LB1093]

SENATOR GAY: Sounds good. Well, we'd look forward to them... [LB1093]

SHARON BRIGNER: Thanks, Chairman. [LB1093]

SENATOR GAY: ...because I...like I say, I think everyone...you know, the challenge is finding an efficient process that--that both parties can live with, right? [LB1093]

SHARON BRIGNER: Yes, for the patients, for the providers. Yes, um-hum. [LB1093]

SENATOR GAY: Thank you for coming, appreciate it. [LB1093]

SHARON BRIGNER: Thank you, thank you. [LB1093]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB1093]

SHARON BRIGNER: Thank you for your time. [LB1093]

LINDA JENSEN: (Exhibit 3) My name is Linda Jensen, L-i-n-d-a J-e-n-s-e-n. And thank you for allowing me to speak today, Honorable Tim Gay and the other members of the Health and Human Services Committee. I'm speaking today for the Nebraska Nurses Association. We wish to express our support for LB1093 to have the pharmaceutical and therapeutics committee use sound clinical evidence to base any limitations on medications that would be furnished under the Nebraska Medical Assistance Program. However, we are hoping--as the last speaker was--that this means more than just one medication, and she also talked about that you couldn't practice "cookie cutter medicine." Some people tolerate one medication but not another. And, of course, also for people with chronic diseases who have several different body systems and several different medications they are taking. So...and you have to remember that hospital costs can actually be lessened by effective medication requirements or treatments, as she just talked about, too--that if people don't have to be hospitalized...hospital costs are, you know...as we all know, if you have to spend a few days in the hospital, it's quite expensive. So keeping people out of the hospital should be more a major concern of controlling costs than necessarily how much the medication is costing. And we, of course, also want to have people on Medicaid be able to receive the effective medications that they need, so that they can be healthier and maybe be more productive, perhaps even get off Medicaid. So we do want to call your attention to the fact that one important group of prescriptive providers have been left out of the statute, and those are the advanced practice registered nurses, the APRNs. And we would like to think that there could perhaps be four APRNs on the committee. I think there's a total of 20 specified in the statute, and so there's some unassigned spots. So we would like to propose that there be four APRNs, which would be a med surg area--which would probably be a family nurse practitioner or adult nurse practitioner; psychiatric area; midwives; and certified nurse anesthetists, to cover a broader area of practice. And nurse practitioners are particularly suited to be on this committee because, first of all, they've been nurses for a number of years before they became nurse practitioners, and so they have become very skilled in observing symptoms and side effects of

medications. And they really practice in prescribing medications for individual patients. So that's our idea for that. And we do wish to...we could be helpful in finding APRNs to serve on the committee, and we want to support the bill. Any questions? [LB1093]

SENATOR GAY: Thank you, Linda. Are there any questions from the committee members? Senator Gloor. [LB1093]

SENATOR GLOOR: Thank you, Chairman Gay. I thank you for testifying. Are advanced practice nurses only nurse practitioners? You can be an advanced practice nurse and not be a nurse practitioner, can't you? [LB1093]

LINDA JENSEN: We were thinking of nurse practitioners. [LB1093]

SENATOR GLOOR: So... [LB1093]

LINDA JENSEN: Actually, there's two...there's different definitions of--and I teach in the graduate program--so different definitions of advanced practice. But in Nebraska, an advanced practice registered nurse is actually a nurse practitioner. [LB1093]

SENATOR GLOOR: Yeah, but there are certifications or credentialing for advance practice nursing that has nothing to do with... [LB1093]

LINDA JENSEN: Right, right. And that's...so that's a special certification in Nebraska. [LB1093]

SENATOR GLOOR: Well, as important...since we're making law, it's pretty important that we be specific and address what you're specifically requesting. And so I think... [LB1093]

LINDA JENSEN: Right. Um-hum, and this is...they're considered advanced practice registered nurses, are...is the designation that they're given in Nebraska for nurse practitioners, midwives, and certified nurse anesthetists. [LB1093]

SENATOR GLOOR: So if we follow that, we'll be okay. [LB1093]

LINDA JENSEN: Yeah, it should be correct. [LB1093]

SENATOR GLOOR: Okay, thank you. [LB1093]

SENATOR GAY: Any other questions? I don't see any. Thank you, Linda. [LB1093]

LINDA JENSEN: Thank you. [LB1093]

SENATOR GAY: Any other proponents? Any opponents? Vivianne, I think you're the only opponent. Just shut the light off. Take it...it's a fairly complex deal, so take the time you need to inform us of what's happening, I guess. [LB1093]

VIVIANNE CHAUMONT: (Exhibit 4) Oh, thanks (laugh). Okay. Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t. I'm the director for the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. I'm here to testify in opposition to LB1093. As you will recall, the department is required by statute to establish a preferred drug list, a PDL, for the Medicaid program. With the PDL process, each therapeutic class of medications is reviewed before inclusion onto the PDL. A therapeutic class consists of medications which are used to treat a particular disease state. Medications within a therapeutic class are often very similar and have the same class effect. With the PDL process, similar medications are compared; benefits and risks of each medication within a therapeutic class are reviewed and evaluated. The first 34 therapeutic classes of drugs were implemented in the fall of 2009 and more classes of drugs will be added to the PDL in the spring of 2010. Nebraska has also joined a multistate purchasing pool. The pool negotiates with manufacturers for supplemental rebates. The state is expected to realize savings from shifting the market to less-expensive medications within the same therapeutic class and through supplemental rebates. The purpose of the PDL is to control drug costs. LB1093 proposes two major changes to the PDL. One change relates to drug costs, and the other relates to new drugs. First, LB1093 changes the responsibilities of the pharmaceutical and therapeutics committee from advising the department on the establishment and maintenance of the PDL to advising the department on any limitations to be imposed on drugs. The P&T committee will no longer be allowed to use cost information in making its recommendations. The determination of net economic benefit will be the responsibility of the department alone. Currently, the committee looks at clinical information first. It then looks at the cost of the drugs. It is important for the committee to be aware of the net costs of medications when evaluating a drug class. Committee members need cost information to judge if a product with a slight therapeutic advantage is worth a significantly higher cost. The total value of a medication includes the financial aspects and the clinical aspects. Both components are necessary to evaluate a medication's place in therapy. The medical community may have general ideas of relative costs of medications. However, rebates that are available to the state may allow certain medications to be obtained for Medicaid patients at a lower cost than the private sector. It is important that the committee has this information when they're recommending which medications to designate as preferred. Second, LB1093 would charge the committee with reviewing new drugs at the committee's next regularly scheduled review of the appropriate class of drugs. Currently, the department goes by the schedule of the multistate purchasing pool. For example, if a new drug comes out one month, and the committee is scheduled to review that class the next month, there would not be enough information available to include the new drug on the agenda at

that time. The purchasing pool would have already submitted requests for supplemental rebates to the manufacturers, and the new drug would have missed the deadline. Also, the clinical information is immature when a new drug first comes out, and experience is lacking. Committee members would not have the information necessary to determine the total value of a new product. The cost information would not include rebate information, and there might not be enough clinical information and post-marketing experience to make an informed decision on the new drug's place in therapy. It would be prudent to stay with the multistate purchasing pool's schedule in order to make the most informed decisions. According to Medicaid Reform of 2005, new drugs are reviewed by the pharmacy consultants and the drug utilization review director, and appropriate products are placed on prior authorization. New drugs are generally on prior authorization for at least six months when they first come out, regardless of their status on the preferred drug list. This means that they are available to Medicaid clients if the physician can document that other available medications are inappropriate or the newer product has a significant advantage for their specific patient. And I want to emphasize that, because the testimony before me makes it sound like these new drugs are not available to Medicaid clients. They are available to Medicaid clients when they come out on the market. They just need to be prior authorized. And what's the purpose of prior authorization? If a physician says, in the twin situation, Nexium works for one and doesn't work for the other one, the physician can call up and say: You know, hey, Nexium doesn't work for her; we need whatever the one was that works. And that gets authorized, and Medicaid pays for it. So there is no delay between getting the new drugs from the manufacturer to the Medicaid client, but they are prior authorized to make sure that that is a drug that is really needed as opposed to a drug that doesn't have prior authorization. And that's up to the physician, and then it gets reviewed by the department. The purpose of the PDL is to provide appropriate pharmaceutical care to Medicaid recipients in a cost-effective manner. The pharmaceutical and therapeutics committee members must have cost information in order to make the good decisions. New drugs should follow the existing procedures, and rushed decisions should not be made for the evaluation of their appropriate place in therapy. I'd be happy to answer any questions. [LB1093]

SENATOR GAY: Thank you. Any questions? Senator Campbell. [LB1093]

SENATOR CAMPBELL: Thank you, Senator Gay. [LB1093]

SENATOR GAY: Sorry. [LB1093]

SENATOR HOWARD: Go ahead. She's very popular. [LB1093]

VIVIANNE CHAUMONT: Don't fight over me now. (Laughter) [LB1093]

SENATOR CAMPBELL: Director Chaumont, in listening to the testimony today, I

understand that you are preauthorizing that new drug, but then there's still a time...isn't that what the testimony is? There's still a lag time between when it goes and is reviewed and gets on the preferred list? [LB1093]

VIVIANNE CHAUMONT: There would be a lag time between the time that it goes on the...okay, so what happens is, it goes on...a new drug goes on six months, and then the DUR board reviews it. So aside from the PDL, the DUR board reviews it, and they determine whether or not to put it on prior authorization...to continue it on prior authorization. So the DUR board could recommend that it stay on prior authorization or not stay on prior authorization. And then at some point, whenever the appropriate time is for the PDL board to meet, the PDL board then...or sorry, the P&T committee then reviews that drug, compares that drug with other drugs in that class, including the cost information, and determines whether or not they're going to be a preferred drug or a not preferred drug. And the only difference is: a preferred drug doesn't require prior authorization; a nonpreferred drug requires prior authorization. So the physician would have to call in and say: You know, that cancer drug--you know, this person throws up on that cancer drug; they need the drug that melts on their tongue. And then we would approve that drug. [LB1093]

SENATOR CAMPBELL: Is...could I just follow up? [LB1093]

SENATOR GAY: Go ahead. [LB1093]

SENATOR CAMPBELL: I think, if I'm looking at your testimony, you feel that the committee does need the financial information along with the clinical information in order to make a decision? I just want to make sure I'm saying that in layman's terms right. [LB1093]

VIVIANNE CHAUMONT: Yeah, in order to make a recommendation to the department about what they...you know, the cost is just part of the puzzle. So you might have two drugs that are pretty identical. One is twice as much as another one. That's an important consideration. You might have a drug that's, you know, at 95 percent but costs three times--you know, one drug is 95 percent as good as that one, but it costs three times as much. As clinicians, do they think that that makes it effective--or does it make sense to have that on the PDL? But, you know, you always have to remember is that the fact that a drug isn't preferred does not mean that it is not available to a Medicaid client, and I think people forget that. [LB1093]

SENATOR CAMPBELL: Well, let Senator Stuthman... [LB1093]

SENATOR GAY: Senator Stuthman--just go down... [LB1093]

SENATOR STUTHMAN: Thank you, Senator Gay. I thought maybe I'd be last, but it's

okay. [LB1093]

SENATOR GAY: Not you (laughter). [LB1093]

SENATOR STUTHMAN: Ms. Chaumont, in your testimony, you know, a new drug comes out and the time frame, you know, there wasn't enough time to get...and enough information available. What type of information would they have to get? Or explain that to me. [LB1093]

VIVIANNE CHAUMONT: I've seen the information that these people review. I mean, they review all kinds of clinical data, information about the effectiveness of the drug, effectiveness of all the different drugs, clinical studies, scientific stuff, that they review along with the cost information. [LB1093]

SENATOR STUTHMAN: So there's an encyclopedia that comes with the drug? [LB1093]

VIVIANNE CHAUMONT: They get a bunch of material, a binder of material, before each meeting. Um-hum. [LB1093]

SENATOR STUTHMAN: And it's the time involved to review that information. Okay. [LB1093]

VIVIANNE CHAUMONT: Yes. So you could have a new drug--I mean, under this bill, you could have a new drug come out February 1; we're scheduled to meet February 15th, and we'd have to consider the drug that day. [LB1093]

SENATOR STUTHMAN: Um-hum. Okay. Thank you. [LB1093]

SENATOR GAY: Senator Howard. [LB1093]

SENATOR HOWARD: Thank you, Chairman Gay. Well, Vivianne, I just...I get such a different picture from the information you present from the previous testimony, which happens sometimes, doesn't it? [LB1093]

VIVIANNE CHAUMONT: It does. [LB1093]

SENATOR HOWARD: But if it were so simple, then we wouldn't be here dealing with it. I'm wondering, when a physician sees someone...there's a new drug that they would like to put them on because they feel for whatever reason it would be effective. All they have to do is pick up the phone and call. There's no forms involved. There's no consideration. There's no we'll get back to you and... [LB1093]

VIVIANNE CHAUMONT: I don't...I--I know it's pretty quick. I don't know the exact process for that, but I know that they have to...they have to explain why...why they... [LB1093]

SENATOR HOWARD: Justify the... [LB1093]

VIVIANNE CHAUMONT: Yeah, justify it and... [LB1093]

SENATOR HOWARD: But it can be done over the phone or by...I suppose a physician's nurse assistant person can do that as well. [LB1093]

VIVIANNE CHAUMONT: Yes. [LB1093]

SENATOR HOWARD: Doesn't have to be a personal call. Well, it seems to me like that would be much easier than going through the whole process. I mean, that's...if I went to the doctor, and I said I have problems with this drug, but is there something else? And they'd say, there's some new product that's out there and... [LB1093]

VIVIANNE CHAUMONT: That's how that works. Or, you know, I went on this...I mean, how many of us have had, you know, you go on this medicine, and that one didn't work so well, or, you know, hey, that pain...I had a pain pill one time gave me nightmares. You know, you come back--(laugh) yeah, really bad nightmares; I blamed it on the pill (laugh)--and, you know, come back and, you know: Hey, I can't take that; it's causing this problem. Switch you to another one. If one is not prior authorized, then the physician calls in. It's...my understanding is that that process isn't that difficult. Now, you know, would...if I were a manufacturer of a drug, would I want any impediments to my drugs being out there for everybody to use without any kind of control? Sure. [LB1093]

SENATOR HOWARD: Well, without that--without the doctor's--his staffing that will call you, it sounds like there would be possibly months and months delay, at least a six-month initial. [LB1093]

VIVIANNE CHAUMONT: No, no, no. There's...there isn't. What...the six-month is the drug is on prior authorization for six months. Okay. [LB1093]

SENATOR HOWARD: Oh, I understand, I understand. [LB1093]

VIVIANNE CHAUMONT: It's not that we take six months to return your phone call. Yeah. So a new drug starts, comes in, and then--you know, and a lot of these new drugs, I mean, come in because the same drug that that manufacturer has, the patent just went off, and now there's a new drug that's slightly different but on patent--more, you know, more expensive than the generic of what the person was taking. So. [LB1093]

SENATOR HOWARD: Okay. Well, thank you. [LB1093]

SENATOR GAY: Senator Wallman. [LB1093]

SENATOR WALLMAN: Thank you, Chairman. Yes, thank you for being here, Director. In regards to samples, you know, that drug companies put out... [LB1093]

VIVIANNE CHAUMONT: Um-hum. [LB1093]

SENATOR WALLMAN: And are they also, you know, pre-approved? Say, you're going to give it to me if I'm on Medicare. [LB1093]

VIVIANNE CHAUMONT: No, the doctor just...they don't charge us for that. Those are free. That's how manufacturers market to physicians, um-hum. [LB1093]

SENATOR WALLMAN: And they keep...sure. And you keep track of the effectiveness of that? The doctor does that? [LB1093]

VIVIANNE CHAUMONT: No. But there are studies...there are studies out there people do that...regarding, you know, the different drugs, and that's what they look at, and... [LB1093]

SENATOR WALLMAN: I'll be the guinea pig, right? [LB1093]

VIVIANNE CHAUMONT: ...you know, the FDA and--Food and Drug Administration--and that, yeah. So that's what they look at. [LB1093]

SENATOR WALLMAN: Um-hum. Thank you. [LB1093]

VIVIANNE CHAUMONT: If everybody got samples, we'd be happy, because that would be free. [LB1093]

SENATOR GAY: Can you explain...on the six-month waiting period, can you explain that a little more? I think in one of these paragraphs you kind of did, but why do we wait six months, then? They want it immediate. Why do we wait six months? [LB1093]

VIVIANNE CHAUMONT: Right. Okay. The six-month issue is...let's not get confused about what the six-month issue is. Currently, before the PDL ever became law, we put in prior authorization--and I think it was a Medicaid reform item--put in that any new drug has to be prior authorized for six months. So that just means that instead of just writing a prescription, the doctor--and it's filled--the doctor has to call and get prior authorization for, you know, whatever reason the doctor thinks that that particular drug is necessary.

So that then after six months, it gets reviewed by the DUR, drug utilization review, and they determine whether or not to leave it on prior authorization or not to leave it on prior authorization process over here. The PDL meets twice a year, and--but only reviews certain classes, just reviews whatever class that particular drug is once a year. So it could be that a drug comes out in February, goes on prior authorization, you know, for six months, and that meeting isn't scheduled, you know, for that particular drug class until September. So there isn't the opportunity to make the case in front of the PDL that there should be no prior auth...that it should be preferred, thereby requiring no prior authorization. The client still gets the drug--so it's just a matter of waiting for the P&T committee to hear that particular class of drugs. [LB1093]

SENATOR GAY: So can you go to the PDL list while you're waiting to get on the DUR; can they be simultaneously negotiating to get on the PDL list? Or do you got to go through the DUR thing first? [LB1093]

VIVIANNE CHAUMONT: No. Well, the DUR is automatic; the first six months is automatic. [LB1093]

SENATOR GAY: You've got to do that. [LB1093]

VIVIANNE CHAUMONT: Um-hum. [LB1093]

SENATOR GAY: So timing...so the six months...so you said in this, because of multistate purchasing pool, is at six months or...? [LB1093]

VIVIANNE CHAUMONT: The purchasing group has...I think they meet twice a year or... [LB1093]

SENATOR GAY: Every six months then, apparently. [LB1093]

VIVIANNE CHAUMONT: Um-hum. [LB1093]

SENATOR GAY: And then you get the rebates and all that, so...but I guess if I'm a company, I can go to the PDL. I can start working the PDL to get it on a preferred drug simultaneously while I'm waiting for the DUR review. [LB1093]

VIVIANNE CHAUMONT: They can put together whatever material they want to get ready for the meeting, but they don't work the PDL. The... [LB1093]

SENATOR GAY: Oh, they don't get any... [LB1093]

VIVIANNE CHAUMONT: No, they don't get...they don't work the P&T...you know, the P&T committee is...is comprised of specialists--physician specialists throughout the

state of Nebraska and pharmacy folks throughout the state of Nebraska. And the manufacturers come in and testify as to their drugs, but they really shouldn't be working the committee members. [LB1093]

SENATOR GAY: Yeah, whatever. But...so then on that...the nurses wrote in on the...I think they wanted to be added on the PDL list is...if I'm reading this right--on the committee makeup, I guess. Is that what--the way you understood it? They wanted a nurse or somebody like that? [LB1093]

VIVIANNE CHAUMONT: Yeah. [LB1093]

SENATOR GAY: What do you...what's your view on that? I mean as far as...does it...does that make sense? [LB1093]

VIVIANNE CHAUMONT: The list is... [LB1093]

SENATOR GAY: Broad? [LB1093]

VIVIANNE CHAUMONT: ...who's on to be--who's on to be--I can't even talk anymore. Who is on the committee is in statute... [LB1093]

SENATOR GAY: Okay. So we need to look at that, then. [LB1093]

VIVIANNE CHAUMONT: ...you know, has to be a...you know, this kind of doctor, that kind of doctor, that kind of pharmacist, that kind of... [LB1093]

SENATOR GAY: Yeah, right. It's pretty specific. [LB1093]

VIVIANNE CHAUMONT: If you folks think that it would be helpful to have an APRN, I would be... [LB1093]

SENATOR GAY: Or...well, there's four things listed here. [LB1093]

VIVIANNE CHAUMONT: Um-hum. [LB1093]

SENATOR GAY: Four different...Senator Howard. [LB1093]

SENATOR HOWARD: I have just a quick question. When you...when we discussed earlier the doctors calling and giving you...or someone the explanation as to why they felt it was an appropriate medication, do the doctors...is that pretty common knowledge with the doctors? [LB1093]

VIVIANNE CHAUMONT: Yes. [LB1093]

SENATOR HOWARD: So you get a lot of calls. It's just not random. It's not just a few. You do get calls on a regular basis. [LB1093]

VIVIANNE CHAUMONT: No. Yeah, um-hum. Sure. [LB1093]

SENATOR HOWARD: Okay. All right, thank you. [LB1093]

SENATOR GAY: And who is it they're calling? [LB1093]

VIVIANNE CHAUMONT: They call a contractor. [LB1093]

SENATOR GAY: Which is... [LB1093]

VIVIANNE CHAUMONT: No, it's not them. It's the contractor that pays the claims. I just blanked...First Health. [LB1093]

SENATOR GAY: Oh, they mentioned them. I got them written down. That's all right. [LB1093]

VIVIANNE CHAUMONT: Sorry. So many contracts, I blanked on that. First Health. It's the people that pay the claims, that process the claims--are also the people that handle that. [LB1093]

SENATOR GAY: But they call the...they call. So they're getting hundreds if not thousands of calls a day or...? A lot, probably a lot. [LB1093]

VIVIANNE CHAUMONT: I don't know how many calls they get, but physicians know this. [LB1093]

SENATOR GAY: Okay. Any other questions? Senator Campbell. [LB1093]

SENATOR CAMPBELL: Thank you, Senator Gay. Director, I want to go back. When we first looked at all of this in the Medicaid Reform Council, we really felt that in the long run we would be saving money. Do you think we are? [LB1093]

VIVIANNE CHAUMONT: Yes, definitely. [LB1093]

SENATOR CAMPBELL: Under the system that we have right now, is there a way that we could be saving more money? [LB1093]

VIVIANNE CHAUMONT: Yes. [LB1093]

SENATOR CAMPBELL: Aha. And how could we save more money? [LB1093]

VIVIANNE CHAUMONT: You exempt three drug classes from the PDL. [LB1093]

SENATOR CAMPBELL: Exempt. [LB1093]

SENATOR GAY: Yeah. Is there a reason we didn't do that? (Laughter) [LB1093]

SENATOR CAMPBELL: There's a reason. There's a very good reason why we did not. One follow-up question, and then Senator Gloor I know has a question too. After the P&T committee has looked at all of that--and they have the financial information, and you've been very clear about that--is there ever a point at which you listen to all of this--because it is the department's final decision--and say: Hmm, I'm going to go back, and I'm going to talk to some of those companies and see if I could get a better deal. Do we ever do that? [LB1093]

VIVIANNE CHAUMONT: No, we have a contractor to do that. The way it works...it's been kind of interesting for me. The P&T committee have, you know, get all their information; they make their recommendations; and they have--you know, okay, this class of drugs they recommend. The contractor...who's that other one? Synergy...thank you, Provider Synergies (laugh). Provider Synergies is the contractor that does all the research and gives the information to the P&T committee, and they recommend things. Then the P&T committee looks at their recommendations and changes. Sometimes they think a drug that we had as nonpreferred should be preferred. I expected that. I didn't expect all the situations where they would say drugs that our contractor said to be preferred they said should be nonpreferred. So they make whatever adjustments they recommend, and then I look at their recommendations, and I think 99 out of 100 times I follow their recommendation. [LB1093]

SENATOR CAMPBELL: So they're reviewing whatever is coming out of the P&T committee. [LB1093]

VIVIANNE CHAUMONT: We review whatever comes out, yeah. [LB1093]

SENATOR CAMPBELL: You review. [LB1093]

VIVIANNE CHAUMONT: Yeah. The contractor gives the information to the P&T committee. The P&T committee reviews all the information, makes their recommendations; and then I say yea or nay. [LB1093]

SENATOR CAMPBELL: So do we ever go back to the contractor and say: I think that information...I think you could get better information or better rebate--or however that is set up? [LB1093]

VIVIANNE CHAUMONT: Well, they negotiate...we can talk to them about improving the information or that. You know, I think they do a pretty good job; they negotiate rebates for a variety of states, not just us. And so I don't think we've had a problem with their negotiating. But you know, this is brand new. We've got four classes of drugs, and we've got...we've gone through the process for two. [LB1093]

SENATOR CAMPBELL: Okay. I'll let Senator Gloor... [LB1093]

SENATOR GAY: Senator Gloor. []

SENATOR GLOOR: Thank you. So that one time--you used a hypothetical (inaudible), probably not completely hypothetical, 99 out of 100--that one time I'll bet there was a cost number that might have affected that decision. I don't think that's a wrong answer. I just...I... [LB1093]

VIVIANNE CHAUMONT: Actually, it wasn't a very popular decision on my part, because they recommended that we pull a drug that was preferred to nonpreferred, and I left it preferred. [LB1093]

SENATOR GLOOR: Okay. This issue of... [LB1093]

VIVIANNE CHAUMONT: So it cost us more money. [LB1093]

SENATOR GLOOR: But you have the final say. [LB1093]

VIVIANNE CHAUMONT: Um-hum. [LB1093]

SENATOR GLOOR: That's an example of how you have the final say. And so the request that we keep this cost information away from the professionals because it--I'm hypothesizing myself here--because it might influence their professional decision-making ability isn't such a bad thing since you have the final say. If you're looking at the numbers--if there's a thousand dollars a dose between two, you could make that decision. [LB1093]

VIVIANNE CHAUMONT: Right. But I don't...I haven't been looking at the information that way. I've been looking at the recommendations. They're the experts. I want them to, you know, to give me the best advice they can, with the most information that these professionals can, regarding what their opinion is, as opposed to me making...you know, yeah, I make the final decision, but it's based on their recommendations. So I think it's very important for them to have as much information as possible--clinical information and cost information--because they're the ones giving advice to me. So why would I want to blindfold them in their advice to me? I would want to get their best

advice based on the totality of the situation. [LB1093]

SENATOR GLOOR: Do you sit in on the meetings? [LB1093]

VIVIANNE CHAUMONT: No, I haven't. [LB1093]

SENATOR GLOOR: Have your staff that do sit in on the meetings come back and shared any stories of where they made decisions that were, you know, if the price is this big a difference--when we should stick with the lower-cost med because there's not... [LB1093]

VIVIANNE CHAUMONT: You know, yeah. The stories that I...that I hear, and yeah, I have staff that...Jenny that I was sitting with is the queen of the PDL back there. She's a doctor in pharmacy...pharmacology. She comes back and tells me what the discussion was. When they...she'll go through the things, and she focuses on the ones where the contract--our contractor recommended one thing and the P&T committee recommended something else. And she will explain to me why, you know, why the...why our contractor thought it should be preferred and the committee thought it should be nonpreferred. And, I mean, I have to tell you that the conversation is clinical. You know, the only time that, really, I hear anything about cost is, you know: The P&T committee thought this drug is exactly the same as this other drug, but it costs twice as much; why would we do it? You know, the clinical information is that these are almost identical drugs; the only difference is one costs more than the other. Most of the time it really is all clinically based. [LB1093]

SENATOR GLOOR: Timing...and I'm confused by all the timing components of this, but are we leaving money on the table because of timing? Are we leaving rebate money on the table because of...understanding that the process is new--it needs to be tweaked--is there an appropriate tweaking here so that we don't lose out on some of the rebates that would be available to us? [LB1093]

VIVIANNE CHAUMONT: The rebate...we...my understanding is that we have the P&T committee meetings to match or to play with the information that we get from the contractor regarding rebates. And they do that whatever--twice a year or whatever it is; you know, they negotiate, and then they bring the new, negotiated rebate information to the committee. So if we had more meetings at different times, we wouldn't have those negotiated rebates. We would put...you know, there wouldn't be time. We would put people on the PDL, and there wouldn't be time to negotiate the rebates. So is it a perfect system? No. When we did the bill, we looked at what other states did, and our understanding was that we were running the PDL pretty much like other states were running the PDL, so--their PDLs--states that had been doing it with a lot of experience. And this contractor is the contractor for PDL for...I forget how many states, so they had that experience to help us set up the PDL. So I don't believe ours is any more onerous

than anybody else's. [LB1093]

SENATOR GLOOR: Thank you. [LB1093]

SENATOR GAY: So, well, on the PDL, you're doing a multistate rebate... [LB1093]

VIVIANNE CHAUMONT: Purchase pool. [LB1093]

SENATOR GAY: ...so it just takes some time, then, is what you're saying. [LB1093]

VIVIANNE CHAUMONT: Um-hum. [LB1093]

SENATOR GAY: And that's probably, you know...you know, it's a tough balancing act of what to do between...I think, you know, being the one that helped write the bill, it's very difficult with that balancing act of trying to please everybody and still be fiscally responsible, is tough; and this is a good learning experience for people to understand the complexities of this situation. But anyway, is there any other questions? Senator Campbell. [LB1093]

SENATOR CAMPBELL: Just a comment. And Director Chaumont and I sat with the Medicaid Reform Council, and we have a lot of new members, and I think we're really trying to do a good job of educating them. This might be the case. I mean, I'm sure that this...at this stage we may work longer on this idea. And maybe it's a question of sitting down and doing some study so we're really clear how this system works and how....and doing a review of it. As you said, do we know this is the best system? And now you've had a chance to work with it. But this might take some more education and study on our part because it's...it's not easy to pick all this up and understand the deadlines. [LB1093]

VIVIANNE CHAUMONT: It's Medicaid; you know, "easy" and "Medicaid" never go in the same sentence. [LB1093]

SENATOR CAMPBELL: (Laugh) Never simple. [LB1093]

VIVIANNE CHAUMONT: But maybe it would be helpful if we...if we tried to put a flow chart of the PDL process--the PDL process and the DUR process--so that you see, you know, how they work and maybe take, like, a recent new drug and kind of see the process that it went through, by example. And I can give that to you; I can get that to you to help with that education. [LB1093]

SENATOR CAMPBELL: Thank you. [LB1093]

SENATOR GAY: Yeah, that would be helpful, I think, to get that. [LB1093]

SENATOR CAMPBELL: But I'd be more than willing to talk to the director. [LB1093]

SENATOR GAY: And also, I mean, depending on what we're going to do here...but, you know, we have interim studies. This is a very complex thing that's just starting. Maybe...maybe it might call for something like that. I don't know; we'll see how it goes. But I would say, while you're here, by the way, Senator Lathrop and I worked a lot with the director on this, and it's a very complex thing, and she's done quite a job, really, to get this whole thing going. I'd commend you on that, and if there's... [LB1093]

VIVIANNE CHAUMONT: Thank you. I pass those commendations on to Jenny back there, because she's been fabulous. [LB1093]

SENATOR GAY: Well, whoever that needs to go to...whoever that needs to go to. But, like I say, it sounds like, you know, it's something we need to continue to monitor--and see if we can improve this, as well, as time goes on, like we would other things. So. (See also Exhibit 5) [LB1093]

VIVIANNE CHAUMONT: Absolutely. Exactly. It'd be nice to get it up and running before we started tweaking it (laugh). [LB1093]

SENATOR GAY: Any other last questions? I don't see any. Thank you. [LB1093]

VIVIANNE CHAUMONT: All right. Thank you. [LB1093]

SENATOR GAY: All right. With that, we will close on LB1093. I'm going to turn this over to Senator Stuthman, and I will be back (inaudible). [LB1093]

SENATOR STUTHMAN: Thank you, Senator Gay. Senator Coash, LB778. []

SENATOR COASH: (Exhibit 1) Good afternoon, Senator Stuthman and members of the Health and Human Services Committee. For the record, my name is Colby Coash, C-o-a-s-h, and I represent the 27th Legislative District right here in Lincoln, here today to introduce LB778. Here's what LB778 does. LB778 provides a clear and balanced education about cord blood banking options for pregnant women. The Department of HHS would place a downloadable, printable publication on its Web site. This publication would include standardized information about umbilical cord banking sufficient to make an informed decision about banking. Information includes the process of collection, storage, and use; the risks of collection, storage, and use; the options of private, public, and family banking; and the potential costs of collection, storage, and use. This bill does not hold providers liable for acting in good faith. So why do we need to do this? Stem cells derived from umbilical cord blood provide both medically effective and cost effective means for treatment. Medically speaking, cord blood stem cells have been

used to treat over 75 diseases, including leukemia, lymphoma, and sickle cell disease. In addition, there are clinical trials underway in which these stem cells are being used for potential cure of Type I diabetes. Furthermore, the use of umbilical cord stem cells among biological family members helps to increase the probability of effective transplant matches. Financially, the use of cord blood stem cells helps to alleviate potentially exorbitant medical costs associated with disease treatment. There is no cost for storage of cord blood in a public bank, and there is no cost for cord blood collection in storage for use by a family member. Other states that have enacted this type of legislation--North Carolina, Texas, California, New York, New Jersey, Michigan, Illinois, Arizona, and Georgia--have all enacted cord blood education bills. Like Nebraska, several of these states do not yet have public cord blood banks. However, banking out of state through public banking services are available across the nation. In addition, disseminating information about the value of this practice will, hopefully, direct interest in investment in Nebraska towards this medically proven and continuously promising operation. I want to talk for a moment about--and I have a couple of things to hand out here--about the fiscal note. Some of you may recall Senator Kopplin's bill LB951 in 2008. By placing the onus on providers instead of the department to print the publication, we have reduced this fiscal note from $10,000 to $5,000. Furthermore, I have an amendment being handed around that directs the department to post a--that allows the department to meet the intent of this legislation to post a link to the national Web site--which I have an example--which should take this fiscal note down to zero if that's what the department chooses to do. So with that, I will conclude my opening and see if there are any questions. [LB778]

SENATOR STUTHMAN: Thank you, Senator Coash, for your opening. Does the committee have any questions? Senator Gloor. [LB778]

SENATOR GLOOR: Thank you, Chairman Stuthman. Senator Coash, I didn't follow you when you said that the bill went from $10,000 to $5,000 because it would shift the cost to the providers. What does that mean? [LB778]

SENATOR COASH: Senator Kopplin's original bill put the responsibility of printing these publications and making them available on HHS. My bill is different in that the providers--the physicians and the providers of these services to women--would just have to make this available, and they would print that out and give that to them. So we've shifted some of the responsibility from HHS to providers. And my understanding is the larger fiscal note in Senator Kopplin's bill had to do with the department's responsibility, which I have now tried--we've tried to make it as easy as we can, especially if we adopt the Web site link example that I passed out. We should be able to get that down to zero. [LB778]

SENATOR GLOOR: What is it that they're going to print out to give them? [LB778]

SENATOR COASH: That the providers? [LB778]

SENATOR GLOOR: Yeah. [LB778]

SENATOR COASH: Well, if we adopt the amendment, they can just put their patients towards the Web site that I'm...that I passed around. Should we not, then the information will be...the department will have to provide information that's enumerated in the bill that providers could then download and give to their patients. [LB778]

SENATOR GLOOR: Would this have to be part of a medical record, a formal medical record, or part of the patient's record, do you think? [LB778]

SENATOR COASH: I don't think so. I think we can ask providers to act in good faith to make this information available. [LB778]

SENATOR GLOOR: Okay. Thank you. [LB778]

SENATOR STUTHMAN: Senator Howard. [LB778]

SENATOR HOWARD: Thank you, thank you, Senator Stuthman. Right now do...you call them providers, but they're really people that are selling a service, aren't they, a storage of the umbilical cord, the blood from the umbilical cord? [LB778]

SENATOR COASH: No. Providers in this case would be providers of healthcare to women with pregnancy that would provide this information to them. [LB778]

SENATOR HOWARD: So they would have access to the information. [LB778]

SENATOR COASH: Yes, and we're asking HHS to make sure that there's some uniformity to that. [LB778]

SENATOR HOWARD: And they're willing to take the cost of this on, or are they...? [LB778]

SENATOR COASH: At, well, $5,000 they are, yeah (laughter). [LB778]

SENATOR HOWARD: (Laugh) Well, what I...because I remember when this bill was here before--when Gail Kopplin had brought this in before--and we had a lengthy discussion about it. And I don't recall if it was passed out of committee or not at that time... [LB778]

SENATOR COASH: It was not. [LB778]

SENATOR HOWARD: ...but...it was not? We kept it in committee? [LB778]

SENATOR COASH: No. [LB778]

SENATOR HOWARD: But I know there were a number of concerns, and there are provider companies out there that are willing to do this. I wonder if the providers are going to just utilize those brochures and that information rather than publish their own. [LB778]

SENATOR COASH: They may. [LB778]

SENATOR HOWARD: All right, yeah, that's what I would suspect, too, so thank you. [LB778]

SENATOR COASH: Um-hum. [LB778]

SENATOR STUTHMAN: Senator Wallman. [LB778]

SENATOR WALLMAN: Thank you, Chairman Stuthman. Thanks for being here, Colby. I know in a neighboring state, if you want to save your baby's stem cells like this...or umbilical cord, it's $50 a month, and you can do that. [LB778]

SENATOR COASH: Um-hum. That's right. My sister did it in Iowa. [LB778]

SENATOR WALLMAN: Yeah. So this could run into a huge bill. [LB778]

SENATOR COASH: It can. That's why part of the infor...and we're just asking the information be placed, and part of the information that's mandated is the cost so people know what the cost is. [LB778]

SENATOR WALLMAN: Sure. Um-hum. [LB778]

SENATOR STUTHMAN: Thank you. Any other questions? Senator Campbell. [LB778]

SENATOR CAMPBELL: Thank you, Senator Stuthman. Senator Coash, you...I thought I was listening. Are there some states that have public banks? [LB778]

SENATOR COASH: Yes. [LB778]

SENATOR CAMPBELL: Ah, and how are those paid for? [LB778]

SENATOR COASH: Couldn't tell you, Senator Campbell. [LB778]

SENATOR CAMPBELL: Probably if they're public... [LB778]

SENATOR COASH: We don't have any here in our state. [LB778]

SENATOR GLOOR: Probably fees. [LB778]

SENATOR CAMPBELL: Probably fees. [LB778]

SENATOR COASH: I would assume fees, yeah. [LB778]

SENATOR CAMPBELL: So in the state of Nebraska, are there all private companies that do this? [LB778]

SENATOR COASH: We don't have any public...we don't have any. [LB778]

SENATOR CAMPBELL: We don't have any. None. [LB778]

SENATOR COASH: No. [LB778]

SENATOR CAMPBELL: So if we distribute the information, the person would have to go out of state... [LB778]

SENATOR COASH: That's right. [LB778]

SENATOR CAMPBELL: ...to do this. [LB778]

SENATOR COASH: And many of our...many women are... [LB778]

SENATOR CAMPBELL: Okay. [LB778]

SENATOR COASH: ...going outside of the state, but...and that's because it's not offered here in Nebraska. My hope with this bill is to raise some awareness and provide some information to Nebraska, so until the time that we do have that option for them in their own state they at least can find it. I believe that the...you know, just linking the federal Web site, which I passed out...that is the way that North Carolina did this. We did a lot of research in our office about how other states are doing it. North Carolina was in a very similar situation to Nebraska, and they didn't have their own but wanted to make sure that women had access...or families--I shouldn't say just women, but families had access to this service. And since there weren't any, what they did is they just said, they asked HHS to make sure a link is provided and asked providers to make sure that that was available in good faith to their patients. [LB778]

SENATOR CAMPBELL: Thank you. [LB778]

SENATOR COASH: Um-hum. [LB778]

SENATOR STUTHMAN: Okay. Thank you. Any other questions from the committee? Seeing none, thank you for your opening. [LB778]

SENATOR COASH: Thank you. [LB778]

SENATOR STUTHMAN: We will now hear supportive testimony for LB778. Those wishing to speak as a proponent, please come forward. Good afternoon. [LB778]

TOM SAFRANEK: Good afternoon, Senators. My name is Tom Safranek. That's S-a-f-r-a-n-e-k. I'm a physician. I work as a state epidemiologist. I'm here as a private citizen on personal leave. My views are personal and do not represent the state of Nebraska Health and Human Services or anyone other than my own. I wanted to make that clear. I'm here in a supportive role to act as a provider, answer questions--informational role to help promote what I believe is a "meritous" concept. LB778 is a positive step in ensuring the dissemination of much-needed information about umbilical cord blood banking options. The promise of this practice is proven, yet studies show that many pregnant women do not have accurate nor adequate information about their options. I wanted to cite two recent studies from the Journal of Reproductive Medicine that point to this problem. A study conducted by Arizona practitioners published in the Journal of Reproductive Medicine August 2006 revealed 37 percent of patients had no knowledge of umbilical cord blood banking. Of those who were familiar, 74 percent were minimally informed; 50 percent were misinformed that umbilical cord blood banking was only for the child I deliver; 71 percent were not planning on using umbilical cord blood banking due to expense and/or insufficient knowledge. Only 14 percent were educated by a nurse or obstetrician, while 90 percent expected answers from their nurse or obstetrician about umbilical cord blood banking. The study concluded that the lack of knowledge and expense remain barriers to umbilical cord blood banking. Opportunities to educate parents and obstetric providers on umbilical cord blood banking should be pursued. The second study, conducted on prenatal clinics and regional hospitals in Nova Scotia in 2003, revealed the following: Over half the respondents had poor or very poor knowledge of umbilical cord blood banking; 68 percent of patients thought physicians should talk to pregnant women about cord blood collection, and they wanted their cord blood information to come from a healthcare professional. While limitations exist regarding public banking, LB778 represents an opportunity to raise awareness about this ethical and successful medical treatment source. And with that, I'd be delighted to answer any questions and address your concerns. [LB778]

SENATOR STUTHMAN: Thank you for your testimony. Any questions from the committee? Senator Campbell. [LB778]

SENATOR CAMPBELL: Thank you, Senator Stuthman. Dr. Safranek, in cases where there are public banks, do people donate them for research? [LB778]

TOM SAFRANEK: There are two issues. One is a private bank, obviously, where you say this is kind of a directed donation that will...you'll retain some ownership, and you have to pay for that. And then there are public banks, where the cords are donated, and there's no guarantee that that would be available to the donor or the donor's family. But it's more, you might say, available to anyone who matches appropriately with it and that could benefit from that. And so that would be the concept behind a public bank. It would not be, you know, public in the sense that it's state-owned and operated and essentially, you know, subsidized by the state. [LB778]

SENATOR CAMPBELL: Well, once you donate to the public bank, it's going to be used for research, and there's no guarantee that if the child needs...has leukemia or whatever, and you wanted to do that, it would not be promised that you could get it. But in a private bank, you could. You could put that restriction on it? [LB778]

TOM SAFRANEK: That's correct; that's correct, um-hum. Yep. [LB778]

SENATOR CAMPBELL: Interesting. Thank you. [LB778]

SENATOR STUTHMAN: Any other questions for Dr. Safranek? Seeing none, thank you for your testimony. [LB778]

TOM SAFRANEK: Thank you, Senators. [LB778]

SENATOR STUTHMAN: Any other testifiers in the support of this bill? I would like to read into the record that we have a letter of support from Greg Schleppenbach, in support of LB778; and also we have a letter in support from the executive director of the Nebraska Right to Life, Julie Schmit-Albin. Okay, now we will hear testimony in the opposition. Seeing none in the opposition, anyone in the neutral? Senator Coash, you're welcome to close. [LB778]

SENATOR COASH: Thank you, Senator Stuthman and members of the committee. Again, I'll just add a couple of things here to answer some questions, and then I wanted to clarify one thing for the committee. Senator Campbell, you had asked about the kinds of blood banks there is. A pregnant woman has four cord blood bank options available to her after birth of her newborn. One is to donate to a public bank; two is to store in a family or private bank for use by immediate or extended family members; three to store for use by an immediate or extended family member via a free family or sibling donor bank program; or four, to discard it. Those are...those are the options. The other thing I just wanted to clarify, because I don't know if I was clear enough in my opening. And

Senator Howard had asked about the providers. All we're doing with this bill, okay, is we're asking HHS to provide this information to providers. We're not mandating that providers hand this out to their patients. We hope that by making it available, providers will, and through the beginning of this legislation we can start to bring some awareness to this issue. But, again, all this does is say that the department is going to make this information available to providers through its...and possibly through its Web site, which, if it's just a link, I think that will take care of $5,000--the fiscal note. So I just want to make sure everybody was good with that. [LB778]

SENATOR STUTHMAN: Thank you, Senator Coash, for your closing. Are there any questions from the committee? Seeing none, thank you. And now, Senator Coash, you can open on LB1027. [LB778]

SENATOR COASH: (Exhibit 1) Thank you. Senator Stuthman and members of the HHS Committee, for the record, I'm Colby Coash, C-o-a-s-h. I represent Legislative District 27, here to introduce LB1027. This is a pretty straightforward bill. If you remember last year, I came in front of this committee and I asked the committee to consider changing some reimbursement mechanisms for disability providers. That bill was passed, and the department in good faith did what we had asked them to do. And as we're finding out with some other issues in front of the body, the...when you ask to amend your state plan to the federal government, they sometimes send back answers that you may or may not agree with or it wasn't what you expected. And that was the case with this particular bill, was that we had found that...what the state wanted to do, what my intentions were, and what the department carried out because of that legislation was not in the...not necessarily what we anticipated. So to that end, what I've done is introduce LB1027, and this was really just a placeholder bill to delay the implementation of that particular piece of legislation, which will give the department and providers who are affected a little bit more time to work out exactly what it is they need to work out in order to meet the intent that I had at the original legislation. Earlier this session, Senator Gay and myself, members from the department, and members of the provider community came together and said: This is what we're seeing; what should we do? And the consensus supported by all sides was we should delay the implementation and give both sides some time to work with the federal government a little bit on our state plan. There are some changes that the federal government is already doing that is starting to help with this kind of thing, and so I may need to come back and say: We don't need this because the feds have seen the light. So with that, I'm going to make sure that the Chair has this amendment, which just simply pushes the...in the original bill, I had said six months, and then the consensus after that meeting was just to push that particular implementation out to March of 2011, which everybody felt was ample time to address those issues. So. [LB1027]

SENATOR STUTHMAN: Thank you, Senator Coash. Are there any questions from the committee? Seeing none, thank you. We will now hear testimony from people in support

of LB1027. Good afternoon. [LB1027]

TRICIA MASON: (Exhibit 2) Good afternoon, Senator Stuthman and members of the committee. I am Tricia Mason, T-r-i-c-i-a M-a-s-o-n, and I am the administrator of Community Based Services with the Division of Developmental Disabilities within the Department of Health and Human Services. I am here to testify in support of LB1027 and the proposed amendment and to provide the committee with some background information regarding the nature of this proposed change. During last year's legislative session, the passage of LB390 required the department to submit an amendment to our developmental disability Home and Community Based Service Waivers to pay for assisted services on a per diem or daily rate basis. Currently, the department pays for assisted services which provide ongoing supports to individuals on a unit or hourly basis. In September of 2009, the department submitted the amendments to four of our waivers to provide for this change. The federal Centers for Medicare and Medicaid Services, or CMS, required us to delineate a minimum number of hours a person would need to be in services in order for the provider to be paid for the day. The waiver amendments submitted required a person to be in services six hours out of every eight-hour period in order for the provider to be paid for the per diem rate. You may wonder why eight hours since the goal was to have a daily rate, but the fact remains that we still have some individuals who have only day services while waiting for residential services. And as you are aware, graduating high school students are entitled to day services in Nebraska, and that makes it difficult for us to truly have a rate that covers a 24-hour period for all assisted services. CMS did approve our waiver amendments at the end of December, and as the department has worked to implement these changes, some issues have arisen which have caused a number of problems. First and foremost, some individuals have a mixture of assisted and supported services authorized. A person may go to an assisted workshop for three or four hours a day, then work a part-time job the rest of the day, and that part-time job would be authorized as supported services. There are approximately 200 individuals across the state who currently are authorized for both assisted and supported day services. This could ultimately result in the provider never getting paid for the three or four hours that the person was at the workshop. For many individuals, this system makes sense and allows them to try new services like supported employment. We do not want to be in the position of making people choose one service over the other; and in order to allow people to have flexibility and choice, we would end up paying for these services using general funds with no Medicaid match, which would be a significant impact to the DD aid budget. In addition, there are a number of individuals who have independent time away from services or who may go home to visit their families. If they are gone more than two hours, the provider will not be allowed to claim the per diem rate even though they provided a number of hours that day. Nebraska has had a system of assisted and supported services for years, and we are realizing that some people do not fit in one category or the other. We are proposing that a third service definition be developed, a hybrid service if you will, that will address the needs of people who are developing their

independence and may require assisted-type services in some instances but who also might benefit from supported services as well. A per diem works best for individuals who are truly in services 24 hours a day, and that is what assisted services should be. The department has met with the provider associations and members of this committee to come to agreement that we need to fix the problems and find a better solution. The department is due to submit renewals for our three adult waivers this summer, which will replace our current waivers which expire on December 31st of this year. Our hope is that we can work closely with providers and advocates to develop service definitions and rates that will work not only for individuals in service but also to ensure that providers are getting paid for the services they provide. This extension will allow us to accomplish that. Thank you for your time, and I'm happy to answer any questions that the committee may have. [LB1027]

SENATOR STUTHMAN: Thank you for your testimony, Ms. Mason. Does the committee have any questions? [LB1027]

SENATOR CAMPBELL: I wish everybody was as succinct as Ms. Mason. That was excellent (laughter). [LB1027]

SENATOR STUTHMAN: Very good testimony, so thank you. I see no questions. [LB1027]

TRICIA MASON: Thank you. [LB1027]

SENATOR STUTHMAN: You bet. Anyone else want to testify in support of LB1027? At this time, I would like to read into the record that we have a letter from ENCOR, from Bob Brinker, in support of this bill, and also we have a letter from NorthStar Services, from Alan Zavodny, also in support of this bill. At this time, I will ask once again, are there any other testifiers in support? Seeing none, any in opposition? Seeing none, any in the neutral? Seeing none, Senator Coash, you're welcome to close. (See also Exhibits 3 and 4.) [LB1027]

SENATOR COASH: Thank you again, members of the HHS Committee. I want to just echo a few things that Tricia said. Tricia and her colleagues at the department have been great in working with the providers that I also have been working with to find the best solution. I do want to say, I believe that the renewals to our adult waiver services that Ms. Mason mentioned hold great promise and will continue to work in good faith with the department to ensure those renewals meet the needs of the people we support and do it in a way that we can provide it. So I appreciate the committee's consideration of allowing a little bit more time from this bill so that they can submit those new waivers and we can move forward in that direction. [LB1027]

SENATOR STUTHMAN: Thank you, Senator Coash. Any questions from the

committee? Seeing none, thank you again; and that closes the hearing for today. [LB1027]

SENATOR COASH: You guys are lucky. Seven bills in Judiciary right now (laugh). [LB1027]