HOWARD: [RECORDER MALFUNCTION] Services Committee. My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: I'm Senator Dave Murman from District 38, Glenvil, seven counties: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

WALZ: Lynne Walz, District 15, all of Dodge County.

ARCH: John Arch, District 14: Papillion, La Vista, and Sarpy.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo Counties.

CAVANAUGH: Machaela Cavanaugh, District 6, Omaha-- west central Omaha, Douglas County.

HOWARD: Also assisting the committee is our legal counsel, T.J. O'Neill; and our committee clerk, Sherry Shaffer. And our committee pages today are Michaela and Angenita. A few notes about our policies and procedures: please turn off or silence your cell phones. This afternoon, we'll be hearing four bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables, near the doors to the hearing room, you'll find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. the day prior to the hearing. Any handout submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We do use a light system for testifying, each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. And when the light turns red, it's time to end your testimony and wrap up your

final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we'll hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a strict no-prop policy in this committee. And with that, we'll begin today's hearing with LB922. Senator Kolterman's bill to require electronic issuance of prescriptions for controlled substances as prescribed. Welcome, Senator Kolterman.

KOLTERMAN: Thank you and good afternoon, Chairman Howard and members of the Health and Human Services Committee. I'm Senator Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n. I represent the 24th District in the Nebraska Legislature. LB922 is a very simple bill that mandates electronic prescribing of controlled substances by January of 2021. This language makes Nebraska law concurrent with federal laws mandating the use of e-prescribing for Medicare Part D by January of 2021, and with a total of 27 other states so far which have already adopted these mandates. You may be asking why we need a mandate when so many pharmacies and physicians already use this technology. It comes down to safety, limiting errors, and lowering the cost of healthcare. First, electronic prescribing of controlled substances adds new dimensions of safety and security. As you would expect, electronic prescriptions cannot be altered, cannot be copied, and are electronically tracking. The DEA rules for electronic controlled substance prescriptions establish strict security measures such as two-factor authentication and reduce the likelihood of fraudulent prescribing. Notably, the state of New York saw a 70 percent reduction in the rate of lost or stolen prescription forms after implementing its own mandatory e-prescribing law. Second, studies show that electronic prescriptions are less prone to errors. According to a study conducted at John Hopkins Medication Outpatient Pharmacy, 89 percent of handwritten prescriptions failed to meet best practice guidelines or, or were missing information that would otherwise be prompted by an electronic prescribing system. By comparison, not a single prescription in that study issued electronically contain that these types of errors occurred. Finally, electronic prescribing drives down healthcare costs. Through the use of tools that allow for greater price transparency at the point of prescribing an enhanced formulary compliance, electronic prescribing practices can help to control

healthcare costs. As I mentioned at the start, 27 other states have already adopted language to require e-prescriptions. In 2019, 12 states, including our neighbors in Missouri, Kansas, and Colorado enacted this legislation. I've also given you AM2202. It's an amendment that has incorporated changes recommended by CVS, NeHII, and the Department of Health and Human Services. This amendment provides that each prescriber shall report the prescription to the Statewide Health Information Exchange for data keeping purposes. It removes exemptions that concern NeHII and removes a section that allows the chief medical officer to issue a waiver. Also contained in the packet I have handed out, I've included letters of support my office has received, a map, and a list of all e-prescribing mandates across the nation and pharmacy and prescriber enablement data. I ask your support for this commonsense bill that will help improve patient outcomes, add an additional layer of safety for our prescriptions in the state, and lower costs in the healthcare system. I welcome your questions. At the same time, before we get into the questions, I would like to say that AM-- the amendment that I gave you, AM2202, that you will hear some concerns about that, some testifiers that will come up and talk about that. I am willing to work with them at this time. I, I just got the amendment back this morning and I thought I'd include it with-- for your, for your opportunity to see it. It's still work-- a little bit of a work in progress, and I willing to cooperate with the people that are gonna be talking. With that, I would try to answer any questions you might have.

HOWARD: Thank you, Senator Kolterman. Are there questions? Seeing none, will you be staying to close?

KOLTERMAN: Yes, ma'am, I will.

HOWARD: Thank you.

KOLTERMAN: Oh, and by the way, thank you for allowing me to testify early. I appreciate that.

HOWARD: You're very welcome. Anything for you, Senator Kolterman. All right, our first proponent testifier for LB922. Good afternoon.

JOEL KURZMAN: Good afternoon. Joel Kurzman, J-o-e-l, Kurzman, K-u-r-z-m-a-n. Chair Howard and members of the committee, good afternoon and thank you for the opportunity to speak with you today. My name is Joel Kurzman, I serve as regional director of State Government Affairs for the National Association of Chain Drug Stores.

In the state of Nebraska, NACDS represents approximately 250 chain pharmacy stores that employ nearly 23,000 individuals, including approximately 1,250 pharmacists. I'm here today on behalf of our members operating in the state of Nebraska to testify in support of LB922, legislation that would require all controlled substances, prescriptions, to be issued electronically. We thank Senator Kolterman for his leadership on this important issue. Chain pharmacy strongly supports policies that promote the use of electronic prescribing to transmit prescription information between prescribers and pharmacists where practical as this use of technology improves the safety and security of prescribing processes. Given the numerous benefits of electronic prescribing, or e-prescribing, that I will highlight further in this testimony, NACDS urges members of the Health and Human Services Committee to advance this important bill from committee to General File. Across the nation, there continues to be substantial growth in the adoption and utilization of e-prescribing. Recent data from the Surescript's 2019 National Progress Report indicates that 1.91 billion prescriptions were issued electronically in the U.S. last year, accounting for 85 percent of all prescriptions. However, within that total, were 115 million prescriptions for controlled substances and only 31 percent of those controlled substance prescriptions were e-prescribed. So as you can see, there is room to improve the rate of e-prescribing for controlled substances. December 2019 data shows that nearly every Nebraska pharmacy, 98.7 percent to be exact, is enabled to receive electronic controlled substance prescriptions, but only 55 percent of prescribers are enabled and using this beneficial technology. Recognizing the important role of e-prescribing in helping to curb the opioid crisis, Congress enacted in 2018, federal legislation requiring controlled substance prescriptions covered under Medicare Part D to be electronically transmitted starting in 2021. We encourage lawmakers in Nebraska to build upon this effort and extend the mandate to apply to all prescriptions issued in the state-- controlled substance prescriptions issued in the state, not just covered-- those covered by Medicare. For controlled substances, in particular, the electronic prescribing of controlled substances adds new dimensions of safety and security. As mentioned by the senator, electronic controlled substance prescriptions cannot be altered, cannot be copied, and are electronically trackable. Furthermore, the federal DEA rules for electronic controlled substances prescriptions establish strict security measures such as two-factor authentication that reduce the likelihood of fraudulent prescribing. Notably, when the state of New York implemented an e-prescribing mandate in 2016, the Department of Health reported a 70 percent reduction in the rate

of lost or stolen prescription forms, e-prescribing practices also improve patient care and outcomes. According to a study conducted at a Johns Hopkins Medication Outpatient Pharmacy and published in 2017 in the Journal of Opioid Management, 89 percent of handwritten opioid prescriptions failed to meet best practice guidelines or were missing information that would otherwise have been prompted by an e-prescribing system. By comparison, not a single prescription in that study issued electronically contained these types of errors. In fact, e-prescribing has been shown to reduce medication errors in the ambulatory setting by as much as sevenfold according to a 2014 study published in Perspectives in Health Information Management. E-prescribing further allows prescribers to track whether the prescription was filled and how often it is refilled. Additionally, this technology enables clinical decision making at the point of care. When e-prescribing is part of a healthcare provider's electronic health records system, prescriptions can be checked for interaction with patient medications, health conditions, and allergies. E-prescribing also drives down healthcare costs through the use of tools that allow for a greater price transparency at the point of prescribing an enhanced formulary compliance. The aforementioned study found savings estimated between 140 billion and 240 billion over 10 years. Given that e-prescribing practices serve important public health goals of reducing opportunities for diversion and abuse and broadly improving patient care, NACDS urges you to advance this legislation to General File as written. We appreciate the opportunity to share the perspective of our members operating in Nebraska. We welcome the opportunity to work with members of the Unicameral on this and other issues that promote high quality healthcare and improve public health. And again, thank you very much for the opportunity to speak with you.

HOWARD: Thank you, Mr. Kurzman. Are there questions? Senator Arch.

ARCH: Thank you, thank you, Chairwoman. And thank you for coming today. I-- just a couple of questions. In background material that we received, it, it indicates that CMS has an effective date of January 1, 2021, and I'm assuming that's correct.

JOEL KURZMAN: Yes.

ARCH: Does, does the date in this bill coincide with that date so that we're requiring all substance-- all, all of these controlled substances to be reported?

JOEL KURZMAN: Yeah, our legislation aims to track with this federal policy.

ARCH: So physicians, providers, everyone will be needing to do that if they participate in Medicare?

JOEL KURZMAN: If they-- yeah, if they-- exactly. That's, that's well said. If they're wanting to serve Medicare Part D patients, this is something that they will be engaging--

ARCH: OK.

JOEL KURZMAN: --already, yes.

ARCH: Are, are you aware-- and this, this may not-- you may not be aware, but are, are you aware of any electronic medical record that does not, that does not contain an e-prescribing module?

JOEL KURZMAN: That is a good question. I would want to do my homework on that and not misspeak.

ARCH: Yeah.

JOEL KURZMAN: But I'd be happy to work on that and provide that insight for you.

ARCH: I was just thinking that for a smaller community physician that may have an EMR or may have purchased an EMR, is that, is that e-prescribing module automatic? I would assume that it is, but I, I don't know.

JOEL KURZMAN: Or add on, it can be added on. I would presume as well. But my job is not to presume,--

ARCH: Right.

JOEL KURZMAN: --it's to provide you facts so I--

ARCH: Thank you. Maybe somebody that follows you--

JOEL KURZMAN: Yeah.

ARCH: --would, would know the answer.

JOEL KURZMAN: Yeah, and I certainly know that stand-alone e-prescribing systems exist. I believe they can be built on. But again, I will follow up with you.

ARCH: OK. Thank you.

JOEL KURZMAN: Um-hum.

HOWARD: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairperson Howard. And thank you for being here. And, and, of course, you represent the change with-- chains, which I think of as large stores. I'm, I'm also from a rural area and concerned about the smaller pharmacies that may not be in that chain. And also the smaller providers that may be not in there. Take me through and tell me so I clearly understand e-filing versus when I used to walk in there and they wrote something on a pad and I carried it to the pharmacy myself. So now I'm assuming it's the provider themselves filling out something, shooting it on-line to the pharmacy. Correct?

JOEL KURZMAN: You know, Surescripts, I think would be an excellent resource to be able to handle any sort of standards based and detailed description of the, of the electronic process. I don't feel like I have mastery over the electronic aspect--

WILLIAMS: OK.

JOEL KURZMAN: --of, of the transmission.

WILLIAMS: I think you mentioned in your testimony that 98.7 percent of, of current pharmacies have the ability to, to do this.

JOEL KURZMAN: Yes.

WILLIAMS: Will somebody be able to tell me about the other small percentage, which I am assuming are small rural pharmacies that maybe don't have that now? What the ability of that will be and what the cost of that will be to them? And then my, my last question, either to you or, or people coming along is the small providers, the, the small doctor's office, the dentist office, the optometrist office that now prescribe different things like that, their ability to meet these things?

JOEL KURZMAN: Yeah, these are, these are fair questions. I'm not clear on resources available to that 1.3 percent of, of pharmacies that are, are not enabled. I presume this means that they do not field prescriptions for the Medicare Part D population, these controlled substance prescriptions.

WILLIAMS: And I know we're only talking controlled substances--

JOEL KURZMAN: Yeah.

WILLIAMS: --here so you don't worry about the optometrists and a few, but--

JOEL KURZMAN: Yeah.

WILLIAMS: --you're still concerned about--

JOEL KURZMAN: So I'm not aware of, of resources, but I suspect that there could be and I'd be happy to research that.

WILLIAMS: I'm sure that'll be addressed by another testifier.

JOEL KURZMAN: I'd like to research that for you, because I suspect in my other eight states I would receive similar inquiries on, on that as well. And I agree with you that you do not want to overlook however small that segment is. You know, I would like to follow up with you on that.

WILLIAMS: Thank you.

HOWARD: Thank you. Are there any other questions? Seeing none, thank you for your testimony today.

JOEL KURZMAN: Thank you.

HOWARD: Our next proponent testifier for LB922. Good afternoon.

TRACIE BOWMAN: Hi. Good afternoon, Madam Chairman and members of the committee. My name is Tracie Bowman and I'm a regional healthcare director for Walgreens in Nebraska. Thank you for allowing me to--

HOWARD: Could you spell your name for us?

TRACIE BOWMAN: Oh, I'm sorry. First time, got excited. Tracie, T-r-a-c-i-e, Bowman, B-o-w-m-a-n.

HOWARD: Thank you.

TRACIE BOWMAN: Thank you for allowing me to testify today on LB922 regarding mandatory electron-- electronic prescriptions. I'm here today on behalf of Walgreens and in support of the bill. I also want to take the opportunity to thank Senator Kolterman for his sponsorship of the bill and his leadership with this important issue. So as many of you are aware, electronic prescribing is the secure transmission of electronically prepared prescription from a prescriber to the pharmacy. So why is this legislation important? With today's technology, it's easier than ever to create fraudulent prescriptions that look like original prescriptions from the providers. Research indicates that between 3 and 9 percent of diverted opioid prescriptions are tied to forged prescriptions that can add up to thousands and even tens of thousands of fraudulent prescriptions being filled in Nebraska annually. Electronic prescribing is just one essential step to help address the challenges of diversion and fraud related to controlled substances. Specifically, the benefit of electronic prescribing includes prescriptions cannot be altered or copied, prescriptions are tractable-- are trackable, doctor shopping is prevented. Electronic prescribing ensures only those authorized to prescribe do so. It eliminates handwriting errors and improves patient safety and outcomes. These benefits of electronic prescribing are not exclusive to pharmacies, but also benefit prescribers and ultimately the patients that we all serve. In my almost 30 years as a Nebraska licensed pharmacist, I've seen-- sadly seen an increase in the cases of fraud and abuse of opioids. Some examples that we experience in our stores quite frequently include stolen or forged prescription blanks. Patients that have written controlled substance prescriptions have altered them. They've altered the strength. In many cases it's they've altered the quantity on the handwritten prescription and sometimes they've even altered the name on the written prescription. In regards to phoned in controlled substance prescriptions, too often there are patients calling in, pretending to be the physician or nurse calling in their own prescription. Sadly enough, there is cases where we've seen nurses acting, calling in their own prescription and pretending to be acting on behalf of the physician. So electronic prescribing of controlled substances is a positive step to help reduce fraud and abuse of these drugs in our communities across the state of Nebraska. Madam Chair and members of the committee, thank you for allowing me to testify today on this important topic. And I would urge you to support LB922 and I'm happy to answer any questions that you might have.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

TRACIE BOWMAN: All right, thank you for your time.

HOWARD: Our next proponent testifier for LB922. Good afternoon.

KEVIN BORCHER: Good afternoon. Thank you, Senator Howard and members of the Health and Human Services Committee. My name is Kevin Borcher, K-e-v-i-n B-o-r-c-h-e-r, and I'm testifying in support of LB922 as amended by Senator Kolterman. Although I'm a member of the Nebraska Board of Health, I'm testifying here today as a senior director of Pharmacy Services at NeHII and the Prescription Drug Monitoring Program director. Electronic prescribing has become an important part of patient care and patient safety. Multiple academic articles have documented the benefits of e-prescribing. These include the reduction of transcription errors, the ability to check the PDMP at the time of prescribing for drug interactions, allergies, and duplicate therapies and reducing fraud and diversion. It also improves provider and pharmacist workflow and patient satisfaction by reducing the time and costs required to manually write, fax, or call in prescriptions. In October of 2018, Congress passed legislation and the SUPPORT Act to require prescribers to issue electronic prescriptions for controlled substances for Medicare Part D and Medicare Advantage Part D patients beginning January 1, 2021. Through the Promoting Interoperability Program, formerly known as Meaningful Use, CMS is mandating that eligible hospitals and eligible providers electronically prescribe controlled substances in January of 2021 also. As previously mentioned, there are 27 states which have enacted legislation to require EPCS. In addition, six states have moved beyond just controlled substance prescribing to require all prescriptions to be electronically prescribed, including Iowa, which went live and their law became effective January 1 of 2020. In addition to improving health outcomes and provider workflow, LB20--922 as amended enhances the accuracy and efficacy of our state's prescription drug monitoring program. EPCS and PDMP compliment and support each other by reducing fraud, diversion, and leading to healthier outcomes for Nebraska patients. We appreciate Senator Kolterman's willingness to include NeHII through this amendment. In order to facilitate and enable EPCS, NeHII is able to provide funding through the SUPPORT Act for all Nebraska provide-- prescribers who care for Medicaid patients to implement EPCS within their electronic health record or even through a mobile device such as their phone. This technology is accomplished

through stringent requirements by the DEA to ensure the safe and secure transmission of information. NeHII has already sent out a EPCS readiness assessment survey to all prescribers in Nebraska. We're waiting for the results of that to understand that information and information was provided earlier that about 55 percent of providers are EPCS enabled through Surescripts now. So we're working to understand that gap better. I thank you to allow me to speak today. NEHII supports the use of electronic prescribing and has an opportunity to facilitate the enablement of electronic prescribing of all prescriptions and, in particular, the electronic prescribing of controlled substances. We support LB922 as amended and are grateful to Senator Kolterman for working with NeHII and other partners on the amendment. With that, I would be willing to answer any questions you may have.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Thank you. Just your opinion between here and there, between here and January 1, is there, is there enough time for a provider to get, to get up to speed if they're currently not e-prescribing?

KEVIN BORCHER: We believe there is. We have already been performing a lot of work through the SUPPORT Act that NeHII has been working on identifying EPCS vendors that are willing to work with us to meet the goal as closely as possible.

ARCH: OK, so they're already in-- and knowing that Medicare's coming January 1, if you're-- if Part D, They're already in process. So it'd only be those who perhaps don't participate, very few, but don't participate in Medicare D that would, would have to get up to speed.

KEVIN BORCHER: That would be correct.

ARCH: OK. Thank you.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you. So I'm looking at this sheet here that's been handed out a couple of times, are, are we talking about five pharmacists? Is that--

KEVIN BORCHER: From my calculations, there are approximately 492 community pharmacies in Nebraska.

CAVANAUGH: OK.

KEVIN BORCHER: Out of that, 98.7 percent are already enabled, less than 15 pharmacies in the state, therefore, are not EPCS enabled.

CAVANAUGH: OK. All right. Thank you.

KEVIN BORCHER: You're welcome.

HOWARD: Other questions? Seeing none, thank you for your testimony today.

KEVIN BORCHER: Thank you.

HOWARD: Our next proponent testifier for LB922.

JIM OTTO: Senator Howard, members of the committee, my name is Jim Otto. That's J-i-m O-t-t-o. I'm president of the Nebraska Retail Federation, and I am here to testify in favor of LB922 on behalf of the Nebraska Retail Federation and also on behalf of the Nebraska Grocery Industry Association. Between the two of us, we have pharmacists who also sell groceries or grocers who have pharmacies. And we just simply want to encourage-- to let the committee know that both associations on behalf of their members truly support this and urge you to move it forward.

HOWARD: Thank you. Are there questions? Thank you, Mr. Otto. All right, our next proponent testifier LB922. Seeing none, is there anyone wishing to testify in opposition? Good afternoon.

MATT SCHAEFER: Good afternoon, Chairwoman Howard, members of the committee. My name is Matt Schaefer, M-a-t-t S-c-h-a-e-f-e-r, testifying today on behalf of the Nebraska Medical Association and the Nebraska Dental Association in opposition to LB922. Let me first start by saying that our groups do support the availability of e-prescribing and we have many, many, many members who choose to use it. But we oppose LB922 today because we think it should remain a choice for prescribers and not be mandated. To quickly respond to the Medicare Part D point brought up, in our preliminary research we think we might disagree with the breadth of the mandate as described earlier. We think that it might be that providers who participate may just have to have the availability to e-prescribe. They may not actually have to issue every prescription electronically. But we are still checking that. And at any rate, that would only subject people or providers who take Medicare Part D to that mandate. And the mandate in front of you

far exceeds, far exceeds that scope by requiring all providers-- or prescribers, whether or not they're Medicare providers to e-prescribe. In getting feedback from our members on this, we heard about several times where an electronic, electronic prescription may not be preferred or may not be the best choice. For instance, we've heard that parents may wish to take a paper script so that they can bring it to their kid's school so that the child can bring the drug to school, other position to e-prescribe noted that there are times where their software is not working. And I think we can all share that frustration when technology is not working at the moment we need it and there are simply other physicians and, and prescribers who do not prescribe that frequently and have chosen to not subscribe to this software because they don't see it as a benefit to them for what it costs. And I, and I do want to emphasize that there is a cost to the software for electronic prescribing. I'm told that it can be upwards of $50 per prescriber per month. So it's not a de minimis, de minimis amount. So I think from our perspective, if, if these for-profit software companies want greater use of their software, there are many options to them short of this legislation. I think they can engage in more outreach, they can engage in more education and, and offer additional incentives to providers and prescribers for greater utilization of their software. This morning we were-- obtained the amendments, and let me just conclude by saying that we'd be strongly opposed to the amendment as well, which adds an additional mandate to the underlying bill by requiring a membership to an additional software and an additional burden on our physicians and physician offices to input prescriptions duplicating efforts already done on the PDMP. I'll conclude there and happy to answer any questions.

HOWARD: Thank you. Are there questions? Can you walk me through the, the concerns about the amendment, AM2202 again?

MATT SCHAEFER: Again, we just received it this morning, but it is our understanding that it would require prescribers to enter information as required by NeHII and to NeHII. We have physicians who choose not to be members of NeHII. And this would effectively mandate participation in NeHII. And it would mandate every time a controlled substance was prescribed, additional information would be inserted into NeHII.

HOWARD: OK.

MATT SCHAEFER: That's how we read it.

HOWARD: What percentage of physicians aren't using electronic health records in the state of Nebraska?

MATT SCHAEFER: I don't know that. I think it's a minority.

HOWARD: A minority. OK. OK. So my understanding was that NeHII worked seamlessly with an electronic health record. And so it wouldn't necessarily be the provider themselves would be sending the information to NeHII. Is that your understanding as well?

MATT SCHAEFER: That's not my understanding of the amendment, but that would be a better situation.

HOWARD: Because I mean, last year we allowed for interoperability between the electronic health record and the prescription drug monitoring program. Is that--

MATT SCHAEFER: I think we did. But again, I don't think every physician uses NeHII.

HOWARD: But every physician is using the prescription drug monitoring program.

MATT SCHAEFER: I think many of them are. But it's my understanding our prescription drug program mandate is on dispensers and not on prescribers today.

HOWARD: Well, it's on dispensing, what's dispensed. Yeah.

MATT SCHAEFER: Yeah, so the dispenser inserts the information into the PDMP, I don't think the prescriber currently is required to insert prescription information into the PDMP.

HOWARD: OK. All right. Thank you.

MATT SCHAEFER: So this would be a new, a new mandate to do that.

HOWARD: Right, but I want to make sure that we understand that it would not be a doctor typing in a prescription into NeHII, because that's not how it works.

MATT SCHAEFER: I mean, the first line in the amendment says each prescribers shall transmit electronically.

HOWARD: Oh, OK. So, so that their discomfort is with the electronic transmission of the prescription?

MATT SCHAEFER: Our discomfort is with lines 1 through 5, as we understand it. If an additional conversation, it's back office function of the PDMP transmitting information that may be more acceptable.

HOWARD: OK. Great. Thank you. Any other questions? Seeing none, thank you for your testimony today.

MATT SCHAEFER: Thank you.

HOWARD: Our next opponent testifier for LB922.

DARRELL KLEIN: I need to get my reading glasses out. Pardon me. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Darrell Klein, D-a-r-r-e-l-l K-l-e-i-n, and I am a deputy director for the Division of Public Health within the Department of Health and Human Services. And I'm here to testify in opposition to LB922, which will require authorized prescribers of controlled substances to use electronic prescription technology for controlled substances. This bill contains 11 exceptions, one of which is a waiver from the Chief Medical Officer of DHHS. And under the bill, a pharmacist is not required to verify a nonelectronic prescription fits any of those exceptions. The pharmacist is expressly allowed to dispense these prescriptions anyway, and the CMO waiver under the bill expressly requires us to adopt rules and regulations. And the bill explicitly states that violation of the electronic prescribing requirements shall not be grounds for discipline under the Uniform Credentialing Act. And without the ability to discipline licensees who violate these provisions, the Department cannot enforce that legislation, which would render a waiver unnecessary. Finally, if Section 4 of the bill is placed in the Uniform Controlled Substances Act, violations may be criminal acts, but not grounds for discipline of a professional license. A waiver from the CMO of what may otherwise be a crime may raise additional problems. In summary, LB922 will not be enforceable by the Department, but would entail additional regulations and possible work to no effect. At a minimum, the waiver provision should be removed. If the committee offers that in an amendment, and I understand that has happened, the agency will withdraw its opposition. And I thank you for the opportunity to testify today. I'd be happy to answer any questions you may have.

HOWARD: Sure. Have you seen AM2202?

DARRELL KLEIN: I have.

HOWARD: OK. And does that meet your aims?

DARRELL KLEIN: For the removal of the waiver, it does. I do want to echo just informationally, the, the provisions on line-- well, lines 1-5 would require the reporting of prescriptions to, to NeHII essentially. And currently what's reported under the PDMP are dispensed prescriptions. So this would be a requirement for a different group of people to report different information because I, I can't give you figures, but not all prescriptions end up being dispensed. So this would be a, a report of the prescription itself into NeHII. And then secondly, if the consideration is to have this being reported into the PDMP, it's not currently set up to receive that. And that would require additional infrastructure changes which having served as legal advice giver to the PDMP folks, I would defer to, to the actual-- to Felicia, and some of the PDMP folks who could do it, and, and Mr. Borcher would also have that information. And then lastly, just as kind of a sideline comment, if the, if the requirement is to not require reporting through the PDMP, but just have the reporting go into the HIE. I will note that I think the law still provides that patients, individual patients can opt out of the HIE. And so there'd be a, a semi-ambiguity there if a prescriber is required under our law to report all controlled substance prescriptions and the patient had opted out of the sharing of that information.

HOWARD: Thank you.

DARRELL KLEIN: A little esoteric, but--

HOWARD: Thank you. Are there questions? All right. Seeing none, thank you, Mr. Klein.

DARRELL KLEIN: Thank you.

HOWARD: Our next opponent testifier for LB922. Seeing none, is there anyone wishing to testify in a neutral capacity?

JONI COVER: Good afternoon, Senator Howard and members of the Health and Human Services Committee. For the record, my name is Joni Cover. It's J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association and I'm here today to testify in a neutral capacity. We

have vetted this bill with our membership. And I will tell you, we are all over the board whether we support it or oppose it. So I'm here neutrally to talk to you just about some of the issues that have been brought forward by, by our members. I want to say thank you to Senator Kolterman and his staff and NACDS and CVS for working with us. Where we started with this bill and where we've ended up with this bill, there have been some significant changes so we want to recognize that and to say thank you for that. I can't speak to AM2202 because our folks have not vetted that yet, but I did pass around an amendment. I'd like to think it's a friendly amendment, so we'll see what you all think, asking for the fees to basically be waived for pharmacies to receive prescriptions, electronic prescriptions. That is one thing we did agree on is when a pharmacist receives an electronic prescription, we're charged a fee, whether it's a correct prescription or an incorrect prescription, we still get a transaction fee. And those fees can go anywhere from 5 cents to 30 cents, which may not seem like a big deal in the scheme of business, but when pharmacies are often underpaid for the prescription that they dispense to the patient and they can't pass along any of the fees to the patients, it can be problematic. So that was why we offered the friendly amendment. That amendment is similar to what is-- I don't know if it's the same wording, but it's similar to the concept for which the prescription drug monitoring program, the PDMP, was set up so that it was to be no cost to the dispensers. So that's sort of what we're pattering-- patterning it after. All pharmacies, I think with the exception of a few, do accept e-prescriptions. I think the one pharmacy that had typewriter only has finally changed over to electronic prescribing so that, you know, hey, we're making progress in Nebraska. But I will tell you, unfortunately, that errors still occur and that we are now starting to see the ability for e- prescribing software to be hacked. We're starting to hear this more, and it's more on the EMR side. So just sort of something to be aware of for the techie folks in the, in the room. We've, we've seen some news stories in states that have, have e-prescribing that, that is happening. So again, I just wanted to say that we appreciate the work, we're willing to continue to work with the committee. And we, we understand the importance of this bill, but we also have some cost concerns. So with that, I think I'll stop. And if you have any questions, I'm happy to answer them.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

JONI COVER: Thank you.

HOWARD: Our next neutral testifier for LB922. Seeing none, while Senator Kolterman is coming up for his closing, I'll read the letters. Letters in support: Ryan Irsik, Walmart Public Affairs & Government Relations; Ken Whittemore Jr., Surescripts. Letters in opposition: Jennifer Tilleman, Magis Clinic. No letters in the neutral position. Welcome back, Senator Kolterman.

KOLTERMAN: Thank you, Senator Howard. Appreciate the dialog we've had today. Somewhat dismayed from the fact that we changed the amendment to accommodate the Health and Human Services, and then they came in opposition anyway so I, I can't figure that one out, but we'll talk about that. On the other hand, I'm more than willing to work with anybody that wants to work with us to make this bill a better bill. As far as the pharmacies are concerned, they're already paying the fee, we're not increasing the fees, the fees would not change. I understand there's a fee, but they won't go away with the other e-prescribing that's already going on. So with that, I would encourage you to work with us to make this a better bill and move forward with it and I'm happy to entertain any questions.

HOWARD: Thank you. Are there any final questions for Senator Kolterman? Senator Hansen.

B. HANSEN: Thank you. Why is there a fee? And where does the money go towards? Do you know?

KOLTERMAN: I, I think it-- I don't, I don't have an answer for that,--

B. HANSEN: That's fine, I should have asked it earlier.

KOLTERMAN: --I don't have an answer for that.

B. HANSEN: Thanks.

KOLTERMAN: I think, as far as I know, the fees have been on there ever since they started e-prescribed.

B. HANSEN: OK.

HOWARD: All right. Seeing no other questions, thank you, Senator Kolterman.

KOLTERMAN: Thank you. And again, thank you for allowing me to testify early.

HOWARD: Sure, absolutely. All right, this will close the hearing for LB922 and open the hearing for LB887, Senator Arch's bill to authorize pharmacists to adapt prescriptions to aid consumers. Welcome, Senator Arch.

ARCH: Thank you. Good afternoon, Senator Howard and members of the Health and Human Services Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County. LB887 was brought to me by the Nebraska Pharmacists Association. The intent of this legislation is to expedite the filling and, and dispensing of prescription medications to ease the burdens on prescribers and pharmacists. LB887 will allow pharmacists with consent of their patients to make changes to a prescription unless a prescriber indicates that no changes can occur, which is already a statutory provision found in 38-28,111. Since the introduction of the bill, an amendment has been drafted to address some concerns that were raised and you all should have a copy. Everyday, pharmacists receive prescription orders that need minor adjustments before the prescription can be filled for a patient. Fixing those changes can easily be done by a pharmacist and some examples of those situations will be provided by upcoming testimony. Much of healthcare these days is dictated by insurers, and while prescribers can prescribe the medications they deem medically necessary for patients, insurers won't always pay for those medications. And I would add, and prescribers may not be aware of that, of that specific. When these scenarios occur, pharmacists currently have to call the prescriber, ask permission to fix an incorrect quantity or dosage for them, or see if the prescriber will let the patient have drug X instead of drug Y because it isn't on the insurance company's formulary. This bill would authorize pharmacists to make those minor adjustments. The Department of Health and Human Services did approach me the other day and indicated the changes sought by LB887 should have gone through the 407 process. I disagree. This bill does not change the scope of practice for pharmacists. This bill does not allow a pharmacist to diagnose a patient nor prescribe a drug. There is no change in scope that would rise to a level of a 407 review. The Nebraska Pharmacists Association has worked on this bill with the Nebraska Medical Association for several months to ensure the language is exact and does not expand scope of practice. The goal of this bill is to provide patients their medication in a safe and timely manner. There is testimony following

me that will go into more detail regarding the provisions of this bill and purpose for its introduction. But if I could answer any questions, I'm available.

HOWARD: Thank you. Are there questions? Seeing none, thank you, Senator Arch. Will you be staying to close?

ARCH: I will.

HOWARD: Thank you. Our first proponent testifier for LB887. Good afternoon.

MARCIA MUETING: Good afternoon, Senator Howard, members of Health and Human Services Committee. My name is Marcia Mueting, its M-a-r-c-i-a M-u-e-t-i-n-g, and I'm the vice president of Professional Affairs for the Nebraska Pharmacists Association, and I'm a pharmacist. On behalf of the members of the NPA, I'm here to testify in support of LB887. And I want to thank, Senator Arch, for introducing this legislation. I also want to thank our colleagues at the Nebraska Medical Association for their collaboration on this bill. We do have an amendment to the bill, so my testimony will reflect the amended language. Pharmacists, as you know, are the drug experts on the healthcare team. We spent a lot of time in, in pharmacy school learning about medications. And we have the expertise to know when a quantity for a prescription can be modified and when drugs can be interchanged by using our knowledge and professional judgment. So what does this bill do? This bill will allow a pharmacist using their expertise to help patients reduce administrative burden on prescribers and expedite care in four distinct ways. First, this bill will allow a pharmacist to modify the quantity of a prescription if the prescribed quantity is not commercially available and intended to be dispensed in a prepackaged container. It's difficult for prescribers to know which, which drugs are available in which package sizes. Antibiotic suspensions, for example, like you'd use for a child, some of them are provided-- they're provided to patients by the entire bottle. Some antibiotic suspensions are available in 100 milliliter bottles, others are 75 milliliters, some are 125 milliliters, 150 milliliters, 200 milliliters, and so on. If a prescription is written for an antibiotic suspension, for example, for 225 milliliters, that would deliver a 10-day supply of an antibiotic, for example. I, as a pharmacist, have to give 2 of the 125 milliliter bottles to supply the amount needed for the entire 10 days. Dispensing those two bottles would require a corrected prescription. Another example is that a prescription written for a 22 gram tube of ointment and the medication is only available in

a 30 gram tube of ointment, the pharmacist would not be able to dispense the entire 30 gram tube without contacting the prescriber for a corrected prescription. Next, this bill would allow a pharmacist to change the dosage form prescribed from tablet to capsule or liquid or chewable tablet. So if a child comes with their parent to Marcia's perfect pharmacy and they can't swallow a capsule, without calling the prescriber and without a delay in treatment, I would be able to substitute the chewable tablet or the liquid for that, that child. This would not allow the pharmacist to modify the dose prescribed. This bill will also clarify that a pharmacist can provide a patient a 90-day supply of medication if a prescription is written with enough refills. I believe this is actually currently legal. Many insurance companies, however, they do allow patients to receive more than a one month's supply of maintenance medications at a time. However, without a law in Nebraska, which allows a pharmacist to modify the quantity that has been dispensed or the days supply, an insurance company can audit the pharmacy and take away payment if the prescription is not filled for the quantity that was prescribed. Lastly, this bill will allow pharmacies to use their drug knowledge and substitute a chemically equivalent drug to comply with a patient's drug formulary or their insurance plan. This currently applies only to a few medications. A great example is an asthma inhaler that's available as brand names Proventil HFA or Ventolin HFA. As a pharmacist, I know these two inhalers are made by different drug companies, but they contain the same medication in the same dose. Insurance companies typically will cover one or the other of these brand name products. Our own Medicaid program requires that the patient receive, right now today, Proventil HFA and they have actually changed recently prior to maybe sometime in last year. They had to have the Ventolin HFA, which meant pharmacies had to carry both products and they had to substitute and change and, and call the prescriber for this change. The, the other-- another way to look at this is insurance substitution. The insurance companies have decided that the drugs are interchangeable and will pay for one, but not the other. Other drugs that could be substituted include hormone replacement like estrogen patches, medications for blood pressure, including Verapamil and Diltiazem. These drugs are supplied by different manufacturers, but are the same drug, strength, and dose. This does not include any mental health drugs. And I apologize, I see that I'm out of time.

HOWARD: Thank you.

MARCIA MUETING: I'm happy to answer any questions.

HOWARD: Thank you. Are there questions from the committee?

WALZ: I have a question.

HOWARD: Senator Walz.

WALZ: Thank you, Chairwoman Howard. Thanks for being here today.

MARCIA MUETING: You bet.

WALZ: I just have a question about the-- I think it was the third or fourth thing that you talked about,--

MARCIA MUETING: Um-hum.

WALZ: --extending a one-time refill.

MARCIA MUETING: Oh, OK, that, that has been stricken.

WALZ: OK.

MARCIA MUETING: Right, I apologize, the amend-- the amendment reflects that that language has been removed.

WALZ: OK. Thank you.

MARCIA MUETING: Thanks for the question.

HOWARD: And, and can you help me understand-- and if it's, if it's been removed by the amendment, I'm not sure. Can you help me understand what best interest of patient care is? Usually, we see with best interests of patient,--

MARCIA MUETING: Um-hum.

HOWARD: --but what's the difference between best interest of patient care?

MARCIA MUETING: I have to think of a specific example, like, for example, modifying a patient if-- your insurance will pay for a 90-day supply. I mean, there are some studies that show if you get a 90-day supply instead of a 30-day supply and have to come back every month, you're gonna be more adherent.

HOWARD: So would that be in the best interest of the patient?

MARCIA MUETING: Or-- and their care. Sure.

HOWARD: And their care. I, I think-- sometimes what I, what I-- when I read bills, I always like to make sure that we could define and defend every piece of it. Right?

MARCIA MUETING: OK.

HOWARD: So if I don't know what the best interest of patient care is--

MARCIA MUETING: Sure.

HOWARD: --and what patient care is overall--

MARCIA MUETING: Here's, here's a better example, for example, let's say that you come to Marcia's perfect pharmacy with your prescription for the Proventil HFA inhaler, this would mean that you would have asthma and Proventil HFA is an inhaler that's used for rescue for someone who's wheezing or actively coughing and cannot breathe. OK, so you're bringing me this prescription. Obviously, this is something that you need. So I, I, I put the medic-- the information into my computer and your insurance company says, oh, we don't pay for Proventil HFA. It has to be changed to Ventolin. This means I have to contact your prescriber. I have to wait for the prescriber to return the call. And then I have to resubmit the prescription to your insurance company at a later time. That means you're not going to get the inhaler right away. I think that's probably the biggest impact on patient care that I can share with you, as far as a delay in care. Does that make sense?

HOWARD: It makes sense, I think more-- it's, it's harder for us to defend because it's not well-defined. I think it's a term of art for your profession,--

MARCIA MUETING: Sure.

HOWARD: --but maybe not a term of art within our own statutes.

MARCIA MUETING: OK.

HOWARD: And so that may be something that we need to work on to just make sure that it's very tight--

MARCIA MUETING: OK.

HOWARD: --as to what your intention is, but also what we can explain within the statutes that we're provided with.

MARCIA MUETING: Sure. Sure. And in this, in this example, I will tell you, as a practicing pharmacist, I've never had a prescriber-- and when I called and said, can we change it from this to this because this is what the insurance company will pay for. I've never had a prescriber say, no, I will not change it to what the patient's insurance will pay for. I mean, it makes sense.

HOWARD: Yeah.

MARCIA MUETING: And a lot of times they're, they're saying, why are you calling me? Why are you bothering me with this very small detail? But right now, our hands are tied because the drugs are not rated equivalent to one another. However, they have the exact same drug, exact same dose, and, and, obviously, the insurance companies think they're interchangeable.

HOWARD: Wonderful. Thank you. Are there any other questions? All right. Seeing none, thank you for your testimony today.

MARCIA MUETING: Thanks for the opportunity.

HOWARD: Our next proponent testifier. Good afternoon.

BOB LASSEN: Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Bob Lassen, that's B-o-b L-a-s-s-e-n. I'm a retired or semi-retired pharmacist and I volunteer and testify on behalf of AARP Nebraska in support of LB887. AARP is a nonprofit, nonpartisan organization that works across Nebraska to strengthen communities and advocates for the issues that matter most to our families and those 50-plus, such as healthcare, employment, and income security. Retirement planning is also part of our process, as is affordable utilities. The roll of the pharmacist has evolved substantially in the recent decades. The traditional activities of the profession primarily focused on the dispensing and supply of medications, while interaction with other healthcare professionals was somewhat limited. Pharmacists today ensure the rational cost-effective use of medications, promote healthcare living, and improve clinical outcomes by engaging in direct patient care in collaborating with many healthcare disciplines as well as patients. Pharmacists are becoming

more and more recognized as key components in improving individualized patient care as part of the healthcare team. Pharmacists are often one of the most accessible healthcare providers and in a unique position to provide a patient-focused primary healthcare service to the community. LB887 would provide pharmacists the ability to optimize in therapeutic outcomes of their patients. Ensuring timely renewals of prescriptions will ensure continuity of patient care, many of which may be emergent situations for continuations of therapy. With the appropriate framework in place, adaptation services can safely optimize medication therapy while promoting efficiencies. I want to thank, Senator Arch, for introducing the important legislation and would ask your support for LB887. I'd be happy to answer any questions at this time.

HOWARD: Thank you. Are there questions? Seeing none, thank you--

BOB LASSEN: Thank you.

HOWARD: --for your testimony today. Our next, our next proponent testifier for LB887. Good afternoon.

JIM OTTO: Senator Howard, members of the committee. My name is Jim Otto, J-i-m O-t-t-o. I'm president of the Nebraska Retail Federation and here to testify in favor of LB887 on behalf of the Nebraska Retail Federation and Nebraska Grocery Industry Association. As I said for the earlier bill, we both have pharmacies as members or, or, or grocers who have pharmacies within their stores. And our membership strongly supports the bill and we just want to go on record as saying that.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today. Our next proponent testifier for LB887.

BETH ANN BROOKS: Good afternoon, Senator Howard and HHS committee members. I am Beth Ann Brooks, B-e-t-h A-n-n B-r-o-o-k-s, a Nebraska licensed physician from Lincoln testing on behalf of the Nebraska Medical Association in support of LB887 as amended. I'm a child and adolescent psychiatrist who evaluates and prescribes medications for adolescents. We would like to thank the Nebraska Pharmacists Association for bringing this bill's concept to the NMA early on and for engaging in an open dialog which resulted in suggested changes into the amended version after review from our position members. The intent behind this bill is to reduce administrative burdens and headaches for both pharmacists and physicians-- excuse me, as a result

of unintended omissions or errors made when using electronic prescriptions. The changes made to the original LB887 would result in fewer back and forth phone calls between pharmacies and physician offices to address issues such as capsule versus tablet, while still requiring notification back to the physician that a change was made to the original prescription. The amendment strengthens the drug substitution language by clarifying that substitutions may only occur for chemically equivalent drug products to meet a patient's drug formulary. Too often, patient drug formularies are updated by substituting one chemically equivalent medication for another as previously described, and it is unreasonable to expect a prescriber to know the current drug formulary for any one patient. Thank you for your time and allowing my testimony today. The NMA respectfully requests the committee's support of LB887 as amended.

HOWARD: Thank you. Are there questions? Doctor, I actually have a question for you. And you mentioned it in your testimony. The language that I'm reading here doesn't show me how a physician would be notified of the change.

BETH ANN BROOKS: I don't have the amendment in front of me, but I thought that there was language that then the physician-- or the prescribers office would be notified.

HOWARD: OK. OK. All right.

BETH ANN BROOKS: I, I can't be sure of that because it's not in front of me, that was my understanding. And frankly, that was one of the points of contention when the-- a large group of physicians met on behalf of the NMA looking at a number of bills, one of the concerns was completing that loop, which is really essential in patient care and ensuring the best interest of the patient and the whole system, the best patient care.

HOWARD: OK. Thank you. All right. Any final questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB887. Seeing none, is there anyone wishing to testify in opposition to LB887?

DARRELL KLEIN: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Darrell Klein, D-a-r-r-e-l-l K-l-e-i-n. I'm a deputy director for the Division of Public Health within the Department of Health and Human Services. And I'm here to testify in opposition to LB887 as written, which would

change the statutes in the Uniform Controlled Substances Act and Prescription Drug Safety Act to allow for modification of prescriptions by a pharmacist. And our reasons for opposing this bill include our belief that the bill expands the current scope of practice for pharmacists without having completed a credentialing review process commonly referred to as a 407. The bill would expand the authority of a pharmacist to make changes, including the modification of quantity, dosage form, or substitution of any drug that has the same active ingredient and dose. Modification of prescriptions is already allowed in the Nebraska Drug Product Selection Act. And this bill does not harmonize with those provisions. Any change in how a pharmacist selects drug products should be in the statutes which constitute the drug products like [INAUDIBLE]. There is an increased risk to patients in allowing a pharmacist to change prescriptions as broadly as this bill would allow without consultation and approval of the prescriber. And in summary, LB887 will expand the allowance of prescription modification without consultation of the prescriber, which is not in the best interests of the patient. We respectfully request the committee oppose the legislation. And I thank you for the opportunity to testify today and I'd be happy to answer any questions. And anticipating the questions, I would say in our conversations with the Nebraska Pharmacists Association, we brought up the Department would feel a lot better about the bill if it required consultation with the prescriber, even if that was after the fact as opposed to before the modification. And anticipated that that language would be in there. We didn't know whether it would say may or shall, we would prefer shall. But I will note that that language is not in the amendment. And I guess there's just a difference of construction of the statutes in between the Pharmacists Association and the Department as to whether this constitutes a change in scope. That's key for whether we think it should go through the 407 because changes in scope of practice go there. And I'll note that the NMA and the NPA have been involved in consultation with us, but that's a narrower group of participating individuals than would be involved if it went through a 407.

HOWARD: Thank you, Mr. Klein. Are there questions? Senator Murman.

MURMAN: Yeah, on the-- thanks for coming, on the 407 process, you listed three reasons there why I think that-- you think that should be involved and one of them is the same active ingre-- ingredient and dose, I assume that would not need to be a 407.

DARRELL KLEIN: I think that the amendatory language goes a ways toward addressing this particular point. So we were testifying-- I was testifying to the original bill but-- yeah. And-- excuse me.

MURMAN: The dosage form wouldn't be and now the quantity, I'm not, I'm not sure. I know one of the testifiers mentioned a different quantity in a, in a tube, but I'm not sure if quantity is involved otherwise.

DARRELL KLEIN: And, and I know it's kind of a fine point. And I want to note that, that I work with Joni and Marcia on other issues and view them as professional friends. I think it's just a-- our position is these changes, even if they're aimed at, at reimbursement and to try to smooth the process back and forth between the dispenser and the prescriber, still give additional authority to a profession. So we think that that fits under the 407 review. The three main acts are kind of implicated by the definition of the practice of pharmacy and that is dispensing of drugs, drug product selection, and pharmaceutical care. And each of those is further defined than in their own statutes, which I won't bore you with. But we looked at what the bill does and, and determined in essence, well, if it doesn't fit here, it does fit here and it's changing that. And so it's changing what's expressly allowed in our statutes right now. So that's why we think it's a 407. To Senator Arch's comments that there are safeguards in the Drug Product Selection Act, a prescriber can write, don't mess with my prescription. And I agree, and the Drug Product Selection Act, it does have that. In my conversations with Joni, we talked and it was my understanding that their position was that this was not drug product selection. So if it isn't drug product selection, then the terms in that section that say a prescriber can stop any modification of the prescription would be absent. So it would be good to see if, if that sort of leeway, which is already reflected in drug product selection would also apply in these circumstances.

MURMAN: Thank you.

HOWARD: Other questions? Mr. Klein, just sort of a yes or no. Is a 407 mandatory for a change in scope?

DARRELL KLEIN: Nope.

HOWARD: OK, perfect.

DARRELL KLEIN: We're just saying that we think that process should be followed.

HOWARD: Just a yes or no. Thank you, Mr. Klein. All right, thank you for your testimony today. Our next opponent testifier for LB887. Seeing none, is there anyone wishing to testify in a neutral capacity for LB887? Seeing none, Senator Arch, you are welcome to close. I'm gonna read your letters. Letters in support: Kurt Schmeckpeper, the Nebraska Academy of Physician Assistants; Dr. Allison Dering Anderson, representing herself. No opposition; no neutral letters.

ARCH: Thank you. I think you've heard good testimony today. I think, I think you also understand there is disagreement on this issue of the 407 process. I think that the NMA and the Pharmacists Association have been working diligently. And those are, of course, the two main bodies are involved in prescribing and the dispensing of these medications. It's-- I-- the intent of this, obviously, is to facilitate. And one of the testifiers mentioned, the back and forth calling on these minor adjustments to, to the medication is, is, is sometimes very, very-- it slows processes down in the offices, it slows processes down in the pharmacy as you're chasing back and forth to get approval for these minor changes. So again, it is-- the intent is not to expand anybody's scope of practice, but rather to facilitate patient care. So with that, I would close and answer any questions that might remain.

HOWARD: Are there questions? I just have two. One I'm hoping that we can discuss sort of tightening that language around best interest of patient care, because I think that's confusing. And then I-- and I had asked Dr.,--

ARCH: On the notification?

HOWARD: --Dr. Brooks, because what I-- what I'm seeing is on page 3 and then on page 5, the same language, "A pharmacist who adapts a prescription in accordance with this subsection shall document the adaptation in the patient's pharmacy record." But I, I want to-- I think what I'm hearing is that we need to make sure that the physician is also receiving some notice of the modification.

ARCH: Right.

HOWARD: And so--

ARCH: Yes.

HOWARD: --you'll work on that?

ARCH: --point well-made. Yes, absolutely.

HOWARD: OK, perfect. Thank you.

ARCH: Yes.

HOWARD: All right, seeing no further questions, this will close the hearing for LB887. And we will open the hearing for LB847, Senator Arch's bill to change requirement for dispensing drugs in certain healthcare facilities. Welcome back Senator Arch.

ARCH: Thank you, Senator Howard and members of the Health and Human Services Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County. These hearings can always be a little difficult because now we have to say, OK, now that was pharmacy in that bill, and now we're talking about pharmacy in this bill. So now we're talking about a different issue here and we'll, we'll change the subject a little bit. LB847 was introduced as a result of nursing facilities getting cited by DHHS for their medication administration processes. So now we're talking about nursing facilities. Due to the impact these citations were having on the facilities and pharmacies, a workgroup was convened to find solutions to the medication issues for nursing facilities, skilled nursing facilities, and assisted nurse-- assisted living facilities, and pharmacies with the goal of providing better care for residents of those facilities. The Nebraska Pharmacists Association, the Nebraska Health Care Association, LeadingAge Nebraska, the Nebraska Hospital Association and staff from the Nebraska Department of Health and Human Services Regulation Licensure worked collaboratively this fall to develop the language found in LB847. The bill addresses ongoing issues regarding label changes when there is a medication dose change or discontinuation for patients in nursing, skilled nursing, and assisted living facilities. Because so many of these facilities utilize pharmacies that are not located in the same community as the facility, there is a delay in the pharmacist making a label change for the patient's medications. The workgroup developed the language in LB847 as a way to improve patient care and ensure medications are safely provided to patients. Again, DHHS approached me after these, these, these workgroups had met with concerns and an amendment has been drafted in an attempt to address those issues and I believe that has been passed out. Other provisions in LB847 include statutory changes to clarify that a patient can ask a pharmacist at

their local pharmacy to compliance package medications they receive from the Veteran's Administration or a different pharmacy at the pharmacist's discretion. LB847 also changes the Emergency Box Drug Act in recognition of electronic E-boxes, as well as updates a few definitions. And once again, a few members of the workgroup are here today to testify in support of LB847, can explain further the details of the bill. But if there are others you'd like to address to me, I, I am available.

HOWARD: Thank you. Are there questions? Seeing none, will you be staying to close?

ARCH: Yes.

HOWARD: Perfect. Our first proponent testifier for LB847.

BOB LASSEN: Hello, again. My name is Bob Lassen, that's B-o-b L-a-s-s-e-n. Chair Howard, members of the Health and Human Services Committee. As a member of the Nebraska Pharmacy Association, I am here today to support LB847, which is a change in requirements for dispensing drugs in certain healthcare facilities. I am a semi-retired pharmacist who has practiced specialized packaging delivery of medications to assisted living, nursing facilities, and skilled nursing practices for over 30 years. The issues that LB847 addresses are not new ones. Medications are packaged and delivered to facilities in cycles of either weekly or monthly intervals. Residents of these facilities may see their medical providers during this time, and medication orders are sometimes changed. The medications set by the pharmacy originally may no longer reflect those administration orders. To provide a little bit of background information regarding the labeling, Section 4 of this act reads that in an assisted living facility, a nursing facility, or a skilled nursing facility, all drugs and devices shall be labeled in accordance with currently accepted professional standards of care, including the appropriate accessory and cautionary instructions and the expiration date where applicable hit the dosage or the directions for a specific drug or device to be used in an assisted living facility, nursing facility, or a skilled nursing facility or changed by the credential practitioner under the Uniform Credentialing Act, a pharmacist shall apply a new label with correct dosage or directions to the drug or drug device for reissue to the facility with the correct label. Since labeling by regulation is a sole function of the pharmacist, the problem has always been: one, the time element between the ordered change and the time that the pharmacist has a pharmacist available to go to the facility to make

the label change. Various ideas have been attempted unsuccessfully to bridge the time frame between the order change and the relabeling by the pharmacy. The most successful practice has been for the nurse at the facility to affix an auxiliary label to the medication at the facility with the wording, change in direction, see the MAR. This alerts the dispensing staff at the facility that the labeling directions are-- on the medication are not current and that they should consult the Medication Administration Records for the most current order. This process allows the pharmacy time to provide current labeling information. This system has worked for many years, but was called in question by state surveyors who indicated that this practice was labeling and not permitted by pharmacy regulations. A workgroup was formed consisting of members of the HHS, nursing, and pharmacy to address this problem. LB847 proposes a solution by specific language, addressing what is labeling and what is not. The new language will include the following: labeling does not include affixing an auxiliary sticker or other such notation to a container after a drug has been dispensed when the sticker or notation is affixed by a credential practitioner under the Uniform Credential Act and a facility licensed under the Health Care Facility Licensure Act. This provision will validate a successful procedure that has been in place unofficially for many years. I would respectfully ask for your support on LB847 and I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you for being here. Can, can you describe to me so I can be a little clearer when-- under the exemption you just talked about, what-- who are the credential persons in a facility then that could make this change?

BOB LASSEN: That would be like an LPN, RN, somebody that's a licensed nurse.

WILLIAMS: So they'd have to be a person that has some form of credentialing?

BOB LASSEN: Yes, the med aides couldn't do this.

WILLIAMS: Thank you.

HOWARD: All right, any other questions? Seeing none, thank you for your testimony today.

BOB LASSEN: Thank you.

HOWARD: Our next proponent testified for LB847.

MACKENZIE FARR: Sorry, feel really short. Senator Howard and members of the Health and Human Services Committee, my name is Mackenzie Farr, M-a-c-k-e-n-z-i-e F-a-r-r, and I'm a pharmacist at Community Pharmacy in Gretna and a member of the Nebraska Pharmacists Association Board of Directors. On behalf of the NPA, I am here in support of LB847 and want to thank Senator Arch for sponsoring this legislation. I'm a pharmacist that cares for patients in nursing facilities, skilled nursing facilities, and assisted living facilities across Nebraska. For several years now, some of these facilities have been cited for medication-related issues, particularly around medication order changes, because the interpretation of regulations by DHHS and its survey teams. It is a big problem and one that many in our industry have tried to solve without much success. The reason for the creation of our workgroup and LB847 is to provide a solution to the issue of how to get a new label on a patient's medication when a change has occurred. Labeling is something a pharmacist does, but it is impossible to have a pharmacist onsite at these facilities at all times to make these label changes. In years past, insurance companies were much more lenient in their allowance of overrides for approvals of these order changes, which happen relatively frequently in these facilities. This allowed pharmacies to receive paid claims for these medications and send out a new supply to the facility to have med-- to have the Medication Administration Record, or the MAR, accurately match the label on the medication. However, in recent years, insurance companies are tightly regulating and restricting these practices, thus forcing facilities, and in turn pharmacies, to find alternative methods to combat this. As a solution, our workgroup agreed that having a facility nurse apply an auxiliary sticker on the medication packaging indicating there's been a direction change was a great and workable solution. This alerts the individual administering the medication to the patient to double check the MAR, which they should be doing as one of the five rights of passing medications before giving medications. We agreed that adding this sticker to the dispense drug does not constitute labeling, and therefore change the definition to reflect that. Once LB847 passes, if a medication is changed by a prescriber, appropriate communication between the facility and the pharmacy will occur and the supervising nurse at the facility will flag that patient's medication with a see MAR sticker to alert the person, typically a medication aide that he or she needs to follow

facility protocol before passing this medication. The pharmacist will continue to attempt to process the medication order change through the patient's insurance, and once approved, an appropriately labeled medication supply will be sent to the facility. This is not a new concept as Iowa identifies and allows this practice in their regulations. I did bring copies for your reference to see how this is addressed as we feel this is very easy language to follow and interpret. We did not put a time in the bill for which the new label had to be put on the medication or new supply had to be sent because that is dependent on the insurer and their approval. In addition, this practice allows for the utilization of the current supply of medication, which results in cost- saving techniques for the resident and or facility, reduces medication waste, and also decreases the potential for diversion of excess of controlled substances being sent to the facility. LB847 also updates the Emergency Drug-- or Box Drug Act by recognizing electronic emergency kits. As technology continues to evolve in healthcare, so does our ability to have emergency kits that are much more secure and easier to use. These kits will allow for integration with pharmacy software, creating a safer opportunity when passing medications in an emergent situation. Sorry. In addition to this, these medica-- or these machines have the capability for real-time tracking of access to these kits and better oversight of pharmacy inventory stored within these kits. We have also added a definition of central fill to the Pharmacy Practice Act as that term will be stricken as our practice regulations are updated. As Senator Arch described in his opening, the NPA, Nebraska Health Care Association, LeadingAge, Hospital Association, and DHHS worked during the fall to develop a solution. We were discouraged to learn that DHHS was planning to oppose the bill since several individuals from DHHS were involved with our workgroup and were involved in drafting the bill. We do have an amendment that we believe alleviates DHHS concerns. The amendment clarifies that the person credentialed is pursuant to the Uniform Credentialing Act, the MAR definition includes assisted living facilities, and we changed the word provider to healthcare practitioner authorized to prescribe controlled substances to be more accurate. Thank you for the opportunity to testify today and I'm happy to answer any questions.

HOWARD: Thank you. Are there questions? I, I want to ask about MAR, that's the first time I've ever heard this term MAR,--

MACKENZIE FARR: OK.

HOWARD: --and is it only used by long-term care facilities?

MACKENZIE FARR: That I'm not 100 percent for sure on. I know sometimes in hospitals they will refer to it as the MAR. It's utilized within that electronic medication record. But that's usually an abbreviation we hear a lot in the long-term care sector.

HOWARD: OK. OK. And then the MAR definition is found in-- you're putting it into 71-2411. But you, you need it to be applied to the Section 4 as well? I'm just wondering if,if you need to have a definition in both places--

MACKENZIE FARR: OK.

HOWARD: --because they're two separate acts, they're in two separate areas.

MACKENZIE FARR: OK.

HOWARD: And then I just had a question, do you have a copy of the bill?

MACKENZIE FARR: I do not. Sorry.

HOWARD: That's cool. OK. At the top of page 4, there's this line that says, "At the sole discretion of a pharmacist, the pharmacist may package drugs and devices at the request of a patient or patient's caregiver." Do-- usually the, the word may sort of implies the sole discretion of the, of the credentialed individual who is, is sort of giving-- we're giving authority to in statute. Can you tell me a little bit more about why the sole discretion piece is important to have in there?

MACKENZIE FARR: I think it-- and I may be misspeaking so I can refer to Joni, too, but I know when our workgroup met, the intent was a pharmacist can decide whether to provide or allow for this practice or they could decide to not engage in this practice. It's, it's dependent upon, it's not enforceable that somebody has to, has to go ahead and utilize those compliance packaging. You know, if somebody goes against wanting to put something into compliance packaging, because maybe they feel that the drug maybe has been tampered with or they can't verify the authenticity of it, you know, it might just be up to them to say, no, I would prefer not to do so.

HOWARD: OK. Perfect. Thank you.

MACKENZIE FARR: Um-hum.

HOWARD: All right. Any other questions? Seeing none, thank you--

MACKENZIE FARR: Thank you.

HOWARD: --for your testimony today. Our next proponent testifier for LB847. Good afternoon.

ASHLEE FISH: Good afternoon, Chairman Howard and members of the Health and Human Services Committee. My name is Ashlee, A-s-h-l-e-e, Fish, F-i-s-h, and I'm here today on behalf of the Nebraska Health Care Association. I'm passing around a letter from our president and CEO, Heath Boddy, that details in support all of the reasons NHCA is supporting LB847. So while I won't read that letter to you today, I'd just like to highlight that NHCA believes LB847 provides necessary clarification as well as ensures the highest quality of care possible when administering medication in long-term care facilities across the state. NHCA would like to thank Senator Arch for introducing the legislation, as well as the Nebraska Pharmacists Association for including us in the workgroup these last few months with the Department of Health and Human Services and others. We believe the legislation addresses and ensures quality care will be provided and would like to urge your support for the legislation and I'd be happy to answer any questions you have.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB847. Seeing none, is there anyone wishing to testify in opposition?

DARRELL KLEIN: Good afternoon, Chairwoman Howard. I apologize if my, if my enunciation isn't perfect, I'd put a cough drop in so I wouldn't cough through this. I am Darrell Klein, D-a-r-r-e-l-l K-l-e-i-n, and I'm the deputy director of the Division of Public Health within the Department of Health and Human Services. And I'm here to testify in opposition to LB847 as written, which would make changes to the Pharmacy Practice Act, Emergency Box Drug Act, and Prescription Drug Safety Act. The bill makes changes in how medication labels can be supplemented in the event of a direction change from a prescriber. The bill would impact facilities with some terms that are not always applicable to all the facilities subject to the bill. Reasons to oppose: I'm gonna go out of order here because two of them are

informational, one of them is, is more substantive. There is no time frame included in this bill as to when the label must be replaced by a pharmacist. Secondly, the bill would impact a practice that is set by law in the Medication Aide Act. If a prescription drug label doesn't match the prescriber's order or the Medication Administration Record, if there is one and there would be one for a medication aide. But that med aide is still required to seek out the person responsible for direction and monitoring, which is in fact a safeguard. And issues may still arise when medications are delayed because of the change in order could not be complied with due to various factors with the type of medication being prescribed. So there's other laws that could impact this and still slow things down in, in other words, and assisted living facilities under certain circumstances are not required to maintain and use a Medication Administration Record. The language of the bill does not, as written, expressly provide for those instances. And if there is no Medication Administration Record, the bill's provisions would otherwise-- that would otherwise protect resident safety would not apply in those instances. We mentioned that the term credentialed person in the bill as drafted should be defined. And also in Section 4, we ask that clarification be made that the credential practitioner who can change the dosage or directions is in fact the original prescribing practitioner. And in summary, LB847 may create complications in facilities in instances where a MAR is not used. It does not set a time limit on when the prescription label must be changed by a pharmacist and its implementation may be met-- impacted by other aspects of the Medication Aide Act. For those reasons, we respectfully request that the committee oppose this legislation. And I appreciate the opportunity to testify and I'd be happy to answer any questions.

HOWARD: Thank you, Mr. Klein. Are there questions? Excuse me, we're both struggling for coughing.

DARRELL KLEIN: Yeah.

HOWARD: Can I ask you some word-- some language questions for this one? For the M-- for the MAR, for the M-A-R, so you said that in certain circumstances they're not required to use the MAR?

DARRELL KLEIN: Yeah, medication-- the Medication Aide Act allows medication-- I'm gonna trip over a term of art here, I'll say administration, in certain circumstances where the person does not have to be a med aide, a family member or a caregiver can administer medications. And in an instance where the resident of a facility is,

is competent, just like you and me, then they can take their own medicines. And so I just wanted to point out, this is, this is not maybe a, a huge, huge issue, but there are instances where there is not going to be a medication aide record that would be an additional safeguard in this. When a medication aide is used, then even assisted living facilities are required by the regulations to have a Medication Administration Record, so it's, it's a subset. I just wanted to point out there are instances where medications can be administered even in an assisted living facility where there wouldn't be that further medication aide record. The other instance-- and, and I want to point out also the content of this bill that we're not opposing, so these are, these are relatively narrow. One of, one of the questions that my brain is not big enough to answer is in the, in the amendment where we're limiting the person who can change the prescription to a basically a prescribing somebody who's credentialed and able to prescribe. Again, we, we preferred that that be the original prescriber, because, frankly, I'm not sure what the legal implications are when a second professional with the authority to prescribe, changes a prescription already issued by somebody else, and I cannot tell you, I don't think that's allowed. I'm just saying that is, that is something that we would have to track down, that would be fixed if that language there said the original prescriber. And then secondly, I understand everything everyone's testified to about facilitating these changes and still allowing the, the pharmacies to be paid. But we still would, would strongly ask that there be a time limitation set in here so that the time that this temporary sticker can serve the place of a label is not at the whim of the insurer, but is a set time limit that ensures resident safety. And, you know, there could even be exceptions to that built in. But we did ask for-- essentially we were thinking of 48 to 72 hour time frame for a real label to be affixed. And, and, and for reasons that I think were testified to for reimbursement, having, in my opinion, nothing to do with resident safety, that was not seen as, as acceptable. So that's what we're looking for, a time limit.

HOWARD: OK. Great. All right. Any other questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you again, Mr. Klein, for being here. Were you part of the working group that worked on this?

DARRELL KLEIN: One meeting. Yeah, I'm, I'm a relative newcomer. So I did attend one meeting.

WILLIAMS: OK.

DARRELL KLEIN: And I think it was a lot of well-intentioned people and everybody that participated in that we worked with all the time. I want to keep working with them because they need to be our partners. I'm not sure there was ever a meeting of the minds--

WILLIAMS: OK.

DARRELL KLEIN: --on, on every issue. Again,--

WILLIAMS: Thank you.

DARRELL KLEIN: --note the things here that I'm not testifying against.

WILLIAMS: OK.

HOWARD: OK. Any other questions? Seeing none, thank you--

DARRELL KLEIN: Thank you.

HOWARD: --for your testimony today. Our next opposition testifier for LB847. Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Arch, you're welcome to close. Letters for the record, record for LB847, three in support: Dr. Allison Dering Anderson, self; Jenifer Acierno, LeadingAge Nebraska; and Todd Stubbendieck, AARP Nebraska; and none in opposition; no neutral. Welcome back, Senator Arch.

ARCH: Thank you. And thank you to the committee for wading into some pretty technical issues with, with pharmacy and dispensing. I think that, I think that as I was listening to the testimony myself, I think it's pretty clear that there is an agreement that clarifying this process, clarifying the interpretation of this is important so that both the surveyors that go out and the facilities that are dispensing these medications know exactly what is expected of them in a workable solution in a world in which we all live in reality how these, how these medications are dispensed to keep the patients safe and allow for good patient care. So that's-- our desire is to find that, is to find that solution and these things need to be clarified. So thank you, we've heard the testimony today, some of this discussion has already occurred. I, I wish it had occurred a little bit earlier, but will, will address the issues as they come. So thank you very much.

HOWARD: Thank you, Senator Arch. Any final questions for Senator Arch? I will-- I have a couple of word issues, they're just little, but they're the, at the sole request, moving-- or having a double--

ARCH: The MAR definition in two sections,--

HOWARD: --MAR definition in two sections.

ARCH: --and top of page 4, the sole discretion.

HOWARD: Yeah, and then on page 4, the words of similar import. I don't know if we need that and I don't know how we define it. And then on line 27, on page 4, you would remove also known as MAR and then change the Medication Administration Record, that they're very-- they're quite small--

ARCH: Thank you.

HOWARD: --for a, for a bill like this. All right, any final questions? Seeing none, thank you for your--

ARCH: Thank you.

HOWARD: --closing. This will close the hearing for LB847 and the committee will take a five-minute break, break. We will reconvene at 3:15.

[BREAK]

HOWARD: [RECORDER MALFUNCTION] and this will open the hearing for LB1052, Senator Wishart's bill to change provisions regarding the preferred drug list under the Medical Assistance Act. Welcome, Senator Wishart.

WISHART: Well, thank you so much for having me back. It's good to be back here today. My-- good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the 27th District in west Lincoln. I'm here today to introduce LB1052. LB1052 is a reintroduction of a bill I introduced last year. And it's a bill that I will keep bringing until this problem is addressed. We spent the summer, my staff and I working with the Pharmacists Association, the Health Care Association to try and address some of the drafting issues that I had in the previous bill. With full disclosure, I am not very familiar with Health and Human Services statutes so this is a steep

learning curve for me, but I think we're a lot closer with the legislation I introduced this year in addressing the issue that our constituents are experiencing. So over two years ago, I was contacted by a constituent, she is here today to speak again on this issue. It was about an issue concerning her brother, who she is guardian for. His name is Curtis and he has schizophrenia and it is the paranoid type. And he suffers from significant obsessive thoughts that cause suicidal and homicidal ideation at times, which has led to several hospitalizations in his past. After many years of work with his doctors, they were able to find a combination of medications and treatments that allowed Curtis to live in his own apartment in Norfolk. He had a part-time job and he enjoyed relative stability and independence. He was able to enjoy this independence with no psychiatric hospitalizations from 2006 to 2017. In February of 2017, Curtis was denied coverage for one of his medications, critical to his stability from his-- from Medicaid. The cost of the medication at the time was $97 per month, which is approximately $1,164 per year. After he was no longer able to have this medication covered, Curtis, who I remind you had remained independent and hospital free from 2006 to 2017, was hospitalized five times at an approximate cost of $32,000 covered again by Medicaid. Since the March 27, 2017 hospitalizations, Curtis has been living, first, in a therapeutic group home, and currently he is in an assisted living facility. He now receives an additional $442 per month, which is approximately $5,304 per year from the state of Nebraska for the state aid to aged, blind, and disabled to cover the additional cost of living in those facilities. While he is now back on the original drug, his managed care organization denied him originally, he may never get back to the level of independence he had for over ten years. He is lucky to have his sister Marlene advocating for his care. And again, she's here today to share more about his story. When I originally started to look into this issue, I was also serving on the LR296 Mental Health Task Force with Senator-- with my colleague, Senator Walz, and we went across the state visiting assisted living facilities where they have a significant population of people that they serve with severe mental health issues. This is one of the most vulnerable populations of people I have ever met. Most, unlike Curtis, do not have family members to support them. They are transient. They've dealt with the criminal justice system and oftentimes their guardian is a lawyer they have never and will never meet. I ask these facilities, every single one I went to, I asked them if they were experiencing similar situations to Curtis where their clients are told that Medic-- their Medicaid-- that Medicaid would no longer pay-- would no longer cover their current medication. All of

these facilities, every single one of them said they have seen this happen and they have seen then the deterioration of their client's mental health. Colleagues, this has to change. Our goal in this state should be to work towards people with mental health issues living as independently as possible, as long as possible, as healthy as possible, and with the least cost possible to the state. In my opinion, and from what I've witnessed on the Mental Health Task Force, these people, people who suffer severe mental health needs in our state are not being provided the level of care that they need to work towards independence. And it really frustrates me when I hear a situation where an individual was able to gain 11 years of independence on his medications that allowed him to be healthy enough even to hold a part-time job, and then his health insurance made it financially impossible for him to continue on that successful path. In addition to the moral and public health imperative to solve this problem, it is crucial that we ensure that the thousands of dollars, public dollars, hundreds of thousands of dollars, I'd anticipate if you add up all the people that have experienced what Curtis has, are not spent due to similar fallout for what happened to Curtis. The bill you see before you today simply adds language that explicitly says that the department, a managed care organization, or a pharmacy benefit manager cannot deny coverage of a drug that falls into the one of three categories: antidepressant, antipsychotic, or anticonvulsant that is deemed medically necessary by the patient's healthcare provider. These drugs are already exempt from the preferred drug list, so I'm confused as to why this is currently happening in our state anyway. Perhaps the Department, I understand that they will be testifying in opposition can explain why we're having these issues in our state similar to what's happening to Curtis and can also address the fiscal note. I did receive that early this morning and reviewed it and I need to do more research into what the issue is that they expect will happen, because I anticipate that by ensuring that people are able to stay on the medications that are supporting them living independently, just like what would have happened to Curtis, we will actually reduce the costs associated to public benefits. Again, I'm committed to solving this problem. I will be back every single year until we address it and make sure that vulnerable, vulnerable Nebraskans are not being taken advantage of and harmed. So I'm happy to take any questions.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Thank you. Thank you, Senator Wishart. I am-- I'm, I'm struggling with on page 2, the, the sub (2) there. It's within the section that says you can prescribe-- a, a healthcare provider up above on line 4, "A health care provider may prescribe a prescription drug not on the preferred drug list." So that's what this is referring to, correct?

WISHART: Yes.

ARCH: So if it's not on the prescription drug list, they may prescribe any of the psychotropic meds that they deem to be medically necessary.

WISHART: Yes.

ARCH: But then the MCO, nobody can challenge the medical necessity. Is that, is that the essence of it?

WISHART: My-- the essence of what I'm trying to get at-- and again, I am-- I'm-- there are healthcare providers who are far more articulate--

ARCH: Sure, that's, that's fine.

WISHART: --in the system than, than me in terms of policy. What I'm trying to get at is that currently what seems to be happening is a person shows up to a pharmacy to get, to get their medication and it's-- they find out it's not covered so they can either pay--

ARCH: It's not on the formulary.

WISHART: --for the true cost of it. It's, it's-- but these aren't even supposed to be, these are supposed to be outside of the preferred drug list, these three categories of drugs.

ARCH: OK.

WISHART: They, they show up, they're told it's no longer covered. And then what happens is their healthcare provider after the fact has to fight to get them back on it. And that month or two of somebody not being able to stay on the same type of medication that they were on can be severely in long term destructive to their life. So I'm trying to address that by saying what should already be happening in our state, which is that a managed care entity should not stop covering somebody's medication if it's one of these three types of medications,

unless a, a physician or that person's healthcare provider has deemed that, that that's all right.

ARCH: OK. Great.

WISHART: Yeah.

ARCH: That's very helpful. Thank you.

WISHART: OK.

HOWARD: Other questions? Seeing none, will you be staying to close?

WISHART: OK. Thank you. I will be here to close, yes.

HOWARD: Perfect. First proponent testifier for LB1052. Good afternoon.

MARLENE WAGNER: Good afternoon. Good afternoon, Senator Howard and committee. My name is Marlene Wagner. I was here again--

HOWARD: Will you spell your name for us?

MARLENE WAGNER: Marlene, M-a-r-l-e-n-e, Wagner, W-a-g-n-e-r.

HOWARD: Thank you.

MARLENE WAGNER: You're gonna get to hear my story again because I said it last year. First of all, I want to begin by thanking Senator Wishart and her staff for their work on LB1052 and for bringing it for your committee for your consideration and hopefully passage out of committee. Lincoln has been my home for 47 years and I live in Senator Wishart's 27th District, and I am here to voice my support for LB1052 and to tell you why. My six siblings and I grew up on a farm in northeast Nebraska. My brother Curtis had what I would describe as a relatively normal childhood. He was smart, funny, kind, performed well in school. But in his late teens, he began isolating himself. And with what he would now tell you, he were have-- he was having feelings of panic and fear. As the years progressed, he began having auditory and auditory hallucinations and delusions. Unfortunately, Curtis's illness went untreated, leading to his attempted suicide and formal diagnosis of paranoid schizophrenia at age 29. For the next 20 years, Curtis and his doctors struggled to find an effective combination of drugs to manage his illness, finally coming to a place where, where his symptoms were under control in 2006. From 2006 to 2017, with proper treatment and medication, Curtis enjoyed relative stability and

independence. And as, as Senator Wishart said he had his own apartment and actually had a part-time job for a while. Sadly, his independence was short lived. In February of 2017, Curtis was denied coverage of one of his medications, Anafranil, which is clomipramine, which was critical to his care and to, and to his ten years of relative stability. One month later, March of 2017, for the first time in ten years, he was hospitalized. He would go on to have four subsequent hospitalizations over the course of 2017 and '18. The last of which followed an attempted suicide. Curtis was experiencing severe delusional thoughts and auditory hallucinations, he heard voices telling him to do dangerous, life threatening things like jump off a bridge. For the first time in his life, he expressed having harmful thoughts toward others. The psychiatrist who treated Curtis at the Faith Regional Hospital in Norfolk said, and I quote, In less than a year he has gone from independent living to possibly needing a secure psychiatric facility for long term. It is felt that the demise of his mental health is reflective of the discontinuation of the Anafranil he had been stable on since 2006, unquote. The psychiatrist contacted the insurance company on Curtis' behalf and requested authorization to put him back on the drug. Thankfully, the request was approved. His condition, condition began to improve, but it took over a year to get his cocktail of drugs back to a place where his mental health was stabilized. Unfortunately, he is not well enough to live on his own and continues to live in an assisted living facility. Curtis is now 61 and has had to live with the reality of this horrible disease for 41 years. As sad as I am about my brother's situation, as angry as it makes me to know that he had to suffer needlessly, this isn't just Curtis' story. There are many Nebraskans suffering from mental illness who have had similar experiences without anyone to speak for them. What happened to them? Where are they now? Imagine if Curtis had not had an advocate. He may have harmed himself or someone else. He may have ended up dead or in jail, all because a managed care organization made a short-sighted decision that negatively affected his care and had real consequences for his life. Think of the others out there in similar situations who, who don't have an advocate. Who will speak for them? I am here today as one small voice because LB1052 is a step toward helping others to not have to go through what happened to my brother. Managed care organizations are not healthcare practitioners and should not be legally allowed to make decisions, effectively changing prescriptions, which could jeopardize the health and safety of their insureds and the public. This is not OK. We need to do better

for each other, better for Nebraskans, better for some of our most vulnerable citizens. Thank you for the opportunity to testify.

HOWARD: Thank you for visiting with us again and telling us Curtis' story once again. Are there questions from the committee? Senator Murman.

MURMAN: Thank you for coming in for your testimony. I have a very similar story and from someone in my district and, and I was just wondering if you-- if the managed care organization-- I guess it wouldn't have been managed care at that time, but the insurance company or--

MARLENE WAGNER: It was UnitedHealthcare, yeah.

MURMAN: OK, well, yes, if they would have kept Curtis approved for the medication, do you think it would have made-- how much difference do you think it would have made?

MARLENE WAGNER: I-- he was living on his own. I mean, he hadn't had any-- people with mental illness will have-- I mean, they, they have issues all along. But his just-- it just spiraled out of control. I mean, he was like a different person. And so when it all happened-- he went off that med one month and the next minute he was-- the next month he was having these, he was having these delusions. He was having auditory hallucinations, things-- you know, that he hears in his mind, like talking in his head. And it tells him, you know, it seems real, like he may think that you are talking to him, even though you're not saying words, he will hear your voice in his head, and he hadn't had any of that in any significant way until that happened. And then it just went downhill because the psychiatrist in Norfolk that finally wrote to the insurance company, that was after he was probably there on his-- he was in Norfolk. He was hospitalized four times in Norfolk, and then one time down here when he tried to take his life. And, and it wasn't right away that she made that connection and wrote that letter so he just got progressively worse.

MURMAN: OK. Thank you very much.

MARLENE WAGNER: Yeah.

HOWARD: All right. Any other questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB1052.

JONI COVER: Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Joni Cover, J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association and I'm here today in support of LB1052. When Senator Wishart reached out to our office this last year, we, we agreed to come sit down with her and talk about this issue. Unfortunately, pharmacists see this kind of thing happen more often than we'd like to say. And we feel like determining the medication necessity for a patient really should be up to the physicians and the pharmacists and not the, and not the payers. It's frustrating for patients when they come to the pharmacy counter and we can't provide the medications because of a formulary change or something's not covered. It's a common occurrence, like I said. It happened to Curtis. It's a sad story, but there's lots of Curtises out there and we want to be at the table to help try to solve this problem because we feel like, again, it's really healthcare providers that should be practicing medicine and not payers. I think it's interesting, I did read the fiscal note and I actually talked to Senator Wishart about this bill. I, I read-- we used to manage the state DUR contract, and I read through this a couple of times and I'm, and I'm not really sure what this says or mean. So maybe some clarification as to-- and maybe Medicaid will do some explanation of this, but I think there's some questions about what the, what the fiscal note says and, and not necessarily that it's accurate, but I don't know what federal regulations or things like that. I just think there's some clarity that needs to be provided. I do know that in the Medicaid program that federally that Medicaid, whether it's managed care, Medicaid fee for service, has to cover outpatient drugs that meet the definition of medical necessity. And that's about as much as I know, because I'm not a pharmacist and we have smart pharmacies that can help you if you need more information about that. So I'm very perplexed as to why this happened to Curtis, but I just wanted to be on the record that we support the bill and we're happy to help Senator Wishart and the other Curtises out there however we can. So thank you.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Yes. Thank you, Miss Cover. I, I-- do you happen to have a copy of the bill?

JONI COVER: I do.

ARCH: Could you help me understand 15 through 17 and maybe this is what you've been really talking about? It appears to me that's kind of stating the obvious.

JONI COVER: Right.

ARCH: Of course, they can.

JONI COVER: Right. Right.

ARCH: Right?

JONI COVER: Right.

ARCH: A healthcare provider may prescribe if the, if the prescription is medically necessary.

JONI COVER: Right. Right. I think, I think really what it means is they can prescribe-- actually they can prescribe any drug they want to. It's getting it paid for that needs to be medically necessary.

ARCH: Right.

JONI COVER: And maybe that needs to be clarified.

ARCH: Different issue.

JONI COVER: Right. Right.

ARCH: Right.

JONI COVER: So yes, they can prescribe, they can prescribe on label, off label, that-- that's their prerogative.

ARCH: Right.

JONI COVER: Paying for it, though is a different issue so I think--

ARCH: Yeah, that doesn't, that doesn't require that. And it-- you know, if, if it is medically necessary and that is as determined by the physician.

JONI COVER: Correct.

ARCH: There-- that could be challenged, which sometimes does happen--

JONI COVER: Yes.

ARCH: --as to the medical necessity. But, but this particular situation in this paragraph, it's the physician, the prescriber--

JONI COVER: Right.

ARCH: --making that determination of medical necessity.

JONI COVER: Right. I think that was supposed to be the intent.

ARCH: OK.

JONI COVER: I'm not speaking for Senator Wishart, though.

ARCH: Right.

JONI COVER: But I'm guessing that that's maybe what she intended.

ARCH: Thank you.

JONI COVER: OK.

HOWARD: Other questions? I just had a question about the lang-- you have it in front of you?

JONI COVER: I do.

HOWARD: On line 27, can you tell me why the-- a pharmacy benefit manager would be included?

JONI COVER: Well-- so in most insurance plans, in most insurance coverage, and I will tell you, I am not an insurance expert, so I'm not speaking on behalf of the insurance industry, just my expertise with dealing with our pharmacists who deal with insurers. Oftentimes, insurance plans contract their pharmacy benefit with companies called pharmacy benefit managers. So for the-- for instance, I think she said UnitedHealthcare, their pharmacy benefit manager is Optum. And so they are the ones who manage that piece of it, sort of separate, but supposed to be in conjunction with the insurance companies. Does that makes sense a little bit?

HOWARD: So they did it on, on behalf of the insurance company or the managed care organization?

JONI COVER: Right. Right. So UnitedHealthcare asks Optum to manage that piece of the insurance coverage if it includes a drug benefit.

HOWARD: OK.

JONI COVER: I have probably people behind me cringing because they'll probably be like, that's not really how this works, but that's my interpretation of how it works, so.

HOWARD: OK. OK. OK, thank you.

JONI COVER: Maybe you can ask them.

HOWARD: I will.

JONI COVER: OK.

HOWARD: All right. Any other questions? Thank you for your testimony today.

JONI COVER: Thank you.

HOWARD: Our next proponent testifier.

BETH ANN BROOKS: Good afternoon again, Senator Howard and HHS committee members. I am Beth Ann Brooks, B-e-t-h A-n-n B-r-o-o-k-s, a Nebraska licensed physician from Lincoln, representing today the Nebraska Medical Association, NABHO, which is the Nebraska Association of Behavioral Healthcare [SIC] Organizations, and the Regional Council of the American Academy of Child and Adolescent Psychiatry. I am testifying in support of LB1052 as a board certified psychiatrist and child and adolescent psychiatrist who has practiced for more than 40 years. I currently treat adolescents. LB1052 clarifies that prescribing medical professionals should be able to exercise clinical decision making when treating patients with serious mental disorders which include major depression, bipolar disorder, schizophrenia, and other disorders presenting with psychotic thinking. Disruptions in medication continuity, as previously described, include delays in receiving or the discontinuation of appropriate medications and they are associated with high rates of symptom exacerbation or relapse, hospitalization, and other adverse consequences. Suicide rates are rising across the United States and, unfortunately, also in Nebraska. Psychiatric patients, especially those who are Medicaid recipients, frequently visit emergency departments when they are in crisis. And emergency departments are being forced to, quote, board, end quote,

patients with serious mental illness because appropriate treatment settings are not always readily available. Nothing is more important to health care professionals than the best treatment outcomes for their patients, including prescribing the best medication option. A urine culture and sensitivity demonstrates which antibiotics will best treat a urinary tract infection. But psychiatry does not have similar tests to guide us in which specific antidepressant, antipsychotic, or anticonvulsant medication will be an exact match to treat an individual's unique mental disorder. No two psychotropic medications are the same. They are among the most complex drugs in terms of understanding how they work and what disorders will benefit from them. We have to rely on our best clinical judgment to pair psychiatric symptoms with appropriate classes of medications and then within those groups to the anticipated benefits and side effects of specific agents. For example, if a first degree family member has responded to a specific psychiatric medication, then that same medication often is best indicated for a patient with similar symptoms. Healthcare providers who prescribe are committed to minimizing costs for patients and health delivery systems. We preferentially prescribe generic medications when appropriate, but cost consideration should not be the primary factor when selecting the best medication for an individual patient. When psychiatric practitioners are forced into a narrow formulary, less than optimal patient care can result in increased costs incurred from higher levels of care, including repeat hospitalizations. Judicious clinical decision making involving medical necessity must be preserved in the treatment of neuropsychiatric disorders. Thank you for allowing me to testify about this bill, which would protect the best interests, well-being, and optimal treatment of some of Nebraska's most vulnerable citizens. I would be happy to entertain any questions you may have.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

BETH ANN BROOKS: Thank you.

HOWARD: Our next proponent testifier for LB1052. Seeing none, is there anyone wishing to testify in opposition?

CARISA SCHWEITZER MASEK: Good afternoon, Chairwoman Howard, members of the Health and Human Services Committee. My name is Carisa Schweitzer Masek, C-a-r-i-s-a S-c-h-w-e-i-t-z-e-r M-a-s-e-k. I'm a pharmacist and I'm the deputy director for population health for the Division of Medicaid and Long-Term Care within the Department of Health and Human

Services. I'm here to testify in opposition to LB1052, which would change provisions related to prescription drugs not included on the Medicaid's preferred drug list, specifically antidepressants, antipsychotics, and anticonvulsants. Federal law, Section 1927 of the Social Security Act requires all state Medicaid agencies to implement a drug utilization review program for outpatient drugs, including the three classes of drugs named in LB1052. Federal law mandates that there is a prospective DUR process that must ensure prescriptions are medically appropriate, medically necessary, and are not likely to result in adverse medical results. At the point-of-sale, the DUR is to occur and includes, but is not limited to, a review of incorrect dosage or duration of drug treatment and clinical abuse or misuse. Each state must use a compendia and literature for medically accepted indications as its source of standards for the review. The federal law goes on to further specify design requirements for the DUR program, which Nebraska currently meets. Recent federal guidance was provided for DUR in the Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Community Act, which is also known as the SUPPORT Act. The Act imposes additional DUR requirements for Medicaid and Medicaid managed care organizations. The requirements include concurrent fill reviews for opioids and antipsychotics due to the risk of respiratory and central nervous depression, and to improve treatment of comorbid mental health disorders by assisting in the coordination of care. All Medicaid covered medications are passed through a pharmacy benefit manager to provide clinical safety review per the DUR. LB1052 would eliminate DHHS' ability to perform the federally mandated prospective DUR putting Nebraska out of compliance with federal Medicaid law. If the state is out of compliance with federal law, the state will be unable to claim federal share dollar amounts above the federal upper limit on the drug specified in this bill and will have an increase in state General Fund expenses of $1.2 as estimated by the Department. In summary, LB1052 will limit the state's ability to insure certain drugs are prescribed safely and will put the state out of compliance with federal regulations, thus sacrificing significant federal matching dollars. We would welcome the opportunity to work with Senator Wishart and any other senators that have an interest in this area, and we respectfully request that the committee oppose this legislation. Thank you for the opportunity to testify today and I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here.

CARISA SCHWEITZER MASEK: Um-hum.

CAVANAUGH: If you could follow up with the committee and send us this federal law that you cite in the second paragraph, Section 1927, it would be helpful to read what exactly the federal law states in regards to that.

CARISA SCHWEITZER MASEK: Yes.

CAVANAUGH: Thank you.

HOWARD: I-- Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you for being here.

CARISA SCHWEITZER MASEK: Um-hum.

WILLIAMS: I, I think it's obvious that we have heard stories that have raised our concern in this area that these things have happened and will continue to happen, and I don't think that's in the best interest of, of Medicaid or, or any of us. With, with that said, is there a fix with this federal law that we could put in state law that would allow the following of what the ascribing doctor who knows that patient and what they are prescribing?

CARISA SCHWEITZER MASEK: Thank you, very good question. As we read over the LB1052, if you look at-- if you have it in front of you, I apologize, if you look at what was paragraph 2 is now paragraph 3, "A health care provider may prescribe a prescription drug not on the preferred drug list to a Medicaid recipient without prior authorization if the provider certifies that the recipient is receiving therapeutic success." And these three drug classes were included in that paragraph, so that gave the authority to the prescriber to say this is medically necessary, it is appropriate for my patient.

WILLIAMS: OK, so taking that out is the problem?

CARISA SCHWEITZER MASEK: Taking that out takes away the ability and the language in paragraph 4 takes away the ability of DHHS Medicaid to do prospective drug review. A prospective drug review is where we do clinical edits and clinical review for patients. These are, as you all know, some of the most vulnerable patients. These are also some of the

most toxic drugs. They result in a lot of liver toxicity. This bill would apply to adults and children. And in children, some of the antipsychotic drugs can lead to diabetes. They can lead to weight gain. And in some of these drugs, they can actually cause a deterioration of the disease that they were treating. So for that reason, that is why it is medically necessary and the prescriber can define medically necessary. Due to the toxicity risks, those clinical edits need to be in place to do that double check and see are there other drugs that this patient could be on that could cause a problem? Is this dose too high, and there might be a risk? That allows for the pharmacy, the MCO, to talk with that physician and say we see a potential risk here. Are you aware of the risk? And then the physician can give the medically necessary paper to say, I'm aware of the risk and I still want this patient on this drug.

WILLIAMS: That process and procedure sounds very useful. It also sounds timely or time consuming. Is there a way that you would know of that the medication could be continued during that period of time while that review is going on so that they're not taken off that medication for that period?

CARISA SCHWEITZER MASEK: Yeah. Thank you, good question. There is a 72-hour rule and I-- that can be applied. I will reference a question we had last year about what happens at the end of that 72 hours. At that point, it provides an opportunity for the provider to get in contact with the MCO, provide that reasoning for why they want to have the patient on this medication, and continue forward with the treatment for that patient.

WILLIAMS: In your judgment, is 72 hours a long enough period of time?

CARISA SCHWEITZER MASEK: We have seen that most often it is.

WILLIAMS: Thank you.

HOWARD: So I, I want to ask a few questions. So I'm trying to understand your opposition and the fiscal note at the same time.

CARISA SCHWEITZER MASEK: Yeah.

HOWARD: So the noncompliance with the federal regulations, the federal regulations that you're referring to are the drug utilization review.

CARISA SCHWEITZER MASEK: Um-hum.

HOWARD: And so it's, it's those exclusively that you are concerned with. And, and you're-- just so I understand it, it's Section 2 of the bill that interferes with the drug utilization review or it's Section 4?

CARISA SCHWEITZER MASEK: It is Section 4.

HOWARD: OK. And tell me a little bit more about why Section 4. Is it because it lists the pharmacy benefit manager?

CARISA SCHWEITZER MASEK: No, it's because it has the specific language that neither any of those three shall deny coverage. When a medication is prescribed, if there is a drug, drug interaction or there is a age contraindication at that point the drug can be denied. That allows the opportunity for the prescriber to call in and explain what their reasoning was or it changed course. That word shall not deny takes away the ability to do any of those medical edits.

HOWARD: Oh, oh, OK. You see, I, I think maybe that's what I'm struggling with is I don't understand how the inability to deny would also create the inability to ask the question.

CARISA SCHWEITZER MASEK: Um-hum. By definition, if a prescription goes in and it hits the edits of the MCO and the PBM just reflects the edits of the MCO, the MCO tells the PBM what the edits are. If it hits those edits, at that point it's considered denying when we have to reach out to the physician to say this has been denied, we see an age contraindication here. We either need additional documentation or something from you saying I am-- I understand that, and this is why the patient should be on this drug.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairman Howard. I, I want to follow up on both Senator Williams' and Senator Howard's questions, starting with Senator Williams'. He pointed you to line 22, the striking of the, the types of medication.

CARISA SCHWEITZER MASEK: Um-hum.

CAVANAUGH: But if you go up to line 15 through 17, it would be my assumption that it was struck in the line 22 because it's moved up and pulled out separately in 15 through 17. So they're not actually

stricken from this legislation, they're just moved to a different location. Am I misunderstanding that?

CARISA SCHWEITZER MASEK: Thank you for asking that. I, I read this a couple times and to be honest, flowcharted it out so that the language would be-- so I would understand what the bill was doing. Section-- what used to be paragraph 2 starting at line 18 in, in, in the proposed bill is paragraph 3, says very specifically within that paragraph that a health care provider may prescribe a prescription drug without prior authorization if the provider certifies if they're achieving therapeutic success. And it lists-- used to list those three drug classes within that. That allows the prescriber to prescribe it. It allows the clinical edits to stay in place for those few times that there does need to be that check. By moving it up into 2 and just stating those three classes and then adding paragraph 4, it says shall not deny coverage. And that is just saying for any reason, whether it's age contraindication or otherwise.

CAVANAUGH: Well, it says both in Section 4 and Section 2 that it has to be medically necessary. And I, in reading lines 18-24, it looks like, and maybe I'm reading this incorrectly, that the reason to move that out is that there has to be a proof of therapeutic success. And if you're starting somebody on a course of antidepressants, you can't prove therapeutic success until they've been on the antidepressants, and 72 hours would not be enough time for a lot of combinations of antidepressants and antipsychotics to prove therapeutic success. So this is saying that if a doctor deems it medically necessary, which I would assume the pharmacists would contact the doctor in advance of processing it if it wasn't on the preapproved list and say, hey, this isn't on the preapproved list, is this what you intended? Which is, I think, the conversation we had last year,--

CARISA SCHWEITZER MASEK: Um-hum.

CAVANAUGH: --and the doctor would say, yes, this is what I intended,--

CARISA SCHWEITZER MASEK: Um-hum.

CAVANAUGH: --and then they couldn't reject it.

CARISA SCHWEITZER MASEK: Yes, at the point the pharmacist would call the physician, that is considered a denial at that point prior to the

phone call to the physician, and that's where the language gets very specific.

CAVANAUGH: It's considered-- so when you get your prescription called in and the pharmacy receives it and they call the doctor with questions, that's considered a denial?

CARISA SCHWEITZER MASEK: If the MCO-- if it has--

CAVANAUGH: Because that happens to me like all the time.

CARISA SCHWEITZER MASEK: Yeah, if it has hit a clinical edit, it says for, for this safety reason, we need to have a conversation with the physician and the drug is not covered at this time

CAVANAUGH: So they have to enter something into a computer?

CARISA SCHWEITZER MASEK: Then they call a physician and have that conversation or the physician calls the MCO and explains why.

CAVANAUGH: And they don't enter anything into the computer, they just call the physician when they get it to ask them questions?

CARISA SCHWEITZER MASEK: The pharmacist, they can do that in some of their workflows.

CAVANAUGH: OK, thank you.

HOWARD: So-- because I, I still don't understand this and I apologize because I really don't understand. So, so is it that you, is it that the language of the statute that's proposed here uses the word deny? Should it be something like they, they can't stop coverage until you've had that discussion or something along those lines? Because, because I think you appreciate the gap that we're trying to address. Right? So if you were to address this gap, knowing what you know about drug utilization review,--

CARISA SCHWEITZER MASEK: Um-hum.

HOWARD: --how would you address that in statute?

CARISA SCHWEITZER MASEK: I would want to sit down with Senator Wishart and see what her thoughts are and where she's at in wanting to meet the needs that she's identified. As, as I've listened and taken notes, we want to be able to meet that need without inadvertently creating a

could be consequential clinical risk for a very large number of patients as this language would take away the ability to do-- to deny coverage for contraindications or anything on clinical safety edits.

HOWARD: OK. And, and I think my other concern sort of about this conversation is I-- you know, we hear from healthcare providers that they are the ones who are working with the patients. They are the ones who know best. They are the ones who sort of know if a, if a medication is working.

CARISA SCHWEITZER MASEK: Um-hum.

HOWARD: And, and to me, I think what I'm hearing is that you'd like to preserve the opportunity to deny coverage, but there's no way for us to intervene and prevent you from saying, no, you can't be on that medication when an entity like the Department or the MCO has never met that patient.

CARISA SCHWEITZER MASEK: Um-hum.

HOWARD: And I think that's, that's sort of the rub here. Since, since we have you here and I know you want to speak to Senator Wishart, Senator Wishart and I have had a few conversations, she is interested in prioritizing this. And, and, and I think there's a lot of sympathy here, at least I have a lot of sympathy. And so I'd like to make sure that the language is correct for what she would like it to do and for what you need to do. And so I hope you'll be able to take the time to really fix this language because-- I mean, we'll Exec on it on Wednesday. And so it'd be great if it could be addressed by then. Thank you. Are there any final questions? Seeing none, thank you for your testimony today. Our next opposition testifier. Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Wishart, you're welcome to come up to close. And we do have a few letters for proponents: Heath Boddy, Nebraska Health Care Association; Annette Dubas, Nebraska Association of Behavioral Health Organizations; Jeffrey Hines, representing himself; Linda Jensen, Nebraska Nurses Association. No letters in opposition or neutral. Welcome back, Senator Wishart.

WISHART: Well, thank you so much, Committee, and I won't be long since I'm the last thing before we head out. But I just did want to say that I think we're getting closer with this bill than we were last year, already my office is gonna reach out and schedule a meeting with the Department to see-- I have no issue addressing their concern about

sort of pharmaceutical abuse and would be happy to work with them on that. I think there's a way where we can still achieve solving sort of this gap that's happening to people like Curtis across the state. So I thank you for your interest in this issue.

HOWARD: Thank you. Are there any final questions? Seeing none, thank you, Senator Wishart. This will close the hearing for LB1052.