LEGISLATIVE COMMITTEE MINUTES

SB149

Bill as Introduced

SB 149-FN - AS INTRODUCED

2021 SESSION

21-1074
10/04

SENATE BILL ***149-FN***

AN ACT adopting omnibus legislation on health and human services.

SPONSORS: Sen. Sherman, Dist 24

COMMITTEE: Health and Human Services

ANALYSIS

This bill adopts legislation relative to:

I. Nursing home standards.

II. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

III. Establishing a harm reduction and overdose prevention program in the department of health and human services.

IV. Automated pharmacy systems.

V. Establishing a rehabilitation bed pilot program.

VI. Health facilities providing care in the declared emergency.

VII. Confidential sharing of information under the controlled drug prescription health and safety program.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

21-1074
10/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation on health and human services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0208, relative to nursing home standards, sponsored by Sen. Ward, Prime/Dist 8.

Part II. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part III. LSR 21-0837, establishing a harm reduction and overdose prevention program in the department of health and human services, sponsored by Sen. Watters, Prime/Dist 4; Sen. Sherman, Dist 24; Sen. Whitley, Dist 15; Sen. D'Allesandro, Dist 20; Rep. Amanda Bouldin, Hills 12; Rep. Woods, Merr. 23; Rep. Conley, Straf. 13.

Part IV. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part V. LSR 21-0997, establishing a rehabilitation bed pilot program, sponsored by Sen. Bradley, Prime/Dist 3.

Part VI. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

Part VII. LSR 21-0833, relative to confidential sharing of information under the controlled drug prescription health and safety program, sponsored by Sen. Giuda, Prime/Dist 2; Sen. Rosenwald, Dist 13; Sen. Carson, Dist 14; Sen. Prentiss, Dist 5; Sen. D'Allesandro, Dist 20; Sen. Soucy, Dist 18; Rep. M. Pearson, Rock. 34; Rep. Marsh, Carr. 8; Rep. Merchant, Sull. 4.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Relative to nursing home standards.

1 New Section; Nursing Home Facilities. Amend RSA 151 by inserting after section 12-b the following new section:

151:12-c Placement in Nursing Home Facilities. A resident of New Hampshire who receives Medicaid and who requires nursing home care shall not be placed in any out-of-state facility which does not meet the requirements of this chapter and other standards of care under New Hampshire

2 Effective Date. Part I of this act shall take effect January 1, 2022.

PART II

Clarifying Medicaid spend-down requirements

and requiring a report to the oversight committee on health and human services.

1 New Section; Spend-Down Requirements for Medical Expenses. Amend RSA 167 by inserting after section 4-d the following new section:

167:4-e Spend-down Requirements for Medical Expenses. For the purposes of off-setting the Medicaid spend-down requirements, mental health expenses shall be included as medical expenses.

2 Report to Oversight Committee on Health and Human Services.

I. The department of health and human services shall submit an interim report on or before October 1, 2021, to the oversight committee on health and human services, established pursuant to RSA 126-A:13, relative to actions taken to ensure the uniform application of spend-down requirements. The report shall include a description of how spend-down requirements were addressed in remedial staff training programs, updates to the policy manual, and updates to the brochure and any other department publications.

II. The department shall submit a final report by October 1, 2022, on the application of spend-down requirements. The report shall include data indicating how spend-down requirements have been applied since the interim report was filed.

3 Effective date. Part II of this act shall take effect upon its passage.

PART III

Establishing a harm reduction and overdose prevention program

in the department of health and human services.

1 Findings. The legislature finds and declares all of the following:

I. Overdose deaths in New Hampshire are an urgent public health crisis. For many years, overdose has been the leading cause of accidental death in the United States and in New Hampshire.

II. Harm reduction and overdose prevention programs (OPPs) are an evidence-based harm reduction strategy that allow individuals to consume drugs in a hygienic environment under the supervision of trained staff, who are able to intervene if the patient overdoses. OPPs also provide sterile consumption equipment and offer general medical advice and referrals to drug treatment and other community social services.

III. There are approximately 165 overdose prevention programs operating in 10 countries around the world, and numerous peer-reviewed studies have confirmed that those programs are effective in reducing overdose deaths and HIV transmission, and in increasing access to counseling, treatment, and other risk reduction services. Research has also demonstrated that those programs

decrease use of emergency medical services, reduce public drug use, reduce syringe debris, and do not increase crime or drug use.

IV. An analysis published in the Journal of Drug Issues in 2016, OPPs in New Hampshire would save the state and municipalities substantial funds by reducing other costs due to opioid use and overdose.

V. An increase in overdose deaths was observed nationwide in 2020 according to the Office of National Drug Control Policy, rising 16.6 percent, based on a comparison of January to April, inclusive, of 2019 with the same time frame of 2020.

VI. As demands for reform of the criminal legal system reverberate around the country, OPPs offer an alternative framework for addressing both drug use as well as the enforcement of drug laws. OPPs bring people inside to a safe and therapeutic space, instead of leaving them vulnerable to police intervention, arrest, and incarceration.

VII. It is the intent of the legislature to promote the health and safety of communities by evaluating the health impacts of OPPs. It is the intent of the legislature to prevent fatal and nonfatal drug overdoses, reduce drug use by providing a pathway to drug treatment, as well as medical and social services for high-risk drug users, many of whom are homeless or uninsured or very low income, prevent the transmission of HIV and hepatitis C, reduce nuisance and public safety problems related to public use of controlled substances, reduce emergency room use and hospital utilization related to drug use, reserving precious space, including intensive care beds, for treatment of COVID-19, and other life-threatening conditions.

VIII. Further, it is the intent of the legislature that OPPs should be evaluated in New Hampshire municipalities that authorize them, as OPPs show great promise to save lives, enhance public safety, improve access to drug treatment, medical care, and related services, reduce emergency department and hospital utilization related to drug overdose, and reduce the human, social, and financial costs of epidemics of drug misuse, homelessness, and COVID-19.

2 New Subdivision; Harm Reduction and Overdose Prevention Programs. Amend RSA 318-B by inserting after section 45 the following new subdivision:

Harm Reduction and Overdose Prevention Programs

318-B:45-a Harm Reduction and Overdose Prevention Programs

I.(a) Notwithstanding any other law, a New Hampshire municipality may approve entities within its jurisdiction to establish and operate overdose prevention programs for persons 18 years of age or older that satisfy the requirements set forth in paragraph IV.

II. Prior to approving an entity within its jurisdiction pursuant to paragraph I, a municipality shall provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The notice of the meeting to the public shall be sufficient to ensure adequate participation in the meeting by the public. The meeting shall be

noticed in accordance with all state laws and local ordinances, and as local officials deem appropriate.

III.(a) The following entities, if self-funded, may operate an OPP upon approval of the municipality's governing body in New Hampshire to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs:

(1) Federally qualified health centers.

(2) Community health centers.

(3) Public health networks.

(4) AIDS service organizations.

(5) Substance misuse support or treatment organizations.

(6) Community based organizations.

(b) The commissioner of the department of health and human services shall adopt rules, pursuant to RSA 541-A, further defining the entities which may operate an overdose prevention program.

IV. Any entity operating an OPP in New Hampshire shall:

(a) Provide a hygienic space supervised by health care professionals where people who use drugs can consume pre-obtained drugs. For purposes of this paragraph, "health care professional" includes, but is not limited to, a physician, physician assistant, nurse practitioner, licensed vocational nurse, registered nurse, psychiatrist, psychologist, licensed clinical social worker, licensed professional clinical counselor, mental health provider, social service provider, or substance use disorder provider, trained in overdose recognition and reversal.

(b) Provide sterile consumption supplies, collect used hypodermic needles and syringes, and provide secure hypodermic needle and syringe disposal services.

(d) Administer first aid, if needed, monitor participants for potential overdose, and provide treatment as necessary to prevent fatal overdose.

(e) Provide referral and linkage to HIV, viral hepatitis, and substance use disorder prevention, care, and treatment services, as appropriate.

(f) Coordinate and collaborate with other local agencies, organizations, and providers involved in comprehensive prevention programs for people who inject drugs to minimize duplication of effort.

(g) Attempt to be a part of a comprehensive service program that may include, as appropriate:

(1) Providing sterile needles, syringes, and other drug preparation equipment and disposal services.

(2) Educating and counseling to reduce sexual, injection, and overdose risks.

(3) Providing condoms to reduce risk of sexual transmission of viral hepatitis, HIV, or other STDs.

(4) Screening for HIV, viral hepatitis, STDs, and tuberculosis.

(5) Providing naloxone to reverse opioid overdoses.

(6) Providing referral and linkage to HIV, viral hepatitis, STD and tuberculosis prevention, treatment, and care services, including antiretroviral therapy for hepatitis C virus (HCV) and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission, and partner services.

(7) Providing referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination.

(8) Providing referral and linkage to and provision of substance use disorder treatment including medication assisted treatment for opioid use disorder which combines drug therapy such as methadone, buprenorphine, or naltrexone with counseling and behavioral therapy.

(9) Providing referral to medical care, mental health services, and other support services.

(h) Post its address, phone number, program contact information, if appropriate, hours of operation, and services offered on its Internet website.

(i) Provide reasonable security of the program site.

(j) Establish operating procedures for the program, made available to the public either through an Internet website or upon request, that are publicly noticed, including, but not limited to, standard hours of operation, a minimum number of personnel required to be on site during those hours of operation, the licensing and training standards for staff present, an established maximum number of individuals who can be served at one time, and an established relationship with the nearest emergency department of a general acute care hospital, as well as eligibility criteria for program participants.

(k) Train staff members to deliver services offered by the program.

(l) Establish a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints.

(m) Establish a policy for informing local government officials and neighbors about the approved entity's complaint procedures, and the contact number of the director, manager, or operator of the approved entity.

(n) Register with the department of health and human services and confirm registration annually on or before November 1 of each subsequent year; provided however, the registration process shall be limited to notification to the department for data collection purposes only.

(o) Report quarterly to the department, which report shall include the following information regarding the program's activities:

(1) The number of program participants.

(2) Aggregate information regarding the characteristics of program participants.

(3) The number of hypodermic needles and syringes distributed for use on site.

(4) The number of overdoses experienced and the number of overdoses reversed on site.

(5) The number of persons referred to substance misuse treatment/services.

(6) The number of individuals directly and formally referred to other services and the type of service.

V. Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of the New Hampshire municipalities, state agencies, hospitals, or overdose prevention programs, acting in the course and scope of employment, shall not be arrested, charged, or prosecuted under RSA 318-B:2 for possession of controlled substances, possession of drug paraphernalia, or allowing drug use on premises, including for attempt, aiding and abetting, or conspiracy to commit a violation of any of those offenses, or otherwise be penalized solely for actions, conduct, or omissions on the site of a harm reduction and overdose prevention program approved under this section, or for conduct relating to the approval of an entity to operate an OPP, or the inspection, licensing, or other regulation of an OPP approved under this section.

VI. Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of overdose prevention programs acting in the course and scope of employment shall not be subject to civil, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability, or have their property subject to forfeiture, solely for actions, conduct, or omissions in compliance with an OPP approved under this section or for conduct relating to the approval of an entity to operate an OPP, or the inspection, licensing, or other regulation of an OPP approved pursuant to this section.

VII. Nothing in this section shall be construed to prohibit the department of health and human services from administering and/or disbursing federal or other funds to harm reduction and overdose prevention programs authorized under this section. The use of state general funds shall be prohibited unless otherwise appropriated by the general court.

VIII. No overdose prevention program shall be located within a drug-free school zone as defined in RSA 193-B:1, II. Exceptions to this prohibition may be granted by the applicable district school board when a request is initiated by a overdose prevention program administrator.

3 Syringe Service Programs; reference Added. Amend RSA 318-B:44 to read as follows:

318-B:44 Syringe Service Programs; Affirmative Defense. It is an affirmative defense, as provided in RSA 626:7, to prosecution for possession of a hypodermic syringe or needle that the item was obtained through participation in a syringe service program or an overdose prevention program under RSA 318-B:45-a. Nothing in this section shall be construed as an affirmative defense for any offense other than as set forth under RSA 318-B:26, [II(f)] II(e).

4 Effective Date. Part III of this act shall take effect 60 days after its passage.

PART IV

Relative to automated pharmacy systems.

1 Pharmacies; Definitions; Automated Pharmacy System. Amend RSA 318:1, XXII to read as follows:

XXII. "Automated pharmacy system" means mechanical systems that perform operations or activities, other than compounding or administration, relative to the storage, packaging, dispensing, [~~or~~] distribution, ***counting, labeling, and delivery*** of medications, and which collects, controls, and maintains all transaction information.

2 New Section; Pharmacies; Automated Pharmacy Systems. Amend RSA 318 by inserting after section 42 the following new section:

318:42-a Automated Pharmacy Systems.

I. In this section:

(a) "Provider pharmacy" means a pharmacy that provides pharmacy services by using an automated pharmacy system at a remote site.

(b) "Remote site" means a long term care facility, hospice, or state or county correctional institution, that is not located at the same location as the provider pharmacy, at which pharmacy services are provided using an automated pharmacy system.

II.(a) A provider pharmacy may provide pharmacy services to a long term care facility, hospice, or state or county correctional institution through the use of an automated pharmacy system.

(b) An automated pharmacy system shall only be used to provide pharmacy services to an inpatient or a resident of the remote site.

(c) Supervision of the automated pharmacy system shall be the responsibility of a licensed pharmacist employed by the provider pharmacy.

(d) Every medicinal drug stored in the automated pharmacy system shall be owned by the provider pharmacy.

(e) An automated pharmacy system shall be under the supervision of a pharmacist employed by the provider pharmacy. The pharmacist need not be physically present at the remote site if the system is supervised electronically.

(f) A provider pharmacy shall have policies and procedures to ensure adequate security.

III.(a) The pharmacist shall ensure that the automated pharmacy system complies with state and federal laws relating to the regulation of controlled substances, for each automated pharmacy system that contains a controlled substance.

(b) The pharmacist shall ensure that the use of an automated pharmacy system does not compromise patient confidentiality.

(c) The pharmacist or a designee shall:

(1) Authorize or deny access to the data from an automated pharmacy system or to a drug stored inside the automated pharmacy system.

(2) Document the training of each person who has access to the data from an automated pharmacy system or to a drug stored inside the automated pharmacy system.

IV.(a) A medicinal drug stored in bulk or unit-of-use in an automated pharmacy system is part of the inventory of the provider pharmacy and is not part of the inventory of any other pharmacy permit for the facility.

(b) A medicinal drug may be removed from an automated pharmacy system for administration to a patient only after a prescription or order has been received and approved by a pharmacist at the provider pharmacy.

(c) A pharmacist at the provider pharmacy shall control all operations of the automated pharmacy system and approve release of the initial dose of a prescription or order. A subsequent dose from an approved prescription or order may be released without additional approval of a pharmacist. However, any change made in a prescription or order shall require a new approval by a pharmacist to release the drug.

(d) A pharmacist at the provider pharmacy shall comply with the patient record requirements in this chapter and in rules of the board and RSA 318-B for every medicinal drug delivered through an automated pharmacy system.

(e) If the facility where pharmacy services are being provided maintains a medication administration record that includes directions for use of the medication, a unit dose medication may be utilized if the provider pharmacy or the automated pharmacy system identifies and records the dispensing pharmacy, the prescription or order number, the name of the patient, and the name of the prescribing practitioner for each medicinal drug delivered.

(f)(1) The stocking or restocking of a medicinal drug in an automated pharmacy system at the remote site shall be completed by a pharmacist or other licensed personnel, except as provided in subparagraph (2).

(2) If the automated pharmacy system uses removable cartridges or containers to store the drug, the stocking or restocking of the cartridges or containers may occur at the provider pharmacy and be sent to the remote site to be loaded by personnel designated by the pharmacist if:

A. A pharmacist verifies the cartridge or container has been properly filled and labeled.

B. The individual cartridge or container is transported to the remote site in a secure, tamper-evident container.

C. The automated pharmacy system uses bar code verification, electronic verification, or similar process to assure that the cartridge or container is accurately loaded into the automated pharmacy system.

(g) A medicinal drug that has been removed from the automated pharmacy system shall not be replaced into the system unless a pharmacist has examined the medication, the packaging, and the labeling and determined that reuse of the medication is appropriate.

(h) Medication to be returned to the provider pharmacy's stock shall meet the requirements in rules adopted by the board.

V.(a) If a provider pharmacy intends to store a controlled substance in an automated pharmacy system:

(1) It shall maintain a separate DEA registration for each remote site at which a controlled substance is stored.

(2) It may utilize one DEA registration to include multiple automated pharmacy systems located at a single address.

(b) A provider pharmacy shall only store a medicinal drug at a remote site within an automated pharmacy system which is locked by a mechanism that prevents access to a drug or to data by unauthorized personnel.

(c) Access to the drugs shall be limited to a pharmacist, authorized technician, or licensed advanced pharmacy technician, employed by the provider pharmacy or licensed personnel in the facility or institution who are authorized to administer medication.

(d) An automated pharmacy system that contains a controlled substance shall prohibit simultaneous access to multiple drug entities, drug strengths, or dosage forms of controlled substances.

VI.(a) The record of transactions with the automated pharmacy system shall be maintained in a readily retrievable manner.

(b) The record shall be available to the board or the board's authorized agent.

(c) The record shall include:

(1) Name or identification of the patient or resident.

(2) Name, strength and dosage form of the drug product released.

(3) Quantity of drug released.

(4) Date and time of each release of a drug.

(5) Name of provider pharmacy.

(6) Prescription number or order number.

(7) Name of prescribing practitioner.

(8) Identity of the pharmacist who approved the prescription or order.

(9) Identity of the person to whom the drug was released.

(d) A record of every transaction with the automated pharmacy system shall be maintained for 4 years.

3 Effective Date. Part IV of this act shall take effect 60 days after its passage.

PART V

Establishing a rehabilitation bed pilot program.

1 New Paragraph; Rehabilitation Bed Program. Amend RSA 151:2 by inserting after paragraph VI the following new paragraph:

VII.(a) Notwithstanding the provisions of paragraph VI, any acute care or critical access hospital shall be permitted to apply for a license to operate rehabilitation care services. Such application shall be made on or before June 30, 2023; provided, however, that the hospital shall demonstrate in advance that its geometric mean length of stay as determined by the Centers for Medicare and Medicaid Services has remained no less than 110 percent during a consecutive 6 month period in the 12 months prior to the hospital's demonstration.

(b) Upon receipt of a hospital's geometric mean length of stay percentage, the department within 15 days shall certify through inquiry to the Center for Medicare and Medicaid Services the accuracy of such percentage and shall inform the applicant of the results of the inquiry.

(c) Upon receipt of confirmation from the department of the geometric mean length of stay percentage, a hospital may file its license application.

(d) The initial term of the pilot program shall end June 30, 2023 and the program will automatically renew.

2 Repeal. RSA 151:2, VII, relative to the rehabilitation program, is repealed.

3 Effective Date.

I. Section 2 of this part shall take effect December 31, 2024.

II. The remainder of this part shall take effect 60 days after its passage.

PART VI

Relative to health facilities providing care in the declared emergency.

1 New Section; Novel Coronavirus Disease (COVID-19) Outbreak; Health Facilities. Amend RSA 21-P by inserting after section 42 the following new section:

21-P:42-a Novel Coronavirus Disease (COVID-19) Outbreak; Health Facilities. Acute care hospitals, assisted living facilities, long-term care facilities, nursing facilities, residential care facilities, ambulatory care clinics (as defined in RSA 151, RSA 151-A, RSA 151-D, RSA 151-E and RSA 151-H), and any other similar facilities providing care to elderly or infirm patients, referred to in this section as "health facilities," and the employees, agents and volunteers of such health facilities, are deemed to have been engaged in preparing for and carrying out emergency management functions for the purposes of RSA 21-P:35 when taking actions to comply, or reasonably attempting to comply, with any executive order, agency order or rule (including but not limited to waivers from the Centers for Medicare and Medicaid Services (CMS)) both issued as blanket waivers by CMS and as requested the department of health and human services pertaining to the state of emergency declared under state or federal law in response to the Novel Coronavirus Disease

(COVID-19) Outbreak. All such orders and rules are deemed to constitute orders, rules, or regulations adopted pursuant to RSA 21-P.

2 Effective Date. Part VI of this act shall take effect upon its passage.

PART VII

Relative to confidential sharing of information
under the controlled drug prescription health and safety program.

1 New Paragraph; Controlled Drug Prescription Health and Safety Program Established. Amend RSA 318-B:32 by inserting after paragraph I the following new paragraph:

I-a. The office may enter into agreements or contracts to facilitate the confidential sharing of information relating to the prescribing and dispensing of schedule II-IV controlled substances, by practitioners within the state and to establish secure connections between the program and a practitioner's electronic health record keeping system. The electronic health record keeping system may allow for the query and retrieval of program information for display and retention in the patient's medical information; provided that nothing in this section shall allow the electronic health record keeping system owner or license holder to perform data queries unrelated to individuals under the practitioner's care. The electronic health record keeping system owner or license holder shall be responsible for ensuring that only authorized individuals have access to program information.

2 New Paragraph; Controlled Drug Prescription Health and Safety Program; Confidentiality. Amend RSA 318-B:34 by inserting after paragraph II the following new paragraph:

II-a. A practitioner who intends to request and use information from the program about a patient shall post a sign that can be easily viewed by the public that discloses to the public that the practitioner may access and use information contained in the program. In lieu of posting a sign, the practitioner may provide such notice in written material provided to the patient.

3 Effective Date. Part VII of this act shall take effect upon its passage.

LBA
21-1074
2/8/21

SB 149-FN- FISCAL NOTE
AS INTRODUCED

AN ACT adopting omnibus legislation on health and human services

FISCAL IMPACT:

The Office of Legislative Budget Assistant is unable to complete a fiscal note for this bill, as introduced, as it is awaiting information from the Department of Health and Human Services and Office of Professional Licensure and Certification. When completed, the fiscal note will be forwarded to the Senate Clerk's Office.

AGENCIES CONTACTED:

Department of Health and Human Services and Office of Professional Licensure and Certification

2021 SESSION

21-1074
10/04

SENATE BILL ***149-FN***

AN ACT adopting omnibus legislation on health and human services.

SPONSORS: Sen. Sherman, Dist 24

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Establishing a harm reduction and overdose prevention program in the department of health and human services.

III. Automated pharmacy systems.

IV. Health facilities providing care in the declared emergency.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation on health and human services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0837, establishing a harm reduction and overdose prevention program in the department of health and human services, sponsored by Sen. Watters, Prime/Dist 4; Sen. Sherman, Dist 24; Sen. Whitley, Dist 15; Sen. D'Allesandro, Dist 20; Rep. Amanda Bouldin, Hills 12; Rep. Woods, Merr. 23; Rep. Conley, Straf. 13.

Part III. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part IV. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

1 New Section; Spend-Down Requirements for Medical Expenses. Amend RSA 167 by inserting after section 4-d the following new section:

167:4-e Spend-down Requirements for Medical Expenses. For the purposes of off-setting the Medicaid spend-down requirements, mental health expenses shall be included as medical expenses.

2 Report to Oversight Committee on Health and Human Services.

I. The department of health and human services shall submit an interim report on or before October 1, 2021, to the oversight committee on health and human services, established pursuant to RSA 126-A:13, relative to actions taken to ensure the uniform application of spend-down requirements. The report shall include a description of how spend-down requirements were addressed in remedial staff training programs, updates to the policy manual, and updates to the brochure and any other department publications.

II. The department shall submit a final report by October 1, 2022, on the application of spend-down requirements. The report shall include data indicating how spend-down requirements have been applied since the interim report was filed.

3 Effective date. Part I of this act shall take effect upon its passage.

PART II

Establishing a harm reduction and overdose prevention program in the department of health and human services.

1 Findings. The legislature finds and declares all of the following:

I. Overdose deaths in New Hampshire are an urgent public health crisis. For many years, overdose has been the leading cause of accidental death in the United States and in New Hampshire.

II. Harm reduction and overdose prevention programs (OPPs) are an evidence-based harm reduction strategy that allow individuals to consume drugs in a hygienic environment under the supervision of trained staff, who are able to intervene if the patient overdoses. OPPs also provide sterile consumption equipment and offer general medical advice and referrals to drug treatment and other community social services.

III. There are approximately 165 overdose prevention programs operating in 10 countries around the world, and numerous peer-reviewed studies have confirmed that those programs are effective in reducing overdose deaths and HIV transmission, and in increasing access to counseling, treatment, and other risk reduction services. Research has also demonstrated that those programs decrease use of emergency medical services, reduce public drug use, reduce syringe debris, and do not increase crime or drug use.

IV. An analysis published in the Journal of Drug Issues in 2016, OPPs in New Hampshire would save the state and municipalities substantial funds by reducing other costs due to opioid use and overdose.

V. An increase in overdose deaths was observed nationwide in 2020 according to the Office of National Drug Control Policy, rising 16.6 percent, based on a comparison of January to April, inclusive, of 2019 with the same time frame of 2020.

VI. As demands for reform of the criminal legal system reverberate around the country, OPPs offer an alternative framework for addressing both drug use as well as the enforcement of drug laws. OPPs bring people inside to a safe and therapeutic space, instead of leaving them vulnerable to police intervention, arrest, and incarceration.

VII. It is the intent of the legislature to promote the health and safety of communities by evaluating the health impacts of OPPs. It is the intent of the legislature to prevent fatal and nonfatal drug overdoses, reduce drug use by providing a pathway to drug treatment, as well as medical and social services for high-risk drug users, many of whom are homeless or uninsured or very low income, prevent the transmission of HIV and hepatitis C, reduce nuisance and public safety problems related to public use of controlled substances, reduce emergency room use and hospital

utilization related to drug use, reserving precious space, including intensive care beds, for treatment of COVID-19, and other life-threatening conditions.

VIII. Further, it is the intent of the legislature that OPPs should be evaluated in New Hampshire municipalities that authorize them, as OPPs show great promise to save lives, enhance public safety, improve access to drug treatment, medical care, and related services, reduce emergency department and hospital utilization related to drug overdose, and reduce the human, social, and financial costs of epidemics of drug misuse, homelessness, and COVID-19.

2 New Subdivision; Harm Reduction and Overdose Prevention Programs. Amend RSA 318-B by inserting after section 45 the following new subdivision:

Harm Reduction and Overdose Prevention Programs

318-B:45-a Harm Reduction and Overdose Prevention Programs

I.(a) Notwithstanding any other law, a New Hampshire municipality may approve entities within its jurisdiction to establish and operate overdose prevention programs for persons 18 years of age or older that satisfy the requirements set forth in paragraph IV.

II. Prior to approving an entity within its jurisdiction pursuant to paragraph I, a municipality shall provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The notice of the meeting to the public shall be sufficient to ensure adequate participation in the meeting by the public. The meeting shall be noticed in accordance with all state laws and local ordinances, and as local officials deem appropriate.

III.(a) The following entities, if self-funded, may operate an OPP upon approval of the municipality's governing body in New Hampshire to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs:

(1) Federally qualified health centers.

(2) Community health centers.

(3) Public health networks.

(4) AIDS service organizations.

(5) Substance misuse support or treatment organizations.

(6) Community based organizations.

(b) The commissioner of the department of health and human services shall adopt rules, pursuant to RSA 541-A, further defining the entities which may operate an overdose prevention program.

IV. Any entity operating an OPP in New Hampshire shall:

(a) Provide a hygienic space supervised by health care professionals where people who use drugs can consume pre-obtained drugs. For purposes of this paragraph, "health care professional" includes, but is not limited to, a physician, physician assistant, nurse practitioner, licensed vocational nurse, registered nurse, psychiatrist, psychologist, licensed clinical social worker,

licensed professional clinical counselor, mental health provider, social service provider, or substance use disorder provider, trained in overdose recognition and reversal.

(b) Provide sterile consumption supplies, collect used hypodermic needles and syringes, and provide secure hypodermic needle and syringe disposal services.

(c) Administer first aid, if needed, monitor participants for potential overdose, and provide treatment as necessary to prevent fatal overdose.

(d) Provide referral and linkage to HIV, viral hepatitis, and substance use disorder prevention, care, and treatment services, as appropriate.

(e) Coordinate and collaborate with other local agencies, organizations, and providers involved in comprehensive prevention programs for people who inject drugs to minimize duplication of effort.

(f) Attempt to be a part of a comprehensive service program that may include, as appropriate:

(1) Providing sterile needles, syringes, and other drug preparation equipment and disposal services.

(2) Educating and counseling to reduce sexual, injection, and overdose risks.

(3) Providing condoms to reduce risk of sexual transmission of viral hepatitis, HIV, or other STDs.

(4) Screening for HIV, viral hepatitis, STDs, and tuberculosis.

(5) Providing naloxone to reverse opioid overdoses.

(6) Providing referral and linkage to HIV, viral hepatitis, STD and tuberculosis prevention, treatment, and care services, including antiretroviral therapy for hepatitis C virus (HCV) and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission, and partner services.

(7) Providing referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination.

(8) Providing referral and linkage to and provision of substance use disorder treatment including medication assisted treatment for opioid use disorder which combines drug therapy such as methadone, buprenorphine, or naltrexone with counseling and behavioral therapy.

(9) Providing referral to medical care, mental health services, and other support services.

(g) Post its address, phone number, program contact information, if appropriate, hours of operation, and services offered on its Internet website.

(h) Provide reasonable security of the program site.

(i) Establish operating procedures for the program, made available to the public either through an Internet website or upon request, that are publicly noticed, including, but not limited to, standard hours of operation, a minimum number of personnel required to be on site during those

hours of operation, the licensing and training standards for staff present, an established maximum number of individuals who can be served at one time, and an established relationship with the nearest emergency department of a general acute care hospital, as well as eligibility criteria for program participants.

(j) Train staff members to deliver services offered by the program.

(k) Establish a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints.

(l) Establish a policy for informing local government officials and neighbors about the approved entity's complaint procedures, and the contact number of the director, manager, or operator of the approved entity.

(m) Register with the department of health and human services and confirm registration annually on or before November 1 of each subsequent year; provided however, the registration process shall be limited to notification to the department for data collection purposes only.

(n) Report quarterly to the department, which report shall include the following information regarding the program's activities:

(1) The number of program participants.

(2) Aggregate information regarding the characteristics of program participants.

(3) The number of hypodermic needles and syringes distributed for use on site.

(4) The number of overdoses experienced and the number of overdoses reversed on site.

(5) The number of persons referred to substance misuse treatment/services.

(6) The number of individuals directly and formally referred to other services and the type of service.

V. Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of the New Hampshire municipalities, state agencies, hospitals, or overdose prevention programs, acting in the course and scope of employment, shall not be arrested, charged, or prosecuted under RSA 318-B:2 for possession of controlled substances, possession of drug paraphernalia, or allowing drug use on premises, including for attempt, aiding and abetting, or conspiracy to commit a violation of any of those offenses, or otherwise be penalized solely for actions, conduct, or omissions on the site of a harm reduction and overdose prevention program approved under this section, or for conduct relating to the approval of an entity to operate an OPP, or the inspection, licensing, or other regulation of an OPP approved under this section.

VI. Nothing in this section shall be construed to prohibit the department of health and human services from administering and/or disbursing federal or other funds to harm reduction and

overdose prevention programs authorized under this section. The use of state general funds shall be prohibited unless otherwise appropriated by the general court.

VII. No overdose prevention program shall be located within a drug-free school zone as defined in RSA 193-B:1, II. Exceptions to this prohibition may be granted by the applicable district school board when a request is initiated by a overdose prevention program administrator.

3 Syringe Service Programs; Reference Added. Amend RSA 318-B:44 to read as follows:

318-B:44 Syringe Service Programs; Affirmative Defense. It is an affirmative defense, as provided in RSA 626:7, to prosecution for possession of a hypodermic syringe or needle that the item was obtained through participation in a syringe service program ***or an overdose prevention program under RSA 318-B:45-a.*** Nothing in this section shall be construed as an affirmative defense for any offense other than as set forth under RSA 318-B:26, [~~II(f)~~] ***II(e).***

4 Effective Date. Part II of this act shall take effect 60 days after its passage.

PART III

Relative to automated pharmacy systems.

1 New Section; Pharmacies; Automated Pharmacy Systems. Amend RSA 318 by inserting after section 42 the following new section:

318:42-a Automated Pharmacy Systems; Long-term Care Facilities, Hospices, or State Correctional Institutions.

I. A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under RSA 151 or to a state correctional institution through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

II. Medicinal drugs stored in bulk or unit of use in an automated pharmacy system servicing a long-term care facility, hospice, or correctional institution are part of the inventory of the pharmacy providing pharmacy services to that facility, hospice, or institution, and drugs delivered by the automated pharmacy system are considered to have been dispensed by that pharmacy.

III. The operation of an automated pharmacy system shall be under the supervision of a New Hampshire-licensed pharmacist. To qualify as a supervisor for an automated pharmacy system, the pharmacist need not be physically present at the site of the automated pharmacy system and may supervise the system data electronically. The New Hampshire-licensed pharmacist shall be required to develop and implement policies and procedures designed to verify that the medicinal drugs delivered by the automated dispensing system are accurate and valid and that the machine is properly restocked.

IV. This section is not intended to limit the current practice of pharmacy in this state. This section is intended to allow automated pharmacy systems to enhance the ability of a pharmacist to provide pharmacy services in locations that do not employ a full-time pharmacist. This section does not limit or replace the use of a consultant pharmacist.

V. The board shall adopt rules governing the use of an automated pharmacy system under this section, not later than January 1, 2022, which shall specify:

(a) Recordkeeping requirements;

(b) Security requirements; and

(c) Labeling requirements.

2 Effective Date. Part III of this act shall take effect 60 days after its passage.

PART IV

Relative to health facilities providing care in the declared emergency.

1 New Section; Department of Safety; Homeland Security and Emergency Management; Novel Coronavirus Disease (COVID-19); Health Facilities. Amend RSA 21-P by inserting after section 42 the following new section:

21-P:42-a Novel Coronavirus Disease (COVID-19; Health Facilities. Acute care hospitals, assisted living facilities, long-term care facilities, nursing facilities, residential care facilities, ambulatory care clinics (as defined in RSA 151, RSA 151-A, RSA 151-D, RSA 151-E and RSA 151-H), and any other similar facilities providing care to elderly or infirm patients ("health facilities"), and the employees, agents and volunteers of such health facilities, are deemed to have been engaged in preparing for and/or carrying out "emergency management" functions for the purposes of RSA 21-P:35 when complying, or reasonably attempting to comply, with any executive order, agency order or rule (including but not limited to waivers from the Centers for Medicare and Medicaid Services (CMS) both issued as blanket waivers by CMS and as requested by New Hampshire department of health and human services pertaining to the state of emergency declared under state and/or federal law in response to the Novel Coronavirus (COVID-19). All such orders and rules are deemed to constitute orders and/or rules adopted and/or regulations promulgated pursuant to RSA 21-P. Accordingly, no such organization or person shall be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule under this section. This section shall not apply to actions of health care facilities, employees, agents, or volunteers of such facilities that are not related to compliance or reasonable attempts at compliance with an emergency order or rule. This section shall not apply to actions performed after such an emergency order or rule is no longer in effect.

2 Effective Date. Part IV of this act shall take effect upon its passage.

LBA
21-1074
Amended 3/23/21

SB 149-FN- FISCAL NOTE
AS AMENDED BY THE SENATE (AMENDMENT #2021-0788s)

AN ACT adopting omnibus legislation on health and human services.

Part I Clarifying Medicaid spend-down requirements

This part has no fiscal impact.

Part II Establishing a harm reduction and overdose prevention program in the Department of Health and Human Services.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / Decrease			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[X] Other

COUNTY:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable

Part II of the proposed legislation would:

- amend RSA 318-B by inserting a section allowing for municipalities to approve entities to operate an overdose prevention program for adults,
- require DHHS to adopt rules defining the entities which may operate an overdose prevention program, and
- require entities to register with and report aggregate client data to DHHS.

DHHS estimates staff time would be required to register and collect data on Overdose Prevention Programs. The expansion of the activities necessitates additional staffing needs in order to manage the registry and data collection and reporting. The position would be a part-time Program Planner I at a labor grade 1 with a fiscal impact of $23,000 in SFY 2021, $24,000 in SFY 2022, and $25,000 in SFY 2023.

AGENCIES CONTACTED:

Department of Health and Human Services and Office of Professional Licensure and Certification

Part III Relative to automated pharmacy systems.

This part has no fiscal impact.

Part IV Relative to health facilities providing care in the declared emergency.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / Decrease			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[X] Other

The Office of Professional Licensure and Certification indicates this part may have an indeterminable fiscal impact on state expenditures. It is not known how many automated pharmacy systems will be established to know if there will be a need for additional inspectors.

SB 149-FN - AS AMENDED BY THE SENATE

03/18/2021 0788s

2021 SESSION

21-1074
10/04

SENATE BILL ***149-FN***

AN ACT adopting omnibus legislation on health and human services.

SPONSORS: Sen. Sherman, Dist 24

COMMITTEE: Health and Human Services OTP/A 5-0 CONSENT

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Establishing a harm reduction and overdose prevention program in the department of health and human services.

III. Automated pharmacy systems.

IV. Health facilities providing care in the declared emergency.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation on health and human services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0837, establishing a harm reduction and overdose prevention program in the department of health and human services, sponsored by Sen. Watters, Prime/Dist 4; Sen. Sherman, Dist 24; Sen. Whitley, Dist 15; Sen. D'Allesandro, Dist 20; Rep. Amanda Bouldin, Hills 12; Rep. Woods, Merr. 23; Rep. Conley, Straf. 13.

Part III. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part IV. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

1 New Section; Spend-Down Requirements for Medical Expenses. Amend RSA 167 by inserting after section 4-d the following new section:

167:4-e Spend-down Requirements for Medical Expenses. For the purposes of off-setting the Medicaid spend-down requirements, mental health expenses shall be included as medical expenses.

2 Report to Oversight Committee on Health and Human Services.

I. The department of health and human services shall submit an interim report on or before October 1, 2021, to the oversight committee on health and human services, established pursuant to RSA 126-A:13, relative to actions taken to ensure the uniform application of spend-down requirements. The report shall include a description of how spend-down requirements were addressed in remedial staff training programs, updates to the policy manual, and updates to the brochure and any other department publications.

II. The department shall submit a final report by October 1, 2022, on the application of spend-down requirements. The report shall include data indicating how spend-down requirements have been applied since the interim report was filed.

3 Effective date. Part I of this act shall take effect upon its passage.

PART II

Establishing a harm reduction and overdose prevention program in the department of health and human services.

1 Findings. The legislature finds and declares all of the following:

I. Overdose deaths in New Hampshire are an urgent public health crisis. For many years, overdose has been the leading cause of accidental death in the United States and in New Hampshire.

II. Harm reduction and overdose prevention programs (OPPs) are an evidence-based harm reduction strategy that allow individuals to consume drugs in a hygienic environment under the supervision of trained staff, who are able to intervene if the patient overdoses. OPPs also provide sterile consumption equipment and offer general medical advice and referrals to drug treatment and other community social services.

III. There are approximately 165 overdose prevention programs operating in 10 countries around the world, and numerous peer-reviewed studies have confirmed that those programs are effective in reducing overdose deaths and HIV transmission, and in increasing access to counseling, treatment, and other risk reduction services. Research has also demonstrated that those programs decrease use of emergency medical services, reduce public drug use, reduce syringe debris, and do not increase crime or drug use.

IV. An analysis published in the Journal of Drug Issues in 2016, OPPs in New Hampshire would save the state and municipalities substantial funds by reducing other costs due to opioid use and overdose.

V. An increase in overdose deaths was observed nationwide in 2020 according to the Office of National Drug Control Policy, rising 16.6 percent, based on a comparison of January to April, inclusive, of 2019 with the same time frame of 2020.

VI. As demands for reform of the criminal legal system reverberate around the country, OPPs offer an alternative framework for addressing both drug use as well as the enforcement of drug laws. OPPs bring people inside to a safe and therapeutic space, instead of leaving them vulnerable to police intervention, arrest, and incarceration.

VII. It is the intent of the legislature to promote the health and safety of communities by evaluating the health impacts of OPPs. It is the intent of the legislature to prevent fatal and nonfatal drug overdoses, reduce drug use by providing a pathway to drug treatment, as well as medical and social services for high-risk drug users, many of whom are homeless or uninsured or very low income, prevent the transmission of HIV and hepatitis C, reduce nuisance and public safety problems related to public use of controlled substances, reduce emergency room use and hospital

utilization related to drug use, reserving precious space, including intensive care beds, for treatment of COVID-19, and other life-threatening conditions.

VIII. Further, it is the intent of the legislature that OPPs should be evaluated in New Hampshire municipalities that authorize them, as OPPs show great promise to save lives, enhance public safety, improve access to drug treatment, medical care, and related services, reduce emergency department and hospital utilization related to drug overdose, and reduce the human, social, and financial costs of epidemics of drug misuse, homelessness, and COVID-19.

2 New Subdivision; Harm Reduction and Overdose Prevention Programs. Amend RSA 318-B by inserting after section 45 the following new subdivision:

Harm Reduction and Overdose Prevention Programs

318-B:45-a Harm Reduction and Overdose Prevention Programs

I.(a) Notwithstanding any other law, a New Hampshire municipality may approve entities within its jurisdiction to establish and operate overdose prevention programs for persons 18 years of age or older that satisfy the requirements set forth in paragraph IV.

II. Prior to approving an entity within its jurisdiction pursuant to paragraph I, a municipality shall provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The notice of the meeting to the public shall be sufficient to ensure adequate participation in the meeting by the public. The meeting shall be noticed in accordance with all state laws and local ordinances, and as local officials deem appropriate.

III.(a) The following entities, if self-funded, may operate an OPP upon approval of the municipality's governing body in New Hampshire to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs:

(1) Federally qualified health centers.

(2) Community health centers.

(3) Public health networks.

(4) AIDS service organizations.

(5) Substance misuse support or treatment organizations.

(6) Community based organizations.

(b) The commissioner of the department of health and human services shall adopt rules, pursuant to RSA 541-A, further defining the entities which may operate an overdose prevention program.

IV. Any entity operating an OPP in New Hampshire shall:

(a) Provide a hygienic space supervised by health care professionals where people who use drugs can consume pre-obtained drugs. For purposes of this paragraph, "health care professional" includes, but is not limited to, a physician, physician assistant, nurse practitioner, licensed vocational nurse, registered nurse, psychiatrist, psychologist, licensed clinical social worker,

licensed professional clinical counselor, mental health provider, social service provider, or substance use disorder provider, trained in overdose recognition and reversal.

(b) Provide sterile consumption supplies, collect used hypodermic needles and syringes, and provide secure hypodermic needle and syringe disposal services.

(c) Administer first aid, if needed, monitor participants for potential overdose, and provide treatment as necessary to prevent fatal overdose.

(d) Provide referral and linkage to HIV, viral hepatitis, and substance use disorder prevention, care, and treatment services, as appropriate.

(e) Coordinate and collaborate with other local agencies, organizations, and providers involved in comprehensive prevention programs for people who inject drugs to minimize duplication of effort.

(f) Attempt to be a part of a comprehensive service program that may include, as appropriate:

(1) Providing sterile needles, syringes, and other drug preparation equipment and disposal services.

(2) Educating and counseling to reduce sexual, injection, and overdose risks.

(3) Providing condoms to reduce risk of sexual transmission of viral hepatitis, HIV, or other STDs.

(4) Screening for HIV, viral hepatitis, STDs, and tuberculosis.

(5) Providing naloxone to reverse opioid overdoses.

(6) Providing referral and linkage to HIV, viral hepatitis, STD and tuberculosis prevention, treatment, and care services, including antiretroviral therapy for hepatitis C virus (HCV) and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission, and partner services.

(7) Providing referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination.

(8) Providing referral and linkage to and provision of substance use disorder treatment including medication assisted treatment for opioid use disorder which combines drug therapy such as methadone, buprenorphine, or naltrexone with counseling and behavioral therapy.

(9) Providing referral to medical care, mental health services, and other support services.

(g) Post its address, phone number, program contact information, if appropriate, hours of operation, and services offered on its Internet website.

(h) Provide reasonable security of the program site.

(i) Establish operating procedures for the program, made available to the public either through an Internet website or upon request, that are publicly noticed, including, but not limited to, standard hours of operation, a minimum number of personnel required to be on site during those

hours of operation, the licensing and training standards for staff present, an established maximum number of individuals who can be served at one time, and an established relationship with the nearest emergency department of a general acute care hospital, as well as eligibility criteria for program participants.

(j) Train staff members to deliver services offered by the program.

(k) Establish a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints.

(l) Establish a policy for informing local government officials and neighbors about the approved entity's complaint procedures, and the contact number of the director, manager, or operator of the approved entity.

(m) Register with the department of health and human services and confirm registration annually on or before November 1 of each subsequent year; provided however, the registration process shall be limited to notification to the department for data collection purposes only.

(n) Report quarterly to the department, which report shall include the following information regarding the program's activities:

(1) The number of program participants.

(2) Aggregate information regarding the characteristics of program participants.

(3) The number of hypodermic needles and syringes distributed for use on site.

(4) The number of overdoses experienced and the number of overdoses reversed on site.

(5) The number of persons referred to substance misuse treatment/services.

(6) The number of individuals directly and formally referred to other services and the type of service.

V. Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of the New Hampshire municipalities, state agencies, hospitals, or overdose prevention programs, acting in the course and scope of employment, shall not be arrested, charged, or prosecuted under RSA 318-B:2 for possession of controlled substances, possession of drug paraphernalia, or allowing drug use on premises, including for attempt, aiding and abetting, or conspiracy to commit a violation of any of those offenses, or otherwise be penalized solely for actions, conduct, or omissions on the site of a harm reduction and overdose prevention program approved under this section, or for conduct relating to the approval of an entity to operate an OPP, or the inspection, licensing, or other regulation of an OPP approved under this section.

VI. Nothing in this section shall be construed to prohibit the department of health and human services from administering and/or disbursing federal or other funds to harm reduction and

overdose prevention programs authorized under this section. The use of state general funds shall be prohibited unless otherwise appropriated by the general court.

VII. No overdose prevention program shall be located within a drug-free school zone as defined in RSA 193-B:1, II. Exceptions to this prohibition may be granted by the applicable district school board when a request is initiated by a overdose prevention program administrator.

3 Syringe Service Programs; Reference Added. Amend RSA 318-B:44 to read as follows:

318-B:44 Syringe Service Programs; Affirmative Defense. It is an affirmative defense, as provided in RSA 626:7, to prosecution for possession of a hypodermic syringe or needle that the item was obtained through participation in a syringe service program ***or an overdose prevention program under RSA 318-B:45-a***. Nothing in this section shall be construed as an affirmative defense for any offense other than as set forth under RSA 318-B:26, [~~II(f)~~] ***II(e)***.

4 Effective Date. Part II of this act shall take effect 60 days after its passage.

PART III

Relative to automated pharmacy systems.

1 New Section; Pharmacies; Automated Pharmacy Systems. Amend RSA 318 by inserting after section 42 the following new section:

318:42-a Automated Pharmacy Systems; Long-term Care Facilities, Hospices, or State Correctional Institutions.

I. A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under RSA 151 or to a state correctional institution through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

II. Medicinal drugs stored in bulk or unit of use in an automated pharmacy system servicing a long-term care facility, hospice, or correctional institution are part of the inventory of the pharmacy providing pharmacy services to that facility, hospice, or institution, and drugs delivered by the automated pharmacy system are considered to have been dispensed by that pharmacy.

III. The operation of an automated pharmacy system shall be under the supervision of a New Hampshire-licensed pharmacist. To qualify as a supervisor for an automated pharmacy system, the pharmacist need not be physically present at the site of the automated pharmacy system and may supervise the system data electronically. The New Hampshire-licensed pharmacist shall be required to develop and implement policies and procedures designed to verify that the medicinal drugs delivered by the automated dispensing system are accurate and valid and that the machine is properly restocked.

IV. This section is not intended to limit the current practice of pharmacy in this state. This section is intended to allow automated pharmacy systems to enhance the ability of a pharmacist to provide pharmacy services in locations that do not employ a full-time pharmacist. This section does not limit or replace the use of a consultant pharmacist.

V. The board shall adopt rules governing the use of an automated pharmacy system under this section, not later than January 1, 2022, which shall specify:

(a) Recordkeeping requirements;

(b) Security requirements; and

(c) Labeling requirements.

2 Effective Date. Part III of this act shall take effect 60 days after its passage.

PART IV

Relative to health facilities providing care in the declared emergency.

1 New Section; Department of Safety; Homeland Security and Emergency Management; Novel Coronavirus Disease (COVID-19); Health Facilities. Amend RSA 21-P by inserting after section 42 the following new section:

21-P:42-a Novel Coronavirus Disease (COVID-19; Health Facilities. Acute care hospitals, assisted living facilities, long-term care facilities, nursing facilities, residential care facilities, ambulatory care clinics (as defined in RSA 151, RSA 151-A, RSA 151-D, RSA 151-E and RSA 151-H), and any other similar facilities providing care to elderly or infirm patients ("health facilities"), and the employees, agents and volunteers of such health facilities, are deemed to have been engaged in preparing for and/or carrying out "emergency management" functions for the purposes of RSA 21-P:35 when complying, or reasonably attempting to comply, with any executive order, agency order or rule (including but not limited to waivers from the Centers for Medicare and Medicaid Services (CMS) both issued as blanket waivers by CMS and as requested by New Hampshire department of health and human services pertaining to the state of emergency declared under state and/or federal law in response to the Novel Coronavirus (COVID-19). All such orders and rules are deemed to constitute orders and/or rules adopted and/or regulations promulgated pursuant to RSA 21-P. Accordingly, no such organization or person shall be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule under this section. This section shall not apply to actions of health care facilities, employees, agents, or volunteers of such facilities that are not related to compliance or reasonable attempts at compliance with an emergency order or rule. This section shall not apply to actions performed after such an emergency order or rule is no longer in effect.

2 Effective Date. Part IV of this act shall take effect upon its passage.

LBA
21-1074
2/8/21

SB 149-FN- FISCAL NOTE
AS INTRODUCED

AN ACT adopting omnibus legislation on health and human services

FISCAL IMPACT:

The Office of Legislative Budget Assistant is unable to complete a fiscal note for this bill, as introduced, as it is awaiting information from the Department of Health and Human Services and Office of Professional Licensure and Certification. When completed, the fiscal note will be forwarded to the Senate Clerk's Office.

AGENCIES CONTACTED:

Department of Health and Human Services and Office of Professional Licensure and Certification

LBA
21-1074
Amended 3/23/21

SB 149-FN FISCAL NOTE
AS AMENDED BY THE SENATE (AMENDMENT #2021-0788s)

AN ACT adopting omnibus legislation on health and human services.

Part I Clarifying Medicaid spend-down requirements

This part has no fiscal impact.

Part II Establishing a harm reduction and overdose prevention program in the Department of Health and Human Services.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / Decrease			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[X] Other

COUNTY:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable

Part II of the proposed legislation would:

- amend RSA 318-B by inserting a section allowing for municipalities to approve entities to operate an overdose prevention program for adults,
- require DHHS to adopt rules defining the entities which may operate an overdose prevention program, and
- require entities to register with and report aggregate client data to DHHS.

DHHS estimates staff time would be required to register and collect data on Overdose Prevention Programs. The expansion of the activities necessitates additional staffing needs in order to manage the registry and data collection and reporting. The position would be a part-time Program Planner I at a labor grade 1 with a fiscal impact of $23,000 in SFY 2021, $24,000 in SFY 2022, and $25,000 in SFY 2023.

AGENCIES CONTACTED:

Department of Health and Human Services and Office of Professional Licensure and Certification

Part III Relative to automated pharmacy systems.

This part has no fiscal impact.

Part IV Relative to health facilities providing care in the declared emergency.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / Decrease			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[X] Other

The Office of Professional Licensure and Certification indicates this part may have an indeterminable fiscal impact on state expenditures. It is not known how many automated pharmacy systems will be established to know if there will be a need for additional inspectors.

LBA
21-1074
Amended 3/23/21

SB 149-FN FISCAL NOTE
AS AMENDED BY THE SENATE (AMENDMENT #2021-0788s)

AN ACT adopting omnibus legislation on health and human services.

Part I Clarifying Medicaid spend-down requirements

This part has no fiscal impact.

Part II Establishing a harm reduction and overdose prevention program in the Department of Health and Human Services.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / Decrease			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[X] Other

COUNTY:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable

Part II of the proposed legislation would:

- amend RSA 318-B by inserting a section allowing for municipalities to approve entities to operate an overdose prevention program for adults,
- require DHHS to adopt rules defining the entities which may operate an overdose prevention program, and
- require entities to register with and report aggregate client data to DHHS.

DHHS estimates staff time would be required to register and collect data on Overdose Prevention Programs. The expansion of the activities necessitates additional staffing needs in order to manage the registry and data collection and reporting. The position would be a part-time Program Planner I at a labor grade 1 with a fiscal impact of $23,000 in SFY 2021, $24,000 in SFY 2022, and $25,000 in SFY 2023.

AGENCIES CONTACTED:

Department of Health and Human Services and Office of Professional Licensure and Certification

Part III Relative to automated pharmacy systems.

This part has no fiscal impact.

Part IV Relative to health facilities providing care in the declared emergency.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / Decrease			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[X] Other

The Office of Professional Licensure and Certification indicates this part may have an indeterminable fiscal impact on state expenditures. It is not known how many automated pharmacy systems will be established to know if there will be a need for additional inspectors.

SB 149-FN - AS AMENDED BY THE SENATE

03/18/2021 0788s
04/01/2021 1055s

2021 SESSION

21-1074
10/04

SENATE BILL ***149-FN***

AN ACT adopting omnibus legislation on health and human services.

SPONSORS: Sen. Sherman, Dist 24

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Automated pharmacy systems.

III. Health facilities providing care in the declared emergency.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

03/18/2021 0788s
04/01/2021 1055s

21-1074
10/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation on health and human services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part III. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Clarifying Medicaid spend-down requirements

and requiring a report to the oversight committee on health and human services.

1 New Section; Spend-Down Requirements for Medical Expenses. Amend RSA 167 by inserting after section 4-d the following new section:

167:4-e Spend-down Requirements for Medical Expenses. For the purposes of off-setting the Medicaid spend-down requirements, mental health expenses shall be included as medical expenses.

2 Report to Oversight Committee on Health and Human Services.

I. The department of health and human services shall submit an interim report on or before October 1, 2021, to the oversight committee on health and human services, established pursuant to RSA 126-A:13, relative to actions taken to ensure the uniform application of spend-down requirements. The report shall include a description of how spend-down requirements were addressed in remedial staff training programs, updates to the policy manual, and updates to the brochure and any other department publications.

II. The department shall submit a final report by October 1, 2022, on the application of spend-down requirements. The report shall include data indicating how spend-down requirements have been applied since the interim report was filed.

3 Effective date. Part I of this act shall take effect upon its passage.

PART II

Relative to automated pharmacy systems.

1 New Section; Pharmacies; Automated Pharmacy Systems. Amend RSA 318 by inserting after section 42 the following new section:

318:42-a Automated Pharmacy Systems; Long-term Care Facilities, Hospices, or State Correctional Institutions.

I. A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under RSA 151 or to a state correctional institution through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

II. Medicinal drugs stored in bulk or unit of use in an automated pharmacy system servicing a long-term care facility, hospice, or correctional institution are part of the inventory of the pharmacy providing pharmacy services to that facility, hospice, or institution, and drugs delivered by the automated pharmacy system are considered to have been dispensed by that pharmacy.

III. The operation of an automated pharmacy system shall be under the supervision of a New Hampshire-licensed pharmacist. To qualify as a supervisor for an automated pharmacy system, the pharmacist need not be physically present at the site of the automated pharmacy system and may supervise the system data electronically. The New Hampshire-licensed pharmacist shall be required to develop and implement policies and procedures designed to verify that the medicinal drugs delivered by the automated dispensing system are accurate and valid and that the machine is properly restocked.

IV. This section is not intended to limit the current practice of pharmacy in this state. This section is intended to allow automated pharmacy systems to enhance the ability of a pharmacist to provide pharmacy services in locations that do not employ a full-time pharmacist. This section does not limit or replace the use of a consultant pharmacist.

V. The board shall adopt rules governing the use of an automated pharmacy system under this section, not later than January 1, 2022, which shall specify:

(a) Recordkeeping requirements;

(b) Security requirements; and

(c) Labeling requirements.

2 Effective Date. Part II of this act shall take effect 60 days after its passage.

PART III

Relative to health facilities providing care in the declared emergency.

1 New Section; Department of Safety; Homeland Security and Emergency Management; Novel Coronavirus Disease (COVID-19); Health Facilities. Amend RSA 21-P by inserting after section 42 the following new section:

21-P:42-a Novel Coronavirus Disease (COVID-19; Health Facilities. Acute care hospitals, assisted living facilities, long-term care facilities, nursing facilities, residential care facilities, ambulatory care clinics (as defined in RSA 151, RSA 151-A, RSA 151-D, RSA 151-E and RSA 151-H),

and any other similar facilities providing care to elderly or infirm patients ("health facilities"), and the employees, agents and volunteers of such health facilities, are deemed to have been engaged in preparing for and/or carrying out "emergency management" functions for the purposes of RSA 21-P:35 when complying, or reasonably attempting to comply, with any executive order, agency order or rule (including but not limited to waivers from the Centers for Medicare and Medicaid Services (CMS) both issued as blanket waivers by CMS and as requested by New Hampshire department of health and human services pertaining to the state of emergency declared under state and/or federal law in response to the Novel Coronavirus (COVID-19). All such orders and rules are deemed to constitute orders and/or rules adopted and/or regulations promulgated pursuant to RSA 21-P. Accordingly, no such organization or person shall be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule under this section. This section shall not apply to actions of health care facilities, employees, agents, or volunteers of such facilities that are not related to compliance or reasonable attempts at compliance with an emergency order or rule. This section shall not apply to actions performed after such an emergency order or rule is no longer in effect.

2 Effective Date. Part III of this act shall take effect upon its passage.

LBA
21-1074
Amended 4/21/21

SB 149-FN- FISCAL NOTE
AS AMENDED BY THE SENATE (AMENDMENTS #2021-0788s and #2021-1055s)

AN ACT adopting omnibus legislation on health and human services.

Part I Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

Part I of the proposed legislation clarifies Medicaid spend-down requirements and requires the Department of Health and Human Services report to the Committee on Health and Human Services. The Department of Health and Human Services states that Part I will have no fiscal impact.

Part II Relative to automated pharmacy systems.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / Decrease			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[ ] General	[ ] Education	[ ] Highway	[X] Other

Part II of the proposed legislation would automate pharmacy systems.

The Office of Professional Licensure states that the fiscal impact of Part II is indeterminable as it is not clear how many automated pharmacy systems will be established. Pharmacy inspectors will have to inspect automated pharmacy systems, taking 45 minutes to an hour to inspect each unit, excluding travel time. The inspector will need to review records concerning replenishment, delivery, discrepancy reports, temperature log review, training, and certification of staff, as well as numerous policies. Additional licensing revenue will not be generated as an additional permit or license is not required by this bill.

Part III Relative to health facilities providing care in the declared emergency.

Part III of the proposed legislation provides that acute care hospitals, assisted living facilities, long-term care facilities, and other similar facilities providing care to elderly or infirm patients,

and the employees, agents, and volunteers of such health facilities, are deemed to have been engaged in preparing for and carrying out emergency management functions when taking actions to comply with any executive order, agency order, or rule pertaining to the state of emergency declared under state or federal law in response to the Novel Coronavirus Disease. The Department of Health and Human Services states that Part III will have no fiscal impact.

AGENCIES CONTACTED:

Department of Health and Human Services and Office of Professional Licensure and Certification

SB 149-FN - AS AMENDED BY THE HOUSE

03/18/2021 0788s
04/01/2021 1055s
3Jun2021... 1295h

2021 SESSION

21-1074
10/04

SENATE BILL ***149-FN***

AN ACT adopting omnibus legislation on health and human services.

SPONSORS: Sen. Sherman, Dist 24

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Automated pharmacy systems.

III. Health facilities providing care in the declared emergency.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

03/18/2021 0788s
04/01/2021 1055s
3Jun2021... 1295h

21-1074
10/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation on health and human services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part III. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Clarifying Medicaid spend-down requirements

and requiring a report to the oversight committee on health and human services.

1 New Section; Spend-Down Requirements for Medical Expenses. Amend RSA 167 by inserting after section 4-d the following new section:

167:4-e Spend-down Requirements for Medical Expenses. For the purposes of off-setting the Medicaid spend-down requirements, mental health expenses shall be included as medical expenses.

2 Report to Oversight Committee on Health and Human Services.

I. The department of health and human services shall submit an interim report on or before October 1, 2021, to the oversight committee on health and human services, established pursuant to RSA 126-A:13, relative to actions taken to ensure the uniform application of spend-down requirements. The report shall include a description of how spend-down requirements were addressed in remedial staff training programs, updates to the policy manual, and updates to the brochure and any other department publications.

II. The department shall submit a final report by October 1, 2022, on the application of spend-down requirements. The report shall include data indicating how spend-down requirements have been applied since the interim report was filed.

3 Effective date. Part I of this act shall take effect upon its passage.

PART II

Relative to automated pharmacy systems.

1 New Section; Pharmacies; Automated Pharmacy Systems. Amend RSA 318 by inserting after section 42 the following new section:

318:42-a Automated Pharmacy Systems; Long-term Care Facilities, Hospices, or State Correctional Institutions.

I. A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under RSA 151 or to a state correctional institution through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

II. The board shall adopt rules governing the use of an automated pharmacy system under this section, not later than January 1, 2022, which shall specify:

(a) Recordkeeping requirements;

(b) Security requirements; and

(c) Labeling requirements.

2 Effective Date. Part II of this act shall take effect 60 days after its passage.

PART III

Relative to health facilities providing care in the declared emergency.

1 New Section; Department of Safety; Homeland Security and Emergency Management; Novel Coronavirus Disease (COVID-19); Health Facilities. Amend RSA 21-P by inserting after section 42 the following new section:

21-P:42-a Novel Coronavirus Disease (COVID-19; Health Facilities. Acute care hospitals, assisted living facilities, long-term care facilities, nursing facilities, residential care facilities, ambulatory care clinics (as defined in RSA 151, RSA 151-A, RSA 151-D, RSA 151-E and RSA 151-H), and any other similar facilities providing care to elderly or infirm patients ("health facilities"), and the employees, agents and volunteers of such health facilities, are deemed to have been engaged in preparing for and/or carrying out "emergency management" functions for the purposes of RSA 21-P:35 when complying, or reasonably attempting to comply, with any executive order, agency order or rule (including but not limited to waivers from the Centers for Medicare and Medicaid Services (CMS) both issued as blanket waivers by CMS and as requested by New Hampshire department of health and human services pertaining to the state of emergency declared under state and/or federal law in response to the Novel Coronavirus (COVID-19). All such orders and rules are deemed to constitute orders and/or rules adopted and/or regulations promulgated pursuant to RSA 21-P. Accordingly, no such organization or person shall be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule under this section. This section shall not apply to actions of health care facilities, employees, agents, or volunteers of such facilities that are not related to compliance or

reasonable attempts at compliance with an emergency order or rule. This section shall not apply to actions performed after such an emergency order or rule is no longer in effect.

2 Effective Date. Part III of this act shall take effect upon its passage.

LBA
21-1074
Amended 4/21/21

SB 149-FN- FISCAL NOTE
AS AMENDED BY THE SENATE (AMENDMENTS #2021-0788s and #2021-1055s)

AN ACT adopting omnibus legislation on health and human services.

Part I Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

Part I of the proposed legislation clarifies Medicaid spend-down requirements and requires the Department of Health and Human Services report to the Committee on Health and Human Services. The Department of Health and Human Services states that Part I will have no fiscal impact.

Part II Relative to automated pharmacy systems.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / Decrease			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[ ] General	[ ] Education	[ ] Highway	[X] Other

Part II of the proposed legislation would automate pharmacy systems.

The Office of Professional Licensure states that the fiscal impact of Part II is indeterminable as it is not clear how many automated pharmacy systems will be established. Pharmacy inspectors will have to inspect automated pharmacy systems, taking 45 minutes to an hour to inspect each unit, excluding travel time. The inspector will need to review records concerning replenishment, delivery, discrepancy reports, temperature log review, training, and certification of staff, as well as numerous policies. Additional licensing revenue will not be generated as an additional permit or license is not required by this bill.

Part III Relative to health facilities providing care in the declared emergency.

Part III of the proposed legislation provides that acute care hospitals, assisted living facilities, long-term care facilities, and other similar facilities providing care to elderly or infirm patients,

and the employees, agents, and volunteers of such health facilities, are deemed to have been engaged in preparing for and carrying out emergency management functions when taking actions to comply with any executive order, agency order, or rule pertaining to the state of emergency declared under state or federal law in response to the Novel Coronavirus Disease. The Department of Health and Human Services states that Part III will have no fiscal impact.

AGENCIES CONTACTED:

Department of Health and Human Services and Office of Professional Licensure and Certification

CHAPTER 179
SB 149-FN - FINAL VERSION

03/18/2021 0788s
04/01/2021 1055s
3Jun2021... 1295h

2021 SESSION

21-1074
10/04

SENATE BILL ***149-FN***

AN ACT adopting omnibus legislation on health and human services.

SPONSORS: Sen. Sherman, Dist 24

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Automated pharmacy systems.

III. Health facilities providing care in the declared emergency.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

CHAPTER 179
SB 149-FN - FINAL VERSION

03/18/2021 0788s
04/01/2021 1055s
3Jun2021... 1295h

21-1074
10/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation on health and human services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

179:1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part III. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

179:2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

179:1 New Section; Spend-Down Requirements for Medical Expenses. Amend RSA 167 by inserting after section 4-d the following new section:

167:4-e Spend-down Requirements for Medical Expenses. For the purposes of off-setting the Medicaid spend-down requirements, mental health expenses shall be included as medical expenses.

179:2 Report to Oversight Committee on Health and Human Services.

I. The department of health and human services shall submit an interim report on or before October 1, 2021, to the oversight committee on health and human services, established pursuant to RSA 126-A:13, relative to actions taken to ensure the uniform application of spend-down requirements. The report shall include a description of how spend-down requirements were addressed in remedial staff training programs, updates to the policy manual, and updates to the brochure and any other department publications.

II. The department shall submit a final report by October 1, 2022, on the application of spend-down requirements. The report shall include data indicating how spend-down requirements have been applied since the interim report was filed.

179:3 Effective date. Part I of this act shall take effect upon its passage.

PART II

Relative to automated pharmacy systems.

179:1 New Section; Pharmacies; Automated Pharmacy Systems. Amend RSA 318 by inserting after section 42 the following new section:

318:42-a Automated Pharmacy Systems; Long-term Care Facilities, Hospices, or State Correctional Institutions.

I. A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under RSA 151 or to a state correctional institution through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

II. The board shall adopt rules governing the use of an automated pharmacy system under this section, not later than January 1, 2022, which shall specify:

(a) Recordkeeping requirements;

(b) Security requirements; and

(c) Labeling requirements.

179:2 Effective Date. Part II of this act shall take effect 60 days after its passage.

PART III

Relative to health facilities providing care in the declared emergency.

179:1 New Section; Department of Safety; Homeland Security and Emergency Management; Novel Coronavirus Disease (COVID-19); Health Facilities. Amend RSA 21-P by inserting after section 42 the following new section:

21-P:42-a Novel Coronavirus Disease (COVID-19); Health Facilities. Acute care hospitals, assisted living facilities, long-term care facilities, nursing facilities, residential care facilities, ambulatory care clinics (as defined in RSA 151, RSA 151-A, RSA 151-D, RSA 151-E and RSA 151-H), and any other similar facilities providing care to elderly or infirm patients ("health facilities"), and the employees, agents and volunteers of such health facilities, are deemed to have been engaged in preparing for and/or carrying out "emergency management" functions for the purposes of RSA 21-P:35 when complying, or reasonably attempting to comply, with any executive order, agency order or rule, including but not limited to waivers from the Centers for Medicare and Medicaid Services (CMS) both issued as blanket waivers by CMS and as requested by New Hampshire department of health and human services pertaining to the state of emergency declared under state and/or federal law in response to the Novel Coronavirus (COVID-19). All such orders and rules are deemed to constitute orders and/or rules adopted and/or regulations promulgated pursuant to RSA 21-P. Accordingly, no such organization or person shall be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule under this section. This section shall not apply to actions of health care facilities, employees, agents, or volunteers of such facilities that are not related to compliance or

reasonable attempts at compliance with an emergency order or rule. This section shall not apply to actions performed after such an emergency order or rule is no longer in effect.

179:2 Effective Date. Part III of this act shall take effect upon its passage.

Approved: July 30, 2021
Effective Date:
Part I shall take effect July 30, 2021.
Part II shall take effect September 28, 2021.
Part III shall take effect July 30, 2021.

Amendments

Sen. Bradley, Dist 3
Sen. Gray, Dist 6
March 8, 2021
2021-0682s
10/04

Amendment to SB 149-FN

Amend the bill by replacing all after the enacting clause with the following:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0837, establishing a harm reduction and overdose prevention program in the department of health and human services, sponsored by Sen. Watters, Prime/Dist 4; Sen. Sherman, Dist 24; Sen. Whitley, Dist 15; Sen. D'Allesandro, Dist 20; Rep. Amanda Bouldin, Hills 12; Rep. Woods, Merr. 23; Rep. Conley, Straf. 13.

Part III. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part IV. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Clarifying Medicaid spend-down requirements
and requiring a report to the oversight committee on health and human services.

1 New Section; Spend-Down Requirements for Medical Expenses. Amend RSA 167 by inserting after section 4-d the following new section:

167:4-e Spend-down Requirements for Medical Expenses. For the purposes of off-setting the Medicaid spend-down requirements, mental health expenses shall be included as medical expenses.

2 Report to Oversight Committee on Health and Human Services.

I. The department of health and human services shall submit an interim report on or before October 1, 2021, to the oversight committee on health and human services, established pursuant to RSA 126-A:13, relative to actions taken to ensure the uniform application of spend-down requirements. The report shall include a description of how spend-down requirements were addressed in remedial staff training programs, updates to the policy manual, and updates to the brochure and any other department publications.

II. The department shall submit a final report by October 1, 2022, on the application of spend-down requirements. The report shall include data indicating how spend-down requirements have been applied since the interim report was filed.

3 Effective date. Part I of this act shall take effect upon its passage.

PART II

Establishing a harm reduction and overdose prevention program in the department of health and human services.

1 Findings. The legislature finds and declares all of the following:

I. Overdose deaths in New Hampshire are an urgent public health crisis. For many years, overdose has been the leading cause of accidental death in the United States and in New Hampshire.

II. Harm reduction and overdose prevention programs (OPPs) are an evidence-based harm reduction strategy that allow individuals to consume drugs in a hygienic environment under the supervision of trained staff, who are able to intervene if the patient overdoses. OPPs also provide sterile consumption equipment and offer general medical advice and referrals to drug treatment and other community social services.

III. There are approximately 165 overdose prevention programs operating in 10 countries around the world, and numerous peer-reviewed studies have confirmed that those programs are effective in reducing overdose deaths and HIV transmission, and in increasing access to counseling, treatment, and other risk reduction services. Research has also demonstrated that those programs decrease use of emergency medical services, reduce public drug use, reduce syringe debris, and do not increase crime or drug use.

IV. An analysis published in the Journal of Drug Issues in 2016, OPPs in New Hampshire would save the state and municipalities substantial funds by reducing other costs due to opioid use and overdose.

V. An increase in overdose deaths was observed nationwide in 2020 according to the Office of National Drug Control Policy, rising 16.6 percent, based on a comparison of January to April, inclusive, of 2019 with the same time frame of 2020.

VI. As demands for reform of the criminal legal system reverberate around the country, OPPs offer an alternative framework for addressing both drug use as well as the enforcement of drug laws. OPPs bring people inside to a safe and therapeutic space, instead of leaving them vulnerable to police intervention, arrest, and incarceration.

VII. It is the intent of the legislature to promote the health and safety of communities by evaluating the health impacts of OPPs. It is the intent of the legislature to prevent fatal and nonfatal drug overdoses, reduce drug use by providing a pathway to drug treatment, as well as medical and social services for high-risk drug users, many of whom are homeless or uninsured or very low income, prevent the transmission of HIV and hepatitis C, reduce nuisance and public safety problems related to public use of controlled substances, reduce emergency room use and hospital

utilization related to drug use, reserving precious space, including intensive care beds, for treatment of COVID-19, and other life-threatening conditions.

VIII. Further, it is the intent of the legislature that OPPs should be evaluated in New Hampshire municipalities that authorize them, as OPPs show great promise to save lives, enhance public safety, improve access to drug treatment, medical care, and related services, reduce emergency department and hospital utilization related to drug overdose, and reduce the human, social, and financial costs of epidemics of drug misuse, homelessness, and COVID-19.

2 New Subdivision; Harm Reduction and Overdose Prevention Programs. Amend RSA 318-B by inserting after section 45 the following new subdivision:

Harm Reduction and Overdose Prevention Programs

318-B:45-a Harm Reduction and Overdose Prevention Programs

I.(a) Notwithstanding any other law, a New Hampshire municipality may approve entities within its jurisdiction to establish and operate overdose prevention programs for persons 18 years of age or older that satisfy the requirements set forth in paragraph IV.

II. Prior to approving an entity within its jurisdiction pursuant to paragraph I, a municipality shall provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The notice of the meeting to the public shall be sufficient to ensure adequate participation in the meeting by the public. The meeting shall be noticed in accordance with all state laws and local ordinances, and as local officials deem appropriate.

III.(a) The following entities, if self-funded, may operate an OPP upon approval of the municipality's governing body in New Hampshire to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs:

(1) Federally qualified health centers.

(2) Community health centers.

(3) Public health networks.

(4) AIDS service organizations.

(5) Substance misuse support or treatment organizations.

(6) Community based organizations.

(b) The commissioner of the department of health and human services shall adopt rules, pursuant to RSA 541-A, further defining the entities which may operate an overdose prevention program.

IV. Any entity operating an OPP in New Hampshire shall:

(a) Provide a hygienic space supervised by health care professionals where people who use drugs can consume pre-obtained drugs. For purposes of this paragraph, "health care professional" includes, but is not limited to, a physician, physician assistant, nurse practitioner, licensed vocational nurse, registered nurse, psychiatrist, psychologist, licensed clinical social worker,

licensed professional clinical counselor, mental health provider, social service provider, or substance use disorder provider, trained in overdose recognition and reversal.

(b) Provide sterile consumption supplies, collect used hypodermic needles and syringes, and provide secure hypodermic needle and syringe disposal services.

(c) Administer first aid, if needed, monitor participants for potential overdose, and provide treatment as necessary to prevent fatal overdose.

(d) Provide referral and linkage to HIV, viral hepatitis, and substance use disorder prevention, care, and treatment services, as appropriate.

(e) Coordinate and collaborate with other local agencies, organizations, and providers involved in comprehensive prevention programs for people who inject drugs to minimize duplication of effort.

(f) Attempt to be a part of a comprehensive service program that may include, as appropriate:

(1) Providing sterile needles, syringes, and other drug preparation equipment and disposal services.

(2) Educating and counseling to reduce sexual, injection, and overdose risks.

(3) Providing condoms to reduce risk of sexual transmission of viral hepatitis, HIV, or other STDs.

(4) Screening for HIV, viral hepatitis, STDs, and tuberculosis.

(5) Providing naloxone to reverse opioid overdoses.

(6) Providing referral and linkage to HIV, viral hepatitis, STD and tuberculosis prevention, treatment, and care services, including antiretroviral therapy for hepatitis C virus (HCV) and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission, and partner services.

(7) Providing referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination.

(8) Providing referral and linkage to and provision of substance use disorder treatment including medication assisted treatment for opioid use disorder which combines drug therapy such as methadone, buprenorphine, or naltrexone with counseling and behavioral therapy.

(9) Providing referral to medical care, mental health services, and other support services.

(g) Post its address, phone number, program contact information, if appropriate, hours of operation, and services offered on its Internet website.

(h) Provide reasonable security of the program site.

(i) Establish operating procedures for the program, made available to the public either through an Internet website or upon request, that are publicly noticed, including, but not limited to, standard hours of operation, a minimum number of personnel required to be on site during those

hours of operation, the licensing and training standards for staff present, an established maximum number of individuals who can be served at one time, and an established relationship with the nearest emergency department of a general acute care hospital, as well as eligibility criteria for program participants.

(j) Train staff members to deliver services offered by the program.

(k) Establish a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints.

(l) Establish a policy for informing local government officials and neighbors about the approved entity's complaint procedures, and the contact number of the director, manager, or operator of the approved entity.

(m) Register with the department of health and human services and confirm registration annually on or before November 1 of each subsequent year; provided however, the registration process shall be limited to notification to the department for data collection purposes only.

(n) Report quarterly to the department, which report shall include the following information regarding the program's activities:

(1) The number of program participants.

(2) Aggregate information regarding the characteristics of program participants.

(3) The number of hypodermic needles and syringes distributed for use on site.

(4) The number of overdoses experienced and the number of overdoses reversed on site.

(5) The number of persons referred to substance misuse treatment/services.

(6) The number of individuals directly and formally referred to other services and the type of service.

V. Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of the New Hampshire municipalities, state agencies, hospitals, or overdose prevention programs, acting in the course and scope of employment, shall not be arrested, charged, or prosecuted under RSA 318-B:2 for possession of controlled substances, possession of drug paraphernalia, or allowing drug use on premises, including for attempt, aiding and abetting, or conspiracy to commit a violation of any of those offenses, or otherwise be penalized solely for actions, conduct, or omissions on the site of a harm reduction and overdose prevention program approved under this section, or for conduct relating to the approval of an entity to operate an OPP, or the inspection, licensing, or other regulation of an OPP approved under this section.

VI. Nothing in this section shall be construed to prohibit the department of health and human services from administering and/or disbursing federal or other funds to harm reduction and

overdose prevention programs authorized under this section. The use of state general funds shall be prohibited unless otherwise appropriated by the general court.

VII. No overdose prevention program shall be located within a drug-free school zone as defined in RSA 193-B:1, II. Exceptions to this prohibition may be granted by the applicable district school board when a request is initiated by a overdose prevention program administrator.

3 Syringe Service Programs; Reference Added. Amend RSA 318-B:44 to read as follows:

318-B:44 Syringe Service Programs; Affirmative Defense. It is an affirmative defense, as provided in RSA 626:7, to prosecution for possession of a hypodermic syringe or needle that the item was obtained through participation in a syringe service program ***or an overdose prevention program under RSA 318-B:45-a***. Nothing in this section shall be construed as an affirmative defense for any offense other than as set forth under RSA 318-B:26, ~~II(f)~~ ***II(e)***.

4 Effective Date. Part II of this act shall take effect 60 days after its passage.

PART III

Relative to automated pharmacy systems.

1 New Section; Pharmacies; Automated Pharmacy Systems. Amend RSA 318 by inserting after section 42 the following new section:

318:42-a Automated Pharmacy Systems; Long-term Care Facilities, Hospices, or State Correctional Institutions.

I. A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under RSA 151 or to a state correctional institution through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

II. Medicinal drugs stored in bulk or unit of use in an automated pharmacy system servicing a long-term care facility, hospice, or correctional institution are part of the inventory of the pharmacy providing pharmacy services to that facility, hospice, or institution, and drugs delivered by the automated pharmacy system are considered to have been dispensed by that pharmacy.

III. The operation of an automated pharmacy system shall be under the supervision of a New Hampshire-licensed pharmacist. To qualify as a supervisor for an automated pharmacy system, the pharmacist need not be physically present at the site of the automated pharmacy system and may supervise the system data electronically. The New Hampshire-licensed pharmacist shall be required to develop and implement policies and procedures designed to verify that the medicinal drugs delivered by the automated dispensing system are accurate and valid and that the machine is properly restocked.

IV. This section is not intended to limit the current practice of pharmacy in this state. This section is intended to allow automated pharmacy systems to enhance the ability of a pharmacist to provide pharmacy services in locations that do not employ a full-time pharmacist. This section does not limit or replace the use of a consultant pharmacist.

V. The board shall adopt rules governing the use of an automated pharmacy system under this section, not later than January 1, 2022, which shall specify:

(a) Recordkeeping requirements;

(b) Security requirements; and

(c) Labeling requirements.

2 Effective Date. Part III of this act shall take effect 60 days after its passage.

PART IV

Relative to health facilities providing care in the declared emergency.

1 New Section; Department of Safety; Homeland Security and Emergency Management; Novel Coronavirus Disease (COVID-19); Health Facilities. Amend RSA 21-P by inserting after section 42 the following new section:

21-P:42-a Novel Coronavirus Disease (COVID-19; Health Facilities. Acute care hospitals, assisted living facilities, long-term care facilities, nursing facilities, residential care facilities, ambulatory care clinics (as defined in RSA 151, RSA 151-A, RSA 151-D, RSA 151-E and RSA 151-H), and any other similar facilities providing care to elderly or infirm patients ("health facilities"), and the employees, agents and volunteers of such health facilities, are deemed to have been engaged in preparing for and/or carrying out "emergency management" functions for the purposes of RSA 21-P:35 when complying, or reasonably attempting to comply, with any executive order, agency order or rule (including but not limited to waivers from the Centers for Medicare and Medicaid Services (CMS) both issued as blanket waivers by CMS and as requested by New Hampshire department of health and human services pertaining to the state of emergency declared under state and/or federal law in response to the Novel Coronavirus (COVID-19). All such orders and rules are deemed to constitute orders and/or rules adopted and/or regulations promulgated pursuant to RSA 21-P. Accordingly, no such organization or person shall be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule under this section. This section shall not apply to actions of health care facilities, employees, agents, or volunteers of such facilities that are not related to compliance or reasonable attempts at compliance with an emergency order or rule. This section shall not apply to actions performed after such an emergency order or rule is no longer in effect.

2 Effective Date. Part IV of this act shall take effect upon its passage.

2021-0682s

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Establishing a harm reduction and overdose prevention program in the department of health and human services.

III. Automated pharmacy systems.

IV. Health facilities providing care in the declared emergency.

Health and Human Services
March 10, 2021
2021-0788s
10/04

Amendment to SB 149-FN

Amend the bill by replacing all after the enacting clause with the following:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0837, establishing a harm reduction and overdose prevention program in the department of health and human services, sponsored by Sen. Watters, Prime/Dist 4; Sen. Sherman, Dist 24; Sen. Whitley, Dist 15; Sen. D'Allesandro, Dist 20; Rep. Amanda Bouldin, Hills 12; Rep. Woods, Merr. 23; Rep. Conley, Straf. 13.

Part III. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part IV. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Clarifying Medicaid spend-down requirements

and requiring a report to the oversight committee on health and human services.

1 New Section; Spend-Down Requirements for Medical Expenses. Amend RSA 167 by inserting after section 4-d the following new section:

167:4-e Spend-down Requirements for Medical Expenses. For the purposes of off-setting the Medicaid spend-down requirements, mental health expenses shall be included as medical expenses.

2 Report to Oversight Committee on Health and Human Services.

I. The department of health and human services shall submit an interim report on or before October 1, 2021, to the oversight committee on health and human services, established pursuant to RSA 126-A:13, relative to actions taken to ensure the uniform application of spend-down requirements. The report shall include a description of how spend-down requirements were addressed in remedial staff training programs, updates to the policy manual, and updates to the brochure and any other department publications.

II. The department shall submit a final report by October 1, 2022, on the application of spend-down requirements. The report shall include data indicating how spend-down requirements have been applied since the interim report was filed.

3 Effective date. Part I of this act shall take effect upon its passage.

PART II

Establishing a harm reduction and overdose prevention program
in the department of health and human services.

1 Findings. The legislature finds and declares all of the following:

I. Overdose deaths in New Hampshire are an urgent public health crisis. For many years, overdose has been the leading cause of accidental death in the United States and in New Hampshire.

II. Harm reduction and overdose prevention programs (OPPs) are an evidence-based harm reduction strategy that allow individuals to consume drugs in a hygienic environment under the supervision of trained staff, who are able to intervene if the patient overdoses. OPPs also provide sterile consumption equipment and offer general medical advice and referrals to drug treatment and other community social services.

III. There are approximately 165 overdose prevention programs operating in 10 countries around the world, and numerous peer-reviewed studies have confirmed that those programs are effective in reducing overdose deaths and HIV transmission, and in increasing access to counseling, treatment, and other risk reduction services. Research has also demonstrated that those programs decrease use of emergency medical services, reduce public drug use, reduce syringe debris, and do not increase crime or drug use.

IV. An analysis published in the Journal of Drug Issues in 2016, OPPs in New Hampshire would save the state and municipalities substantial funds by reducing other costs due to opioid use and overdose.

V. An increase in overdose deaths was observed nationwide in 2020 according to the Office of National Drug Control Policy, rising 16.6 percent, based on a comparison of January to April, inclusive, of 2019 with the same time frame of 2020.

VI. As demands for reform of the criminal legal system reverberate around the country, OPPs offer an alternative framework for addressing both drug use as well as the enforcement of drug laws. OPPs bring people inside to a safe and therapeutic space, instead of leaving them vulnerable to police intervention, arrest, and incarceration.

VII. It is the intent of the legislature to promote the health and safety of communities by evaluating the health impacts of OPPs. It is the intent of the legislature to prevent fatal and nonfatal drug overdoses, reduce drug use by providing a pathway to drug treatment, as well as medical and social services for high-risk drug users, many of whom are homeless or uninsured or very low income, prevent the transmission of HIV and hepatitis C, reduce nuisance and public safety problems related to public use of controlled substances, reduce emergency room use and hospital

utilization related to drug use, reserving precious space, including intensive care beds, for treatment of COVID-19, and other life-threatening conditions.

VIII. Further, it is the intent of the legislature that OPPs should be evaluated in New Hampshire municipalities that authorize them, as OPPs show great promise to save lives, enhance public safety, improve access to drug treatment, medical care, and related services, reduce emergency department and hospital utilization related to drug overdose, and reduce the human, social, and financial costs of epidemics of drug misuse, homelessness, and COVID-19.

2 New Subdivision; Harm Reduction and Overdose Prevention Programs. Amend RSA 318-B by inserting after section 45 the following new subdivision:

Harm Reduction and Overdose Prevention Programs

318-B:45-a Harm Reduction and Overdose Prevention Programs

I.(a) Notwithstanding any other law, a New Hampshire municipality may approve entities within its jurisdiction to establish and operate overdose prevention programs for persons 18 years of age or older that satisfy the requirements set forth in paragraph IV.

II. Prior to approving an entity within its jurisdiction pursuant to paragraph I, a municipality shall provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The notice of the meeting to the public shall be sufficient to ensure adequate participation in the meeting by the public. The meeting shall be noticed in accordance with all state laws and local ordinances, and as local officials deem appropriate.

III.(a) The following entities, if self-funded, may operate an OPP upon approval of the municipality's governing body in New Hampshire to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs:

(1) Federally qualified health centers.

(2) Community health centers.

(3) Public health networks.

(4) AIDS service organizations.

(5) Substance misuse support or treatment organizations.

(6) Community based organizations.

(b) The commissioner of the department of health and human services shall adopt rules, pursuant to RSA 541-A, further defining the entities which may operate an overdose prevention program.

IV. Any entity operating an OPP in New Hampshire shall:

(a) Provide a hygienic space supervised by health care professionals where people who use drugs can consume pre-obtained drugs. For purposes of this paragraph, "health care professional" includes, but is not limited to, a physician, physician assistant, nurse practitioner, licensed vocational nurse, registered nurse, psychiatrist, psychologist, licensed clinical social worker,

licensed professional clinical counselor, mental health provider, social service provider, or substance use disorder provider, trained in overdose recognition and reversal.

(b) Provide sterile consumption supplies, collect used hypodermic needles and syringes, and provide secure hypodermic needle and syringe disposal services.

(c) Administer first aid, if needed, monitor participants for potential overdose, and provide treatment as necessary to prevent fatal overdose.

(d) Provide referral and linkage to HIV, viral hepatitis, and substance use disorder prevention, care, and treatment services, as appropriate.

(e) Coordinate and collaborate with other local agencies, organizations, and providers involved in comprehensive prevention programs for people who inject drugs to minimize duplication of effort.

(f) Attempt to be a part of a comprehensive service program that may include, as appropriate:

(1) Providing sterile needles, syringes, and other drug preparation equipment and disposal services.

(2) Educating and counseling to reduce sexual, injection, and overdose risks.

(3) Providing condoms to reduce risk of sexual transmission of viral hepatitis, HIV, or other STDs.

(4) Screening for HIV, viral hepatitis, STDs, and tuberculosis.

(5) Providing naloxone to reverse opioid overdoses.

(6) Providing referral and linkage to HIV, viral hepatitis, STD and tuberculosis prevention, treatment, and care services, including antiretroviral therapy for hepatitis C virus (HCV) and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission, and partner services.

(7) Providing referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination.

(8) Providing referral and linkage to and provision of substance use disorder treatment including medication assisted treatment for opioid use disorder which combines drug therapy such as methadone, buprenorphine, or naltrexone with counseling and behavioral therapy.

(9) Providing referral to medical care, mental health services, and other support services.

(g) Post its address, phone number, program contact information, if appropriate, hours of operation, and services offered on its Internet website.

(h) Provide reasonable security of the program site.

(i) Establish operating procedures for the program, made available to the public either through an Internet website or upon request, that are publicly noticed, including, but not limited to, standard hours of operation, a minimum number of personnel required to be on site during those

hours of operation, the licensing and training standards for staff present, an established maximum number of individuals who can be served at one time, and an established relationship with the nearest emergency department of a general acute care hospital, as well as eligibility criteria for program participants.

(j) Train staff members to deliver services offered by the program.

(k) Establish a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints.

(l) Establish a policy for informing local government officials and neighbors about the approved entity's complaint procedures, and the contact number of the director, manager, or operator of the approved entity.

(m) Register with the department of health and human services and confirm registration annually on or before November 1 of each subsequent year; provided however, the registration process shall be limited to notification to the department for data collection purposes only.

(n) Report quarterly to the department, which report shall include the following information regarding the program's activities:

(1) The number of program participants.

(2) Aggregate information regarding the characteristics of program participants.

(3) The number of hypodermic needles and syringes distributed for use on site.

(4) The number of overdoses experienced and the number of overdoses reversed on site.

(5) The number of persons referred to substance misuse treatment/services.

(6) The number of individuals directly and formally referred to other services and the type of service.

V. Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of the New Hampshire municipalities, state agencies, hospitals, or overdose prevention programs, acting in the course and scope of employment, shall not be arrested, charged, or prosecuted under RSA 318-B:2 for possession of controlled substances, possession of drug paraphernalia, or allowing drug use on premises, including for attempt, aiding and abetting, or conspiracy to commit a violation of any of those offenses, or otherwise be penalized solely for actions, conduct, or omissions on the site of a harm reduction and overdose prevention program approved under this section, or for conduct relating to the approval of an entity to operate an OPP, or the inspection, licensing, or other regulation of an OPP approved under this section.

VI. Nothing in this section shall be construed to prohibit the department of health and human services from administering and/or disbursing federal or other funds to harm reduction and

overdose prevention programs authorized under this section. The use of state general funds shall be prohibited unless otherwise appropriated by the general court.

VII. No overdose prevention program shall be located within a drug-free school zone as defined in RSA 193-B:1, II. Exceptions to this prohibition may be granted by the applicable district school board when a request is initiated by a overdose prevention program administrator.

3 Syringe Service Programs; Reference Added. Amend RSA 318-B:44 to read as follows:

318-B:44 Syringe Service Programs; Affirmative Defense. It is an affirmative defense, as provided in RSA 626:7, to prosecution for possession of a hypodermic syringe or needle that the item was obtained through participation in a syringe service program ***or an overdose prevention program under RSA 318-B:45-a.*** Nothing in this section shall be construed as an affirmative defense for any offense other than as set forth under RSA 318-B:26, [~~II(f)~~] ***II(e)***.

4 Effective Date. Part II of this act shall take effect 60 days after its passage.

PART III

Relative to automated pharmacy systems.

1 New Section; Pharmacies; Automated Pharmacy Systems. Amend RSA 318 by inserting after section 42 the following new section:

318:42-a Automated Pharmacy Systems; Long-term Care Facilities, Hospices, or State Correctional Institutions.

I. A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under RSA 151 or to a state correctional institution through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

II. Medicinal drugs stored in bulk or unit of use in an automated pharmacy system servicing a long-term care facility, hospice, or correctional institution are part of the inventory of the pharmacy providing pharmacy services to that facility, hospice, or institution, and drugs delivered by the automated pharmacy system are considered to have been dispensed by that pharmacy.

III. The operation of an automated pharmacy system shall be under the supervision of a New Hampshire-licensed pharmacist. To qualify as a supervisor for an automated pharmacy system, the pharmacist need not be physically present at the site of the automated pharmacy system and may supervise the system data electronically. The New Hampshire-licensed pharmacist shall be required to develop and implement policies and procedures designed to verify that the medicinal drugs delivered by the automated dispensing system are accurate and valid and that the machine is properly restocked.

IV. This section is not intended to limit the current practice of pharmacy in this state. This section is intended to allow automated pharmacy systems to enhance the ability of a pharmacist to provide pharmacy services in locations that do not employ a full-time pharmacist. This section does not limit or replace the use of a consultant pharmacist.

V. The board shall adopt rules governing the use of an automated pharmacy system under this section, not later than January 1, 2022, which shall specify:

(a) Recordkeeping requirements;

(b) Security requirements; and

(c) Labeling requirements.

2 Effective Date. Part III of this act shall take effect 60 days after its passage.

PART IV

Relative to health facilities providing care in the declared emergency.

1 New Section; Department of Safety; Homeland Security and Emergency Management; Novel Coronavirus Disease (COVID-19); Health Facilities. Amend RSA 21-P by inserting after section 42 the following new section:

21-P:42-a Novel Coronavirus Disease (COVID-19; Health Facilities. Acute care hospitals, assisted living facilities, long-term care facilities, nursing facilities, residential care facilities, ambulatory care clinics (as defined in RSA 151, RSA 151-A, RSA 151-D, RSA 151-E and RSA 151-H), and any other similar facilities providing care to elderly or infirm patients ("health facilities"), and the employees, agents and volunteers of such health facilities, are deemed to have been engaged in preparing for and/or carrying out "emergency management" functions for the purposes of RSA 21-P:35 when complying, or reasonably attempting to comply, with any executive order, agency order or rule (including but not limited to waivers from the Centers for Medicare and Medicaid Services (CMS) both issued as blanket waivers by CMS and as requested by New Hampshire department of health and human services pertaining to the state of emergency declared under state and/or federal law in response to the Novel Coronavirus (COVID-19). All such orders and rules are deemed to constitute orders and/or rules adopted and/or regulations promulgated pursuant to RSA 21-P. Accordingly, no such organization or person shall be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule under this section. This section shall not apply to actions of health care facilities, employees, agents, or volunteers of such facilities that are not related to compliance or reasonable attempts at compliance with an emergency order or rule. This section shall not apply to actions performed after such an emergency order or rule is no longer in effect.

2 Effective Date. Part IV of this act shall take effect upon its passage.

2021-0788s

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Establishing a harm reduction and overdose prevention program in the department of health and human services.

III. Automated pharmacy systems.

IV. Health facilities providing care in the declared emergency.

Sen. Giuda, Dist 2
March 30, 2021
2021-1049s
10/04

Amendment to SB 149-FN

Amend the bill by replacing section 1 , Sponsorship, with the following:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Kniirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part III. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

Amend the bill by deleting Part II and renumbering the original Parts III and IV, and the references to those parts in the effective date section for the respective part, to read as Part II and Part III, respectively

2021-1049s

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Automated pharmacy systems.

III. Health facilities providing care in the declared emergency.

Senate Finance
March 30, 2021
2021-1055s
10/05

Amendment to SB 149-FN

Amend the bill by replacing section 1 , Sponsorship, with the following:

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0427, clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services, sponsored by Sen. Rosenwald, Prime/Dist 13; Sen. Hennessey, Dist 1; Sen. Whitley, Dist 15; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Rep. Guthrie, Rock. 13; Rep. McMahon, Rock. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Mullen, Hills. 7.

Part II. LSR 21-0936, relative to automated pharmacy systems, sponsored by Sen. Carson, Prime/Dist 14.

Part III. LSR 21-1006, relative to health facilities providing care in the declared emergency, sponsored by Sen. Gray, Prime/Dist 6.

Amend the bill by deleting Part II and renumbering the original Parts III and IV, and the references to those parts in the effective date section for the respective part, to read as Part II and Part III, respectively

2021-1055s

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

II. Automated pharmacy systems.

III. Health facilities providing care in the declared emergency.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Jeb Bradley, Chair
Sen James Gray, Vice Chair
Sen Kevin Avard, Member
Sen Tom Sherman, Member
Sen Rebecca Whitley, Member

Date: February 11, 2021

HEARINGS

Thursday	02/18/2021
(Day)	(Date)

Health and Human Services	REMOTE 000	1:30 p.m.
(Name of Committee)	(Place)	(Time)

Note: The Committee will meet at 1:30 p.m. or 30 minutes following the end of Session.

1:30 p.m.	**SB 150-FN**	establishing a dental benefit under the state Medicaid program.
1:45 p.m.	**SB 144-FN**	relative to child care scholarships.
2:00 p.m.	**SB 149-FN**	adopting omnibus legislation on health and human services.

Committee members will receive secure Zoom invitations via email.

Members of the public may attend using the following links:

1. Link to Zoom Webinar: https://www.zoom.us/j/92006060503
2. To listen via telephone: Dial(for higher quality, dial a number based on your current location): 1-301-715-8592, or 1-312-626-6799 or 1-929-205-6099, or 1-253-215-8782, or 1-346-248-7799, or 1-669-900-6833
3. Or iPhone one-tap: 16465588656,,92006060503# or 13017158592,,92006060503#
4. Webinar ID: 920 0606 0503
5. To view/listen to this hearing on YouTube, use this link: https://www.youtube.com/channel/UCjBZdtrjRnQdmg-2MPMiWrA

6. To sign in to speak, register your position on a bill and/or submit testimony, use this link: http://gencourt.state.nh.us/remotecommittee/senate.aspx

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EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 150-FN

Sen. Rosenwald	Sen. Whitley	Sen. Watters	Sen. Cavanaugh
Sen. D'Allesandro	Sen. Kahn	Sen. Sherman	Sen. Prentiss
Sen. Soucy	Sen. Perkins Kwoka	Sen. Bradley	Sen. Giuda
Rep. Nordgren	Rep. Wallner	Rep. Marsh	Rep. Langley

SB 144-FN

Sen. Whitley	Sen. Rosenwald	Sen. Perkins Kwoka	Sen. Watters
Sen. Hennessey	Sen. Prentiss	Sen. D'Allesandro	Sen. Soucy
Sen. Sherman	Rep. McWilliams	Rep. Nordgren	Rep. Wallner

SB 149-FN

Sen. Sherman

Kirsten Koch 271-3266

Jeb Bradley
Chairman

Senate Health and Human Services Committee

Kirsten Koch 271-3266

SB 149-FN, adopting omnibus legislation on health and human services.

Hearing Date: February 18, 2021

Time Opened: 4:03 p.m. **Time Closed:** 5:34 p.m.

Members of the Committee Present: Senators Bradley, Gray, Sherman and Whitley

Members of the Committee Absent : Senator Avard

Bill Analysis: This bill adopts legislation relative to:

I. Nursing home standards.

II. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.

III. Establishing a harm reduction and overdose prevention program in the department of health and human services.

IV. Automated pharmacy systems.

V. Establishing a rehabilitation bed pilot program.

VI. Health facilities providing care in the declared emergency.

VII. Confidential sharing of information under the controlled drug prescription health and safety program.

Sponsors:
Sen. Sherman

Who supports the bill: There are 128 names signed in support of this bill. If you would like to view the sign in sheet, please contact the Legislative Aide for the Senate Health and Human Services Committee, Kirsten Koch, at kirsten.koch@leg.state.nh.us

Who opposes the bill: Robert Stout, NH Pharmacists Association; Charles Champagne, Northeast Rehabilitation Hospital Network; David Ross, Paul Worsowicz, Northeast Rehabilitation Hospital Network; Lisa Shapiro, Northeast Rehabilitation Hospital Network; John Prochilo, Northeast Rehabilitation Hospital Network; Mark Taylor, Northeast Rehabilitation Hospital Network; Elizabeth Sargent, NH Association of Chiefs of Police.

Who is neutral on the bill: Nick Abramson; Melissa St. Cyr, DHHS: Marissa Chase, NH Association for Justice; Jennifer O'Higgins, DHHS; David Creer, BIA.

Summary of testimony presented in support:

Senator Ward, District 8

- Part 1. Nursing home standards.
- Individuals on Medicaid that needs nursing home care can potentially be sent to another state to receive care. Individuals sent out of state for care should get the care they expect to receive in NH.
- Part I enforces NH standards of care on out-of-state nursing homes that receive Medicare patients that are NH residents.
- Senator Bradley asked, is this the same bill you submitted two years ago?
    - Senator Ward said yes.

Senator Rosenwald, District 13

- Part 2. Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee on health and human services.
- Behavioral health services are covered. This does not expand the benefit. This just makes it clear that mental health care is health care and there should be no cost to Medicaid. This bill is necessary because is ongoing confusion in district offices. This part also requires reporting to DHHS for this year, and the next, to ensure fair application.
- This provision was a bill last session that was tabled last year.
- Also, as a note, Part 7 language is entirely incorporated in SB 45, which passed last week.
    - Senator Bradley recommended that Senator Rosenwald work with Senator Giuda on what to do about the language in Part 7 already appearing in SB 45.

Senator Watters, District 4

- Part 3. Establishing a harm reduction and overdose prevention program in the department of health and human services.
- This bill is meant to add harm reduction programs to the efforts in NH.
- We reduced stigma and supported recovery programs.
- We have seen a great increase in overdose deaths; 16.6% increase nationwide.
- We have yet to look at harm reduction as a strategy for helping substance abusers. Prevention programs are evidence based. Individuals can consume drugs in a hygienic environment with trained staff that can intervene for safety. These programs prevent other diseases as well, such as HIV.
- The program is modeled on the needle-exchange program. There needs to be disposal services and health care services. People there want help, treatment, and information about health risks. The harm reduction program would be for ages 18 years and older. This would be a good place to provide Oxone to prevent overdoses at these locations. There should also be health screening services for HIV, Hepatitis, and other disease here too.
- Page 3 details that harm reduction programs would save municipalities and the state substantial funds.

- This legislation enables municipalities to establish these programs and collect data. This is entirely enabling legislation. Part III of this bill gives municipalities the authority.
- Page 4 establishes entities that could operate this program, under rules that should be defined by DHHS.
- Page 5 has a system for reporting so NH can collect data and better understand the needs of individuals.
- The legal standing of these programs has gone back and forth between being challenged and accepted by the courts.
- Section 5 covers criminal liability.
- Part 6 of this bill has raised a couple of issues about civil liability. We do not want to exempt civil liability from someone who commits egregious behavior. We may need to amend this section, or have it removed.
- This program will not use any general funds, only grant funds.
- Senator Bradley asked, where is the section on civil liability?
    - Senator Gray said, it is on page 10.

Senator Carson, District 14

- Part 4. Automated pharmacy systems.
- Representatives of these systems are looking for legislative approval.
- Representatives of these systems will be testifying later during this hearing.

Senator Bradley, District 3

- Part 5. Establishing a rehabilitation bed pilot program.
- It would establish a pilot and authorize it to enable new licensing for new rehab beds for where there is a need for beds.
- There is a need to lift the moratorium on the needs for new beds. It has been in place for 25 years.
- Representatives of hospitals will speak to the need.

Senator Gray, District 6

- Part 6. Health facilities providing care in the declared emergency.
- We are adding a subparagraph to 42(a) to define COVID. We needed to be more specific.
- Senator Gray said he is opposed to deleting the section on civil liability that was mentioned by Senator Watters. We need volunteers and all the help we can get. We need to provide them legal protection.

Senator Giuda, District 2

- Part 7. Confidential sharing of information under the controlled drug prescription health and safety program.
- Senator Giuda said, if we do not pass this section of the bill, we will lose Medicaid.

Hon. Nancy Murphy

- Ms. Murphy testified in support of Part 2 of this bill.
- Eligible citizens are required to show medical bills equal to the amount before the spend down coverage begins. If the spend down amount is not met, or if the coverage for

mental/behavioral services is not properly applied by DHHS, then the Medicaid recipient is denied medical coverage.

- Being denied coverage would not happen for other services (ex. gastroenterology) instead of mental health services.
- We need a compliance section for DHHS staff to ensure Medicaid coverage is applied for mental health care.
- This section does not expand coverage. It clarifies what expenses can be applied to the spend down.
- Ms. Murphy shared an anecdote about a similar bill, HB 739, that she worked on in the NH House in the past.
- Senator Bradley asked, do you recall the vote in the House committee on this bill?
    - Ms. Murphy said, I do. It was 15 to 3.

Hon. Joe Hannon, NH Harm Reduction Coalition

- Mr. Hannon testified in support of Part 3 of this bill.
- Mr. Hannon said, there are operating harm reduction programs in Manchester and Nashua. They saw overdose death drops in the last year. The Manchester program successfully reversed 3,000 overdoses last year on Sundays alone during a 2-hour period. These programs have also reported that they reduced preventable infections, skin infections, that lead to other disease. This also reduces medical costs and frees up more of medical providers' time, especially during the pandemic.
- Mr. Hannon said, we are concerned with municipalities responsibility of these programs because it can be prohibitive to human right to seek resources near them. If individuals have to travel to access these services, because it is not available in the municipality, there is a danger of DUI, spread of disease, and there will be a general lack of access to services in some areas. Most of these services are available in larger cities.
- Mr. Hannon shared anecdote about a facility in Canada that saw the benefits of a harm reduction program.
- Mr. Hannon recommended implementing mobile harm reduction facilities.

John Burns

- Mr. Burns testified in support of Part 3 of this bill.
- Mr. Burns said municipal control is problematic.
- *Note: When Mr. Burns was testifying, he experienced connectivity issues. The committee members told Mr. Burns he could not be heard. Mr. Burns continued testifying while he was inaudible during some sections.*
- Mr. Burns said he supports Part III and believes harm reduction is lifesaving. There is data to back that up.
- Senator Sherman asked Mr. Burns to submit the study to the committee that he mentioned in his testimony.
    - Mr. Burns agreed to do so.

Nikki Fordey, Social Worker

- Ms. Fordey testified in support of Part 3 of this bill.
- Ms. Fordey shared an anecdote about losing clients to substance abuse.

- Ms. Fordey said her clients need all the tools they can get to get better. The obsession with abstinence of drug use needs to end. We need to accept people where they are and ask them what they need to survive and thrive. People who use drugs do not deserve to die. This bill will save lives.
- Ms. Fordey does support giving municipalities authority over these programs; this should be a community effort.
- Providing harm reduction services saves lives, reduces harm, and provides people with dignity and worth.

Asma Elhuni, Rights and Democracy

- Ms. Elhuni testified in support of Part III.
- Ms. Elhuni shared an anecdote about her work and a story of a substance abuser.
- Ms. Elhuni said, NH has the sixth highest rate of overdose deaths in the country.
- This bill would increase public safety and reduce disorder.

Jody Fenelon and Derek Corriveau, Partners Pharmacy

- Ms. Fenelon and Mr. Corriveau testified in support of Part 4.
- Mr. Corriveau provided background on the Partners Pharmacy remote automated medication dispensing system known as Passport.
- This service offers an impact on patient safety, especially during the pandemic, and does not make mistakes.
- This service provides a cost savings for carriers. You only pay for what you use. This eliminates waste on medications.
- The medication in machine is double locked and on camera monitored by security 24/7.
- Remote automated dispensing is safe and decreases pharmacy costs.

John Skevington and Dean Carucci, Portsmouth Hospital

- Mr. Skevington and Mr. Carucci both testified in support of Part 5 of this bill.
- Mr. Carucci said there are some interpretations that we need to iron out with DHHS. Please hold this section until we can do this.
- Mr. Carucci said, we introduced this bill due to the issues we are having. Our patients are at 192% due to access issues.
- Senator Bradley asked, do you believe on the seacoast there is an absolute need for more rehab beds?
    - Mr. Skevington said, that is correct.

Dean Carucci later testified again in response to Mr. Champagne's testimony.

- Mr. Carucci said, I think it is easy for Northeast Rehab, who owns 70% of the beds in NH, to want to restrict the addition of beds.
- Our average length of stay is double the length of stay defined by Medicare.
- For an acute facility, every bed that we cannot discharge timely, means there is a patient that has to leave the state for care. It takes on average six referrals to get a patient placed in a facility for care. That drives up the length of state.

John Friberg, Solution Health

- Mr. Friberg testified in support Part 6 of this bill.
- Mr. Friberg said, this proposed legislation will confirm the legislature's intent of the applicability of the emergency statute RSA 21(p), when providers have attempted to follow emergency orders/rules from federal or state order in response to COVID. This provides legal protection and makes these services immune to liability arising from, or in relation, to such activities.
- This is happening in numerous jurisdictions and has been resolved by either executive order or legislation. We ask NH to come in line with this policy action.
- March 13, 2020 was the day on which many federal disaster declarations were issued on COVID, followed by a flurry of unprecedented state and federal rules designed to slow the spread of COVID and prepare the health care system to respond to an overwhelming need due to COVID. Some of those directives and waivers resulted in cancellation of elective procedures. They also authorized tele-health visits. This also expanded places where we provided care (ex. conference centers, parking lots, etc.) on an emergency basis. They prohibited visits, cut down on documentation process, and how we triage ER patients. The sourcing and utilization of PPE was utilized and deployed in nontraditional ways by encouragement of the authorities. Some of which was to a facility's own detriment.
- A very real fear of these providers is falling responsible to civil liability for complying with these mandates and authorizations, that in many cases, took the standards and norms they have known, and turned them upside down. The delivery of care became very different. This caused health care to be delivered in nontraditional ways. We want to be very clear that these providers and organizations will not later be penalized for the very actions they were encouraged or mandated to take. These actions should not later be utilized in civil lawsuit.
- Emergency management compliance should never cause civil tort liability exposure.
- RSA 21(p) conveys immunity. The NH Attorney General confirmed these organizations and providers should be protected under that statute. However, the Attorney General's opinion does not make this point as indisputably clear as legislation would.
- Part 6 makes succinctly clear that actions by health care providers and institutions in compliance with such emergency orders and rules constitutes as emergency management activity and are subject to the necessary liability protections for those very actions.
- This is an important effort for ensuring medical providers are not later penalized for doing what they were required to do to protect their communities.
- Senator Bradley said, while you have based Part 6 on the Attorney General's interpretation of the emergency order, there was a key piece that was not in it that the immunity was limited to the performance of emergency activities at the direction of the Governor or another agency. My suggestion would be, if the comprehensiveness of the Attorney General's opinion is complete, then we could go forward with this easily.
    - Mr. Friberg said that is mutually agreeable and we are working to fine tune this part together with other proponents.
    - Senator Gray offered to handle the amendment for Part 6.

Paula Minnehan, NH Hospital Association

- Ms. Minnehan testified in support of Part 6 and Part 7 of this bill.
- Part 6

- Ms. Minnehan said, we are supportive of Part 6. We agree with Mr. Friberg.
- Part 7
  - Ms. Minnehan said, I am fine with Part 7 being removed because the identical language is in SB 45. We are fine with whatever vehicle will get this bill passed.

Summary of testimony presented in opposition:

Robert Stout, NH Pharmacists Association

- Mr. Stout testified in opposition of Part 4 of this bill.
- Mr. Stout says he has no issues with the accuracy and benefits of automated pharmacy systems.
- Mr. Stout said he is disappointed that the Board of Pharmacy would refer this to the legislature side for a fix. In 2010 we came before you to ask for authorization to manage these systems. Look at statute 318(5)(a)(12) procedures for automated pharmacies. This bill belongs in Rules. I have a lot of questions.
- The state currently has automated pharmacy dispensing systems already in use in long term care facilities. PH 70502 already relates to use in these facilities.
- We are worried about controlled substances in these machines. This bill establishes that if you have a controlled substance in the machine, you have to get a separate license from the DEA to have it. This could trump 70502. Currently we do not require a separate license for the machines because they are considered emergency use kits, because of the pandemic, so it would be referred to the Board of Pharmacy.
- If we write a law stricter than the federal guidelines, then the stricter law applies. We do not want to see these machines removed.
- Mr. Stout said, this bill limits to placing these machines only in long term care facilities. People are going to come back and ask to put these machines in more places.
- Senator Bradley said, I am told the Pharmacy Board told the proponents to come to the legislature.
  - Mr. Stout said he could not answer that because he was not there. My concern is that they eliminated the Executive Director at the Board of Pharmacy and now we are relying on the commissioners. There are internal problems.

Jody Fenelon joined in to answer questions.

  - Ms. Fenelon said, after discussion with the Board of Pharmacy, they did ultimately direct us to the legislature.
- Senator Bradley asked, does this bill allow or require rulemaking by the Board of Pharmacy? Would it be a way of resolving the concept? There seems to be a tangle between the legislature and the board.
  - Ms. Fenelon said, I understand the DEA point of view and the registration for controlled substances in the machines. We do follow that guidance under what the state and DEA would require.

Robert Stout later testified again.

- Mr. Stout said, my only fear that this legislation may force the machines already out there to be pulled. One of the solutions to this would be to file a formal rule making petition.
- Senator Bradley said, please work that out with Senator Carson and the proponents of Part 4. If this all gets worked out, then we may not need this section of the bill.

Charles Champagne, Northeast Rehabilitation Hospital (NRH) Network

- Mr. Champagne testified in opposition of Part 5 of this bill.
- Mr. Champagne said, Northeast Rehab does not believe there is not a need for more rehab beds on the seacoast.
- NRH provides acute rehabilitation services in four NH locations. A typical patient requires an intensive course of rehabilitation therapy (ex. after a stroke, spinal injury, etc.). We are not a skilled nursing facility, a long-term care facility, or an inpatient psych facility.
- Mr. Champagne said, in Portsmouth, we opened a standalone, 33 bed facility to meet the community's needs. We heard from our partners that there was a need from acute hospitals for a place to omit COVID patients. NRH Salem has omitted over 200 patients in NH. Inpatient facilities require certification by CMS and must follow a high degree of standards of care. NH is best served by having acute hospitals to work collaboratively for their patients to have access to inpatient facilities.
- Senator Bradley asked, can you address the testimony that says you need more rehab beds?
    - Mr. Champagne, we operate 33 individual room facility. It has an occupancy of 90%. It may be full some days. We do not have a problem omitting patients that need the criteria. We have to maintain the 60% rule. Patients must maintain an acute level of medical necessity. Patients have to be able to sustain 3 hours of therapy a day to be in our facility. We are not aware of an additional need for beds.
- Senator Bradley asked, do you accept all Medicaid patients?
    - Mr. Champagne said, yes, we do. About 12% of our patients are Medicaid.

Neutral Information Presented:

Melissa St. Cyr, DHHS

- Ms. St Cyr testified on Part 1 and Part 5 of this bill.
- Part 1
    - Ms. St. Cyr said, the concern that DHHS has is with the language. If you go to another state's nursing home, you get that state's Medicaid and you are under their standards. Being sent out of state for nursing home care is very, very rare and only done when the individual has specific needs that cannot be met in state. It is a contractual obligation.
    - We do not have the authority legally to force another state's nursing home to follow our law. We cannot execute this statute as written if passed.
    - The DHHS is happy to work with Senator Ward on this going forward.
- Part 5

- The way it is written acute care hospitals and critical care hospitals are allowed to apply for a license to operate rehab care services. The way our laws are set up right now, an acute care/rehab hospital is allowed to apply for hospital beds. There is no moratorium on new hospital beds. These hospital beds can be used any way the hospital sees fit, such as for psychiatric services, etc.
- This legislation permits these hospitals to do something they are already allowed to do. This legislation seems to have more to do with opening a rehab hospital, which has different licensure. If this is the goal is to allow a rehab hospital to be opened, then we need to change the language so that it does not say "acute care or critical access hospital" and instead says "a rehabilitation hospital shall be permitted to apply for a license."
- Senator Sherman said, what would constitute opening a rehab hospital? Would it require separate licensure?
    - Ms. St. Cyr said, most hospitals would just apply for additional beds and then do with them as they see fit. It wouldn't restrict them based on using them for any specific services. Specifically, rehabilitation hospitals have a specific component of rehabilitation to the beds they have. They have a special type of license because they cannot offer regular hospital services. There is nothing under statute right now that would stop them from increasing their capacity of their hospital, even at another location.
- Senator Sherman said, is there a benefit to not being under the hospital license? Is there a reimbursement difference?
    - Ms. St. Cyr said, there could be. Someone else can speak to that.

Marissa Chase, NH Association for Justice

- Ms. Chase testified on Part 3 and Part 6 of this bill.
- Part 3
    - Ms. Chase said, there is another concern in Part 3 of the bill regarding the liability that Senator Watters suggested should be eliminated.
- Part 6
    - Ms. Chase said, we have been working with Mr. Friberg. We get nervous when we see any limitation of liability. We agree with Mr. Friberg in principle on the bill. The language we see now is just so broad. If there was a very complete opinion added in, then that would be agreeable. We do not want to make this any more difficult during the pandemic.
    - Ms. Chase said she is happy to work with Senator Gray on any amendments.

KNK
Date Hearing Report completed: February 24, 2021

SENATE CALENDAR NOTICE
Finance

Sen Gary Daniels, Chair
Sen John Reagan, Vice Chair
Sen Bob Giuda, Member
Sen Erin Hennessey, Member
Sen Chuck Morse, Member
Sen Lou D'Allesandro, Member
Sen Cindy Rosenwald, Member

Date: March 25, 2021

EXECUTIVE SESSION

Tuesday	03/30/2021	
(Day)	(Date)	
Finance	REMOTE 000	1:00 p.m.
(Name of Committee)	(Place)	(Time)

1:00 p.m. EXECUTIVE SESSION ON PENDING LEGISLATION

Committee members will receive secure Zoom invitations via email.
Members of the public may attend using the following links:
1. To join the webinar: https://www.zoom.us/j/92066815028
2. Or Telephone: Dial (for higher quality, dial a number based on your current location): 1-301-715-8592, or 1-312-626-6799, or 1-929-205-6099, or 1-253-215-8782, or 1-346-248-7799, or 1-669-900-6833
3. Or iPhone one-tap: 13126266799,,92066815028# or19292056099,,92066815028#
4. Webinar ID: 920 6681 5028
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Deb Martone 271-4980

Gary L. Daniels
Chairman

Speakers

Name	Title	Representing	Position	Testifing
Scionti Jeff	A Member of the Public	CEO of Frisbie Hospital	Support	Yes
Giuda Bob	An Elected Official	NH Senate District 2	Support	Yes
Carson Sharon	An Elected Official	Senate District 14 Part IV PRIME	Support	Yes
Sherman Senator Tom	An Elected Official	SD24	Support	Yes
Watters Senator David	An Elected Official	Myself (SD 4)	Support	Yes
Gray Senator James	An Elected Official	Senate District 6 Supporting Part VI Prime	Support	Yes
Ward Senator Ruth	An Elected Official	Senator District 8 Supporting Part I Prime	Support	Yes
Skevington John	A Member of the Public	Myself	Support	Yes
Fordey Nikki	A Member of the Public	Myself	Support	Yes
Stout Robert	A Member of the Public	New Hampshire Pharmacists Assoc	Oppose	Yes
Snook Jason	A Member of the Public	Myself	Support	Yes
Fenelon Jody	A Member of the Public	Partners Pharmacy	Support	Yes
Corriveau Derek	A Member of the Public	Partners Pharmacy	Support	Yes
Minnehan Paula	A Lobbyist	NH Hospital Association	Support	Yes
Burns John	A Member of the Public	Myself	Support	Yes
bradley jeb	An Elected Official	Myself SD 3 Jeb Bradley PART V	Support	Yes
Friberg John	A Member of the Public	Solution Health	Support	Yes
Norton Steve	A Member of the Public	Solution Health	Support	Yes
Morris Polly	A Member of the Public	Myself.	Support	Yes
Murphy Hon. Nancy	A Member of the Public	Myself	Support	Yes
Elhuni Asma	A Lobbyist	Rights and Democracy NH	Support	Yes
Champagne Charles	A Member of the Public	Northeast Rehabilitation Hospital Network	Oppose	Yes
St Cyr Melissa	State Agency Staff	DHHS	Neutral	Yes
Chase Marissa	A Lobbyist	NH Association for Justice	Neutral	Yes
Abramson Nick	A Member of the Public	Myself	Neutral	Yes
Hannon Joe	A Member of the Public	NH Harm Reduction Coalition	Support	Yes
Rosenwald Cindy	An Elected Official	SD 13	Support	Yes
DeMark Richard	A Member of the Public	Myself	Support	No
OHiggins Jennifer	State Agency Staff	DHHS	Neutral	No
Lanigan Cathy	A Member of the Public	Myself	Support	No
Henrichon Margaret	A Member of the Public	Myself	Support	No
Kaplan Susan	A Member of the Public	Myself	Support	No
Rung Rosemarie	An Elected Official	Myself	Support	No
Berry Jake	A Lobbyist	New Futures	Support	No
Ross David	A Member of the Public	Myself	Oppose	No
Mercurio Anthony	A Member of the Public	Myself	Support	No
Mangipudi Latha	An Elected Official	Hills 35	Support	No
Newman Ray	An Elected Official	Myself	Support	No
Graham Nancy	A Member of the Public	Myself	Support	No
Blake Karen	A Member of the Public	Myself	Support	No
Lapian William	A Member of the Public	Myself	Support	No
Carole Kimberly	A Member of the Public	Myself	Support	No
Bergevin Leslie	A Member of the Public	Myself	Support	No
Greenwood Nancy	A Member of the Public	Myself	Support	No
Hayes Ariel	A Member of the Public	Myself	Support	No
Donovan Julie	A Member of the Public	Myself	Support	No
Fedorchak Gaye	A Member of the Public	Myself	Support	No
Mancuso Charles	A Member of the Public	Myself	Support	No
Wild Gail	A Member of the Public	Myself	Support	No
Wiggins Frank	A Member of the Public	Myself	Support	No
van der Bijl Dana	A Member of the Public	Myself	Support	No
Lariviere Kendal	A Member of the Public	Myself	Support	No
Richard-Snipes Robert	A Member of the Public	Myself - Robert Richard-Snipes	Support	No
Koch Helmut	A Member of the Public	Myself	Support	No

Worsowicz Paul	A Lobbyist	Northeast Rehabilitation Hospital Network	Oppose	No
Shapiro Lisa	A Lobbyist	Northeast Rehabilitation Hospital Network	Oppose	No
Prochilo John	A Member of the Public	Northeast Rehabilitation Hospital Network	Oppose	No
Taylor Mark	A Member of the Public	Northeast Rehabilitation Hospital Network	Oppose	No
Brennan Nancy	A Member of the Public	Myself	Support	No
Hayes Rebecca	A Member of the Public	Myself	Support	No
Mayne Kenneth	A Member of the Public	Myself	Support	No
Beaudoin Jennifer	A Member of the Public	Myself	Support	No
Cutshall Catherine	A Member of the Public	Myself	Support	No
Vivado Mauricio	A Member of the Public	Myself	Support	No
Covert Susan	A Member of the Public	Myself	Support	No
Hruska Jeanne	A Lobbyist	ACLU-NH	Support	No
Jones Stephanie	A Member of the Public	Myself	Support	No
wilczynski patricia	A Member of the Public	Myself	Support	No
Vaillancourt Jody	A Member of the Public	Myself	Support	No
M Sandra	A Member of the Public	Myself	Support	No
hatch sally	A Member of the Public	Myself	Support	No
Schissel Mary	A Member of the Public	Myself	Support	No
Vincent Laura	A Member of the Public	Myself	Support	No
Gordon Laurie	A Member of the Public	Myself	Support	No
Clark Martha	A Member of the Public	Myself	Support	No
Fulmer Kathleen	A Member of the Public	Myself	Support	No
St Germain Diane	A Member of the Public	Myself	Support	No
McClain Trysten	A Member of the Public	Myself	Support	No
Carter Marissa	A Member of the Public	Myself	Support	No
Lambert Joshua	A Member of the Public	Myself	Support	No
Mott-Smith Wiltrud	A Member of the Public	Myself	Support	No
QUISUMBING-KING Cora	A Member of the Public	Myself	Support	No
ARONSON LAURA	A Member of the Public	Myself	Support	No
Stinson Benjamin	A Member of the Public	Myself	Support	No
Platt Elizabeth-Anne	A Member of the Public	Myself	Support	No
Heslin Mary	A Member of the Public	Myself	Support	No
DiNapoli Pamela	A Member of the Public	NH Nurses Association	Support	No
Kiefner Robert	A Member of the Public	Myself	Support	No
House Don	A Member of the Public	Myself	Support	No
Sargent Elizabeth	A Lobbyist	NH Association of Chiefs of Police	Oppose	No
Cahill Kathy	A Member of the Public	Myself	Support	No
Berube Heather	A Member of the Public	Myself	Support	No
Vigroux Kerran	A Member of the Public	NH Providers Association	Support	No
Maranhas Andrew	A Member of the Public	Myself	Support	No
Padmore Michael	A Lobbyist	NH Medical Society	Support	No
Creer David	A Lobbyist	BIA	Neutral	No
Raspiller Cindy	A Member of the Public	Myself	Support	No
zavgren john	A Member of the Public	Myself	Support	No
Jones Andrew	A Member of the Public	Myself	Support	No
Keeler Margaret	A Member of the Public	Myself	Support	No
Brown Howard	A Member of the Public	Myself	Support	No
Brown Morgan	A Member of the Public	Myself	Support	No
Brown William	A Member of the Public	Myself	Support	No
Zaenglein Barbara	A Member of the Public	Myself	Support	No
Zaenglein Eric	A Member of the Public	Myself	Support	No
Pospychala Erin	A Member of the Public	Myself	Support	No
monahan sean	A Member of the Public	Myself	Support	No
Lindpaintner Lyn	A Member of the Public	Myself	Support	No
Blanchard Sandra	A Member of the Public	Myself	Support	No

Green Debra	A Member of the Public	Myself	Support	No
Falk Cheri	A Member of the Public	Myself	Support	No
Damon Claudia	A Member of the Public	Myself	Support	No
Perencevich Ruth	A Member of the Public	Myself	Support	No
Garen June	A Member of the Public	Myself	Support	No
Torpey Jeanne	A Member of the Public	Myself	Support	No
Ellermann Maureen	A Member of the Public	Myself	Support	No
Dewey Karen	A Member of the Public	Myself	Support	No
Hinebauch Mel	A Member of the Public	Myself	Support	No
Stockwell Heather	A Lobbyist	Myself	Support	No
Larson Ruth	A Member of the Public	Myself	Support	No
Hackmann Kent	A Member of the Public	Myself	Support	No
Anderson Keryn	A Member of the Public	Myself	Support	No
Bruce Susan	A Member of the Public	Myself	Support	No
Destefano Kim	A Member of the Public	Myself	Support	No
Rettew Annie	A Member of the Public	Myself	Support	No
McCue Dara	A Member of the Public	Myself	Support	No
Nardino Marie	A Member of the Public	Myself	Support	No
Taylor Gale	A Member of the Public	Myself	Support	No
Brickett Jane	A Member of the Public	Myself	Support	No
Hope Lucinda	A Member of the Public	Myself	Support	No
Neville Betsey	A Member of the Public	Myself	Support	No
blakeney gordon	A Member of the Public	Myself	Support	No
Mitchell Karen	A Member of the Public	Myself	Support	No
Carter Lilian	A Member of the Public	Myself	Support	No
Fenner-Lukaitis Elizabeth	A Member of the Public	Myself	Support	No
Richman Susan	A Member of the Public	Myself	Support	No
Spencer Louise	A Member of the Public	Myself	Support	No
Reed Barbara	A Member of the Public	Myself	Support	No
Mooney Bridget	A Member of the Public	Myself	Support	No
Kallinich Kayla	A Member of the Public	Myself	Support	No
Carucci Dean	A Member of the Public	CEO of Portsmouth Hospital	Support	Yes

Testimony

Kirsten Koch

From: Nikki Fordey <nikkif610@gmail.com>
Sent: Tuesday, February 16, 2021 2:27 PM
To: Kirsten Koch
Subject: Additional testimony and information in support of SB149
Attachments: additional info OPPs.docx

Follow Up Flag: Follow up
Flag Status: Completed

Dear Senate Health and Human Services Committee,

Attached is research demonstrating the efficacy and outcomes for overdose prevention programs and harm reduction initiatives - submitted in support of Part III of SB149 - AN ACT adopting omnibus legislation on health and human services. Available here:
http://gencourt.state.nh.us/bill_status/billText.aspx?id=1071&txtFormat=html&sy=2021

This bill is set for public hearing on Thursday 2/18 in the afternoon and I have signed up to testify. Please let me know if you have any questions.

Best,
Nikki Fordey, MA, MSW, LICSW, MLADC
Fordey Counseling, PLLC

Additional Testimony from Nicole Fordey, LICSW, MLADC in Support of **SB149** – AN ACT adopting omnibus legislation on health and human services **Part III** - Establishing a harm reduction and overdose prevention program in the department of health and human services

In 2018, New Hampshire had the sixth highest rate of drug overdose deaths in the U.S., at 35.8 deaths per 100,000 population (Hedegaard, Miniño, & Warner, 2020). One policy change that has the potential to decrease the amount of fatal drug overdoses is the legalization of overdose prevention programs (OPPs). According to McGinty et al. (2018), overdose prevention programs are "[...] places where people can legally use previously purchased opioids or other drugs under medical supervision" (p. 73). OPPs are effective at preventing overdose fatalities because they allow for a trained professional to respond to overdoses immediately (Leary, 2019). OPPs are one type of harm reduction initiative. As defined by the New Hampshire Harm Reduction Coalition (2020), "Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associates with drug use." This is a shift from traditional abstinence-based interventions that primarily focus on stopping drug use. Harm reduction in general, and OPPs in particular, have the potential to save lives and make real lasting changes in the Granite State.

History of Overdose Prevention Programs

The first OPP opened in 1986 in Bern, Switzerland, and since then, the idea of a hygienic and non-judgmental location for open drug use has spread to many countries struggling to respond to the harms caused by substance use (International Network of Drug Consumption Rooms, 2015). OPPs currently exist in Canada, Australia, and throughout continental Europe (European Monitoring Centre for Drugs and Drug Addiction, 2018). The first OPP in North America opened in 2003 in Vancouver, Canada and is called Insite. Insite's goals are "to reduce public injection drug use and the unsafe disposal of syringes in public spaces, the reduction of

overdoses and infectious disease risk, and improve access to healthcare services among [people who inject drugs]" (Wood et al., 2004).

The Canadian government granted Insite an exemption to federal law on the condition that its impacts be rigorously evaluated (Wood et al., 2004). In a study of fatal overdose statistics for the two years before and the two years after Insite's opening, Marshall, Milloy, Wood, Montaner, and Kerr (2011) found a 35% decrease in fatal overdoses within 500 meters of Insite after it was opened to the public, while in the rest of Vancouver the fatal overdose rate only dropped 9.3% over the same time period. Marshall et al. (2011) suggested that other cities with areas of concentration of fatal overdoses should consider OPPs. Over the years, Insite was granted multiple 1-year extensions of operation with varying levels of opposition, until securing permanent status with a victory in the Canadian Supreme Court in 2011, in which a unanimous decision stated that closing Insite would be unconstitutional as it would undermine the public's health and safety (MacDonald, 2011). Currently, Insite handles on average 10 overdoses per day and in over 15 years of operation has not had a single death occur within the facility (Stubbs, 2019). Case studies and meta-analyses conducted around the world post-OPP implementation support the conclusion that OPPs save lives (Bourque, Pijl, Mason, Manning, & Motz, 2019; Kennedy, Karamouzian, & Kerr, 2017; Kral & Davidson, 2017; Olding et al., 2020).

Fatal Overdoses in New Hampshire

While communities with access to OPPs around the world have experienced a decrease in the fatal drug overdoses, New Hampshire has continued to struggle to stop the deaths. The latest fatal overdose statistics released from the New Hampshire Drug Monitoring Initiative (2020) state that 411 people in NH were confirmed by toxicology report to have died from a drug overdose in 2019, and Strafford County had the highest overdose death rate per unit population

of all the counties in NH. According to Stopka et al. (2019), people who use drugs in New Hampshire are more vulnerable to overdose than those in other New England states due to: difficulty in accessing sterile equipment (ex. syringes), especially in more rural areas; emphasis on abstinence-only treatment and fewer programs that can handle complex comorbid medical and mental health needs; higher proportion of uninsured/underinsured residents unable to access care; limited access to naloxone (opioid overdose reversal agent); and limited trust in the Good Samaritan Law which is supposed to protect people from prosecution if they are discovered to be in possession of controlled substances because they called 911 to help someone who was overdosing. The multiple deficiencies in the way New Hampshire has responded to the harms related to substance misuse is beyond the scope of the current analysis. However, OPPs are able to address many of these service gaps and inefficiencies, especially if funded in such a way that ensures access to all. OPPs provide safety, cleanliness, advice, linkages to treatment, and immediate intervention in the event of an overdose (Jozaghi, 2020; Kennedy et al., 2017). Therefore, the operation of OPPs in New Hampshire would be expected to decrease the state's rate of drug overdose deaths per unit of population.

What is key for OPPs to be successful is working with the community and all stakeholders impacted before implementation so that any conflicts can be resolved prior to operation. It is imperative that all groups are consulted in a non-judgmental way and provided with accurate and up to date information about OPPs, and substance use in general. People who use drugs (and the people who would be using the OPP as a client) need to be involved in every step of the planning and evaluation process. Additionally, professional and peer staff need to be carefully recruited, more than adequately compensated financially, and supported emotionally in order to maintain a facility that meets clients' needs. Best practices for OPP operation and

maintenance need to be thoroughly explained and adhered to in order to ensure positive outcomes. OPPs need to be realized as a tangible tool in the fight against the harms suffered as a result of substance use. Do's and don'ts for OPPs can be illustrated from legal OPPs in other countries' trial and error processes as well as the studies available about OPPs operating illegally in the U.S.

There have been "underground" OPPs in the U.S. for several years, operating secretly but being of great benefit to clients and communities – even if everyone that benefits has not been aware of the sites' existence (ex. Kral & Davidson, 2017). However, the limitations and risks of operating illegally (such as staff members risking their licenses if discovered to be part of an OPP) have stopped the intervention from being widely replicated. New Hampshire needs to remove the barrier of illegality and shine light on what has been proven time and time again – people who use drugs will accept help if met with genuine care and concern targeted to self-determined goals of service (which typically reject non-users' preference for sobriety). The current prevailing practice of waiting until sobriety has been achieved before providing ongoing supportive services is not working. Instead, OPPs provide a space for drug use to happen in the light – for the very behavior at issue to be seen in its entirety – and then amended or amplified for the safest outcome possible. In OPPs, people survive, there is opportunity for a future. Without OPPs, fatal overdose risk continues to loom large in NH.

Prevalence of and Response to Fatal Drug Overdoses in NH

The NH Governor's Commission on Alcohol and Other Drugs was created by the state legislature in 2000 and updated in 2014, to include a specific focus on opioid use disorder, in response to the drastic increase in overdoses and other substance use related harms as fentanyl (a synthetic opioid magnitudes more powerful than heroin) flooded the state (New Hampshire

Department of Health and Human Services [NHDHHS], 2016). Since its inception, the Commission has focused its efforts on the prevention and treatment of substance use disorders and specifically on "identifying unmet needs [and] the resources required to reduce the incidence of alcohol and drug abuse in NH" (NHDHHS, 2016). The Commission has created and revised strategic action plans every few years with a stated commitment to evidence-based interventions. The Commission's latest strategic action plan (to cover the years 2019-2021) lists as its first objective "Reduce the number of lives lost to drug and alcohol use" with a target of decreasing the number of drug overdose deaths by 25% by 2021 (New Hampshire Governor's Commission on Alcohol and Other Drugs, 2019, p. 6). This focus specifically on reducing use and not on reducing harm is a weakness in the Commission's ability to address the current reality of substance misuse in New Hampshire. Progress can be seen in that there is a section on harm reduction interventions included for the first time in this latest action plan, supporting syringe service programs and availability of naloxone without a prescription, however as a whole the plan relies on abstinence-only initiatives.

Despite a multitude of abstinence-based interventions strengthening in funding, size, and accessibility throughout the state, as a result of the Commission and other advocacy groups, NH continues to lose residents to fatal drug overdoses. In numbers finalized by the New Hampshire Medical Examiner's Office, 411 people in NH died from a drug overdose in 2019 (New Hampshire Drug Monitoring Initiative [NHDMI], 2020). Strafford County had the highest fatal overdose rate per unit population at 4.38 deaths per 10,000 residents in 2019 (NHDMI, 2020). A desire to change or stop drug use continues to be seen as a prerequisite for recognition of need and intervention by the state. This pushes many of the people who currently use drugs out of the conversation and decreases their connection to resources.

In a recent mixed methods study of 76 people who use drugs in New Hampshire, Meier et al. (2020) found that 70% of the respondents reported overdosing at least once in their life. According to Meier et al. (2020), "There was near unanimous agreement that fentanyl was the cause of increased overdose rates in NH, mostly due to [fentanyl/fentanyl laced heroin] batch potency and variability making it 'pretty hard to make a safe dose for yourself' [as described by one participant, a 33 year old male]" (p. 4). Fentanyl was the substance involved in the majority of drug overdose deaths in New Hampshire according to the NHDMI report (2020). Respondents in Meier et al. (2020)'s study stated that fentanyl has been coming into the state from Massachusetts and NH communities near the I-95 interstate are at particular risk as the substance is trafficked north. There are no signs that the flow of fentanyl and fentanyl laced heroin will slow or stop entering New Hampshire. If the drugs are here, people will use them, and be at risk for overdose and other drug-related harms. Interventions to reduce these harms must include people who use drugs regardless of their individual readiness for sobriety. This requires a harm reduction approach for the improved public health of all.

Support and Evidence for Overdose Prevention Programs

Proponents of OPPs point out potential public health benefits of reduced HIV/HCV transmission rates, soft tissue infections, and overdose deaths for people utilizing the site, but also fewer episodes of injecting or smoking drugs in public and fewer used syringes and other drug paraphernalia being disposed of unsafely – which all benefit society as a whole (Kral & Davidson, 2017). Over a 2-year period, an illegal OPP served over 100 people who inject drugs in an undisclosed urban area of the U.S. by invitation only. Over 90% of participants anonymously answering questions reported that they would be injecting in public if the site was not available and almost 70% admitted that they typically dispose of drug paraphernalia in

unsafe ways, whereas at the site all equipment was disposed of safely (Kral & Davidson, 2017). Further updated research published about this illegal OPP has recently revealed that after 5 years of operation and 10,514 supervised injections, the site experienced 33 overdoses that were all successfully reversed by staff members with no transportations to outside medical facilities and no deaths (Kral, Lambdin, Wenger, & Davidson, 2020). Similar results were found in the year following an emergency declaration from the British Columbia, Canada Health Minister instructing OPPs be added to existing health care infrastructure; the 25 sites implemented throughout British Columbia received approximately 545,488 visits and successfully reversed over 2,500 overdoses, with no fatalities at any site (Pauly et al., 2020).

Pauly et al. (2020)'s qualitative study included interviews with staff and service users at 3 health care facilities that added OPPs in Victoria, British Columbia, Canada. Staff members reported being able to intervene early and utilize less invasive measures to reverse an overdose than if they had found someone blue and unconscious in the bathroom in full cardiac arrest, which many reported was a common occurrence before drug use was permitted to occur under supervision (Pauly et al., 2020). Overdose deaths are prevented not only because the person is not using alone, but also because OPPs provide the space and time for the user to test drugs and less "rushed" use, which is what often occurs in public and can result in overdose, infection, and ultimately death (Pauly et al., 2020). In addition, earlier intervention in overdoses led to less need for naloxone and ambulance/emergency response calls—which can be costly and labor intensive (Pauly et al., 2020).

While cost of these services is certainly a concern, several studies have shown an economic benefit to OPPs. According to a cost-benefit analysis by Irwin, Jozaghi, Bluthenthal, and Kral (2017), a single OPP with 13-booth capacity in San Francisco, CA would save the city

$3.5 million per year—for every dollar spent in start-up and maintenance costs, $2.33 would be saved in cost to the city due to averted deaths and infections that otherwise would have strained the health care system. Pinkerton (2010) performed a cost-benefit analysis of Insite in Vancouver and found that while it costs approximately $3 million Canadian to run Insite per year, the facility is saving almost $18 million Canadian in lifetime costs to the country's health care system because of an average 84 prevented HIV transmissions per year. A further five studies on the cost-effectiveness of Insite all found that this OPP is actually saving Canadian taxpayers money (Kennedy et al., 2017).

In their meta-analysis of 47 published research articles on OPPs, Kennedy et al. (2017) concluded that there is "consistent, methodologically sound evidence demonstrating the effectiveness of [OPPs] in achieving their primary health and public order objectives" (p. 177). According to Kennedy et al. (2017), studies from Canada, Australia, Germany, Spain, Denmark, and the Netherlands provided evidence that OPPs have: reduced the rate of fatal overdose (as staff are available to reverse an overdose immediately), increased use of sterile injection and cooking equipment (as needed items are made available free of charge for the user), increased connection to addiction treatment and other health and social services (as people who use drugs are able to form trusting relationships with medical and mental health professionals), decreased public drug use and publicly discarded drug-related equipment (as the OPP provides a place for people to go to use substances out of the public eye and dispose of items safely). Additionally, multiple studies found that the implementation of OPPs has not been associated with any change in the number or frequency of crimes reported in the neighborhood to police (Kennedy et al., 2017). Pauly et al. (2020)'s research also concluded that OPPs increased the potential for connecting people who use drugs to social services, with one staff member explaining, "I had

someone in the first week that we opened ask up for help and he was like, 'that's the first time I've ever felt comfortable asking for help in my entire life,' [...] I think people were just happy to feel welcomed in this space, while injecting, cause that's such a new idea, unfortunately" (p. 9). OPPs create an atmosphere in which people who use drugs are treated with respect and dignity. When this is achieved, changes become possible that improve public health outcomes for those directly and indirectly impacted by the OPP – everyone in our shared society.

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New Hampshire Hospital Association

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

February 18, 2021

SB 149 – Adopting Omnibus Legislation on Health and Human Services

Testimony

Good afternoon, Chairman, and members of the committee. My name is Paula Minnehan, Senior VP, State Government Relations with the New Hampshire Hospital Association (NHHA), representing all 26 of the state's community hospitals as well as all specialty hospitals.

The NHHA wishes to comment on two parts of SB 149: Part VI and Part VII. NHHA is supportive of both Parts. Part VI, regarding health facilities providing care in the declared emergency, is essentially codifying the NH Attorney General Opinion No. 2021-01 that was issued on April 22, 2020 to DHHS Commissioner Shibinette. In the interest of time, I am providing the link to the letter: https://www.doj.nh.gov/public-documents/documents/opinion-2020-01-immunity.pdf This provision, which is limited in scope to COVID-19, is very important to our hospitals that are providing care to patients during the pandemic.

Part VII is a provision that was included in a bill that Senator Giuda sponsored in 2020 (SB 676) but did not ultimately pass due to the timing of the pandemic impacting the legislative process. We appreciate this legislation being reintroduced this year. The Prescription Drug Monitoring Program (PDMP) is an essential tool for practitioners, defined as both prescribers and dispensers, to understand a patient's medication history which can assist them with proper treatments and prescriptions. We believe that the changes put forward in Part VII of SB 149 will only enhance a practitioner's ability to utilize this crucial information for patient care and safety.

Section I-a. of the bill is enabling legislation that will allow the Office of Professional Licensure and Certification to enter into agreements or contracts with health care entities to allow practitioners to query and retrieve PDMP information and to save it as part of a patient's electronic medical record. It will be up to the health care entity to ensure that only authorized users have access to PDMP information.

Section II-a of the bill was included to ensure that there is an opportunity for the patient to know that the PDMP could be utilized as part of the practitioner's process to review a patient's medication history. We believe that this language, consistent with other states' that we reviewed, would provide proper notice to the patient.

NHHA is in support of Parts VI and VII of SB 149 and we ask for your support as well. Thank you for the opportunity to provide our comments.

Hillsborough County Nursing Home

400 Mast Road
Goffstown, NH 03045

David J. Ross
Administrator
Telephone
(603) 627-5540

Fax
(603) 627-5547

February 18, 2021

NH Senate
Health and Human Services Committee
33 North State Street
Concord, NH 03301

RE: SB 149

Dear Honorable Senators,

My name is David Ross and I am the administrator of Hillsborough County Nursing Home. I am writing IN OPPOSITION of one of the provisions of SB 149, specifically **PART V Relative to establishing a rehabilitation bed pilot program.**

Inpatient Rehabilitation Facility (IRF) beds provide an acute level of rehabilitative services to a specific, targeted patient population. It is intended as an intensive therapeutic environment for use during a short-term, acute period of illness and recovery.

Skilled Nursing Facilities (SNF) provides a sub-acute level of rehabilitative services to a broader segment of the patient population. This environment is intended to provide a therapeutic environment during the post-acute phase of illness and recovery.

The level of care provided in these settings can be quite similar. The primary difference is typically the level of intensity, or duration, of service. The IRF patient must meet eligibility criteria that may include the ability to tolerate therapy services up to 5 hours per day. The SNF patient may not require the same level of intensity, and may achieve the same clinical outcome at a different pace.

It is my opinion that creating new IRF capacity without an assessment of the clinical justification for this growth will have significant financial implications for the State of N.H..

Since 2016 RSA 151:2, VI has enacted a moratorium on the increase in inpatient SNF and IRF beds specifically to address both capacity and the costs of providing care throughout the State.

VI. (a) No new license shall be issued for, and there shall be no increase in licensed capacity of, any nursing home, skilled nursing facility, intermediate care facility, or rehabilitation facility, including rehabilitation hospitals and facilities offering comprehensive rehabilitation services. This moratorium shall not apply to any rehabilitation facility whose sole purpose is to treat individuals for substance use disorder or mental health issues or to any continuing care facility for which a certificate of authority has been issued by the insurance commissioner pursuant to RSA 420-D:2.

(b) This moratorium shall not prohibit the relocation or transfer of beds to a nursing home, skilled nursing facility, or intermediate care facility; provided that the beds to be transferred or relocated were in existence as of July 1, 2016, that the receiving facility is located in the same county as the facility where those beds were located as of July 1, 2016, and that the action shall not reduce the number of Medicaid beds located in that county. This restriction on transfers shall not apply to any beds transferred from one entity to another before the effective date of this paragraph.

(c) This moratorium shall not prohibit the relocation or transfer of beds to a rehabilitation facility, including rehabilitation hospitals and facilities offering comprehensive rehabilitation services; provided that the beds to be transferred or relocated were licensed on July 1, 2016. This restriction on transfers shall not apply to any beds transferred from one entity to another before the effective date of this paragraph.

Although the level of care provided is quite similar in both Inpatient Rehabilitative Facilities and Skilled Nursing Facilities, the costs of providing care varies greatly. The average length of stay (ALOS) in an IRF ranges 12-14 days, the average cost is approximately $1,600 per day. Whereas the ALOS for a SNF ranges 21-30 days, however for about 1/3 of the cost per day, approximately $600/day.

It is essential to note that nearly all nursing facilities in N.H. operate as Skilled Nursing Facilities. The revenue received from short term rehabilitative services offsets the losses incurred from providing long term care services to Medicaid beneficiaries.

New Hampshire's nursing facilities cannot survive without Skilled Nursing Facility revenue. It is a hard reality.

Privately owned and operated facilities will be faced with either closure or increased Medicaid occupancy. This will have the cascading impact of overburdening the Medicaid line item for long term care services.

As a County owned and operated facility there are other funding sources available to my facility should Skilled Nursing Facility revenue disappear; specifically, the taxpayers.

The Long Term Care Services and Support system in New Hampshire is certainly not perfect, but it has done well to help shift care delivery to lower level providers which are able to provide appropriate care at a reduced cost. This has allowed for the expansion of care options throughout the state. This proposed legislation is a move backwards, not forward.

It is concerning that a hospital's "...length of stay during a consecutive 6 month period in the 12 months prior..." is the metric being used. The COVID pandemic has mandated that Nursing Facilities close to admissions. This mandate invariably creates the very conditions that are to be

used. It is understandable to observe that hospital length of stay has increased as a direct result of the required pandemic response in Skilled Nursing Facilities.

It is inappropriate to use this State of Emergency as a means to remove the moratorium and create new capacity.

If, in fact, this bill is intended to provide temporary relief to hospitals **during** this period of pandemic response, then I suggest that there are other measures, such as a time-limited Emergency Order during the declared State of Emergency, that may be an effective intervention.

Once these facilities are licensed, even for a "pilot program", they will be operational. This bill contains no mechanism to revoke licensure following the expiration of the pilot program. The associated costs and the cascading impact to the healthcare funding system in New Hampshire will remain.

I strongly object to this provision of SB 149 and request that greater consideration be given to utilization and need data before any action is taken.

Respectfully submitted,

David J. Ross, NHA

David J. Ross
Administrator
Dross@HCNH.Org

Kirsten Koch

From: Griffin Roberge
Sent: Thursday, February 18, 2021 6:12 PM
To: Kirsten Koch
Subject: Fwd: SB 149 follow up

Sent from my iPhone

Begin forwarded message:

> **From:** Marissa Chase <mchase@nhaj.org>
> **Date:** February 18, 2021 at 6:09:26 PM EST
> **To:** Jeb Bradley <Jeb.Bradley@leg.state.nh.us>, James Gray <James.Gray@leg.state.nh.us>, Becky Whitley <Becky.Whitley@leg.state.nh.us>, Kevin Avard <kevin.avard@leg.state.nh.us>, Tom Sherman <Tom.Sherman@leg.state.nh.us>
> **Cc:** Griffin Roberge <Griffin.Roberge@leg.state.nh.us>
> **Subject: SB 149 follow up**
>
> Senators,
>
> Thank you very much for indulging our concerns re: SB 149 at 5:30pm after a long day of hearings. My cell is (603) 854-9330, I would be happy to do my best to answer any questions you may have.
>
> Our concerns/proposed changes:
>
> Section III
>
> 318-B:45-a(VI) – prohibits civil liability for anything relating to the conduct on or off the premises.
>
> We respectfully request paragraph VI on page 6 lines 17-24 be eliminated. Think for example if a nurse gives a patient a syringe, watches them inject themselves, and lets them leave the facility and get into a car to drive impaired and kill someone on the way home. Under this statute neither the nurse, the facility, or the driver can be held liable for the wrongful death of the victim. The driver can still be arrested in this example because it happened off site of the facility, but the victim cannot though. What if the same scenario and the patient flips his car severing his spine and resulting in permanent paralysis? I am sure there are any number of scenarios, but the first one is probably the most foreseeable.
>
> Section VI
>
> Our concern is we construe this to be granting immunity to all health care providers and facilities for all activities during the Governor's state of emergency. It is our understanding that is not the intent of the proponents of this legislation. After speaking with John Friberg,

Steve Norton, Jim Monahan, and Kate Horgan yesterday it seems that in principle, we are all aligned that the intent should be to codify the Attorney General's opinion (link here).

To make that happen, we respectfully suggest an amendment to insert the same language from the AG's opinion found at the link above on page 5, 2nd full paragraph: "While a private actor may be entitled to assert immunity under RSA 21-P:41, it is limited to the performance of emergency management activities at the direction of the Governor [or another government agency]." to SB 149 at the top of page 11, after line 2.

Please do not hesitate to contact me if you have any concerns, would like me to schedule a call with stakeholders, or can be of any other assistance.

Thank you,
Marissa

Marissa Chase
Executive Director
New Hampshire Association for Justice
10 Ferry Street, #311
Concord, NH 03301
O 603.224.7077 I **F** 603.224.3256 I **C** 603.854.9330

Testimony
Senate Executive Departments & Administration Committee
SB 149 –relative to Automated pharmacy systems
February 18, 2021

Dear Senator Carson, Chair, and Members of the Committee:

My name is Robert Stout. I am a past president of the NH Board of Pharmacy, and I have been involved in community practice for over 40 years. I am the current president of the NH Pharmacists Association, and I am here today to testify for the Association in **opposition** to SB 149.

We have many questions regarding details in this proposed statute. Certainly, the wording of this bill with this much detail should appear in the rules section of the pharmacy code. I can list the questions and issues we have in this current language if the committee would like specific details. These are the kind of issues that are normally hashed out among stakeholders during public hearings. Also, the Board has specific authority to write rules regarding automated pharmacy systems. **RSA 318-5 (a) XII. Procedures for the use, documentation, security, maintenance, and monitoring of automated pharmacy systems, including the placement of automated pharmacy systems in long-term care facilities, hospices, and state or county correctional institutions, for the purposes of storage and dispensing of controlled and non-controlled prescription drugs.** The board has written rules regarding the use of automated pharmacy systems for use as emergency drug kits in facilities. They are in the rule book under Ph 705.02. I have attached those here for reference if needed. Automated emergency drug kits do not need DEA licenses for the location as the DEA has put the authority for regulation and oversight with the Boards of Pharmacy. Any rules related to automated dispensing systems should appear together for clarity. The authority above allows the Board to write rules not just for the application requested here but for automated systems in the future that may be located in clinics, hospitals or other locations where telemedicine or tele pharmacy are implemented. Having the regulations in rule allow for more timely changes to current practice as we have seen all practices evolve rather quickly during these trying times. To modify anything here would require we come back before you for any changes.

Some of the specific concerns in this bill as written are:

*does the supervision by a pharmacist require that pharmacist be licensed in NH?
*policies and procedures for security should be written by the board in the interest of the public not by the permit holder
*it states the pharmacist or designee shall authorize or deny access.
Who decides who is qualified to be a designee?
Is the designee a licensed person?
If the pharmacist is responsible do they designate and control the designee?
Are there controlled drugs in the ADS the designee has access to?
* Does the compliance unit at OPLC have authority to inspect the machines and their procedures?
* States the provider pharmacy shall control all operations of the system and approve the initial dose of a prescription order? So is this an E-kit for starter doses or a dispensing unit used to provide ongoing doses?

*states a licensed advanced pharmacy technician may perform these functions but by statute an LAPT can only work in the presence of a pharmacist so would not be allowed to independently restock a machine.

These are just a few of the questions we have, and many other stake holders may have other issues. I ask that you direct the Board of Pharmacy to commence rule making for the use of these dispensing machines. This would allow for clarity, input from all stakeholders and developing rules that will be easily understood for ADMs in all practice settings.
Thank you for your time.

Sincerely,

Robert Stout, RPh

NHPA President

I have attached the statutes regarding automated dispensing Systems, definition of a Licensed Advanced Pharmacy Technician and the current rules related to automated dispensing system for emergency drug kits.

XXXIII. "Licensed advanced pharmacy technician" means a person licensed by the board who:
(a) May perform all functions allowed by federal or state law and approved by the board, under the supervision of a licensed pharmacist who is physically on premises and holds an unrestricted license issued by the board.
(b) May conduct product verification, process refills, verify repackaging of drugs, and perform other pharmacist tasks not required to be completed by a licensed pharmacist.
(c) May perform duties allowed by either certified or registered pharmacy technicians.
(d) Shall not interpret or evaluate a prescription or drug order, verify a compounded drug, or counsel or advise individuals related to the clinical use of a medication.

RSA 318-5 (a) XII. Procedures for the use, documentation, security, maintenance, and monitoring of automated pharmacy systems, including the placement of automated pharmacy systems in long-term care facilities, hospices, and state or county correctional institutions, for the purposes of storage and dispensing of controlled and non-controlled prescription drugs.

Ph 705.02 (b) "Automated electronic emergency drug kit" means an automated medication storage system for the immediate administration to patients/residents upon the order of a practitioner as set forth in rules adopted under RSA 151.

(c) "Automated medication dispensing system" means a computerized drug storage device or cabinet designed for use in long term care facilities and other health care institutions.

(d) The placement of controlled substances in emergency drug kits in non-federally registered long term care facilities/specialized care facilities shall be deemed to be in compliance with the Comprehensive Drug Abuse Prevention and Control Act of 1970 provided that:

(1) Controlled substances shall be stored in the emergency drug kit as deemed necessary and jointly approved by the pharmacist in charge and the consultant pharmacist, medical director and the director of nursing services;

(2) The source from which controlled substances for emergency drug kits are obtained shall be a DEA registered hospital, clinic, pharmacy or practitioner;

(3) Controlled substances in emergency drug kits shall be limited to a maximum of 16 separate drug entities with not more than 8 single use containers of each drug entity;

(4) The emergency drug kit containing controlled substances shall be closed with a tamper proof seal and kept in a locked medication room, cart or closet;

(5) Only the director of nursing services, registered nurse on duty, licensed practical nurse on duty, pharmacist or practitioner shall have access to controlled substances stored in an emergency drug kit;

(6) Controlled substances in emergency drug kits shall be administered to patients only by authorized personnel and only as expressly authorized by an individual practitioner and in compliance with the provisions of 21 CFR 1306.11 and 1306.21;

(7) A usage record shall be contained in the emergency drug kit for each separate drug included which shall be completed by the nursing staff when using any controlled substance or substances from the kit;

(8) The pharmacist shall receive and file for 2 years a copy of all completed usage records;

(9) When the emergency drug kit is opened:

a. The pharmacist shall be notified by the facility within 24 hours; and

b. Shift counts shall be done by the nursing staff on all controlled substances until resealed by the consultant pharmacist;

(10) Shift counts of the controlled substances contained in the emergency kit shall not be required when the kit is sealed;

(11) The pharmacist shall check the controlled substances in the emergency drug kit at least monthly and so document inside the kit; and

(12) The placement of controlled substances in emergency drug kits shall be only upon the written authorization of the board of pharmacy.

(e) Automated electronic emergency drug kits shall meet the following conditions:

(1) Real time electronic communication to the provider pharmacy;

(2) For access, employ at least but not limited to:

a. Bio-Identification; and

b. Unique individualized password protections assigned by the provider pharmacy;

(3) Automatically generate notice to the provider pharmacy whenever the kit is accessed and provide at least the following information:

a. Name of individual accessing the kit;

b. Date and time the kit was accessed;

c. Name, strength and quantity of drug removed; and

d. Name of patient for whom the drug was administered; and

(4) Upon restocking the automated electronic emergency drug kit the following conditions shall be met:

a. The filling/restocking of an automated electronic emergency drug kit shall be performed by a licensed pharmacist, physician, physician assistant, advanced practice nurse, registered nurse and registered pharmacy technician.

(5) "Automated medication dispensing system" means a computerized drug storage device or cabinet designed for use in long term care facilities and other health care institutions. An automated medication dispensing system may be used as an electronic emergency drug kit provided the system performs operations or activities relative to the storage, packaging, dispensing and distribution of medications, and which tracks and maintains a record of transaction information;

(6) Automated emergency drug kits shall be allowed as set forth in rules adopted under RSA 151;

(7) Non-controlled legend drugs may be stored in the emergency drug kit in quantities deemed necessary and jointly approved by the pharmacist in charge of the provider pharmacy, consultant pharmacist, medical director and the director of nursing services; and

(8) The placement of controlled substances in automated electronic emergency drug kits in non-federally registered long term care facilities and other health care institutions shall be deemed to be in compliance with the Comprehensive Drug Abuse Prevention and Control Act of 1970 provided that:

a. Controlled substances shall be selected and stored in the automated electronic emergency drug kits in quantities deemed necessary and jointly approved by the pharmacist in charge and the consultant pharmacist, medical director and the director of nursing services;

b. Only the director of nursing services, registered nurse on duty, licensed practical nurse on duty, pharmacist, registered pharmacy technician or practitioner shall have access to controlled substances stored in an automated electronic emergency drug kit;

c. Controlled substances in automated electronic emergency drug kits shall be administered to patients only by authorized personnel and only as expressly authorized

by an individual practitioner and in compliance with the provisions of 21 CFR 1306.11 and 1306.21; and

d. When an automated electronic emergency drug kit is utilized, notification of usage shall be reported in accordance with Ph705.02 (e) (3).

SUPPORT ACCESS TO SEACOAST REHABILITATION CARE

SB 149

There is currently a moratorium on new rehabilitation care beds in New Hampshire. With the fastest growing number of older adults in the country, New Hampshire's 65-and-older population is expected to double in the next two decades. Due to a moratorium[1], there has not been an increase in post-acute care rehabilitation beds in New Hampshire for over 25 years and the need for rehabilitation services is on the rise as our residents grow older. Since it takes two – three years after receiving state approval to increase access to inpatient rehabilitation care, patients in need of care cannot afford to wait.

In the Seacoast region, there is a need for at least 23 new beds to provide adequate access to rehabilitation care. The Seacoast has nearly three times (11.2%) as many transfers to rehabilitation care when compared to the state with an expected growth of 188 percent over the next 10 years. With an increase in population, patients are being forced to stay six days longer in an acute care setting well beyond the Geometric Mean Length of Stay (GMLOS) – length of stay based on a patient's diagnosis-related group (DRG) – and recover away from their families and support network. Studies show these factors have a negative impact on patient outcomes and the overall cost of care.

Inpatient rehabilitation care provides unique and critical services treating patients who require hospital-level care with intensive rehabilitation to regain the level of function needed to heal – based on an individual's ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being – and transition home. These services may include physical therapy, occupational therapy, speech and language therapy, cognitive therapy, and social services.

INPATIENT REHABILITATION CARE MAY BE REQUIRED AS A RESULT OF DISEASE, INJURY, OR TREATMENT INCLUDING:

- Amputation
- Brain Injury
- Stroke
- Spinal Cord Injury
- Burns
- Neurological disorders
- Orthopedic injury and surgery
- Cardiac disease and surgery

Research shows the effectiveness in rehabilitation therapies stating that functional status – level of an individual's ability to perform normal daily activities – was a greater indicator of hospital readmissions (within 30 days) than comorbidities. Functional impairment may be an important and under-addressed factor in preventing readmissions for adults over the age of 65.[2]

INCREASING DEMAND

Ranked as the fastest growing population of older adults in the country, 20% of New Hampshire residents are age 60 and older[3]

Over the next two decades New Hampshire's 65-and-older population is **expected to double** [4]

Rise in demand for rehabilitation services, particularly physical therapy, among the increasing aging population [5]

When rehabilitation results in independent patient function, there is a **90 percent cost saving** compared with costs for custodial care and repeated hospitalizations. [6]

Inpatient rehabilitation hospitals are playing a **critical role for COVID-19 recovery** [7]

Studies show hospital-based inpatient rehabilitation programs improve patient recovery and **reduce preventable readmissions** [8]

In 2020, nearly 600 patients were **forced to travel 30 miles** from the Seacoast region to access to rehabilitation care

Seacoast hospitals average **an extra cost of $2,000** when holding a patient in an acute setting

Seacoast patients are being **forced to stay six days longer in an acute care** setting. Geographical alterations cause for prolonged, inappropriate in-hospital waiting [9]

Discharge delay or inappropriate in-hospital stay is associated with **increased risk of infection** and both short- and long-term mortality [10]

PILOT PROGRAM WILL BENEFIT PATIENTS AND THE SEACOAST REGION

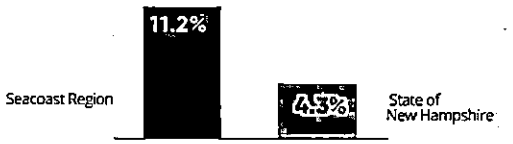
ADDRESSING THE NEED FOR REHABILITION CARE

GEOGRAPHIC NEED AND ACCESS

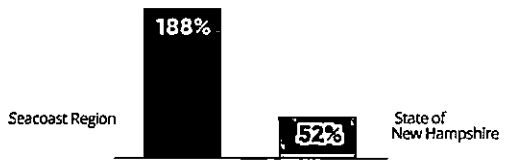
Inpatient rehabilitation beds are in high demand in the Seacoast. A recent analysis determined a need for 23 more rehabilitation beds in the region. With 322 beds statewide, the Seacoast has approximately **22 percent**[11] of the New Hampshire's population and only **10%** of total rehabilitation beds (33).

In the last 10 years, there have been almost three times **3x** (11.2%) as many transfers from acute to rehabilitation care in the Seacoast when compared to the state (4.3%). Additionally, the Seacoast projects a 188 percent growth for transfers to rehabilitation care over the next 10 years while the state estimates a 52 percent growth.

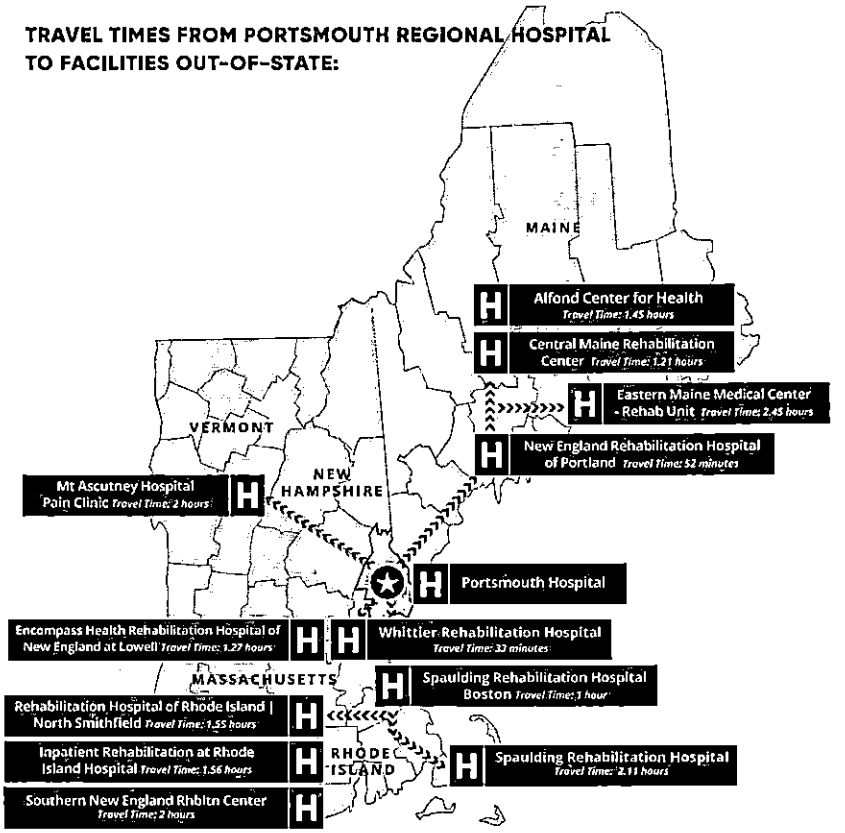
PERCENTAGE OF TRANSFERS FROM ACUTE TO REHABILITATION CARE OVER THE PAST 10 YEARS



PROJECTED PERCENTAGE GROWTH OF TRANSFERS OVER THE NEXT 10 YEARS



TRAVEL TIMES FROM PORTSMOUTH REGIONAL HOSPITAL TO FACILITIES OUT-OF-STATE:



From Portsmouth Regional Hospital alone, nearly 600 patients in the Seacoast region receive care far from their community, traveling more than 30 minutes to receive inpatient rehabilitation services. **12 percent of patients are forced out-of-state to receive access to rehabilitation care** away from their family and support network. Studies show this increases costs, increases readmission rates and has a negative impact on outcomes. Family participation is critical to success of patient care at home.

IT'S TIME TO EXPAND ACCESS TO INPATIENT REHABILITATION FOR THE SEACOAST REGION

Optimizing the post-acute rehabilitation services provided and expanding access to more patients who can benefit from this intense level of services reduces chances of readmissions, helps keep patients within the health system, and ultimately helps patients reach their recovery goals faster and drive better patient care.

The proposed Pilot program (SB 149) would allow acute care and critical access hospitals for a limited period of time to apply for the addition of new rehabilitation beds. In order to apply, a hospital would have to certify a Geometric Mean Length of Stay of 110% over a four-month period. After the hospital has provided, and DHHS has verified with the Centers for Medicare and Medicaid Services (CMS), the hospital's 110% GMLOS percentage, it can then file an application with the Department of Health and Human Services for new beds within its facility. The pilot program sunsets on June 30, 2023 if the legislature affirmatively choses to do so; if the legislature does not, it ends on June 30, 2025.

Content developed by Portsmouth Regional Hospital, Parkland Medical Center and Frisbie Memorial Hospital.

1 Title 11 - HOSPITALS AND SANITARIA (§§ 151:1 — 151-I:2), New Hampshire Revised Statutes
2 "Reducing Hospital Readmission: Current Strategies and Future Directions," US National Library of Medicine, 2015
3 "New Hampshire State Plan on Aging," New Hampshire Department of Health and Human Services, Committee on Aging, 2019
4 (2018, February 14) "New Hampshire's aging population poses serious challenge," Seacoast Online
5 "Physical Therapists" US Bureau of Labor Statistics, 2019
6 "Resources for Optimal Care of the Injured Patient," Committee on Trauma, American College of Surgeons, 2014
7 (2020, November 10) "Inpatient Rehab Hospitals Play Critical Role In COVID-19 Recovery," HealthLeaders
8 (2020, June 03) "Reducing Readmission Rates Through Rehabilitation," HealthLeaders
9 "Prolonged patients' In-Hospital Waiting Period after discharge eligibility is associated with increased risk of infection, morbidity and mortality: a retrospective cohort analysis," US National Library of Medicine, 2015
10 "Prolonged patients' In-Hospital Waiting Period after discharge eligibility is associated with increased risk of infection, morbidity and mortality: a retrospective cohort analysis," US National Library of Medicine, 2015
11 "2019 Population Estimates of New Hampshire Cities and Towns," New Hampshire Office of Strategic Initiatives, 2020

SB149 section 3

Asma Elhuni <asma@radnh.org>

Tue 2/23/2021 2:59 AM

To: Jeb Bradley <Jeb.Bradley@leg.state.nh.us>; James Gray <James.Gray@leg.state.nh.us>; Tom Sherman <Tom.Sherman@leg.state.nh.us>; Becky Whitley <Becky.Whitley@leg.state.nh.us>; Kevin Avard <Kevin.Avard@leg.state.nh.us>; Kirsten Koch <kirsten.koch@leg.state.nh.us>

1 attachments (263 KB)

21.02.18 Mike Testimony on New Hampshire SB-149-FN.pdf;

Dear Committee Members,

My name is Asma Elhuni and I am the Movement Politics Director for Rights and Democracy. On Feb 18th I spoke to SB 149 section 3. I read from our coalition partner letter. I wanted to share that letter with you to look at for your convenience. I do hope for the sake of the many family members who are now living without their loved ones because of overdose and the many more deaths that will occur that doctors are watching from afar while not being able to help until you give them the ability to through this bill, that you pass section 3 of SB 149.

--

Asma Elhuni
Movement Politics Director
Rights and Democracy NH
asma@radnh.org

"*Collective Liberation or No Liberation*"

NATIONAL
HARM REDUCTION
COALITION

Testimony at Public Hearing
Senate Health and Human Services Committee

Thursday, February 18th, 2021
Support for SB 149-FN

Good afternoon Chair Jeb Bradley, Vice Chair James Gray, and thank you to the entire Senate Health and Human Services Committee for this opportunity to testify. My name is Mike Selick and I am the Associate Director of Capacity Building for the National Harm Reduction Coalition, a national organization that promotes the rights, dignity, and health of people who use drugs. I am responsible for supporting harm reduction programs in the North Eastern region of the country.

As you are all well aware, we are currently dealing with a crisis of overdose deaths in this country and in this State. Overdose has been the leading cause of accidental death in New Hampshire for many years. The New Hampshire overdose rate of 33.1 per 100,000 in 2018 is significantly higher than the national overdose death rate of 20.7 per 100,000.[1] In fact, New Hampshire had the unfortunate honor of being the state with the 6th highest overdose rate in the country.[2] These are needless deaths and most if not all could have been prevented with harm reduction interventions such as the ones outlined in SB 149-FN.

National Harm Reduction Coalition supports lifesaving interventions to prevent overdose deaths such as naloxone distribution, syringe service programming, access to Medications for Opioid Use Disorder (MOUD), and Overdose Prevention Programs. The issue of Opioid Prevention Programs may have become politically charged in the use, but internationally this is a very well-studied, common, and safe intervention for people who are struggling with their drug use. There are more than 165 Overdose Prevention Programs operating around the world and not a single death has occurred at any of them.

Overdose Prevention Programs do much more than just prevent overdose death. They are controlled hygienic settings where people have access to trained staff that provide a wide array of services including but not limited to base health care needs, access to a primary care doctor, counseling, mental healthy support, Medications for Opioid Use Disorder (MOUD) which is the gold standard for reducing opioid overdose deaths., as well as drug treatment and many other services that can help provide the supports a person needs to stabilize their life.

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[1] https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/new-hampshire-opioid-involved-deaths-related-harms

[2] Hedegaard H, Miniño AM, Warner M. Drug Overdose Deaths in the United States, 1999–2018.pdf icon NCHS Data Brief, no 356. Hyattsville, MD: National Center for Health Statistics. 2020.

Numerous peer-reviewed scientific studies have proven the positive impacts of Overdose Prevention Programs. These benefits include:

- Increased access to drug treatment, especially among people who distrust the treatment system and are unlikely to seek treatment on their own. [3]
- Reduced public disorder, reduced public injecting, and increased public safety. [4]
- Reduced HIV and viral hepatitis risk behavior (e.g. syringe and other injection equipment sharing, unsafe sex). [5]
- Reduced bacterial infections (e.g. staph infection, endocarditis). [6]
- Reduced overdose deaths. [7]
- Cost savings resulting from reduced disease, overdose, and need for emergency medical services and increased preventive healthcare and drug treatment utilization. [8]

In addition, research has shown that Overdose Prevention Programs do NOT:

- Increase drug use in the surrounding community. [9]

---

[3] Tyndall, M., Kerr, T., Zhang, R., King, E., Montaner, J., & Wood, E. (2006). Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. *Drug and Alcohol Dependence,* 193-198.; Wood et al. (2006). Service uptake and characteristics of injection drug users utilizing North America's first medically supervised injection facility. *American Journal of Public Health,* 96: 770-773.; Wood, E., Tyndall, M., Zhang, R., Stoltz, J., Montaner, J., & Kerr, T. (2006). Attendance at supervised injecting facilities and use of detoxification services. *New England Journal of Medicine, 354*(23).

[4] Boyd et al. (2008). Public order and supervised injection facilities: Vancouver's sis. *Health Canada,* 29.; DeBeck et al. (2008). Police and public health partnerships: evidence from the evaluation of Vancouver's supervised injection facility. *Substance Abuse Treatment, Prevention and Policy, 3:1-5.*

[5] Kerr, et al. (2005). Safer injecting facility use and syringe sharing among injection drug users. *Lancet,* 366: 316-318.; Kerr et al. (2007). The role of safer injection facilities in the response to HIV/AIDS among injection drug users. *Current HIV/AIDS Reports,* 4: 158-164.; Milloy et al. (2009). Emerging role of supervised injecting facilities in human immunodeficiency virus prevention. *Addiction,* 104: 620-621.

[6] Lloyd-Smith et al. (2008). Risk factors for developing a cutaneous injection-related infection among injection drug users: a cohort study. *BMC Public Health,* 8: 405.; Lloyd-Smith et al. (2009). Determinants of cutaneous injection-related infection care at a supervised injecting facility. *Annals of Epidemiology,* 19: 404-409.

[7] Marshall et al. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *Lancet,* 377: 1429-1437.; Kerr et al. (2007). A micro-environmental intervention to reduce harms associated with drug-related overdose, evidence from the evaluation of Vancouver's safer injection facility. *International Journal of Drug Policy,* 18: 37-45.; Milloy et al. (2008). Non-fatal overdose among a cohort of acting injection drug users recruited from a supervised injection facility. *American Journal of Drug and Alcohol Abuse,* 34: 499-509.; Milloy, M.-J., Kerr, T., Tyndall, M., Montaner, J., & Wood, E. (2008). Estimated drug overdose deaths averted by North America's first medically-supervised safer injection facility. *PLOS ONE, 3*(10), 1-6.

[8] Andresen, M., & Boyd, N. (2010). A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility. *International Journal of Drug Policy,* 70-76.; Bayoumi et al. (2008). Cost-effectiveness of the Vancouver safe injection facility. *Candian Medical Association Journal.*

[9] Kerr, T., Stoltz, J., Tyndall, M., Li, K., Zhang, R., Montaner, J., & Wood, E. (2006). Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study. *British Medical Journal,* 220-222.

- Increase initiation into injection drug use. [10]
- Increase drug-related crime. [11]
- Attract new drug users to the area. [12]

Overdose Prevention Programs are a vital part of a comprehensive public health approach to reducing the harms of drug use. They cannot prevent all risky drug use or related harms. However, evidence demonstrates that they can be remarkably effective and cost-saving and improve the lives of people who inject drugs and the safety and health of our communities. National Harm Reduction Coalition urges you to pass SB 149-FN so that New Hampshire can be a leader in reducing overdose deaths and saving the lives of our neighbors, our friends, and our families.

Sincerely,

Mike Selick, MSW
On behalf of National Harm Reduction Coalition
Phone: (201) 755-3474
Email: Selick@HarmReduction.org

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[10] Kerr, T., Tyndall, M., Zhang, R., Lai, C., Montaner, J., & Wood, E. (2007). Circumstances of first injection among illicit drug users accessing a medically supervised safer injection facility. *American Journal of Public Health, 97*(7), 1228-1230.; Kerr, T., Stoltz, J., Tyndall, M., Li, K., Zhang, R., Montaner, J., & Wood, E. (2006). Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study. *British Medical Journal*, 220-222.

[11] Wood et al. (2006). Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. *Substance Abuse Treatment, Prevention and Policy,* 1: 1-4.

[12] Wood, E., Kerr , T., Small, W., Li, K., Marsh, D., Montaner, J., & Tyndall, M. (2004). Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection users. *Medical Association Journal*, 731-734.

BUSINESS & INDUSTRY ASSOCIATION
New Hampshire's Statewide
Chamber of Commerce

Testimony of David Creer
Business & Industry Association
SB 149
Senate Health and Human Services Committee
February 18, 2021

Dear Members of the Senate Health and Human Services Committee, my name is David Creer and I'm director of public policy for the Business and Industry Association (BIA), New Hampshire's statewide chamber of commerce and leading business advocate. BIA represents more than 400 members in a variety of industries. Member firms employ 89,000 people throughout the state, which represents one in seven private workforce jobs, and contribute $4.5 billion annually to the state's economy.

BIA supports Part VI of SB 149, adopting omnibus legislation on health and human services. This section of the bill clarifies that health care facilities are deemed to have been operating under emergency management functions when complying with the emergency orders related to COVID-19. This will protect them from lawsuits from any reduced standard of care that was necessary to help the state manage coronavirus infections. Health care facilities should not face threat of lawsuits while trying to reduce the impact of the ongoing coronavirus pandemic.

Thank you for your consideration.

THE NH PROVIDERS ASSOCIATION

Representing Alcohol & Other Drug Service Providers in New Hampshire

February 18, 2021

Senator Jeb Bradley, Chair
Senate Health & Human Services Committee
State House Room 100
Concord NH 03301

Via email: Jeb.Bradley@leg.state.nh.us
James.Gray@leg.state.nh.us
kevin.avard@leg.state.nh.us
tom.sherman@leg.state.nh.us
becky.whitley@leg.state.nh.us
kirsten.koch@leg.state.nh.us

RE: SB 149 – adopting omnibus legislation on health and human services – Part III

Dear Chairman Bradley and members of the Committee:
The NH Providers Association, representing providers of substance use prevention, treatment and recovery services, wishes to register its **support** for Part III of SB 149, establishing a harm reduction and overdose prevention program in the department of health and human services.

NHPA sees the value of evidence-based harm reduction strategies in our united effort to prevent overdose deaths. We would like to see the establishment of a study commission to explore bringing an overdose prevention program to New Hampshire, with a representative from NHPA on that commission. We would also like to see academic institutions in our state to consider establishing pilot programs in this area.

We understand that these ideas are new, but if we look to other countries that have reduced their overdose rates, we see the efficacy of overdose prevention programs and we see models for programs here. We must see if these programs would help New Hampshire to continue to reduce overdose rates. We have seen overdose rates go down with the availability of naloxone and the expansion and funding of syringe services programs and other harm reduction programs. We have embraced low barrier access to medication-assisted recovery and telemedicine. All of these efforts were considered new and pioneering once but are now proven and successful.

New Hampshire has been employing evidence-based harm reduction strategies for several years and it seems to be working. Now we must look to another harm reduction strategy in an attempt to stop preventable overdose deaths.

Thank you for your consideration.

Sincerely,

Kerran Vigroux
Executive Director

Ryan Fowler, Chair
NHPA Policy Committee

Voting Sheets

Senate Health and Human Services Committee

EXECUTIVE SESSION RECORD

2021-2022 Session

Bill # SB149-FN

Hearing Date: 2/18/21

Executive Session Date: 3/10/21

Motion: OTP **Vote:** No Vote

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X				
Sen. Gray, Vice Chair	X	X			
Sen. Avard	X				
Sen. Sherman	X				
Sen. Whitley	X				

Motion: Amendment 0682s **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X	X		X	
Sen. Avard	X		X	X	
Sen. Sherman	X			X	
Sen. Whitley	X			X	

Motion: OTPA **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard	X			X	
Sen. Sherman	X	X		X	
Sen. Whitley	X		X	X	

Motion: Consent Calendar **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard	X			X	
Sen. Sherman	X	X		X	
Sen. Whitley	X		X	X	

Reported out by: Sen. Gray

Notes:

Senate Finance Committee

EXECUTIVE SESSION

Bill #SB 149-FN

Hearing date: N/A

Executive session date: 03/30/21

Motion of: OTP/A VOTE: 7-0

		Made by Senator:	Seconded by Senator:	Reported by Senator:
	Daniels	☐	☐	☐
	Reagan	☐	☑	☐
	Giuda	☑	☐	☐
	Rosenwald	☑	☑	☑
	D'Allesandro	☐	☐	☐
	Morse	☐	☐	☐
	Hennessey	☐	☐	☐

Motion of: Move Amdmt #1049s VOTE: 4-3 Reagan Rosenwald D'Allesandro

		Made by Senator:	Seconded by Senator:	Reported by Senator:
	Daniels	☐	☐	☐
	Reagan	☐	☐	☐
	Giuda	☑	☐	☐
	Rosenwald	☐	☐	☐
	D'Allesandro	☐	☐	☐
	Morse	☐	☐	☐
	Hennessey	☐	☑	☐

Committee Member	*Present*	*Yes*	*No*	*Reported out by*
Senator Daniels, Chairman	☑	☑	☐	☑
Senator Reagan, Vice-Chair	☑	☑	☐	☐
Senator Giuda	☑	☑	☐	☐
Senator Hennessey	☑	☑	☐	☐
Senator Rosenwald	☑	☑	☐	☑
Senator Morse	☑	☑	☐	☐
Senator D'Allesandro	☑	☑	☐	☐

Amendments: _____

Notes: _____

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE
FOR THE CONSENT CALENDAR

Wednesday, March 10, 2021

THE COMMITTEE ON Health and Human Services

to which was referred **SB 149-FN**

AN ACT adopting omnibus legislation on health and human services.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 5-0

AMENDMENT # 0788s

Senator James Gray
For the Committee

This bill, as amended, adopts omnibus legislation with four parts. The first part of the bill clarifies the Medicaid spend-down requirements and requires a report to the oversight committee on health and human services. This part of the bill provides clarification for individuals who utilize the Medicaid program. The second part of the bill establishes a harm reduction and overdose prevention program in the department of health and human services. This part of the bill assists in resolving the opioid crisis. The third part of the bill is relative to automated pharmacy systems. This part of the bill regulates and allows for the use of automated pharmacy systems used by long-term care facilities, hospices, or state correctional institutions. The COVID-19 pandemic has drastically increased the need for automated pharmacy systems. The fourth part of the bill is relative to health facilities providing care in the declared emergency. This part of the bill establishes employees, agents and volunteers of health facilities engaged in, preparing for and/or carrying out "emergency management" functions when complying with any executive order, agency order, or rule shall not be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule.

Kirsten Koch 271-3266

FOR THE CONSENT CALENDAR

HEALTH AND HUMAN SERVICES

SB 149-FN, adopting omnibus legislation on health and human services.
Ought to Pass with Amendment, Vote 5-0.
Senator James Gray for the committee.

This bill, as amended, adopts omnibus legislation with four parts. The first part of the bill clarifies the Medicaid spend-down requirements and requires a report to the oversight committee on health and human services. This part of the bill provides clarification for individuals who utilize the Medicaid program. The second part of the bill establishes a harm reduction and overdose prevention program in the department of health and human services. This part of the bill assists in resolving the opioid crisis. The third part of the bill is relative to automated pharmacy systems. This part of the bill regulates and allows for the use of automated pharmacy systems used by long-term care facilities, hospices, or state correctional institutions. The COVID-19 pandemic has drastically increased the need for automated pharmacy systems. The fourth part of the bill is relative to health facilities providing care in the declared emergency. This part of the bill establishes employees, agents and volunteers of health facilities engaged in, preparing for and/or carrying out "emergency management" functions when complying with any executive order, agency order, or rule shall not be liable for the death of or injury to persons, or for damage to property, as a result of such compliance or reasonable attempts to comply with such an emergency order or rule.

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Tuesday, March 30, 2021

THE COMMITTEE ON Finance

to which was referred **SB 149-FN**

AN ACT adopting omnibus legislation on health and human services.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 7-0

AMENDMENT # 1055s

Senator Cindy Rosenwald
For the Committee

Deb Martone 271-4980

General Court of New Hampshire - Bill Status System

Docket of SB149

Docket Abbreviations

Bill Title: adopting omnibus legislation on health and human services.

Official Docket of **SB149.**:

Date	Body	Description
2/9/2021	S	**Introduced** 02/04/2021 and Referred to Health and Human Services; **SJ 4**
2/11/2021	S	Remote **Hearing:** 02/18/2021, 02:00 pm; Links to join the hearing can be found in the Senate Calendar; **SC 11**
3/10/2021	S	Committee Report: Ought to Pass with Amendment **#2021-0788s**, 03/18/2021; Vote 5-0; CC; **SC 15**
3/18/2021	S	Committee Amendment **#2021-0788s**, **RC** 23Y-1N, AA; 03/18/2021; **SJ 8**
3/18/2021	S	**Ought to Pass with Amendment** 2021-0788s, **RC** 23Y-1N, MA; Refer to Finance Rule 4-5; 03/18/2021; **SJ 8**
3/30/2021	S	Committee Report: Ought to Pass with Amendment **#2021-1055s**, 04/01/2021; **SC 17A**
4/1/2021	S	Committee Amendment **#2021-1055s**, **RC** 13Y-11N, AA; 04/01/2021; **SJ 10**
4/1/2021	S	**Ought to Pass with Amendment** 2021-1055s, **RC** 24Y-0N, MA; OT3rdg; 04/01/2021; **SJ 10**
4/13/2021	H	Introduced (in recess of) 04/09/2021 and referred to Health, Human Services and Elderly Affairs **HJ 7** P. 100
4/20/2021	H	Public Hearing: 05/03/2021 09:00 am Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/91978983838 / Executive session on pending legislation may be held throughout the day (time permitting) from the time the committee is initially convened.
5/5/2021	H	Executive Session: 05/17/2021 09:00 am Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/95933161404
5/24/2021	H	Majority Committee Report: Ought to Pass with Amendment **#2021-1295h** (Vote 18-2; RC) **HC 26** P. 24
5/24/2021	H	Minority Committee Report: Inexpedient to Legislate
6/3/2021	H	Amendment **#2021-1295h**: AA VV 06/03/2021
6/3/2021	H	FLAM **#2021-1767h** (Rep. Cushman): AF DV 146-230 06/03/2021
6/3/2021	H	**Ought to Pass with Amendment** 2021-1295h: MA DV 255-121 06/03/2021
6/10/2021	S	Sen. Bradley Moved to Concur with the House Amendment, MA, VV; 06/10/2021; **SJ 19**
7/15/2021	S	Enrolled Adopted, VV, (In recess 06/24/2021); **SJ 20**
7/15/2021	H	Enrolled (in recess of) 06/24/2021

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB 149-FN **Senate Committee:** FINANCE -2ND COMMITTEE

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee

X All Calendar Notices

___ Hearing Sign-up sheet(s)

___ Prepared testimony, presentations, & other submissions handed in at the public hearing

___ Hearing Report

X Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

X - amendment # 1049s ___ - amendment #_____

X - amendment # 1055s ___ - amendment #_____

X Executive Session Sheet

X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment #_____ ___ - amendment #_____

___ - amendment #_____ ___ - amendment #_____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):

___ Enrolled Bill Amendment(s)

___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

___ as amended by the senate ___ as amended by the house

___ final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Deb Martone 07/20/21

Committee Aide **Date**

Senate Clerk's Office _____

Senate Inventory Checklist for Archives

Bill Number: SB 149-FN **Senate Committee:** HHS

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee

X All Calendar Notices

X Hearing Sign-up sheet(s)

X Prepared testimony, presentations, & other submissions handed in at the public hearing

X Hearing Report

X Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

___ - amendment # _____ X - amendment # 2021-0788s

___ - amendment # _____ X - amendment # 2021-0682s Bradley/Gray

X Executive Session Sheet

X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment # _____ ___ - amendment # _____

___ - amendment # _____ ___ - amendment # _____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):

___ Enrolled Bill Amendment(s)

___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

X as amended by the senate ___ as amended by the house

X final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Kirsten Koch 7/26/21

Committee Aide **Date**

Senate Clerk's Office _____