MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Sixth Session
May 23, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 1:33 p.m. on Monday, May 23, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/76th2011/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman Steven Brooks
Assemblyman Richard Carrillo
Assemblywoman Lucy Flores
Assemblyman Jason Frierson
Assemblyman Pete Goicoechea
Assemblyman John Hambrick
Assemblyman Scott Hammond
Assemblyman Pete Livermore
Assemblyman Mark Sherwood
Assemblywoman Debbie Smith

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Sheila Leslie, Washoe County Senatorial District No. 1

Minutes ID: 1287

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Linda Whimple, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Lynn O'Mara, M.B.A., State Health Information Technology Coordinator, Office of Health Information Technology, Department of Health and Human Services
Amber Joiner, Director of Governmental Relations, Nevada State Medical Association
Janine Hansen, State President, Nevada Eagle Forum
Lynn Chapman, State Vice President, Nevada Families Association
Rebecca Gasca, Legislative and Policy Director, American Civil Liberties Union of Nevada

Chair Mastroluca:
[Roll was called.] We have two bills that we are hearing today; Senate Bill 43 (1st Reprint) and Senate Bill 113 (1st Reprint). Let us get started with Senate Bill 43 (R1), which makes changes relating to electronic health records.

Good afternoon, Ms. O'Mara.

Senate Bill 43 (1st Reprint): Makes various changes relating to electronic health records. (BDR 40-443)

Lynn O'Mara, M.B.A., State Health Information Technology Coordinator, Office of Health Information Technology, Department of Health and Human Services:
I am here to present to you Senate Bill 43 (R1). There are a few qualifying and clarifying statements I would like to get on the record that we also made to the Senate Committee on Health and Human Services.

First of all, there is no general fund associated with this particular bill. It is completely funded with stimulus funds, and it is not part of the health care reform legislation that has gone through. The funding for this particular project is fully obligated and we do not expect any interruptions between now and the end of the project period, which is February of 2014. Something that was of concern to the Senate committee was that this puts an emphasis on the rural areas to ensure that they are included in all of the activities and efforts that are going along with this particular project. Again, it was of great concern on the Senate side, and we wanted to reassure the Assembly as well that it will be given close attention.

This particular bill attempts to meet the requirements of the stimulus fund portion of the American Recovery and Reinvestment Act of 2009 (ARRA) addressing the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), and that is the implementation of electronic health records as well as the health information exchange required now in order for those records to be able to communicate with each other and to exchange information. It supports the terms and conditions of the State Health Information Exchange Cooperative Agreement that Nevada has through the U.S. Department of Health and Human Services (HHS) to establish this statewide health information exchange system (HIE). It does align with the state health information technology strategic and operational plan that is a requirement of both at the federal statutory level as well as part of the State Health Information Exchange Cooperative Agreement. We just received approval for the state plan late last week.

It reflects the recommendations made by the Health Information Technology Blue Ribbon Task Force, which was a very diverse group of stakeholder leaders and professionals who made contributions to the state plan and reviewed what would work best for Nevada.

With that, Madam Chair, I am not quite sure how you would like me to proceed. Would you like me to walk through the provisions of the plan? There was some background information presented. I am not sure what the pleasure of the Committee is.

Chair Mastroluca:
If you would like to go through the background information—we do not need to go detail by detail—but if you would give us an overview on how this works to help us get in our mind the difference between this and the other information plan.

Lynn O'Mara:
I would be happy to do that.

There was a handout that was submitted on Friday afternoon entitled "ARRA HITECH Act and Nevada" (Exhibit C). This gives you background information regarding the HITECH Act and what the stimulus funds are meant to be used for, as well as some additional background information on the progress of what we are doing and how this ties in with Senate Bill 43 (R1).

As I said, this HITECH Act was part of ARRA and its purpose is to enable improving health care quality and efficiency by having all of the electronic information regarding someone's medical care, and then having providers, primarily doctors and hospitals, able to exchange that information. This particular project also supports another provision under the HITECH Act that the Division of Health Care Financing and Policy is working on and overseeing that we collaborate and coordinate with, and that is there are financial incentives for certain eligible providers to receive dollars if they choose to adopt electronic health records. However, in order to get the incentives they also have to have the component of being able to do health information exchange and to be able to do it securely and safely. That is what this project is focused on.

Page 3 of the handout (Exhibit C) talks about the four different kinds of funding that the HITECH Act allocated monies for. As I said, these have all been obligated. We have already been working with the Office of the National Coordinator for Health Information Technology (ONC) to ensure that these funds are safe and we will be allowed to use them through the project period, which again ends February 2014.

Page 4 shows the four key parts that I will be talking about, and that have to coordinate and play together in order for this to be accomplished, as I have been expressing both to our task force as well as to our federal grantor. Nevada has one shot to do this, so we want to be sure that we do it in the most correct way we can that will be effective for everyone. The ultimate stakeholders in this are you, me, and all Nevadans, so it is very important that we do this in a very deliberate and coordinated manner.

Page 5 gives us an overview of the actual State Health Information Exchange Cooperative Agreement that we have. We do not have just a grant. This funding is being managed much more like a contract, and as such, there are a lot more reporting requirements. We have our reporting requirements as well as additional ones specific to this project. There is a match requirement for the $6,133,426 we received; however, the state has already met its match through a contingency fund that we received two years ago and we were allowed to use $165,000 of that as the state's contribution. There will be no more required from the state. There are other sources we will be drawing from.

Page 6 is more information about the project. It is targeted funding. It can only be used for very specific activities as part of the project. We do have the mandatory coordination with Medicaid, and we also have mandatory coordination with other ARRA projects in related ARRA-funded programs. There are some broadband activities that we are coordinating with as a result, and also some public health activities that we also are collaborating on and making sure that everything works together.

As part of health care reform, we are being encouraged to also support those efforts in whatever way we can. In particular, we see some overlap where we can support the health insurance exchange that has been proposed under Senate Bill 440. As I already stated, our state health information technology plan was approved at the end of last week, and S.B. 43 (R1) supports and aligns with it.

On page 8 you can see a little more on the financial incentive payments for Medicaid. It is for eligible providers, chiefly primary care physicians as well as hospitals, in order to be able to exchange this information. While that will be the focus initially, eventually it would be to everyone's advantage to have all providers and all hospitals able to exchange information. This will be a much more comprehensive thing, and that is what the statewide system for Nevada will be established to accomplish.

As I mentioned, we did have a health information technology task force of diverse stakeholders to help make recommendations that were incorporated into the state health information technology plan. Those recommendations also led to some of the provisions that are in S.B. 43 (R1). The task force did have bylaws. It met under open meeting law, and as often as we could we used the legislature's facilities so we could also have those meetings broadcast over the Internet. That generated a lot of good feedback for those who could not attend the meetings in person.

We had a lot of support and help from many groups. I would like to acknowledge the University of Nevada, Reno College of Business. We had both faculty and MBA students who helped us with research and analysis so that the task force could make what they believed were the best decisions.

Since this is ARRA funding, there will be some jobs associated with it. We do believe that there will be information technology professionals needed, many more than we have right now, so we are looking at that.

We have been coordinating with the Nevada Broadband Task Force as well as with the broadband grants that have been given to Nevada. We know that the rural areas are going to have the greatest need, so we want to be sure that we will be working with them to address it. My office has been working not only with the task force, but also with those grantees, so we can make sure that we do have a very coordinated effort.

The College of Southern Nevada is piloting a program that eventually all of our community colleges could adopt to train professionals in how to use electronic health records and that is office managers, physicians, and other providers so that we can be sure they understand what the purpose is and also how to meet the requirements so that they can get their financial incentives.

HealthInsight is our Health Information Technology Regional Extension Center. They are kind of our boots on the ground. They are helping both Medicaid with the incentive program as well as the Director's office for the Department of Health and Human Services (DHHS) for the health information exchange component.

On page 11, we look a little bit at the workforce. Essentially, Nevada is going to need approximately 5,000 information technology professionals between now and about 2016. It takes a while for those folks to get trained, so there is a little concern about whether or not we will be able to do it. The conservative estimate nationwide is that we will need about 50,000 of these professionals, which means if we cannot get enough trained in time to meet our needs, we may be competing with other states for these kinds of services. This may also stimulate some small businesses to be formed as a result. If you will—and I have used this analogy before—the doctor's offices and even some of the rural hospitals may need the equivalent of the Best Buy Geek Squad, so when there is an upgrade to be done, or there is problem, they will have a service that they would subscribe to or they are contracted with, to come in and fill those needs.

There are some challenges to this, although we are not the only state that is facing the challenges. The Office of the National Coordinator has allocated dollars to have a curriculum developed that could be implemented by all the states and do it on a nationwide basis. We do know that it is not going to be an easy task to do this; however, the upside is we do believe it will improve the quality of care, and also improve efficiency of care.

Finally, because there is that workforce development component that is important, my office is part of the Health Care Sector Council of the Governor's Workforce Investment Board to look at how we might pool resources together and address it. It is a priority area. Also, the Northern Nevada Development Authority has recently formed both a technology and a health care advisory committee and health information technology is included. They do realize that they would like to support any of the small businesses that may want to form to support the effort and take advantage of the opportunity, and also with the workforce as well, and also to be able to be sure that those electronic health records get implemented and that eligible providers receive their incentive payments.

Would you like me to go through the provisions of the bill, Madam Chair?

Chair Mastroluca:
Yes, please. Are you going to follow the summary that you provided?

Lynn O'Mara:
Yes.

Chair Mastroluca:
Perfect. I love that summary; it was very helpful. Thank you.

Lynn O'Mara:
Hopefully you have a two-page summary (Exhibit D) of the provisions of the bill. This is based on the first reprint.

Section 1 stipulates that Chapter 439 of *Nevada Revised Statutes* (NRS) will be amended. Section 2 states that terms used in sections 2 to 12, inclusive, will have the meanings assigned to them in sections 3 and 4. In sections 3 through 4.8—the Senate Health and Human Services Committee agreed—we adopted all of the language or the definitions that are in the HITECH Act itself. We wanted to be as consistent as possible. The ones that are currently in statute for other chapters were not quite inclusive enough, so that is the reason we went with those.

Section 5 specifies the powers and duties of the Director of the Department of Health and Human Services as the designated health information technology authority who would be required to meet the federal requirements for the health information exchange, and who would be authorized to promulgate any necessary regulations, and also to accept gifts, grants, and donations in order to carry out the provisions of the bill. This was important, especially because of the match requirements that will be needed.

Chair Mastroluca:
In section 5, subsection 1(b) makes it pretty clear that this is not mandatory to participate in this system; it is optional. Is that correct?

Lynn O'Mara:
In section 6, it requires the Director to establish the health information exchange governance entity to meet federal requirements, requires that governing entity to comply with open meeting law, and requires the Director to certify health information exchanges that wish to be part of the statewide system.

Assemblywoman Pierce:
What kind of nonprofit entity would be the governing body?

Lynn O'Mara:
In the HITECH Act and also in the terms and conditions of the State Health Information Exchange Cooperative Agreement, they envisioned a nonprofit entity that would oversee the health information exchange in the state that would be separate from a state entity or agency that would be able to act as an open forum for all the stakeholders to be able to bring concerns and issues, and also to provide oversight and to work with the state authority, which would be the Director of the Department of Health and Human Services, ensuring that everyone, if you will, plays by the rules.

Assemblywoman Pierce:
Do these entities already exist, or is this something that is starting to exist because states are doing it?

Lynn O'Mara:
In some states they already existed. In this case, the bill allows the Director to either establish an entity of this kind, or to go out and contract with one. We are not aware of any that currently exist in Nevada, so we most likely would be establishing one independently.

Assemblyman Goicoechea:
It sounds like the agency or the group could opt whether to go or not, but how about the patient? Let us say it was a clinic and the clinic decided they were going to go ahead with this plan, but the patient said, "No, I do not want any part of it."

Lynn O'Mara:
In later provisions in this bill, the patient is allowed—it is an opt-in provision. In other words, the patient has to make the choice. Their information will not automatically be exchanged.

Assemblyman Anderson:
Do we not already have state agencies that deal with health records? Why would we not look to them to take on this function to make sure that this data, that is obviously sensitive, has the highest standard of security or control?

Lynn O'Mara:
The health information exchange entity is not going to be maintaining data. It is only going to be facilitating the exchange of data between providers through electronic health records. The data will stay resident at its point of origin.

In this case, once a provider creates an electronic medical record for an individual, that data stays resident. The health information exchange would allow a query to be done for the information that was being requested. It is not going to be remaining resident there. Also, it is a requirement of the HITECH Act and our terms and conditions of the cooperative agreement. The preference that most states are following is to have a separate entity so that it is always operating and there is no interruption of service.

Assemblyman Livermore:
It sounds like a large bureaucracy to me, the way you are describing it. By this nonprofit meeting under the open meeting law requirements and these kinds of things, is it subject to the Freedom of Information Act of the press to obtain your records?

Lynn O'Mara:
I believe it is, although I cannot say for certain. My understanding would be if it is subject to open meeting law, it would be subject to those as well.

Assemblyman Livermore:
Where is patient freedom and privacy in this? I have had a lot of emails in the last couple of days with people inquiring about this.

Lynn O'Mara:
Later in the bill are more stipulations about privacy and security. Per the terms and conditions of the cooperative agreement, we must comply with the security and privacy framework as well as the Health Insurance Portability and Accountability Act (HIPAA) requirements that are already in existence. This does not preempt those, nor does it preclude those. So all of the protections that are there have to be met and we expect that there will have to be additional regulations put in place, if we see a gap, to also address that gap area.

Assemblyman Livermore:
In the last five or six months, pick a week, and all of the sensitive security information that has been leaked around the world. How can you assure me that this will be private and secure? Can you possibly do that?

Lynn O'Mara:
I cannot at this point. I am not going to pretend that I have all the answers on this today. We do know that there is technology in place that ought to be able to secure it. We know that there are procedures and policies that can be adopted to secure it; however, today I cannot guarantee it.

Assemblywoman Benitez-Thompson:
I just wanted to make sure I was right for the definition of health care provider. In section 4.2 it references *Code of Federal Regulations*, Title 45, Section 160.103. I do not know what that is. So it is pretty much anyone who provides any type of health care services or are there a certain number of patients that the facility has to be serving in order to qualify?

Lynn O'Mara:
That is a federal definition that includes all of the providers who would be involved with health information exchange and electronic health records. The reason it was adopted was so that we could be as inclusive as the federal level is.

Assemblywoman Benitez-Thompson:
So would that mean your hospitals, skilled nursing homes, or any type of family practitioner's office? Anyone who is providing any kind of service—very broad?

Lynn O'Mara:
That is correct. It is a very inclusive definition that HHS put in place, so we are just requesting to adopt that here.

Chair Mastroluca:
Please continue on. I believe you are on section 6.

Lynn O'Mara:
Section 6 is where the requirements are for the statewide system. Section 7 is where the Director would have to establish standards for the security and confidentiality of the electronic health records as well as the health information exchange in alignment with applicable federal laws. As I said, there is a federal security framework in place that we would have to be aligned with as well as all of the HIPAA laws that are currently in place.

As a side note, the HITECH Act reinforced the enforcement of the HIPAA laws. They were not really as strong as they could have been, so as part of all of the stimulus funding, they did do that. It was also because of the electronic health record adoption and the use of the health information exchange that it was important to do that.

Chair Mastroluca:
In section 7, subsection 1(f), it says, "For notifying a patient if the confidentiality of information contained in an electronic health record of the patient is breached." I notice it does not specify a time frame. Was there any discussion on the Senate side about putting something in there that said,

"As soon as practical or within a certain amount of time of the breach being identified?"

Lynn O'Mara:
That was not specified because it is already in HIPAA. We would cite that as part of the actual process that we expect to be put into regulation. It would be done in the same time frames as allowed by HIPAA.

Chair Mastroluca:
Do you know what the time frame is?

Lynn O'Mara:
Not off the top of my head. I am sorry, Madam Chair.

Chair Mastroluca:
Please continue.

Lynn O'Mara:
In section 8, it also requires the Director to establish regulations and a system for the filing of complaints in the event that a breach has occurred or there is another violation, whether it is a patient, a provider, or a facility wanting to report it. That would apply to both violations resulting from the use of the electronic health records, or from the health information exchange itself.

Section 9 provides immunity from liability for providers who, with reasonable care, rely on information received from an apparent genuine and accurate electronic health information record and through an approved system. We are aware that not all of us remember all of the data accurately when we provide it to our physicians, and there may be information that may be an error in the record. There was concern expressed by the Senate Health Committee about that, and therefore they chose to include some immunity provisions in here to allow for that.

Chair Mastroluca:
Does this reflect similar immunity provisions for handwritten medical records? What if my doctor writes something and someone spills coffee on it and the three now looks like an eight? There is a problem. Is that same immunity available?

Lynn O'Mara:
I believe there is, and that is why we wanted to be consistent.

Chair Mastroluca:
If you could find out for me, I would be interested to know if the immunity provision is the same.

Lynn O'Mara:
I will do that. I will also find out about the breach time frame in HIPAA.

Section 9.5 includes immunity for the governance entity and for HIEs that are part of the system, as well as any administrating entity that may be contracted by the governance entity. There is no way for them to know if data was accurate or not. They are simply a facilitator allowing information to be exchanged, and again the Senate Health Committee felt that was important to include.

Section 10 stipulates the providing information to an electronic health record or participating in the health information exchange system does not constitute an unfair trade practice. That is fairly consistent with provisions that have been adopted by several other states that are also going through this same exercise.

Section 11 requires the patient's consent for the electronic transmittal of health records via the electronic health information exchange. It also specifies the patient's rights. Many of those rights are also consistent with HIPAA.

Section 12 ensures that the electronic health records are maintained according to the bill's provisions, and they also comply with other laws concerning written health care records and directives, access to health care records, and the confidentiality of the health care records. There are already several provisions in Nevada in NRS that also deal with some of this. We wanted to be sure that was all aligned and consistent.

Section 13 defines individually identifiable health information. Some of the other sections—14 through 26 are merely related sections of the various medical practice acts to align with the provisions of S.B. 43 (R1).

Section 26 amends NRS 720.140 so that the provisions of the chapter do not apply to a digital signature that is used to sign an electronic health record in accordance with sections 2 to 12 inclusive.

Finally, section 26.5 provides that in collaboration with the applicable state agencies, the Department of Health and Human Services will study and determine standardization for the electronic transmission of prior authorization for prescription medications using the statewide health information exchange system. This is something that many states are starting to look at. It is something that may be easier to facilitate using electronic exchange information versus doing it by hand, so we will be looking at that to see if it is feasible. It is already being done under certain circumstances by our state Medicaid agency, so we will start with that, but we are looking at what we might be able to do with this on a statewide basis. There are other states that are also looking at this as well.

Section 27 stipulates the effective date of this act.

Chair Mastroluca:
Thank you, Ms. O'Mara, for going through this.

Section 18, subsection 4 talks about adopting regulations for electronic transmission of prescriptions for dangerous drugs, but is that not already covered in federal law?

Lynn O'Mara:
It is not currently. The NRS does not allow for it. We are simply asking that we are brought into alignment with what is in federal law.

Chair Mastroluca:
So currently you cannot transmit a prescription for dangerous drugs electronically?

Lynn O'Mara:
Yes, that is correct.

Assemblyman Hambrick:
I understand there is no fiscal impact initially. What would you guess to be the cost of this program two or three years from now? You say, "One-shot deal," but a little while ago you mentioned that we would have many nice-sounding techies—my word—coming on board to assist in this. Would these be state employees or county employees? The ripple effect on this—is there an aftermarket effect on this? If this is passed and ARRA funding takes care of the initial funding, what happens two or three years from now?

Lynn O'Mara:
There would be no state or local jobs that I am aware of. This would be envisioned as private sector jobs. The cost is an issue that many states are looking into—we do not know exactly just yet because we have been asked to do this very quickly. However, the state health information technology plan does require that we have a sustainability portion, and that is whatever is put together is expected to be self-sufficient by the end of the grant period. That

means they should be able to stand on their own two feet and they should have their own funding sources. That would be up to the governing entity to determine how they are going to accomplish that.

Assemblyman Hambrick:
Several places throughout the piece of legislation is about opting out and looking to make sure that the patient has certain rights. Would there be a hiccup or problem if someone opted out? I have not seen any provision where they would still be guaranteed the right to receive care if a provider says, "Well, if I cannot use your information electronically, maybe you should see another physician or go someplace else." I am of a generation that may not be overly confident of electronic transmissions. Would a patient have an opportunity to say, "I just do not trust this"? One of my colleagues, Mr. Livermore, talked about the security of the system. I am also concerned about the security of the individual.

Lynn O'Mara:
That is an issue of great concern nationwide. Right now if an individual appears in an emergency department, under the Emergency Medical Treatment and Active Labor Act, they must be treated. While the issue did come up in the Senate Health Committee, they wanted to first see what would happen when we implemented the health information exchange before deciding if there was anything required in legislation. Obviously, if we believe that there was something that would be needed to be done in regulation, that would be a first step and possibly come back next session to put further provisions and protections in. If the guidance is followed within the HHS security framework and also under the HIPAA provisions that allow individuals to decide whether or not their information is exchanged. There is also a provision in S.B. 43 (R1) that does not require a physician to participate in the exchange.

Part of our state health information technology plan will also be looking at alternatives for those individuals who choose not to have their information exchanged electronically, but would like all of their providers to have access to it. We are going to be looking at other ways to allow that to happen beyond merely faxing over pages. There are technologies coming on board, under a patient's full control, that would facilitate getting his information to all of his providers and being able to communicate not necessarily through the health information exchange.

Assemblyman Livermore:
I will go back to my first line of questioning about security. You have the health care provider. That is the human element of this. Health care providers are not always government agencies. They are private business people. They come,

they go, they merge, they sell, and they close, everything that you could possibly think of in a business operation. I know, because I have seen where physicians, practices, or clinics basically close up and go out of business. Who has the authority over those electronic medical records, and how can a patient be positive that his information does not wind up in a box in a storage shelf someplace and two years later someone else opens it up and does not have the authority to access it?

Lynn O'Mara:
Last session there was legislation passed regarding when provider offices and hospitals close up, and what has to happen to those medical records. I believe that the State Board of Medical Examiners and other medical boards get involved. There is certain information that has to be transmitted by the provider who is shutting down shop. They have to make provisions as to where those records are and notify the individuals as to where they can go to claim them. There would be no difference with these records. A medical record is a medical record.

Assemblyman Livermore:
Sometimes the records are part of the sales transaction. You get a value for the charts that you have on your wall. When a physician closes and sales merge, those charts are part of a saleable product. I do not know if you are aware of that or not, but it is. Again, where is the patient's protection in this?

Lynn O'Mara:
In both the NRS, with the legislation passed last session, as well as what is already in HIPAA, again, the patient has to consent to have that record, if it is included as part of the assets of the business provided to the new provider, the patient does have to authorize whether or not that record ends up going to the new owner.

Assemblyman Livermore:
You are probably right that it exists in NRS, but in practicality and reality, if I have not seen a doctor in four, five, or six months. I go to see him and his door is closed. Where are my records? That is my point.

Lynn O'Mara:
If that does indeed surface to be a problem, it is something that the state would have to deal with, and we may have to start with regulation and then look at next session if we need to add more protections. One thing to keep in mind is that these health information exchanges are very new. Not everyone knows what all of the pitfalls are going to be. This is a very fast-track effort. We are going to be doing our best—I am going to say reach out and get as much

information—to address the issues as they come about. However, there are unknowns. It is going to be a challenge to meet those.

Chair Mastroluca:
Ms. O'Mara, I want to make sure that I am hearing this correctly. It seems like it is not going to be this giant database that a doctor of any kind can access to say, "I want to get Mr. Livermore's medical records." Would it not be more of, "I am the doctor. My patient has signed saying that I can do this, and therefore only I can access this information. If I want to transfer it to another doctor, then I have to get permission from the patient in order to go to another doctor." It is not like every doctor in the world can look at this information any time they want. Am I hearing that correctly?

Lynn O'Mara:
That is exactly correct.

Chair Mastroluca:
So it is not a big free-for-all. It is out there for everyone, but there are still issues that need to be dealt with as far as security and safety concerns. It is not like a giant yellow pages of people's medical information.

Lynn O'Mara:
That is correct.

Assemblywoman Benitez-Thompson:
I think what might help clarify for me is what the status quo is right now and how medical records and information is shared and exchanged and how it would look different under this. If someone requests medical records, they can be mailed over, faxed, or picked up in person. Even with all of the things that we do currently, there is always an element of risk. Medical records can be lost in the mail, they can be sent to the wrong fax number, or someone can mistype. I almost feel better with the electronic component because I think it is harder for someone to break into an electronic system and hack out information than it is for someone to punch in a window and break into a medical office to steal a record if they really wanted to. As a consumer, how would it look different for me?

Lynn O'Mara:
You are correct in what you described. As a consumer, it would be different in that the information, because it would be electronic, would be available almost immediately. For example, if you showed up in an emergency department and the permissions were given, they would get that information right away.

Assemblywoman Benitez-Thompson:
So if I had to schedule a surgery and Doctor A needed my medical records from Doctor B, if they were available electronically, Doctor A's office could access them and we could get things scheduled versus waiting for things to be sent via courier, mailed, or faxed.

Lynn O'Mara:
That is correct. It would be much quicker and it might actually be a little more accurate because the physicians would be able to know right away if they did not get everything they needed and could communicate and get what they did need.

Assemblyman Anderson:
I want to go over the "why" of this bill. I think Mrs. Benitez-Thompson hit on it pretty well. Do you believe this will help create a better safety record for everyone involved in all areas of medicine because there will be less confusion, data will be laid out more clearly, and it will be easier to get information in a timely manner? Do you believe those things to be true?

Lynn O'Mara:
That is the guiding principle of this project. The ability to get accurate information quickly is in the best interest of the patient. Having also worked with some patient safety issues in my career, this would seem a way to reduce the number of errors that are occurring.

Amber Joiner, Director of Governmental Relations, Nevada State Medical Association:
I am sorry I did not know the answer to your question offhand; however, I did find the answer for what happens when there is a breach of information under HIPAA. It appears that it is no later than 60 days, but the delay cannot be an unreasonable delay. What that means is if the discovery happens and the physician is able to give notice within 10 days, they need to do that. The standard is unreasonableness and then 60 days at a maximum.

The Nevada State Medical Association supports this bill for the reasons that have already been stated, so I will be very brief. We do think this is a way to improve the quality of care and also the accuracy for information that physicians have. Unfortunately, the way that our world works people wind up in emergency rooms without medical records attached to them. So this is a way for their physicians to instantly get their medical records from their primary care physicians or from other hospitals that they may have been at recently. We do think this helps facilitate the quality of care that patients can receive. It is also much more efficient. You do not have to deal with couriers, the mail system, or the time delay involved in the current medical record system.

We also think this is important because this enables us to enact federal legislation, enables us to accept federal funds, which as we know with the state of our budget is always helpful, so we think that medical records are moving into the future and that this is a way for us to get federal funds to help us implement this to improve efficiency. I would be happy to answer any questions.

Chair Mastroluca:
Are there any questions for Ms. Joiner? [There were none.] Thank you very much for your testimony.

Is there anyone else who would like to testify in support of S.B. 43 (R1)? [There was no one.] Is there anyone who would like to testify in opposition of S.B. 43 (R1)?

Janine Hansen, State President, Nevada Eagle Forum:
There was a lot of work done in the Senate, and one of the amendments that we requested was included in the bill on page 6, line 24, that provides that a particular physician or health care provider is not required to participate in this program. We felt that was very important. However, we are concerned—and we have been concerned since 1999—about the issues of identity theft. I have provided you with an article that talks about that (Exhibit E). For instance, over 260 serious data breaches of patient medical information have occurred in the last 18 months. MidState Medical Center in Connecticut lost information on 93,000 patients. Health Net lost information on nearly 2 million people. The Family Planning Council in Philadelphia reported the data loss of 70,000 patients containing information such as HIV, STD, and cancer screening.

This is one of the problems. Individual health records are very, very valuable. They are very valuable to potential employers, insurance companies, pharmaceutical companies, and people doing research. They are also very valuable to unscrupulous people who would want to use them in cases of identity theft. There are other problems, besides the fact that genetic information and psychiatric information is contained in there, so these are records that could, according to this article, have a generational effect with the loss or control of those.

My concern is that it does ensure in page 8, section 11 that it provides that a patient must not be required to participate in the information exchange. I certainly support that. The problem is that a patient might not have any options. If a provider says, "We will not take you unless you participate in the exchange," then the patient may have, in the law, some kind of an option, but in reality they do not have any. This was discussed in the Senate and Senator Wiener and others were interested, amenable, and concerned about this, but in the ultimate end they did not respond to it because they felt it might interfere with a private business decision. Now every day the state of Nevada interferes in private business decisions. They mandate insurance, and they mandate other requirements in order to protect the citizens in the state of Nevada. Under this bill, there is no protection for citizens except in words, because you may have absolutely no choice as to whether or not your records are included if the provider says we must have them now.

Last year I had a ruptured appendix. I went to the only hospital in Elko and if they had a requirement that I had to be engaged in the electronic health care system, I would not have had any choices. Also, my own physician in Reno, the one I still have there, would probably be likely to not want to participate in this program, and so I could go there, but in Elko or practically anywhere in this state, if they feel that through the financial incentives or whatever other reasons they determine to participate because of convenience, pretty soon a person has no choice. In the law it says they have a choice, but in practicality, because there is only one choice, and that choice is everyone requires that, you do not have a choice.

My amendment is a conceptual amendment (Exhibit F) and it essentially says that because a person has opted not to participate in the health information exchange system, they shall not be denied medical care by providers. I think that there probably will not be a lot of people who determine to do that, although more and more people are becoming concerned about the safety of electronic records and the abuses that can occur and the data mining that happens. Many people are far more aware of that than they used to be, so some might not choose to participate. I think it is an important issue because in reality, if you do not provide that people can access medical care, even if they choose not to participate in an electronic system, then essentially there is no choice. That is my concern, that we make sure that people have a choice.

We know what happened with social security numbers. We know that it was originally promised that it would not be used as the universal identifier, and of course we know now that it is the universal identifier, and if you do not have one essentially you are blocked out of the system. The same thing could happen with electronic health records. I express those concerns. I know that this is a mandate from the federal government; of course I do not support mandates from the federal government, but my concern on the state policy level is making sure that patients do have a real choice as to not to participate. Thank you, Madam Chair.

Chair Mastroluca:
I see very clearly your concerns, and I can understand, especially living in a rural area where that could be an issue if you had them or did not have them. I am wondering about in an urban setting. I think it would be a hardship on a physician if they had made a conscious decision to go to electronic records and were required by law to have nonelectronic records for a small handful of patients. I think that that would slow down their processes. It would make it more difficult for them to do their work. For example, my daughter went to a doctor for a while where everything was done electronically. He did not even take notes with a pen. It was all done on a computer, and when we got prescriptions they were printed out. They were not handwritten. If we did not agree to do electronic records, then they would be forced to print everything out, keep it in a file, and then have these handful of folders over here. I think that would slow down their process. I understand your point, but I am also looking at it from the other side, which is you do not want the mandate on the patient, which I can respect, but in return you are putting a mandate on a doctor. I do not have the answer, but that was something that occurred to me.

Janine Hansen:
I agree that there could be some difficulties. Actually, doing an electronic record within the particular doctor's office, I do not think would be the part that a person would oppose. They could just say that they did not want them transferred and that is supposed to be in the bill. The problem is that someone here is going to have to bear the burden because I believe that through the incentives, almost all doctors' offices will participate. It becomes an even greater issue with hospitals. I do not think any hospitals will not have electronic records. So it does not matter if you are in an urban area or in a rural area. If you do not comply with electronic records, then you may be denied care. As Ms. O'Mara said, we do not know how this is all going to be played out, so we do not know in the end what will happen. I understand that there may be some hardship on some particular doctors. I think it is a greater issue because maybe you can find another doctor who you may be able to work with. Maybe not. If you live where I do, you probably cannot. If you are in a larger urban area, you may be able to find someone else, if they take patients. But with a hospital it is a particularly big issue because you do not have many choices, or any choices in some cases. Although you may be able to find another doctor, you probably will not be able to find another hospital. So this idea that you have a choice once this bill passes is essentially not real.

Chair Mastroluca:
I think that is a matter for debate and perception, but I do appreciate your point.

Assemblyman Anderson:
I have a couple of thoughts on this issue about whether someone could be denied care. The first thing I thought of was the Hippocratic oath. As a doctor, you cannot turn someone away with a ruptured appendix, can you?

Janine Hansen:
The hospitals are forced to take people under the current laws, and they have to service them, but maybe it is elective surgery that may have a long-term impact on your life. My friend just called me and said she had breast cancer, and although it was not emergency surgery, it was life-saving surgery she had to have. I think that although it may not be an emergency, you have to have it, so you have to make a choice. The choice would probably be if you are going to save your life or not, you are going to participate in the electronic system. There are all kinds of implications for an individual who does not want to have his records in there. He may ultimately be forced into that choice, because he has no other.

Assemblyman Sherwood:
I guess the challenge for us is the federal government. Part of the reason, I think, that we do not know how it is going to play out is, what does health care coverage look like? If it turns out that it is universal coverage, all the plans go away, and there is only one provider. That provider has to be queued up with the individual receiving the benefit. So if we were to say we were not going to do this, and then it goes through, are we not behind the eight ball? I get the overall issue, but if that is the way that we go federally, if we said no to this legislation, then we are stuck without a vehicle to administer health care, correct?

Janine Hansen:
Yes, I believe this is going through no matter what. I think the mandate from the federal government and the money and the incentives are going to ensure that it does, so it will not matter what your policy decisions are in the end. You will be going with this program. I believe that with the health care mandates from the federal government that you may be behind the eight ball. I am not unrealistic enough to believe that this will not be going forward, so you will be prepared when this system goes into operation. I did not testify against the entire bill, although I have serious concerns about the whole thing. My concern is just for that one piece we may be able to protect of individual privacy and individual choice, which I think is under assault in this bill, as well as many of the things that have been mandated by the federal government. I am not

suggesting to you that you not go forward on this because I believe that the reality is that you will be going forward.

Chair Mastroluca:
I am going to finish the opposition testimony and then at the end I will let you come back and you can make your point then. Thank you.

Lynn Chapman, State Vice President, Nevada Families Association:
I was not able to come to the meeting in the Senate, but I was watching online and sent in my questions. I noticed there was some immunity from liability, but that was one of my questions in the Senate. Who ends up having liability if a person's private medical information is compromised? How would a person be made whole? It does cost thousands of dollars to right your name after someone has stolen the information and used your information to do criminal acts, et cetera. I was wondering who has the final liability? I believe it is in the bill that research companies cannot take your private medical information and use it for their research without consent. I want to make sure that is. I think I read that in the bill, but I cannot find it.

People can look over their medical records and make sure they are correct, but what about our children? Since they are our children and we do have the responsibility for them until they are 18 years old, we do pay the medical bills. Are we allowed as parents to see our children's medical information and make sure that it is correct?

Chair Mastroluca:
Ms. Chapman, that is in the bill. It is in section 7, subsection 1, paragraphs (b) through (d).

Lynn Chapman:
Okay. Those were my questions.

Assemblywoman Pierce:
I understand the concerns about privacy. Sometimes I go into a doctor's office and the doctor comes in and he has this big fat manila folder that he has been carrying around for 10 years, and you know he cannot find anything in it. It is like stepping back to 1963 and you wonder, when are these guys going to get with it? One of the unintended consequences of this will be I think a lot of medical forms will start to get standardized. We all know that one of the huge expenses—one of the things that makes American health care so inefficient and so much more costly than any place else in the world—is that everyone has a whole set of forms completely different from everyone else. There is no standardization. I think that this will begin to standardize some of that

information. I think it is important. I think back over the last 10 years. I remember one time taking my own medical records around and thinking, "Is this a good idea?" I support the concept, although I do understand people's concerns about privacy. I think this is a big step forward.

Chair Mastroluca:
I can agree with you on that point. I can remember being given X-rays for one of my children and told that that was the copy and not to lose it. What if something happened and I had all these things in my hand?

Is there anyone else that would like to speak in opposition to S.B. 43 (R1)? [There were none.]

Rebecca Gasca, Legislative and Policy Director, American Civil Liberties Union of Nevada:
We have been working on this bill in tandem with many stakeholders for over a year and a half since the Blue Ribbon Task Force was first convened to take a look at this issue. As a result of many meetings and many discussions, the bill was introduced on the Senate side. The Senate treated the bill with much care, put in some very comprehensive amendments, and we believe a majority of our issues were certainly taken care of. For the Committee's benefit, the American Civil Liberties Union (ACLU) of Nevada was of course interested in protecting the privacy and confidentiality of these records, creating things like audit trails so that a patient would know who is accessing their records and why. One of the most important things for us was that the system be set up so that it was an opt-out system, which indeed it has been presented to the Committee this way. We really appreciate the care and questions that have been offered today.

I want to make sure that it is clear that the governing entity under the bill will be subject to open meeting law, which we think is incredibly important, especially since it would be a private organization that essentially takes on a very important function that would certainly affect the privacy and confidentiality of the medical records of the citizens of Nevada.

While certainly not every single question has been answered with respect to confidentiality and privacy, we believe many of these issues will be brought up within the regulation process, not only between now and the next legislative session, but then thereafter. We certainly look forward to continuing to work with all of the stakeholders who do have a say in these electronic records of health information, and look forward to working with them to ensure that the confidentiality and the privacy of individuals are maintained.

Chair Mastroluca:
Thank you very much, Ms. Gasca. I appreciate your work on the bill.

Assemblyman Hambrick:
You mentioned about the open meeting law. We have heard from Ms. O'Mara that she envisioned maybe in a year or two, three, four, or five that this might be a private entity operating some of these things. I am not sure if the open meeting law would have any effect or concern in the private sector.

Rebecca Gasca:
As far as we are aware, the provisions of this bill would subject the governing entity to this. I think Ms. O'Mara would certainly be the person better suited to answer the specifics of that question. I think that the intent of the Senate on this issue was that this entity be covered and forced by statute to have their meetings open to the public because of the sensitive nature of this kind of governing entity, and that it would be kind of a partnership or body that takes on this function that affects so many members of this state.

Assemblyman Hambrick:
I appreciate the term "governing," but if it is private industry, perhaps governing might be a misnomer. Maybe the "managing" entity, which would have a different effect on them.

Rebecca Gasca:
That is a very good point and a specific nuance, and I think Ms. O'Mara would be the best person to talk about the specifics of that. I do not have the bill in front of me. My apologies.

Chair Mastroluca:
Are there any other questions for Ms. Gasca? [There were none.] Thank you very much.

Is there anyone else who would like to testify on S.B. 43 (R1), either in support, opposition, or neutral? [There was no response.] Ms. O'Mara, would you like to come back and make your closing statements?

Lynn O'Mara:
I would like to clarify my comments about the open meeting law for Assemblyman Hambrick. The intent of the HITECH Act as well as the terms and conditions of our cooperative agreement, is transparency, and that is why we agreed with the Senate. We actually proposed it to make sure that the governing entity follows the open meeting law process. It was a very important

thing for the task force, and we envision that it will continue with the governing entity.

As far as governing entity goes and the semantics, that is language that is in the HITECH Act as well as our terms and conditions. It really means that yes, it will be a private entity. You are correct in that it is probably more of a managing role. However, the state health information technology authority will be an ex officio member of that board and will also be overseeing what is happening, so that in the event the state needs to do any enforcement, it has the opportunity, it is aware and will do that.

I would also like to clarify some of the comments made by Assemblyman Sherwood. The health information exchange is under the stimulus bill. It is not part of the health care reform act. That is what is really being challenged. This is not. This is supposed to be independent of that decision. This is law. We have the funding to implement it and that is what we are attempting to do. It is really independent of the health care reform act. I would be happy to answer any other questions.

Chair Mastroluca:
Are there any final questions for Ms. O'Mara? [There were none.] Thank you very much. With that, I will close the hearing on S.B. 43 (R1).

We will move on to Senate Bill 113 (1st Reprint), which revises provisions relating to the care of certain children during disasters. Thank you, Senator Leslie, for your patience. When Senator Leslie was the Chair of the Legislative Committee on Child Welfare and Juvenile Justice, she educated us quite a bit on this topic. I appreciate you bringing this forward.

Senate Bill 113 (1st Reprint): Revises provisions relating to the care of certain children during disasters. (BDR 38-198)

Senator Sheila Leslie, Washoe County Senatorial District No. 1:
Thank you for hearing the bill. I think this is the last time you will see me this session in the Assembly Committee on Health and Human Services. It has been a pleasure. I appreciate all of the hard work you have done on our health bills.

This bill, as the Chairwoman said, did come out of the work of our interim Committee on Child Welfare and Juvenile Justice. If you still have that report, you can reference the testimony on page 89. I also had a particular interest in this topic as one of ten commissioners on the National Commission on Children and Disasters. I was the lone state legislator appointed to that national commission where I served for two years. The Commission has just finished its work and delivered its final report to Congress and the President. This bill was reviewed by the Commission staff and their suggestions were included in the amended version that you have before you in the first reprint.

During the interim, our committee heard testimony from Save the Children and other groups regarding the need to include requirements in statute for emergency preparedness planning at the state and local levels with a special focus on child welfare including foster care and juvenile justice facilities. Think for a moment about all of the terrible disasters that our country has faced in the last year and just in the last two days. I was watching CNN this morning where they said 87 people had died in Joplin, Missouri. So imagine if there was a foster child in one of those homes and how information in the aftermath of the disaster would get to the responsible agency, whether it be the court of the child welfare agency, not to mention the natural parent. You can see why we really believe we need to have procedures in place before a disaster hits.

The idea of strengthening regulations by requiring that elements of disaster planning be included in the conditions for licensing of foster homes was raised, and this would be very similar in the bill as what is used in child care facilities. In the example I just cited, if there is a disaster—it could be something as simple as having an 800 number printed on a card in every foster parent’s wallet. Hopefully, it would still be intact and they could call after a disaster to report in on the status of the child. That kind of information could be linked up to a database that is duplicated out of the disaster zone.

The Committee made two recommendations to be included in draft legislation for this session, and that is what you have before you today. It was amended in the Senate to ensure that regulations are adopted to establish these minimum requirements and procedures for plans for the care of the children in custody during a disaster. The bill requires each child welfare agency to develop and implement a plan for their children, and provide a copy of the plan to each person or entity that has physical custody of the children. It also requires the Division of Child and Family Services (DCFS) to develop a plan for the care of children in the custody of other agencies that provide child welfare services during a disaster. So that would be if there was a disaster—say there was an earthquake in Washoe County, and it was terrible earthquake, and the county system was unable to respond. This bill would require the state to think about that ahead of time and have a plan to go into a damaged county like that and help them and take over the mechanisms for tracking these kids.

It requires foster homes and facilities for the detention of children to develop plans as well. We heard testimony at the national commission level and also in our interim committee about Hurricane Katrina and what happened there when the kids under the jurisdiction of local jails and the local detention facilities. The flood waters came, they could not let the kids out, and they could not find the judges. Better planning would have helped lessen the chaos. It is always going to be chaotic after a disaster, but hopefully if there is planning in place, it will help us keep track of what is going on.

The last thing that is included in the bill is encouraging training exercises in conjunction with local emergency planning professionals on a regular basis to ensure better coordination and communication before, during, and after disasters. This came out of some of the national work I was doing, where you have all of these professionals and emergency planning, and they tend to be guys with radios and they have all this high-tech communication, but they do not know the first thing about foster families, child welfare, or even how a juvenile detention facility works and the fact you cannot open the doors and let people go, even if it is flooding, like what happened in Katrina. So by forcing and encouraging this collaboration between the two where they are actually exercising their disaster plans at the juvenile detention facility, for example, with the emergency preparedness planning folks, they not only get to know each other, but they can share their plans and hopefully if a disaster happened things would roll out much more smoothly.

This bill was declared exempt because they thought it had a fiscal note, but they did not read the word, “Encourage.” It does not require. It encourages. I wish we could require, but DCFS did testify that there is no fiscal note. They have already made contact with the emergency planning people and they are planning to do exercises with them, which really makes me happy.

That is the bill. I am not aware of any opposition at this time, although there could be. I would be happy to answer any questions.

Chair Mastroluca:
The one question I had was about the effective date. Is that a realistic enough amount of time for licensees who operate foster homes to be able to put their plans together?

Senator Leslie:
That is a very good question. That did not come up, but looking at that date of July 1, 2011, I think that is a very reasonable question. No one indicated that they would have a problem with that date.

Chair Mastroluca:
We do not have anyone here from the agencies, so with your permission I will follow up with them and ask them that question. I think this is too important of

an issue to try and rush. I would rather know that they have good solid plans that they feel they can actually implement instead of putting something down on a piece of paper to satisfy a date.

Senator Leslie:
It does say the Division shall do something in consultation—they shall develop a plan. I think that is a reasonable question, and they did not indicate a problem. Certainly if they need some more time, that is fully understandable.

Assemblyman Anderson:
My question would just be based on the family foster homes. What would you anticipate—I could understand the agencies having plans as they have a much bigger burden. What would a family foster plan look like?

Senator Leslie:
We had quite a discussion about that. The testimony was that they would incorporate this plan into their training. Foster families have to have initial training and then they have to have ongoing training. They felt that it was something that could be accomplished and should be accomplished so that a foster family would know exactly what they were supposed to do in the event of an emergency. So it is not intended to be a big plan that sits on a shelf in a binder, but rather more along the lines of a laminated card to put in your wallet that has the 800 number to call in with some very basic types of disaster response. The training would be in the annual training or the initial training.

I have learned from this experience—serving on the national commission—that it is more about thinking it through ahead of time. It is like when our kids come home with the family disaster planning—every parent has had to do that. Now that my daughter is gone I just discovered in my basement over the weekend our disaster planning box. Unfortunately that is what happens. You do it for a school project and it ends up in the basement where it does not do any good. Just having to go through that exercise on a regular basis and update your card I think is what we are looking for. So nothing super elaborate. Just very common sense types of plans.

Assemblyman Anderson:
That is sort of what I was thinking. My parents always told me, “We are going to meet by this tree if there is a fire. Run out of the house and meet here.” I was just curious.

Senator Leslie:
With foster children, these are not our natural children, so we have an even bigger burden to make sure that we report the status of these children back to the appropriate authorities.

Assemblyman Livermore:
Some time ago we had Senator Settelmeyer here with a court appointed special advocate with foster children, and they were developing a plan, too. How can these plans all integrate together? I do not read anything in this bill that would prohibit an integration.

Senator Leslie:
No. Definitely not. Child welfare agencies, interestingly enough, have a federal requirement right now that they must have disaster planning. I say that is interesting because juvenile detention facilities do not have a federal requirement, so on one side of these kids in custody, the federal government has already required that. This bill contemplates two extra levels of planning: one at the state level, which we have never had that requirement and asked the state agencies to think ahead where if the disaster at the local level was so immense that the state needed to come in and take over the care and custody of those children; and another at the local level, the foster family level that we were just discussing. Certainly those efforts should be coordinated and it is what I anticipate. The state is the ultimate authority over the local child welfare and juvenile justice agencies, so they have a duty to report to them. They share training exercises as it is.

My vision is that all of this would be integrated, not only in our own child welfare and juvenile justice systems, but just as importantly with the emergency planning people who are over here in a whole different area. That is really what I want to accomplish with this bill. Make sure the plans are in place and then make sure that these plans are integrated with the professionals who do emergency planning. What we might think of as a plan—the guys who do emergency planning, as I learned—is a whole different field. It is a very specialized field that I do not think from my experience working in human services that we are adequately planning for. We need to learn from these folks who know how to do it.

Chair Mastroluca:
Are there any further questions for the Senator? [There were none.] I do not have anyone else signed in to testify, so that must mean it is a really good bill.

Senator Leslie:
I think people are getting sick of us. As I recall, we had a hearing and a work session in the Senate, and in the work session after we amended the bill, there was no expressed opposition.

Chair Mastroluca:
Thank you very much for your time and for bringing this forward. I appreciate it. I will close the hearing on S.B. 113 (R1).

Is there anything else to come before the Committee? [There was no response.]

Committee members, we still need to work session these two bills. I have one more bill that I am waiting very patiently to come from the Senate. The good news is that all of these bills are exempt, so they are not subject to the deadline on Monday. The bad news is that all of these bills are exempt, so they are not subject to the deadline on Monday, which means it will be a little more difficult to get things moving because there are so many other things ahead of it.

I ask that you pay attention to your emails and our staff will be in touch with your attachés, but we will have a meeting at the call of the Chair and I ask that you do what you can to be there. The last bill that we have and are waiting for from the Senate is a pretty big bill and important to a lot of people, and a lot of people have been working on it, so I really want to make sure that we can give it our time and attention.

Is there anything else to come before the Committee? [There was no response.] Is there any public comment? [There was no response.] This meeting is adjourned [at 2:57 p.m.].

RESPECTFULLY SUBMITTED:

____
Linda Whimple
Committee Secretary

APPROVED BY:

____
Assemblywoman April Mastroluca, Chair

DATE: ____________________________

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: May 23, 2011 **Time of Meeting: 1:33 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 43 (R1)	C	Lynn O'Mara	Presentation
S.B. 43 (R1)	D	Lynn O'Mara	Summary of Provisions
S.B. 43 (R1)	E	Janine Hansen	Document
S.B. 43 (R1)	F	Janine Hansen	Conceptual Amendment