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

Seventy-Eighth Session
May 1, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 12:54 p.m. on Friday, May 1, 2015, 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/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblyman Nelson Araujo
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblywoman Amber Joiner
Assemblyman Brent A. Jones
Assemblyman John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Joseph (Joe) P. Hardy, Senate District No. 12

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Karen Buck, Committee Secretary
Cheryl Williams, Committee Assistant

OTHERS PRESENT:

Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services
Deborah Huber, Nevada Executive Director, HealthInsight, Las Vegas, Nevada
Joan Hall, Private Citizen, Reno, Nevada
Joanna Jacob, representing Dignity Health St. Rose Dominican Hospital, Las Vegas, Nevada
Chris Bosse, Vice President, Government Relations, Renown Health, Reno, Nevada
Daniel Mathis, President, Chief Executive Officer, Nevada Health Care Association
Chuck Callaway, Police Director, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department
Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Eric Spratley, Lieutenant, Legislative Services, Washoe County Sheriff's Office
Mona Lisa Samuelson, Private Citizen, Las Vegas, Nevada
Vicki Higgins, Private Citizen, Las Vegas, Nevada

Chair Oscarson:
[Roll was taken. Committee rules and protocol were explained.] We will now begin our work session on Senate Bill 14.

Senate Bill 14: Revises provisions governing the Pharmacy and Therapeutics Committee within the Department of Health and Human Services. (BDR 38-325)

Kirsten Coulombe, Committee Policy Analyst:
This bill was sponsored by the Division of Health Care Financing and Policy. It was heard on April 22, 2015. Senate Bill 14 revises the membership of the Pharmacy and Therapeutics Committee, Department of Health and Human Services, by reducing the minimum number of members from 9 to 5. The bill also eliminates the stipulation that no more than 51 percent of the members may be active physicians, pharmacists, or persons with doctoral degrees in pharmacy. There are no proposed amendments for this bill (Exhibit C).

Chair Oscarson:
Is there a motion?

ASSEMBLYMAN THOMPSON MOVED TO DO PASS SENATE BILL 14.

ASSEMBLYWOMAN SPIEGEL SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chair Oscarson:
I will give the floor statement to Assemblyman Thompson. We will now hear Senate Bill 31.

Senate Bill 31: Revises provisions relating to detoxification technicians, facilities and programs. (BDR 40-329)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 31 was sponsored by the Division of Public and Behavioral Health. It was also heard on April 22, 2015. Senate Bill 31 transfers from the Division of Public and Behavioral Health, Department of Health and Human Services, to the State Board of Health the authority to adopt regulations that prescribe continuing education requirements and applicable fees for detoxification technicians, facilities, and programs. There are no proposed amendments for this bill (Exhibit D).

Chair Oscarson:
Is there a motion?

ASSEMBLYMAN GARDNER MOVED TO DO PASS SENATE BILL 31.

ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chair Oscarson:
I will give the floor statement to Assemblyman Gardner. We will now hear Senate Bill 196 (1st Reprint).

Senate Bill 196 (1st Reprint): Makes various changes concerning health care. (BDR 40-84)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 196 (1st Reprint) was sponsored by the Senate Committee on Health and Human Services and was heard on April 22, 2015. This bill requires the Division of Public and Behavioral Health, Department of Health and Human Services, to establish and maintain the Stroke Registry to compile information and statistics concerning the treatment of patients who suffer from strokes. The Division must adopt and carry out procedures for the Registry that improve the quality of care provided to stroke patients and compile an annual report to be posted online and also submitted to the Governor and the Legislative Committee on Health Care (Exhibit E).

The bill requires the Division to include in its list of hospitals certified as primary stroke centers hospitals those that are also certified by the Joint Commission as comprehensive stroke centers. Each hospital included on this list is required to report to the Registry certain data concerning treatment of patients who suffer from strokes.

Lastly, with certain exceptions, a provider of health care is authorized to use credit earned for continuing education relating to Alzheimer's disease in place of certain other continuing education requirements. There are no proposed amendments for this bill.

Chair Oscarson:
Is there a motion?

ASSEMBLYMAN SPRINKLE MOVED TO DO PASS SENATE BILL 196 (1ST REPRINT).

ASSEMBLYWOMAN SPIEGEL SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chair Oscarson:
I will give the floor statement to Assemblyman Sprinkle. We will now hear Senate Bill 281 (1st Reprint).

Senate Bill 281 (1st Reprint): Revises provisions governing dismantling of certain vehicles. (BDR 40-590)

Kirsten Coulombe, Committee Policy Analyst:
The last bill we will hear for consideration is Senate Bill 281 (1st Reprint), which was sponsored by Senator Hammond and was heard on April 22, 2015. Senate Bill 281 (1st Reprint) removes from regulation the provision that any vehicle owned by a licensed automobile wrecker or licensed salvage pool and designated for dismantling as a source for parts is a "solid waste." There are no proposed amendments for this bill (Exhibit F).

Chair Oscarson:
Is there a motion?

ASSEMBLYWOMAN DICKMAN MOVED TO DO PASS SENATE BILL 281 (1ST REPRINT).

ASSEMBLYMAN GARDNER SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chair Oscarson:
I will give the floor statement to Assemblywoman Dickman. I will now open the hearing on Senate Bill 48 (1st Reprint).

Senate Bill 48 (1st Reprint): Revises provisions relating to health information exchanges. (BDR 40-323)

Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services:
I am here today to present to you Senate Bill 48 (1st Reprint). This bill revises language related to health information exchanges. We are proposing these

changes to reflect the advances in technology and lessons learned during implementation of the State Health Information Technology Strategic and Operational Plan. In section 2 of the bill, we are clarifying the definition of a health information exchange (HIE), as the current definition is too broad.

In section 3, we are removing the requirement for the director to establish a statewide health information exchange and replacing this with compliance and oversight of health information exchanges operating in our state. Section 3, subsection 2, changes the language to provide the state flexibility to create or contract with an HIE to serve as a statewide HIE if it is decided there is a need for a statewide exchange in the future.

In section 4, we are removing language relating to the governance of the statewide health information exchange. The creation of the statewide exchange was piloted, but the nonprofit board authorized by the Department of Health and Human Services to establish the system determined that a statewide system could not be fiscally sustainable once the federal funding ceased. Instead, we are proposing to create a certification program for all health information exchanges that want to operate in the state. This structure would provide Nevadans with added security by allowing the state to suspend or revoke certification if the HIE were found in violation of the provisions of state or federal law.

Section 5 revises provisions relating to patient consent to reflect current business practices, which does require patient consent at the time the provider retrieves a record, rather than when a record is entered in an HIE. Once consent is granted, it remains until revoked by the patient, which can be done through any provider participating in the same HIE. This section also removes provisions related to excluding portions of the health information records. Keeping this provision would prevent HIEs from operating and being certified, as there is currently no technical way to make medical records searchable. This type of technology is being explored nationally but is not sufficiently available among HIE platforms today in order to have this as a requirement.

In section 6, we are removing previous requirements around the operations of a statewide exchange. Section 7 clarifies that any changes to medical records or requests for patient records must be made through the provider rather than the HIE. In addition, there was a fact sheet provided regarding the federally funded HIE project, which ended in February 2014 (Exhibit G). At this time, I would be happy to answer any questions.

Assemblyman Sprinkle:
There was a pilot program to have a statewide exchange, but it ran out of money and is not able to be funded now. However, now we have independent exchanges. Could you describe what those are? Would they be within hospital systems or office facilities that are associated?

Dena Schmidt:
Currently, there is only one operational health information exchange in Nevada. HealthInsight operates that and they are a nonprofit. They will be coming to the table to testify, and they can explain their operations better.

Assemblyman Sprinkle:
In regard to the Health Insurance Portability and Accountability Act (HIPAA), what type of information is uploaded into these data centers and how is it protected?

Dena Schmidt:
Many hospitals operate and have electronic health record systems. That system can then feed into a health information exchange, which allows multiple providers to share information. If you were seeing a doctor within your network but needed to see specialists outside of your network, they could easily access your information if you gave them the authority to do so. It does improve service to individuals and allows for a faster exchange of information. Any of your health information that goes into an electronic medical record would go into a health information exchange.

Assemblyman Thompson:
In section 4, subsection 4, where it talks about "When the Director intends to deny, suspend or revoke a certification, he or she shall give reasonable notice. . . ." It also says that if they want to "contest the action" they have to "file an appeal with the Director." Who is going to make that determination? If the director said no once, is he or she not going to say no again? Once something is contested, who is going to decide whether it was valid or not, or if it will be reconsidered?

Dena Schmidt:
We would put into regulations those rules and how that would operate, similar to any other process. They could file a complaint or appeal, and we would review the process to ensure that all the information was correct and available and that the decision we made was correct. However, ultimately, the director would have the ability to override that if he felt the original decision was still substantiated.

Assemblyman Thompson:
There has to be someone even higher than the director because if the director was the one that denied them in the first place, he would uphold what he originally decided. It seems like there has to be a third party that is neutral who needs to hear the case.

Assemblyman Jones:
We tried to do a state-run exchange, and we wasted $4.2 million. It did not work, correct? You could not make it work. If we have this nonprofit, which I assume is in the private sector, how are they going to fund their activities?

Dena Schmidt:
The project that had operated ran out of funding. Because of many delays, we had asked for the current federal funding to be extended and were denied that extension. As far as the current nonprofit, they have been up and running for several years now. When they come to the table, they can answer the question about how they fund their operations. I am not as familiar with that operation.

Assemblyman Jones:
As far as you are aware, the state is not going to be paying for any of the fees for the nonprofit or funding them in any way?

Dena Schmidt:
The only time the state may pay a fee is if they are paying for HealthInsight's information. It would be like if Medicaid were paying a fee to get health information by utilizing the services of the health information exchange.

Assemblyman Trowbridge:
In section 4, subsection 6, it provides that the "Director may impose an administrative fine...in an amount established by the Director by regulation." Is there any guidance as to how much those fines would be and who approves the regulation?

Dena Schmidt:
There is a lot of federal guidance around health information exchanges. We would look to other states and be regulating this through the Division of Public and Behavioral Health in their regulatory office. We would adopt those regulations at that time. I do not have an idea of what that number would be right now.

Assemblyman Trowbridge:
Who approves the regulation?

Dena Schmidt:
I believe it comes through the interim process.

Chair Oscarson:
It actually comes through the Legislative Commission.

Assemblyman Gardner:
In section 2, in the definition of health information exchange, why was it decided to put in "a person" instead of an organization? Do we plan for this to be a single person or are organizations excluded?

Dena Schmidt:
That verbiage was at the suggestion of the Legislative Counsel Bureau Legal Division to be the normal process for language.

Risa Lang, Committee Counsel:
In *Nevada Revised Statutes*, "person" is used not just to refer to a natural person, but it is defined in the preliminary chapter to include corporations and other entities as well.

Assemblywoman Titus:
For clarification regarding Assemblyman Jones' questions, the Silver State Health Insurance Exchange that failed was a supplier of insurance. Here we are talking about a pathway for medical providers to exchange information regarding a patient. Is that correct? One of the issues for rural areas is not all of the electronic medical records communicate with each other because of different systems. For example, I may have a patient who went to the emergency room at Renown Hospital in northern Nevada and then, while vacationing in southern Nevada, seeks medical care. Part of the national requirement, even though they are unfunded federal mandates, is that these systems have to communicate with each other. This bill is like the next section to that wheel to make sure that everything flows. There is already concern about HIPAA violations, but when information is used for patient care, it is not a HIPAA violation. These are the components that patients do have to agree to. Part of why we need this kind of process is to make sure that we keep information private and still follow the federal mandate. We do need to develop policies in which we can exchange information so that we do not have to rely on faxes and things like that.

Chair Oscarson:
I will now take testimony in support.

Deborah Huber, Nevada Executive Director, HealthInsight, Las Vegas, Nevada:
We are a Nevada not-for-profit, and our mission is to transform our health care system and improve the health care of all Nevadans. We have several federal designations. We are the Quality Improvement Organization for Nevada, Utah, Oregon, and New Mexico. That is a designation by the Centers for Medicare and Medicaid services, whereby we work with providers to improve the quality of health care. We are also the HealthInsight Regional Extension Center for Nevada and Utah, which is a program from the Office of the National Coordinator for Health Information Technology. This is a program that we have had for four to five years that helps our doctors in our small rural areas and critical access hospitals adopt electronic health records and then use them in a meaningful way that allows them to get certain financial incentives. We also, as was referenced earlier, manage and operate Healthy Nevada, which is a private nonprofit Nevada corporation. It is the only statewide community-based, community-governed, and community-funded health information exchange in Nevada.

I am here to speak in support of S.B. 48 (R1). We have worked closely with Ms. Schmidt and others to make sure that this language will improve the health care of all of us here in Nevada. We look forward to assisting you to move this important legislation forward. I am happy to answer any questions.

Assemblyman Jones:
Thank you very much for being a private enterprise and doing this. How much did it cost you to develop this system that actually works?

Deborah Huber:
The unfortunate thing is it cost us about the same as what the state spent. We had access to seed funding that the state also had access to. Our hope had been to combine our efforts to move this forward. A health information exchange is a costly endeavor, and it is several million dollars per year. As you pointed out, this is all privately funded by those users of the health information exchange. All the providers, health insurance plans, laboratories, x-ray centers, and anyone else who participates in the exchange, pay to participate.

Assemblyman Jones:
The thing is, though, yours is working. It does work?

Deborah Huber:
Yes, it does.

Assemblyman Jones:
Thank you for that. I like this bill now.

Chair Oscarson:
Thank you for your efforts in southern Nevada. You have been doing this for many years, and I appreciate your support and your participation in this process in helping to make the health information exchange better.

Joan Hall, Private Citizen, Reno, Nevada:
I am here representing myself as the former chairman of the first state HIE, the failed one, and currently a board member of Healthy Nevada's HIE. I am urging your support for this. These changes will make it more possible for the HIE to be functional. I am happy to answer any questions.

Joanna Jacob, representing Dignity Health St. Rose Dominican Hospital, Las Vegas, Nevada:
Dignity Health St. Rose Dominican Hospital participates in Healthy Nevada, and I am here at their request to urge your support for this bill.

Chair Oscarson:
Is there any other testimony in support either here or in Las Vegas?

Chris Bosse, Vice President, Government Relations, Renown Health, Reno, Nevada:
We are also in support. We have spent lots of time with a broad group of stakeholders working with Healthy Nevada, and we very much support this effort, especially the revised language.

Daniel Mathis, President, Chief Executive Officer, Nevada Health Care Association:
I say ditto.

Chair Oscarson:
Is there any other testimony in support? [There was none.] Is there any opposition either here or in Las Vegas? [There was none.] Is there any neutral testimony? [There was none.] I will now close the hearing on S.B. 48 (R1). I will now open the hearing on Senate Bill 114 (1st Reprint).

Senate Bill 114 (1st Reprint): Makes changes relating to prescriptions for certain controlled substances. (BDR 40-239)

Senator Joseph (Joe) P. Hardy, Senate District No. 12:
To bring the Committee up to date, Senate Bill 459 (2nd Reprint) was just concurred with on the floor of the Senate moments ago. It took a lot of the work of this Committee, and I appreciate everything you have done, not just in Committee but across the way and down the halls. It is very sobering when we

consider what the reality is in life. The headline in the *State Legislatures* February 2015 edition says "Pain Killers Are Killing Us." These are quotes from the article:

> States are on the front lines of a drug overdose epidemic that kills an estimated 113 Americans every day—more than die from motor vehicle crashes, according to the Centers for Disease Control and Prevention.
>
> . . . the crisis is devastating families and costing states millions of dollars in health care, lost productivity and law enforcement.
>
> Drug overdose deaths in the United States have tripled since 1990, primarily due to increasing rates of prescription opioid painkiller abuse and accidental misuse, the CDC says.

That brings us to Senate Bill 114 (1st Reprint), which is a companion piece of legislation with S.B. 459 (R2). Senate Bill 114 (1st Reprint) requires the State Board of Pharmacy to allow a law enforcement officer to have Internet access to the Prescription Drug Monitoring Program database if the employer of the officer approves and submits certification to the Board that the officer meets certain requirements. [Continued reading from (Exhibit H).]

I can walk through the bill, but in essence, what has happened is we found that the State Board of Pharmacy already knows who the bad actors are. This bill will allow them to talk to the different boards, such as the Board of Medical Examiners, State Board of Osteopathic Medicine, State Board of Podiatry, and Board of Dental Examiners of Nevada. They will actually be able to communicate. The State Board of Pharmacy has had the opportunity to know who writes the most prescriptions for medicine and who the patients are getting the most medicine. They can then let the practitioner know if one of those patients is his, allowing him to decide how to use that information to prevent the patient from using too much. I would be happy to answer any questions.

Assemblyman Jones:
Tell me if my quick overview is correct. This bill uses our existing reporting in the pharmaceutical industry for prescriptions, and it allows police officers to monitor that to see if certain people are getting overprescribed. If those people are being overprescribed, they look into it. It does not require all doctors to be involved in another layer of bureaucracy, but rather uses existing reporting requirements and allows only the bad actors to be detected. Is that it in a nutshell?

Senator Hardy:
Yes, it is. I have with me Chuck Callaway, a police director, who can be more specific to your question.

Chuck Callaway, Police Director, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department:
We are here in support of the bill. To answer your question, Assemblyman Jones, law enforcement has, in the past, had access to the system. However, about a year ago I was approached by our narcotics detectives who had some conversations with the State Board of Pharmacy. Their general counsel had told our detectives that, based on the language in the law as currently written, it did not authorize law enforcement to have access. Therefore, they no longer would allow our detectives access. That was the starting point for this bill. They said they approved of us having access, but it would require putting specific language in the law for them to once again grant access. It is important to note that we are talking about a very small number of officers who are assigned to a prescription drug task force as their sole duty. This would not be an officer in the field wearing a uniform or a traffic officer accessing the system. It would strictly be an officer whose only job is to investigate prescription drug fraud or abuse. Secondly, fishing, for lack of a better term, would not be allowed. An officer could not access the system just to pull up data on someone to determine if anything looks out of the ordinary.

In order to access the system in this bill, the officers would first have to go through the training required by the Board. They would then be issued a log-in number so that any time they enter the system, it can be tracked to ensure accountability. Lastly, our agency would have policy and procedure in place to ensure that the system is not misused. They could only access the system to investigate a specific incident, not to go in and fish. An example would be if someone calls the police department and reports the belief that a neighbor is selling prescription medication to kids at the schoolyard and that the person is going from doctor to doctor to get prescriptions and then sells the medication. The officer, based on that tip, could then generate an incident number and access the system to determine if there is truth or merit to the allegation. If the officer accesses the system and sees that this person has gone to numerous doctors over the past few months and has gotten prescriptions, that would be reasonable suspicion to potentially get a search warrant to investigate further. It would be very limited in scope, and there would be checks and balances in place to ensure privacy and that the system is not misused.

Assemblyman Jones:
I am all for getting bad actors since that is the point. What we are not doing is creating another overlay of bureaucracy that doctors or pharmacists have to comply with. It just allows the portal to be used as it exists now to specifically find the bad actors.

Chuck Callaway:
That is correct.

Assemblyman Jones:
I like that.

Assemblyman Thompson:
Is this compliant with the Health Insurance Portability and Accountability Act (HIPAA)?

Chuck Callaway:
I am not a HIPAA attorney or expert. I believe if law enforcement has information that criminal activity is occurring, there are some exemptions for investigating those allegations that do not violate HIPAA.

Assemblyman Thompson:
Why would the information be uploaded prior to it happening instead of making it case by case? Why have all of these people in a database who could potentially be vulnerable since the bill talks about needing the supervisor's permission for access? Why would it not be at the point of discovery that you go through the process, instead of having everyone uploaded into the database?

Chuck Callaway:
I am not sure that I fully understand your question, but I believe currently the system is voluntary. The information that is in there, which is provided by the doctors, is voluntary. Is that correct, Senator Hardy?

Senator Hardy:
I have someone with me who represents the people who work with pharmacy issues. The prescription monitoring program is a program that a physician can access to find out what his patient is doing. For instance, a person goes to a doctor as a new patient claiming he has back pain and wants Percodan. It sounds like a legitimate request because he looks like he is in pain. The doctor steps out to check the database, and lo and behold, the patient leaves because he knows what the doctor is doing and what he will find. The patient has already seen three doctors today and hit each one up for 60 Percodan. The doctor will find that in the system.

The doctor has access to the database because he is registered. He just has to type in his secret number. The database shows what is filled in a pharmacy rather than showing what the doctor has prescribed. He does not access it to see what he has prescribed as much as what the patient has filled. That is beyond the doctor and beyond the policeman; however, if the policeman catches this person on the corner with three bottles of Percodan, he knows the person has been doctor shopping and can access the database for his name. They each have a secret number and can access the database for that person only in order to determine where and what that person has been doing recently.

Assemblyman Thompson:
I feel very uneasy about that because people can say whatever they want about you. I would like to know the exact process for law enforcement before that officer or detective can put in his number for access.

Senator Hardy:
We have had this same debate. There has to be some credibility before the policemen can access someone. This bill has penalties if they access the system for any other reason than to investigate a specific incident. In the process of investigating it, even if there was credibility and they misuse the information to do something else, then the policemen who accessed it are guilty of a crime.

Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
I would like to address some of my comments to Assemblyman Thompson and his concerns. Retail Association of Nevada was involved in the implementation of this prescription monitoring program in the 1990s. We were very clear and very worried that this would be something that could possibly be used in a negative way for these patients at some point in time, therefore, regulations and oversight were written into it. At the time, the Department of Public Safety was the only law enforcement agency that was allowed access. Other law enforcement agencies could get information through them. I understand this is very burdensome now, so we sat down with law enforcement and Senator Hardy and looked at what we could do going forward.

To give you some comfort in this, the State Board of Pharmacy will be working on regulations because it is another piece that shows prescription drug abuse in both the prescriber and the patient. One of the things the State Board of Pharmacy hopes to do is to approach some of the patients from the database to help them get treatment and move forward. They do not have the money available to broaden that scope, but helping patients has already been going on with information from the database. The database information is submitted

within a 24-hour period from a pharmacy for those who have filled prescriptions. If a doctor prescribes something for me, but I do not fill it, that information will never be in there. That is one thing in S.B. 459 (R2) that we fought to keep out. We did not want information that law enforcement may see and utilize that may not be accurate. There is a level of comfort to be had once the regulatory process begins, and I feel certain that law enforcement is not looking at this for a fishing exercise. I feel a great deal of comfort with that at this point in time.

Assemblyman Thompson:
I understand what you are saying, but it is like putting the cart before the horse because I would have to feel comfortable with the regulations before I can feel comfortable voting on this.

Assemblyman Moore:
In section 1, subsection 7, it states, "As used in this section, 'law enforcement officer' means any person upon whom some or all of the powers of a peace officer are conferred...." I am really uncomfortable with "whom some...of the powers." Could that be a Peace Officers' Standards and Training certification in Categories I, II, or III?

Chuck Callaway:
In section 7, that is the standard definition of law enforcement throughout statute, but I would defer to Legal. If you look at section 1, subsection 1, paragraph (a), the only person that would be able to access this system would be someone whose "primary responsibility...is to conduct investigations of crimes relating to prescription drugs." For the Las Vegas Metropolitan Police Department, that would be a Category II police officer who is assigned to a prescription drug task force. That is his sole duty. For example, it could not be an animal control police officer with limited police powers who might be Category I. That person would not be able to access this system because it is not his duty to investigate prescription medication abuse.

Assemblyman Moore:
Would the bill's sponsor be open to an amendment that would possibly put safeguards in place? Everyone has good intentions, and no one is saying that anyone is going to abuse the privilege of looking into our private lives and seeing what we are being prescribed. However, no one is going to die right now whether you get to look at this or not. In that spirit and since there is not an urgency, would you be open to an amendment that would have you obtain a search warrant prior to accessing the information? Obviously, if you have a tip, you are going to investigate, the same way as if I were growing pot in my house.

Chuck Callaway:
That is a very good question. The reason it is impractical is because this is the information used to obtain a search warrant. At the point where the officer accesses the database, we are operating on reasonable suspicion, which has not risen to the level of probable cause where an officer could get a search warrant. In the scenario I gave earlier, if someone made a report to law enforcement that a person was selling prescription medications to kids on the school ground, we do not have enough probable cause at that point based on allegations to get a search warrant for that person's home. The access to the database is one of the overall pieces to the puzzle that make up the investigation to give us that threshold of probable cause, allowing us to get a search warrant. If a warrant were required to access the database, law enforcement would never have enough probable cause at that stage of the investigation to access the database in the first place.

Assemblywoman Benitez-Thompson:
We are allowing access specifically to peace officers, such as sheriffs and gaming control folks, as stated in *Nevada Revised Statutes* (NRS) 289.150 and NRS 289.360, but leaving out others, like legislative police and school police. Can you talk about the decisions on different types of law enforcement officers to include in this?

Chuck Callaway:
The intent of this bill is only for officers whose assigned primary duty is to investigate prescription drug fraud and abuse. The definition in the bill is to define what law enforcement is in general. There are various categories of law enforcement officers in statute, including Category I and Category II officers, depending on their duties. For example, school or legislative police have a very limited scope of duties. They deal strictly with the schools or the Legislature.

Assemblywoman Benitez-Thompson:
I misread this and my apologies. It is NRS 289.150 to NRS 289.360, so that is going to be everyone. For some reason, I thought it said "and," so I will correct myself for the record. The intent is all the broad scope of law enforcement.

Chuck Callaway:
The purpose of section 1, subsection 7, is to define what, in general, a law enforcement officer is. I cannot fathom a reason why a school police officer would be put on a task force to investigate prescription drug abuse. It is a small number, about 12 officers in the whole state, who are assigned to investigate prescription medication abuse. I believe your question is, would there be other law enforcement entities that might be able to access this

system. The answer would be no, unless they are assigned for their primary duty to be prescription medication investigations.

Assemblywoman Benitez-Thompson:
In section 1 when we talk about the intent of the officer whose primary duties are to conduct investigations of crimes relating to prescription drugs, am I correct that the language that corresponds to that states the law enforcement employer would specifically get to certify certain employees? Is it up to each law enforcement agency to apply that certification process?

Chuck Callaway:
Yes. The way this would work is, for instance, the Las Vegas Metropolitan Police Department would designate which officers who currently do prescription medication investigations would need to potentially access this database in the course of their duties. We would notify the State Board of Pharmacy that these four or five officers would need access to the database. They would have to be trained to be certified by the Board and be issued a personal identification number to access the database, and then we would certify them. Not just any officer could have access. That criteria would have to be in place.

Assemblywoman Benitez-Thompson:
In section 1, subsection 4, where it talks about the law enforcement officer is given access to the database to investigate a crime, could you clarify what that would mean? There are still some members, including myself, trying to figure out at what point the investigation actually starts. I would think it would start with the filing of a police report, but I do not know if that is true. Would the investigation be after a report is filed?

Chuck Callaway:
If the officer who is part of the task force receives information that a crime has occurred, he can file a report. However, a crime report might not necessarily be filed. In order for a crime report to be filed, you would potentially need a victim. In some cases, you do not yet have someone coming forward claiming he was victimized by this crime. If the person alleges someone sold his child Percocet, he could be a victim who files a report. However, often in these cases, it is going to be someone who believes that suspicious activity is occurring. To give you an example, we get reports all the time where someone says, "My neighbor across the street has cars coming and going all the time. There are different vehicles during all hours of the night. People swing by for five minutes, and then are gone. I smell a strange odor coming from the home. I have seen the person out in front making hand exchanges with people through the car windows. I believe they are selling drugs there."

At that point, it is a tip. We do not have a crime report and have to look into it further. We do not have enough for a search warrant and have nothing more at that point other than the tip. We have to conduct an investigation to either clear the person and say they are not selling drugs or, yes, there is some illegal activity happening. Then we have enough evidence for a warrant.

This system would be used in the same way. If an officer received a tip or a report was made that suspicious activity was occurring that they believe is criminal in nature, and if the officer believed that a crime was being committed, he would be able to access this database. Access to the database may clear the person that the allegations were made against. The officer may say there is no suspicious activity there, or it may provide reasonable suspicion to further the investigation and possibly have enough probable cause to issue a warrant. Access to the database is one piece of the investigatory puzzle.

Assemblywoman Benitez-Thompson:
Is the intent of this bill to look for physicians who might be at fault for overprescribing? Or is the intent to find patients who are looking for physicians who are overprescribing? It sounds like the patients who are shopping for prescription drugs, but I do not know if that is correct.

Senator Hardy:
There are two parts to this bill. There is the law enforcement part and the patient part. I appreciate your asking, Assemblywoman Benitez-Thompson. When the bill was first being written, I wanted a way to find the physicians who were prescribing more than they should by looking at the top five percent of narcotic prescribers. The Board of Medical Examiners could then ask those people if they are aware that they are in the top five percentile of prescribers of opiates. That did not sit well with other physicians, so I asked myself how this could be done. That is why the bill is written in two parts. The second part is the focus of the bill and is mainly about the patient. The Board of Pharmacy keeps track of the patients and how much medicine they get. They are then in a position to pick up the phone to the Board of Medical Examiners to make them aware that the patient is using an inordinate amount of Percodan or oxycodone. If the patient using the oxycodone is taking 1,800 pills a month, you have a problem. The State Board of Pharmacy notifies the Board of Medical Examiners, which oversees the doctors of medicine (M.D.), and they now know that this patient got his prescriptions from certain physicians. The State Board of Pharmacy has no technical jurisdiction over M.D.s, doctors of osteopathic medicine, or podiatrists. They are under the Board of Medical Examiners or the State Board of Osteopathic Medicine, which are their licensing boards. However, now the State Board of Pharmacy can warn those licensing boards that they have a doctor who has a patient using an amount of medicine that is

unlikely needed. Therefore, the Board of Medical Examiners can determine what to do with the information. They are not compelled to make an investigation, impose a sanction, or do anything to the prescriber, but, rather, they can pick up the phone—or in whatever manner they want—to make the doctor aware that his patient is using 1,800 oxycodone a month. When the doctor is notified, he can determine if he was unaware of it or that he knows because that is what he usually takes, and that is the dosage he always writes. If the Board of Medical Examiners feels that physician is writing more than is rational, they can allow that physician to get help on his prescribing methods.

This is two different bills combined into one in order to accomplish two different things. One is to make sure that the physician/patient relationship is honored and that physicians have the opportunity, if they are prescribing incorrectly, to amend their ways. However, this bill predominantly looks at the patient and how to protect him from being in a position of taking too many drugs. That gives the State Board of Medical Examiners the opportunity to investigate if it chooses. There is the medical side to this bill, and also the law enforcement side. They are two different issues.

Assemblywoman Benitez-Thompson:
I was trying to understand one intent behind this bill, but it seemed like I was hearing two separate conversations regarding the bill. One was the process Mr. Callaway was talking about—the intent of officers accessing the database. That was different than what I was hearing about helping patients who overuse prescription drugs. Thank you for the history of how the two bills came together.

Chair Oscarson:
Is there testimony in support of the bill here or in Las Vegas?

Eric Spratley, Lieutenant, Legislative Services, Washoe County Sheriff's Office:
We are very much in support of this bill and all of the testimony.

Assemblywoman Benitez-Thompson:
Do we have law enforcement in Washoe County who are designated to a prescription drug task force or who have those duties?

Eric Spratley:
Yes, Assemblywoman Benitez-Thompson, we have one detective who is specifically assigned to that task force and fits the description in the bill.

Chair Oscarson:
Is there any other testimony in support here or in Las Vegas? [There was none.] Is there any testimony in opposition here or in Las Vegas?

Mona Lisa Samuelson, Private Citizen, Las Vegas, Nevada:
I am a 25-year resident here in Nevada. I am here today because I have quite a bit of difficulty with this bill. I do not know if you know this, but I usually come out to speak on medical marijuana issues. I realize that this is currently talking about prescription drugs. However, I think the communities overlap themselves because when you are talking about the medical marijuana community, a lot of people come into this trying to get off of prescription drugs. That is usually how it goes. When I hear Senator Hardy say the intent is really for the patient's good, that this is to protect our health, I do not feel that this bill is going to help our health. This is already under the assumption, as he said, that the State Board of Pharmacy knows who the bad guys are. I am here to tell you, as a patient for over 20 years with chronic debilitating pain, the State Board of Pharmacy has no idea what is really going on with these physicians handing out prescriptions to people. I am a medical patient, and I do not think anyone's health care records belong in the hands of law enforcement. There is one thing to have what you call a prescription monitoring database. I believe the integration of health information and exchange should be there, but then maybe it should be as a registry of offenders. That is one thing. However, to have a database where you are putting medical patients in a vulnerable spot, many of us are prescribed huge amounts of pain killers. I do not think many of us use that many of them either.

This is a very interesting bill when it claims that it is going to be for our health. You are regulating contention; that is what you are doing in these communities. Based on the testimony of Mr. Callaway, reasonable suspicion is all that it takes to decide who gets to look into this. It is not enough to go on reasonable suspicion and hearsay when superseding our HIPAA laws. If hearsay is not a good enough thing to use in a murder charge, I do not think it is going to work to supersede HIPAA. This is a system that should not be monitoring medical patients as criminals. You should have to get a search warrant in order to access these kinds of records. I highly doubt that the good these laws will do is very much. As someone brought up, once they saw that these patients were taking a lot of drugs, they would come back with doctors who would help them. They can have these types of databases that do not go into the hands of any type of law enforcement if that is the true intent. I want you to know that as medical patients, we are very upset. I am so tired of Nevada using "for the good of the patients" in order to get a quick and easy way to regulate us into criminal action. I take offense to any bill that is going to put the sick, injured, and dying at further risk of poor policing policies. I will tell you how to protect

your medical patients. It is very simple. Please just listen to us. We are here to tell you that this is bad policy. We all feel it very strongly, and that is why I am here.

Vicki Higgins, Private Citizen, Las Vegas, Nevada:
I agree with Assemblyman Thompson that this could very well be a HIPAA infringement. I appreciate the efforts and intent of this bill to protect patients in the community, but I agree that a mass database is unreasonable. I am a patient who went through many years of unexplained pain and mountains of pain medications and suffered as the result of it. I appreciate your efforts to control and make sure that doctors are not overprescribing, but I think you are overstepping personal rights by using a theory or a tip to call and find out what our medicine is. That is between me and my doctor. I do not think the law enforcement officer has anything to do with that unless I am standing on a corner and visually selling it to kids. There has to be an extremely reasonable suspicion before our HIPAA laws are breached like this. Why bring the police in? I thank you for your efforts. I hope we can get this straightened out to where it is a good bill.

Chair Oscarson:
For the record, I have asked Committee Counsel to look into the HIPAA component of this, so that we can get clarification with the Committee before we vote in work session. Is there any other testimony in opposition? [There was none.] Is there any testimony in neutral? [There was none.]

Senator Hardy:
I left out a key item about what I tried to do with the top five percent of doctors prescribing narcotic medications. Obviously, doctors who are in chronic pain management rise well above the ninety-fifth percentile of prescribing pain medicine, so the five percent did not work well. People who treat chronic pain have patients in hospice, and have palliative care, are going to prescribe more pain medicine. The two parts of the bill may be somewhat confusing, so the second part of the bill that deals with the medical standards are not designed to "turn over to the police" but to allow the Board of Medical Examiners to help the physician and the patient relationship, so that the patient is not having to use more than expected for what his particular injury or illness is. I appreciate the concerns that the Committee has and will be happy to work with whomever on whatever questions they may have offline.

Chair Oscarson:
Seeing no further testimony, I will close the hearing on S.B. 114 (R1). Is there any public comment either here or in Las Vegas? Seeing none, we will adjourn the hearing [at 2:04 p.m.].

[(Exhibit I) was submitted but not discussed.]

RESPECTFULLY SUBMITTED:

_____
Karen Buck
Committee Secretary

APPROVED BY:

_____
Assemblyman James Oscarson, Chair

DATE: _____

EXHIBITS

Committee Name: Assembly Committee on Health and Human Services

Date: May 1, 2015 **Time of Meeting: 12:54 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 14	C	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 31	D	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 196 (R1)	E	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 281 (R1)	F	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 48 (R1)	G	Dena Schmidt, Department of Health and Human Services	Fact Sheet
S.B. 114 (R1)	H	Senator Joseph (Joe) P. Hardy	Testimony
S.B. 114 (R1)	I	Nevada State Medical Association	Letter of Support