MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-first Session
March 9, 2021

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:32 p.m. on Tuesday, March 9, 2021, Online. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Dallas Harris
Senator Joseph P. Hardy
Senator Ben Kieckhefer

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Norma Mallett, Committee Secretary

OTHERS PRESENT:

Sara Cholhagian, Executive Director, Patient Protection Commission
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Kyra Morgan, Chief Biostatistician, Division of Public and Behavioral Health, Department of Health and Human Services
Claudia Duck Tucker, Teladoc
Greg Ott, Chief Deputy Attorney General, Office of the Attorney General
Kyle Zebley, American Telemedicine Association
Charlie Shepard, Nevada AARP
Jasmin Tobon, Planned Parenthood
Chelsea Capurro, Health Services Coalition
Dalton Hooks, Nevada Self Insurers Association
Tom Clark, Nevada Association of Health Plans
Debi Reynolds, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services

Helen Foley, Delta Dental
Sandie Ruybalid, Chief Information Technology Manager, Division of Health Care Financing and Policy, Department of Health and Human Services
Asher Lisec, PhRMA
Bill Welch, Nevada Hospital Association
Katie Ryan, Dignity Health - St. Rose Dominican
Bobbette Bond, Culinary Health Fund
Chris Bosse, Renown Health
Dan Musgrove, Valley Health System of Hospitals
Katie Robbins, Planned Parenthood
Mark Krueger, Chief Deputy Attorney General, Office of the Attorney General
Chris Neal, CarFax

CHAIR RATTI:
I will open the hearing on Senate Bill (S.B.) 5:

SENATE BILL 5: Makes changes relating to telehealth. (BDR 40-416)

SARA CHOLHAGIAN (Executive Director, Patient Protection Commission):
I will provide you with an overview of the Patient Protection Commission, their work, the process and how these measures came about (Exhibit B). The Commission was created by S.B. No. 544 of the 80th Session, sponsored by the Governor, and received unanimous bipartisan support.

The Commission is comprised of healthcare experts, advocates, providers and industry professionals who systematically review issues related to the healthcare needs of State residents including quality, accessibility and affordability, and prescription drugs. The Commission also makes recommendations to the Governor and Legislature to improve health care for all Nevadans.

The goal of S.B. 5 is to enact legislation to codify telehealth flexibilities granted during the Covid-19 public health emergency, specifically aimed to increase patient access to high-quality care while reducing costs and improving patient and provider safety through the inclusion of clear, effective and sustainable telemedicine language in the *Nevada Revised Statutes*.

The request expands service by establishing all-payer parity, requiring a third-party payer to cover services provided through telehealth in the same amount as services provided in person, except for services using a standard telephone. It also requires the Department of Health and Human Services (DHHS) to establish a data dashboard allowing for analysis of data relating to access to telehealth.

SENATOR KIECKHEFER:
Is a cellular telephone considered a standard telephone?

MS. CHOLHAGIAN:
It does. I would like DuAne Young to specifically respond to the question.

DUANE YOUNG (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
This language is in standard *Nevada Revised Statutes,* and it does apply to both landline and cellular devices.

SENATOR KIECKHEFER:
The provision of telehealth will include services provided through a standard telephone, but they can be billed differently. Is this correct?

MR. YOUNG:
Yes. The telephone is restricted by the federal government because it is a non-HIPPA compliant platform. This federal regulation is governed by the Office of Civil Rights within the Department of Justice. Language in the *Nevada Revised Statutes* (NRS) 422 states "to the extent applicable" which gives S.B. 5 the authority to allow telephone if it were to be allowed by the federal government "to the extent applicable." It also sets up the Division of Health Care Financing and Policy (DHCFP) for the discretion to not pay parity. Nevada Revised Statute 422 requires parity for in-person services in telehealth; this would allow us to set up a separate modifier for telephone delivered services, and we could pay them at a different rate than what we have paid traditional telehealth or in-person visits.

I serve as part of the Western States Pact for the Governor's Office, and a portion of this language is something other states have done. When they face a budget shortfall or crisis, they do not have to cut rates across the board. They can set payments from those services delivered via telephone versus those by telephone only, particularly when they are dealing with providers who are cost-based reimbursed. The challenges of buying telehealth equipment or setting up shop for in-person visits are taken into consideration and billing those rates as opposed to making a telephone call.

SENATOR KIECKHEFER:
If I am using a software application on my telephone, am I using a telephone or am I using a technology service in the broader definition of telehealth?

MR. YOUNG:
This is the modality, so if this is a standard telehealth visit, there are audiovisual requirements. If it is telephone, there is a certain audio requirement. There are apps utilizing remote patient monitoring codes. Those are different current procedural terminology (CPT) codes which are billed usually in conjunction with another visit. Nevada does not currently cover those codes. Usually working through a health app is not part of the reimbursement process in working with a physician.

SENATOR KIECKHEFER:
There is some discussion about the types of definitions allowed, provided by synchronous or asynchronous technology. Is it your belief the definition is covered under our existing statute?

MR. YOUNG:
Yes, it is covered under NRS 422, the section governing Nevada Medicaid.

SENATOR HARRIS:
Who would be able to access this all-payer system? Is the information aggregated and who has the ability to pull information?

CHAIR RATTI:
There is some confusion between the two bills we are hearing today because both bills have a data collection component. The claims database is actually in another bill that will be discussed later today. I understand why there might be confusion. Senate Bill 5 also has some data collection components. Ms. Cholhagian, could you please provide clarification?

MS. CHOLHAGIAN:
Senate Bill 5 is not a data collection bill but mirrors a similar bill we will hear today. Senate Bill 5 puts the burden on the State to utilize the best resources of data collection efforts done within the State. There is no burden on any payers

or insurance to submit data for the dashboard. The intent is for the State to utilize existing information to create the dashboard. The idea behind it was you cannot improve what you cannot measure. When you look at health and want to address equitable access for patients in our State, you want to have measurement of the data. The creation of the data dashboard is the first step to measure telehealth access to address equitable access and start looking at vulnerable populations.

SENATOR HARRIS:
Am I understanding correctly that whoever is the administrator of the dashboard only would have access to the data itself; the rest would be publicly available in the dashboard.

MS. CHOLHAGIAN:
Yes. Sections 1, 2, 3, 5, and 6 of this bill establish the parameters for the DHHS to create this data dashboard. There is a requirement it get posted on the agency website as well as the Commission website. If you are familiar with data dashboards the State has produced related to Covid-19, it is very similar. The agency is going to create a data dashboard which will be housed on the DHHS website as well as the Commission's website so consumers can see and access the data; however, it is created by DHHS. There is no data released or requested in this bill as it is only about the creation of the data dashboard.

SENATOR HARRIS:
Will it be DHHS who will put into place all of the protections around the data? When we get personalized data, we want to see how the data is allowed to be used and who can control it.

CHAIR RATTI:
This bill does not contemplate any new data collection. It only uses data the State already has, for example, Medicaid claims covered by HIPAA and all the rules for Medicaid, or the number of individuals who are receiving respite care. It is only the data the State already owns. An effort is being made by DHHS to create a data unit by pooling all the statistician data people into one unit.

The bill asks we take all the data and put it into a dashboard which makes data understandable to the general public and all of us. It is less about new data. Whatever protections are currently in place for the data still stand, and this bill does not do anything about that. The next bill we will be hearing does have a lot of questions about data because it is new data. This bill is about taking the data we currently have under existing protections and presenting it in a useful way.

SENATOR HARRIS:
This helps. I worry a bit about consumer protection, and anytime you centralize a large amount of data, even if you already have access to it, there are some questions. However, your explanation makes sense.

CHAIR RATTI:
Ms. Cholhagian, can you speak to the nature of how this data is intended to be presented, I am assuming aggregated, and identified? There is nothing in the dashboard that would have any individual records or information about any individual patient, is this accurate?

MS. CHOLHAGIAN:
Yes. Kyra Morgan from the Division of Public and Behavioral Health (DPBH) will later provide testimony on the proposed amendment (Exhibit C); however, she is available now to answer your specific question.

CHAIR RATTI:
Ms. Morgan, could you talk about data the State now has and is currently protected?

KYRA MORGAN (Chief Biostatistician, Division of Public and Behavioral Health, Department of Health and Human Services):
The information on the data dashboard and our amendment will be addressed in public comment at the end of the hearing; however, all the data we present would be aggregated. There would not be anything to identify a person on an individual level.

SENATOR HARDY:
I have similar questions regarding the creation of a data dashboard which allows for the analysis of telehealth by different groups and populations which must: "Allow for the user to sort data based on the race, ethnicity, ancestry, national origin, color, sex, sexual orientation," etc., as stated in S.B. 5, section 1, subsection 1, paragraph (a), subparagraph (2). Do we actually have data for individuals which can then be disaggregated or aggregated? I am not sure how you did the data collection and how you use it.

MS. MORGAN:
This is actually applicable to the amendment we submitted from DBPH. It adds language around the dashboard for us to collect and present data, contingent on what data is available and within federal regulations. It is likely the dashboard will be a subset of what is essentially the big goal from the Commission, but we will be able to include at an aggregate level as much information as possible.

SENATOR HARDY:
What are you going to do with it?

MS. CHOLHAGIAN:
The intent of the data dashboard is the first step to measure telehealth access, address equitable access and look into vulnerable populations. It requires DHHS to create the data dashboard, and the agency must utilize it in the decision-making process.

In addition, the data dashboard ties in other advisory boards in the State, including the Commission, Commission on Behavioral Health, five regional behavioral health policy boards, as well as the Legislative Committee on Health Care. These entities will review the data dashboard and include it in the review of their own policies. It is looking at the long-term recovery and aiming to address health equity to ensure we create and have good data that is available and review and put it into consideration for future policy decisions, in addition to ensuring it is on the Commission website. The thought behind this was to make sure patients and consumers would be able to easily access and review the information themselves and also be able to opine on it.

SENATOR HARDY:
Is someone else doing this, and is it working somewhere?

MS. CHOLHAGIAN:
The State of Colorado is doing this and has built an equitable dashboard using the same thought process as the Commission's intent. I am not aware of any other state doing this. DuAne Young may be able to speak to this because as he mentioned earlier, we are part of the telehealth multistate collaborative.

MR. YOUNG:
Yes, Colorado has done this. This did not particularly influence the decision of the Commission, but other states within the Western States Pact, such as

California, are looking at this as well. It is important to have this data centered in certain areas of our State where telehealth is heavily relied on, such as rural and urban areas which do not necessarily have the healthcare infrastructure and had a difficult transition in the pandemic. Having this type of data and knowing how the services are delivered will help us figure out how to more equitably address grants when they are available and how to better support providers who have not made and are having difficulty making the transition.

CHAIR RATTI:
We may not know the race, gender and ethnicity of an individual patient, but we may be able to see utilization patterns within the Medicaid telehealth utilization. We may be able to overlay the data with neighborhoods where we have census information and where we might know if there are higher concentrations of people of color, for example. This would give us not only a patient-by-patient piece of information but meaningful information in terms of equity and how we are doing in terms of access to services. We can look at people who have generally not had access, such as people of color or lower income neighborhoods. Is this the idea?

MR. YOUNG:
Yes.

SENATOR SPEARMAN:
Do you have the ability in data collection to share information from certain categories, such as sexual orientation or gender identity, so it is not just one particular portion of health care and we do not have the information for another? Once you collect the data with the appropriate information redacted, do you have the ability to share it with other internal agencies?

MS. CHOLHAGIAN:
The intent is to share the information and have it housed on the DHHS website, as well as the Commission website, and for those other public bodies and the public to review the dashboard.

SENATOR SPEARMAN:
Policy will be directed based upon that. For example, if you can get one particular demographic hardest hit with Covid-19, you will direct resources to the community so the underlying mobilities would be addressed in the case of

another pandemic. You would also be able to do some other things like prevention education. This is helpful information.

SENATOR KIECKHEFER:
Regarding the data analysis and policy recommendations, are you specifically asking for eight different boards to provide policy advice to you?

MS. CHOLHAGIAN:
The intent is to have them included in their review process. Whether they make it a priority is going to be at the discretion of each public body. We are making it known we intend for the data dashboard to be created and to be reviewed.

SENATOR KIECKHEFER:
My follow-up question on the telehealth issue is related to behavioral health parity and whether it creates a disparity for behavioral health services in terms of reimbursement disparities being solely telephonic.

CHAIR RATTI:
Could you please clarify your question because there are two things in your question: behavioral health parity versus modality parity?

SENATOR KIECKHEFER:
Behavioral health services may be fully adequate provided over a telephonic means, but then are we reducing reimbursement for a service which may be fully appropriate for a telephonic service?

MS. CHOLHAGIAN:
The intent of the Commission's bill was to allow for increased access through payment parity on all-payer parity insurers, but recognizing the use of a standard telephone may not warrant the same type of payment parity or standard of care. The Commission did not want to restrict the use of a standard telephone but also recognized it does not want to change the standard of care in saying it is the same as in-person service.

SENATOR KIECKHEFER:
Was there any discussion about whether this was an appropriate decision for mental health services as well as physical health care?

MS. CHOLHAGIAN:
Yes, there was discussion about telehealth access particularly for behavioral health, but it was not included specifically in this measure.

CHAIR RATTI:
I understand there is movement at the national level. We are in an uncertain time right now in terms of reimbursement for telephone only or voice only versus a full true telehealth solution. If we wanted telephone to be fully within parity, we would also be saying the State would have to pay 100 percent because it is not a Medicaid reimbursement. We are waiting to see if the federal government moves on this. You said earlier the bill is written in such a way if there is movement, it would be a benefit to us and all Nevadans. Could you please tell us a little bit more about this?

MR. YOUNG:
Yes, there are conversations at the federal level. This is a federal regulation governed in HIPAA by the Office of Civil Rights within the Department of Justice. During the pandemic and declaration of public emergency, the Office of Civil Rights made non-HIPPA compliant platforms which include telephone. They decided not to enforce the prohibition on those so the Centers for Medicare and Medicaid Services (CMS) provided a directive this could be reimbursed and utilized. The State then covered it in a section 1135 waiver of the Social Security Act.

We are reimbursing for telephone services with certain exceptions. Back to the language in NRS, if the federal government were to move on this, and the existing language within this law was not modified to the extent applicable, we would be able to receive reimbursement or match. We interpreted this as our ability, if the federal government were to allow this and we were to get matched, to certainly continue those flexibilities. If not, we would continue operating under NRS 422, the telehealth provisions as cited in our chapter as we have been.

Not changing this language gives us the discretion we have used during the pandemic through our Covid-19 memos to provide further guidance about services which were and were not traditionally allowed for telehealth but certainly not appropriate for telephone. We have done this with some rehabilitative mental health services as well as some health services on the medical side. We have provided the guidance on our website and announcements to providers. We do not see this bill as changing anything in our operation but allowing for this enhancement and allowing us to take advantage should the federal government move in a different way. We would then craft parameters in permanent policy around the reimbursements for telephone services if reimbursed by the federal government.

CHAIR RATTI:
The federal government would have to address the HIPAA issue, and then CMS would have to address the reimbursement issue.

MR. YOUNG:
Correct.

CLAUDIA DUCK TUCKER (Teladoc):
We support S.B. 5 and I have provided written testimony (Exhibit D). We support legislation to codify telehealth flexibilities granted during Covid-19 public health emergency into law. The clarifications to the telehealth statutes will ensure the latest innovations in technology such as asynchronous communications are compliant with Nevada law to allow remote patient monitoring which is critical to those with diabetes and cardiovascular disease.

We encourage language which will allow for expanded access to expert medical second opinion services to the best specialist in the Country without incurring the cost and inconvenience of travel.

CHAIR RATTI:
There is an S.B. 5 amendment request, (Exhibit E), submitted on behalf of Teladoc. It is focused on the definitions and some of the other pieces in this bill.

We understand from our legal counsel, if the definition is inclusive and we start listing things out of it, we may have some unintended consequences. Ms. Tucker, why do you think the bill as written does not include the technologies you are concerned about?

MS. TUCKER:
I think it is unclear to laymen, our clients, who read this, but is quite clear to me as I live this every day. Anytime we can clarify statutes so everyone understands it, we are all better for it.

CHAIR RATTI:
Mr. Robbins, please speak to what you think the bill says or does in terms of inclusivity and clarity.

ERIC ROBBINS (Counsel):
This is mainly dealing with more of the existing language of NRS 629.515. The definition talks about the use of information and audiovisual communication technology. I do not interpret "and" to mean you have to have both or it is not telehealth. It can be either one; the "and" just means the definition of telehealth includes both of those things. The store and forward technology falls within the definition.

Nevada Revised Statutes 629.515 does not authorize or prohibit anyone from engaging in any activity depending upon whether or not it is telehealth. It does not say if it is not telehealth you cannot do it. It does not say if it is telehealth you can do it. All it says is if you are going to use telehealth for the purposes prescribed in subsection 1, you have to be licensed in this State and the boards are allowed to regulate beyond that. Basically, the particular statute and definition are not about what people are allowed to do or not allowed to do. The one exception is if you are doing the things described in subsection 1 through telehealth, you have to have a license.

MS. CHOLHAGIAN:
I have our attorney, Greg Ott, on the telephone who helped me review this and looked up the clarification of the intent.

GREG OTT (Chief Deputy Attorney General, Office of the Attorney General):
I agree with Mr. Robbins and came to the same conclusion regarding the statute.

CHAIR RATTI:
You are both saying it is broadly written; therefore, it can be inclusive of anything. It really is only tied specifically to licensing.

MR. ROBBINS:
Yes.

KYLE ZEBLEY (American Telemedicine Association):
I am testifying in support of S.B. 5. I will read from my written testimony (Exhibit F) and offer the proposed amendments (Exhibit G) to this bill.

CHAIR RATTI:
There are similar concepts here. The peer-to-peer notion is not explicitly covered in State law and establishing the patient relationship pieces. Mr. Robbins, are there any concerns about the language suggestion regarding peer-to-peer?

MR. ROBBINS:
No. This would be something we could include. It would not be legally problematic, it would basically restrict the ability of the professional licensing boards to regulate these sort of consultations.

CHAIR RATTI:
Is the same thing true in terms of establishing a patient relationship by a telehealth visit currently requiring it be done in person?

MR. ROBBINS:
It is up to the individual boards who regulate the various healthcare professions. I am not sure what requirements they have, but it is up to their regulations, standards and practice.

CHAIR RATTI:
The notion of those two amendments is the Legislature dictating that versus the boards regulating it.

MR. ROBBINS:
Exactly.

SENATOR HARDY:
Peer-to-peer consultations happen all the time. If the peer-to-peer also have a patient in the middle of the peer-to-peer, can it charge the peer in the other state or can the peer in the state of patient residence charge? Is it just allowing a peer to talk to a peer? What does this proposed amendment do differently than calling on the phone and talking to a specialist in Salt Lake City or in Los Angeles? Does it mean the peer in Nevada can charge the patient's insurance or patient themselves? What about the conversation a doctor in Nevada has by talking to a doctor in Utah? Is this what we are talking about?

MR. ZEBLEY:
This is not in regards to reimbursement. It would just be the Legislature making clear it is an appropriate way to have telehealth interactions with another peer in another state.

SENATOR HARDY:
This does not make sense. We can pick up the phone in Nevada and talk to someone at UCLA or University of Utah. Is it illegal now and we are going to make it legal?

MR. ZEBLEY:
It would be making it explicitly legal. I do not know if it is explicit at the moment. I do not believe it is.

CHARLIE SHEPARD (Nevada AARP):
Nevada AARP supports S.B. 5 since it will improve access to health care by increasing the availability of telehealth for Nevada families who must rely on standard telephones with audio only. I will read from my written testimony (Exhibit H).

JASMIN TOBON (Planned Parenthood):
We are in favor of S.B. 5 because making telehealth accessible through the standard telephone would be a long-term investment in the health, safety and well-being of Nevadans. Telehealth helps connect geographically isolated areas vitally important in health care, and is an essential tool in addressing the health disparities for Indigenous and People of Color, rural and medically underserved communities. The removal of restrictions and increased public and private coverage for telehealth due to Covid-19 has allowed providers to see more patients safely and efficiently. This temporary expansion has provided a demonstration of what innovative, broadened access to telehealth can do.

CHELSEA CAPURRO (Health Services Coalition):
We oppose S.B. 5. Telehealth has great resources and we support the general concept. We also support the data dashboard since it will be a great service to all of our members. We have concerns about the pay parity piece in this bill, which is why we are opposed.

DALTON HOOKS (Nevada Self Insurers Association):
We oppose S.B. 5. We are concerned about the impact of audio only, as other asynchronistic modalities for the provision of medical services will have on the workers compensation system. Section 7, which modifies NRS 616C.730, and section 9, which redefines the definition of telehealth as contained in NRS 629.515, are particularly concerning.

Workers compensation is not the same as general health insurance and the Nevada Industrial Insurance Act represents a careful balancing of the interests of multiple parties including employers, insurers, third-party administrators and injured workers. The initiation of a claim under the Act involves reporting a potential workplace injury to the employer and seeking appropriate medical care. This involves assessment by a medical professional who would, of necessity, need to see injuries and signs of an illness. Aside from finding a diagnosis, the professionals are charged under the Act with opining as to whether upon their examination or told by the allegedly injured worker, they can "directly connect the injury or occupational disease as being job incurred." This is not the same as a doctor in private practice.

We are concerned about secondary gain and fraud issues, identity verification, malingering and lack of nonverbal observations. Increasing the complexity in the system and lack of adequate definition under NRS 629.515 to include which modalities could be done via telehealth. For these reasons, we oppose this bill in its current form.

TOM CLARK (Nevada Association of Health Plans):
We oppose S.B. 5. We do have some concerns, however. We recommend insurers continue to have the flexibility to negotiate prices to keep health coverage affordable for the consumer. Services provided by telehealth must be comparable to the services provided in an office visit. Insurers and providers must be able to establish different reimbursement rates based on the clinical effectiveness and intensity of the business. It is important to develop value-based arrangements by focusing on health outcomes, not just the volume of services provided. The payment parity provision is contradictory to telehealth's cost effectiveness. If telehealth can help reduce costs by using the health care system to reduce provider visits, it is contradictory to mandate those services be paid at the same rate.

DEBI REYNOLDS (Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services):
The proposed amendment brought forward by DHHS allows us to collect and report on the data currently available to us. The bill as written does not refer to data only available to us at this time. We understood it to mean we would need to reach out and collect the data which is why there is such a large fiscal note on it. The amendment as proposed would allow us to remove our fiscal note.

CHAIR RATTI:
This is in line with the testimony on the bill intended to collect existing data and share it.

SENATOR HARDY:
I need clarification on the amendments we are discussing, as there are several.

CHAIR RATTI:
The Teladoc and American Telemedicine Association (ATA) amendments were addressed under support of S.B. 5 and questions about those amendments were answered. We are now focused on the amendment from DHHS, and the administrators will discuss whatever data and funding are available, followed by information about the dashboard.

SENATOR HARRIS:
It has been made clear we are going to be using data we are already collecting, so there is no additional expense there. I imagine the creation of the dashboard itself is still going to cost something, correct?

MS. MORGAN:
We are confident with our current staff and software we can build the dashboard by using existing resources.

CHAIR RATTI:
Ms. Morgan, your colleagues testified this amendment would remove the fiscal note. Is this your assessment as well?

MS. MORGAN:
Correct. The amendment clarifies language to strengthen it and ensures we are not relying on additional data collection. We would use the data and resources

already available to create the dashboard, which would eliminate the fiscal note from DPBH.

HELEN FOLEY (Delta Dental):
We support the DHHS amendment. The language to the "extent resources and data are available," satisfies our needs and concerns. Delta Dental does support telehealth and has been working on these issues throughout the United States. Our initial concern was there might be intrusive questions asked of a patient such as gender identify, sexual orientation and if the patient has mental health problems. We did not feel those questions were appropriate. This amendment only includes data already available and reassures us over concerns we had. We do not have an objection to the legislation.

SENATOR HARDY:
This bill has nothing to do with preventing a doctor from talking to a doctor somewhere else, nor does it have anything to do with getting payment for that, nor does it allow or not allow a doctor from talking to another patient's family or a family caregiver, nor does it allow payment for the interchange because it is already going on. Even though it is not specifically allowed, it is what we do anyway, and this bill does not change nor reimburse for this, correct?

MS. CHOLHAGIAN:
Correct. There may be questions related to one of the proposed amendments seeking to modify this.

MR. OTT:
Yes, it is also my understanding.

CHAIR RATTI:
The original amendment is the peer-to-peer piece in both the ATA and Teledoc amendments, or is it just in the ATA amendment?

MEGAN COMLOSSY (Analyst):
It is in both the ATA and Teledoc amendments.

CHAIR RATTI:
Mr. Robbins, what is current law in terms of peer-to-peer interaction, and would this amendment have an effect?

MR. ROBBINS:
Under Nevada law, it is up to the individual statutes and regulations governing the different professions. For physicians in particular, NRS 630.047 subsection 1, paragraph (b), says physicians do not have to have licenses if they are consulting with or providing assistance to a Nevada licensed physician and they are legally qualified to practice in the state where they reside. The statute does not exclusively mention telehealth, but where telehealth is not explicitly made different, we interpret the same provisions which apply to in-person services apply to the provision of telehealth services. Consultation on an irregular basis for physicians is explicitly allowed by NRS 630.

CHAIR RATTI:
The testimony from those who were seeking the amendment was they were looking for it to be more explicit, but the testimony from our attorney is it is already allowed.

I will now close the hearing on S.B. 5. The hearing on S.B. 40 is now open.

SENATE BILL 40: Provides for the collection of certain data relating to health care. (BDR 40-415)

MS. CHOLHAGIAN:
I will provide you with an overview of the Commission's activities and what led to S.B. 40, (Exhibit I). The intent of this measure seeks to enact mandated reporting of data to the Commission, DHHS and the Attorney General's Office to allow for the monitoring of the healthcare industry.

This is another measure seeking to improve access to health care with the same mindset that you cannot improve what you cannot measure. This is the first step to monitoring the healthcare industry and costs. Specifically, the request does five things which I will highlight for you and are specifically outlined in the attached Exhibit I.

Section 20 of this bill requires an inventory of currently reported health data to be used for analysis in costs/prices, consolidation and patient access to care. Section 14 requires an annual report summarizing healthcare quality for presentation to the Governor, Legislature and Commission. Section 1 ensures the Commission and DHHS have authority to request ad hoc reports.

The largest portion of this measure relates to the establishment of an All Payer Claims Database (APCD). In the last Session, Senator Spearman paved the way for this conversation to happen by introducing a measure which sought to establish an APCD and, as a result of many conversations, is being included in this bill. Senate Bill 40 requires DHHS to establish an APCD relating to healthcare insurance claims provided in this State. Public and private insurers who provide health benefits and are regulated under State law must submit data to the database, and certain insurers regulated by federal law may submit data to the database.

SENATOR HARRIS:
The standard for all health information will continue to be HIPAA. Who will have access to this database; who will be able to access the information on an individual level; and what types of protections or parameters do we anticipate being put around access?

MS. CHOLHAGIAN:
This legislation focuses on authorizing the State to create the data dashboard and establishing regulations to include the data collection process and data release process. I defer to Sandie Ruybalid, Chief Information Technology Manager for the DHCFP and the guru of APCD efforts for our State.

SANDIE RUYBALID (Chief Information Technology Manager, Division of Health Care Financing and Policy, Department of Health and Human Services):
To answer the first question about security requirements, we would contract with a third-party vendor. Part of the contracting process is requiring the party have certifications: Health Information Trust Alliance certification which ensures the party would comply with HIPAA regulations; and the National Institute of Standards and Technology security certification and requirements which protects the data we would house both in transit and stored and in release of the data. As far as releasing the data, most of it would be de-identified and aggregated. Someone would not be able to ping the database for one particular patient. Data released in an identified manner for research purposes would be governed and controlled with data use agreements between the parties to ensure there is an agreement and liability so the data is not released improperly.

MS. MORGAN:
I would add we are already collecting all of this information on our Medicaid population. The security protocols we have in place to protect this information

would be extended to this population. We also collect highly sensitive data around our communicable diseases, including HIV, where we have to maintain confidentiality with the highest regard. We have a lot of processes in place to protect this information. This would be an extension to include payers not already captured in some of our existing data collection mechanisms.

SENATOR HARDY:
I have misgivings about section 5 which indicates a patient with all the other identifications. I know banks are hacked, DETR is hacked and the State is hacked; there has not been an unhackable situation yet. This one takes an individual name, social security number, telephone number, medical record number, health plan beneficiary number, license number, vehicle identification number, serial number, internet address, electronic billing, biometric identifier and photograph image. This is a recipe for disaster when someone hacks it. I have major misgivings about this. This is more of a statement than a question.

MS. CHOLHAGIAN:
I can tell you this specific language was not included in the Commission's request. It was a product of drafting interpretation and indicating it was a necessary component of this measure.

CHAIR RATTI:
This is the information they are specifically saying cannot be released individually and must be aggregated. This is a list of things we want to protect. Correct?

MR. ROBBINS:
This is the definition of the term direct patient identifier. It is not saying the information is going to be necessarily included in the APCD. It is just saying if any information does wind up in the APCD, it has to be treated in a certain manner under section 13. The people who have access to information are very limited, especially with respect to other types of information possibly in the database.

CHAIR RATTI:
If any of the information makes it into the APCD, are we protecting the individual identifying information?

MR. ROBBINS:
Yes.

SENATOR SPEARMAN:
I think when we discussed it last Session, there were concerns around this as well. The State of Washington has something very similar, and I know they have increased security on this type of information. A lot of the information is redacted, so other than researching or trying to establish what the patterns are, I do not know if there is identifiable information on a person. Some of the protections are in redaction, ensuring when it is disaggregated there is no information that could identify an individual.

CHAIR RATTI:
Time has passed since we looked at this concept two years ago. Ms. Cholhagian, could you talk about the number of states who have APCDs and what is happening at the federal level around APCD?

MS. CHOLHAGIAN:
I am aware of 19 states with established APCDs. There is a national effort under the No Surprises Act to entice other states to create APCDs. There is also an opportunity for federal funding which is a noncompetitive application process. I will defer to Ms. Ruybalid about the federal grant process she is monitoring as well as what other states are doing.

MS. RUYBALID:
There are 19 to 23 databases in existence in varying sizes. There is a lot of interest at the federal level. There is a noncompetitive grant for all states to apply. The funding would be available in October, and we intend to apply for the grant. There is $2.5 million available over a period of two and one-half years to either improve your existing database or establish an APCD.

CHAIR RATTI:
Can you also talk about what data is typically collected in an APCD?

MS. RUYBALID:
At the base level, it is claims data. What would be included in normal standard claims transaction is what is included in an APCD. Some states have decided to have other feeds into the database to help enrich their data. At the very minimum, it is claims data. We would not find a vehicle identification number or

biometric information as described in section 5. I am sure some other states have done this; maybe they have connections and needs for the data.

CHAIR RATTI:
The intent of this legislation is claims data so we are talking about a patient, what the patient's condition was, what was billed and what was paid. The point of this bill is for us to understand how much health care costs so we can start to make informed decisions about how we invest our dollars in terms of health care and how we manage healthcare costs.

MS. RUYBALID:
Correct.

SENATOR HARDY:
Going back to the prior bill, S.B. 5, with the social security number, I suspect they can figure out age. The comment made about age apparently is not in this? Have any of these 19 to 23 states ever had a data breach from their database?

MS. RUYBALID:
I am not aware of any data breaches in APCD. The nature of the data housed in the databases is very important, and we focus on security and privacy of information. There are strict standards in place for the technology and the behavior of anyone housing the data.

CHAIR RATTI:
Would the social security number typically be in an insurance claim?

MS. RUYBALID:
Not generally, no. We would not want to collect data which is not necessary just because of the risks.

SENATOR KIECKHEFER:
In 2011, the State Health Information Exchange talked a lot about individual patients' ability to make decisions regarding whether they wanted their information uploaded into a government-run system. The way I read this bill, you cannot have private insurance or public insurance without having your healthcare claims submitted to this database. Is there an opt-out?

MS. RUYBALID:
I have seen other states include opt-out language of identifiable data. Again, the data we would publicly publish would be aggregated data. It would not have any unique patient identifiers. The only time direct patient identifiers would be released is in the case of researchers requesting data. We would have strict data use agreements in place.

SENATOR KIECKHEFER:
I understand we try to protect the data as best as we can, but when we hold it all in one place, it becomes a target. I share Dr. Hardy's concerns about an individual who is potentially required to carry health insurance, then have the data collected by the health insurance company as a part of the payment system and be required to be turn over data to the government for analysis. It is more of a philosophical statement than a question.

ASHER LISEC (PhRMA):
We support S.B. 40 and the APCD. We have submitted two clarifying amendments (Exhibit J). This will help highlight the cost drivers in the State and provide important Nevada-specific data on healthcare costs. The first relates to the definition of proprietary financial information in section 7. The second amendment relates to section 20. If there is a report released and available, the report should consider race, ethnicity and other health disparities. This is an important area for the State to consider—especially given the pandemic and inequities we have seen in health care. It would not require DHHS to collect any additional information, but consider if you can determine information based on neighborhood or zip code. We have reviewed amendments submitted by others, and PhRMA has some concerns with the amendment offered by the Office of the Attorney General in section 1, subsection 2. We look forward to seeing the passage of S. B. 40.

MR. CLARK:
We support this bill. I am speaking to a conceptual amendment on S.B. 40 on behalf of Nevada Association of Health Plans, Nevada Hospital Association, Nevada State Medical Association and Pharmaceutical Care Management Association (Exhibit K). The APCD will be a tool for public policy which will benefit Nevada long-term. We want to make it robust, accurate and as uncomplicated as possible. I will speak to sections 9 through 14 and section 17. Bill Welch will discuss section 8 regarding needed definitions Exhibit K.

BILL WELCH (Nevada Hospital Association):
We support S.B. 40. I will speak specifically about section 8 and the definitions as outlined in Exhibit K.

KATIE RYAN (Dignity Health – St. Rose Dominican):
We support the conceptual amendment submitted on behalf of Nevada Hospital Association and passage of S.B. 40.

MS. CAPURRO:
On behalf of the Health Services Coalition, we support S.B. 40. We want to be on the record to ensure anything in the APCD is HIPAA compliant for our clients and should there be any sort of data breach, our clients are not responsible.

BOBBETTE BOND (Culinary Health Fund):
We support S.B. 40. By way of disclosure, I am a member of the Commission but am here on behalf of the Culinary Health Fund. We support the bill in its current version. We support the legislation for three reasons: Current State healthcare transparencies are incomplete and behind many states; it is an important vehicle to monitor and evaluate the healthcare system going forward; and it is an important foundation for new models, price and quality management.

The Employee Retirement Income Security Act plans are optional; individuals can participate by choice. The product has to be transparent, and so it is a process. We support the program being housed within the public health arena and urge the Senate Committee on Health and Human Services to pass the bill as created, not the bill as amended by the stakeholder amendments. Particularly, we oppose legislation which would de-identify the elements needed in a database, such as the provider, facility and price paid for services or care. We need this information for the database to work. The database should also span times. The amendments we heard about today indicate the database would not include these elements; trends are important so we want to make sure the data is included. We want to ensure the committees assigned are advisory only and not in charge of deciding what data would be submitted in the end. This enabling legislation has a long way to go in the regulatory process, but we support the program as it develops.

CHRIS BOSSE (Renown Health):
We support S.B. 40 with the conceptual amendments offered by the industry stakeholders. We appreciate the work the Commission has done to prioritize the implementation of an APCD in Nevada. The Commission recognized the important impact an APCD could have. The industry stakeholder group came together providing feedback on S.B. 40 to ensure best practices and lessons learned from other states were incorporated on the front end of our implementation. The recommendations the industry has proposed will ensure successful implementation, operation and meaningful use of the APCD as early as it can be recognized.

DAN MUSGROVE (Valley Health System of Hospitals):
We support S.B. 40. We also support the conceptual amendments submitted by the stakeholders, led by Bill Welch and Tom Clark. We want to look at the best practices of other states and want to have the best bill we possibly can.

KATIE ROBBINS (Planned Parenthood):
We support S.B. 40. The ability for the Commission to create an APCD will be an important tool in identifying how we can improve care and costs for all Nevadans. Having a more holistic understanding of quality, efficiency and cost of care is a good step toward making health care more equitable and fair in Nevada, something we know is critically needed.

MARK KRUEGER (Chief Deputy Attorney General, Office of the Attorney General):
I am testifying as neutral and will explain the amendment submitted (Exhibit L). There seems to be unintended consequences with capturing confidential investigations by the Office of the Attorney General.

CHAIR RATTI:
We need clarification on the second piece of your amendment.

MR. KRUEGER:
The second piece is in section 13. Under our Unfair Trade Practices Act under NRS 598A, we conduct confidential investigations and many times we work with the Federal Trade Commission, Department of Justice, under a court order or with other states. The unintended consequence of not exempting out the confidentiality of those investigations would put us at odds with our federal or state partners or a court in our ability to continue our investigations, which we already have authority under NRS 598A. Exempting us out from the reporting of

information we receive during those investigations would protect that information and allow us to conduct our investigation. If information becomes public at a later time, we have no objection to cooperating with the Commission and turning information over to the extent we can.

CHAIR RATTI:
You believe there is language in this bill which would prohibit activities you are already doing?

MR. KRUEGER:
The bill's language will not prohibit us from doing the activities but will make it impossible for us to do activities with our federal or state partners. It would act as a barrier for us being able to conduct our thorough investigations into antitrust. Ironically, these are the exact reasons for the bill and intent, to take a peek at healthcare costs and make sure the healthcare costs have good competition in the marketplace. At the same time, we might be able to benefit in our investigations by seeing certain information from the Commission collected through this bill. The information, to the extent we could receive and conduct investigations under our authority, may also help us while making sure the markets are competitive and robust.

CHAIR RATTI:
Is it specifically the claims data we anticipate being in the database you are concerned about?

MR. KRUEGER:
No, it is not specifically the claims data, it is going back to section 1. It is the data regarding the cost of health care and particularly, consolidation among entities who provide for health care. It is the market data, anticompetitive or competitive behavior.

CHRIS NEAL (CarFax):
I am testifying as neutral and will read from my written testimony (Exhibit M) to propose an amendment to S.B. 40. We believe the current definition of "direct patient identifier" in the bill requires amendment. The vehicle identification number should be stricken from the list of identifiers. The current definitions of "direct" and "indirect" patient identifiers should reclassify the license plate number to "indirect identifier" given its public visibility and inability to identify an individual.

SENATOR KIECKHEFER:
In section 1, subsection 2 the Commission is empowered to mandate analysis of healthcare information from local governments. Have you received any feedback from those local governments on this language?

MS. CHOLHAGIAN:
I have not received any feedback from local governments on this language, but would be happy to reach out and connect with them and come back to you.

SENATOR KIECKHEFER:
It is one thing to get a report or request an existing report, but requiring another governmental entity to do an analysis of information is something new.

MS. CHOLHAGIAN:
Section 1 states the Commission may request a report which would happen in the form of a public meeting or a public request by the Commission. The local governments would be properly notified of what the Commission is intending to request. It is not an automatic mandate on the local governments.

CHAIR RATTI:
I will now close the hearing on S.B. 40. One of the two concepts brought forward today is making sure gains, in terms of use and access of telehealth during the state of emergency, could continue after the emergency is completed. The second concept is taking a significant step forward toward the transparency of health care so we can manage costs.

Ms. Cholhagian, please talk about the exciting announcement made today about a project which includes Nevada.

MS. CHOLHAGIAN:
I am happy to share the news Nevada has been selected to participate in a multistate collaborative effort with Peterson-Milbank Foundation on a program to address sustainable healthcare costs. I anticipate further discussion on this project at the Commission's next meeting on March 15.

CHAIR RATTI:
Hearing no public comment, the meeting is adjourned at 5:56 p.m.

RESPECTFULLY SUBMITTED:

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Norma Mallett,
Committee Secretary

APPROVED BY:

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Senator Julia Ratti, Chair

DATE:_______________________________________

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Begins on Page**	**Witness / Entity**	**Description**
	A	1		Agenda
S.B. 5	B	1	Sara Cholhagian / Patient Protection Commission	Presentation
S.B. 5	C	1	Kyra Morgan / Department of Health and Human Services	Proposed Amendment
S.B. 5	D	1	Claudia Duck Tucker / Teladoc	Written Testimony
S.B. 5	E	1	Claudia Duck Tucker / Teladoc	Proposed Amendment
S.B. 5	F	1	Kyle Zebley / American Telemedicine Association	Written Testimony
S.B. 5	G	1	Kyle Zebley / American Telemedicine Association	Proposed Amendment
S.B. 5	H	1	Charlie Shepard / AARP	Support Statement
S.B. 40	I	1	Sara Cholhagian / Patient Protection Commission	Presentation
S.B. 40	J	1	Asher Lisec / PhRMA	Proposed Amendment
S.B. 40	K	1	Tom Clark / Nevada Association of Health Plans	Proposed Amendment
S.B. 40	K	1	Bill Welch / Nevada Association of Health Plans	Proposed Amendment
S.B. 40	L	1	Mark Krueger / Office of the Attorney General	Proposed Amendment
S.B. 40	M	1	Chris Neal / Carfax	Proposed Amendment