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

Seventy-Fifth Session
May 12, 2009

The Committee on Health and Human Services was called to order by Chair Debbie Smith at 7:25 p.m. on Tuesday, May 12, 2009, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 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/75th2009/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Debbie Smith, Chairwoman
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Ty Cobb
Assemblyman Mo Denis
Assemblyman John Hambrick
Assemblyman Joseph (Joe) P. Hardy
Assemblywoman Sheila Leslie
Assemblywoman April Mastroluca
Assemblywoman Bonnie Parnell
Assemblywoman Ellen B. Spiegel
Assemblyman Lynn D. Stewart

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Amber Joiner, Committee Policy Analyst
Chris Kanowitz, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Sabra Smith-Newby, Director, Department of Administrative Services, Clark County, Las Vegas, Nevada
Kathleen Silver, Chief Executive Officer, University Medical Center, Las Vegas, Nevada
Virginia Carr, Director of Eligibility and Placement, University Medical Center, Las Vegas, Nevada
Elizabeth Aiello, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Bill M. Welch, President/CEO, Nevada Hospital Association, Reno, Nevada
George Ross, Las Vegas, Nevada, representing Hospital Corporation of America Inc., Nashville, Tennessee; and Sunrise Hospital and Medical Center, Las Vegas, Nevada
Bobbette Bond, Las Vegas, Nevada, representing the Health Services Coalition, Las Vegas, Nevada; Nevada Health Care Policy Group, North Las Vegas, Nevada; Culinary Health Fund, Las Vegas, Nevada
Jennifer Stoll-Hadayia, Public Health Program Manager, Washoe County District Health Department, Reno, Nevada
Laura Hale, Management Analyst IV, Office of the Director, Department of Health and Human Services
Deborah Williams, Manager, Office of Chronic Disease Prevention and Healthy Promotion, Southern Nevada Health District, Las Vegas, Nevada
Lynn O'Mara, Program Manager, Repository for Health Care Quality, Sentinel Event Registry, Health Division, Department of Health and Human Services
Marla McDade Williams, Bureau Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services

Chairwoman Smith:
[Roll called. Quorum present.] We are having this meeting tonight in the hopes that it will take some pressure off of us, since we have a major deadline coming this week. We will hear two bills and then have several bills in work session. I will open the hearing on Senate Bill 24 (1st Reprint).

Senate Bill 24 (1st Reprint): Requires the Director of the Department of Health and Human Services, within the limits of available money, to include in the State Plan for Medicaid a program to provide preliminary determinations of eligibility for certain assistance. (BDR 38-450)

Sabra Smith-Newby, Director, Department of Administrative Services, Clark County, Las Vegas, Nevada:
The bill you have before you today relates to presumptive eligibility. I would like to introduce two people in Las Vegas who can speak to this bill. One is Kathy Silver, the Chief Executive Officer (CEO) of University Medical Center (UMC), and the other is Virginia Carr, Director of Eligibility and Financial Services at UMC. As they come up to the table, I would like to point out that section 1, subsection 1 was amended in the Senate to include the language "within the limits of money available for that purpose." There was a fiscal note attached to this, and the Senate felt that it was important to specify that while this was a priority and something that they wanted to do, it should be done within the limits of money available. So that language was inserted on the Senate side.

Kathleen Silver, Chief Executive Officer, University Medical Center, Las Vegas, Nevada:
This is a bill that was introduced through Clark County on behalf of UMC. I think the important thing to note about this bill is that it has already been amended to reflect the tight financial circumstances that the state is facing. We feel this bill is important not only to UMC, but also to the other acute care hospitals, as it will ultimately benefit all acute care hospitals across the state. Most importantly, we feel that it is in the best interest of patient care. This allows us, as an acute care hospital, to move patients to the appropriate level of care. We feel that it is not in the patient's best interest to remain in an acute care hospital setting that is no longer appropriate. The patient is better served and rehabilitated by being moved to a lower level of care. It ultimately saves money for the state and is beneficial to the patient.

Virginia Carr, Director of Eligibility and Placement, University Medical Center, Las Vegas, Nevada:
We sponsored this bill due to the volume of patients who are held in the acute hospital setting awaiting a payment source for an appropriate lower level of care, such as a nursing home, a skilled nursing facility, or a rehabilitation center. At any given time, UMC alone has more than 18 patients who are waiting for placement into an appropriate care setting due to the lack of a payment source. This is a community-wide issue and it impacts all of the acute care hospitals.

For those patients who are eligible for Supplemental Security Income (SSI), Medicaid becomes their medical pay source at the time of approval. Supplemental Security Income can be a complex and lengthy process during which patients remain in the acute care setting, sometimes for months. In moving a hospitalized patient to the appropriate lower level of care, such as a rehabilitation center, there are reduced costs and improved medical outcomes for the patient. Non-acute patients in the hospital can be at risk for infection and ongoing debilitation, increasing medical needs and costs exponentially. These cases cost hundreds of thousands in health care dollars to facilities, as well as to the state. Every patient's situation is different, but there is a common thread, which is the need for an established payment source for those lower levels of care.

I would like to share a patient's story with you. We took care of a patient in our emergency room who came in with a headache. During the process of evaluating the patient, our physician determined that the patient had previously, in another setting, had an emergency craniotomy. Part of that involves a partial removal of the skull, which is retained many times in the patient's abdomen, waiting until the patient can have that reattached. The reattachment is considered more restorative, and not emergent. Therefore, the reattachment did not occur at the time the patient had this emergency service. When the patient came into our hospital, she had suffered a secondary head injury resulting in the need for her to be institutionalized forever. She was 45 years old at the time of the second injury and living independently. She now has SSI and Medicaid, and she will probably be in a nursing facility for another 30 years. When you look at the dollar amount related to that patient's care—at about $160 per day—it is a pretty significant cost for one individual. I do not think that can compare to the fact that she will never be able to be independent again.

Chairwoman Smith:
This is one of those cases where it seems like a "no-brainer." I wonder why we are just now doing this, and do we need to have legislation for this? I suppose we do, but I am just curious why we have not done this before.

Kathleen Silver:
This bill has been attempted in previous sessions where it was introduced in a broader form. It presumed eligibility for a larger population of patients. What we attempted to do this time was to narrow the scope of the bill to patients who are already hospitalized in an acute care setting and need to be moved to a different level of care. You are right, it does seem like a "no-brainer," but the fact of the matter is there is a fiscal note attached, and it does accelerate the money that the state needs to spend. Initially there is an impact because the state's payments for these patients are accelerated, as the eligibility

determination is essentially predetermined. So rather than waiting 12 to 18 months for a patient to be deemed eligible, the patient becomes eligible earlier, which impacts the state earlier. Eventually that levels out, and it is a one-time fiscal hit to the state.

Chairwoman Smith:
I guess saying "money is available" puts a different view on it.

Kathleen Silver:
That is correct. Obviously, we would love it if the bill could be expanded to include the other classes of patients that can be presumed eligible, but we felt that was a "bridge too far," given today's current financial constraints. The bill has already been amended to reflect those constraints.

Assemblyman Denis:
What does that really mean, "if money is available"? If money is not available right now, then it will just sit and wait for the money?

Kathleen Silver:
That is correct. The bill would be on the books, but until money is appropriated, the bill would be essentially unavailable to us.

Assemblyman Denis:
So we pass the bill, and because we do not have any money, it is just going to sit there for two years until we come back? Or are you going to go to the Interim Finance Committee?

Kathleen Silver:
It depends on what options are available to us. We were trying to be cognizant of the state's current financial situation. We would be pleased for the bill to be on the books, at least, and should money become available during the interim, then we would pursue that.

Chairwoman Smith:
Ms. Aiello, could you come up and address the fiscal note?

Elizabeth Aiello, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
I am here to testify regarding S.B. 24 (R1) and to provide some further information regarding this bill.

As we have heard, this bill is to determine preliminary eligibility on cases that would be SSI- or disability-eligible. What this bill would do is create a program

to do a preliminary determination that would make people Medicaid-eligible faster. This does have an element of cost savings because if people can get medical services sooner that might help in preventing future costs; however, it also has a cost to the state. There is the cost of the earlier eligibility and services and the cost of the staffing required to perform the processing, so the state would need to hire a contractor. We would need medical disability determinations completed, which is how we determine if people are disabled based on medical records. That duplicates the Bureau of Disability Adjudication's lengthy process. This would also create a new eligibility group. Under the American Recovery and Reinvestment Act of 2009 (ARRA), we would receive the regular Federal Matching Assistance Percentage (FMAP), not the higher FMAP.

This proposed change to preliminary determination would require a State Plan change, and the Medicaid State Plan has comparability. We cannot just limit it to the SSI potential disability determination that is in a hospital, or just this one diagnosis. It is a State Plan change and, if undertaken, Medicaid would need to be fully funded to implement that change. It is not possible to approve a State Plan change for a limited implementation of the benefit, or for a limited number of applicants. That is an important distinction to make as the amended bill does have several instances where it says "within the limits of available money."

The calculated fiscal note projects $12.5 million for the next biennium. That covers medical costs, costs of contractors to handle each disability adjudication, and welfare eligibility processing. At this time, I do not know that there would be sufficient funding to do that State Plan change because it has to be completely done if we do it in a Medicaid State Plan.

Chairwoman Smith:
Let me see if I understand you correctly. You really cannot change the plan because the money is not available to implement the plan?

Elizabeth Aiello:
That is correct. It appears that it would cost about $12.5 million to do it over the biennium. It would be an eligibility process change which must be applied to all Medicaid recipients applying for Social Security disability eligibility.

Chairwoman Smith:
So you would not even start the change to the State Plan until the money became available?

Elizabeth Aiello:
Once the State Plan is approved, we would have to implement it.

Chairwoman Smith:
That is a problem.

Elizabeth Aiello:
That is why we did not pull the fiscal note on this. I know that Director Willden has met with the Bureau of Disability Adjudication to determine what is causing some of the processing delays. We cannot guarantee that we could do this quicker because we must gather all medical records and information to substantiate the disability, which can be a process itself.

Chairwoman Smith:
This is a crazy situation. We are spending more money in the long run because we have patients sitting in the wrong place when they could be in a more reasonable situation.

Elizabeth Aiello:
I agree.

Assemblyman Hambrick:
I do not think any of us likes these situations because we can see the need. With the fiscal implication at this point, do we dare tie the hands of future Legislatures? Would this be a candidate for an initiative petition? I do not know what else to do with that large of a fiscal note.

Chairwoman Smith:
I think the way the bill is written, it is not going to be implemented until the money is there. So the state will not incur the fiscal note, because nothing is going to happen if there is no money.

Assemblyman Hardy:
Regarding the rate limiting step of SSI, what is the period of time it takes to be evaluated for SSI? What is the evaluation time for Medicaid? Does the $12.5 million apply just to these people who would be put into the queue sooner, or is it just $12.5 million over the biennium?

Elizabeth Aiello:
Regarding your first question, my understanding is that the disability determination runs concurrently to the Medicaid application, if they need the disability determination to be Medicaid-eligible. Medicaid does all the processing and the Bureau of Disability Adjudication does the disability determination.

When that comes in, and they get the disability determination, it is usually a 10-day turnaround to get the Medicaid eligibility. I do not understand all the rules around the disability adjudication process.

If you are asking about the state fiscal note, it includes funding for a medical director at Medicaid to develop policies and oversee the disability adjudication program. It would also cover the cost of contractors who would be hired to handle the disability adjudications and process incoming applications. It was estimated that each disability adjudication would cost approximately $500. It also covers the cost of staff at the Division of Welfare and Supportive Services.

There will be some people who get a disability determination but not from the Social Security Administration. Those people would not be a cost to Medicaid. It does not mean that they do not need the service. In the fiscal note, there are some different costs. The fiscal note that is posted was revised because the original was based on the enhanced FMAP.

Assemblyman Hardy:
You have answered some of my questions, but as I look at your $12.5 million fiscal note, you have alluded to the fact that we would have to revise our State Plan and fully fund Medicaid if we were to implement this. But is the fiscal note the cost of the implementation of this as opposed to implementing a bigger State Plan?

Elizabeth Aiello:
I understand your question now. We would need to have that $12.5 million to cover this program. In other words, once it is in the State Plan, it is not like a waiver program that says you can stop the process after 100 people. There is comparability across the eligibility determination. We are not talking about fully funding the total Medicaid program. We are talking about the additional costs for this program.

Assemblyman Hardy:
So the total cost, even after you have to revise the State Plan, is $12.5 million.

Elizabeth Aiello:
That is the estimate for the biennium.

Assemblyman Hardy:
If each person costs $500 dollars to adjudicate, that probably does not include all of the costs, or you would be processing 10,000 people every year.

Elizabeth Aiello:
No, that cost also includes the increased medical expenses.

Chairwoman Smith:
The bottom line is, tell us the advantage of passing this legislation at this point in time.

Elizabeth Aiello:
I would have to say that we are neutral on this bill. The hospitals are the ones that have put this forward. I would hope, since it is somewhat of a duplicative process, there might be a way to assist in the other process. I know Director Willden is working on that issue, so I do not know if I can answer that question.

Assemblyman Hardy:
If this were in place a year ago, would it have been a new program even if we had not funded it, and so it would be eligible for the ARRA?

Elizabeth Aiello:
The ARRA was maintenance of effort for July 1, 2008. They were looking at what was in place on July 1, 2008.

Chairwoman Smith:
Is there anyone else who would like to testify on this bill?

Bill M. Welch, President/CEO, Nevada Hospital Association, Reno, Nevada:
We are here in support of this legislation. Regarding the presumptive eligibility, this legislation may or may not cost the state $12.5 million. I think one of the things that the Committee needs to understand is, and I understand the fiscal restraints, currently if a person is eligible at the time of application, the coverage is retrospective. This is a cash-flow issue. We either put the money up today or we put the money up next year retroactive to today, because the date of the submission of the application is when the person becomes eligible. So the cost of the services a person is receiving would be incurred by the state and would be paid for.

The risk to the state is that cash-flow issue, and then also the population that may not ultimately become eligible for Medicaid in the end because of their disability. The timing on this disability determination by the federal government, and that is where this determination is made, is a minimum of 12 months, but the hospital's experience is generally 18 months. The challenge and the issues are that these patients are in a holding pattern for up 18 months before they get into the appropriate delivery care system, because most private providers on the

nursing home levels or in physicians' offices are not going to accept those patients until they have some kind of financial coverage. This helps expedite getting a patient into the appropriate setting of health care, and the difference is that 12- to 18-month determination period, not just the 18 patients sitting in our hospital emergency rooms today.

The presumptive eligibility allows the state to collect all of the information at the time of the submission of the application and to make the same determination while the federal government goes through their 12 to 18 months to make their ultimate determination. I do not know why it takes that long, but it does. There is a significant delay in getting a patient into the right system and, again, the real cost to the state is the cash flow because the majority of those patients will ultimately be approved by the SSI.

Assemblywoman Leslie:
This is like all of the presumptive eligibility questions that we have had through the years, especially through the Interim Health Committee, right? It is the same issue—different group, but same issue. I understand the cash-flow issue, but unless we build the $12.5 million into the budget, we cannot do it. Did this go to the Senate Committee on Finance?

Chairwoman Smith:
It did.

Assemblywoman Leslie:
I am shocked that it did. So what is the answer for how we build the $12.5 million into the budget?

Bill M. Welch:
The question is did they need legislative authority to go forward? It was our understanding that they did, and so we were trying to make this legislation permissive, rather than "must," so that they would have the authority in the event that funding became available sometime in this biennium. I understand now that they do not need permission to go forward, so I hate to speak against our own efforts here, but...

Assemblywoman Leslie:
Okay. I thought I was missing something. We have had a lot of bills like that this session. If this bill came to the Committee on Ways and Means, I think they would just walk out of the room because we have had so many bills that depend on "if money is available." I had a bill like that myself, so I understand it, but there is no money available.

Chairwoman Smith:
We heard a bill the other day in Ways and Means, and Speaker Buckley asked, "Does this cost money?" The witness said "Yes," and she replied, "Then we are not going to talk about it anymore." That is the point we have come to and it is very sad. The cost benefit analysis does not really apply to us right now.

George Ross, Las Vegas, Nevada, representing Hospital Corporation of America Inc., Nashville, Tennessee, and Sunrise Hospital and Medical Center, Las Vegas, Nevada:
We would like to echo the testimony of UMC and Mr. Welch. Our sense of the purpose of this bill, and how it finesses what Assemblywoman Leslie asked, is that it basically sets up the framework. Then someday the money will be there and, when it is, we have the framework all set up. Whenever we sit down with our folks at Sunrise, we ask them what they could do to improve patient care and help the financial situation of the hospital. The first word out of anybody's mouth, on the financial side, is "presumptive eligibility." If you are disabled, you do not always go to one of these places; you can go home. This would make a big difference, if and when it is implemented, for those types of people because once they leave the hospital, they do not get any kind of follow-up care. They do not go to the clinic, they do not go to the doctor, they do not get their medication checked, and they do not get all the tests every three months to make sure everything is working correctly. The next time they see a doctor is when they are brought back to an emergency room. For those people who are disabled and were sent home, this would make a big difference.

Bobbette Bond, Las Vegas, Nevada, representing the Health Services Coalition, Las Vegas, Nevada; Nevada Health Care Policy Group, North Las Vegas, Nevada; Culinary Health Fund, Las Vegas, Nevada:
We support any efforts that will close the gaps and get people access to the right care at the right time. This has been such a barrier to being able to get people the appropriate care. I understand we cannot talk about cost benefit analysis, but that is not a reason to not support the bill.

Chairwoman Smith:
Is there anyone else who would like to speak in support of S.B. 24 (R1)? Is there anyone who would like to speak in opposition to or neutral on the bill? [There was no response]. I do not see anybody coming forward so I will close the hearing on S.B. 24 (R1) and open the hearing on Senate Bill 340 (1st Reprint).

Senate Bill 340 (1st Reprint): Revises provisions governing the allocation of certain money from the Fund for a Healthy Nevada. (BDR 40-1133)

Jennifer Stoll-Hadayia, Public Health Program Manager, Washoe County District Health Department, Reno, Nevada:

I have provided a copy of our written testimony (Exhibit C), so in the interest of time, I would simply like to highlight some key points in regards to our support of S.B. 340 (R1) and what this bill will do. I would like to thank the sponsor for bringing this bill forward for us. Senate Bill 340 (1st Reprint) represents almost a year's worth of dialogue among key tobacco prevention and control stakeholders in Nevada, including the current recipients of the tobacco prevention and control allocation of the Fund for a Healthy Nevada (FHN), as well as the local health districts and the state Health Division. We held these discussions in an effort to identify ways to maximize our impact on tobacco use and exposure in our state.

Senate Bill 340 (1st Reprint) proposes to redirect only the tobacco prevention and control allocation of the Fund for a Healthy Nevada to the Nevada Health Division, which is currently responsible for managing the state's other sources of tobacco prevention and control funds as well. So those funds would have the opportunity to be blended and brought together. The Health Division would then distribute the funds to the local health districts, to programs in rural counties, and to statewide programs, including those for evaluation and smoking cessation.

The regional model proposed by this bill is a structure recommended by several national organizations, including the Institute of Medicine (IOM) and the Centers for Disease Control and Prevention (CDC), as it allows for two core principles of effective tobacco prevention and control practice to be achieved. The first is local decision making to meet local tobacco prevention and control needs, coupled with statewide assurance of vital tobacco prevention and control services, such as cessation, and statewide accountability of those funds. In this way, we believe S.B. 340 (R1) creates the best of both worlds in terms of programming to address this issue.

The tobacco prevention and control programs funded by the Fund for a Healthy Nevada are a true public health success story. Prior to the initiation of these programs, Nevada was considered one of the smokiest states in the nation. At its worst, almost one-third of adult Nevadans were smokers. We are happy to say that today that rate has dropped by 10 percent. However, in this time of scarce resources, we feel that we can do more with these funds and more with our programs. The structure that would be created as a result of this bill would give us the opportunity to do that.

Chairwoman Smith:
You have worked with all of the folks who normally receive this money, and there is consensus about changing this program?

Jennifer Stoll-Hadayia:
I have been part of a group that was called together by the Grants Management Advisory Committee of the Department of Health and Human Services in multiple meetings. The meetings included all of the recipients and offered an opportunity to identify potential new structures and discuss concerns. The structure that is presented in this bill represents a consensus of those meetings. I believe I have a colleague in the audience who will speak to that process in more detail.

Assemblyman Hardy:
The Task Force for Funding a Healthy Nevada always seemed to be a statewide organization with local people participating, so I hear the same kind of thing: this is going to be statewide with local people participating. So what is new and different that is going to be so wonderful?

Jennifer Stoll-Hadayia:
The process of allocating the funds has been a statewide process that has included input from local subject matter experts. The process that we are putting forth in this new structure would give us the opportunity to blend those funds with other tobacco prevention and control funds, thereby leveraging our ability to address this issue, which is not available in the current structure. We believe by blending there will be a greater leveraging of resources. There would also be a greater assurance that, when funds are allocated to local communities, they are in response to a regionally developed tobacco prevention and control plan, which is not currently a part of that structure. We see several benefits even though there is a statewide and a local component now. The component we are proposing would build in some additional details that are not currently in that structure.

Assemblyman Hardy:
Do you have a list of those?

Jennifer Stoll-Hadayia:
I am going to defer to my colleague from the Grants Management Advisory Committee who has been convening these meetings.

Laura Hale, Management Analyst IV, Office of the Director, Department of Health and Human Services:
I have previously served as Chief of the Grants Management Unit, which administered these funds. We currently have 17 grants. Four of them are statewide and the rest are individual entities from nonprofit organizations to county or university grantees. One of the key structural differences is that right now all of those 17 entities compete with each other for funds. What would happen under this strategy is that the health districts would be able to do regional planning and bring in other grantees as partners with them. So they would look at more regional planning. Right now, it is just an open competitive process across the board. As Ms. Stoll-Hadayia mentioned, this model is utilized in other states and is recommended by experts in the tobacco control field.

Assemblyman Hardy:
So would we be able to get a Federal Matching Assistance Percentage (FMAP) for any of this money if we structure it correctly?

Laura Hale:
No. It is still the tobacco settlement dollars that we are blending with our CDC dollars that are used for tobacco control and prevention, which have always been managed through the Health Division. From the Director's office perspective, moving this money to the Health Division is where we get the blending and leveraging because they are already operating those tobacco control programs. Originally they were under the Grants Management Unit, along with some of the other grants for the Fund for a Healthy Nevada, because it was a new, high-profile program. At this point, it makes more sense to move it to the Health Division and let them combine those funds.

Assemblyman Hardy:
We would like to have a list of the programs that are being cast aside, and the programs that are being proposed, because it sounds like that is what we are trying to figure out.

Laura Hale:
Everyone who is a current grantee will still be able to apply. All of those stakeholders did participate in a series of meetings that we held last fall to get input. What the bill does is direct funds to some specific programs, such as the state Helpline and the Statewide Evaluation Plan, which are CDC best practices, and to the health districts in Washoe and Clark Counties. From there the money flows to other providers.

The proposal that is not reflected in this bill is that there would be a requirement set by the Health Division, as administrator of the overall funds, to the districts to say that they must grant out a percentage of those funds. It is not intended that the money just goes to the Health District and they operate their programs. All of the current grantees must still have an opportunity to get some of the funds and continue to provide services. We would need to determine what the percentage is that would allow the health districts to do some of the administrative piece that is now managed by the state and to continue some of their programming. Again, we see that benefit as regional planning and being able to make some decisions at the local level. Instead of Washoe County having to compete with other providers in the region, they would work collaboratively with them to come up with that plan.

Chairwoman Smith:
That was the point I was trying to get to. You had worked with a large group of people over some considerable time, and those were the people who had been involved in these programs to get to this point.

Is there anyone else who would like to testify?

Deborah Williams, Manager, Office of Chronic Disease Prevention and Healthy Promotion, Southern Nevada Health District, Las Vegas, Nevada:
You should have a copy of my testimony (Exhibit D) so I will just touch on some points.

I want to start by commending the state staff for facilitating the planning process that has been talked about; it is the way these things should be done. We at the Southern Nevada Health District (SNHD) feel that S.B. 340 (R1) reflects the recommendations that were developed through that process, and we support this new structure. We believe that this new structure will support ongoing regional planning, will ensure that local efforts are responsive to local needs, and should facilitate coordination and collaboration among local stakeholders. We feel that the local health districts have the capacity and expertise to take on this enhanced role.

The Tobacco Prevention and Control Program of the SNHD has focused considerable efforts on youth smoking rates. Prior to the inception of our program in 2000, our youth smoking rate was around 33 percent. In 2007, that number dropped to 13.6 percent. We feel that this enhanced role and coordination at the local level structure will be significant helping us continue with that investment in the health of our children and the future of the state.

Assemblyman Hardy:
I hear a lot of statements that begin with "we feel." Do we have some substantive studies that corroborate what you are talking about?

Deborah Williams:
As Ms. Stoll-Hadayia alluded to before, there are a couple of documents that have best practices that include administrative structure. There is a recent document from the National Association of County and City Health Officials which outlines the role of the local health department in tobacco prevention and control. It includes many of the things that we are talking about regarding regional planning and about coordination and collaboration at the local level. There are documents that support our statements: the CDC best practices and the Institute of Medicine's report, which outlines the role of the state and local public health systems.

Assemblywoman Mastroluca:
I am just wondering, what would happen if the rural counties do not apply for the 15 percent? Does it just sit? Will there be an educational program to help them apply for this?

Laura Hale:
In the eight years that we have been administering the Fund for a Healthy Nevada, we usually have requests for three to four times the amount of funds available, so that has not been an issue. We put out the notices on the requests for applications to a list of about 1,000 nonprofit organizations throughout the state and other eligible parties. We always hold orientations for applicants so that they will know how to apply for funds. I think that process would continue.

Jennifer Stoll-Hadayia:
The way that S.B. 340 (R1) outlines the new structure, there is a unique carve-out of the funds that would go to support programs in counties with populations of less than 100,000. So there is an assurance that program funding will go to those counties, in addition to the two counties with populations of 100,000 or more.

Assemblyman Hardy:
I would like to see the studies. Not that I do not believe you, but I do not believe anything until I see it. This seems to be a reasonable thing to say, and if it is, then please show me.

Chairwoman Smith:
Are there any other questions from Committee members? Seeing none, is there anyone who would like to testify in support, opposed, or neutral on S.B. 340 (R1)? I do not see anyone, so I will close the hearing on S.B. 340 (R1). Let us begin our work session.

Let us begin with Senate Bill 7 (1st Reprint).

Senate Bill 7 (1st Reprint): Makes various changes to the Advisory Council on the State Program for Fitness and Wellness. (BDR 40-23)

Amber Joiner, Committee Policy Analyst:
Senate Bill 7 (1st Reprint), which was sponsored by Senator Wiener, was heard on May 11, 2009. It makes several revisions to the membership of the Advisory Council on the State Program for Fitness and Wellness, provides that the Chair and Vice Chair will be selected by the Council, and authorizes the appointment of committees and subcommittees. This measure also revises an appropriation made by the 2007 Legislature to pay the operational costs of the Council to clarify that the funds must be accounted for in the account in statute that does not revert to the State General Fund (Exhibit E). There were no amendments offered in writing during the hearing on this measure, and there was no testimony in opposition.

Chairwoman Smith:
It looks like this bill will be one that will go to the Committee on Ways and Means. It still has that $100,000 appropriation in it. This is amazing to me. These bills have been passing unanimously on the Senate side. Do we want to rerefer the bill to Ways and Means?

> ASSEMBLYWOMAN PIERCE MOVED TO REREFER SENATE BILL 7 (1st REPRINT) TO THE ASSEMBLY COMMITTEE ON WAYS AND MEANS WITH THE RECOMMENDATION OF DO PASS.

Chairwoman Smith:
I correct myself. It is a 2007 appropriation that the balance is not reverting.

Assemblywoman Pierce:
I withdraw my motion.

Chairwoman Smith:
I would entertain a motion to do pass.

ASSEMBLYWOMAN MASTROLUCA MOVED TO DO PASS SENATE BILL 7 (1st REPRINT).

ASSEMBLYWOMAN SPIEGEL SECONDED THE MOTION.

Chairwoman Smith:
Is there discussion?

Assemblyman Hardy:
Let me understand this. We are looking for money. If this does not revert, and we cannot bind another Legislature in the future, then how can we not consider this as reverting if we want it to revert and we are looking for money?

Chairwoman Smith:
Well, you certainly could. The other thing that can happen, which we have seen, is that money can always be swept.

Assemblyman Hardy:
That is my point. In these times, we are looking at something that "feels good" but there are other things that are looking for money as well. That is why I am going to say that it may be wise not to be bound by previous legislators, and look for this money to be used in some way.

Chairwoman Smith:
Our Legal Counsel is telling us that we are correct in our discussion. The money has been previously allocated. What we are doing is making a decision whether to revert the balance. Legal is indicating that it is probably appropriate to go ahead and send it to Ways and Means and let them decide how to deal with the fiscal part of this. Ways and Means may just end up being able to handle the fiscal and pass out the policy, if worse comes to worse, because the policy is important to get out since there is some restructuring of the committee. And this bill is not exempt, so we would have to act on this by Friday, which we could do. It is a simple bill and a simple concept.

Assemblywoman Mastroluca:
I will amend my motion.

ASSEMBLYWOMAN MASTROLUCA MOVED TO DO PASS AND REREFER SENATE BILL 7 (1st REPRINT) TO THE ASSEMBLY COMMITTEE ON WAYS AND MEANS.

ASSEMBLYWOMAN SPIEGEL SECONDED THE MOTION.

Chairwoman Smith:
Is there discussion?

Assemblyman Hardy:
I like the policy, but I do not like the policy having the axe of the Ways and Means Committee over its head without giving them some indication. So I will be voting no, but I will reserve my right to change my vote in Ways and Means.

Chairwoman Smith:
That is certainly acceptable. The fact that you have a voice in Ways and Means, and the fact that there is some policy in here that can be decided without having to keep the money in it, are significant. So vote your conscience, but the Ways and Means Committee will have the ability to separate those two issues and decide on them.

Is there further discussion?

> THE MOTION PASSED. (ASSEMBLYMEN COBB, HAMBRICK, HARDY, AND STEWART VOTED NO. ASSEMBLYMAN HARDY RESERVED THE RIGHT TO CHANGE HIS VOTE IN WAYS AND MEANS.)

Chairwoman Smith:
Let us move on to Senate Bill 17 (2nd Reprint).

Senate Bill 17 (2nd Reprint): Revises provisions governing health care records. (BDR 54-607)

Amber Joiner, Committee Policy Analyst:
Senate Bill 17 (2nd Reprint) was sponsored by Senator Wiener and was heard on May 11, 2009. It extends from five to seven years the amount of time a provider has to retain medical records. It also requires the posting of information relating to the destruction of patient health care records (Exhibit F).

Senator Wiener proposed an amendment during the hearing, and you can see the mock-up attached (Exhibit G). It adds provisions that clarify exceptions for pharmacies and requires the State Board of Pharmacy to post certain information relating to records retention on its website.

There was a second amendment proposed (Exhibit H) based on discussion during testimony and among the members. This amendment would clarify that upon a person attaining 25 years of age, his records may be destroyed if they are more than 7 years old.

There was no testimony in opposition to this bill.

Chairwoman Smith:
There was a question about the first amendment (Exhibit G) regarding a clinic that is operating in the same physical facility as a retail pharmacy. I do not see anyone here from the Retail Association. I think they had asked Senator Wiener to put this amendment in. The question was, are they being treated differently than a regular clinic, and where will those records be housed? Will they be housed within the pharmacy? Dr. Hardy, I think you have paid particular attention to this bill. Do you know the answer?

Assemblyman Hardy:
The way I interpret the amendment is that a pharmacy is where the pharmacist works, not in the bigger building where everyone else works. If that is the case, then it does not matter if there is another place in the store that has a clinic with a provider of health care in it. That would be separate and distinct from the pharmacy.

Chairwoman Smith:
But I think the question here is that this is saying "a provider of health care other than a pharmacy or a retail clinic operating within the same physical facility as the pharmacy." Does that exempt that clinic from the medical records provision? It does not seem logical.

Assemblyman Hardy:
I do not think the pharmacist currently keeps the prescriptions for five years. I think they are in a different class somewhere.

Chairwoman Smith:
But what about the clinic that is at the pharmacy?

Assemblyman Hardy:
The clinic that is in a building that we commonly call a pharmacy is different from a pharmacy.

Chairwoman Smith:
But this is saying that the retail clinic operating within the physical facility of the pharmacy is exempt from these provisions.

Assemblyman Hardy:
They could not be exempt.

Chairwoman Smith:
But isn't that what this is saying? It is saying "other than." It seems to me that they are being exempted.

Assemblyman Hardy:
Are you looking at the sign provision? Or the keeping of the prescription?

Chairwoman Smith:
I am looking at the "keeping of the records" on page 2. I think we should hold this bill until tomorrow and talk to the people who brought this amendment, and get clarification on the intent.

Assemblyman Hardy:
We cannot treat the health care provider differently in a retail clinic than we do somewhere else. We cannot do that.

Chairwoman Smith:
I agree. That is what I want to clarify. Let us save that one until tomorrow. Let us move on to Senate Bill 79 (1st Reprint).

Senate Bill 79 (1st Reprint): Revises provisions governing various commissions, boards and committees relating to health. (BDR 38-327)

Amber Joiner, Committee Policy Analyst:
Senate Bill 79 (1st Reprint) was sponsored on behalf of the Department of Health and Human Services and was heard on May 6, 2009. [Read (Exhibit I).]

During the hearing there was a request for a chart showing the changes, and you can see that attached (Exhibit I).

Chairwoman Smith:
Is there any discussion?

ASSEMBLYWOMAN PARNELL MOVED TO DO PASS SENATE BILL 79 (1st REPRINT).

ASSEMBLYWOMAN LESLIE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chairwoman Smith:
Let us move on to Senate Bill 131 (1st Reprint).

Senate Bill 131 (1st Reprint): Revises provisions governing mental health consortiums that provide mental health services to children with emotional disturbance. (BDR 39-660)

Amber Joiner, Committee Policy Analyst:
Senate Bill 131 (1st Reprint), sponsored by Senator Cegavske, was heard on May 11, 2009. [Read (Exhibit J).]

There were no amendments proposed in writing during the hearing and there was no testimony in opposition.

Chairwoman Smith:
Is there any discussion?

ASSEMBLYWOMAN LESLIE MOVED TO DO PASS SENATE BILL 131 (1st REPRINT).

ASSEMBLYWOMAN PARNELL SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chairwoman Smith:
Let us consider Senate Bill 229 (1st Reprint).

Senate Bill 229 (1st Reprint): Establishes the Physician Visa Waiver Program in the Health Division of the Department of Health and Human Services. (BDR 40-368)

Amber Joiner, Committee Policy Analyst:
Senate Bill 229 (1st Reprint) was sponsored by Senator Carlton and was heard on May 6, 2009. [Read (Exhibit K).]

Chairwoman Smith:
Is there discussion?

Assemblyman Cobb:
I knew there was a fiscal note on this bill, but there was also discussion about the fees involved. I just wanted to see if there was any type of confirmation that the fees that will be charged—to be paid either by the applicant or the organization that they work for—will actually cover the cost involved in the fiscal note and the implementation of the program.

Chairwoman Smith:
Is there anyone from the Health Division who can answer this question?

Lynn O'Mara, Program Manager, Repository for Health Care Quality, Sentinel Event Registry, Health Division, Department of Health and Human Services:
With respect to the fiscal note, the proposed fee was meant to be a supplement to the federal grant funding we use for the program. As is stipulated by the bill, we have covered some of these additional site visits that might be required, along with a physician and employer education program, which were identified as deficiencies. The way the bill is written, if the State Board of Health did establish that fee, it would be a shared responsibility between the physician and the employer, and would be capped at a $500 total between the two.

Chairwoman Smith:
So there is no responsibility to the state. It is between the fee that would be provided by the employer and the recipient of the visa?

Lynn O'Mara:
That is correct. This program uses no General Fund money whatsoever.

Assemblyman Cobb:
I just recall the testimony was suggesting that a lot of these site visits require travel all across Nevada, and that it can take up days of time and a lot of money and resources. So there is no fiscal impact to the state because the $500 fee, which is to be paid either by the physician or by the entity that employs that physician, or I suppose it could be both, will pay for any of the costs involved with the program.

Lynn O'Mara:
That would be correct. This program uses no General Fund money, and the fee that is proposed would simply supplement the federal grant funds that we already use to administer the program.

Assemblywoman Pierce:
And this is called a HRSA grant? What does that stand for?

Lynn O'Mara:
That stands for the Health Resources and Services Administration (HRSA). It is a subagency of the federal Department of Health and Human Services.

Assemblyman Hardy:
If it is a $500 total shared between the doctor or employer, one or both, could that be looked at as a new fee, a.k.a. a new tax, a.k.a. a two-thirds vote? Has the Governor agreed to this?

Chairwoman Smith:
It does take a two-thirds vote, and the Governor has actually signed several fee bills already.

Lynn O'Mara:
I have no answer to that question because I do not know.

Chairwoman Smith:
I am going to leave that up to the sponsor of the bill.

Assemblyman Cobb:
I am not going to speak for anyone else, but this is a voluntary fee for the individuals who wish to apply for this program. So all this is doing is allowing someone to apply and then providing a user fee for the program.

Chairwoman Smith:
I just had the same conversation with a member of the Governor's staff today about another bill that has a fee in it, and it was the same response, because the fee was voluntary. However, it still requires a two-thirds vote.

> ASSEMBLYMAN STEWART MOVED TO DO PASS SENATE BILL 229 (1st Reprint).
>
> ASSEMBLYMAN HAMBRICK SECONDED THE MOTION.

Chairwoman Smith:
Is there discussion?

Assemblywoman Leslie:
I think this is a very important bill. Before we were sidelined with the hepatitis C crisis during the interim, this was a major issue, as I am sure Assemblyman Hardy remembers, and it seems that a lot of the issues that were raised about the J-1 Visa program are addressed by the bill. I just want to thank the sponsor of this bill. I think this is a very good bill.

Chairwoman Smith:
Is there any other discussion?

THE MOTION PASSED UNANIMOUSLY.

Chairwoman Smith:
Let us go on to Senate Bill 231.

Senate Bill 231: Makes various changes concerning food establishments connected with a child care facility. (BDR 40-975)

Amber Joiner, Committee Policy Analyst:
Senate Bill 231 was sponsored by Senator Cegavske and was heard on April 22, 2009. [Read (Exhibit L).]

After the hearing, the Southern Nevada Health District (SNHD) proposed adding a definition of the term "kindergarten" to the measure to clarify the category of facilities to which the measure relates. That mock-up is attached. Also attached is an explanation from the SNHD about this amendment (Exhibit L). The actual amendment appears on page 2 of the amendment mock-up, and it starts on line 7 where the little 3 is, and that is the new language for kindergarten. That should have been highlighted in yellow. There was no testimony in opposition to this bill.

Chairwoman Smith:
We had a lot of discussion on this bill.

ASSEMBLYWOMAN SPIEGEL MOVED TO AMEND AND DO PASS SENATE BILL 231.

ASSEMBLYMAN COBB SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chairwoman Smith:
Let us go to Senate Bill 319 (1st Reprint).

Senate Bill 319 (1st Reprint): Revises provisions governing certain reports of sentinel events and related events. (BDR 40-828)

Amber Joiner, Committee Policy Analyst:
Senate Bill 319 (1st Reprint) was sponsored by Senator Breeden and was heard on May 6, 2009. [Read (Exhibit M).]

There were no amendments proposed in writing during the hearing on this bill and there was no testimony in opposition.

Chairwoman Smith:
Is there any discussion?

Assemblywoman Parnell:
It seems that we have other "sentinel event" bills out there. I was just wondering if this conflicts with them.

Chairwoman Smith:
There are some differences in these bills. My thought was to get those bills out of committee and get them into conference to compare them.

Marla McDade Williams, Bureau Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services:
The bills are complementary to each other; they just build on different pieces of sentinel events. The other bill is Assembly Bill 206, which is currently in the Senate.

Assemblyman Hardy:
In section 4 it says, "Each medical facility which provided medical services and care to an average of 25 or more patients during each business day in the immediately preceding calendar year...." Does that not include doctors' offices?

Marla McDade Williams:
It does not, because medical facilities are defined as hospitals, ambulatory surgery centers, et cetera. Doctors' offices are not currently defined as medical facilities.

Chairwoman Smith:
So "medical facility" is meeting the intent in our statute already. Thank you for clarifying that.

Assemblyman Hardy:
So if you were to share with us the testimony and concerns that led to a split vote in the Senate, what would be the concerns that you would remember?

Marla McDade Williams:
I am sorry; I do not have an answer.

Chairwoman Smith:
I would entertain a motion for do pass.

ASSEMBLYWOMAN LESLIE MOVED TO DO PASS SENATE BILL 319 (1st REPRINT).

ASSEMBLYMAN DENIS SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMEN COBB, HAMBRICK, HARDY, AND STEWART VOTED NO. ASSEMBLYMEN HARDY AND STEWART RESERVED THE RIGHT TO CHANGE THEIR VOTES ON THE FLOOR.)

Chairwoman Smith:
Our last bill is Senate Bill 278 (1st Reprint).

Senate Bill 278 (1st Reprint): Requiring the Legislative Committee on Health Care to study certain issues concerning the provision of public health. (BDR S-1061)

Amber Joiner, Committee Policy Analyst:
Senate Bill 278 (1st Reprint) was sponsored by Senator McGinness and was heard on May 6, 2009. [Read (Exhibit N).]

There are two amendments proposed. The first is from Senator Washington (Exhibit O) and the other from Assemblyman Hardy (Exhibit P).

Chairwoman Smith:
This addresses the needs and the requests of the counties with populations under 100,000, and it also addresses the original request of Clark County. We heard testimony from the Southern Nevada Health District (SNHD) regarding their concerns, and if we take out "public" from "health" it takes care of their concerns. Is there any discussion?

Assemblywoman Parnell:
I was not here for the hearing on this bill. Are Carson City, Lyon County, and Douglas County okay with this amendment? They initially brought forth the idea about studying the consolidation.

Chairwoman Smith:
Bob Crowell and Mary Walker both testified, and this was all worked out.

Assemblyman Stewart:
Did we get rid of the fiscal note on this?

Chairwoman Smith:
That was taken care of in the reprint, but let us double-check.

Assemblywoman Leslie:
I was not here for the hearing either. Can anybody explain to me what Senator Washington was trying to do with his amendment where he is removing alcohol and drug abuse prevention services from the list of things to look at? I am not sure why it was in there since Clark County does not really do that. He wants to study the feasibility of establishing regional centers. What is that about?

Chairwoman Smith:
That came from one of the people from the Substance Abuse Prevention and Treatment Agency (SAPTA) who asked for the amendment (Exhibit O) to be added to the list.

Assemblywoman Leslie:
But it says Senator Washington brought forth the amendment.

Chairwoman Smith:
He sponsored it, but it was offered by SAPTA.

Assemblywoman Leslie:
Okay. I just do not understand what they are trying to do.

Chairwoman Smith:
I felt that because it was a study and not actually changing anything, it seemed okay to me. I believe that when the bill was completely changed in the first reprint, where you see all those deleted sections and it was turned into a study that took the fiscal note out.

ASSEMBLYMAN HAMBRICK MOVED TO AMEND AND DO PASS SENATE BILL 278 (1st REPRINT).

ASSEMBLYMAN HARDY SECONDED THE MOTION.

Chairwoman Smith:
Just to clarify that includes both amendments, Assemblyman Hambrick?

Assemblyman Hambrick:
Yes, Madam Chair.

THE MOTION PASSED UNANIMOUSLY.

Chairwoman Smith:
That completes our work session. Thank you very much, Committee. We did a lot of work tonight, and I appreciate your attentiveness and everyone being here this evening. Is there any public comment? I do not see any, so I will adjourn this meeting [at 8:48 p.m.].

RESPECTFULLY SUBMITTED:

_____
Chris Kanowitz
Committee Secretary

APPROVED BY:

_____
Assemblywoman Debbie Smith, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: May 12, 2009 Time of Meeting: 7:25 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 340 (R1)	**C**	Jennifer Stoll-Hadayia	Testimony
S.B. 340 (R1)	**D**	Deborah Williams	Testimony
S.B. 7 (R1)	**E**	Amber Joiner	Work Session Document
S.B. 17 (R2)	**F**	Amber Joiner	Work Session Document
S.B. 17 (R2)	**G**	Amber Joiner	Proposed Amendment Mock-up to S.B. 17
S.B. 17 (R2)	**H**	Amber Joiner	Proposed Amendment Mock-up to S.B. 17
S.B. 79 (R1)	**I**	Amber Joiner	Work Session Document and Chart
S.B. 131 (R1)	**J**	Amber Joiner	Work Session Document
S.B. 229 (R1)	**K**	Amber Joiner	Work Session Document
S.B. 231	**L**	Amber Joiner	Work Session Document, Proposed Amendment Mock-up, and explanation
S.B. 319 (R1)	**M**	Amber Joiner	Work Session Document

S.B. 278 (R1)	**N**	Amber Joiner	Work Session Document
S.B. 278 (R1)	**O**	Amber Joiner	Senator Washington's amendment
S.B. 278 (R1)	**P**	Amber Joiner	Assemblyman Hardy's amendment