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

Seventy-Fifth Session
April 8, 2009

The Committee on Health and Human Services was called to order by Chair Debbie Smith at 1:13 p.m. on Wednesday, April 8, 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, Chair
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
Darlene Rubin, Committee Secretary
Chris Kanowitz, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Justine Harrison, Vice President, Legal and Government Affairs, Nevada Cancer Institute, Las Vegas, Nevada
Kathy Silver, CEO, University Medical Center, Las Vegas, Nevada
Brian G. Brannman, COO, University Medical Center, Las Vegas, Nevada
Nancy McLane, Director, Department of Social Services, Clark County, Las Vegas, Nevada
Steve Hiltz, Directing Attorney, Children's Attorney Project, Legal Aid Center of Southern Nevada, Las Vegas, Nevada
Janice Wolf, Deputy Directing Attorney, Children's Attorney Project, Legal Aid Center of Southern Nevada, Las Vegas, Nevada
Diane J. Comeaux, Administrator, Division of Child and Family Services, Department of Health and Human Services
Mike Capello, Director, Department of Social Services, Washoe County, Reno, Nevada
Tracey Woods, Reno, Nevada, representing Nevada Youth Care Providers, Las Vegas, Nevada
Thomas Morton, Director, Department of Family Services, Clark County, Las Vegas, Nevada
Calvert Collins, Director, Junior League of Las Vegas, Las Vegas, Nevada
Michelle O'Connell, representing the Junior League of Reno, Nevada
Julianna Ormsby, Carson City, Nevada, representing the Nevada Women's Lobby, Reno, Nevada
Jerri Strasser, representing Service Employees International Union, Las Vegas, Nevada
Vincenzo Variale, CEO, North Vista Hospital, North Las Vegas, Nevada
Dan Musgrove, representing The Valley Health System, Las Vegas, Nevada
Greg Boyer, CEO, Valley Hospital Medical Center, representing The Valley Health System, Las Vegas, Nevada
George Ross, representing Sunrise Hospital and Medical Center, Las Vegas, Nevada
Lisa Foster, Reno, Nevada, representing the City of North Las Vegas, Nevada
Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada

Lawrence Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada

Bobbette Bond, Executive Director, Nevada Health Care Policy Group, LLC, North Las Vegas, Nevada

Romaine Gilliland, Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services

Jon Sasser, Statewide Advocacy Coordinator, Washoe Legal Services, Reno, Nevada

Jan Gilbert, Northern Nevada Coordinator, Progressive Leadership Alliance of Nevada, Reno, Nevada

Paula Berkley, representing Nevada Network Against Domestic Violence, Reno, Nevada

Sam McMullen, representing the Las Vegas Chamber of Commerce, Las Vegas, Nevada

Susan Hallahan, Chief Deputy District Attorney, Family Support Division, Washoe County District Attorney, Reno, Nevada

Carol Sala, Administrator, Aging Services Division, Department of Health and Human Services

Luana Ritch, Chief, Bureau of Health Statistics, Planning, and Emergency Response, Department of Health and Human Services

Lawrence Sands, Chief Health Officer, Southern Nevada Health District, Las Vegas, Nevada

Marla McDade Williams, Chief, Bureau of Health Care Quality and Compliance, Department of Health and Human Services

Sabra Smith-Newby, Director of Administrative Services, City of Las Vegas, Nevada

J. David Fraser, Executive Director, Nevada League of Cities and Municipalities, Carson City, Nevada

Fred Schmidt, Carson City, Nevada, representing Clark County Water Reclamation District, Las Vegas, Nevada

Brian McAnallen, Director of Government Affairs, Embarq, Las Vegas, Nevada

Debra Gallo, Director/Government and State Regulatory Affairs, Southwest Gas Corporation, Las Vegas, Nevada

Judy Stokey, representing NV Energy, Las Vegas, Nevada

David Bowers, Assistant City Engineer, Department of Public Works, City of Las Vegas, Nevada

Neil Mann, Director of Public Works, City of Reno, Nevada

Barney Rabold, Deputy Director-Operations, Utility Services, City of Henderson, Nevada

Shirle Eiting, Assistant City Attorney, City of Sparks, Nevada

Karen Storms, City Clerk, City of North Las Vegas, Nevada

Darren Schulz, Deputy Public Works Director, City of Carson City, Nevada

Jeff Fontaine, Executive Director, Nevada Association of Counties, Carson City, Nevada
David Noble, Assistant General Counsel, Public Utilities Commission
Marlene Lockard, Reno, Nevada, representing Subcontractors Legislative Coalition, Las Vegas, Nevada
Randy Brown, representing AT&T Nevada, Reno, Nevada
Bob Gastonguay, Executive Director, Nevada State Cable Telecommunications Association, Reno, Nevada
Karen Pearl, Executive Director, Nevada Telecommunications Association, Reno, Nevada

Chairwoman Smith:
[Roll called.] We have a quorum. We are going to reopen the hearing on Assembly Bill 433, Assemblywoman Pierce's bill, and then we will have a hearing on Assembly Bill 364. Those were the two bills we were unable to finish on Monday. We will have a work session after that. Assembly Bill 525 will not be heard today. [General introductory remarks.]

I will open the hearing on A.B. 433.

Assembly Bill 433: Requires county hospitals to provide cancer treatment as part of their care to indigent persons. (BDR 40-976)

On Monday, after hearing the presentation by Assemblywoman Pierce, we heard testimony in support and some in opposition, but I would like to invite the representatives from the University Medical Center (UMC) and the Nevada Cancer Institute to resume their testimony.

Justine Harrison, Vice President, Legal and Government Affairs, Nevada Cancer Institute, Las Vegas, Nevada:
I appreciate the opportunity to present additional testimony today on Assembly Bill 433. I want to provide a point of clarification and also answer any questions you may have. The Nevada Cancer Institute's (NVCI) nonprofit, tax-exempt status is based on the public benefit it provides as a medical research organization. We provide significant research, education, navigation, and outreach to the state in addition to the clinical care services. We receive no government funds to pay for indigent medical care, and we are not a safety net organization. However, based on our core values since opening our doors to the public, we have always provided charity care to our patients, and we continue to do so, as we believe it is vital to meet this critical need in our community. Alongside many other providers in southern Nevada, we are currently seeing patients who are no longer able to access care at UMC. The remainder of my testimony that I provided Monday was submitted in writing as well.

Chairwoman Smith:
I think we will back up a little and revisit some of what we talked about on Monday so that your testimony is not fragmented and you have the opportunity to answer these questions. I raised the issue on Monday that $2 million had been quoted as the shortfall that prevented the treatment from being able to continue, so perhaps you want to answer that. The other question I have is how long had it been since you had taken a contract for those services?

Justine Harrison:
The NVCI had been in the contract for one year when UMC notified us that they were going to be cutting that service line and no longer providing those services to patients.

Chairwoman Smith:
Did you have an opportunity to negotiate that or try to be helpful in being able to continue those services?

Justine Harrison:
When we revisited our multi-year contract at the end of the first year, we were informed that the service line would be cut. At that point, in November, we began a very quick dialogue with the County Commissioners as well as with key stakeholders in the community, including the County Manager, UMC, and a variety of other cancer interest groups including Susan G. Komen for the Cure and the American Cancer Society. We have held multiple meetings discussing multiple proposed solutions to the crisis, both short-term and long-term.

Assemblywoman Leslie:
Is there a short-term plan to end this crisis?

Justine Harrison:
Yes. We have all been discussing this, and, informally, all accepted more charity care patients; but that is a short-term solution, and there may be a flow of patients beyond what the individual providers can afford. In the short-term, together with other cancer providers in southern Nevada, we have offered free physician services to provide continuous care to patients at UMC. My understanding is that the challenge lies with the great cost of pharmaceuticals, and those are questions for the hospital to answer. But there has been a willingness by the NVCI and other providers in the community to provide charity care at UMC.

Assemblyman Stewart:
Who makes the decision on what is a charity case?

Justine Harrison:
As a contracted vendor at UMC, when we were at UMC they performed the intake and therefore did the processing and designated who was self-pay, charity care, et cetera. For patients who come in the door at independent providers and practices like ours, Comprehensive Cancer of Nevada, and other providers in the community, each provider has its own set of criteria and financial counselors to do intake and determine whether people meet their eligibility criteria.

Kathy Silver, CEO, University Medical Center, Las Vegas, Nevada:
I think you all know the challenges we are facing in southern Nevada. We are ground zero in the foreclosure crisis, we are seeing our gaming and tourism revenues go out the door, we have seen a construction industry that for all intents and purposes has been decimated, and we have watched former icons of profitability that are now facing bankruptcy. I think it is fair to say this is no ordinary situation in southern Nevada. We have watched this Committee in the special session and in the current Session, and we know you have had to make very difficult choices on many different fronts: choices about what to keep and what to cut. What we are suggesting to you is that is the same exercise that UMC went through when we were faced, essentially overnight, with a $21 million additional shortfall as a result of cuts to the Medicaid budget, the Indigent Accident Fund (IAF), and the Supplemental Fund (SF). University Medical Center was clearly the hardest hit in the state because we are the largest Medicaid provider in the state. All of those changes hit us particularly hard, and it was with that as a backdrop that we made the decision to cancel certain services. We did not do that lightly. It was very painful: nobody wants to cut services. University Medical Center, historically, has not been operating in a way to cut services to patients; in fact, our mode has usually been to expand services to patients. So the decision to cut some of those things was particularly hard.

I know that we are here today to talk specifically about oncology. We have had some conversations with individuals, and we know how important it is to this group to try to restore some services in the community. We are going to work with you to try to make that happen. We probably need to make some changes in the language of the bill so that we can get more comfortable with knowing the expectations. We feel that it is extremely broad as it is written. We are really concerned about what that might mean to the hospital financially if it is maintained in its current broad form because it is wide-open and open-ended in terms of what expectations would be. I will be happy to answer any financial questions. I think we can probably answer those questions better than Justine Harrison. I will say that the decision to end the contract was a mutual one. Business decisions were made on both sides, neither right nor wrong.

We highly regarded the services that Nevada Cancer Institute provided while they were at the hospital. It was clearly a different standard and higher level of care than had been provided before, and we are sorry that it ended. We are going to try to find different ways to restore some of the services at UMC, but it is not that easy to do, and it cannot be done overnight.

Chairwoman Smith:
Let us go back to the cost issue and clarify the $2 million issue versus the $50-plus million fiscal note. I think we touched on that on Monday: that perhaps the fiscal note brings in all services and all people, so if you will clarify that for us. Also, if you went back to the level of service you were providing that was eliminated, is $2 million the actual amount that you had to cut?

Kathy Silver:
No, it is not. The fiscal note is accurate in terms of both inpatient and outpatient oncology services.

Chairwoman Smith:
But you only cut the outpatient services, correct?

Kathy Silver:
That is correct; we continue to provide the inpatient services.

Chairwoman Smith:
I realize the bill is written quite broadly, and I am assuming that is why you did that. So let us talk about the realities of the outpatient care.

Kathy Silver:
What we are really looking at is approximately $26 million in charges in fiscal year 2008 for just the outpatient oncology services. You folks are used to dealing with health care so you know that charges do not equate to costs. At our facility that represents probably about $7 million in actual costs. Of that amount, 43 percent had no pay source, so that is about $3.5 million. The $2 million figure we used was for a partial year, for the period of time we had to stop the service.

Chairwoman Smith:
So for a year it would be $3.5 million?

Kathy Silver:
It depends on what our payer mix is.

Chairwoman Smith:
I am just talking about the estimate you used when you made your decision. That was $3.5 million for the year and then $2 million for a portion of that year.

Kathy Silver:
Correct.

Chairwoman Smith:
We have all talked about the *60 Minutes* show and the issues that arose because of that. I know that you have Health Insurance Portability and Accountability Act (HIPAA) sensitivity, but we heard differing stories about those patients whom we saw on the program: that patients were being served, but yet the show ended with the fact that patients were not being served, and it was an updated version. Without violating anything, can you talk about whether or not people are actually being served?

Kathy Silver:
I was a little confused myself. We obviously did not have editing rights to anything they aired, and it was a little confusing when you watched the vignettes of the various patients because, in particular, we know that Clark County Social Services is being served. Those patients have access to health care. Yet, there may have been something in the story that went a little deeper than that: a reason why, perhaps, the decision was made not to get chemotherapy for that particular patient. I am not familiar with that patient's case and would not be able to speak to it if I was familiar with it, but just from watching the program myself, I had the same question because we know—we talk to Clark County Social Services all the time—that they have gone out to providers in the community. They are attempting to get contracts with many providers: NVCI, Comprehensive Cancer Centers, Dr. Nicola Spirtos, who was featured in the show, and Dr. John Ellerton, who I believe testified on Monday; so I think they are attempting to make that as broad-based as possible.

Chairwoman Smith:
Is it your belief that everyone who needs cancer treatment is getting it?

Kathy Silver:
No. I think what we specifically said and talked about in the *60 Minutes* story is that the poor are getting care, the rich are getting care, but the middle class are not.

Chairwoman Smith:
But those were the patients who were featured in that story.

Kathy Silver:
Not necessarily.

Chairwoman Smith:
That was the way it was described, I guess.

Kathy Silver:
The patients with Clark County Social Services are being served. We can assume that the one patient who was mentioned had some assets which did not allow her to be eligible for some type of program. They did not go into a lot of detail about the financial aspects of that case.

Chairwoman Smith:
As I expressed on Monday when we began the discussion, my frustration is that you are right. At the beginning of your testimony you alluded to the difficult decisions we have before us, certainly with our revenue shortfall approaching 40 percent. We have spent eight weeks going through budget discussions and making difficult decisions, but we keep talking about essential services. I just cannot come to terms with the fact that, when you were looking at life and death issues, the decision was made to eliminate that type of treatment for people. Was there no other direction to go?

Kathy Silver:
The difficulty is, we were already behind the 8-ball. We were looking at a $51 million budgeted deficit that was already spiraling past that amount. Overnight, when the Medicaid cuts were made, it was an additional $21 million, so we had to make decisions—not unlike decisions that families across the state are making right now—to prioritize what we were going to spend our money on. If you have very scarce resources, how do you spend it? How do you decide this program is worth more than another program? They are heart-wrenching and difficult decisions. What we were trying to do was evaluate what the core services of the hospital were and then try to preserve those core services. I think everyone in this room knows we have the only Level I trauma center, the only burn unit, the only dedicated HIV program, a pediatric subspecialty service, and a broad base of services that we felt were very valuable to the community. We needed to take whatever steps we could to preserve as many of those services as possible. Candidly, we felt oncology services were provided elsewhere in the community. Unfortunately, no one stepped forward. We felt that if everybody took a little bit, it would not be too much for any one entity. We know what is happening in southern Nevada: more people are losing their jobs and their benefits; it is a growing problem, not one that is stabilized at this point.

Chairwoman Smith:
We understand that, and I appreciate the work that your hospital does. As you know I visited your hospital before Session started, and I was just amazed at the trauma center and the burn unit. I just cannot get past the fact that unless everybody shares the pain, some people will die.

Kathy Silver:
And that is the problem—not everybody is sharing the pain.

Chairwoman Smith:
I am talking about within your environment, where you talked about everybody having to give a little bit to get to that decision.

Assemblywoman Leslie:
I share your concerns, Ms. Silver. We have been going through these very difficult budget times. We know what you are going through; we have had to make tough decisions, and we decided not to cut kids off autism treatment, for example, because we felt that would be hurting them. We are trying very hard to put together a package that is better than the Governor's Budget so we can protect the hospitals, and I am the Chair of the Budget Subcommittee that is working on it, so I know you know what we are trying to do for you. But, at the same time, to hear that this was a $3.5 million program that was shut down—betting that other doctors would share the pain and step up and take these patients—is just unacceptable. I watched the *60 Minutes* show this morning, and people are dying. I received emails from people in Las Vegas today; I have gotten them since that show aired. People think that we, meaning the Legislature, shut down this clinic. I did not make that decision. I understand what you are saying about how the overnight cuts and all the rest have hurt you, but I did not make that decision, and I want to go on record: I would not make that decision. I think there are some decisions that you just cannot make, and I have not made those here at the Legislature. I am not going to cut kids off of autism treatment; I am not going to do that. I share the Chair's concern. I cannot understand that in your budget and in Clark County's budget, not just UMC's, there was not a way to comb through the contracts, look at outsourcing, look at other areas, and come up with money to keep that clinic open. And if you could not keep it open over the long term—that is why I asked the question about the short term—how could you close that clinic with no plan for these people? That is what I do not understand.

Kathy Silver:
The decision to close oncology and some of the other services was not made in a vacuum and was not made as a first step. We had already done all kinds of other things that were operational in nature, cost-saving measures that had not

up to that point affected any patient-care services. But what happens when confronted with a huge change in revenue with no time to plan? It cannot be fixed by reducing the cost of Styrofoam cups. There is a certain economic scale that is mind-numbing when you talk in terms of $20 million and where do you go to find it when you have already tried a lot of the other things. It was just a big gaping hole that was very difficult to try to fill.

Assemblywoman Leslie:
I understand. I just could not have made that decision and lived with myself. Going forward, is there a plan to put that back, because I still have not heard one. Where are these people today? If a middle-class person loses his job, loses his health insurance, gets cancer—it could happen to anyone of us in this room—he needs chemotherapy, but nobody will pay for it. What is our plan for these people?

Kathy Silver:
I cannot sit here and tell you there is a plan to give health care to everyone who is uninsured.

Assemblywoman Leslie:
That is not what I said. I am just talking about the patients who you were serving through this cancer clinic. Not everybody in the state is uninsured; it was the people whom you were serving before who are now not getting services. Is there any plan from UMC or the Cancer Institute or anybody to serve those people?

Kathy Silver:
At this point what we are looking at—and we have support from the board on this on a number of fronts—is hiring physicians to actually work in some capacity at the hospital. If oncology needs to be one of those areas, then that is what we are going to look at. We have tried this method over a couple of different iterations. We had one provider for many years, that contract changed, NVCI came on board, we liked the service that we had with NVCI, and we would like to see a model created along those lines.

Assemblywoman Leslie:
But you do not have a plan right now?

Kathy Silver:
No.

Assemblywoman Leslie:
All right, that is what I needed to know to vote on the bill.

Assemblyman Hambrick:
In your testimony a few moments ago you said, "The pain is not being shared." Would you care to elaborate on that?

Kathy Silver:
I am not trying to throw anybody under the bus here, but there are a lot of publicly-traded oncology practices and health care providers in Las Vegas, and they are profitable or they would not stay there. If everybody took a little bit of this uninsured care, then it would not be so difficult for one provider who had to take it all. What happened is that over the 20 years the clinic was in place, the demographic of Las Vegas changed dramatically. The health-care landscape changed dramatically. We went from smaller hospitals and a lot of private practices to publically-traded, large, multi-facility enterprises. What occurred is that a lot of patients were seen in those practices until they lost their insurance and then they were told to follow up at UMC. There were patients who were screened in Las Vegas, the disease was identified, if they had a pay source they went to the private facilities, and if they did not, they went to UMC. We had an unfair share of the burden of those patients, and it grew steadily over time. That caused part of the dilemma in which we found ourselves.

Assemblyman Hambrick:
This question is for NVCI. Since you are representing the private sector in the room today, should any private provider assist in this area, realizing they are not going to be reimbursed? Is that a business expense that may be deductible, or could the business obtain some other benefit for taking on that uncompensated care?

Justine Harrison:
I can only speak from the nonprofit point of view because I work for a nonprofit exempt organization. I do know that on our public tax return, which is a form 990, we do report our charity care and public service. I do not know if there is a tax benefit to for-profit practices. One of the challenges faced by private practices and some of the other hospitals is that we do not qualify for the 340B Drug Discount Program; that is a federal program that allows a discount of 40 to 50 percent for drugs used in the outpatient setting by institutions with a disproportionate share of low-income patients, like UMC, the only hospital, Nevada Health Centers, and a few other providers in southern Nevada. Giving charity care is significantly higher for both nonprofits and for-profits than it is for other institutions that are able to purchase these expensive chemotherapeutic agents at deep discounts through the 340B pricing.

Kathy Silver:
There are also drug recovery programs that any facility can take advantage of. The downside is that they are relatively onerous in terms of the paperwork and the hoops to jump through to get the reimbursement. For clarification, the drug recovery programs require "up fronting" the drug—and there is an eligibility process to determine whether the patient meets the standard of eligibility under the recovery program—and the drug company reimburses the provider by sending replacement drugs. That is one way to offset the cost. Justine is correct that UMC and Nevada Health Centers are the only ones eligible for 340B pricing, but right now we are trying to extend that to inpatients.

Chairwoman Smith:
Maybe there will be a cancer drug donation program, too, of which you can avail yourselves.

Assemblyman Hambrick:
To the witnesses who have spoken so far, if you were sitting here, what questions would you ask? What might we be missing? What do you want us to know?

Brian G. Brannman, COO, University Medical Center, Las Vegas, Nevada:
To put this in context, the one thing I would like to do is to stress that the decision on oncology care was not done in a vacuum. The situation that we face within the UMC is that it is very difficult to identify any particular area of health care where the elimination would not be catastrophic. The conversation that went on was: looking at the pantheon of services we provide, what services are truly unique to us versus those services provided at least in some capacity in the community. Outpatient oncology services really fit that category. If we eliminate the three neonatal intensive care units (NICUs) in the community, which are at capacity, that would be catastrophic, and there would be an advocacy for that. We are the only Level I trauma center. When I made rounds in our trauma center yesterday afternoon, we had three different trauma activations for motorcycle accidents from Arizona, southern Nevada, and one other case. Take that trauma center away, and it is catastrophic. The burn center is another example where removal would be catastrophic. In the course of going through this, it is a decision among terrible choices. Oncology presented at least some opportunity where, if people in the community were willing to step up to the plate, it would not be as difficult.

Assemblywoman Spiegel:
Two panelists have used the expression "step up to the plate." That spawned two separate but related questions. First, were there discussions through the hospital association about how do we as a community deal with this?

Second, were outreach and specific requests made of other hospitals and providers to say, "Let's all pitch in together and figure out how we are going to solve this"?

Kathy Silver:
There were. The county actually was the host or catalyst to try to bring concerned community interests together to find a way to address the problem in southern Nevada. Disappointingly, we did not have a great showing. We had a number of nonprofits, we had NVCI, Comprehensive Cancer Center, and Nevada Health Centers, plus Dr. Ellerton. The rest of the appropriate community were all invited but did not attend. It was like "one hand clapping," it did not make a lot of noise. In their defense, there is no easy solution for this, no easy, compact way to come forward and say this is how we are going to address oncology care in southern Nevada, not for the poorest of the poor, not for the rich, but for the middle-class who are uninsured. That is what we are struggling with as a facility: we hear you, we want to help you, we want to provide the service to the community, but we just do not want to be it. The traditional role of giving people chemotherapy is usually in a physician practice, it is not typically done in a hospital unless the drug is of a certain type that is going to create a problem for the patient medically, which would only be best given in an environment such as an acute care hospital. There are practices all across the valley where chemotherapy treatments are given all day long; they are just not being given to patients who do not have insurance.

Chairwoman Smith:
That raises an issue for me. We are talking outpatient treatment, not inpatient treatment. Surely there are other outpatient treatments you provide that are provided in other facilities as well. But I guess that is part of the business.

Kathy Silver:
Could you explain what you mean?

Chairwoman Smith:
You indicated that chemotherapy is better done in doctors' offices outside of your environment, but what was cut was being done outpatient. You do other outpatient services, too, that could be done elsewhere, I suppose. So it is just that balance that you are providing all kinds of outpatient services.

Kathy Silver:
We are, and most of the other outpatient services are not expensive to the same degree as the oncology services.

Chairwoman Smith:
I understand that, and I certainly appreciate the financial straits that you are in because we are all feeling it.

Assemblywoman Spiegel:
I know that the pharmaceutical companies have some programs for people who cannot afford medications. Do they have something for uninsured people who need chemotherapy?

Justine Harrison:
Various pharmaceutical companies do have what they call "drug replacement programs", under which, in certain circumstances if a patient meets their qualifying criteria, they will cover the drug. As Kathy Silver testified, in our experience at the Cancer Institute, what typically happens is a patient presents who needs treatment immediately. We know it is going to take quite a while and a lot of paperwork to navigate the process to get approval for the drug replacement, and we know that waiting will be dangerous to that patient's health. So we start administering the drug up front, which we have already paid for, and on the back end we apply through the program for reimbursement for the drug. The challenge is that we do not always get that reimbursement. Another challenge can be that often chemotherapy is given in what are called "cocktails," where different drugs are combined to get the best efficacy, and sometimes the drugs in those combinations are from different companies. For one treatment for one patient we are trying to navigate two different drug replacement programs that have different criteria and different timelines. So, it is possible, but it certainly is not smooth, easy, or guaranteed.

Assemblyman Stewart:
Does this bill just apply to UMC?

Kathy Silver:
Just UMC. We are the only county hospital, so when the bill was rewritten specifically to say "county hospital," it meant just UMC.

Justine Harrison:
To address Assemblyman Hambrick's earlier question, if I were in your place the question I would be asking is not only what do we do to stop this crisis immediately, to make sure that the patients who are in need can get care immediately, but also what do we need to be looking at so that this crisis does not repeat itself in the future? Furthermore, what do we need to look at to put a long-term sustainable solution in place?

Kathy Silver:
To Assemblywoman Leslie's earlier question about a plan, we have been approached by two different organizations to reestablish services at UMC. We are entertaining both of those options, but I did not want to mislead you and say we had a plan at this moment. I just want to make you aware that is taking place.

Also, as Justine Harrison brought up in her testimony, it would be helpful for many of these folks who find themselves without insurance if there was something similar to the presumptive eligibility bill for inpatients. This is where you know that people will need care, that there will be a cost associated with the type of treatment they need, and that their assets are not going to allow them to weather the storm. If they could somehow be presumptively eligible for Medicaid or some other type of program, I think that would give providers some comfort level in being able to take care of those patients while they are going through that eligibility process, which is often lengthy and may be beyond the time frame that the patient is either with us or is going to need that care. It is something to consider as you talk about different options to try to resolve some of these issues.

Assemblywoman Leslie:
I appreciate those remarks, especially what you said more eloquently than I. I completely agree; we need an immediate stop to this problem, a solution now. I would just ask you to work with us. Those people from *60 Minutes* haunt me. I cannot sleep thinking about that woman: they took away her wheelchair and her bed, and she has no cancer treatment. That is as horrific as it gets, but then there were also the pictures of the people lined up in the middle of the night trying to get a social services appointment. You do not have to make very much not to qualify. There are a lot of people out there who are dying, and we are saying, "Gee, we just don't have the money. We do not have a plan. We are still looking at options." We need an immediate solution, and we will do whatever we do with the bill. I am willing to work with you to solve it, but it has to be solved, and I will help. I want to send that message loud and clear.

Assemblywoman Parnell:
I agree with the comments, and I thank you for what you are trying to do as well. I happened to catch the *PBS Now* program, then when I heard there was a story on Sunday night on CBS, I thought it was a repeat story, but I was quite alarmed when I realized it was a different look at the same issue. What everyone in this room needs to recognize is that we really have a statewide problem. The last line on the CBS show was something along the lines of "the Legislature may even make matters worse by cutting additional funding." Being one of those people to whom the commentator was referring was pretty

appalling, and I agree with my colleague that it was hard to sleep after watching that. But I do not think it is just about UMC, and it is not about Carson-Tahoe Hospital in my district. Everybody is having difficulty, and what we need to remember and rise above is that as a state we really need to make the decision that we cannot stand for this. Thank you for what you try to do and to everyone trying to find good answers in a very bad situation.

Chairwoman Smith:
There is no question that, with everything we have heard in the last eight weeks and what we continue to hear every day, we have big problems that have to be resolved. We are trying to wrap all the hospital issues together under Assemblywoman Leslie's direction in the Ways and Means Committee; trying to figure out how we can restore some funding and do a better job. The bottom line is these are taxpayer facilities. The Nevada taxpayers gave $5 million to the Cancer Institute out of the 74th Legislative Session, and it is very painful to know that our taxpayers cannot receive treatment. I hope we can work together and resolve this. I am sure that it weighs heavily on you; it has to. It cannot be easy to make those decisions and live with them every day. Thank you for your testimony. Is there anyone else who wants to testify?

Nancy McLane, Director, Department of Social Services, Clark County, Las Vegas, Nevada:
[From Las Vegas.] I want to respond to Assemblywoman Leslie's questions. I may be able to address some of the things that she had concerns about regarding the patients currently in care. In connection with the *60 Minutes* story, we have followed up with the people who were featured in the vignettes and, as I said in my testimony on Monday, everyone who was an eligible client with Clark County is receiving care. We are following up again with the folks in that story to see if we need to reevaluate any who might have been found ineligible. I have to speak in broad terms because of the HIPAA requirements. Regarding some of the information depicted in the story: people standing in line. While that is very concerning to us, most of the people who come in with serious medical needs are coming in via the hospitals; they do not have to wait in line during the night to be seen and have their situation evaluated. In some ways, that information was not entirely accurate because seriously ill people are seen in a priority order, and often we go to them.

Our agency serves people who are not eligible for other programs. Our eligibility criteria generally is 180 percent of poverty, and we do provide Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage for those people who have lost their employment and are unable to meet those premiums. If someone is on the borderline of eligibility, and they have a catastrophic health condition, we will make allowances for that in light of their condition and often will err on

the side of covering their COBRA so that they can receive care from their normal provider. From the time that UMC closed its oncology center, we have worked very hard with UMC to make sure that the folks who are in care are transitioning from inpatient services to the outpatient facilities with which we are working. We are working with five providers in the community. Dr. Spirtos and Dr. Ellerton are the ones who have been working with UMC. We also have Nevada Cancer Centers, Las Vegas Cancer Center, and Comprehensive Cancer Centers of Nevada, through the Great Basin HealthNet. We have 38 eligible clients who are receiving cancer treatment right now, and those are people who have been newly-diagnosed with cancer since the center closed. University Medical Center has been continuing to treat the individuals who were in the midst of their treatment at the time the center closed, and we are trying to transition them in an orderly fashion so as not to disrupt their care. All of the folks who have been eligible at 180 percent of poverty have had no interruption in their care, and have been transitioning to these providers who we are working with and who are being paid to deliver these services.

We are exploring the ability of working with UMC on what is known as "e-recovery," which is to help us recover the cost of the cancer medications to allow our money to go farther. We are treating 18 different types of cancer, the entire range of the spectrum, and probably more to come as more clients are identified.

I want to let you know that we are serving these folks, and in terms of the undocumented people and the people who are over-income who do not meet the eligibility requirements, they are being referred to Great Basin HealthNet, which is similar to Access to Healthcare in the north, and is a self-pay program that offers significantly discounted rates for individuals who come into care. They do have the entire complement of services from radiology to labs to the Comprehensive Cancer Centers of Nevada. We believe that we have something to offer to the people who have been affected by this disruption, and I want to make sure that you are aware that we have been very conscious of their needs and working very hard to make this an orderly process.

Chairwoman Smith:
Thank you, Ms. McLane. We appreciate your updating us about the work that you are doing. I am very glad to get all of that information.

Assemblyman Stewart:
Did *60 Minutes* make any effort to contact you?

Nancy McLane:
Only to photograph the lines.

Chairwoman Smith:
Is there anyone else wishing to testify? [There were none.] Committee, it is a good thing the people who have been emailing us have not signed in to testify. We would be here for a week. We will close the hearing on A.B. 433. I will open the hearing on Assembly Bill 364. This is Assemblywoman Mastroluca's bill.

Assembly Bill 364: Makes various changes concerning the protection of children. (BDR 38-1092)

Assemblywoman April Mastroluca, Clark County Assembly District No. 29:
Assembly Bill 364 is about looking at the process of foster care and bringing about a few changes that are needed to make the process run more smoothly. As Mr. Hiltz will testify, the first eight sections are relatively clear. We are already doing many of these things, and we need to ensure the law is very clear as to how it works. I believe the last two sections of the bill are very important. One is section 9, which addresses siblings who are separated in the foster care system and visitation rights among those siblings. Section 10 is a piece of legislation that will begin a process to keep track of the number of psychotropic medications that are given to children in foster care facilities. Some of the information that you will receive today, or perhaps already received on Monday, will tell you that the majority of children in care, who are under Medicaid, receive psychotropic drugs. The numbers of children on Medicaid in the foster care system are 2 to 1 over any other patients in the Medicaid system who receive psychotropic drugs. Those psychotropic drugs range from 3 to 4 different medications per child, and that is not tracked. There is no parent to ask, "Why is my child being given this medication?" No one is questioning that. We are asking that we begin a process of keeping track of that medication and finding out why it is being administered and who is prescribing it, to make sure it is in the best interests of the child.

Chairwoman Smith:
I want to thank you for bringing this issue forward. I serve on the Court Improvement Program (CIP) that deals with the children who are in the state's care, and this is one of the issues being studied this year. It is really worth looking into.

Assemblyman Cobb:
Which authority or group is designated to pay for the extra examinations called for?

Assemblywoman Mastroluca:
I will have to refer that to Mr. Hiltz, but I believe some of that is already standard practice.

Assemblyman Cobb:
I mean the new examinations, because it specifically states that you want outside nonaffiliated professionals to be involved, which obviously is not a step that is being done right now but is being called for in the bill. I am curious to know who organizes and pays for it.

Steve Hiltz, Directing Attorney, Children's Attorney Project, Legal Aid Center of Southern Nevada, Las Vegas Nevada:
We are a not-for-profit private law firm. We are here today in support of Assembly Bill 364. To answer Assemblyman Cobb's question, this is an amendment to a bill that was passed by this Committee, Assembly Bill No. 369 of the 73rd Legislative Session, and that bill called for a second opinion, so this is not an additional opinion. The original bill called for the department or the division to be responsible for providing a second opinion. Whether or not they can be reversed by Medicaid depends upon whom they find to get the second opinion. The purpose of this amendment is to make that second opinion a much fairer process by not allowing anyone who works with the person who issued the first opinion do the second opinion.

The first eight sections of this bill are spelled out quite well by the Legislative Counsel's Digest and mainly clarify a few of the provisions in the original bill giving children in foster care certain rights before they can be placed in a locked mental health facility. That bill, A.B. No. 369, has made a tremendous difference in the care and length of stay for children. Formerly, these children were placed in these facilities without any oversight, or court approval, or any rights at all, for between 6 to 18 months, often for status offenses, such as running away or playing hooky. Four years ago the law made it very clear that they have a right to an attorney, to a hearing, and to a petition alleging that they are likely to harm themselves or others.

Section 2 of A.B. 364 clarifies that a petition must be filed; the language was not that clear before. Section 4 talks about the child's entitlement to an evidentiary hearing, instead of just an informal proceeding. The only slight substantive change occurs in section 7, subsection 3. When the court makes a finding that a child is likely to harm himself or others and, therefore, needs to be placed in a locked facility, that decision is good for up to 90 days, and if there is a request to continue the child's stay, there must be a renewal petition. This section clarifies that the same standard is to be used to keep the child there, namely that he is likely to harm himself or others.

Section 8 extends the time for the facility to come up with a discharge plan. Formerly it was 5 days, but the amendment calls for 10 days, which makes sense and is reasonable and is something that I proposed.

What I would mainly like to discuss is section 9, subsection 3. I have been discussing this with Assemblywoman Mastroluca, and today I tried to reach the Legislative Counsel Bureau. There seems to be some misunderstanding in the drafting of the bill. This is meant to be an extension of the right that siblings have who are separated in foster care. Under *Nevada Revised Statutes* (NRS) 432B.580, subsection 4, when siblings are separated in foster care, the court must issue an order of sibling visitation, to make sure they stay in contact with each other. The problem arises when one or more of the siblings is about to be adopted. Right now, when that happens, no one knows about it, so the siblings have no protection at all. This amendment was meant to require—and I would like to work on the revision of it—that the adoption court be informed that a sibling visitation order exists, that the adoption court consider whether that sibling order should be continued in its original or a revised form in the adoption decree, and that any interested party, namely the child care agency, any child affected by this, or any other party including the proposed adoptive parents be given the right to intervene in that determination.

Chairwoman Smith:
You have referred to the amendment. Mrs. Mastroluca, is there an amendment, or are we just talking about the bill?

Assemblywoman Mastroluca:
We are talking about the bill. We have been working on an amendment, but we did not have clear enough language to give to the Committee, and I did not want to confuse the issue.

Chairwoman Smith:
I just wanted to clarify. I assumed you were talking about amending current language, but I wanted to make sure because we do have a couple of amendments coming.

Steve Hiltz:
Section 10 deals with psychotropic medication, and I would like my colleague, Janice Wolf, to address that issue.

Janice Wolf, Deputy Directing Attorney, Children's Attorney Project, Legal Aid Center of Southern Nevada, Las Vegas, Nevada:
The proposal here is a wonderful beginning. I think that everybody in the state and at the county level is very much in support of doing something about

attacking the problem of psychotropic medications that are being fed to our children in foster care. As the Committee has seen from the materials provided, the number of children receiving these medications is disproportionately high when you look at the foster care population versus the nonfoster care population. I am fortunate to have been asked to chair the Statewide Subcommittee on Psychotropic Medications, and as was indicated, this is an issue that the Court Improvement Program is currently taking a very hard look at. We have not narrowed down how we are going to address the problem, but we have been meeting actively to come up with proposals for addressing the problem on a systemic basis. Our committee is now made up of a very good cross section: we have attorneys in private practice; Tom Morton, Director of Clark County Family Services; his counterpart from Washoe County; Legal Aid; the Special Public Defenders Office; and Diane Comeaux from the Division of Child and Family Services. They are all part of the committee that is making an effort to attack the problem in a global way that will adjust policy. We hope to educate the people who are making the decisions and signing the consent forms for our children.

The only question we had in section 2 that has not been answered yet is: what teeth can be put into this in the event the appropriate policies are not established? Also we need to come up with a definition of "appropriate."

Chairwoman Smith:
Are you going to be offering anything, keeping in mind that today is the last day that we meet?

Janice Wolf:
I feel that this is an area that the Psychotropic Subcommittee will be able to address in terms of policy and protocol.

Chairwoman Smith:
Are you saying that you want to leave the language the way it is in the bill and wait to see what the Court Improvement Program does?

Janice Wolf:
Absolutely. I think we have expertise on the committee to address the subject.

Assemblyman Hardy:
I would like some clarification. The bill talks about a "locked facility" and also about "agency." Are we talking about all foster children?

Steven Hiltz:
This bill refers to children who are in the foster care system and who are placed by that system in a locked juvenile psychiatric hospital.

Assemblyman Hardy:
Is it limited to the foster child who is admitted to a locked, agency-oriented place?

Steven Hiltz:
Yes, except it is not an "agency-oriented place." In Clark County we have three juvenile psychiatric hospitals; two are private facilities, but the placement occurs from the child care agency. The caseworker places the child into the hospital and remains responsible for that child.

Assemblyman Hardy:
To make it more clear, there are a lot of foster children who never go to the hospital, who never go to a locked facility. This bill does not apply to all of those children out there, is that right?

Steven Hiltz:
No, not at all.

Assemblyman Hardy:
This does not apply to a foster child who has a psychotropic medication, but is not admitted to a hospital?

Steven Hiltz:
I am sorry. Sections 1 through 8 apply to the children going into the locked facility. Section 10 applies to all the children in foster care, many of whom are receiving very heavy psychotropic medications. It is not uncommon for children who are 6, 7, or 8 years old to be on multiple antipsychotic drugs.

Assemblyman Hardy:
For a foster child who happens to have Attention Deficit Disorder (ADD) and/or anxiety disorder and/or depression, section 10 applies to him, and I would be getting a second opinion on that child.

Steven Hiltz:
No. Section 10 requires that appropriate policies be established. The second opinion only applies to the foster care children who are being locked in a facility. Section 10, as Ms. Wolf said, is really a first step to look at this whole issue, which is quite appalling in terms of the overmedication of these children.

Assemblyman Hardy:
As a physician, I do not know what "overmedication" is. There are some things that are a challenge for me.

Assemblywoman Mastroluca:
Dr. Hardy, I respect what you say as a physician, and I do not think any of us know what "overmedicated" means. The question regarding the psychotropic drugs really comes down to who is making the decision and who is regulating it. In a normal situation, if your child had Attention Deficit Hyperactivity Disorder (ADHD) and depression, you, as the parent, would decide which medications that child would take and be able to evaluate that decision on a regular basis by seeing how your child was doing. In a foster care system that is not always possible. A doctor may prescribe one medication when a child is in a locked facility, then the child leaves the locked facility and goes into a home because he is doing well, and now another doctor may prescribe another medication for another, or an additional, reason. There is no way to keep track of that now. We want some oversight to say how many drugs these children are getting and why.

There are at least four bills going through the Senate on the same topic; this is not something new or something happening in a vacuum. It is something that we need to look at as a state. Many other states have taken serious looks at this problem, starting at the basics where we are today. They are saying we just need to keep track. We, as a state, are responsible for these children: they are our wards, and as members of the State Legislature we are responsible for making sure these children have the best health care possible, and knowing what they are getting and why is one way to do that.

Assemblyman Hardy:
I am writing a prescription for Ritalin. Who is going to come to me and say we want to see the child, or your records, et cetera, because you have also put this child on Benadryl for allergies as well? Who is the doctor in the sky who is going to look at the other doctors who are taking care of the children? How do you implement this? I would like to know if another state has done this and how it is working.

Assemblywoman Mastroluca:
I would be happy to give you that information. Texas has done a very large study. I do not anticipate this portion to be a very large, overworked project. The information is out there, it is in the child's chart, with their social worker.

Janice Wolf:
I do not think the concerns have arisen because of a Benadryl or a Ritalin prescription. We have clients on our caseloads, as do other agencies—children who are 5 or 6 years old—who have 12 and 13 diagnoses, who have been prescribed numerous psychotropic medications. We have children clients who are on cocktails of medications that include Seroquel, Depakote, Abilify, Lithium, Haldol, and the list goes on. I have had one client who has been in the foster care system for 2 1/2 years and has been on 17 different psychotropic medications. We are talking about psychotropic and antipsychotic drugs, not just the ADD or ADHD medications. What we are trying to do is to get a handle on these kids. Most of the drugs are not Food and Drug Administration (FDA) approved for children, and some of them have fairly serious side effects. As an example, I have a child client now who is on a Parkinson's medication because he has tremors as a result of an antipsychotic drug that he was prescribed. We are not trying to second-guess doctors, but rather to come up with something reasonable to guide a caseworker on when it is appropriate to get a second opinion. When is something too much, when is enough enough, and what works? There are doctors who are doing a good job of helping us identify children who should not be medicated at all or who may not need as much medication.

We are looking at three groups of children. We have the foster care children who end up in locked facilities, have more serious mental illnesses, and are on larger quantities of drugs or multiple cocktails. Then we have the foster children who have never been in a psychiatric hospital and probably never will be, and they represent the largest number. And there are still others who are being prescribed medications for behavior control; they are too rambunctious, aggressive, or have mood swings, and this group of children is being prescribed antipsychotic medications to control behavior rather than mental illness. It is a multipart process, a process of educating people as to what these drugs can do, the potential side effects, and the alternatives. One of the major alternatives is therapy, and that is something we have to look into.

Assemblywoman Parnell:
Does anyone have any statistics that show this? Can you give us something that states X number of children in foster care are three times more likely to get psychotropic drugs? This conversation is making me uncomfortable when it is all speculation, and I have yet to see anything that shows more children in this situation are likely to take drug X, Y, and Z.

Steven Hiltz:
We will provide the Committee with statistics regarding children in foster care: their ages and the number of medications they receive. We do not have

a comparison to children who are not in foster care and who are not receiving Medicaid. However, what we do have is shocking, and we will be submitting that.

Chairwoman Smith:
This is the last day for this Committee, and any information that the Committee needs to receive must be in our possession today. We do have a little time because we will be back this evening, but I want to make you aware of that, and I am sure the bill sponsor can work on it.

Diane J. Comeaux, Administrator, Division of Child and Family Services, Department of Health and Human Services:
I want to clarify a couple of things and see if I can respond to your concerns. The overuse of psychotropic medications for foster kids is a national issue and not unique to Nevada. Many states are in the process of figuring out how to address this issue. The way they are trying to address it is not by stopping the use of psychotropic medications but to insure that they are appropriately prescribed, that there is informed consent when someone agrees to place a child on psychotropic medications, and that there are appropriate diagnoses in place which indicate why they should be placed on those medications. We have been gathering a tremendous amount of information. As Ms. Wolf indicated, there is a subcommittee of the CIP that is looking at this issue and trying to bring a symposium to Nevada to educate us and also to help us figure out all of the policies that we need to put into place.

Dr. Hardy asked: how do we get that information out there; and how do we insure that people are following the policies, that the parents are all informed in their consent, and that the child welfare workers are educated in whether they should be consenting to those kinds of things? We will be happy to share that information with you.

The one thing I do want to clarify, because I have heard a lot of testimony on this, is section 10. Section 10 amends NRS Chapter 433B, which is the statute that deals with Children's Mental Services and the Division of Child and Family Services (DCFS). The amendment that you see here (**Exhibit C**) is to require me, as the Administrator, to insure that I have policies in place for those kids who are placed in my Division's facilities. That is the limit of this requirement. Those facilities for the Division are Desert Willow Treatment Center and Oasis On-Campus Treatment Homes, in Las Vegas, Adolescent Treatment Center, in Reno, and the Family Learning Homes. If it is the intent of the bill writer that the Division adopts policies for the use of psychotropic medications for all children in foster care, this amendment does not do that. This is limited to

a requirement on me, as the Administrator of DCFS, to insure that my facilities have appropriate policies in place.

Chairwoman Smith:
Would this be normal for you to adopt policies? I am sure you have policies for other issues for the kids in your care. When I first looked at this I thought: how would that happen, how would those policies be adopted, do you need a committee? When you look at the tighter parameters, I am sure you already have many policies in place regarding similar issues.

Diane Comeaux:
We have many policies in place. There is a process that we go through to include the Mental Health Commission which has final review and approval of all the Division's policies. This is a normal process for us. This is not requiring us to do something we are not already required to do. We do not have an issue with the wording at all. I have heard testimony that indicates that we will be adopting statewide laws to cover all foster children, and if that is the intent, this is not going to get us to that place.

Chairwoman Smith:
Thank you for that clarification. Assemblywoman Mastroluca, do you want to put your intent regarding this issue on the record?

Assemblywoman Mastroluca:
I would like to see this bill cover all foster children for the purpose of establishing policies for prescribing, use, and distribution of this medication.

Chairwoman Smith:
So you would broaden it? [Assemblywoman Mastroluca agreed.] Ms. Comeaux, how would that happen?

Diane Comeaux:
I am not certain because this, again, is specific to the Division's facilities, or this part of the NRS is specific to the Division's facilities. I can certainly take a look at that and get something back to you today. I will check with our attorney general on how to draft that.

Chairwoman Smith:
Let us hear the rest of the testimony on this particular issue. When we have our break, it would be good if you would get together and figure that out. You can probably make the request to the attorney general at any time.

Assemblywoman Spiegel:
In section 9, subsection 3, is there leeway for a judge to deem that, for whatever reason, sibling visitation is not appropriate? Would he have the ability to make that order?

Steven Hiltz:
There should be that flexibility. The intent is not to mandate the outcome; the intent is to bring the issue before the adoption judge and mandate that he consider whether visitation is in the best interest of all concerned. We will hopefully submit revised language today.

Assemblywoman Leslie:
We put in the audit process for all the facilities. One of the things judged is whether policies are in place and how well they are being followed. Some of the Division's facilities did not get very good marks in terms of how they were following those policies. When I went out to Nevada Youth Training Center (NYTC) a couple of years ago, the nurse there told me they were weaning kids off their psychotropic medications—I thought inappropriately—and so the Division went through a whole process to do the policies and procedures. I agree with Diane Comeaux that this is something they are already doing, but, not to muddy the waters further, I would put training in there. I think there needs to be more training on the existing policies to make sure that they are actually followed.

Mike Capello, Director, Department of Social Services, Washoe County, Reno, Nevada:
I concur with Assemblywoman Leslie that over the last couple of years a lot of the facilities have developed operational policies and procedures around the issue of medication. The absence of those policies certainly was made clear as a result of the audits that were done, which really brought that issue to the forefront. I would agree that the Division has developed those policies over the years. I concur with Ms. Comeaux that we should take a broader look beyond the Division's facilities; we should be looking at the wider population of children in foster care who are on psychotropic medications. Moreover, I agree that our staff from the child welfare agencies, who is involved in these decision-making processes, need to be trained on such policies. I would support that, as well.

Chairwoman Smith:
You would insure that appropriate policies and training are established, although—I hate to say the "F" word—it could put a fiscal note on it if we are talking about training. That is something you will have to talk about when you all confer on the break.

I want to make sure that the sponsor and the initial people testifying have been able to say everything they wanted to say on the record before moving on.

Assemblywoman Mastroluca:
I am finished.

Steven Hiltz:
I want to thank Ms. Comeaux for pointing out that her agency is not necessarily responsible for all of the children in the foster care system, just her facilities. We will be submitting slightly revised language to make this section applicable to the Clark County Department of Family Services. In my discussions with Michael Willden, it is not really clear what the DCFS's responsibilities are towards children in the Clark County Department of Family Services, and I think that should be clarified.

Tracey Woods, Reno, Nevada, representing Nevada Youth Care Providers, Las Vegas, Nevada:
We want to thank Assemblywoman Mastroluca for bringing this important legislation. Our group consists of private treatment agencies, mostly in southern Nevada but also in northern Nevada. Regarding sections 1 through 8, we support the policies that enable children to get access to the appropriate types of services when they need them the most. We also support policies that allow for youth to continue to receive treatment, such as that provided in locked treatment facilities, if medically necessary and appropriate to meet their needs. [Ms. Woods submitted a written statement (**Exhibit D**).]

We want to make sure that the proposed changes outlined in sections 1 through 8, which I have discussed with Assemblywoman Mastroluca, would not have any unintended consequences of limiting a youth's access to appropriate services.

Chairwoman Smith:
I have read your statement, and I understand what you want to do. How do you want to ensure that it is done?

Tracey Woods:
We just want to make sure that if a child needs treatment quickly, he will not be caught up in the process of the court.

Chairwoman Smith:
I understand that, but do you want to change what is written to ensure that?

Tracey Woods:
Yes. We can work with Assemblywoman Mastroluca on that. I think we can do that on the break.

Chairwoman Smith:
Okay, continue on then.

Tracey Woods:
In section 9, we do support the concept of protecting sibling visitation rights in cases of the termination of parental rights. We would ask the sponsor to consider some changes, and I think that has been discussed in the testimony of the witnesses in Las Vegas. If a court must put a visitation plan in place, we ask that the input of the appropriate caregivers and treatment agencies be considered; for example, if a treatment agency has that child and knows about that child, they should be allowed to opine on the determination. Also, we request that, when orders are given by the court, they are looked at on a case-by-case basis, as there are many variables to be taken into consideration when determining the appropriate type, frequency, and intensity of contact among siblings. Finally, in this section we would suggest a review of the plan to determine if changes need to be made or if the plan is working in the best interests of the child, because there can be many different sibling changes—maybe before the adoption they were together in foster care and now they are separated. How does all that play out?

In section 10, I echo other testimony. I think there are global concerns around the administration of psychotropic medication of children, and having policies which address the use and distribution in the Division's facilities would be a good start. The more data gathering we can do on this issue the better in order to make the appropriate policies.

Assemblyman Cobb:
I wanted further clarification on my earlier question about the costs of the outside medical professionals.

Mike Capello:
The bill currently requires the public child welfare agency to pay for the costs of a second opinion, and that has already been in place for the last four years and has not been an issue. I wanted to talk about a potential operational challenge. In a community like Reno, where we have one primary mental health provider, many of our psychologists, psychiatrists, and physicians who have expertise in this area are affiliated with that hospital. So it could present an operational challenge to find someone to issue a second opinion who was not affiliated. I am not sure if there is a way. I completely respect the concern which brought

the bill. We do not want a second opinion to merely be a rubber stamp or have someone issue the second opinion who is unduly influenced by the initial evaluator. But in some parts of our state, and Washoe County in particular, "affiliated," if that is interpreted to mean they have practice privileges at the same hospital, could present an operational issue. Insofar as the cost of second opinions, those are currently borne by the public child welfare agency—and potentially Medicaid, if the child is eligible and if the particular procedure is approved.

Assemblyman Cobb:
In your opinion, is it going to add to your costs overall if you add new doctors on top of this?

Mike Capello:
I do not believe it would be a new or an additional cost, because we are paying for second opinions now when they are asked for. The issue is that the bill currently limits who we can go to for that second opinion. Potential additional costs could come in if, for example, we had to go out of our community to bring someone in who met the nonaffiliation test. Otherwise, the cost for second opinions is something that is already built into our budgets.

Assemblyman Hambrick:
Depending on the physician's diagnosis, would you go for a second opinion in the same subspecialty, or would you go to a broader category?

Mike Capello:
I think the decision on a second opinion is going to come out of the court process, and the judge will ultimately make a recommendation in consultation with the child's attorney and the pubic agency. I could see where the disagreement about the initial opinion could be in a certain area, it could be about the medication, it could be about a number of different things. In practice, second opinions would be born out of that court process and what the disagreement or concern about the initial opinion was.

Chairwoman Smith:
Let us go to Las Vegas for those witnesses.

Thomas Morton, Director, Department of Family Services, Clark County, Las Vegas, Nevada:
To clarify Ms. Comeaux's comments in regard to section 10, subsection 1, paragraph (d), the "Division" is defined in NRS 433B.060 and means the Division of Child and Family Services. *Nevada Revised Statutes* 433B.070 defines "Division facility," and NRS 433B.110 designates the Division's

facilities, so there is a clear reference. If Assemblywoman Mastroluca's intent is to broaden this to all foster children, I would suggest that the appropriate language belongs in NRS Chapter 432B rather than NRS Chapter 433B. Other than that, I would agree with sections 1 through 8. I do have a concern and would have to say, that if the current bill remained intact in regard to section 9, subsection 3, I would oppose it because I think, perhaps, it creates an undue burden on adoptive parents and a potential barrier to adoption. If it is amended, as Mr. Hiltz suggests, to require this information be presented to the court and that the judge consider it in determining an appropriate plan of visitation, I think that is more appropriate. Child welfare, obviously, is a difficult field because it pits the rights of parents against the rights of children. From a policy perspective, I certainly support continued contact among siblings but would also say there are certain circumstances where that contact may not be appropriate. Therefore, I would be reluctant to have judges uniformly enter orders requiring visitation between siblings. For example, there are certain circumstances where siblings do pose a degree of harm to their other siblings.

Calvert Collins, Director, Junior League of Las Vegas, Las Vegas, Nevada:
We also have an organization in Reno, and we are in support of this bill. Four years ago, in A.B. No. 369, Assemblywoman Mastroluca and the Junior League of Las Vegas were instrumental in passing the statute that is currently in place. Our mission is to improve the lives of women and children in southern Nevada, a mission shared by our sister organization in Reno, as well. I recently emceed the "Walk Me Home" event through Clark County's Division of Foster Care Services and spoke to a number of parents who had multiple foster children—who were also soon-to-be adoptive parents—about the need to keep these children together. In our organization we have a number of divorced women with children. As a child of divorce myself, I understand: I have seen firsthand the importance of keeping children together because of age disparity and because of the need to have someone who understands your circumstances. Our position as a volunteer organization is to improve the lives of women and children. We support section 9, specifically, in keeping the children together or at least, in having visitation available for those who are then adopted from foster care.

Chairwoman Smith:
Do you support the recommendation from the previous testimony regarding including the guardians and caretakers in that decision along with the judge?

Calvert Collins:
Yes, we do.

Chairwoman Smith:
We are coming back here to the Committee for additional testimony and then we will take a break.

Michelle O'Connell, representing the Junior League of Reno, Nevada:
We are in favor of A.B. 364. I have been through foster care training, so I know a little bit about these children who are somewhat pushed under the rug. We feel it is extremely important to keep siblings together when they "age out" of foster care or when they are adopted. It gives them the only sense of family they have.

Chairwoman Smith:
Mrs. Mastroluca, I think we will come back to this and actually reopen the hearing after you have all had a chance to talk through some of the issues. It sounds like there is still quite a bit to resolve. If that works for you, we will revisit it this evening. Is there anyone else whom I have missed who wishes to speak on this issue?

Julianna Ormsby, Carson City, Nevada, representing the Nevada Women's Lobby, Reno, Nevada:
All of my concerns have been addressed. We have spoken to the sponsor of the bill and appreciate her bringing this forward. We are looking forward to working with her on some of the amendment language.

Chairwoman Smith:
I will close the hearing on A.B. 364. We will take a 15 minute break for Committee photographs. [2:56 p.m.]

Meeting reconvened [3:47 p.m.]. This is a very difficult part of the session when we are trying to meet deadlines and everyone has to be in different places. Everyone's bill is either going to live or die in these couple of days. We need to spend as much time as we can on the issues and make thoughtful decisions, so it sometimes makes us run a little behind. We have lost a couple of members so we are not going to work session right now. We are going to open the hearing on Assembly Bill 52.

Assembly Bill 52: Requires hospitals in certain larger counties to provide certain types of emergency services and care. (BDR 40-448)

Kathy Silver, CEO, University Medical Center, Las Vegas, Nevada:
[Ms. Silver read from prepared testimony (**Exhibit E**), excerpted here.] Hospital costs have increased dramatically over the past decade, and in Clark County, hospitals have been able to pare some of those costs by reducing or eliminating

services of physician specialists to provide coverage for the emergency room patients. Patient interfacility transfers occur when a patient presents to a hospital emergency room, is assessed by a physician, and is determined to need medical treatment unavailable at the hospital. As a result, interfacility patient transfers have become increasingly more routine and problematic for receiving facilities, especially for University Medical Center (UMC). University Medical Center negotiates many relatively expensive contracts with specialists in order to provide this on-call coverage.

Chairwoman Smith:
I have a question about 53 percent of the transfers. Is that 53 percent of the individuals, not related to the cost?

Kathy Silver:
Fifty-three percent of the patients transferred do not pay the full cost of the care.

Chairwoman Smith:
When you say "cost of care" you mean bill charges?

Kathy Silver:
I mean the actual cost of the care.

Chairwoman Smith:
I do not know if we are always comparing apples to apples, so will you help me out?

Kathy Silver:
Twenty-six percent were uninsured, self-pay; there was some payment or no payment, it would vary. Combined, the Medicaid and Medicare fees for service and health maintenance organizations (HMO) were another 23 percent. Then "other governmental"—which usually means the Clark County Detention Center or other type of payer like Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), TriWest Healthcare Alliance—was 4 percent. My reference is that 26 percent were uninsured if you accept the fact that Medicare and Medicaid do not actually pay the full cost of providing hospital services to patients. We are talking about costs, not charges.

Chairwoman Smith:
Of the 53 percent, does that mean they do not pay anything, or they are just not paying for the whole cost?

Kathy Silver:
Twenty-six percent, which are self-pay, are probably not paying anything, or very little. The next percentage, which would be another 23 percent, is not paying the full cost of the care.

Chairwoman Smith:
What I was trying to get to: regarding the 53 percent, does that mean they do not pay anything?

Kathy Silver:
No. Only 26 percent, we are presuming, pay nothing.

Chairwoman Smith:
Is there anyone who would like to testify in support?

Jeri Strasser, representing Service Employees International Union, Las Vegas, Nevada:
[From Las Vegas.] I am sitting in for Stacy Shaffer, Political Director, Service Employees International Union (SEIU). We are in support of the bill with the amendments. The bill, I understand, has been amended?

Chairwoman Smith:
There is an amendment offered, I believe, by the Rural Hospital Association.

Kathy Silver:
Yes, there is an amendment (**Exhibit F**), and it was a deadline snafu that caused it not to arrive in time. It was essentially modifying the language in the bill to change it from one physician to four physicians and also to eliminate ophthalmology.

Chairwoman Smith:
Yes. Sorry, I have that. Thank you.

Assemblyman Hardy:
Regarding the amendment that talks about the four physicians, in looking at the handout (**Exhibit E**) and the people who are specialists in Las Vegas—I do not know who provided the handout on physicians and specialties.

Kathy Silver:
That handout came from me. Those are interfacility transfers by specialty by system. For example, if you look under the column for Hospital Corporation of America (HCA) hospitals, the main reason for transfer was "out of contract." As you move down the column, you see "Burn" or "ENT," and so on.

Those are the numbers of transfers by those specialties. "Out of Contract" was simply a way of explaining HCA's numbers: why such a large number is sent to us; in many cases it is because they do not have a contract with Sierra Health at any of their facilities.

Assemblyman Hardy:
I looked at it differently. How many ear, nose, and throat (ENT) doctors do we even have in Las Vegas, would any hospital have four on staff that are willing to do emergency call, and how many times are we recounting them? How many specialties are there?

Kathy Silver:
We have not provided that.

Assemblyman Hardy:
My challenge with that is, if I require somebody to have four physicians, I may not even get four physicians.

Kathy Silver:
The point of the amendment is that if you do not have four physicians in that specialty, then the bill does not bind you to that specialty.

Assemblyman Hardy:
I am looking at the specialty of urology, for example. Again, I think there is another problem. How many urologists are on staff at a given hospital; could they be counted twice, or three, or four times? The doctor may be on staff at several hospitals, and it looks like we have more doctors than we do.

Kathy Silver:
I hear what you are saying from a medical staff roster perspective, but the bill does not require that each hospital be able to provide all those services. Understanding that, we are saying that, if you have a hospital within your system which could provide those services for your system, then the bill would apply. The other two or four hospitals in the system would have the option of transferring the patient within the system to where that service could be provided.

Chairwoman Smith:
Now that I am looking at the amendment (**Exhibit F**), I just want to clarify, on the second page where it deletes one physician and changes to four physicians, you are saying if the hospital has four physicians in each specialty. For instance, the amendment refers to four cardiologists, not four of the specialties on the list.

Kathy Silver:
If you have four physicians in any of those specialties that we have identified: four ENTs, four urologists, or four neurosurgeons, then the bill would apply. If you do not have that many on your staff, then it would not apply.

Chairwoman Smith:
How was the number four arrived at?

Kathy Silver:
We felt it would be unreasonable to assume that a hospital, which had one or two of a particular specialty on call, would be able to cover 30 days of call. I do not think four is a magic number. I do not know if there is a magic number, but we are basically trying to establish a starting point for dialogue or for some attempt to determine what the proper balance is.

Assemblyman Hardy:
I guess we are on to the amendment, because we are talking more about the amendment than the bill, right?

Chairwoman Smith:
I think since it is the sponsor's amendment, that should be where we are basing our discussion.

Assemblyman Hardy:
Following up on that amendment, on page 3 it says, "the hospital has entered into a written agreement for the transfer and treatment of patients, if such an agreement is required pursuant to subsection 2." As I read that, I may be the only physician in that specialty, and the market is going to cost more money for having my services. That is where I am curious about the access to care and how much that cost will increase.

Kathy Silver:
We are very familiar with that argument and with having that discussion, because that is the same discussion that probably prompted us to put this bill forward. Physicians come back to us and say, "We did not intend to take call for the entire Las Vegas Valley. As a result of our taking call for the entire Las Vegas Valley, we are going to charge you more." This is the hospital's real concern: it will put the balance of power in the hands of the physicians. In certain specialties, I think that is a risk. I think there is a way to mitigate that, either through transfer agreements with hospitals that are providing those services or working with the medical staff in your particular facilities to see if the doctors can be encouraged to be a little more active in terms of covering the hospitals. Dr. Hardy, you have been a physician a long time. You know that,

typically, in many community hospitals or hospitals around the country, in order to have staff privileges in a certain specialty you offer to take emergency room (ER) calls for the hospital. We do not find that as often in our community.

Assemblyman Hardy:
If we look at one hospital making a contract with another hospital, we are going to get into that same issue of what the market will bear. I am looking at Mesquite or Boulder City Hospital as being little hospitals that are going to say, "We do not have anybody." All of these little contracts that are not going to be so little will create another issue. The bottom line is, we have a problem with the economy, we do not have enough money, and we are trying to figure that out.

Kathy Silver:
I think we wrote this in such a way that Mesquite and the outlying hospitals would not be affected.

Assemblyman Hardy;
And if you did not, you mean to do that?

Kathy Silver:
We would not want them to be affected.

Chairwoman Smith:
Is there anyone else who would like to testify in support? [There were none.] Okay, we will have some testimony in opposition.

Vincenzo Variale, CEO, North Vista Hospital, North Las Vegas, Nevada:
North Vista Hospital is a general, acute-care, for-profit community hospital with 178 beds, which pays property and sales tax to partially support medical services located in North Las Vegas. We have 680 employees providing basic medical services to the community for 50 years, including a 24/7 emergency department and an obstetric unit, with a heavy Medicaid population. Unfortunately, on January 1, 2009, we had to close down our neonatal unit due to recent cuts. Even though located in Clark County, North Vista Hospital is the only hospital in North Las Vegas, serving a population base of 212,000. Our hospital is located in an economically-challenged section of downtown, at Lake Mead and Las Vegas Boulevards. North Vista Hospital is not part of a local hospital system; therefore, we are not able to transfer patients in need of services beyond our present hospital capabilities to a sister facility. North Vista Hospital takes all its obligations seriously, and we routinely provide uncompensated care to patients with emergency medical conditions, including women in active labor who do not have the ability to pay for emergency

services. [Mr. Variale continued reading from prepared testimony (**Exhibit G**), excerpted here.]

Chairwoman Smith:
Thank you for your testimony. I appreciated visiting your facility when I was in Las Vegas, and I know you provide an important role in your community. Have you looked at the amendment with the changed language adding four physicians?

Vicenzo Variakle:
That is how I came up with the $1.5 million. I took that into account.

Dan Musgrove, representing The Valley Health System, Las Vegas, Nevada:
I am going to turn my time over to Mr. Greg Boyer who is the CEO of the Valley Hospital. Mr. Boyer is also the current chair of the Nevada Hospital Association Board of Directors, but I want to be clear that today he is representing only The Valley Health System. As you know, this is an issue that involves all hospitals, and the Nevada Hospital Association (NHA) is taking a side seat to let us work this out among ourselves.

Greg Boyer, CEO, Valley Hospital Medical Center, representing The Valley Health System, Las Vegas, Nevada:
Statistics are always easy to manage and manipulate. Valley Hospital, Sunrise Hospital and Medical Center, Catholic Healthcare West (CHW), North Vista Hospital, and the NHA have been negotiating in good faith with UMC on this issue for several months. University Medical Center has acknowledged that the transfer issue is moving in the right direction from the standpoint of managing the transfers appropriately. I believe that we are going to resolve this without legislation, and I hope to find your support in that.

In looking at Valley's numbers—and I have to speak for The Valley Health System, which has five hospitals in Las Vegas—we compared the two most recent quarters—the 4th quarter of 2008 and the 1st quarter of 2009—for the number of transfers that we transferred to UMC. The number is declining. The average number of transfers per month in the 1st quarter of 2009 was only 18.7. That is down from a total average number of 21.3 in the prior quarter, a 17 percent reduction, so we are working to address our emergency transfer issues. The Valley Health System now spends over $5 million on physician contracts to cover emergency services in obstetrics (OB), orthopedics, general surgery, and neurosurgery, and there are other specialties on line. To break down the type of patients that we transferred to UMC: 46 percent were trauma patients—UMC is the only trauma facility—4 percent were burn patients—again, UMC is the only burn center—and 13 percent were pediatric patients—we do

not have pediatric facilities at Valley, nor do many of our hospitals, but we are evolving our pediatric hospital at Summerlin, and as we evolve those services, we do not expect to transfer pediatric patients to anyone but ourselves. The balance is a combination of mostly ENT, which presents a particular problem in Las Vegas because of the lack of ENT physicians, and then urology at 9 percent. After that, very few patients are transferred.

I think that this bill has the unintended consequence of having physicians holding more leverage in negotiations with contracts for ER coverage. I think that hospital systems are addressing these issues and that A.B. 52 is not necessary.

Chairwoman Smith:
Are all of the patients we are talking about being transferred from an emergency room to inpatient status, or are they sometimes transferred ER to ER?

Greg Boyer:
I believe most if not all of the patients are ER to ER transfers. I also want to dispel the myth that The Valley Health System and the other hospitals in Clark County do not provide their fair share of indigent care. In 2007, the most recent reporting period, on the state-required Assembly Bill No. 342 of the 73rd Session report, Valley Hospital reported $23.4 million in self-pay patients. The Valley Health System provides $64 million out of an overall state budget of $188 million. So I believe that we accept and care for as many indigent patients as we can and we do provide our share.

George Ross, representing Sunrise Hospital and Medical Center, Las Vegas, Nevada:
We certainly agree with virtually everything that has been said by the three previous speakers. I just want to add some statistics and perspective because, as some of you have heard me say before, UMC is not the only recipient of many indigent, uninsured, and Medicaid patients, none of whom cover all their costs. In terms of transfers, which includes insured and uninsured, in fiscal year 2008, Sunrise had 2,941 transfers from other regional or rural hospitals and 1,342 transfers from local hospitals, for a total of 4,283 transfers. The reason they come to Sunrise, in many cases, is because Sunrise has the ability to handle complex cases, often with high technology. That is why we have that technology; we do not mind taking those patients. That is the whole purpose of the hospital. University Medical Center took 1,144 transfers in that same period of time, so I think it is important to understand that other hospitals are taking a great many people. Did UMC transfer to Sunrise? Yes. They transferred 29 patients in 2008, of which 23 were either indigent or on Medicaid. Did Sunrise transfer patients to UMC? Yes, in certain cases we

transferred ENT, and, as you will note on the data sheet (**Exhibit E**), a large number of folks were "out of network." There is a reason for that: if they are stable enough to be transferred, if they are out of network at Sunrise, then they will not end up paying out of network charges for the rest of their care if they go over to UMC. It is far better financially for the patient to do that if they are able to transfer.

With regard to Sunrise's other two hospitals, Mountain View and Southern Hills, they transfer virtually all of their indigent patients who need high-level care to Sunrise. We trade back and forth; there are certain burn patients and ENT patients who go to UMC. When UMC needs someone with pediatric cardiology, cardiovascular, or cardiac defibrillation, they transfer to Sunrise. As Mr. Boyer pointed out, a lot of this has been worked out in the normal course of events. Our main point is this: other hospitals do a lot of transfers as well. It is not all one-sided, and other people contribute. We do not feel that a bill, which seems to punish all the rest of the people who are doing their fair share, is appropriate. Rather, we definitely feel this can be worked out among the hospitals and UMC in a cooperative manner so that we all work together for the common good.

Assemblywoman Pierce:
Of the transfers that you cited, how many are within your own system? Are you counting transfers within your own system to Sunrise?

George Ross:
No.

Lisa Foster, Reno, Nevada, representing the City of North Las Vegas, Nevada:
I am here to state our concern in support of the only hospital in the community. We, too, would like to see some of these things worked out outside of the Legislature, if possible. Perhaps some of the issues need to be studied more thoroughly, but we do not want the only hospital in North Las Vegas to be too severely impacted.

Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada:
This bill requires a range of services that is beyond the capability of small hospitals, and accidentally captured the hospitals in Boulder City and Mesquite in the definition of which would be subject to the bill. I have proposed an amendment (**Exhibit H**) to take those two hospitals out of the bill. I appreciate Ms. Silver's statement that she did not want the small hospitals to be affected. The amendment adds language to subsection 2 of section 1 of the bill that simply says, "and which has more than 50 acute beds." In that way, these two hospitals are exempted from the bill.

Lawrence Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:

We are neutral on the bill. Whether you process it or not, an underlying issue which has come up in a number of discussions before this Committee and others, is the continuing, growing problem of the health professional workforce, especially in specialty care. Dr. John Packham, Adjunct Professor of Sociology at the University of Nevada, Reno, is completing his annual study of health workforce issues, and the national data from which he will extrapolate information has shown that, once again, on general surgery and surgical specialties, Nevada is last in the country in terms of the number of physicians to population. However you deal with this particular bill, during the interim I think it is something the Legislative Committee on Health Care and other bodies need to look at; how to deal with the health professional workforce shortages that are impacting emergency departments. This is not surprising because the emergency departments tend to be the place where every problem in the healthcare system gets magnified and often gets passed off. It is about our ability to meet the needs of Nevadans in a growing way.

Bobbette Bond, Executive Director, Nevada Health Care Policy Group, LLC, North Las Vegas, Nevada:

We do not have a position on this bill because we do not know what the solution should be. The current situation in Clark County, when there is one public hospital and predominately for-profit hospitals around it, works out well when times are good and the profits can go back into more infrastructure creation, which has actually happened with our systems. The for-profit hospitals have been willing to invest some of their profits into creating new hospitals in Clark County. Then those new hospitals can lose money for a while because they are subsidized by their sister hospitals, gain some ground, and then make a profit and provide some infrastructure. That is the upside. The other upside should really be that they take their fair share of the uninsured and share the transfers as needed among the system when possible. When times are good that is a barely-workable model. When times are bad, you see all the consequences of having one public hospital taking far more than would normally be expected in uncompensated care.

There are many ways for that to occur. This bill is the result of several strands of uncompensated care ending up in UMC because of policy decisions and non-policy decisions: either habits, the ability to do it, or decisions made internally. While we are really happy to see this issue vetted here—we are happy to see all the hospitals working on this—the issue may not be resolved without legislation, because the issue has been going on for quite some time. It is only the introduction of legislation that has brought to this Committee the issue of how all the patients end up at UMC. Without legislation, I am fearful

that the hospitals will simply revert to their earlier practices before they started working on this together. We would not like to see that happen. We would like to see all the hospitals remain viable, and the only way to do that is for all the hospitals to share the economic impact.

It is true that some of the other hospitals are doing some of this, but, still, these transfer protocols are a problem. Some of the current problems are the result of the economy. Some are the result of healthcare planning in the past and funding in Clark County for healthcare, in general, and some has been the pressure on UMC for years, inside this Committee and inside this building, not to make a profit. So being able to expand to have a wide array of services and be able to stay stable and strong in good times so they can ride out bad times is something that does not happen, because as soon as they make very much money for very long, the other hospitals call it competitive and do not want them to do that. They want UMC to be a county-only hospital, but you cannot have a service mix and a payer mix that are so lopsided and still stay viable. So, while I can understand this Committee's frustration with what has happened with the cancer center and everybody's concern that UMC, the only county hospital in the valley, is not doing its job, this has been a long-time, long-growing problem of underfunding and lack of foresight about payer mix and about being able to develop a healthy service mix, so that they could ride these things out. Without that, we are going to be in this situation forever. So, while we are neutral on the bill, we are very concerned about the issue. We hope that there is some resolution and further study of it.

Chairwoman Smith;
Are there any further questions? [There were none.] I will close the hearing on A.B. 52, and with that we are going to stand in recess because we have lost several members to the Education Committee. We will be monitoring that committee and give those members time to take a breather after their work is done there before we resume our evening meeting. [Recessed at 4:35 p.m.]

[Reconvened at 7:11 p.m.]

Chairwoman Smith:
[Meeting called to order.] We are going to hear Assembly Bill 485, which is a Committee-sponsored bill. I will turn the chairmanship over to Vice Chair Pierce, and I will introduce the bill. Thereafter we will do a work session.

Vice Chair Pierce:
We will open the hearing on Assembly Bill 485.

Assembly Bill 485: Revises provisions governing the program to provide Temporary Assistance for Needy Families. (BDR 38-1117)

This bill is sponsored by the Assembly Committee on Health and Human Services.

Assemblywoman Debbie Smith, Washoe County Assembly District No. 30:
This is one of the issues that I started looking at after learning a little more about Temporary Assistance to Needy Families (TANF) issues in the Assembly Committee on Ways and Means. It is a simple little bill. It eliminates the "sit-out" period which families receiving assistance through the TANF program are currently required to take. The federal government limits TANF assistance to 60 months, total, over a lifetime. We have heard quite a bit about TANF already in this Committee. Currently, Nevada state law requires that once a family has received assistance for a total of 24 months, they must sit-out for a period of time. Although the 24 months of assistance can be consecutive or accumulative, the sit-out time must be 12 consecutive months. After the 12 month sit-out, they can continue to receive assistance up to their 60-month lifetime limit. It is my understanding that, at the time the sit-out was established, the concern was that families receiving assistance might be short-sighted and make a decision to stay on assistance for an extended period of time. The fear was that they would use up all of their lifetime allotment, 60 months, which would leave them without any assistance left to carry them through an unexpected hardship in the future. However, I believe that this 12-month sit-out requirement is arbitrary and unnecessary and does not take into consideration the needs of individual families. Twenty-four months really is an arbitrary time limit: there is no basis in reality for determining what a particular family might need. I have thought about the idea that we do not want people getting all of this money all at once, but we heard what that dollar amount was the other day; it is not enough money for someone to exist on alone.

As we face rising unemployment and hard economic times, individuals may experience extraordinary circumstances and have a difficult time reaching self-sufficiency in 24 months, and we did hear a lot about that as well. Some of these families are in extraordinary circumstances and require a lot of assistance in getting back into the workforce. The Division of Welfare and Supportive Services (DWSS) already had the ability to influence how long a family stays on the program for any stretch of time through development of a personal responsibility plan (PRP), and they counsel them about not using up all their time if it is not necessary. Since the PRP has developed into such an effective tool, I think the arbitrary time limit is unnecessary, and it would be better to work with clients on an individual basis to meet the unique needs of

their families. The support services that families receive when they are participating in TANF are extremely important to their ability to reach self-sufficiency, which I think is our goal: to have these families become self-sufficient.

In addition to losing the monthly TANF grant during the sit-out period, the family also loses part of the support services they depend on to make the transition, such as child care assistance. It is hard to become self-sufficient if you are a working single mom and you do not have any help with child care. Assembly Bill 485 would help families work toward self-sufficiency without facing a roadblock after 24 months.

Some information we gathered from the staff is that between 2005 and 2008, the sit-out provision affected an average of 554 households. In fiscal year 2009, 298 cases went into sit-out for the first 24 months, 49 cases went into sit-out for the second 24 months, and 29 cases were terminated because they had exhausted all of their assistance. The family does continue to receive medical assistance during the sit-out, and there is currently an exception in the law for the 24-month-on/12-month-off rule. If the head of the household is suffering a hardship, they may qualify for an extension of six months of assistance before having to sit-out.

I did ask for a couple of examples of real cases to give you some idea of what this really is about. One case involves a client who is attending the University of Nevada, Las Vegas (UNLV) for 15 hours a week in pursuit of an English degree, is expected to complete her studies in May 2009, and is working part-time, 12 to 13 hours a week, for the library system. The TANF ended in April for the 24th month. This person will lose the childcare benefit and go on partial pay, or become "at risk." So, here we have this person who is just on the verge of finishing a degree and likely becoming self-sufficient, and the decision would have to be made to terminate. It just does not make sense to me. It seems like the agency should have some flexibility there.

Another case is that of a 27-year-old client with four children who recently completed culinary training and was job searching. She received an offer for employment at CityCenter; however, it will not open until August 2009, at the earliest. Her TANF ends in May for the 24th month, but the caseworker was able to grant a three-month extension to find work. So that is another example of someone right on the cusp of being where she needs to be when her assistance is required to be suspended. Anyway you look at it, recipients have a maximum benefit allowed, but the flexibility not to have that sit-out period right in the middle of what they are trying to accomplish just makes sense.

It seems so arbitrary. It seems that if there was a real basis for why we do this, it would make some sense, but I do not see it.

That is the testimony as to why I wanted the Committee to consider this issue. I think Mr. Gilliland is here from DWSS and he can answer questions better than I, and there are some other people here who want to testify.

Vice Chair Pierce:
Are there any questions?

Assemblyman Cobb:
Under the scenario that you offered about the college attendee, would we not, as a policy, want to encourage her to do something such as take out low-interest student loans, federal Pell grants, that type of thing, as opposed to putting her through the welfare system? I do not know a lot of students who were on welfare through college rather than taking out student loans.

Assemblywoman Smith:
I will respond and then ask Mr. Gilliland to answer more technically. I am responding here only to what the current situation is, and I think you are referring back to the beginning—would they not have been better off taking out loans rather than to be on TANF to begin with? But what I am talking about is: they are here in this system and would not take out a student loan at this point, and they have just a few months left to achieve this really significant accomplishment of finishing school; would it not make sense to let them complete that piece? But you have a different question about whether it would make more sense back at the beginning.

Romaine Gilliland, Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services:
It would be very difficult to answer that question because you really need to go back to the very beginning of the case. What we look at are the circumstances of a single mother with a child and the fact that, based on their circumstances, they qualify for TANF. Putting them into a personal responsibility plan would move them toward their highest level of self-sufficiency. What we have here is a situation where we got to the very end, and while this might be a case where an eligibility worker would encourage the individual to request a hardship exemption, she may fall between the cracks. I think this is an example of one that partially fell through the cracks. The other thing you have to look at is the childcare aspect. While they are on TANF, they are eligible for a 100 percent subsidy for childcare, provided they meet the educational and work participation requirements. But once they fall off of TANF, then they end up in what we call the "at risk" category, and in that status, while they still receive partial

childcare, it is not 100 percent subsidized. So this is really an example of where "natural continuity" may have been a desirable method of going forward.

Jon Sasser, Statewide Advocacy Coordinator, Washoe Legal Services, Reno, Nevada:

As I mentioned during discussion of Assemblyman Cobb's bill last week, I have been involved with these issues through task forces in the Legislature for over 20 years. This is a revisiting of a policy decision that was made in the mid-1990s, during a time that welfare reform was the hot topic of the day. At that time, Congress passed a bill that said each state had the right under a change in the program—changing it from an entitlement to a block grant—to have a lot more flexibility in developing the laws that governed the program. Congress imposed a five-year lifetime limit on the receipt of TANF benefits by each family. Nevada, like a few other states, decided to go beyond that five-year time limit and impose a time limit of its own. Under the one we came up with, you can be on for 24 months, off for 12 months, on for 24 more months, off for 12 months, and then go back on for the final 12 months, making up the 60-month lifetime limit. That is not necessarily consecutive months, however. So, for example, if a mom goes on and was on for 17 months, three years ago, and now when the economy comes crashing down she goes back on, she has only seven more months before she hits her 24-month mark and has to be off for 12 months. So when you think of it only as people who have been on for the last 24 months, it gives you one scenario. But there are many other scenarios. You might say, "Well, why do they not just give them a hardship exemption in these tough times?" The Legislature defined hardship to include such things as physical or mental incapacity or caring for a sick child at home. Those are defined in the statute today. There is nothing in the statute about hard economic times being a hardship.

The purpose in the beginning for this two-year limit was to allow people to save a longer period of time in this five-year lifetime limit. When the Nevada Legislature faced its budget crisis this last year, we looked at the "Rainy Day Fund" and said, "It's a rainy day; we're going to have to spend it." It is a rainy day for these families, and to put them into the forced savings plan of having to drop off for 12 months, at a time when it is very, very difficult to get a job, I question whether it makes sense today.

As to Mr. Cobb's question, I do not want people to get the impression that people on TANF, as a general rule, are putting themselves through four-year colleges. The federal government very strictly defines an acceptable activity that counts as a work participation activity so that the state can meet its work activity rate. Going to a four-year college does not count; for it to count, you have to be in an education program that leads to employment within

12 months. So, if this person has been in here very long and is meeting her work participation requirements, then she is doing this college time on top of another series of hours for work participation if she is going to count toward our positive work participation rate. Not every family has to meet the work participation requirement, so there is some flexibility for the Division not to require that in a given person's personal responsibility plan. But, as Mr. Gilliland said, I believe that would affect her eligibility for childcare if she is not participating and meeting the work participation plan rates.

Finally, there is a fiscal note of $333,000 on this. I know money is very tight this session. I would say two things about that. If you as a body feel that this is good policy, I would ask you to pass it out of the Committee on Health and Human Services and let the Committee on Ways and Means decide. I do not think it is an automatic $333,000 because the way it is built, as I understand it, is on an assumption which may or may not come true. We went into this last biennium with almost $27 million in reserve in the TANF account. We are going through that rapidly because our economy has crashed. The federal government, as part of the Stimulus Bill, has said they will pay 80 percent of the cost of our increased caseload growth up to 50 percent of our federal block grant. The projection of the Division is that will probably run out, if things continue as they are, sometime during this biennium. If it does, then the extra caseload would have to be paid for from the General Fund. But it may not, and as the Chairwoman knows, these projections will be looked at a number of more times by the end of this session by the Committee on Ways and Means. So I ask that the decision be placed there, and then we will know what the exact final numbers are in May. That committee can make the final decision.

Assemblyman Cobb:
I am talking about a larger policy. We, as a Legislature, are setting miniscule policies but setting a larger social policy as well. Under this scenario there are tens of thousands of college students or older Nevadans going back to college, and you are suggesting "go ahead and get on TANF and attend college." I do not understand. What is the difference between someone who is just deciding to go back to college for maybe their first degree, or maybe another degree, who has kids and may qualify for TANF benefits, and someone else who qualifies for TANF benefits? On one hand we are saying, "indebt yourself and be responsible for your own education through very low interest rates and federal grants as you are working your way through college; that is the right way to do it." On the other hand, "if you want to be on welfare, go ahead; we will give you all these child tax credits. Do not put yourself out; we will cover you." We are sending two messages at once. That is the point I am making here.

Jon Sasser:
The point I was making is that is not a common scenario. The reason it is not a common scenario is, each individual TANF recipient must have a personal responsibility plan that says what they are going to do, and then the state says what it is going to do, in terms of this contract. The State Welfare Division looks to the client to meet the federal work participation requirements, and those requirements are not going to count a four-year college as a countable work activity. The state has a huge financial incentive to get as many people into countable work activities as possible because, if we do not meet certain quotas, then we are subject to a federal penalty. There is some degree for individual negotiations on a plan, I am not saying it cannot be done, but if the state does that to any large degree, it then jeopardizes itself in terms of federal penalties. Mr. Gilliland may want to clarify that further, but that is my understanding of the federal work participation rates. The education one must be in must be deemed to lead toward employment within 12 months in order to count. So if one just gets into a four-year college, that does not meet that requirement.

Jan Gilbert, Northern Nevada Coordinator, Progressive Leadership Alliance of Nevada, Reno, Nevada:
It is very interesting having been through the change in 1997 when Aid for Dependent Children became TANF, and it became a work program. Prior to that, the average time on welfare, month after month after month, was two years. I actually wonder if the governor at the time saw that and said, "Oh, let us make a time limit of two years." There was a misconception that there were a lot of people just staying on welfare for as long as they could, but the record keeping that the Welfare Division would send out every month showed that the average time was two years. We do not feel this is going to be a burden to the Welfare Division. If anything, it is going to help them. They have to do a tracking system to record people's time: two years on, then the sit-out, which I have always thought was a terrible name because what are these families supposed to do in this sit-out? Are they homeless; how do they live anyway on $372 a month? That is the average grant. They sit-out for a year, and then they get back on.

As TANF became a work program, more and more people got work and left the welfare rolls. The result was more and more of the people on the rolls were those that were harder to serve because they were having a more difficult time getting back on their feet. It is common knowledge that at one point we were finding it was harder to get work for people who were left on the rolls because they had more obstacles, whether it was domestic violence, a lack of education or training, treatment if they had a problem, and so on. Some of them, and many of them, got off in two years. As you heard, only 500 had to sit-out for

the 12 months. But, if they had that extra month, or two months, you wonder if perhaps they would have been successful. The Welfare Division and the recipient create the plan, and I think we should let them follow and complete the plan. It is a plan that is very well thought out with their eligibility worker who helps them determine what will help them succeed in the workforce. I urge you to pass this bill, and I think it would simplify the tracking system for the Welfare Division. They keep very accurate records, and those can be viewed online all the time. This bill is not going to increase the time a recipient spends on welfare. It is a very small population that has difficulty. I think this is really going to help those who are the hardest to serve, and I would appreciate your vote on this.

Assemblyman Hardy:
What happens after five years?

Jan Gilbert:
I did not support the welfare reform movement because I do think there are some who are going to have a real hard time. I do not know the numbers, but I think those who do not succeed are a small percentage. When you consider the difficult economic times and the difficulty in finding jobs, it is very frightening. Some will be homeless with their children. I do not support time limits, but that is what we are living with, and so we felt this five-year limit is a more realistic way to look at this system.

Julianna Ormsby, Carson City, Nevada, representing Nevada Women's Lobby, Reno, Nevada:
For a family of three receiving TANF cash assistance over a 12-month period, if they are receiving that consecutively the total is about $4,400. If someone were to receive TANF for the full five years, it would amount to about $22,000; that is the maximum they could ever receive. That is not a lot of money. This bill does not take into consideration the special needs of particular groups of people who could really benefit from this, particularly young mothers, mothers with very young children, larger families, and victims of domestic violence. Those are the groups that could be affected by this bill. Furthermore, with our unemployment rate around the state hovering at about 10 percent, and higher in some areas, this is a particularly salient issue to be looking at.

I would also like to point out that some of the research on this welfare sit-out has been done by our own social work department at the University of Nevada, Las Vegas, and I would be happy to forward that on to the Committee if you are interested. Thank you for bringing this bill and considering this issue.

Paula Berkley, representing Nevada Network Against Domestic Violence, Reno, Nevada:
Probably there are a few domestic violence victims who would need to be in the program for two years. We want to express our interest in taking out the arbitrary two years since it does not help or hurt anyone, and there was no logic to it that we could see. It appears that this year the average stay on welfare is 16 months, so it is going down rather than up. Therefore, it is not likely that most recipients will hit that ceiling. However, when it is there, an arbitrary two years does not seem to make sense. If one has been tied to a domestic violence issue for some months, it may take a little longer to reestablish identity and get things in order. In that case, it could extend beyond the two year period, and that extra time would be needed. I know that when our domestic violence victims sign that contract with a personal responsibility plan, they are very motivated to stay on the plan and remain qualified.

Sam McMullen, representing the Las Vegas Chamber of Commerce, Las Vegas, Nevada:
I am not an expert in this; however, the explanations I have been given seem to indicate that this is not about money but about getting people back on their feet in a reasonably efficient time frame. I know there are money issues and timing issues, however, it seems to make sense to encourage the consistent progress that people are making and the support that they need.

Vice Chair Pierce:
Is there anyone who would like to speak in opposition to A.B. 485? [There were none.] Is there anyone to speak on neutrality? [There were none.] I will close the hearing on A.B. 485, and turn the hearing back over to Chairwoman Smith.

Chairwoman Smith:
Let us start our work session. We will begin with Assembly Bill 20.

Assembly Bill 20: Revises provisions governing homes for individual residential care and other facilities and agencies licensed by the Health Division of the Department of Health and Human Services. (BDR 40-335)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored on behalf of the Department of Health and Human Services and heard on March 11, 2009. There is an amendment (**Exhibit I**). The Department of Public Safety requested the amendment, and Assemblyman Cobb submitted it to the Legal Division on their behalf. It adds gross misdemeanors to the list of disqualifying convictions for individuals wishing

to work in health care facilities licensed by the Health Division. There was no testimony in opposition to this measure.

Chairwoman Smith:
Is there discussion? [There was none.]

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 20.
>
> ASSEMBLYMAN HAMBRICK SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.]

Mr. Cobb, since you had the amendment on that bill would you like to take the floor statement?

Assemblyman Cobb:
Yes.

Chairwoman Smith:
Let us consider Assembly Bill 89.

Assembly Bill 89: Revises provisions governing the regulation of licensed child care facilities. (BDR 38-334)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored on behalf of the Division of Child and Family Services (DCFS), and heard on February 23, 2009. It expands the list of crimes that the Bureau of Services for Child Care must include in background checks for certain childcare facility applicants, licensees, employees, residents, or participants in outdoor youth programs. There is a mock-up (**Exhibit J**) with several of the amendments from DCFS. On page 2 is the first main change, which is to delete the two sets of fingerprints. In testimony, it was indicated that two sets were not necessary when submitted electronically. Amendment B is in response to discussion during the hearing about whether the background check would be retroactive. Due to a lack of clarity about whether it would apply to current licensees or employees, the Legislative Counsel Bureau (LCB) staff consulted with DCFS to develop the proposed amendment. On page 4 of the mock-up there is added language that clarifies how quickly and how often background checks must be conducted for certain future applicants, employees, licensees, residents, or participants. On page 6 of the mock-up is transitory language that provides that the Bureau is not required to conduct the background check on

licensees who are in place on October 1, 2009, until six years after their license was issued or renewed. For employees, residents, and participants, the Bureau is not required to conduct the background check until six years after their first day of employment, residency, or participation. There was no testimony in opposition to this measure.

Chairwoman Smith:
Is there discussion? [There was none.]

> ASSEMBLYWOMAN LESLIE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 89.
>
> ASEMBLYMAN DENIS SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Mrs. Mastroluca, will you do the floor statement on A.B. 89, please.

We will now consider Assembly Bill 101.

Assembly Bill 101: Revises provisions governing the support of children. (BDR 38-340)

Amber Joiner, Committee Policy Analyst:
This bill is sponsored by the Assembly Committee on Health and Human Services on behalf of DWSS. It was heard on February 23, 2009. It requires Clark and Washoe Counties, and authorizes other counties, to participate fully in and pay for the cost of the program for the enforcement of child support created under federal law. This measure also revises provisions governing the administration and enforcement of the programs. The DWSS proposed the amendment (**Exhibit K**) which would provide that each county may elect to participate in the program for the enforcement of child support. The county participating in the program must enter into a contract with the DWSS. If the county wishes to discontinue participation in the program, it must notify the state of its intent by September 1 of an even-numbered year, to be effective on July 1 of the following year.

Chairwoman Smith:
You may also remember that there was a question regarding the custody of the child in the *Rivero* case, and we did have verification from the Department, from their legal analyst, that that is not something which is debatable: it is not

something we can change based on that Supreme Court decision. Is there any discussion about this?

Assemblyman Hambrick:
Looking at the notes, it appears that Washoe County has a potential fiscal impact of $5 million. Have we been able to address that issue?

Susan Hallahan, Chief Deputy District Attorney, Family Support Division, Washoe County District Attorney, Reno, Nevada:
The fiscal note involved the Washoe County District Attorney's Office taking over the Reno Program Welfare Office and their staff. It also involved having to pay 100 percent of the program rather than just one-third, which we currently pay. We are reimbursed two-thirds by the federal government, so there would not be a fiscal impact on us with the amendment, and we support the amendment.

Chairwoman Smith:
Are there any questions? Any discussion? [There was none.]

> ASSEMBLYWOMAN PARNELL MOVED TO AMEND AND DO PASS ASSEMBLY BILL 101.
>
> ASSEMBLYMAN DENIS SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Assemblyman Hambrick, would you do the floor statement, please.

Let us next consider Assembly Bill 111.

Assembly Bill 111: **Revises provisions governing certain residential facilities for groups and homes for individual residential care. (BDR 40-99)**

Amber Joiner, Committee Policy Analyst:
This bill was sponsored on behalf of the Legislative Commission's Subcommittee to Study Issues Relating to Senior Citizens and Veterans and was heard on March 11, 2009. It creates an endorsement for facilities for the dependent, medical facilities, or homes for individual residential care that offer housing for independent living. It also prohibits certain residential facilities for groups and homes for individual residential care from providing accommodations to a person who does not meet the requirements for admission to that home. During the hearing, concern was raised by the sponsor about the exemption

provided to persons related to employees within the third degree of consanguinity. Chair Smith proposes the following amendment (**Exhibit L**) which is to remove the words "or employee" in section 5, page 2, of the mock-up. There was no testimony in opposition.

Chairwoman Smith:
Is there any discussion? [There was none.]

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 111.
>
> ASSEMBLYWOMAN PARNELL SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

We will ask Assemblywoman Spiegel to do the floor statement on that.

Let us now consider Assembly Bill 263. That was the Program for All-Inclusive Care for the Elderly (PACE) bill brought by Assemblywoman Leslie.

Assembly Bill 263: Requires the Aging Services Division of the Department of Health and Human Services to establish a program of all-inclusive care for the elderly in certain counties. (BDR 38-509)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored by Assemblywoman Leslie and heard on April 1, 2009. It requires the Aging Services Division to establish and administer a program of all-inclusive care for the elderly, also known as a PACE program, in Washoe County. The following amendments (**Exhibit M**) are offered. The sponsor, Assemblywoman Leslie, proposes: (A) change "shall" to "may" so that the Aging Services Division is not required to establish and administer a PACE program, but the Division may do so; and (B) require that the Aging Services Division submit a report to the Legislature every six months on the progress of the establishment of a PACE program. The report should be submitted to the Legislative Committee on Health Care when the Legislature is not in session. There was no testimony in opposition to this measure.

Chairwoman Smith:
Carol Sala, would you please come to the table and confirm for the Committee that by changing this to "may" it would allow you to begin to develop this program, if you are able to, and remove the fiscal note.

Carol Sala, Administrator, Aging Services Division, Department of Health and Human Services:
As the amendment is proposed, we would no longer have a fiscal note on this bill and the Division would start looking at and beginning the work on moving forward with the PACE program, which we believe is a very good model.

Chairwoman Smith:
Are there any questions of Ms. Sala?

Assemblyman Cobb:
Do you need us to pass this bill for you to do this examination of the PACE program?

Carol Sala:
No, it is not required. It is something we could always look at. I believe the thought was that if it is in there then it would help us get it on the horizon and start moving forward with such a program.

Chairwoman Smith:
I think the thing I also like about passing this is that the reporting requirement is in it, and I would like to have that report back, if we passed the bill, or if you are involved in it, about the development of the program. It is very positive.

Carol Sala:
Right. The amendment does add the requirement to report back during the interim to the Health Committee.

Assemblywoman Leslie:
I want to thank you personally, Ms. Sala, for the work you have done so far in this regard. I think the reason we should put the authority in there is, if things speed along, a benefactor comes, and we are able to get this program started, it would give you a little bit more ability to come to the Interim Finance Committee (IFC) with a program and say, "We can do it." I know it is a long shot, but if we do not start working on it now, two years from now we are going to be in exactly the same situation. It is probably going to take at least two years of work to get this started, unless a benefactor falls out of the sky.

Typically, we have done this with waivers. We believe that the Legislature feels that this is an important program and one you should seriously look at. My experience in the Legislature has been that when we do pass authorizing legislation like this, and especially when it is tied to a report back to the Legislative Committee on Health Care—which meets every month during the interim—it is much more likely that the preliminary work will get done. You may

find out it is impossible to do this in Nevada, but given the testimony we had here and the work already done behind the scenes, I look forward to getting those reports. Maybe two years from now, we would be in a position to implement this and give seniors in our state a whole lot more options than a nursing home.

Carol Sala:
I believe it gives the program visibility. It is just a word in a statute, but it does raise it to a level of visibility.

Chairwoman Smith:
Any questions or discussion? [There was none.]

> ASSEMBLYMAN DENIS MOVED TO AMEND AND DO PASS ASSEMBLY BILL 263.
>
> ASSEMBLYWOMAN PIERCE SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMEN COBB AND HAMBRICK VOTED NO. ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Let us consider Assembly Bill 359 (1st Reprint).

Assembly Bill 359 (1st Reprint): Revises provisions governing certain personnel who work with children with autism. (BDR 34-1024)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored by Assemblywoman Woodbury and heard on April 6, 2009. The First Reprint creates the Grant Fund for the Training and Education of Personnel Who Work with Pupils with Autism to provide grants to school districts and charter schools that will provide training for personnel who work with them. It also requires that certain federal money received be deposited in the Grant Fund and requires personnel of the Health Division who provide early intervention services to possess certain knowledge and skills.

The sponsor proposes Amendment No. 3875 (**Exhibit N**) shown in the mock-up. The main changes include changing the frequency of screening a child for autism from at least once before the age of two years old to "the age levels and frequency recommended by the American Academy of Pediatrics." The next amendment would be to revise provisions relating to the knowledge and skills required of personnel and the screening of children so that they also apply to entities with which the Health Division contracts to provide early intervention

services to children with autism. Finally, it would clarify that information about "evidence-based treatments and interventions" must be provided to parents. There was no testimony in opposition.

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 359 (1st REPRINT).
>
> ASSEMBLYMAN DENIS SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Chairwoman Smith:
The sponsor is here in the audience, and she will do the floor statement.

Next, let us consider Assembly Bill 213.

Assembly Bill 213: Requires the establishment of the Cancer Drug Donation Program. (BDR 40-39)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored by Assemblyman Anderson and heard on April 1, 2009. It requires the Nevada State Board of Pharmacy to establish the Cancer Drug Donation Program. Amendment A (**Exhibit O**), proposed by the State Board of Pharmacy, proposes the definition of cancer drug not include prescription drugs that are used to treat the side effects of cancer, the side effects of prescription drugs used to treat cancer or its side effects, or medical supplies used in the administration of a cancer drug. The second main amendment (included in **Exhibit O**) was from the American Cancer Society Action Network which proposed the following: First, any donor of cancer drugs or supplies, or any participant in the program who exercises reasonable care in donating, accepting, distributing, or dispensing cancer drugs or supplies under the program is immune from criminal or civil liability and from professional disciplinary action for any injury, death, or loss relating to the program. Second, a pharmaceutical manufacturer is not liable for any claim or injury arising from the transfer of any cancer drug, such as a failure to transfer or communicate product or consumer information, or the expiration date of the drug.

Just a note on this is that the reference to the word "supplies" in Amendment B is in conflict with the removal of "supplies" in Amendment A, so it might be something that you would want to clarify in a motion.

Chairwoman Smith:
Committee, this amendment was developed by all of the parties involved in this, and I have been advised by the sponsor, as well as by those who were in opposition, that everyone is in agreement. I think they modeled it after the Florida legislation—the American Cancer Society amendment that was offered. Ms. Joiner noted that "supplies" is used in both amendments, so if we adopt both it will remove that.

> ASSEMBLYWOMAN PARNELL MOVED TO AMEND AND DO PASS ASSEMBLY BILL 213 WITH BOTH AMENDMENTS.
>
> ASSEMBLYMAN STEWART SECONDED THE MOTION.

Discussion?

Assemblyman Stewart:
I had a fourth grade class in my district that had me introduce a similar bill. I withdrew it when this bill came forward, so on behalf of Mrs. Aiello's class, I will vote "yes" on this, and I am glad to see that the liability was removed so we can go forward.

> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Chairwoman Smith:
Let us go to Assembly Bill 112.

Assembly Bill 112: Establishes provisions relating to the coordinated response to public health emergencies and other health events. (BDR 40-214)

Amber Joiner, Committee Policy Analyst:
This bill is sponsored on behalf of the Legislative Committee on Health Care and was heard on March 9, 2009. It requires the Governor to declare a public health emergency if there is an immediate threat to the health and safety of the public and creates the Committee on Public Health Emergencies. The sponsor recommends the following amendment: replace the entire bill with the attached mock-up (**Exhibit P**). The main provisions of that mock-up include:

A. Provide that if a health authority identifies an event that poses an immediate threat to the health and safety of the public in a health care facility or provider's practice, the authority must immediately transmit a report of the event to the Governor;

B. Provide that the Governor must determine whether the event requires an immediate coordinated response. If the event requires a response, the Governor shall issue an executive order designating an emergency team under the direction of the State Health Officer;

C. Provide that following the executive order, the Governor may request assistance in carrying out inspections of certain health care facilities from a Governor of a contiguous state; and

D. Provide for the composition and duties of the emergency team.

There was no testimony in opposition to this measure.

Chairwoman Smith:
I would ask Ms. Leslie to comment on that. I think she worked on that since we heard this bill at our February hearing in Las Vegas.

Assemblywoman Leslie:
At your direction, I did meet with the parties, and I believe many of them are here tonight: Larry Matheis, in particular, and Luana Ritch, from the State Health Division. We met with the county health people as well. I think the amendment does a good job of addressing the concerns that were raised. The main concern was that we wanted to make sure we were not interfering with the state's emergency plan. That is the reason for the language of "an event that poses an immediate threat." That language is important. Remember that this bill came from the Legislative Committee on Health Care, the interim committee that we have with the Senate, because of the chaos after the hepatitis C public health emergency. This bill is really aimed at the state getting its act together and making sure there is a coordinated response from the different state agencies, in coordination with the locals.

This amendment came rather late. We have been working on it, but we might want to get how everyone feels about it on the record, because I am not 100 percent clear that everyone is on board with every single word.

Chairwoman Smith:
That is fine. Mr. Matheis, may we hear from you and anyone else who worked on this who wants to comment. I appreciate the time that you and Ms. Leslie spent working this out. We had three sizeable bills that had to be resolved, so we appreciate the work.

Lawrence Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:

The bill now is really on pages 10, 11, and 12 of the mock-up. We have bills that came out of the hepatitis outbreak experience dealing with making sure that each agency has the authority that it needs to be able to do things. We have bills dealing with what licensing boards should do, other bills dealing with the Attorney General's authority, and bills about what the various public health entities need to do in securing information. The one remaining piece is what to do when an event occurs in either a licensed health care facility or in the practice of a licensed health professional, and the patients, their families, and maybe others, might be put at risk. The health authority—the health districts or the State Health Division—would be the first to know that there was some occurrence. Reporting that to the Governor then gives the Governor's Office the chance to see how many state agencies have some responsibility, and if it is a serious enough event, to make sure that a team is put together, with a primary person from each of the agencies that have authority; and they are working together to make sure they have the information they need, that the public gets the same information at the same time, and that the Governor and the Legislature are kept in the loop while this issue is being addressed. So it is a very circumscribed set of circumstances, but ones that we know from experience can happen. The need is for the state to bring maximum attention to it immediately. The Attorney General decides on the legal advice, whether to assign the deputies from those agencies or handle it through her office. But basically this bill walks the agencies through what they need to do, so that we have guidance in statute. Also, at the end of the event, the bill provides that whatever lessons are learned are formally presented to the Legislature and the Governor to make sure that the system improves itself.

Luana Ritch, Chief, Bureau of Health Statistics, Planning, and Emergency Response, Department of Health and Human Services:

The amendment really did remove our concerns and the conflict we felt regarding the issues with the original language between public health emergency response and emergency management. We want to thank Ms. Leslie and Mr. Matheis for working with us to get that accomplished in the amendment.

Lawrence Sands, Chief Health Officer, Southern Nevada Health District, Las Vegas, Nevada:

[From Las Vegas.] I appreciate the opportunity to comment on this bill. I share many of Dr. Ritch's comments, and I want to commend Mr. Matheis and Assemblywoman Leslie for helping to rework the language on this and bring it back to what was always the original intent. But having said that, I still have some concerns about a couple of items that I want to get on the record. First, in talking with State Health Division staff earlier today, I have been told,

as Mr. Matheis said, that this legislation is not meant to impede or alter the ability of the local public health authority to conduct a public health investigation that falls under its jurisdiction. Also, it does not alter what currently exists as the chain of communication between local health authorities and the State Health Officer in reporting public health events and emergencies. We want to be sure that the intent of the bill does not alter that. We ask, if possible, to have some clarification on that. The other concern is with the duties outlined for the emergency team in section 26 of the mock-up. The way it is worded seems to indicate that there may be some conflict with the responsibilities of the state or local public health agency and their duties to investigate a public health emergency or other health event. We think it should be made clear that this team would not supersede the authority of the public authorities to investigate, respond, and disseminate information to the public in an emergency. Specifically, that section states that the team shall "investigate the public health emergency." That certainly means something specific to those of us in the health authorities, and we want to be sure that does not mean that there will be a duplication of our efforts or an overtaking of our responsibilities and duties to do the investigation.

Chairwoman Smith:
Would it suffice for the bill to say that the team would work cooperatively to investigate the public health emergency? Or, what do you need for your comfort level—it seems like the intent is pretty clear from the testimony?

Lawrence Sands:
You would have to ask Mr. Matheis, when writing that, what the specific intent was with the word "investigate." What I would envision is that this team would not be doing the investigation of the public health emergency. Rather, it should be receiving and reviewing those reports about the investigation, the progress being made, and any actions taken to respond to the emergency and to mitigate any problems and be there, as was said earlier, to coordinate at the state level the way the state agencies needed to respond in order to support the investigation and response by the health authorities and address any issues that only can be addressed at the state level.

Lawrence Matheis:
The intent is that these state agencies each have authority over either a licensed health care facility or licensed professionals, and they have to investigate those entities or professionals they license. They are not doing the epidemiology or that follow-up; that is the health authority's jurisdiction. Rather, it is the role of these identified entities to do their investigations about what the health professionals may or may not have done, whether the facilities operated properly, or whether license sanctions should be taken in order to ensure that

these state agencies are able to fulfill their responsibilities. It is really only talking about investigations within the purview of the jurisdiction of the members of that team, which are the state agencies that have some authority. It does not address what the current law or requirements are for health authorities to follow-up on the transmission of disease, and so forth; that is a separate issue.

Lawrence Sands:
Having heard that, I am much more comfortable, so long as that is the understanding. I am wondering if there is a way to qualify that or make it clearer in that section. I would be comfortable with the term that Mr. Matheis uses: "within the purview of the agencies that make up the team."

Chairwoman Smith:
Realistically, people are only going to do what they are legally allowed to do within the state, which is what we are trying to get to anyway. But if we could add something in there that would provide a comfort level, then I am fine with that. So, Committee, let us see if we can come up with a conceptual idea and add that to the amendment.

Lawrence Matheis:
In the floor statement you could simply provide the intent for the record.

Assemblywoman Leslie:
We will see what our Legal staff comes up with, but I think within that section we can add some language. In the beginning it could say, "The emergency team shall within their appropriate jurisdiction." Or we could even put a sentence in there that says specifically that the emergency team investigation does not supersede what Dr. Sands is talking about, the local investigation. I think it is probably important to put that in the statute. We can mention it in the floor statement, as well, but we want to put a structure in there so that when none of us is here, and if something of this magnitude happens again, a governor or people at the state level can look in the statute and see very clearly what was intended. I do not want to leave it up to question what our intent was; I would prefer to work with Dr. Sands and Mr. Matheis and get some appropriate language.

Chairwoman Smith:
Any other discussion on this? [There was none.]

> ASSEMBLYWOMAN LESLIE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 112 WITH CLARIFICATION.

ASSEMBLYMAN STEWART SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Chairwoman Smith:

Ms. Leslie, will you please take that floor statement.

Let us go to Assembly Bill 123. This was one of the other bills that we heard at the Las Vegas hearing in response to the hepatitis C crisis. And you will also remember, Committee, that we heard Assemblywoman Gansert's bill that had the same provision for licensing as is in this bill.

Assembly Bill 123: Revises provisions governing certain offices of physicians and related facilities and surgical centers for ambulatory patients. (BDR 40-215)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored on behalf of the Legislative Committee on Health Care and heard on February 21, 2009. It requires certain facilities to obtain a permit from the Health Division before offering services involving certain levels of sedation. It also requires surgical centers for ambulatory patients to maintain accreditation by a nationally recognized accrediting organization; requires the Health Division to conduct annual unannounced inspections to certain facilities; and requires the Board of Medical Examiners and the State Board of Osteopathic Medicine to forward reports to the Health Division about the number and types of surgeries requiring various levels of sedation. There is one amendment proposed by Assemblywoman Smith, and you can see a mock-up attached (**Exhibit Q**).

Chairwoman Smith:
Committee, you will remember that one of the issues that arose out of the discussion at the hearing in Las Vegas was from some physicians who were concerned about this particular bill possibly overreaching and requiring some physicians' offices to have to go through licensing to administer pain or anxiety medications. This amendment, in section 8, would clarify that the office of a physician which administers medication for pain or anxiety relief, is excluded from the bill. That is the only change to the bill as it was originally heard. We had a lot of supportive testimony, and this is a very, very important part of the outcome of the interim committee's work on the hepatitis C outbreak.

Lawrence Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:
I think this does try to get to the conscious-sedation-level issue, which is a huge expansion of what has to be looked at for purposes of office licensing. I think that what you have done is a step that captures the basic idea, but I think the concern is that this is a new area of regulation and the state does not have experience with it. We are going to be relying on national accrediting bodies, which in the past have done very few of these nationwide, and now all of a sudden they will be asked to do a lot. The concern is whether we could do the three levels of sedation and properly regulate that in the next two years. The proposal I suggest is to delay the implementation of the conscious sedation level by two years. You get to the higher levels where there is more likelihood, because of the kinds of procedures being done, that there are going to be more injections undertaken. Remember, the context for this is really about injection safety, not about surgical outcomes, so we are using an imperfect model because it is the only one that six or so states are experimenting with. I think this is a good step, but when this bill goes to the Senate we will make those same points about the regulatory issue. Also, I think you will be getting bills from the Senate that address this same area, so I suspect that at the end of the Session there will be a conference or some effort to bring these together.

Chairwoman Smith:
You are right, and I think with the fiscal note it will go somewhere else first.

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 123.
>
> ASSEMBLYWOMAN LESLIE SECONDED THE MOTION.

Discussion?

Assemblywoman Leslie:
I want to thank you, Madam Chair, for working this out, and it really is an important first step. It might not go as far as I personally would like to see, but I think it is a reasonable compromise, and we will see in two years. I really feel the obligation to show the citizens in Las Vegas that we are taking their tragedy very seriously and instituting a remedy so that something like that never happens again. It is very important, and we will continue to work on it.

Chairwoman Smith:
I appreciate those comments, and I agree. I commented when we were in Las Vegas that we had expected hundreds of people to turn out after what we saw in the original hearings in the interim and, in fact, that did not happen.

I was hopeful that it was because they felt that the Interim Committee on Health Care duly addressed the concerns, and I think this Committee is doing the same. I think this is a good measure.

> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSSENT FOR THE VOTE.)

I will do the floor statement on that. Let us move on to Assembly Bill 206.

Assembly Bill 206: Revises provisions relating to public health. (BDR 40-858)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored by the Assembly Committee on Health and Human Services and was heard on February 21, 2009. It revises provisions relating to reports of sentinel events by medical facilities, authorizes health authorities to conduct investigations in suspected cases of infectious disease and issue cease and desist orders as needed, authorizes the Health Division to take control of certain medical records, revises provisions relating to the licensure and discipline of certain facilities, and requires the Director of the Office of Consumer Health Assistance to assist consumers in filing certain complaints. Three amendments have been proposed since the hearing on this bill, and I believe the sponsors are here to explain them.

Amendment A is by the representatives from the Nevada Rural Hospital Partners and the Health Division. They proposed the attached amendment mock-up No. 4063 (**Exhibit R**).

Marla McDade Williams, Chief, Bureau of Health Care Quality and Compliance, Department of Health and Human Services:
I want to begin by thanking Ms. Joiner for all of her help in working through these various amendments. As she noted, the proposed Amendment No. 4063 is the amendment worked on by Robin Keith, Nevada Rural Hospital Partners, Bill Welch, Nevada Hospital Association, and me. On page 1, there was just clarification concerning the reports submitted by the medical facility. On page 2, section 4, although this mock-up shows that this section would be deleted, in consultation with our legal counsel they recommended that we keep subsection 3 of section 4 so that it provides additional clarification for the state health officers and the local health authorities that they have this authority. It is very permissive, as you can see: "a court may issue" but it offers a reminder that they do have that option to pursue, and Ms. Keith and Mr. Welch have concurred with keeping subsection 3 of section 4.

On page 3, in subsection 3 of section 7, we have agreed to strike that language regarding the form. That really is an administrative and a regulatory process, and it just seemed like it did not belong in the statutes. Moving to page 4, subsection 3 of section 9, the concern from the hospital representatives is that they wanted to make sure they had some due process opportunities if they were going to face an administrative fine for not submitting a sentinel event report. So, rather than this section as it is written requiring us to go to the State Board of Health to adopt a new set of regulations, we consulted with your legal counsel and recommended referencing our current authority under our administrative sanctions statute, which is NRS 449.165. It is my understanding that they now understand that and will make that clarification in this particular section. So, rather than this whole new section stating you will adopt new regulations, it will refer back to our existing administrative sanctions where we already have those processes in place.

Chairwoman Smith:
Committee, please ask questions as we go, if you have them, so that we do not lose track.

Marla McDade Williams:
Let me back up to the top of page 4, and you will see that additional language: "and any additional information requested by the Health Division pursuant to section 3 of this act." That is just to make sure that the information related to the sentinel events reports is not discoverable by anyone. So if we send information to the State Board of Health, it being a public body, someone could not petition the State Board of Health to say, "Give us this public information related to a sentinel event report," which is already protected under the sentinel events statutes. This just provides that additional clarification and level of ease for the industry.

Moving on to page 5, section 14, this is more of a legal term: "release" versus "production." There was some concern that if you release the records, the facilities have to release their entire original record. So by changing it to "production," they can produce a copy, and that is sufficient and understandable for everyone. That was our change for section 14.

The changes to sections 15 and 16 are in the other amendment from the Southern Nevada Health District. That is proposed Amendment No. 4093 (included in **Exhibit R**). It is my understanding that the majority of these changes all reflect what is already in the first amendment, No. 4063, but the major changes come in sections 14, 15, and 16. The hospital associations and I do not have any concerns about sections 14 and 15, with some clarification on section 14, lines 38 and 39. I will not discuss that just yet, but the

Health Division did have concerns with section 16, and we are not supportive of amending out that section, so we have worked with the Southern Nevada Health District. I do not know if the Committee members were able to get a copy, but they have submitted some revised language to which we are agreeable. It would essentially rewrite section 16 by saying, "A public agency, law enforcement agency or political subdivision of this State which has information that is relevant to an investigation relating to an infectious disease or other event which significantly impairs the health, safety and welfare of the public shall share the information and any medical records and reports with the appropriate state or local health authority as necessary to further the investigation of an infectious disease or other event which significantly impairs the health, safety and welfare of the public." Then they would add another subsection saying, "The State Board of Health shall promulgate regulations identifying the public agencies with which protected public health information can be shared and the circumstances and procedures under which protected information can be shared with such agencies." They were concerned about section 16 being too broad and that protected public health information might be released pursuant to this section, so their rewrite gives them comfort that that will not happen, and we are okay with that.

Chairwoman Smith:
We are going to have a really hard time doing that without being able to see it. May I ask staff to pick up that amendment and make copies, please. We may have to come back to this after we go over it, so everyone has time to digest what we are doing here.

Marla McDade Williams:
Then if I can go back to our original amendment, those would be the only other changes to our original amendment that we worked on with the hospital representatives.

Chairwoman Smith:
Are there questions? [There were none.] Ms. Williams, you can stay there, and Dr. Sands, will you comment?

Lawrence Sands, Chief Health Officer, Southern Nevada Health District, Las Vegas, Nevada:
Certainly a lot of work has gone into this. I want to go over some of the amendments that we had offered, beginning in sections 12 through 16. On the Amendment No. 4063 mock-up, some of the amendments that we initially proposed were able to get in there, but a couple got missed. In section 13, we had talked on February 21 about expanding the definitions a little to add "suspected exposures," and we had also asked that language be added into 13

to read, "Except as otherwise required pursuant to NRS 441A.160, a health authority may conduct an investigation of a case or suspected cases of infectious disease within its jurisdiction or suspected exposure to a biological, radiological, or chemical agent, or other significant event which significantly impairs the health, safety or welfare of the public within its jurisdiction."

Chairwoman Smith:
That was in the second amendment, not the first amendment, right? That is in your mock-up?

Lawrence Sands:
I just want to be sure that is in there. It expands the authority so that events like what occurred here with unsafe injection practices do not happen again. Also, we would need to be able to have the authority to investigate lead exposure, for example, and other significant events that can impact health, just as we do with communicable diseases currently.

One of the other concerns identified during the response to the outbreak was the issue of accessing records necessary to complete the investigation if a facility was not cooperative. This was a very real issue with a similar outbreak in New York State, which caused a delay of about two years before patients were notified of the risk because of the difficulty of getting information. That was the purpose of the amendments that we proposed in section 14, making clear that the health authorities had the ability to access information necessary to an investigation. If a facility chooses to defy a statute, the end result would be to pursue access through the legal system. We had some concerns about specifying that this be done through subpoena authority, because that could potentially have unintended consequences where, whenever we did make a request, we would be required to get a subpoena to do that, and it would delay our ability to respond quickly.

Finally, after discussion with the hospital associations, they had some concerns about the statement that currently reads "the determination of what is necessary to carry out the investigation is at the discretion of the public health authority," which they felt was overly broad, and I agree. I believe we probably left out an important word. It should read "the determination of what *information* is necessary to carry out the investigation is at the discretion of the public health authority." The hospital associations were comfortable with that.

Regarding section 15, with the recommended amendments that were proposed to section 14, we believe that this section could be eliminated. However, if it is believed to be necessary to retain this section, we would recommend that there be language to clarify that a subpoena could be issued if an agency is defying

statute by not providing access to needed information and also to insure that the records requested are received in a timely manner, as delays can significantly impair the public health agency's ability to respond in a quick and effective manner.

Regarding section 16, where Ms. Williams read the proposed Amendment No. 4093, I think that really fits more with what our needs are under NRS Chapter 441A in terms of describing what information public health authorities need in order to complete their investigations and giving public health authorities the ability to determine how to protect the information.

Chairwoman Smith:
Ms. Williams, I think you can probably sum that up for us. It sounds like the SNHD's mock-up, with one of your provisions added in, is what they desire. However we do this, we are not going to be able to move this tonight. Everybody is going to need some time to look at this, and we will figure out the next step.

Assemblyman Hambrick:
Is there going to be time to get these three mock-ups together, clean, including the verbal amendments, tonight?

Chairwoman Smith:
They are basically already created, and they are really not that different if you look at each one. But I know it is very difficult for us in this quick environment to do that. Ms. Williams, if you would answer that, and then we will figure out where we go from here. I will explain the third amendment, which I submitted.

Marla McDade Williams:
If I understand, it is taking what we had initially worked on in Amendment No. 4063 and then incorporating what has come forward in Amendment No. 4093. I think that is feasible.

Chairwoman Smith:
I think our staff is saying there are no major conflicts between the two; it is just very difficult putting them side-by-side and trying to make sense of them. Would that meet the Committee's desire if we had the staff work up one mock-up? Then we could have at least a day to look at it and then do a behind-the-bar meeting, if that is what we need to do?

Assemblyman Hardy:
I do not know if Dr. Sands has seen the one sheet; if that has been faxed down. It made sense to me, and so I would ask him if it made sense to him, too.

Chairwoman Smith:
He submitted it. I am answering for you, Dr. Sands.

Lawrence Sands:
That is correct, Dr. Hardy.

Chairwoman Smith:
I submitted the third amendment based upon our discussion at the hearing in Las Vegas. We were talking about information that would be available in facilities—we actually talked about it in the "whistle-blower" discussion—so that we would make sure that employees are aware of the law. We had discussed that this bill was really the most appropriate place to put it, not in that bill. And that is what this amendment does; it just requires that the information be posted, similar to posting minimum wage or Occupational Safety and Health Administration (OSHA) notices in a facility.

If it meets the approval of the Committee, I will ask Marla Williams and Dr. Sands to work with our staff in the next few hours to do one mock-up that everybody can agree with, and then our group will be able to look at it.

Next, let us move to Assembly Bill 227.

Assembly Bill 227: Revises provisions relating to the provision of foster care. (BDR 38-187)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored by the Assembly Committee on Health and Human Services and was heard on March 18, 2009. It requires persons who wish to operate an agency, which assists an agency that provides child welfare services in placing or arranging for the placement of children in foster care, to obtain a license from the Division of Child and Family Services (DCFS). The bill also requires persons who operate a treatment foster home to obtain a license from the appropriate licensing authority. The amendments proposed include one from the representatives from Clark County in consultation with representatives from DCFS. They proposed an amendment with several parts at the original hearing. You can see the attached mock-up (**Exhibit S**).

On page 2, there are some technical changes to the definitions. They also use the word "specialized" instead of "treatment" foster homes. On page 3,

there is a change: the license is effective for two years instead of one year. After line 23, on page 3, it would require a plan of corrective action to be completed within a specified time frame to be no longer than 90 days. Most of the rest of the mock-up is just changing the word "treatment" foster home to "specialized" foster home. There is a change in the adoption of regulations date in sections 18 and 19, on page 11, from October 1, 2009, to July 1, 2010, then from January 1, 2010, to 2011.

The second amendment that was proposed at the original hearing was from representatives from the Nevada Youth Care Providers. They proposed four main amendments: first, to require that foster care agencies be consulted in the adoption of regulations; second, to remove the language that relates to the reasonable fee for the issuance of renewal of a license; third, to authorize the issuing of a provisional license of shorter duration; and fourth, to change the date for the adoption of regulations to January 1, 2010.

Chairwoman Smith:
One thing to keep in mind, Committee, is that the DCFS has indicated support for items 1 and 3 of the proposal from Nevada Youth Care Providers, and I think the fee issue is going to need to be decided in the Committee on Ways and Means. So I hope we can figure out the policy on this. After talking to a great number of people, it does seem that this is really an important piece of legislation to get moving on so that we can get these regulations developed.

Diane J. Comeaux, Administrator, Division of Child and Family Services, Department of Health and Human Services:
You are correct. We have indicated to your staff that we have no issue with their items 1 and 3; we support adding those to the bill.

Assemblywoman Leslie:
I agree with that. I am still having a problem with the suggestion from the Youth Care Providers about item 2: they want to remove the language regarding the reasonable fee, and I just do not see how that is going to be possible. Are you going to move it without that?

Chairwoman Smith:
My thought was that we would just base our recommendation on the policy and let the Committee on Ways and Means continue discussing the fee issue.

Assemblywoman Leslie:
I just want them to understand that this might go forward with fees.

Chairwoman Smith:
I would entertain a motion that we amend and do pass and also include items 1 and 3 of the Nevada Youth Care Providers suggestions.

> ASSEMBLYWOMAN LESLIE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 227 TO INCLUDE ITEMS 1 AND 3 OF THE NEVADA YOUTH CARE PROVIDERS SUGGESTIONS.
>
> ASSEMBLYMAN HARDY SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Assemblywoman Mastroluca, will you take that floor statement, please.

Let us move on to Assembly Bill 326.

Assembly Bill 326: Revises provisions governing controlled substances. (BDR-40-558)

Amber Joiner, Committee Policy Analyst:
This bill was sponsored by Assemblyman Denis and was heard on March 30, 2009, and April 1, 2009. It revises provisions relating to the tracking of prescriptions for controlled substances, provides that the State Board of Pharmacy is exempt from state purchasing provisions for certain service contracts, and requires the Legislative Committee on Health Care to conduct a study of the abuse of prescription narcotic drugs. The sponsor, based on suggestions from the Prescription Controlled Substance Abuse Prevention Task Force and the Retail Association of Nevada, proposes the following amendment, as shown on the mock-up (**Exhibit T**):

A. Delete the provisions in section 1 relating to the State Board of Pharmacy entering into professional services contracts;

B. Clarify that each person to whom the Board has provided Internet access to the database has "*voluntarily* elected to provide Internet access to pharmacists"; and

C. Provide that when the State Board of Pharmacy and the Investigation Division of the Department of Public Safety spends grant funds on the program database software, such contracts are exempt from the State purchasing provisions of Chapter 333 of the *Nevada Revised Statutes.*

There was no testimony in opposition.

Chairwoman Smith:
This is a bill we recently heard; that helps the familiarity. Mr. Denis, do you want to comment on your thoughts about this amendment?

Assemblyman Denis:
What I would like to do, having looked at this further and also having talked with purchasing, is remove the purchasing part of this. In other words, I want to retain amendments A and B. And then I want to drop C: on the mock-up, line 19 on the last page, I want to delete the words, "The expenditure of such grants for the program database software are exempt from NRS Chapter 333."

Chairwoman Smith:
The sponsor is saying the amendment is fine with the elimination of "The expenditure of such grants for the program database software are exempt from NRS Chapter 333." I agree with that. I get nervous about exempting provisions from those chapters. Any discussion? [There was none.]

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 326 WITH THE ELIMINATION OF AMENDMENT C.
>
> ASSEMBLYWOMAN LESLIE SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Chairwoman Smith:
Good work on that Mr. Denis. That was a lot to pull together. I know it took a lot of leg work. You will be doing that floor statement.

Let us talk about Assembly Bill 227 again for a moment. Ms. Leslie, you were the maker of that motion. Legal would just like us to clarify that the provisional license which we amended in would be developed in regulation. As the maker of the motion, would you agree to that?

Assemblywoman Leslie:
Yes.

Chairwoman Smith:
Thank you, Kristin Roberts, for watching out for us, even if you are not in the room.

I would like to comment on a couple of bills.

Assembly Bill 4: Creates the Statewide Alert System for the Safe Return of Missing Older Persons. (BDR 38-148)

Assembly Bill 4 was the alert for missing or endangered seniors. We know it was a pretty difficult hearing with a lot of issues, and the group was never quite able to completely solve all of the problems that were generated out of that discussion. So, the sponsor asked if we would not move the bill but if I would request that the groups continue working together and come back to the next session with a recommendation. I think they can get there; it was too much to solve in these last few weeks. I would like to note that.

Assembly Bill 269: Makes various changes concerning the provision of health care to certain children who do not reside with a parent or legal guardian. (BDR 38-146)

Assembly Bill 269 was the bill dealing with Medicaid for homeless youth who are not in foster care. I was hoping we would have someone from the agency here who could address that, but I do not see anyone. We had heard in testimony that they are able to provide that now. The sponsor recognized that Dr. Hardy had raised several issues about that bill, and the sponsor asked if we would just continue working with the agency to try to resolve the issues they have in providing care for homeless youth. We will do that.

Let us talk about a couple of the bills we have heard today. First, Assembly Bill 433, Ms. Pierce's bill. We had an amendment (**Exhibit C**) from Clark County.

Assembly Bill 433: Provides that failure to wear a safety belt is a primary traffic offense. (BDR 40-976)

Assemblywoman Pierce:
We had an amendment from Clark County. In section 1, subsection 1, we changed "public" to "county" hospital, and in subsection 2 we changed "state" to "county." Also, I wanted to amend it to say "provide outpatient cancer treatment" on page 2, line 10, or anywhere that phrase exists, to signify that this is outpatient cancer treatment.

Chairwoman Smith:
Committee, A.B. 433, page 2, beginning at line 10, would read "a county hospital must provide outpatient cancer treatment to indigent persons who are residents of this county and were residents of this county at the time they were

diagnosed with cancer." Subsection 1 already has "county" substituted for "public." So it is basically changing "state" to "county," and adding "outpatient" before "cancer treatment."

> ASSEMBLYWOMAN LESLIE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 433.
>
> ASSEMBLYMAN DENIS SECONDED THE MOTION.

Does the maker of the motion want to speak to the motion first?

Assemblywoman Leslie:
I will pass. I think I made my views clear earlier today.

Assemblyman Hardy:
Do we need to have the "indigent" definition on the record?

Chairwoman Smith:
We did get that earlier. But do you want it on the record or in the bill? Let us get it on the record.

Assemblyman Hardy:
While we are waiting, there is a $7 million fiscal note now, is that right?

Chairwoman Smith:
That is for the county, not for us. That was the testimony when I asked about the outpatient provisions: the cost would be $3.5 million a year.

Okay, Amber Joiner has that definition if you want to read it into the record.

Amber Joiner, Committee Policy Analyst:
During the hearing earlier today, Legal clarified that that definition is not in that chapter, so if you wanted it clarified in the bill, you could actually put it in that chapter. It is currently found in NRS 439B.310.

> For the purposes of NRS 439B.300 to 439B.340, inclusive 'indigent' means those persons:
>
> 1. Who are not covered by any policy of health insurance;
> 2. Who are ineligible for Medicare, Medicaid, the Children's Health Insurance Program, the benefits provided pursuant to NRS 428.115 to 428.255, inclusive, or any other federal or state program of public assistance covering the provision of health care;

3. Who meet the limitations imposed by the county upon assets and other resources or potential resources; and

4. Whose income is less than:

(a) For one person living without another member of the household $438.

(b) For two persons $588.

(c) For three or more persons, $588 plus $150 for each person in the family in excess of two.

For the purpose of this subsection, 'income' includes the entire income of a household and the amount which the county projects a person or household is able to earn. 'Household' is limited to a person and his spouse, parents, children, brothers and sisters residing with him.

Assemblyman Hardy:
So when I am listening to the definition of indigent—and I heard testimony that the poor can get care, the rich can get care, and it is the middle-class who cannot get care—this does not get the middle-class.

Chairwoman Smith:
I thought that was exactly what was described in here, that these are people who are in that group who do not qualify for Medicaid, and they do not have their own insurance. I thought that was the way the description read.

Assemblyman Hambrick:
Since it is a verbal amount, would it be appropriate to hear from someone from Clark County to get their input, or are we beyond that point at this juncture?

Chairwoman Smith:
Clark County offered the amendment, and in fact this narrowed it more because we defined "outpatient." Clark County is welcome to come to the table and comment, but that is where the amendment came from. Do you want to come to the table?

Assemblyman Hardy:
So Clark County is going to put this in their budget?

Sabra Smith-Newby, Director of Administrative Services, City of Las Vegas, Nevada:
We did submit the amendment on the bill to clarify that the persons would be coming from the county. At this point, Clark County Social Services is providing outpatient care for folks who qualify.

Chairwoman Smith:
I did not mean to indicate that you were supporting the bill because you put in the amendment. I just want to clarify that the amendment did come from the county, so you are aware of what we were talking about.

Sabra Smith-Newby;
That is correct.

Assemblyman Hardy:
Does the county have this in their budget?

Sabra Smith-Newby:
Obviously this bill came out of a situation where the outpatient care was eliminated. However, it is my understanding that most of the patients are being covered through Clark County Social Services at this point. I am sure there are folks that did cease to have coverage. So for those people who are not eligible for social services, I understand they are probably the ones who are seeking care elsewhere. If you are asking if it is an unfunded mandate, yes it is. But I understand that most of those patients are being covered right now.

Assemblyman Hardy:
If our unfunded mandate is covering the people, and it is going to be covering them anyway, because it is in the Clark County budget, do we need a bill to say that the county will pay when they are going to pay anyway?

Sabra Smith-Newby:
I suppose that is within your purview as the Legislature to make bills to require things to be done or not.

Chairwoman Smith:
I think the difference is that this bill requires the hospital to provide the outpatient treatment, and it appears that now it is happening in a variety of different places and ways. I think that is the very big difference between what is happening and what would happen if this bill passed.

Further discussion? [There was none.]

ASSEMBLYWOMAN LESLIE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 433.

ASSEMBLYMAN DENIS SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMEN COBB, HAMBRICK, HARDY AND STEWART VOTED NO. ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Let us move to Assembly Bill 52. This was the bill we heard this afternoon, presented by UMC. You had an amendment regarding—it is a terrible term—"patient dumping." It is very disconcerting to have the hospitals in the position where they are in opposition to each other. We heard some conflicting testimony about who was sending patients where and who was spending more. I was thinking what might be most helpful would be to amend this bill to just require the hospitals to report—I think we had the amendment from Robin Keith, as well, that eliminated the two smaller hospitals in Clark County—the transfer of patients, so that this Committee in the next Legislative Session would be able to consider whether this issue has resolved itself adequately or still needs to be addressed. I think that is a reasonable solution for both parties to be able to come to some decisions about this issue. I welcome some discussion about whether you think that makes any sense.

Assemblywoman Mastroluca:
I agree with the Chair. I think this is something that needs to be investigated more and we need to do a little oversight to find out what these numbers really look like.

Chairwoman Smith:
Any further discussion? [There was none.] I would entertain a motion, if you would like to do that, Mrs. Mastroluca. This would be a conceptual motion of a report, and the Committee can see the amendment as it is developed.

ASSEMBLYWOMAN MASTROLUCA MOVED TO AMEND AND DO PASS ASSEMBLY BILL 52.

ASSEMBLYMAN HARDY SECONDED THE MOTION.

Discussion?

Assemblyman Cobb:
Just for purposes of clarification, we are asking all hospitals to report to the Legislature two years from now as to the underlying issue of this bill?

Chairwoman Smith:
What we are asking is that they would report the information we heard today. Traditionally, it goes to the Interim Health Committee, and then we would see it ultimately—I say "we" as in this Committee, whoever is here next time. It

would be the same type of information that is reported today, but not in any similar form or fashion. Any further discussion? [There was none.]

THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE)

We sent a group out to resolve the issues on Assembly Bill 364. That was the bill that Assemblywoman Mastroluca presented on the foster care and psychotropic drug issue. I hope it is an easy solution.

Assembly Bill 364: Makes various changes concerning the protection of children. (BDR 38-1092)

Assemblywoman Mastroluca:
Our proposed amendment to the bill is in the mock-up (**Exhibit U**). The first thing we did was, in section 3, we added a requirement to NRS Chapter 432B that policies be established regarding psychotropic medication. As Ms. Comeaux explained to me, when the policies are created, training is an automatic piece of that. It is not an additional cost, it is what they already do. If you look at the last page of the mock-up, page 7, it refers back saying, "Ensure that appropriate policies are established concerning the prescribing, use, and distribution of psychotropic medication to children in division facilities that are consistent with the policies adopted pursuant to section 3 of this act."

To provide the data that Mrs. Parnell was looking for earlier, I have also handed out to you some information (**Exhibit V**) that was provided by the Department of Health and Human Services (DHHS) regarding the amount of psychotropic drugs that are given to children in the program.

Next, there were concerns about subsection 1 of section 8, on page 4. To reiterate, the ability to have a second opinion is already in the law, if it is requested by the child or the child's attorney. What this says is that whoever does the first examination must not be the same doctor that does the second. We cleared up that language to make it sharper: they can work in the same facility, which might happen in the small, rural hospitals, but we do not want them to be affiliated with one another, i.e., not partners in the same practice. I am looking at Ms. Comeaux to see if she agrees. I appreciate the amount of time she spent this afternoon working on this.

Chairwoman Smith:
Ms. Comeaux, will you come to the table, please. And Mike Capello, please.

Assemblywoman Mastroluca:
On page 5, of the mock-up, we removed what was section 11 and replaced it with section 12 on page 6. All of this was agreed to by the folks from the Youth Care Providers, Tracey Woods, who testified earlier. What this says is that when a child is placed for adoption, if an order for visitation with a sibling is already in place, a copy of that order will go to the court, and the court will make a decision based on the best interests of the child as to whether visitation is still acceptable.

Chairwoman Smith:
This does address the issue that that organization raised about involving the foster parent or others?

Assemblywoman Mastroluca:
It does. If you look at subsection 2, it states that anyone who is an interested party can petition the court. And, in the discussions we had, we felt that what would more than likely happen is that the judge would ask that party to be a witness, and he would not have to go as far as petitioning: he would already be asked to give an opinion as to the relationship between the siblings, to determine the viability of the visitation.

Chairwoman Smith:
Does this expand the policies on the use of psychotropic medications to all kids in foster care rather than just those in the facilities? We talked about that issue during the hearing.

Diane J. Comeaux, Administrator, Division of Child and Family Services, Department of Health and Human Services:
If you look at the first page of the mock-up, section 3 has been added, and that specifically addresses this issue. It requires each agency that provides child welfare services to establish appropriate policies regarding the use of psychotropic medications. That was originally contained in section 10—which I believe has been changed to section 13—which still requires the Division to adopt policies for kids in our facility, but section 3 expands it to child welfare youth.

Mike Capello, Director, Department of Social Services, Washoe County, Reno, Nevada:
I think that works for the child welfare agency, and we would be supportive of that language.

Assemblyman Hardy:
As I understand it, section 3 means that any foster child in any foster home is now subject to the policies that will be developed on psychotropic medication by the agency?

Diane Comeaux:
That is correct. Any child in the custody of a public entity will be subject to the policies.

Assemblyman Hardy:
On page 4, where it says "five business days," sometimes it is difficult to get an appointment within five days, especially when the kind of thing we are talking about is not a 10-minute visit. Then regarding adoption, section 12, subsection 2, if we have an interested party in the adoption and visitation, and the judge says, "Yes, you can visit," will that preclude the adoptive parents from moving to another neighborhood, state, or country, which would preclude a potential sibling visitation?

Diane Comeaux:
Currently under NRS Chapter 432B, there is a requirement for sibling visitation. What this particular subsection does is to expand that to also be considered once one or the other, or both, of the siblings are adopted. Does it preclude them from moving out of state? I am not certain of the answer. I would assume that if there is a visitation agreement included in the adoption decree, they would need to go back to the court and modify the agreement in the event they were to move. I do not believe it would preclude that, but I do think they would have to modify that section of the adoption decree.

On page 4, line 21, where it talks about five business days after the court authorizes the exam, I think you are correct; it is probably too quick, but, again, these are typically kids who are in crisis and who need to be placed into a locked facility, so I think that is probably necessary. I do not think we would take issue with that. You had another question?

Assemblyman Hardy:
It was a comment about the requirement that the agency have an established policy for prescribing medications to include every foster child, so it would be out of the hands of the foster parent and into the hands of the agency, which I think is going to be somewhat problematic.

Mike Capello:
I think that the bill specifies that we are only talking about psychotropic medications, so we would not be limiting regular medications that might be

prescribed for an illness. We are talking about very specific types of medications that fall under that policy.

Assemblyman Hardy:
If I look at the KLAS-TV letter I have regarding "x" number of children on medication, have we looked at that fiscal note for trying to keep track of those children who are on those medicines and following up on them?

Diane Comeaux:
This amendment simply requires us to adopt policies around the authorization or use of psychotropic medications. I am not sure that we have clear records of all the children in child welfare custody currently in the Unified Nevada Information Technology for Youth (UNITY) System who are taking psychotropic medications. But, it is our policy to track that already. I think where we are having an issue is there is not necessarily follow-up. Once they come into the system, we have a pretty good methodology for figuring out what medications they are on, but a lot of times they may go to an appointment but the foster parent does not follow up with the caseworker. I think the policy would specifically address that, and since it is something we already have in our system and a policy we have in place, it may increase the workers' workload once the information starts coming in, but I do not believe it will add a fiscal note.

Assemblyman Hambrick:
In section 3, line 13, where is says, "establish appropriate policies," who determines what is appropriate policy? Is it a medical professional?

Diane Comeaux:
That is a good question. I think that is just a directive to ensure that our policies cover all aspects of how the caseworkers will handle kids who are on psychotropic medications. I am not sure who would approve it as "appropriate." As I testified earlier, there are a number of states that have already done this, and we would look at the policies they have in place to see if we can adapt them to Nevada.

Assemblywoman Parnell:
The word that concerns me in section 3 is "prescribing." I do not think the state or the agencies have any place dealing with issues about which a doctor should have sole discretion, namely prescribing medications. I think that word should probably be deleted from that line. If it said "policies concerning use and distribution of" I would be okay with that, but when you get into things like prescribing, it is not appropriate.

Diane Comeaux:
I think what we did was to pull that language from the other section, where it affected only the Division's facilities, and in that instance we have doctors who do prescribing in our facilities. So I agree; we do not have an issue with taking the word "prescribing" out.

Assemblywoman Leslie:
I think this is really important. Mr. Capello, you have been in the business even longer than I. I will never forget that visit to Elko, which I mentioned earlier, where the nurse told me they had just "weaned" this kid off his psychotropic meds, like it was something he should be weaned from. I have had a concern for a long time that we are not monitoring—and no criticism of any particular doctor—when kids move between the systems, that their medications appropriately follow them. How I am interpreting this might be a little different than some of the people on the Committee. To me, this is something we should have done long ago. This will simply ensure that somebody within the child welfare agencies is really looking closely to make sure the child has had the proper evaluation, the proper psychiatric care, if necessary, and then the proper medications. What we do not want to have happen is some caseworker decides she does not like a certain medication and puts the child on another one. I have seen a lot of that in my experience. I am wondering, Mr. Capello, what is your professional view of this?

Mike Capello:
I would concur. I think one of the challenges that children in foster care face is they often come into the system in a crisis. We often do not have a really good, accurate history of their past medical and mental health, so decisions are sometimes being made in a crisis without that kind of information. We have challenges with continuity of medical and mental health care throughout the system, whether they move from a shelter to a foster home, one foster home to another, or back to their parents. We see reports where some children are being prescribed a medication by a pediatrician, which probably should have some level of follow-up by a psychiatrist to see how the child's behavior is changing in response to that medication. Those kinds of things seem to be very common in the child welfare system: there is a disconnect. I think that is why we often see these types of problems. If we are more focused and are required to develop policies which will set in place some processes and procedures that staff will have to follow, we will minimize some of that. I think there are some bigger system challenges out there that this will not solve, but it will be a beginning. It will make it an issue that we are going to pay a lot more attention to at the line level, and those folks who are making difficult decisions during a crisis will have some more guidelines in terms of how they make those decisions.

Chairwoman Smith:
I was looking at section 3, and perhaps taking out the word "prescribing" and substituting "monitoring" would be better in that section. They could use distribution and monitoring of those drugs, rather than prescribing.

Assemblyman Hardy:
I think a lot depends on the comfort level the physician has in writing psychiatric medications. How many child psychiatrists do you have in Washoe County?

Mike Capello:
I do not know the exact number, but I think there are probably three to five child psychiatrists.

Assemblyman Hardy:
Can someone get an appointment within five days? You do not need to answer that.

Mike Capello:
It is going to be a challenge, but, again, most of the time the children that we are talking about are already in a facility because we have petitioned to put them there. They have asked for a second opinion, so we have an inside track. Would we be happy with seven days? Probably.

Assemblyman Hardy:
I am not going to argue about days because it is not possible to get an appointment with a child psychiatrist in five days unless you are an inpatient. And this does not always have to do with inpatients. If you look at the child psychiatrist, it is the physician, and only the physician, who can do the medication. So you can talk about the psychologist and the social worker and all the others but, whether it is an outpatient or an inpatient, it is only the physician who can do medication. If we are targeting medication that is problematic: trying to get the child psychiatrist in five days—if you want to use a psychiatrist, when your pediatrician or family doctor has a comfort level with medications, and he may well be fully capable of handling that. I think what we are trying to prevent is overmedicating children, and I do not know that there are any secrets the child psychiatrist has about overmedicating—just how much medicine are you on and what are you taking? That may be a rather simplistic view, but I do not know if we are going to be able to do everything we want to within the confines of this bill.

Chairwoman Smith:
Dr. Hardy, I just want to clarify, are you talking about section 10 on page 5, because that does mean inpatient, right?

Assemblyman Hardy:
There are two issues: one in section 5 that is a five-day situation and then the five-day situation in section 8. Some of the bill is for all foster children in Nevada, and some is for foster children in a facility.

Chairwoman Smith:
Section 3 refers to prescribing, use, and distribution of the medication to all children in the system. Section 5 refers to after the emergency admission—at that point the child would be an inpatient. Then section 8 refers to a facility, so that child is an inpatient. I think this is difficult to get one's brain around, but I have separated out those two issues in those sections, and it helped me.

Assemblyman Hardy:
I think you are accurate on that.

Assemblywoman Mastroluca:
I appreciate the complexity of this bill, and I have been reading and rereading it for awhile now, so I understand Dr. Hardy's confusion. But, these really are different issues. The purpose is not to prevent medications from being given to foster children; it is just to take a look at that as a state. As I said earlier, we are the parents of these children because they are wards of the state. The first parts of the bill relate directly to locked facilities and just ensure that someone else is taking a second look. The child has the option of asking to have a second opinion. There are many different pieces to this. I want to ask Ms. Parnell if she wants to remove "prescribing" from section 3 and section 13.

Chairwoman Smith:
If I can intervene, it was clear that there are doctors involved in that area, because they are in facilities, right?

Diane Comeaux:
That is correct. The Division's facilities have psychiatrists who prescribe there, so it is appropriate in section 13 that the child welfare agencies do not do the prescribing.

Chairwoman Smith:
Is there further discussion or questions? [None.] I would then entertain a motion to amend and do pass, and I would suggest taking out the "prescribing" and substituting "monitoring," if that makes sense to the Committee.

ASSEMBLYWOMAN LESLIE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 364, WITH THE AMENDMENT PRESENTED BY THE SPONSOR AND CHANGING "PRESCRIBING" IN SECTION 3, LINE 13, TO "MONITORING."

ASSEMBLYWOMAN PIERCE SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMEN COBB, HAMBRICK, HARDY, AND STEWART VOTED NO. ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

Thank you, staff, for working on this so late and staying with us to clarify the issues. [A short recess followed at 9:40 p.m.].

[Meeting reconvened 9:54 p.m.]

Chairwoman Smith:
We will open the hearing on Assembly Bill 80.

Assembly Bill 80: Revises provisions relating to excavations. (BDR 40-483)

We heard this bill earlier in the Session and understood the magnitude of the issue, and since that time we have had multiple people working on a resolution to this sewer-lateral issue. We have certainly made the rounds tonight from subject to subject.

I would like to open this hearing and indicate that it makes sense to me, if we have an amendment offered, a substitution offered to the bill, that we offer that amendment, take some testimony, and have some discussion on the amendment. It does not make a lot of sense to me that we go back to the original bill, since so much work has been done on crafting the compromise. Committee members, you have copies of the amendment (**Exhibit W**). Who will speak to the amendment?

J. David Fraser, Executive Director, Nevada League of Cities and Municipalities, Carson City, Nevada:
I just want to comment that this long evening is symbolic of the long process that brought us here. We bring to you tonight an amendment that represents a hard-fought agreement by the parties before you. From the League's perspective, this amendment does represent something that we think we can live with.

Chairwoman Smith:
This amendment is a replacement of A.B. 80?

Fred Schmidt, Carson City, Nevada, representing Clark County Water Reclamation District, Las Vegas, Nevada:
Yes. The amendment before you (**Exhibit W**) uses the same colors as your Legislative Counsel Bureau uses to make it simpler to follow. The black is essentially language in current statute. The blue is what was to be amended in the current statute by the original bill, with the exception of sections we are now striking. The green is all new language that was replaced. And the purple is language that is being stricken. I can explain each of the sections and what they do, if that would be appropriate.

Chairwoman Smith:
That would be. Committee, let us ask questions as Mr. Schmidt walks through these sections.

Fred Schmidt:
The basic purpose of the bill is to enable sewer operators to begin to take the responsibility for marking sewer laterals and to do it in such a form that it provides some flexibility for both rural and urban areas, without necessitating sewer rate hikes throughout the state. At the same time, we must make sure there is flexibility so that there are no substantial new burdens or costs on those who excavate and demolish in the streets. With me are representatives of major utilities in the state and of government entities. All of them will be coming up, after these five that we have tried to reach out to, to make sure we are accommodating the differences that might exist throughout the state. So the cities in southern and northern Nevada all have representatives here who believe this issue is very important to them and their budgets.

The first sections of the bill do not change—they are just definitional—except to make sure we have a definition of what a sewer service lateral is. Section 4 is where it gets interesting, and we met with the Public Utilities Commission (PUC) and numerous utilities. We did not necessarily meet with everybody who might have an interest in this bill but tried to meet with as many representatives as we could and hear their comments regarding our original bill. You may recall our original bill, which received a lot of complaints, provided a very elaborate and complex distinction between when boring occurs, when trenching occurs, and what types of methodologies are used. In section 4 we simplified the methods that can be used for marking to three different types. Those methods are contained in paragraphs (a), (b), and (c) of subsection 1. Paragraph (a) is probably the most simple and most basic and will allow for the use of documents where sewer laterals are identified and can be provided to an entity

to be utilized in the field to locate sewer laterals as they are doing their project. Paragraph (b) is an even more basic method, where we really cannot identify or do not know where the sewer lateral is and indicate so by a method that is used in statutes in other states: to put a green triangle out there to identify that there is a sewer counterlateral in the area, but we do not know where it is. Paragraph (c) is probably the most important. It is a method that allows the identification and actual location of the sewer lateral, so that the sewer operators, who are now offering to step forward and do this, would begin to collect that data and provide it over time.

In subsection 1, paragraph (a), we realized that there were certain things that, when we were providing documents, we could do quickly and within the current two-working-day standard that is in the bill. We also realized that that is the standard that everyone wants us to meet. So, in subsection 2, we changed what we had in the original bill and made it clear that we will make best efforts as operators to try and provide all the information, where we have to identify or locate, even if it is very complicated. You may recall, as Mr. Rabold explained, even with camera trucks and safety equipment blocking off streets, we will try to do it. We will make our best effort to do it within two working days whenever possible.

In subsection 3, the compromise we came up with—and we believe strongly in it—is that, to the extent that we have actual costs, we must explain and provide them, and only collect those costs. We will have to do that through our own permitting processes in each of the local jurisdictions. That will be another phase which we will have to go through to be able to recover those costs. This also gives another opportunity to those who oppose or challenge the cost to go to the local bodies that oversee the sewer operators and make their case. The nice part of this for the sewer operators in the rural areas is it allows them to make sure they can recover their costs, even if greater than the $200 limitation in the original bill. There will probably be opposition from those entities who had no costs related to the service previously.

To the extent that the flexibility in section 4, subsection 1, allows for records and/or green triangle markings to be used, it provides a vehicle for those entities to avoid that larger cost when it is not necessary or appropriate for the type of activity they have.

The last additional change in subsection 4 is a new section, a new requirement that makes clear that the operator of the sewer main is taking responsibility—once the initial locate is done, whether in new construction or a situation where we have already located the lateral and we have our records—to go out and identify the location from that information. It is our burden from

that point forward, and it is a significant step toward our accepting more responsibility, as contrasted with the original bill.

We eliminated section 5 altogether so that the gathering of identifying information and the responsibility for it will remain with the sewer operators and will not be a new burden on contractors in the field. It also means that sewer operators will have to develop more systematic means of beginning to identify, through their sewer mains, where all the laterals are located as opposed to relying on contractors on a project-by-project basis.

Section 6 merely reflects the fact that we have taken section 5 out of the bill.

Section 7 deals with the concern regarding liability for marking things for which we did not have good information. All we did in that section was retain the waiver of liability. We did not hear a lot of negative feedback, except that it was too complicated: we did not need two sections. So we consolidated the sections into one, capturing one of the important concepts of the first section in the new green language in what was subsection 2.

Chairwoman Smith:
Basically you are saying that, in this new language, there is no more liability than what you already had?

Fred Schmidt:
That is correct. We are not accepting any other responsibility or liability. Every community has ordinances that say we do not have any responsibility for that structure, only where it connects to the main, and then from the main on.

Assemblyman Hardy:
In section 7, the third line that is lined out in red, "a connection of a sewer service lateral to the sewer main if the operator of the sewer main is not the operator of the sewer service lateral." So, the operator of the sewer main owns the sewer main. Who is the operator of the sewer service lateral?

Fred Schmidt:
This is a very sticky issue, and I want to be careful how I answer because there is a dispute between those at this table and others in the room as to who actually has ownership or responsibility, not for the lateral as it sits on private property, but for the portion of the lateral that may sit underneath the public right-of-way. We are not trying to resolve that dispute by virtue of this legislative change.

That takes us to the final changes made in the amendment, which are in section 12. There was criticism that the global positioning system (GPS)—which was mandated in that section as the preferred way to locate, mark, and make sure that all laterals were known—was not flexible enough, either for some operators' preferences on this new responsibility or for some entities who would be in the field doing the work as contractors. So, section 12, under subsection 2, has a new approach: you can install permanent devices at the location of the sewer lateral and the sewer main, or at the location where the lateral exits the right-of-way. This will give the best information on all new laterals because you will have two points of record: at the end of the street and at the location at the main. Once we get that information, we would be able to identify both points. Paragraph (a) is intended to refer to the current law which allows for certain types of devices other than GPS to be utilized. Paragraph (b) preserves the option of GPS use. Paragraph (c) is a new option, where some operators have indicated that, rather than rely on the contractors development of the information, they would like to do it themselves and take that responsibility. We have provided a section that allows the operator, if he requests, to do that on-site. All of that is intended to be done within the time frame that works for the contractor and does not delay or impose other burdens on the project.

Finally, because we know there will be criticism that there could be much more done, that we are not going far enough, fast enough—this is really pioneering legislation for the west coast: California, Arizona, or Utah—we have offered a new section that commits to you that we will report not only the amount of locating we will do, but the method and the cost associated with that. So prior to the next legislative session, you will have complete information from at least one full year of how this is working. This is important because we had heard a desire to "sunset" this approach or to limit it, and we do not have enough information, and we know you do not either, to be able to decide whether it should be sunsetted in any specific year. By providing this informational report in detail, if there is a desire to either sunset or tighten up the statute, you will have the information to do it next session or beyond.

Chairwoman Smith:
You did a good job of presenting that information.

Assemblyman Stewart:
I cannot believe we are all sitting at this same table together. Does this mean that Nevada will be Number One in sewer lateral legislation?

Fred Schmidt:
No.

Brian McAnallen, Director of Government Affairs, Embarq, Las Vegas, Nevada:
We agree to this compromise amendment. It has been a challenge today, but we are here to support it and move forward. We have been trying to work on a consensus for several months now, and we do not want to be a barrier to the progress we have made on this issue. There are challenges with the language, and we would still like to make it better; nevertheless, we are here today to agree to this and move forward.

Chairwoman Smith:
Let me say, I know this has been hard, because I have either been following you around or having you in my office. And I know that not one person here is saying "Yeah, I won!" Everyone, it seems, gave up something, and I am sure some feel like you gave up more than others. I appreciate the fact that you stayed with it. I swore that we were not going to be here on the last night doing this, and here we are. I know that so many of you have worked hard to accomplish this.

Debra Gallo, Director/Government and State Regulatory Affairs, Southwest Gas Corporation, Las Vegas, Nevada:
We, too, are here in agreement with this amendment. I do think this is a positive first step, and we appreciate all the work by all the parties and look forward to continuing to work with them. I believe that, although we may not be Number One in sewer lateral legislation, it is an improvement and will help improve safety in the state.

Judy Stokey, representing NV Energy, Las Vegas, Nevada:
I echo what our other utility friends have said, and we are in agreement with this very, very hard-fought compromise.

David Bowers, Assistant City Engineer, Department of Public Works, City of Las Vegas, Nevada:
I echo the same comments. We support the amendment. It has been a long, hard battle, and I would like to commend both sides for the work they have done in this compromise.

Neil Mann, Director of Public Works, City of Reno, Nevada:
We also support the amendment as presented by Mr. Schmidt.

Barney Rabold, Deputy Director-Operations, Utility Services, City of Henderson, Nevada:
We completely support the amendment. We believe that this gives us the flexibility, the tools, and the means to go forward and improve the safety of our

community, the citizens, our people who work in the right-of-way, and our assets.

Shirle Eiting, Assistant City Attorney, City of Sparks, Nevada:
We are here in support of the amendment presented by Mr. Schmidt.

Karen Storms, City Clerk, City of North Las Vegas, Nevada:
I echo the comments that have been made, and we, too, support the amendment.

Sabra Smith-Newby, Director of Administrative Services, City of Las Vegas, Nevada:
We are in support of the agreement and amendment by Mr. Schmidt.

Darren Schulz, Deputy Public Works Director, City of Carson City, Nevada:
We are in full agreement with the amendment as presented.

Jeff Fontaine, Executive Director, Nevada Association of Counties, Carson City, Nevada:
We are in agreement with the amendment.

Chairwoman Smith:
Anyone to speak against this bill? Mr. Noble, I notice you do not have any supporters on either side of you. Welcome to the Committee, and thank you, too, for your contribution to this. I know that a lot of people have been in an awkward position, so I appreciate your help.

David Noble, Assistant General Counsel, Public Utilities Commission:
Before I get to the actual language, I would like to respond to some comments that were made by the presenters of the bill in the previous hearing. There are a few things I think we need to have on the record from the Commission's perspective. First was a statement by Mr. Rabold, representing the City of Henderson, in which he said that the public health and safety was paramount. The Commission is in full support of that statement. The problem is that words do not reflect their actions. That is in regard to the presentation by the southern Nevada sewer entities, which included North Las Vegas, City of Henderson, Clark County Water Reclamation District, and City of Las Vegas. In practice, North Las Vegas currently marks the connection point to the laterals in response to a request for a marked excavation. The City of Henderson marks their mains, but they do not mark their laterals. Clark County Water Reclamation District does not even have any locators, so they do not mark their mains or their laterals. It is our understanding that in the last couple of months they have actually started providing documentation to excavators, which is

better than nothing. They are happy about that, but for the last 18 years, they have been flouting NRS Chapter 455, which requires that operators mark their facilities prior to excavation. With regard to the City of Las Vegas, again, they are not marking their mains or laterals prior to excavation activities. It has also been reported that they have a large sewer fund and have loaned $80 million of that fund to their city's redevelopment. So, when the Commission hears that these proposals are very expensive and they do not have the money, the question that comes to the Commission's mind is, if you have this type of money and can loan it to other aspects of your municipality, what is going on?

The other comment that Mr. Schmidt made on behalf of Clark County Water Reclamation District was that, in regard to the Commission's rulemaking investigation, the PUC was ignoring their arguments. I completely disagree with that. The Commission spent 1 1/2 years dealing with this issue, and just because the Commission had a different viewpoint and disagreed does not mean we ignored it. Also heard at the last hearing was a question whether the PUC even had any authority to require municipalities to mark sewer laterals. The argument was that the PUC regulates utilities not municipalities. We are the enforcement agency under NRS Chapter 455; we do not regulate public utilities under that chapter. The only exemption under NRS Chapter 455 is Nevada Department of Transportation (NDOT). That is consistent throughout the nation, the department of transportation is usually exempt: they have their own separate records, and that is the norm.

The two main issues which are really the sticking points here are: the sewer operators do not want to mark the location of the sewer laterals prior to excavation, and the sewer operators do not want to pay for those excavation activities. The question the Commission has is: why should they be treated any differently than any other operator—gas, electric, telecom, water—they are an operator of subsurface installations. They should be treated just like everybody else. There has been testimony that they have made compromises, and this is a great thing, but in reality, they have been flouting the law for 18 years, and the fact that they are finally acknowledging that they have a responsibility is unique.

I also heard in the last hearing that boring excavation activities were the cause of this problem. I would suggest that boring has highlighted this problem, not caused it. Even if boring was banned in the State of Nevada, sewer operators should still be marking the laterals. That problem does not go away. The boring, in part, has been caused by the municipalities who have these "no cut" moratoriums that do not allow excavators to cut into new roads. Or, for example, if the excavator has a 2-foot-wide cut for their excavation, instead of being allowed to fill that in, the municipalities are looking to these excavators to

actually help pay for repavement. They will require that the excavators pave at least that lane or half the street, instead of just filling in what they have disturbed in the street.

So, the Commission would say that what is happening here is that our sewer system operators are being rewarded for their bad behavior for the past 18 years, and we question what kind of precedent that sets.

With regard to the actual language proposed in the amendment, if you look at section 4, subsection 1, paragraph (a), it requires, at the option of the operator, to just provide documents to the excavator, and then the excavator has to make those marks. Right there, the sewer operator is shirking its responsibility. It has documentation that would demonstrate, supposedly, where those sewer laterals are, but it is not going to mark them. It is going to require the excavator to read those maps, figure them out, and go out and mark them. In subsection 1, paragraph (b), the triangular mark is a good practice. The problem is that, according to subsection 3, they are going to be able to charge for that. If the sewer operator is already out marking its main, how much more is it going to cost them to put a triangle somewhere saying, "We do not know where the lateral is that services this property, but we should be paid for it." With regard to subsection 1, paragraph (c), identifying the location of the connection point of the sewer service is good for North Las Vegas, which already has that information. And any of the sewer operators who have been proactive also have that. Or, if they have been marking the new laterals since October 2005, they will also have that information. But what it ignores is the other permanent devices that are going to be used out there in the field, whether sewer clean outs, "S" stamps on the curbs, or marker balls that are being used underground. Those are also very good indicators of where that lateral will be, not just the connection point. And if you have any point along that lateral, you have a very high likelihood of knowing where the approximate location of that facility is, for marking purposes under NRS Chapter 455, because the vast majority of those laterals come off at 90-degree angles. The "S" stamps on the curbs are going to be fairly accurate because they are put in by the developer when they stub in all the facilities. When they come back and actually build the structure, they know where they stubbed out the sewer laterals.

With regard to the fees, again it is the issue of transferring the cost from one operator to another. Mr. Schmidt represented that there would be no rate hikes. I say there will be as a result of the excavators having to pay for the operators' marking activities. So you have a transfer of cost from the rate payers of the sewer system operators to the rate payers of the operators of those other subsurface installations, and that is just patently unfair and not logical. The sewer system operator, whether it is municipality, a private

business, or a public utility, is marking your facilities, including laterals, as a cost of doing business in this state. It is not an unfunded mandate; it has been in place for the last 18 years. The fact that many of these sewer system operators have not done it for the last 18 years has magnified the problem tremendously. Regarding the other fee issue, Mr. Schmidt has represented that if there was an issue that the fees would be too high, the other operators could go to the local elected bodies and argue their positions. To me, that proposal is without merit, because what is the incentive for the municipality to agree with the other operators? They are collecting these fees; why would they not collect these fees? This is a cash cow, I believe, for the municipalities.

Mr. Schmidt also represented that this is way ahead of the practices in California, Arizona and Utah. I represent that it is way behind the operations of Oregon and Idaho, which require sewer operators to mark their laterals. Assemblyman Stewart, you had asked whether this makes Nevada Number One. We are actually Number One in our statute right now: it is very simple, straightforward, and easy-to-follow when people use logical reasoning. However, in practice, we are not Number One, and that is what the Commission tried to address in its rulemaking when we designated that the sewer system operators needed to mark the lateral from the connection point up to the property line of the entity being serviced by that lateral. I represent that, if you have any point of demarcation for that lateral, you are going to know, the vast majority of the time, where that lateral is throughout that public right-of-way.

With regard to section 4, subsection 3—this is just a question—what are the franchise fees being used for by the municipalities now? Those charges would be in addition to the franchise fee.

The Commission has no problem with section 6, section 7, and section 12. In the new section that would require the reporting, which is in lieu of having a sunset provision, the reality of the situation is that the vast majority of sewer operators cannot mark laterals consistently according to the statutes right now. So this is sort of a free pass for a certain period of time. The Commission represents that you need to establish a certain date at which point this hybrid methodology goes away and sewer operators start marking like every other operator. We represent that it would be better to do it now or we will be here in two years trying to figure out when to sunset this provision, regardless of what you do here. If you pick a time, there is always the opportunity for the operators to come in with reports demonstrating that they are doing everything they can, that it is just not working, and they need additional time.

Chairwoman Smith:
I do not know where to start. I am surprised that you are very critical of what has happened, and I understand that. I did not hear many positive things about this group working out a solution and coming to an agreement, although not everybody loves it.

David Noble:
The original proposal in A.B. 80 is not much different from what is here, and so from the Commission's standpoint, they have not really made any concessions. They have changed things around, but, effectively, it does exactly what A.B. 80 does in its original form. If the goal is to actually get sewer system operators out in the field and marking their facilities, this does not do it. Fees are a whole different issue, and that is a policy determination. If you want to treat sewer system operators differently, and it is above and beyond the franchise fee, it is a policy decision that people can disagree about. The Commission thinks that every operator should bear its own costs and not transfer those costs on to other operators. But there needs to be a concerted effort to get them out and marking. The City of Las Vegas and Clark County Water Reclamation District are not even doing that right now. Clark County Water Reclamation District, it is my understanding, may be hiring some locators in the future.

Chairwoman Smith:
They should be marking mains, not laterals, currently?

David Noble:
It is the Commission's view that they should not only be marking mains but also laterals, because their system does not operate without those laterals. Many municipalities have passed ordinances saying that the operators do not own them; it is the property owners that own those laterals, even in the public right-of-way. The Commission asked us on several occasions; I have yet to see any title report on any property that demonstrates that they own that lateral.

Chairwoman Smith:
But there is nothing in the statute that says that the operators should have been marking the lateral, is that correct? It refers to the mains only?

David Noble:
Actually, I disagree with that. There is no distinction between laterals and mains. It is just subsurface installations, which have a very extensive definition, and laterals are one of those. Laterals for water are marked, as well as gas and underground electric laterals; every other utility marks its laterals, but not sewer system operators.

Assemblyman Hardy:
I think your points are well taken, Mr. Noble. I look at the new section of the proposed amendment, and I think we have a means to follow up and hear the report of the number of sewer service lateral connections that have been identified. I think the key for us, having gone through this a few sessions now, is that we are moving forward, and so I suggest that the forward-looking approach to this will get us further down that road than looking backwards.

Chairwoman Smith:
I would tend to agree with that. I am very concerned about the fee issue here and the comment about the cash cow. I have talked and talked to the various representatives about that issue, but as Dr. Hardy said, this body can always revisit a decision that is made if in fact it is not working well—which we always do if we look at the various bills that we hear and pass. It is not usually creating something new; it is usually "tweaking" something that we have already done. The reporting is very important for us to see the progress, and I do not really see how this would not cause sewer lateral locations to start happening. I do not see how this bill does not make that happen.

David Noble:
It does require those sewer system operators, who are currently not marking their laterals, to do something now. So for those who have not been doing anything, this is progress.

Chairwoman Smith:
And that is a lot of progress.

David Noble:
And for those who have already been doing that, this can allow them to slide back.

Chairwoman Smith:
But even those who have been marking are not finished, right? There are plenty out there that have not been done.

David Noble:
It is actually the practice of marking laterals: it covers the entire spectrum, from marking none to marking all of them.

Chairwoman Smith:
Well, I guess in a perfect world that makes sense. But what did we hear—700,000 laterals—that is kind of hard to get your brain around. Is there anything else for Mr. Noble?

Assemblywoman Pierce:
I am just a little confused. This has been a problem for a long time and you are suggesting that you have better answers than the ones everyone came up with. Why did you not tell us this some time ago?

David Noble:
Staff of the PUC was given increased enforcement authority two years ago under Senate Bill No. 396 of the 74th Session, and that is when this issue arose. Before that, the ability of the Commission to enforce these statutes was not very good, and so this has really come to a head in the last two to four years. The Commission, at some point in the past, was naïve to actually think that sewer operators were following the law, according to what it believed was the law. When it started taking a harder look, and was given the enforcement authority, that is when this came to light.

Chairwoman Smith:
And some regulations were developed in the last interim and went to the Commission, but they were not processed, and so it is back here.

Marlene Lockard, Reno, Nevada, representing Subcontractors Legislative Coalition, Las Vegas, Nevada:
After listening to everything, I think we are in the middle of a very big fight. But we represent the little guys: the electrical workers, the Nevada Underground Contractors Association, and the plumbers. We were not included in any discussions, unfortunately, and did not receive this amendment until very late in the day. We have no other choice but to go on record as opposing this legislation. Our folks have not had a chance to evaluate the amendment, but I would say the fee section greatly concerns us, with the $200 being removed and the cost now being totally open-ended. Remember that we are talking about plumbers and small guys. It is really wide open to have a cap at $5,000, and an unlimited cap on the franchise piece—which our guys do not have.

Chairwoman Smith:
You said you represent the National Utility Contractors Association?

Marlene Lockard:
Nevada Underground Contractors Association. Would you like me to list all that we represent?

Chairwoman Smith:
No, we had testimony from that group, so I wanted to clarify whether that group was on your list. I know they offered some written testimony, which the

Committee should have, which addresses the original bill. The piece they were objecting to, in section 5, is eliminated with the excavators' responsibility.

Randy Brown, representing AT&T Nevada, Reno, Nevada:
We do appreciate the efforts that were put in by the group to come to some sort of compromise on this. I just want to list our concerns with section 3, largely for the reasons that have been stated already: the open-ended dollar amount as far as the fee, and the transferring of the fee from one utility to another. And we also have concerns with the intent to limit our ability to bring action as a fee-paying franchisee to the municipality under statute.

Chairwoman Smith:
Mr. Brown, would you say that in terms that I understand. This Committee does not deal a lot with franchise fees and that part of municipal issues, so help us out here.

Randy Brown:
I am not an attorney, either, but our understanding is that the limiting language placed in section 4, subsection 3, is basically asking us to waive our right, today and in the future, to say that any other fees, which are added on above the 5 percent franchise fee, are permitted. And we are saying we are not willing to waive that right, specifically for the sewer operator or for any others.

Chairwoman Smith:
You are saying you pay your franchise fee and you do not want to pay any more.

Randy Brown:
Yes, that is accurate. And I would also go on the record as saying that there are instances today where we may pay a permitting fee for a specific project.

Chairwoman Smith:
Meaning, if you are going to shut down the street or dig, and so on?

Randy Brown:
Right. We would pay a permitting fee. And I suppose the argument could be made that that is also in addition to the 5 percent franchise fee. We do it today, but I think this language is severely limiting and waiving all future rights for us to contest that. And I think that Mr. Schmidt and others—though I do not speak for them—are concerned with that possibility as well, and that is the reason for the limiting language.

Bob Gastonguay, Executive Director, Nevada State Cable Telecommunications Association, Reno, Nevada:
I am moving from opposed, as I signed in at the last hearing, to neutral. I did work with the Committee on some of this agreement language; however, I cannot get buy off from my largest member because he is out of touch.

Karen Pearl, Executive Director, Nevada Telecommunications Association, Reno, Nevada:
I am trying to make a little clarification, and maybe I misunderstood. Regarding some questions asked by Assemblywoman Pierce about the laterals, this language is strictly for "call before you dig," whether it be a very small hole or a complete subdivision. They call the one-call center and make the "locates" based on that call ticket. In my position, I was originally opposed to the bill, and all I can say now is that I neither love it nor hate it. I think the parties did a very fine job and the PUC has valid arguments, and I leave it to you to decide.

Chairwoman Smith:
Is there anyone else who would like to testify on the amended version of this bill? [There were none.] I am going to bring this back to the Committee to see how you are feeling. We can move this and allow the discussion to continue in some forum as it moves along.

Assemblyman Hardy:
I was a little intrigued by the concept of coupling the permitting fee with a charge. I would hate to see the local jurisdictions require a permit and charge a fee in addition to that, if the permit fee covers that cost. I would suggest that they look at that issue.

Chairwoman Smith:
I think that is basically what we are talking about here, is it not?

Fred Schmidt:
The concept in section 4, subsection 3, is to allow for that flexibility. Most entities do not have any significant permit fee costs today. Certainly none of it was developed with the intention of recovering a sewer-lateral-locating cost. So, the way the section is drafted, it could allow for that. Regarding entities doing locating now, Mr. Noble said they locate everything; that is not actually true. North Las Vegas locates all laterals installed since 2001 because they have been requiring an "S" stamp in the curb since then. But they cannot locate laterals any differently than anyone else prior to 2001 without the more expensive undergrounding to get it accurate. Entities like that may actually have locators in their system and may already have some of the fees, so they do not have to raise sewer fees and may not have to charge any significant

permit fee. The purpose of the flexibility of subsection 3 was to reflect that difference. I understand that creates fear on the part of other entities that people in government may charge fees that are not warranted. That is why we put language in there that was recommended to us by the utilities: the fees must be actual costs and must be reasonable. It can be done by the permitting process, but it does not have to be done that way.

Assemblyman Hardy:
The way I look at the reporting in the new section, in the last two lines, "the costs accrued by the operator of the sewer," would be part of that report that comes back to us?

Chairwoman Smith:
Absolutely. If it is a cash cow, the Committee would revisit it. Mr. Schmidt, it was suggested that you would only be doing one piece of it and that would be the "call before you dig" piece. Section 6 deals with maintaining the information that is developed by the operator, but is that only the "call before you dig"? I did think we had talked about going forward, that the operators would develop records. For example, if a new subdivision is going in, you would start developing those records.

Fred Schmidt:
If you turn to section 12, it is specifically designed to address how we will deal with new construction and development. Section 12 is much more specific in what it requires, and I think Mr. Noble agreed with this as well. Section 12 requires two points, and it provides some flexibility because we did hear feedback from homebuilders and others that not all of them want to do GPS.

Chairwoman Smith:
And for some of the smaller entities that may have a harder time with technology?

Fred Schmidt:
Yes.

Chairwoman Smith:
Committee, what would you like to do?

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 80.
>
> ASSEMBLYWOMAN MASTROLUCA SECONDED THE MOTION.

Further discussion?

Assemblywoman Leslie:
I still do not like it, so I am going to vote no at this point. I cannot really discuss it in detail. There is just something about it. I do not think local government is doing enough. Mr. Noble made some arguments that were very persuasive to me, and I am troubled by what Mr. Brown said, but it is deadline night, and I will just vote no.

Chairwoman Smith:
I would like to say that, as the Chairman, I understand that this may be a work in progress if this bill moves forward. Sometimes we find it offensive if the bill gets worked on in the other house, but, in this case, it is a big issue and we know there are some lingering concerns. So take that lightly, but as the Chairman, I am comfortable with it. Other discussion?

Assemblyman Stewart:
I think I am in favor. I am going to reserve my right to change my vote.

> THE MOTION PASSED. (ASSEMBLYWOMAN LESLIE VOTED NO. ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE. ASSEMBLYMAN STEWART RESERVED THE RIGHT TO CHANGE HIS VOTE ON THE FLOOR.)

Chairwoman Smith:
Thank you all for staying with us tonight. Committee, we have the final unresolved issue of Assembly Bill 206.

Assembly Bill 206: Revises provisions relating to public health. (BDR 40-858)

Our staff cannot have that mock-up ready for us for a behind-the-bar tomorrow. What I can suggest to you, which we have done in the past, is we can do an amend and do pass, combining those amendments as discussed earlier, and then the amendment will not move forward until you have all seen it and signed off on it. That will allow us to make the deadline, allow the staff time to do the mock-up, and allow you all the opportunity to sign off on it.

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 206.
>
> ASSEMBLYMAN STEWART SECONDED THE MOTION.

Assemblywoman Leslie:
That is with the amendments we heard about, plus the one that you added?

Chairwoman Smith:
Right. It is all three amendments combined.

> THE MOTION PASSED. (ASSEMBLYWOMAN SPIEGEL WAS ABSENT FOR THE VOTE.)

My goodness, Committee, you did heroic work tonight. We really accomplished a lot and moved through so many different types of discussions. It was amazing. Also, please join me in thanking our staff [applause]. I had my last conversation with Amber Joiner at 1:15 a.m., and she was still emailing me even when we left, and she still had to drive home and come back this morning to finish this work session document. We are so fortunate to have this staff. And, Kristin Roberts, who I know is listening and who has been corresponding with us throughout the evening, thank you. Chris Kanowitz and Olivia Lloyd, thank you all so much for hanging in there with us.

Meeting adjourned [11:03 p.m.].

RESPECTFULLY SUBMITTED:

_____
Darlene Rubin
Committee Secretary

RESPECTFULLY SUBMITTED:

_____
Karyn Werner
Editing Secretary

APPROVED BY:

_____
Assemblywoman Debbie Smith, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: April 8, 2009 **Time of Meeting: 1:13 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 433	C	Diane Comeaux	Amendment
A.B. 364	D	Tracey Woods	Amendment
A.B. 52	E	Kathy Silver	Testimony
A.B. 52	F	Kathy Silver	Amendment
A.B. 52	G	Vicenzo Variale	Testimony
A.B. 52	H	Robyn Keith	Amendment
A.B. 20	I	Amber Joiner	Work Session Document/Amendment
A.B. 89	J	Amber Joiner	Work Session Document/Amendment
A.B. 101	K	Amber Joiner	Work Session Document/Amendment
A.B. 111	L	Amber Joiner	Work Session Document/Amendment
A.B. 263	M	Amber Joiner	Work Session Document/Amendment
A.B. 359	N	Amber Joiner	Work Session Document/Amendment
A.B. 213	O	Amber Joiner	Work Session Document/Amendment
A.B. 112	P	Amber Joiner	Work Session Document/Amendment
A.B. 123	Q	Amber Joiner	Work Session Document/Amendment

A.B. 206	R	Amber Joiner	Work Session Document/Amendment
A.B. 227	S	Amber Joiner	Work Session Document/;Amendment
A.B. 326	T	Amber Joiner	Work Session Document/Amendment
A.B. 364	U	Assemblywoman Mastroluca	Amendment
A.B. 364	V	Assemblywoman Mastroluca	Letter from DHHS
A.B. 80	W	Fred Schmidt	Amendment