MINUTES OF THE
JOINT SUBCOMMITTEE ON HUMAN SERVICES/CIPS
OF THE SENATE COMMITTEE ON FINANCE
AND THE ASSEMBLY COMMITTEE ON WAYS AND MEANS

Seventy-fifth Session
March 19, 2009

The Joint Subcommittee on Human Services/CIPS of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Bob Coffin at 8:08 a.m. on Thursday, March 19, 2009, in Room 3137 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Bob Coffin, Chair
Senator Bernice Mathews

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman Sheila Leslie, Chair
Assemblyman John Oceguera, Vice Chair
Assemblyman Morse Arberry Jr.
Assemblywoman Heidi S. Gansert
Assemblyman Joseph (Joe) P. Hardy
Assemblywoman Debbie Smith

SUBCOMMITTEE MEMBERS ABSENT:

Senator William J. Raggio (Excused)
Assemblywoman Barbara E. Buckley (Excused)

STAFF MEMBERS PRESENT:

Gary L. Ghiggeri, Senate Fiscal Analyst
Laura Freed, Program Analyst
Barbara Richards, Committee Secretary

OTHERS PRESENT:

Richard Whitley, M.S., Administrator, Health Division, Department of Health and Human Services
Mary Keating, CPA, Administrative Services Officer, Health Division, Department of Health and Human Services
Alicia Hansen, M.S., Chief Biostatistician, Bureau of Health Statistics, Planning, and Emergency Response, Health Division, Department of Health and Human Services
Mary E. Wherry, R.N., M.S., Deputy Administrator, Health Division, Department of Health and Human Services
Maria Canfield, M.S., Chief, Bureau of Child, Family, and Community Wellness, Health Division, Department of Health and Human Services
Luana J. Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning, and Emergency Response, Health Division, Department of Health and Human Services

Brian M. Patchett, M.P.A., M.S., President/CEO, Easter Seals Southern Nevada
Dennis Mallory, Chief of Staff, American Federation of State, County and Municipal Employees, AFL-CIO
Marcia O'Malley, Executive Director, Family Voices Coordinator, Family Ties of Nevada
Todd Myler, Administrative Services Officer, Health Division, Department of Health and Human Services
Jack Lazerson, M.D., Professor Emeritus, Department of Pediatrics, University of Nevada School of Medicine

CHAIR COFFIN:
The first budget account (B/A) we will hear this morning is the Cancer Control Registry.

HUMAN SERVICES

HEALTH AND HUMAN SERVICES ADMINISTRATION

HHS - Cancer Control Registry – Budget Page HEALTH-20 (Volume II)
Budget Account 101-3153

RICHARD WHITLEY, M.S., (Administrator, Health Division, Department of Health and Human Services):
We will review and hit the highlights of this budget.

MARY KEATING, CPA (Administrative Services Officer, Health Division, Department of Health and Human Services):
This budget is funded from a grant and it funds seven positions. The Governor's recommended budget continues that funding. There are a few replacement items in fiscal year (FY) 2010-2011, in accordance with the Information Technology Services schedule.

SENATOR MATHEWS:
Did your Division oversee the Fallon cluster?

MR. WHITLEY:
We invited the Centers for Disease Control and Prevention (CDC) to come and assist the State. They are now in control of it.

CHAIR COFFIN:
People leave the State to have cancer surgeries in another state. Is there a way to track how many people from Nevada do this?

MR. WHITLEY:
Our Cancer Registry would capture the individuals diagnosed in our State. Physicians report this as well.

ASSEMBLYMAN HARDY:
For clarification, is the physician reporting or does it go from the laboratory to the Cancer Registry?

MR. WHITLEY:
According to our State biostatistician, both the physician and the laboratory report to the Cancer Registry.

CHAIR COFFIN:
We will move to B/A 101-3190, Health Statistics and Planning.

HHS - Health Statistics and Planning – Budget Page HEALTH-20 (Volume II)
Budget Account 101-3190

MS. KEATING:
Health Statistics and Planning is often known as "vital records." In this budget, it funds 18 positions. A few adjustments are included. Decision unit E-275 requests software maintenance. Decision unit E-605 is an issue subject to a budget amendment. I will prepare the amendment tomorrow; we will go through the process and move to correct it. We also have decision unit E-606 which is a budget reduction in the staffing that went with the Technology Investment Request (TIR).

E-275 Maximize Internet and Technology – Page HEALTH-23

E-605 Budget Reductions – Page HEALTH-23

E-606 Staffing and Operating Reductions – Page HEALTH-24

CHAIR COFFIN:
Does decision unit E-605 adjustment need an amendment because of the error in the calculations of the Behavioral Risk Factor Survey? We need to get that on the record.

MS. KEATING:
In decision unit E-605, there is a reduction to the General Fund and an offsetting reduction to a grant category. That decision unit is in error and needs to be corrected. The original base and the original module M-150 complicate the error, making the cost of the error $245,000 annually. It must be corrected to restore the General Fund as well as put the grant category back where it needs to be.

CHAIR COFFIN:
The error is a shortage of $486,102 to the General Fund.

MS. KEATING:
That is correct. That is the extent of this budget.

CHAIR LESLIE:
On the data warehouse issue, those positions were never filled.

MR. WHITLEY:
Correct. They were never filled.

CHAIR LESLIE:
Is there anything in the new budget to address that?

MR. WHITLEY:
We proceeded with consolidating data functions as part of our reorganization. We are still proceeding with the hope of funding opportunities coming which will make us more competitive for federal funding.

ASSEMBLYWOMAN SMITH:
I saw an article last week regarding a survey on openness in government. It spoke of the access of information, especially on the Internet. It seems that Nevada did not fare well with respect to access to birth certificates, death certificates, etc., in that survey. Did you look at that? Where do we fit in with what other states are doing? Will you let us know regarding this?

MR. WHITLEY:
The data in the data warehouse concept was to provide aggregated data related to the health status in our State. The openness of access to data, for consumers to get their birth or death certificates, is one technology need. We are moving down that path in terms of an Electronic Birth Registry (EBR). We have implemented an Electronic Death Registry (EDR). The data warehouse enhancement is to make better use of the data collected, in terms of health indicators. We are often criticized in grant applications for not effectively telling the story of what the need is by fully analyzing all the data available. The TIR related to the data warehouse would have helped us with the capacity. We are proceeding with this with the resources we have. Nevada will benefit from it, as well as the consumer path with making data more available.

ASSEMBLYWOMAN SMITH:
I thought the survey was interesting and I found it surprising we did not fare better. I will be interested in your opinion.

CHAIR COFFIN:
We need to give an admonition to our witnesses that when data is being asked for, we need to know if it is required to make decisions on the budget. Please be cautioned that requested information is needed as soon as possible.

ASSEMBLYMAN ARBERRY:
What is the impact to this budget if the General Fund is not restored in decision unit E-605?

MS. KEATING:
In the event the General Fund is not restored, this agency will have to analyze the expenditures that are General Fund supported. The grant will have to be restored because the federal dollars have to meet the federal expenditure. If the General Fund is not restored, they will have to manage activities of the Agency without the funds. It may result in staff layoffs. It will have an impact on their ability to meet their goal of providing birth certificates in a timely manner.

ASSEMBLYMAN ARBERRY:
Under the software maintenance appropriation, decision unit E-275, you have an annual expense for multiyear licenses. Can you elaborate on this?

MS. KEATING:
We have included and provided to your staff a software list which requires payment annually for maintenance. We have items which are part of the EBR and the EDR. They require different software. When they were developed, they were free from the vendor for the first couple of years. Now they are expensive. One is $92,000 a year. It is required to maintain the electronic data the hospital provides to us and for us to provide the information to the outside consumer.

ASSEMBLYMAN ARBERRY:
We need to know why your expenditure budget is in an operating category rather than an information services category.

MS. KEATING:
Traditionally, software maintenance can go into either category 04 or category 26. We will move it to category 26 if the Committee desires.

ASSEMBLYMAN ARBERRY:
Can some of the programs function without these enhancements?

MS. KEATING:
You lose the effectiveness of electronic infrastructure you put in if you are no longer able to maintain it.

ASSEMBLYMAN ARBERRY:
Can you explain why the Social Security Administration (SSA) reimbursement is decreasing? It shows approximately a 20-percent decrease, or $91,690, from the base year amount.

MR. WHITLEY:
The software need helps us report more timely to the SSA the birth and death data for which we get reimbursed. We have been delayed in providing that information because we do it manually. We have not been meeting the timeline to get reimbursed by the SSA.

ASSEMBLYMAN ARBERRY:
Will this speed up the turnaround time for processing of the social security cards?

MR. WHITLEY:
Yes, it will, as well as to the consumers. We get complaints, especially around tax time, when parents want their child's birth certificate. We are moving that to the EBR which will enhance the timeliness both to the consumer and the SSA.

ASSEMBLYMAN ARBERRY:
Please explain why the reductions to the State worker pay and benefits were balanced with reductions to the SSA reimbursement.

MS. KEATING:
When these decision units were created by the Budget Office, they asked the Health Division to assist with the fund map. If the SSA reimbursement is

included, it is most likely an error and needs to be corrected. It does not pay for payroll.

CHAIR COFFIN:
I thought we received the software enabling us to do this. We are just beginning to pay for it, but why are we still doing the reporting manually?

MR. WHITLEY:
We purchased the software, but we just began implementing the EBR with the hospitals. The EDR was fully executed last year.

CHAIR COFFIN:
We have a lot of people getting passports this year. They will need birth records. I want to ensure we do not inconvenience the public because we are late on that.

MR. WHITLEY:
The implementation deadline for going live with the EBR is June 30, 2009. Our intent is to initially go back for the last five years for data entry and to become current as of June 30, 2008.

CHAIR COFFIN:
How long will it take to get current?

ALICIA HANSEN, M.S. (Chief Biostatistician, Bureau of Health Statistics, Planning, and Emergency Response, Health Division, Department of Health and Human Services):
With the implementation of the EBR, we currently have an old electronic system that is basically an index of information for birth certificates. That information will be converted into the new system which will be used as a look-up function. We will have the birth certificates in our vault for people born before June 30, 2009. When their requests come in, we will be able to pull the paper and provide the birth certificates to them.

CHAIR COFFIN:
We will go to B/A 101-3194, Consumer Health Protection.

HHS - Consumer Health Protection – Budget Page HEALTH-28 (Volume II)
Budget Account 101-3194

MS. KEATING:
This is the budget that involves food inspections at locations other than ones having public health districts. The inspections also look for water-borne illnesses to make these establishments environmentally sound.

Included in this budget are approximately 30.51 positions. It has the traditional items you see in the other budget. It has a few other enhancements we want to talk about. The first one is decision unit E-226 where we eliminate an administrative services officer as part of our consolidation. The next one is decision unit E-228 where we eliminate a management analyst. It is also part of our consolidation. The last one is decision unit E-229 which eliminates an

information technologist. These are all related to the enhancement of the consolidation process we are going through.

E-226 Eliminate Duplicate Effort – Page HEALTH-31

E-228 Eliminate Duplicate Effort – Page HEALTH-32

E-229 Eliminate Duplicate Effort – Page HEALTH-32

There are some transfers in decision units E-901, E-902, E-903 and E-904. They are also part of the reorganization seen in the other documents.

E-901 Transfers 2 EHS FTE from 3194 to BLC, BA 3216 – Page HEALTH-34

E-902 Transfers RAF from 3218 to BA 3194 – Page HEALTH-35

E-903 Transfers from 3194 to BA 3101 – Page HEALTH-35

E-904 Transfer Chief from 3194 to BA 3216 – Page HEALTH-36

CHAIR COFFIN:
This reorganization is certainly within the purview of your office. I would like you to outline why you think it will work. You are the sentinel; the barrier between disease and wellness in these 14 smaller counties.

MR. WHITLEY:
We identified layers of fiscal management at the program level, the bureau level and the administrative level. It was not as efficient as it could be, but it utilized resources that could go towards direct services. The consolidation of the fiscal function leads to more efficiency and also makes more funding than available for programmatic activities. Specifically, as it relates to environmental health inspections, two full-time employees did food inspections and inspected health facilities even though they were in a program isolated from health facility inspections. The lost opportunity there was the lack of communication between programs that inspect the same facility. When the inspectors look at food preparation in nursing homes and hospitals, their eyes should also be open to issues that could trigger the health facility surveyors to look at more systemic issues. Consolidating the regulatory function made sense. This Environmental Health section is rural frontier focused, but the State facility function is statewide. That was another reason for consolidating the activities. The fiscal benefit is it frees up funding that was diluted by having the pieces fragmented across the agency.

CHAIR COFFIN:
You realize that you are losing three positions. One is an administrative services officer I (ASO) and someday you might want the ASO back. Do you believe you can give it up now?

MR. WHITLEY:
Yes. I am hopeful we will be successful in bringing in additional federal funding. I hope I can come before you and make a request for additional dollars since I brought in additional dollars and added complexity that warrants more staff

support. At this time, I am confident this not only builds efficiency, but we can do the job.

ASSEMBLYMAN HARDY:
This was an opportunity to look at this budget in a productive way. I understand the concept of looking at nursing homes and hospitals and deleting the duplication of effort.

MS. KEATING:
Budget Account 263-3212 is the Public Health Tobacco Fund.

HHS - Public Health Tobacco Fund – Budget Page HEALTH-51 (Volume II)
Budget Account 263-3212

This budget was created previously in A.B. No. 474 of the 70th Session which takes 10 percent of the tobacco settlement proceeds to the Trust Fund for Public Health (TFPH). The budget was built with a Base Budget. There are no enhancements. The budget will be funded if approved by the Legislature.

CHAIR COFFIN:
There are some bills pending on tobacco taxation. I would like to know more about the taxation issue.

CHAIR LESLIE:
The federal government has added a 60-cent tax to a pack of cigarettes. Research shows when you add tax to tobacco products, consumption declines. It is hard to say what is going to happen. Tobacco companies have increased their prices in advance of the upcoming tax. People are naturally upset. The group most price sensitive to tobacco tax increases is teenagers. The impact of less tobacco consumption on this budget will have to be decided. The problem is, the Public Health Trust Fund was depleted due to budget reductions.

MR. WHITLEY:
The funding source for this account is the interest from the settlement funds. It would not be impacted by increasing the tobacco tax. The funding is not primarily directed at tobacco prevention. It is compiled of a board of trustees who award funds for projects centered on wellness and prevention. As these funds disappear, the awards will be eliminated.

CHAIR COFFIN:
Who are the grantees?

MARY E. WHERRY, R.N., M.S. (Deputy Administrator, Health Division, Department of Health and Human Services):
There are several focus areas for the tobacco monies. One of the focus areas is the promotion of public health in programs for the prevention of disease or illness. Since 2001, 25 projects have been funded under that focus area for $1.7 million. There have been 13 projects funded on research related to public health for $1.4 million. There have been 20 projects funded for direct health care services to children and senior citizens for $1.3 million. We have a list of all the awardees given grant money since the inception of this program. We can forward that document to you.

CHAIR COFFIN:
What is the long-term future of this? We are running out of money.

MS. WHERRY:
They are all set to terminate June 30, 2009.

CHAIR COFFIN:
Has there been an add back submitted on this budget?

MR. WHITLEY:
No.

CHAIR COFFIN:
I think everyone knows what we did over the last nine months to take that money. We will go on to B/A 101-3218, Public Health Preparedness Program.

HHS - Public Health Preparedness Program – Budget Page HEALTH-92 (Volume II)
Budget Account 101-3218

MS. KEATING:
The Public Health Preparedness Program (PHPP) budget is funded for the preparation, management and mitigation in response to public health emergencies, primary health care planning, development of health care systems and combined health care planning. Included in this budget are 24 positions. This budget is federally funded by two primary grants. Decision unit E-226 eliminates a public service intern. Decision unit E-902 transfers three health program specialists and one health resource analyst from this budget to Consumer Health Protection. Decision unit E-903 requests transfer of one health program specialist from the Maternal Child Health Services (MCHS) to the PHPP budget to better align those activities. Decision unit E-904 requests transfer of the federal Primary Care Office from the MCHS to the PHPP. Decision unit E-905 transfers the State Systems Development Initiative (SSDI) from the MCHS to PHPP. Decision unit E-927 covers the consolidation of the accounting unit.

E-226 Eliminate Duplicate Effort – Page HEALTH-95

E-902 Transfers RAF from 3218 to BA 3194 – Page HEALTH-98

E-903 Transfers from 3222 to BA 3218 – Page HEALTH-98

E-904 Transfers 3222 PCO Program to BA 3218 – Page HEALTH-99

E-905 Transfers 3222 Federal SSDI to BA 3218 – Page HEALTH-100

E-927 Transfer Fiscal Staff to BA 3223 – Page HEALTH-100

CHAIR LESLIE:
In Decision unit E-903, there is a transfer of a health program specialist into the PHPP budget. Are the duties going to change in that position?

MR. WHITLEY:
The Office of Primary Care was placed in the MCHS which is the J-1 Visa program and other planning functions. The functions were already occurring in the MCHS. The transfer puts it in a like infrastructure.

CHAIR LESLIE:
How will the metabolic screening feature be maintained?

MR. WHITLEY:
It will be maintained programmatically within the MCHS. The collection and analysis of the data will be in Health Planning under the biostatistician. This is in line with the data warehouse concept: putting the data together to improve the way we tell the story of children born in our State and what the issues are. Instead of having a newborn metabolic screening fragmented at a program level, the newborn screening will be placed under the biostatistician.

CHAIR LESLIE:
I trust you and your organization have decided the best place for these positions.

ASSEMBLYMAN HARDY:
The metabolic screening used to be done in Oregon. We would draw the blood and send it to Oregon. Is that still the case?

MR. WHITLEY:
We have a budget item related to newborn screening. We have a contract with the state of Oregon. All of the screening done in Nevada is sent to Oregon's Health Science System. The metabolic follow-up is contracted and done by a physician in Utah who is associated with the Oregon Health Science System.

ASSEMBLYMAN HARDY:
I assume it is better economically to do it that way than keeping it in our State with our State laboratory in southern Nevada.

MR. WHITLEY:
We did a study on laboratory resources. We looked at the public dollars coming into the State and going out in a fragmented way. They all go to different places. Our Public Health Preparedness Grant has an earmark for laboratory capacity. The CDC suggested we look at the capacity they fund to determine if we could build our capacity in our State laboratory to do newborn screening in Nevada. Through the State laboratory director, we asked outside facilitators to come in and provide strategic planning on how we can keep our dollars in Nevada and do screening of children born in Nevada. This is important because it is the after care part that is fragmented further with the out-of-state specialists who come here. We have not built the capacity for the specialty services here. An example is the metabolic screening from an out-of-state physician. We are looking at this issue. The strategic planning is this month. The association for state laboratory directors is sending a facilitator who has done this in other states. We have the support of the CDC for realigning our investments with laboratory capacity funded from the CDC grant. Then we will not be funding laboratory equipment waiting for a public health emergency. It will be utilized routinely by doing laboratory tests that are a benefit to our State.

ASSEMBLYMAN HARDY:
I am interested in seeing if we can keep the technology and the people who do the technology in our State, within our borders, and use our money to enjoy that kind of elevation of our technology in the State.

CHAIR LESLIE:
In decision unit E-905, the SSDI is being moved from MCHS to PHPP. How is that more efficient?

MARIA CANFIELD, M.S. (Chief, Bureau of Child, Family, and Community Wellness, Health Division, Department of Health and Human Services):
The SSDI grant is funded by the U.S. Health Resources and Services Administration. It is a planning grant related to the MCHS block grant around the needs assessment function. It made sense to us that it should be located with the rest of the data analysis and data collection capacity within the Agency.

CHAIR LESLIE:
Do we have a problem with the reclassification of the management analyst to a health emergency preparedness evaluator? Will we need a class code change?

MR. WHITLEY:
No. There was an error in not communicating that. It stayed the same grade, but the title changed.

CHAIR LESLIE:
Please double check with our staff to make sure we all understand the title change.

CHAIR COFFIN:
Please tell us about the preparedness for pandemic influenza. This is the best budget to discuss it.

MR. WHITLEY:
This is the budget that received resources for a pandemic influenza plan. The plans are regionalized. The role of the State is to combine them into a systemic statewide plan. Updating is an ongoing process. We are preparing to respond; learning who are the vaccinators in our State; how equipped they are if we need to immunize; and how we would contain or isolate individuals or groups of individuals if needed. The plan is comprehensive at a community level. The funding comes from the State to the local health authorities. They develop a community-based plan. We can make those specific plans available if you would like more of a briefing on them. The resources are not dedicated to purchasing the antiviral medications. We have some stockpiled, but we do not have federal funding for all the activities in the plan. The federal grant funds the plan itself and the infrastructure supporting it. The grant does not fund the stockpiling of medications.

CHAIR COFFIN:
Do we have a grant funding this kind of preparedness material?

MR. WHITLEY:
This is a planning grant. When there were carryforward funds, the CDC approved the purchase of pharmaceuticals. The public health workforce purchased antiviral medications stockpiled in the State, but for residents in the State, there is no dedicated funding source to make that purchase. Part of the planning process is to work with business and industry in terms of what their role could be and how to protect their workforce.

CHAIR COFFIN:
I am still concerned. You showed me an audit from the CDC of our operations and it was mixed; good in some areas, but not so good in others. I do not know what our State is going to do if we have an emergency. I know you cannot create an antiviral mix which matches the influenza outbreak. You may feel the progress of the flu will be controlled or predictable, but you should prepare for the unexpected so the State can tell the public there is something to depend on.

LUANA J. RITCH, PH.D. (Chief, Bureau of Health Statistics, Planning, and Emergency Response, Health Division, Department of Health and Human Services):
The PHPP has received funds over the years from the CDC and from the assistant secretary for the Public Readiness and Preparedness Act which is under the federal Department of Health and Human Services (HHS). Included were specific funds targeted toward pandemic influenza preparedness. We have made progress. Some of the information provided to you included the fact that over a year ago the CDC assessed Nevada's readiness for bringing in the strategic national stockpile which would include vaccines, antivirals, ventilators and other things needed in a pandemic. In the past year, we increased the score from a 34 to an 84. In the next year we are anticipating we will have an assignee from the CDC to help Nevada improve even more. We recently added a public information officer to the PHPP realignment who will help with developing communication plans for the public, internal and external partners. We will know what we need to be communicating to the public, fitting the guidance we receive from our federal partners, particularly the CDC, on what actions Nevadans need to take to protect themselves. We are increasing our efforts to inform the public during the seasonal flu of actions to take. We are working together with multiagency, multilevel, local health departments and local health providers in helping us improve readiness across the State.

CHAIR COFFIN:
I think we need to keep telling people to prepare for themselves because we will not be able to do it for them. That could be the major function of your public information officer: sending the word out to the public before the first case breaks. If panic ensues and people try to buy masks they need, there may not be any left. I think masks should be stockpiled now.

ASSEMBLYMAN HARDY:
Did we say, "Get the flu shot"? It is interesting that some studies have shown about 44 percent fewer respiratory infections of any kind occur when you get the flu shot. There is something about heightening your immunity with the flu shot that may not "cross-react" antigenically. Yes, if you get the flu shot, you decrease your susceptibility to other infections as well. Usually, if you die from the flu, you also have another illness such as pneumonia or a secondary

infection. Your immunity is lessened when you are already sick. Get the flu shot.

CHAIR COFFIN:
We will now hear B/A 101-3235, Emergency Medical Services.

HHS - Emergency Medical Services – Budget Page HEALTH-150 (Volume II)
Budget Account 101-3235

MS. KEATING:
This budget is the Emergency Medical Services (EMS) program which is to promote and support a system of efficient and appropriate medical care, transportation and trauma care to people in Nevada. Included in this budget are 8.51 positions. The main decision unit in this budget is the medical marijuana program transfer from the Department of Agriculture to the Health Division. This budget is going to be included as a budget amendment to be filed tomorrow. It cleans up the transfer and will result in approximately $40,000 savings annually to the General Fund.

CHAIR COFFIN:
Why did the internal audit recommendation suggest this program transfer from the Department of Agriculture to the EMS?

MR. WHITLEY:
I do not think the internal audit made specific recommendations to the EMS. The recommendation was to the Health Division. The decision to place it with the EMS program was related to like activities. I do not have another program that is a consumer-based registry, other than in the EMS. They have a do not resuscitate registry that has some of the same functional requirements: an application; physician's note and an identification card issuance. It was placed in this program because of like activity, functionally and not topically, for efficiency of management.

CHAIR COFFIN:
Yesterday, the Attorney General of the United States, said the federal government will not interfere in the operations of medical marijuana dispensing if the state law permits it. What is your reaction to that?

MR. WHITLEY:
This program does not dispense marijuana. It simply issues the card to the consumer.

CHAIR COFFIN:
Do you anticipate any changes in demand? What do you foresee because of that?

MR. WHITLEY:
I do not project or foresee any change with the program as it has been transferred to us.

CHAIR LESLIE:
That was an interesting explanation you gave. Most people wonder what medical marijuana has to do with the EMS. Is it going to be a separate budget? I am unsure how we are going to account for this properly.

MS. KEATING:
What is envisioned in this budget is the payroll for the person who will actually be doing the work. It will be funded in this budget because this is the *Executive Budget*. All other expenditures related to the program sit in a nonexecutive budget. If this is approved, and the bill that transfers this is approved, the Budget Office, with the controller, would change B/A 101-4554 to the Division of Health and all activity would take place in that budget account for all costs, excluding the cost of the payroll.

AGRI, Administration – Budget Page AGRICULTURE-1 (Volume II)
Budget Account 101-4554

CHAIR COFFIN:
We will go to B/A 101-3204, Office of Minority Health.

HHS - Office of Minority Health – Budget Page HEALTH-38 (Volume II)
Budget Account 101-3204

MS. KEATING:
The purpose of this Office is to ensure the quality of health-care services, access to health-care service and to disseminate information regarding matters concerning health-care issues of interest to minority groups. This budget is 2.51 positions and has no significant decision units.

ASSEMBLYMAN ARBERRY:
Was this Office recommended to be eliminated?

MS. KEATING:
There was nothing in the agency request or in this budget eliminating it.

MR. WHITLEY:
Our agency is reliant on federal and fee funds. Because the programs are not equal, the approach we took was to make reductions equitably on those programs that make up the General Fund. If it was evident we needed additional reductions, this program would have been impacted by the need to make reductions in the General Fund. That did not occur.

SENATOR MATHEWS:
I notice that you are getting statistics on health. Are you looking at sexually transmitted diseases (STDs) – the obvious kinds of things?

MR. WHITLEY:
Most of our categorical programs that come from the CDC are not only in a category but sometimes refer to body parts: breast and cervical cancer programs, diabetes programs, etc. They do not look at the whole person, let alone racial or ethnic minorities. A benefit of the Office of Minority Health is to actually pull the thread across our categorical programs to have a better

understanding of what other programs are doing. If the case is not made, dollars are not invested in actual strategies or interventions for outreach.

SENATOR MATHEWS:
How does this get to the Committee?

MR. WHITLEY:
It has an advisory committee that is appointed. The representation on that board and the public forums are one vehicle. The other is the commitment to imbed that information back into those categorical programs. We have had success in bringing some additional funds in programs like the HIV Prevention Program when the case was made that minorities are disproportionately affected. We could analyze the data and see where outreach could be focused.

SENATOR MATHEWS:
I have been a minority for 75 years. I have never received one piece of information on it.

CHAIR COFFIN:
We will move to B/A 101-3208, the Early Intervention Services.

HHS - Early Intervention Services – Budget Page HEALTH-43 (Volume II)
Budget Account 101-3208

MS. KEATING:
This budget identifies infant and toddlers at risk for developmental delays. Included in this budget are items that are significant. The first one is decision unit M-200. That decision unit includes an appropriation from the General Fund of $920,000 the first year and $1.8 million in the second year of the biennium. That is to fund the growth that is anticipated.

M-200 Demographics/Caseload Changes – Page HEALTH-45

The second decision unit is M-201 which also is an appropriation from the General Fund of over $2.8 million the first year and $4.8 million in the second year of the biennium. This funds the wait list which is a result of the growth and budgets.

M-201 Demographics/Caseload Changes – Page HEALTH-45

Decision unit E-605 is the only budget cut. It eliminates a health program manager in Reno. That position is vacant.

E-605 Budget Reductions – Page HEALTH-47

CHAIR COFFIN:
What is being solved by this increase in the budget?

MS. WHERRY:
The two decision units, M-200 and M-201, are to address the existing wait list. We currently have 507 children waiting for services. It will also address the caseload growth we are anticipating. The number of referrals we are getting to

this program is continuing to grow. We do not see business slowing down because of the changing economy. There may be more demand since people may lose their health insurance. That is the driver of the funding.

CHAIR COFFIN:
Where, geographically, will you be spending the money?

MS. WHERRY:
The plan for this budget is not to continue to grow State government to maintain the base that we have but to grow access out into the community. Our goal is to pass this money out to community partners. For example, we have two community partners: Easter Seals of Southern Nevada and the REM Nevada, Inc. They are both located in Las Vegas and have the potential of expanding to northern Nevada. We have an interested party in the north and another in the south but have not had the funding to continue to grow access. Our goal is to use these funds to act more expeditiously. The private sector could be more responsive to hiring personnel and competing in the marketplace if government can. We are not planning, at this time, to have community partners in the rural areas. They are stable in their operations and their caseload growth.

CHAIR LESLIE:
I understand that southern Nevada has had the biggest problem over the years in terms of the waiting list and time frames. This is one of the few areas in the budget where the Governor has included a major increase. Does the north not have a waiting list? Are all the problems solved in northern Nevada?

MS. WHERRY:
The north has a small waiting list. This money is not all dedicated to southern Nevada.

CHAIR LESLIE:
Is there a caseload growth in northern Nevada?

MS. KEATING:
I think what may be driving that assumption is the money we currently spend for aid to the community partners is in Las Vegas. Those are the general ledgers we used in our decision unit, but do not assume the money is only going to Las Vegas.

CHAIR LESLIE:
Let me read what our staff analyst says and tell me if this is incorrect: "All the enhanced funding would be for waiting lists and caseload growth in southern Nevada. There is no funding being designated for northern Nevada in these enhancements."

Is that correct?

MS. KEATING:
I believe you can make that assumption from the data we provided on the caseload. Our commitment is to address the waiting list no matter where it is in the State.

CHAIR LESLIE:
We need to somehow see that reflected in the budget.

MR. WHITLEY:
That information is not correct. It is intended statewide. If there are private partners in the north, we would like to engage them as well. The dollars will follow the need. If that has been misstated in how we built the budget, we need to clarify that.

CHAIR LESLIE:
Are you saying that since there are no private providers in the north, none of the money can be used there?

MR. WHITLEY:
I think the misunderstanding is with the intent to grow capacity with private partners, and currently there are no private partners in northern Nevada.

CHAIR LESLIE:
My concern would be to serve the children whether it is private providers or the State. I do not have a bias against the State employees providing services. I know it has been hard to find the right kinds of services in the past. With the present economy, maybe that is changing. A State employee can provide good service as well as a private provider. I am uncomfortable if that is where this is going – that this money is only for private providers.

MR. WHITLEY:
The category of the contractual would be one that the State could use as well. Most of our licensed clinicians are working with us in our clinic as contractors. This would allow us to also bring those clinicians onto the State Early Intervention Services (EIS). We built our budget in the contractual column. The purchasing-approved organization is called AccuStaff. In our State, we currently operate early intervention, and utilize most of our licensed clinical staff through that vehicle. This allows us to enhance State service and to grow that capacity with the community provider, should there be one interested.

CHAIR LESLIE:
Can you reproject this to show where you will likely spend the funding in both areas of the State so we can be reassured the children are going to be served? Also, we need some kind of statement that State employees can be used if it is the best service for the child.

MR. WHITLEY:
Yes, we can do that.

CHAIR COFFIN:
Thank you, Chair Leslie, for drawing out those answers. I am surprised there is not a private organization wanting to dispense these services in northern Nevada.

MR. WHITLEY:
There is an organization, the Continuum, in the north who made a request for funding.

MS. WHERRY:
We have a wait list of about 400 children in southern Nevada and over 100 in the north. That is our intent. We have a request for information on the streets with expectations of hearing from people by the end of this month. The goal is to see who is out there; what kind of service they think the State should be operating; what the partnership between the State government and the private sector should be; and what their interest is in providing services north, south and statewide. We will be holding public hearings in the north and south with regard to the information we receive.

CHAIR COFFIN:
Are these the children who have been waiting more than 30 days?

MS. WHERRY:
Yes, all children coming into the program must have an Individualized Family Service Plan (IFSP) and then they wait for services.

CHAIR COFFIN:
I think our staff has derived, from the data you sent, you are doing a good job of getting the services to the children with the IFSP.

ASSEMBLYMAN ARBERRY:
I see where you have $3.9 million in the American Recovery and Reinvestment Act of 2009 (ARRA) funds available for the EIS. Will the Budget Division be submitting an amendment to offset some of the General Fund?

MS. WHERRY:
The federal government and the ARRA have provided a little information on the Part B program of Individuals with Disabilities Education Act (IDEA) and some information of Part C. Our understanding is our State would be receiving $3.9 million. That is to be split in half. We hope to hear, in the next week or two, about whether we will get the first 50 percent this fiscal year, as soon as April. The goal would be to move that money out as quickly as possible, to release General Fund monies for FY 2010-2011 and to serve children right away with the monies when they come in. The rest of the monies would be allocated in October 2009 according to what we are hearing if the Part C program follows the Part B program. All of the dollars from the ARRA must be spent by December 2011. We would be recommending the release of the $3.9 million in the General Fund and replacing it with the ARRA money.

ASSEMBLYMAN ARBERRY:
Do you think you might have some before July 1?

MS. WHERRY:
That is the hope. We had to make caseload and rate reductions to our community partners. The faster we can rebuild their caseload, the better off they will be in the economy scale issue with the budget reductions.

CHAIR COFFIN:
You must have people who can help children get off these waiting lists. It must be tough recruiting if you have to compete with the school districts. What does

a person make in the developmental specialist area? That might be the kind of person who can help them get off the wait list.

MR. WHITLEY:
It is not an individual discipline. The developmental specialist is a discipline, but it is the array of specialty clinicians like audiologists and physical therapists. We have not been able to recruit and retain, through State employment, those therapy specialists. Beyond that, the community also has the same challenge; it is a capacity issue for having those clinical types in our State. They are highly competitive in the public and the private sector. There is no single discipline. It is a treatment team approach and that makes it more complex.

CHAIR COFFIN:
Is our university system turning out enough people to do this, or are we short in programs there?

MR. WHITLEY:
Most of our developmental specialists come from the University of Nevada, Reno or the University of Nevada, Las Vegas. We do not produce enough specialty services for physical and occupational therapy, and then we do not compete well enough to hire and retain them.

CHAIR COFFIN:
What is the difference in salaries between what we offer and what they get paid elsewhere?

MS. WHERRY:
We are paying, through AccuStaff, probably on average $55 an hour, including the small contract fee for the AccuStaff administration for the average therapist. We do not have a class concept for the physical and occupational therapists. For dieticians, we pay $33 an hour and the going rate in the rural areas is more like $50 to $55 an hour. There is no way we can compete when there is that kind of spread. For AccuStaff contractors we pay $55 an hour for therapists because we cannot recruit them in a State concept or a State salary.

CHAIR COFFIN:
AccuStaff has to take a cut. What do you think the therapist's share is? Does the provider net that $55 or is it shared in some way?

MS. WHERRY:
The direct therapist nets probably 90 to 95 percent of that. There is an administrative fee. There are two types of contracts with AccuStaff. One is an independent contractor and one is an actual employee. There is a difference between what the net is, based on the employee getting a W-2 form and having taxes taken out of his check, or the independent contractor getting a 1099 form and paying his own taxes.

CHAIR COFFIN:
We can move on to another point in the same budget.

CHAIR LESLIE:
Can you comment on the effect of the ARRA on this budget?

MS. WHERRY:
We expect to get $3.9 million. If we get 50 percent of the money in April, we will start to roll it out as soon as we can. We would then offset the balance of what we have from ARRA in the FY 2010-2011 budget during that funding period. We expect the final 50 percent of the money by October 2009.

CHAIR LESLIE:
Will there be a budget amendment that outlines this for us?

MS. KEATING:
We will work through the Director's Office and the Budget Office to make sure the proper budget amendments are offered.

CHAIR LESLIE:
The problem is our timeline. We understand you have yours, but we have ours. We have a Work Session on this budget next week. We have to have it.

MS. WHERRY:
We have been on every conference call possible. The Part C staff has an Office of Disability Service (ODS) budget. Every call they have been on has been pressure for them to come out with the information. Part B is a bigger budget at the federal level than Part C. We are assuming they will follow the same timeline. They gave a projection to the Part C staff of about two weeks before we would have final declaration about how they are planning to roll that out.

CHAIR LESLIE:
We are going to ask you to work with us because we cannot wait. We will have to work with whatever information you have.

MS. WHERRY:
The dollar amount has been the one constant and the 50 percent is the one constant. If there is some rollout in this fiscal year and the remainder in the next fiscal year, at least we will have some constants.

CHAIR LESLIE:
It sounds like you are planning on spending some of that in the year we are in. We really need to know what you are spending this year and what you are projecting for the next two years so we will have the right amount.

CHAIR COFFIN:
Will you address the issue of folding of the EIS into the larger agency? How will it fit? How will it keep its identity?

MR. WHITLEY:
In November 2007, the Part C office, the oversight that receives the federal funding, was moved to the ODS. This occurred because the oversight authority was residing with the direct services and enmeshed with them. The appearance to private partners was that we had the oversight embedded with the direct services with the State direct service program. The move to the ODS more clearly distinguished the role of oversight. When we restructured our fiscal unit in administration for efficiency, it removed additional staff from the

administrative office for Part C. That left the bureau chief and two support staff who administratively made up the oversight for the bureau.

Many challenges we have had were local ones in terms of building capacity. The issues in southern Nevada and northern Nevada are unique. The available partners, the university system and the assets that exist are different regionally. Having the program operationalized more at a community level than from Carson City made more programmatic sense. This was all going on when we had budget reductions occurring. My approach was to cut from the top down, not from the bottom up, in terms of direct service provision; to look at economy in terms of management, not in terms of reducing direct services. By eliminating the Carson City office and placing the management level at the community level, there were both efficiencies and economies by not needing to replicate administration. The manager at the local site is a one grade, 5-percent lower than the bureau chief. The bureau chief was relocated to cover the northern part of the State. The position was eliminated in lieu of eliminating direct services. We are in the process now of having both positions, in the north and the south, reviewed by the State Department of Personnel for appropriateness of classification.

CHAIR COFFIN:
That was good. I was going to ask you if there is a dilution on direct services by having different staff.

MR. WHITLEY:
I think it is strengthened because it is hard to build partnerships remotely. Anchoring the clinic site and bringing the partners to that clinic site strengthens the system.

CHAIR LESLIE:
Is the vacant position you mentioned the health program manager III? You are moving the bureau chief into that position in Reno to essentially perform those functions. Is that what you are saying?

MR. WHITLEY:
The bureau chief has assumed those functions. There is a program manager in Las Vegas. Both positions were vacant. The one in Las Vegas was filled, and we eliminated the one in the north. We will have the Department of Personnel review those functions to determine the actual classification. I have added some duties to both positions in terms of the responsibility for building those community partnerships. The person in the south may actually have more complex duties and be viewed as a bureau chief. That is the Department of Personnel's determination.

CHAIR LESLIE:
I was concerned to see that vacant position eliminated, but this seems like a reasonable approach.

CHAIR COFFIN:
It looks like an $800,000 a year reduction to the community partners in the biennium. Are services going to be reduced?

MS. KEATING:
It is not intended for services to be reduced. It would be integrated through the cost of the Division throughout the year. Those are dollars needed to cover the cost-allocation issue going on in this budget.

CHAIR LESLIE:
Our information is the enhancements are related to about $658 per child per month. We are billing Medicaid $509 a month. We have heard there are some community partners who think that is too low and they might have to stop providing services. Is that accurate?

MS. WHERRY:
One of the challenges we had with our prior reimbursement methodology to the community partners was we rolled all of our costs for B/A 101-3208 into the map. Not all of the costs are borne by the community partners. We employ 1.5-time physicians in Las Vegas and a 32-hour AccuStaff physician in the north. They may have to provide some medical services because of an IFSP, and that is close to $500,000 between all of those physicians and their benefits. We backed out those costs that are unique to the State and recalculated a more appropriate rate based on the true cost of delivering the IFSP host of services according to the Part C rules and regulations.

CHAIR LESLIE:
Have you had that discussion with the community partners so they understand that?

MS. WHERRY:
We engaged them throughout the whole process. We are very transparent. We shared all of our documents and all of our budget details so they could understand and see for themselves exactly where our costs are allocated and how we have to account for them.

CHAIR LESLIE:
The Part C compliance staff moved to the Department of Health and Human Services (DHHS) last Session because we wanted to keep that separate. Now it looks like both the Part C compliance staff and the direct services staff have to ask for the grant. The manner in which people are accessing the Part C money appears awkward to our fiscal staff. Is that really how we want to do it?

MR. WHITLEY:
The IDEA Part C office is the grantee. They make the award to us. The U.S. Department of Education who oversees IDEA Part C would only award the grant to one entity.

CHAIR LESLIE:
Can you meet with our fiscal staff and discuss this? This is a technical issue about how the money comes into the State system. It just looks odd.

MR. WHITLEY:
Yes, we can meet and discuss this.

CHAIR COFFIN:
We will move to B/A 101-3213, Immunization Program.

HHS - Immunization Program – Budget Page HEALTH-55 (Volume II)
Budget Account 101-3213

MS. KEATING:
Budget account 101-3213 is our immunization program which works with State and county health agencies to provide the medical and to the private communities to promote immunization among infant children and adults. Included in this budget is funding for approximately ten positions. There is one decision unit I want to point out that is in this budget uniquely, M-101, which is the inflationary adjustment for medications. We have followed the same 5.7-percent rate that you have seen from other divisions within the DHHS. We have no other significant items to promote in this budget.

M-101 Inflation - Agency Specific – Page HEALTH-57

MR. WHITLEY:
The immunization program is a focus on vaccine for children. The CDC does an annual survey of states to find out what their rates are. Nevada has historically ranked as the worst for children 19 to 35 months old. We had a site visit this week from the CDC. This year, Nevada has moved up from 50th to 46th in the rankings for our immunization rates. It is not a lot, but it is movement in the right direction. A lot of this has to do with our immunization registry because the way the survey is conducted, the CDC phones households in our State and asks the parents if their child has been immunized and to produce their record. They then contact the physician to verify whether or not the child was immunized. If the parent does not have the record, they are counted as nonimmunized. Our belief is with the portability of children moving from provider to provider, we have not done a good job of keeping the records. We may be better immunized than what the survey has historically shown. We cannot say children are not immunized because we do not have the data for that. This recent survey shows progress, whether it is attributed to the registry, or we are immunizing more children. The fact is we have shown improvement.

CHAIR LESLIE:
I know we had to take back some of the funding we had given you to continue with the immunization registry plan. What progress still needs to be made?

MS. WHERRY:
We have enrolled our 600th provider. We anticipate there are approximately another 1,200 providers or provider sites out there for us to reach out to and enroll. We still have a lot of work ahead of us. We believe we are on the right path. We are working closely with the CDC and their partners to determine how we can create a better seamless system between the Southern Nevada Health District, where the lion’s share of these children are, and the rest of the State. We think we will be able to continue to reach out to them.

CHAIR LESLIE:
Does the budget reinstate some money so the program officer I position can come back? Last Session we set aside some money for half-time positions in the counties. It looks like they declined those positions. Why was that?

MR. WHITLEY:
Correct. Part of it is the reliability of the funding. They have the same challenge as we do. If they commit to taking resources and create a new position, they want some guarantee that it will continue. The State has taken on that role. It has worked out well. We did not have staff in southern Nevada previously. That has added a new element and a presence for the immunization program.

CHAIR LESLIE:
We got rid of the universal select and we do not need to get into a long policy discussion on that, but is it clear to the public where the federal immunization funds go? Is there a document somewhere? I hear there is some confusion about that.

MR. WHITLEY:
On our Website, we have a document summarizing childhood immunizations. It has a fund map of the resources that fund vaccine for children. All children have a pay source for vaccine. The federal entitlement program assures that as a safety net. Often the public, and sometimes the provider, does not know where the vaccine is coming from. When we did community forums to speak of this transition from providers, the issue was not so much the Federal Vaccine for Children program, but reimbursement from health plans for the vaccine. Our coalitions in the State have done a great job educating providers about negotiation of their contracts and how to maximize billing to get reimbursed. Sometimes, if you are the only one holding a forum, you become the vehicle for all the issues that have been bottled up. We found that with immunization. There was a lot of frustration. It is complex because the pay sources are different. I think it is good that a parent does not know who pays for their child's vaccine, but even if they are underinsured, they get the vaccine.

CHAIR LESLIE:
It is not the parents I hear from. It is more the doctors and the health care providers who still are confused about where the money is going. We will talk about that later.

CHAIR COFFIN:
I am glad you brought up the issue of progress. I am happy to hear we have moved up in the ratings. Can we sustain that with the General Fund decrease of 30 percent?

MS. KEATING:
The only decision units in this budget related to budget decreases are the traditional E-670s. I do not know about the 30 percent.

CHAIR COFFIN:
I am looking at the amount of the General Fund that could be spent. We now have a reduction in General Fund support. Can we keep it going?

MR. WHITLEY:
Yes, we can keep it going. We have the commitment from the CDC. They are the bulk of the resource invested in the registry. They will continue that. It is a national agenda to immunize children. We are committed to it as an agency and I do not believe the General Fund impact will negatively affect the immunization rates.

CHAIR COFFIN:
We have been putting nearly one-half of the money in from the General Fund; about half of what the CDC was sending us.

MR. WHITLEY:
That is actually for the vaccine itself.

CHAIR COFFIN:
We will move to B/A 101-3214, WIC Food Supplement.

HHS - WIC Food Supplement – Budget Page HEALTH-62 (Volume II)
Budget Account 101-3214

MS. KEATING:
This budget provides nutritional foods to supplement the diets of limited income, pregnant, postpartum and breast-feeding women and their children. Included in this totally federally funded budget are several decision units. Decision unit E-225 eliminates four administrative assistants due to the Division's centralization and reorganization.

E-225 Eliminate Duplicate Effort – Page HEALTH-65

Decision unit E-906 transfers from the MCHS one family services specialist from B/A 101-3222 to B/A 101-3214, to gain efficiencies through centralization and reorganization.

E-906 Transfer from 3222 to B/A 3214 – Page HEALTH-67

The last decision unit is E-924 which is part of the accounting consolidation.

E-924 Transfer to 3223 – Page HEALTH-67

CHAIR COFFIN:
We feel your projections are too low. Do you agree?

MS. KEATING:
Yes. However, this budget was prepared in accordance with the way it has been prepared historically. The traditional module M-200 that you are referring to is something we never did in the previous two Sessions.

M-200 Demographics/Caseload Changes – Page HEALTH-45

As the projections increase, we consistently prepare work programs to bring to the Interim Finance Committee (IFC) to enhance this program.

CHAIR COFFIN:
What are the most recent projections?

MS. KEATING:
The most recent projections are done in December which, if looking at them today, would probably be adjusted again. It is about $1.5 million to just under $1.6 million each year that we would want in additional funds and provide as aid to the individuals.

CHAIR COFFIN:
Can you translate that to participants at the end of this fiscal year and then at the end of the next fiscal year?

MS. WHERRY:
We anticipate a 9-percent increase in caseload for 2009 over 2008 for about 775,000 recipients served; for 2010 we anticipate 813,750; for 2011 we anticipate 854,500. That is a 5-percent growth rate each year. The federal government's entitlement to us is based on the prior year. All states will be struggling with this. The ARRA funds for the Women, Infants and Children (WIC) is only dedicated to electronic system improvements. The federal government provides a prioritization of persons eligible for the WIC services should we have to go to that extent to control our caseload growth.

CHAIR COFFIN:
Our data shows that 20 percent of the funds is for information management. Another 80 percent is going for benefits. Is that possible since $500 million has been granted to all the states?

MS. WHERRY:
All the discussions our WIC staff has had with the federal government have indicated it is to enhance the Electronic Data Transfer Systems.

CHAIR COFFIN:
We need to get that clarified. Please communicate with our staff on that.

CHAIR LESLIE:
Is it your feeling we will be able to serve everybody who qualifies for the WIC?

MS. WHERRY:
We are not projecting that we cannot serve everybody. We are not employing any kind of immediate exercise to start to set limits on new enrollees with regard to the federal prioritization. We are monitoring this closely. If we get to that point, the first group affected would be the breast-feeding women, infants and postpartum women. Not knowing how long this economic downturn will continue, it is difficult to project if or when that will happen.

CHAIR COFFIN:
We will go to B/A 101-3215, Communicable Diseases.

HHS – Communicable Diseases – Budget Page HEALTH-70 (Volume II)
Budget Account 101-3215

MS. KEATING:
The mission of the STD program is to work with local health authorities and the general public to prevent and control the STDs in Nevada. Included in this budget is the specific inflation factor for medications of 5.7 percent. That is in decision unit M-101. In decision unit E-225, we also have some efficiencies that we discovered which eliminate two administrative assistants III and one management assistant II. We have the traditional replacement equipment and some transfers. This is the transfer of the bureau chief from Community Health Services budget to this budget. The last decision unit is E-225 which is the transfer related to the consolidation of the accounting unit.

M-101 Inflation - Agency Specific – Page HEALTH-72

E-225 Eliminate Duplicate Effort – Page HEALTH-73

CHAIR COFFIN:
Communicable disease has a broader meaning than sexually transmitted but why the name change? This is still focused on sexually transmitted diseases.

MR. WHITLEY:
Not all communicable diseases are sexually transmitted and there is stigma attached to that title. People might become infected with Human Immunodeficiency Virus (HIV) or hepatitis through other means than sexual transmission. I think it is an artifact of decades of calling it STD.

CHAIR COFFIN:
What is the caseload growth here? What are the reasons for the growth?

MR. WHITLEY:
We are seeing an increase in enrollment in the program and it is mostly as a result of the economy, people either losing their jobs or becoming financially eligible. The eligibility for the Acquired Immunodeficiency Syndrome (AIDS) drug assistance program is 400 percent of the poverty level. This program is a payer of last resort; a safety net. People who access it cannot have health insurance or be eligible for Medicaid or Medicare. It helps people who have no access to other medications. We are seeing more of these people; people between 200 and 400 percent of the poverty level who are working, but cannot pay for their medication.

We had a Letter of Intent from last Session that if we reached a waiting list, we should go back and look at prioritizing; reducing the poverty level or removing medications. If we get to that point I would want to come before the IFC or this Committee to revisit that. With the economy change, we would send the wrong message, to people who are working and need their medication, to stop working to become eligible for this program. I think that is a factor that was not occurring when we were facing a waiting list in previous Sessions. The environment is different and the profile of the consumer we are seeing is different.

CHAIR COFFIN:
Can you tell how much of the caseload growth is due to employment problems versus spread of the disease?

MR. WHITLEY:
Most of the people we are seeing are not newly diagnosed. They are people living with HIV. We collect eligibility. It would be interesting and worth our while to collect a bit more information. I am reporting anecdotally in terms of the experiences people report, but factually, we see an increase in the people who fall between the 200 to 400 percent of poverty.

CHAIR COFFIN:
You are counting on some pharmaceutical rebates to a great extent to find the medications for this. Do you feel you can rely on them for the next two years?

MR. WHITLEY:
It is an opportunity, and we have to explore fully and aggressively. It is another funding source that goes to supporting this program. Our Notice of Grant award has not yet been received. The funding begins in April. We do not know if we will have an increase, a decrease or what the level of funding will be. We anticipate level funding. With all of the funding sources, we aggressively try to get as much as we can. None of them are reliable.

CHAIR COFFIN:
You have listed your anticipated funding, but you said you do not know if you will get an increase. There is a contradiction there.

MR. WHITLEY:
The Ryan White Care Act (RWCA) awards funds to the State in a Base Grant and an earmark for medication. If we are reaching a waiting list for medications, we can use the Base Grant to support the pharmaceuticals or the medications. We have been doing that, seeing the State's role as being the only receiver of the RWCA funds to purchase medications statewide. It is our priority to do that.

We have been able to fund the support services in southern and northern Nevada, but there are other funding sources from the RWCA that go directly to the area. For example, in Clark County $3.3 million out of the RWCA part A go directly to Las Vegas as an eligible metropolitan area. Northern Nevada does not get an earmark like that. The funds that go to those communities are there to provide the support services. The State's role is the medication piece. To stave off a waiting list, we should continue to embrace the State's role as the assurer of medication coverage. We might be placing more funding from the Base Grant into the medication as needed. We have tried to work with our community partners, although they are all being eliminated from various fiscal sources. If we commit to something in the service and those funds are not utilized, we put that carryover back into medication.

CHAIR LESLIE:
On that point, I understand. The community provider in southern Nevada was upset because they felt the money was removed quickly. They may not have had all that information. I think you said we might use that money. Has the decision been made to remove the Part B money?

MR. WHITLEY:
Yes. There are three organizations in southern Nevada receiving support service funding. In the contract there is a 30-day notice. Depending on what our Notice

of Grant award is, I want to make sure that we have noticed them. Sometimes we get a Notice of Grant award after the grant period begins. I have had a request from the people who have been contacted and want to meet you and I am committed to that. All of these programs have to work together to really support the consumer.

CHAIR LESLIE:
No one has worked harder on this issue in this State than you to make sure there is not a waiting list. That is my main concern. It is like a death sentence to have a waiting list for life-saving medication. On the caseload, I am still not clear how you projected the enrollment growth of 16 percent would happen. Is there a formula you are using? What is that based on?

MS. WHERRY:
Our staff met with the economist that DHHS was able to hire this past year to look at all the economic indicators with regard to our caseload. Those projections have been modified based on having that resource available to us.

CHAIR LESLIE:
Economic indicators certainly play into this, but this is more complicated than that.

MS. WHERRY:
It is more than just that. The economist looks at all the historical experiences in the program and what is happening with those trends. That is why we have adjusted.

CHAIR LESLIE:
Do you have some analyses you can provide to our staff to see what the economist projected, to review it and make sure we understand it? This is an important point and we want to make sure we get it as accurate as possible.

MS. WHERRY:
Yes. We also have this relationship contract with Catalyst Rx which is one of the reasons why we have a higher confidence level in our ability to collect the rebate revenue. We have better reporting and data now to merely focus on the specific drugs that were given and not just the recipients who would use drugs.

CHAIR LESLIE:
Do you have a number for us as to how much General Fund you are expecting we will have to use for medications?

MS. KEATING:
We are working with your staff on doing the fund amount. You will be able to see that and we will work with them for that.

CHAIR LESLIE:
Thank you for all your hard work on this program. As you know, it is really important to people.

CHAIR COFFIN:
We will now go to B/A 101-3220, Chronic Disease.

HHS – Chronic Disease – Budget Page HEALTH-103 (Volume II)
Budget Account 101-3220

MS. KEATING:
The mission of this program is to identify risk factors, develop strategies and objectives to aid in the implementation and control of chronic diseases in Nevada. The Base Budget includes funding for 24 positions. Decision unit E-225 is the elimination of two positions: the Women's Health Connection program manager and a management analyst II.

E-225 Eliminate Duplicate Effort – Page HEALTH-106

CHAIR LESLIE:
There are not any major issues. Are there any questions from the Committee?

We can go ahead and move to B/A 101-3222, Maternal Child Health Services.

HHS - Maternal Child Health Services – Budget Page HEALTH-111 (Volume II)
Budget Account 101-3222

MS. KEATING:
Decision unit E-600 is just a mathematical reduction to meet the budget targets.

E-600 Budget Reductions – Page HEALTH-116

CHAIR LESLIE:
Are we limiting sub-grants to the nonprofit organizations through this budget production? What is the impact?

MS. KEATING:
We have entered a generic general ledger to make that work. It would be the program's desire to maximize those dollars as much as we can. We did not specifically want to identify a certain entity or group that would be reduced, but this was to meet the budget reductions.

CHAIR LESLIE:
I understand that, but our job is to understand how that translates into the community. Who is not getting a grant?

MS. WHERRY:
There are many drivers to how we are looking at the contractors we have been working with in this program for the last 20 years. We spent a lot of money on the children with special health-care needs. That program is for children who have no other funding stream who meet one of the regulatory disease definitions. We pay up to $10,000 of their medical expenses. That program has been a big challenge for the MCHS area because the demand continues to increase and we continue to try to meet it. We are looking at what the most important program areas are. We are working with the MCHS advisory board when we can. We are looking at the genetics clinic; we would continue to fund using the United Health money to fund the Fetal Alcohol Spectrum Disorder (FASD) clinics, but we have had the genetic clinic's dollars go into that clinic for 20 years. We have to consider the priorities. A small volume of children are

being served. There may be other resources in the community for that. We cancelled the genetics clinic's portion of the contract and we are trying to negotiate with the FASD portion of that contract. However, they do not want to be obligated to claim all third-party payers. We believe we need to collect as much revenue as possible for any child who has been seen so we can turn around and use that revenue to serve more children.

CHAIR LESLIE:
What about decision unit E-906? It seems there is a position that is being changed.

E-906 Transfers from 3222 to B/A 3214 – Page HEALTH-120

MR. WHITLEY:
This is a functional reorganization with locating the activity closest to where the services are provided. The manager of the WIC has cleaned up the fiscal and oversight management of that program. We have had some criticism on the programmatic side; breast-feeding, for example. We do well with initiating but not with continuing breast-feeding. The U.S. Department of Agriculture (USDA) would like to see us enhance and imbed more programmatic activities. The WIC program is different than some of the other USDA funded commodities like the food bank and school and senior meals. It has a huge opportunity for capturing children who may be at risk. Moving this position and the function, which was already working with that program, into the program itself frees up the funding for direct services in the MCHS.

CHAIR LESLIE:
I have a question on the MCHS block grant. It seems that there has been a significant decrease in the budget across all the Health Division budgets. We have some concern and we do not understand why. We are wondering if there is a fund map error. Where is the money going? It looks different this year.

MS. KEATING:
We have committed to work with your staff to finish up the fund map because we agree there is a shortfall on paper where we believe we will get the grant. Money not reflected here may actually be available.

CHAIR LESLIE:
Senator Coffin was inquiring about our discussion on the University genetics clinic. Maybe you could give us a brief, written summary of what that situation is for us to discuss it in greater detail. We do not want to see those services lost. You brought up a good issue that needs to be worked out. They have to maximize all available funding.

CHAIR COFFIN:
We will now go to B/A 101-3224, Community Health Services.

HHS - Community Health Services – Budget Page HEALTH-137 (Volume II)
Budget Account 101-3224

MS. KEATING:
This budget provides public health nursing in the community. Included in this budget are several decision units we can discuss. Decision unit E-225 eliminates five positions as a result of the Division's reorganization.
E-225 Eliminate Duplicate Effort – Page HEALTH-141

Decision unit E-250 is an additional requirement that we need to provide funding for practice oversight for the advanced practice nurses we employ.

E-250 Working Environment and Wage – Page HEALTH-142

The last one is the transfer which is part of the reorganization of the Division. This transfers the health bureau chief from Community Health Services to the Communicable Disease Program. It is just for the consolidated accounting unit.

CHAIR COFFIN:
These positions are vacant now. How long have they been vacant? This is rural Nevada. We need to find out because if you include Carson City as a rural you are saying all five come from rural Nevada. If not, Elko, Pershing, Lyon and Humboldt are losing community health nurses. What is left in those areas?

MR. WHITLEY:
I am told they have been vacant for three years. Nevada is unique. Most states have local health departments or districts in every county. We administer programs in the urban areas and direct serve in the rural areas. The nursing program really is that public health arm in the rural frontier area, much like Southern Nevada Health District, Washoe County District Health Department or Carson City Health Department. We have the added challenge of recruiting nurses and the funding sources that support them. We have traveling nurses. We cover all areas of the State. We have satellite clinics through a partnership with the counties. They provide the office space and also contribute resource. We go to the county commissioner meetings. They stay involved with us if we are having trouble recruiting. Each county is different because the needs are different. We have been flexible with that community in terms of the services we provide whether it is immunizations or family planning.

CHAIR COFFIN:
What are the counties contributing to this?

MR. WHITLEY:
It is not a standard formula, and it is not statutorily required. They contribute staff with the clerical support to the clinic; they supply office space; and some supply funding.

MS. WHERRY:
We sent a report to you on February 23, 2009. It is a standing report that we have because of a Letter of Intent from last Session. On the last page of that report, we show what the county participation is for State FYs 2006-2007, 2007-2008 and 2008-2009, broken out by county and school district.

CHAIR COFFIN:
Is any county not contributing to this?

MS. WHERRY:
Some counties are only contributing about $4,000. Other counties may contribute as much as $110,000.

CHAIR COFFIN:
Are counties contributing what they can afford?

MS. WHERRY:
Yes. Humboldt County, for example, is the largest with $110,000.

CHAIR COFFIN:
How about Elko County?

MR. WHITLEY:
A few years ago, Elko County approached us and asked if we would deliver a new service model. They qualified for a federally qualified health center. Nevada Health Centers (NHC) opened a primary care clinic serving the same population we were serving. We now sub-grant to the NHC. The county puts their funding into the NHC. Where we provide just preventive care, the NHC provides primary care. That is an example of doing business differently in a community that wanted something different.

CHAIR COFFIN:
That is a good explanation. We do not have any great exceptions in our staff's analysis. This is the end of the Committee's work on the budgets. This Committee is finished hearing these budgets. Any further gatherings of this Committee are going to be on the subject of closures. It is earlier than any Session in history to get to this point. We owe our staff a debt of gratitude for that. You need to get any questions that have not been answered to our staff. They have been working long hours, every day.

We will now invite public comment. Please be specific on the budget area and discuss the issues that are a concern to you.

BRIAN M. PATCHETT, M.P.A., M.S. (President/CEO, Easter Seals Southern Nevada): I have provided you with written testimony (Exhibit C). I am here to testify on the EIS portion of the budgets. I am happy that there is an increase over the next biennium to this budget. The need for these services is dramatic. The waiting list is over 500 now, and the projections are there over the next two years. The fact that has been dealt with in this budget, and what we see in the ARRA, the $3.9 million, has us anxious to see when that will hit so we can provide services to more children. I want to thank those who just testified for all their work on this and all their support and willingness to meet with us. I also want to thank the people from IDEA Part C who have been wonderful to work with over the last few years.

Early intervention is critical. We are able to provide services for children who have disabilities, starting as close to birth as possible, through age three. What we see in outcomes over life is dramatic because brain development primarily takes place between birth and five years. There are so many things that happen between birth and three years. Another program that Easter Seals provides is an adult day program for adults with significant disabilities. Every time I go into

that service and I talk with the individuals, what strikes me is that these are individuals who did not get early intervention. Had they received the services at a young age, these people would be far more able to take care of themselves. We would see a different outcome.

We are able to provide some choice for parents and some capacity because of the ability to have multiple providers. This is not unlike most states in the country where there are multiple providers. There are benefits because of that. Easter Seals of Southern Nevada is part of an association of Easter Seals across the country which is one of the largest providers of early intervention in the United States. I understand the budget needs and why we are able to put money back into the General Fund because of the Part C money. I wish it was otherwise because I think there are more children we could probably find that have not been identified.

As we look at the $9 million, the most important thing to me, and to all those who work within my agency, is that children get served. We are a nonprofit organization. We do not try to make money. No one on our board of directors gets paid, so people are not concerned about how much money Easter Seals makes as long as we deliver quality services. I am willing to talk about how we will make sure the services are delivered. The funds should not just go to private providers. They need to go where the services are needed. I would hate to see people in northern Nevada, or other places, not served because there was no flexibility there.

DENNIS MALLORY (Chief of Staff, American Federation of State, County and Municipal Employees, AFL-CIO):
Mr. Brian Patchett actually touched on our issue. The way I understand it, the $9 million added to this budget is solely for this public/private partnership. We should be careful when we do this because we are tying the hands of the Health Division. The main goal in this is to serve children. If we limit how the money is being disbursed, whether through private companies or within the State, I think we would be doing a disservice to the children. As the budget is written, there is no flexibility. We would like the Health Division to have an opportunity to be able to spend that money where they see fit. We have heard we do not have a lot of versatility in the services of northern Nevada through the private sector. We are having a difficult time funding those services in the rural sector. I hate to see $9 million sitting there that is 100-percent allocated to this public/private partnership, but we cannot spend the money because the Health Division's hands are tied on how they can allocate that money. Theoretically, we could have $3 million sitting in this fund, but it cannot be touched by the Health Division because it has been earmarked specifically for these private companies. If we are really here to deliver services to these children, I think that Richard Whitley and his staff need to have the flexibility and ability to spend the money where they see fit. I will work with Brian and Richard to make sure some sort of measures are put in place to allow that kind of flexibility.

MARCIA O'MALLEY (Executive Director, Family Voices Coordinator, Family Ties of Nevada):
I am the executive director of Family Ties of Nevada. We are a statewide nonprofit organization that serves people with disabilities of all ages. We are

also an affiliate of a national organization called Family Voices that speaks on behalf of children and youth with special health-care needs. We also have a contract with the State of Nevada to operate the single point of entry which is the referral center for the EIS in southern Nevada.

I have provided you with my written testimony (Exhibit D). Thank you for your time and I appreciate being able to share my story.

CHAIR COFFIN:
Thank you for your moving testimony and providing it in writing. That picture of Ian indicated how well you did those first 30 days. I cannot imagine the full growth of this youngster because of your attention and dedication. It is a wonderful story.

TODD MYLER (Administrative Services Officer, Health Division, Department of Health and Human Services):
I am a concerned citizen of the State and a concerned parent of a son, Cannon, who is 20 months old and does not speak. Everything is a duck. I am a duck, my wife is a duck and our house is a duck. We contacted the EIS in early February to see if we could get some kind of diagnosis and help. Due to staff and funding restraints, they cannot come to our home to see Cannon until the end of this month. That is another two months lost in his speech development. After they do an initial assessment, I understand we will be on a waiting list again before actual speech therapy begins. I am urging the Committee to support the budget increases in the early intervention budget.

JACK LAZERSON, M.D. (Professor Emeritus, Department of Pediatrics, University of Nevada School of Medicine):
I am a professor of pediatrics at the University of Nevada School of Medicine (UNSOM), and former chair at a pediatric clinic in Las Vegas. I am coming here on behalf of talking about the concern referable to the cancellation of the contract for genetics clinics. I am speaking for Dr. Colleen A. Morris, my colleague, whom I recruited in the late 1980s to help develop a genetics program for the State through the UNSOM. She prepared a nice document (Exhibit E) and I would like to comment and read some of it to you.

CHAIR COFFIN:
We have received some e-mails on this subject. We would like to hear from you.

DR. LAZERSON:
I want to reiterate some of the information and concern regarding the cancellation of this genetics clinic contract through 2010. The Division of Health actually contracted with the UNSOM to develop a genetics program and clinic back in 1991. It followed a series of five years of discussions and negotiations about the importance of genetics services within the State. My discipline happens to be in inherited disorders of hematologic diseases and I am intimately involved with the genetics programs. When those clinics were first organized, they provided genetics services for children with developmental delays and a number of birth defects that were served by the EIS. The rationale behind the decision to create genetics programs was that early diagnoses would then guide appropriate therapy. If one can intercede and diagnose patients early on, one can then come up with appropriate therapeutic regimens for reasonable

outcomes. If one looks at what this program has serviced over the 20-year period, there have been almost 3,000 Nevada children who have gone through these clinics, held in both Las Vegas and Reno. The contract pays for 28 of these clinics.

We are all familiar with the importance of early detection genetic services. The bottom line is if one does not have adequate genetic services within the State for early detection, many of these children will go out of State and the cost to the State is going to be more since the Medicaid costs will increase. Major hospitalizations occur because of genetic abnormalities, many of which can be prevented. Many can be dealt with on an outpatient basis. I think there is a great need for adequate genetics clinics where one can provide the early diagnosis and provide or recommend therapeutic interventions which end up going to the EIS. Dr. Morris provided you with a number of statistics about how the clinics function and what they have done. They also include the fetal alcohol syndrome as you discussed before. If one looks at genetics programs throughout the country, historically and at present, there is no genetics program that functions on patient dollars. Most genetics programs are created and exist financially because they have genetics laboratories. One has to, in our State at least, rely heavily on the State to assist with funding for such clinics. Dr. Morris has one of few academic departments in Las Vegas with a genetics laboratory. It is a research laboratory and has not gone into the clinical arena because of difficulties with contracts.

CHAIR COFFIN:
I know that what you have done is provide an additional illumination on the concerns I had. I would like Ms. Wherry to return for comments on this.

MS. WHERRY:
The contract for the genetics clinic is $74,000 annually. That is to cover 18 clinics. A clinic constitutes one day. On average they see about six children a day. We spend $3,400 per clinic. We have worked with Dr. Morris who gave us some ideas about ways to offset expenditures. We could only collect from Medicaid $100 for one of those visits, and we spend about $400 per child for the cost of that clinic day. We will continue to work with her. We have looked at the laboratories. We are exploring whether we could cut back our lab's double draws. The way the genetics clinics have worked in the past, the lab does a second draw if the child is suspected of having a genetic disorder to make sure it is an accurate outcome. With the changing technology today, Dr. Morris' recommendation is to do one lab, so we are looking to see if we could change our policy and just require one lab and what kind of revenue or cost savings we would have with that change in policy. We are exploring other ways to be able to maintain all or portions of that contract. We will continue to work with them.

CHAIR COFFIN:
I would like to hear back from you on this.

ASSEMBLYMAN HARDY:
I probably should say I am intimately familiar with the genetics issue. My 18-month old grandson was just diagnosed with osteogenesis imperfecta, otherwise known as brittle bone disease. He has had 15 months without a

fracture. The concept of having genetics clinics in this State is quite important. It is not as rare as we may think. As a physician, I refer to the genetics clinic quite often and I hope to be able to continue doing that.

CHAIR COFFIN:
This is our final hearing on this. I have not been able to absorb all the information given to me. We want you back for our Work Sessions to answer questions, if necessary.

There being no further business to come before this Committee, this meeting is adjourned at 10:52 a.m.

RESPECTFULLY SUBMITTED:

_____
Barbara Richards,
Committee Secretary

APPROVED BY:

_____
Senator Bob Coffin, Chair

DATE:_____

_____
Assemblywoman Sheila Leslie, Chair

DATE:_____