MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND EDUCATION

Seventy-fifth Session
March 30, 2009

The Senate Committee on Health and Education was called to order by Chair Valerie Wiener at 2:51 p.m. on Monday, March 30, 2009, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, Las Vegas, 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.

COMMITTEE MEMBERS PRESENT:

Senator Valerie Wiener, Chair
Senator Joyce Woodhouse, Vice Chair
Senator Steven A. Horsford
Senator Shirley A. Breeden
Senator Maurice E. Washington
Senator Barbara K. Cegavske
Senator Dennis Nolan

GUEST LEGISLATORS PRESENT:

Assemblywoman Heidi S. Gansert, Assembly District No. 25

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Committee Policy Analyst
Mindy Martini, Committee Policy Analyst
Sara Partida, Committee Counsel
Paul Townsend, Legislative Auditor
Maureen Duarte, Committee Secretary

OTHERS PRESENT:

Ann Lynch, HCA Healthcare Services
Thomas Zumtobel, Member, Executive Committee, Health Services Coalition, Clark County
Rusty McAllister, President, Professional Firefighters of Nevada

Jeff Ellis, Vice President and Chief Financial Officer for Corporate Benefits, MGM Mirage
Bill Noonan, Senior Vice President of Administration, Boyd Gaming; Management Trustee, International Culinary Union Trust Fund; Executive Board Member, Health Services Coalition
Dale Carrison, D.O., Chairman of Emergency Services, University Medical Center; Regional Director of Emergency Services, St. Rose Hospital
Jules Silver, M.D., Emergency Room Physician, Group Regional Medical Director, Doctors Medical Services
Patricia Allen, President, Health Strategies Inc.
Kelly Halloway
Helen Foley, Nevadans for Affordable Health Care
Bobbette Bond, Government and Community Affairs Manager, Nevada Health Care Policy Group
Donna Juell, R.N., MBA, CMPE, Practice Administrator, Premiere Surgical Specialists, Reno
James Wadhams, Attorney at Law, Jones Vargas; Nevada Hospital Association
Bill Welch, President/CEO, Nevada Hospital Association
Wade Sears, M.D., Nevada American College of Emergency Physicians
David DeValk, Chief Executive Officer, Reno Heart Physicians
Colonel Christopher Benjamin, Commander, Mike O'Callaghan Federal Hospital, Nellis Air Force Base
Fred Barton, Master Chief Petty Officer, Fallon Naval Air Station
Laura Crehan, Ed.D., State Liaison Office, Department of Defense
Colonel Dave Belote, Installation Commander for Nellis, Creech, and Nevada Test and Training Range
Dotty Merrill, Executive Director, Nevada Association of School Boards
Dan Musgrove, K-12, Inc.; Education Management Services Company; McDonald-Carano-Wilson, LLP
Rocky Finseth, Managing Partner, Carrara Nevada; American Lung Association
Mary Wherry, Deputy Administrator, Health Division, Department of Health and Human Services
Robin Keith, President, Nevada Rural Hospital Partners
Lillian Mandel
Brian Patchett, President/CEO, Easter Seals Southern Nevada
Karen Taycher, Executive Director, Nevada Parents Encouraging Parents
Lisa Erquiaga, Executive Director, Northern Nevada Center for Independent Living; Strategic Plan Accountability Committee
Mark Bennett, President/CEO, Health Insight

Debra Huber, R.N., Transparency Strategy Director, Health Insight
Marla McDade Williams, Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services
Tim Tetz, Executive Director, Office of Veterans' Services
Erin McMullen, HCA Sunrise

CHAIR WIENER:
We will open with Senate Bill (S.B.) 325.

SENATE BILL 325: Requires hospitals to establish a program concerning methicillin-resistant Staphylococcus aureus. (BDR 40-42)

SENATOR BARBARA K. CEGAVSKE (Clark County Senatorial District No. 8):
Methicillin-resistant Staphylococcus aureus (MRSA) will always be referred to as MRSA. This is a very important issue that we need to bring up. As you know, MRSA is a type of bacteria that is resistant to certain antibiotics. These antibiotics include methicillin and other common antibiotics such as oxacillin, penicillin, and amoxicillin. This bacteria, MRSA, occurs most frequently among patients who undergo invasive medical procedures or have weakened immune systems and are being treated in hospitals and health-care facilities such as nursing homes and dialysis centers.

In healthcare studies, it has been shown that MRSA can cause serious and potentially life-threatening infections such as bloodstream infections, surgical-site infections and pneumonia. I am here today to talk about what we can do. There is good news that MRSA is preventable. The first step is to prevent it and then prevent health-care infections in general. Infection control guidelines produced by the Centers for Disease Control and Prevention (CDC) and the Healthcare Infection Control Practices Advisory Committee are central to the prevention and control of health-care infection, and ultimately MRSA, in health-care settings.

This bill requires each hospital in the State establish a MRSA program to identify patients that have it, isolate such patients, enforce hand-washing policies and report information about such infections to the State Health Officer. The State Health Officer is required to compile information about the reported cases, and MRSA, and make such aggregated information available on the Website of the Health Division of the Department of Health and Human Services (DHHS). That is our goal.

Here with me today is Ann Lynch. She has brought to my attention some of the issues with MRSA. They are reporting MRSA, getting this information and keeping it at the hospitals. The link that we are missing is how to get this information to the health districts. I would bring the awareness to everyone about this, and how critical it is that we get that information and help to stop the spread of MRSA in hospitals. By doing so, I do not want to harm the businesses and the health institutes that are trying to do this in a timely fashion. To make changes now and have a set date would inhibit them.

Ms. Lynch has a recommendation and I agree with her. I would like to see us follow through and then have a report in the next Legislative Session.

ANN LYNCH (HCA Healthcare Services):
The majority of our hospitals in the State already adhere to all of the preventions. They are very concerned about MRSA and we are very aware of it. Once it was tried to make reports to the Clark County Health District, now known as Southern Nevada Health District (SNHD), but the reporting became so cumbersome that it just did not work. We would like to find a way to report this without violating the Health Insurance Portability and Accountability Act of 1997 (HIPAA) and without causing undue paperwork which does not get us anywhere. We are willing, and I have offered to Senators Cegavske and Wiener, that our infection control people, the state health office and SNHD sit down to work out a system whereby we can report these cases in a manner that makes sense, that makes prevention easy and can allow for some double-checking.

One of the issues we need to flesh out is that most of the State, and in particular Las Vegas, we have a tremendous number of visitors from out of state; we need to report those cases, and how we separate them. Even though we are taking care of them, and we help them, we have to have a statewide overview of the situation so we can keep MRSA from spreading.

We urge you to let us form a work group of professionals in the infection control area and from the state department to sit down and develop a strong and useful reporting system.

We know we have legislation before us so we will talk to the sponsor to see whether she wants us to proceed or not.

SENATOR CEGAVSKE:
I would like to withdraw S.B. 325. We made a statement that we know it is an issue, and would withdraw. In two years we will have a report before this very Committee, again, in hopes that we have a program set up and a way to accommodate this.

CHAIR WIENER:
Your intention is in the record, and we will keep an eagle eye on the health community. Thank you for your offer to work on this issue.

MS. LYNCH:
I have spoken with members of the DHHS and the infection-control people. I will carry that message to other hospitals, and I am sure they can put together a committee and develop some kind of reporting system.

CHAIR WIENER:
Hopefully, it will be timely enough before the next Session so if we do need to take appropriate legislative action, we will have that opportunity. We will withdraw the bill and take no action on it. Is there anyone to come forward on S.B. 325, now that the sponsor has withdrawn it? There is no action on that measure. We will close the hearing on S.B. 325 and open the hearing on S.B. 157.

SENATE BILL 157: Limits the amount that certain hospitals and physicians may charge for the provision of certain services and care. (BDR 40-808)

CHAIR WIENER:
I will speak from here, as this is a Committee bill. For those of you who may be new to the process, the Committee is allocated so many bills to prefile before Session begins. The former Chair, Senator Washington, had certain bills to prefile. I was allocated a few bills to prefile. We had a certain number of bills we could introduce at the request of the public, or some that did not make the deadline. There are a lot of reasons we do bill introductions through the Committee. This is one of the measures that I brought through the Committee process so that it could have a whole hearing in the Senate Committee on Health and Education. I know there are others who are here to speak for and against the measure, and that is what the process is about.

THOMAS ZUMTOBEL (Member, Executive Committee, Health Services Coalition, Clark County):
The Health Services Coalition, a nonprofit organization, is a group of 20 employers' unions in municipalities which represent more than 300,000 employees and families in Clark County. I have submitted a copy of my written testimony on S.B. 157 (Exhibit C).

VICE CHAIR WOODHOUSE:
Are there questions from Committee members of Mr. Zumtobel? Mr. McAllister?

RUSTY MCALLISTER (President, Professional Firefighters of Nevada):
I am in a unique position that I not only represent firefighters involved in the transport of the patients to hospitals. I am also the chair of Las Vegas Firefighters' Health and Welfare Trust Fund that provides health insurance for approximately 2,000 people: firefighters, retirees and their families.

I will talk about the transport portion of this. In Clark County, there is a set of emergency medical services (EMS) protocols that are established by the SNHD in cooperation with the physicians, the hospitals and EMS providers, to provide the best level of care for the patient. That is certainly what we want to do. The protocols have established certain types of injuries or illnesses, and to where those patients get transported based on their condition, regardless of their insurance situation or their ability to pay. Last night I looked through the protocols in southern Nevada for EMS providers. There is a trauma protocol, there are three catchment areas, so EMS providers have to know where they are located, within what geographical location. If they are in that geographical location, and they have a trauma patient, that is where the patient goes, regardless of whether the patient has insurance there; that is where they go, because it is a geographical location, a catchment area.

A new protocol has been set up that is called the chronic public inebriate. They can be taken to a facility other than a hospital unless the paramedics suspect a medical problem. If they have a medical problem, or it is suspected that they have some form of medical problem, they must be taken to the closest emergency room (ER).

Pediatrics are taken to one of five facilities in southern Nevada. There are 11 hospitals in southern Nevada, and pediatric patients can only be taken to 1 of 5 units. The criterion for burns is that they go to one hospital. If they need

burn criteria, that is where they go. Cardiac protocol says, depending on the severity of the problem, and if the patient is unstable, patients are taken to the closest advanced life-support hospital, regardless of their ability to pay or the insurance situation, or their request. If a person requests to be taken somewhere, protocol says "you will go here." For respiratory patients, the protocol says if I, as a paramedic, do not have the ability for a specific patient to secure an airway, I must take the patient to the closest advanced life-support hospital, regardless of their request. Sexual assault victims are in the protocols, and it is based on age. If the patient is under 13 years of age, they are taken to 1 hospital, if age 13 to 18, they are taken to 1 of 2 hospitals. If over age 18, they are taken to the other hospital. There are two hospitals that get those patients. The patients in the middle-age bracket go to either one. Pediatrics will go to one place, adults to another, based on age. They must go there.

An internal disaster means a hospital states they are on internal disaster based on the number of patients, or whatever. Protocol says we must bypass that hospital with all patients. We cannot take anybody there, period. Currently, they are working on some stroke-destination protocols in southern Nevada that would designate certain hospitals, and there are only three right now in southern Nevada. If you were having a stroke, the paramedics would need to know where you are and where to take you, one of those three facilities, regardless of your request.

SENATOR WASHINGTON:
Can we request the staff to get those protocols from southern Nevada as well as northern Nevada, and some rules from health districts and the DHHS, as well? Can we get those protocols?

MR. MCALLISTER:
Yes, we can make arrangements to make sure you have copies of those protocols.

From the transport side of things, there is a checkerboard in southern Nevada where you can take patients based on their medical condition, regardless of their request and regardless of their condition. From the standpoint of a chairman of a small health insurance trust fund, I will give you a couple of examples. One example is not one of our members but is one of your members, a Legislator, whose husband had a heart attack. According to protocol and with no choice of hospital given, he was taken to the closest advanced life-support

hospital where he was treated—and is still alive. They then got a bill for over $20,000 because they do not have insurance at that facility.

A second example, somebody from my trust fund had to take their child to the ER for burns. They were referred to the burn unit within their hospital outpatient care that met burn criteria. They received treatment for two weeks, and then the bill came. What they thought was covered, and even though the hospital is a contracted facility, the physician who worked in that facility is not a contracted physician. He charged full-bill charges, did not tell them, did not inform them that was the situation, they just got a bill. They thought since it was a contracted hospital that they would be covered. They were quite surprised when they got a bill that was way outside the normal ranges of contracted rates. The physician does not have to contract, though, because there is a steady stream of patients coming from the ER right up to him. Patients cannot go anywhere else for burn treatment because it is the burn unit. He is a specialist in that particular area and has a steady stream of patients, he does not need to contract, and evidently does not.

Those are a couple of examples, at least from our standpoint, both from the EMS transport portion of it, and from the health insurer, of why we think this is an essential piece of legislation and that we need some form of relief. There is no way we can keep this up. There is not enough money to keep paying what they want. They want it all and they cannot have it all. We will go broke.

SENATOR WASHINGTON:
Can you tell me who "they" are?

MR. MCALLISTER:
Yes, they are the hospitals and the physicians. There is not enough money to keep continuing to have the rise in rates that we continue to pay. We do not have the ability to go and continue to get contributions for our members. There is only so much money they can pay, to continue to pay the increasingly rising costs of health care. These costs are going up 12 to 15 percent a year. Wages are not matching the contributions required to pay these bills. Who sets the protocols? Is it the county health districts? Are the protocols statutory or regulatory?

MR. MCALLISTER:
The protocols are established by a hit or miss group working within the SNHD. This group is made up of physicians, hospitals and a couple of representatives from the EMSs in that group.

SENATOR WASHINGTON
Has any emergency medical transport company ever deviated from these protocols? Are they etched in stone? Are there any exceptions?

MR. MCALLISTER:
There is no written exception in the protocol. Can I say nobody ever deviated from them? I would be speaking out of line if I said no one has ever done that, because I do not know. Are they putting themselves at risk? Absolutely. If something goes wrong and you have deviated from your scope of practice, you deviated from the protocols. The guidelines that you uphold, and if you deviate from those, and something goes wrong, you open yourself up to legal liability. As long as you stay within your scope of practice, then you are okay. If you deviate from that, you open yourself to the legal world.

SENATOR WASHINGTON:
Would the tort you may be charged with come from the patient, the hospital or the doctor?

MR. MCALLISTER:
Certainly the patient, if things were wrong. I am not sure if the hospitals knew we were transporting to places that we were not supposed to go, I do not know the possibilities for follow-up. If they have the ability to go through the legal world, I do not know.

SENATOR WASHINGTON:
Under the protocols and the scenario that you just indicated, if a patient was conscious, knowing it was cardiac arrest and their contract indicated a certain provider, could the patient request or suggest to be sent to a hospital or a provider?

MR. MCALLISTER:
Yes, they can make the request and can ask to be taken to a specific place. Based on the protocols, we cannot deviate to take them outside of the prescribed area. If I bypass one advanced life-support hospital to take them to

another hospital where they are contracted or have insurance, and they go into cardiac arrest between point A and point B and they suffer irreparable damage, I open myself up to the legal process.

SENATOR WASHINGTON:
I see a couple of issues here. I am not sure I fully understand the protocols, whether statutory or regulatory. But you did say it was a group of EMS providers that set those protocols, which basically, if not followed, could lead to some manner of legal tort. But it is not in statute, there are no *Nevada Revised Statutes* (NRS).

MR. MCALLISTER:
My understanding is that it is not set in statute, but the SNHD has regulatory authority over all health services in southern Nevada. They set the guidelines that we work under. They license us so we work under their authority.

SENATOR WASHINGTON:
I really want to see those protocols from both counties.

VICE CHAIR WOODHOUSE:
We will make sure that we get those.

SENATOR CEGAVSKE:
I would like your e-mail address as I was going to forward these e-mails I have been getting for you to answer for me. Seriously, I do have somebody who sent me some questions and I do not know the answers. In an e-mail, the sender states there are already binding contracts in place and that I was concerned about what they are requesting. Again, this is from somebody who has e-mailed me and it is one out of thousands we have all gotten that did not agree with your position.

Are there binding contracts right now? Are there parties that have anything that is binding with the hospitals? Do you have contracts now?

MR. MCALLISTER:
Do you mean contracts for hospital care or insurance?

SENATOR CEGAVSKE:
I mean managed-care contracts. I can talk to you about this later because I do not know the answers to the questions that have been asked of me. I am just concerned about some of the issues being brought up and would like some answers. I will be more than happy to share them with you, if you want.

MR. MCALLISTER:
From the standpoint of a health insurer and insurance trust fund: do we have contracts in place? We are a preferred provider (PPO) network and we contract with a company named Beech Street Corporation. They negotiate with physicians to be part of their contract network. Those are the physicians we would use within our PPO network. We also allow our members to go outside the network if they want, but if they choose to go outside the network they pay a higher cost. The vast majority of our membership uses PPO doctors within the PPO network.

As far as hospital contracts, we ally as part of the Health Services Coalition (HSC) our part of the negotiation process with regard to negotiating contracts with hospitals for rates of hospital stays, as outlined in my handout (Exhibit D).

SENATOR CEGAVSKE:
You are saying that you already have contracts in place and they have been negotiated. How would this jeopardize, or what would this do to what you already have in place? It changes everything.

MR. MCALLISTER:
My assumption is that if we have a contract in place, we would work from that. This is in the event that you do not have a contract. Currently, we do have a contract with all the hospital networks in southern Nevada. There is no guarantee that is going to continue. I am only speaking for those who are covered by the HSC. There are others, as an example the Legislator with another health insurance program, that does not have a contract. At this point in time, there is no guarantee that those will continue. Some other people in southern Nevada, or many other people, do not have contracts with all facilities.

SENATOR CEGAVSKE:
I would love some more information about this. The e-mail eventually talks about a federal Emergency Medical Treatment and Active Labor Act (EMTALA) that is already in place.

MR. MCALLISTER:
Senator, that is way over my head.

SENATOR CEGAVSKE:
If the EMTALA is already established, maybe this is taking care of your concern. Is there anybody that can address that? I do not know about it. I would love some information, if staff knows about it. I have not heard of it before. In a sense, you want to renegotiate.

MR. MCALLISTER:
I do not want to renegotiate. We have a contract. Why would we reopen it and renegotiate at this point in time. Will those contracts expire at some point? Yes, they will. Then, will we be going into negotiations again? Yes, we will.

SENATOR CEGAVSKE:
When you go back, will this be part of what you ask for?

MR. MCALLISTER:
I do not sit at the table in negotiations, so I could not answer that.

SENATOR WASHINGTON:
Section 1, subsection 1 of S.B. 157 pertains to facilities of 100 or more beds, not operated by federal, state and local agencies. Basically you do not see that in southern Nevada. I want to know, in your protocols that you listed earlier, is University Medical Center (UMC) listed as one of these protocols?

MR. MCALLISTER:
Yes.

SENATOR WASHINGTON:
Are they a burn center?

MR. MCALLISTER:
They are the treatment center for burns. They are also one of the catchment areas for trauma.

SENATOR WASHINGTON:
Do you contract with UMC?

MR. MCALLISTER:
My particular health insurance plan does have a contract with UMC, yes.

VICE CHAIR WOODHOUSE:
We are going to speak to testifiers in Las Vegas. We have Jeff Ellis, Bill Noonan, and two patients' stories.

JEFF ELLIS (Vice President and Chief Financial Officer for Corporate Benefits, MGM Mirage):
I will speak briefly about employer impact and why we are in favor of this bill, and maybe clean up a little of what has been going on so far. The MGM Mirage spends about $120 million a year in southern Nevada for health care. One of the issues that we are faced with is providers, as Mr. Zumtobel described earlier, that are servicing our patients in an emergency setting, in the hospital, that either do not have or refuse to have a contract with the local payors. This comes up occasionally. Fortunately, as a large employer, we have the majority of the providers under contract, but occasionally we have providers that feel they do not need to contract with payors and can charge us 100 percent of their bill charges. It is the bill charges that are an issue, and one of the issues that this bill is trying to address. Bill charges can vary significantly from provider to provider, from hospital to hospital. While one prior provider charges for a current procedural terminology code (CPT) that could be three times as much as another provider charges. Bill charges really do not represent any relationship to the cost of a procedure. What this bill is trying to install is some ceiling as to what an employer, or provider, would pay or have to pay in Nevada for a procedure. The bill has selected 200 percent of Medicare. We looked at our database, and in the majority of cases 200 percent of Medicare is very close to a lot of the providers in this community's charge structure. There are the outlying providers that have very significant bill charges that are in no relation to anything that they are doing from a medical perspective, but they feel that they can charge certain payors that charge, and refuse the contract.

All of these providers, especially the physicians in an emergency setting, accept Medicare as a payor. They are accepting 100 percent of the Medicare fee structure. We feel that 200 percent of the Medicare fee structure is more than adequate to cover them for their services, given the fact that Medicare, a lot of the time, is really the gold standard from a payor's perspective in the community and in the nation at large. We have to feel that Medicare has gone through very rigorous studies throughout the years to come up with what they

consider to be a relative value, which is a fair reimbursement to physicians at 100 percent of the Medicare fee schedule. To go to 200 percent of Medicare fee schedule obviously provides a physician or hospital with enough reimbursement to cover their cost of care. That is what we are looking to do.

We have this situation often, as Mr. McAllister has described, where we have patients go into an emergency setting. The physician has no contract, they are the on-call physician in a certain specialty, they provide either surgical care or emergency care, and then they bill our patient 100 percent of charges. We process that claim initially. For an out-of-network claim, we only pay 50 percent of reasonable and customary charges, leaving the patient with a huge balance due. A lot of times we will go to that provider and try to negotiate a fair and reasonable rate to cover that cost of care. What we are trying to do with this bill is deal with those isolated instances where the provider of care refuses to contract with us and assumes and expects 100 percent of bill charges.

VICE CHAIR WOODHOUSE:
Senator Horsford has a question.

SENATOR HORSFORD:
Mr. Ellis, is the issue just with hospitals, or is it with physicians within hospitals? Can you elaborate on how frequent an issue this is, and the number of insured participants who are charged at the full bill charge rate?

MR. ELLIS:
As we have indicated earlier, we have contracts with all of the hospitals in southern Nevada, so this is not necessarily a hospital issue. I also have a casino in the northern end of Nevada, in the Reno area, and this does become an issue up there because the two hospitals historically maintain that if you contract with one, you cannot have a contract with the other. Often, somebody will show up in an emergency situation at the noncontract facility, as Mr. McAllister describes, from an emergency transport, and then we enter difficult negotiations because these hospitals historically refuse to have joint-provider relationships.

In the southern Nevada area, we are really more concerned with this issue from the physician and emergency physician perspective. This happens, and as a large payor, we are not at risk for that much. In 5 to 10 percent of our admissions, we have a noncontract provider seeing our patients. In southern Nevada we insure about 60,000 lives.

BILL NOONAN (Senior Vice President of Administration, Boyd Gaming; Management Trustee, International Culinary Union Trust Fund; Executive Board Member, Health Services Coalition):

As you can well imagine, I wear many hats in the health-care arena for large groups of employees and their dependents. For the sake of brevity, I would like to second all of the items that Messrs. Zumtobel, McAllister and Ellis have just spoken about to the Committee. I would add a couple of additional perspectives on this issue.

As you know, Boyd Gaming is a company created by what has become one of the first families of gaming, the Boyd family, and we call Nevada our home. We clearly want to protect the needs of our employees and their financial viability. It has been a difficult time for all of us and our industry, as you can well imagine. Boyd Gaming currently continues to contribute significant sums within our local Nevada economy, and nationally spends nearly $100 million in annual health-care.

I would like to clear up the issue of why UMC has been carved out of this particular piece of legislation. The large hospital excluded in this bill is UMC, but it was the intent to exclude any county hospital for the same reason. County hospitals are excluded from the definition of major hospital in the cost-containment statutes created in NRS 439, and are governed instead by NRS 450. This has been true for nearly 20 years. The UMC is the only not-for-profit public hospital overseen by elected officials. We all, already, pay for UMC to ensure the county can provide essential care to our residents. The Clark County elected officials who oversee UMC are well aware of the importance of commercial payors to offset taxpayer costs. The high market share of uninsured and charity care provided and referred to UMC by other hospitals makes them unique. The only reason it exists is to care for our community. The UMC not only helps us, it helps the other hospitals in our community a great deal. As such, we want to treat all county-controlled hospitals alike.

I would like to address the ongoing relationship with the hospitals now serving all of us in southern Nevada. We have a very good working relationship with all hospitals at the current time. We have joined them in their message in Carson City and elsewhere about the impact of Medicaid and Nevada Check-up on their profits. Frankly, we see that the hospitals have generally prospered in Nevada, as recorded documents that have been presented show. I am

disappointed that even after several attempts, their legislative representatives have not come to the table with us on this issue. I hope we can change that for both the hospitals and the doctors who are refusing to accept what we consider to be reasonable rates. Together, we have made great progress on other issues. Together we can make sure this legislation is fair for all parties, and continue to work together to face the health-care challenges for Nevadans. Frankly, your Committee, with our business involvement, can help make this happen.

SENATOR WASHINGTON:
You made reference to UMC. Last Session, UMC was in some financial difficulty, maybe because of uncompensated costs or whatever the situation might have been, or lack of leadership or provisions by the county itself. Under this bill, UMC is excluded. I am wondering whether, from your standpoint, exclusion of UMC puts all the other providers at a disadvantage. Do you agree or disagree?

MR. NOONAN:
We actually work very closely with UMC. We, as one company, and I cannot speak for all, have had few, if any, problems at UMC relative to the fact that we will always contract with them because we want to support UMC. Secondly, we have not had an issue with the doctors at that facility not wanting to contract with us. Because of their very nature, where they frankly want our private dollars to help subsidize them so they do not have to go to the taxpayer for future funds, UMC works very closely to make sure those private dollars are available.

SENATOR WASHINGTON:
How many employees did you say you serve now?

MR. NOONAN:
Boyd Gaming has approximately 10,000 members, and that is certainly on top of the Culinary Health Fund and those serviced by the HSC.

SENATOR WASHINGTON:
And you are part of the HSC?

MR. NOONAN:
Yes, we are.

VICE CHAIR WOODHOUSE:
Mr. Noonan, Mr. Ellis, do you have speakers there? On your sign-in sheets there are two patients' stories listed. If they would come forward and proceed.

DALE CARRISON, D.O. (Chairman of Emergency Services, University Medical Center; Regional Director of Emergency Services, St. Rose Hospital):
I debated seriously, after hearing all the testimony, whether I should speak or not, but Senator Washington asked a great question—who are they? I am one of them. I am a practicing emergency physician at several hospitals in southern Nevada. I have concerns about this bill. I have concerns because this is simply another regulation to me, to tell me what I can charge or what I cannot charge for my services. Now, am I contracted? Yes, I am contracted with every one that has testified here today. Are there instances where patients have been billed exorbitant amounts? Absolutely. I would not deny that at all.

A legislative body and government get into trouble when we try to make one shoe fit all. In California, this has led to what is called balanced billing. If I am not contracted with an insurance company, they can essentially tell me what they are going to pay me, period. You say, well, 200 percent of Medicare is reasonable—Medicare is reasonable, they have done it. If you speak to most physicians in the community, Medicare is barely livable, much less reasonable. If we look at what we are trying to do by putting a cap on something, what happens next year when they come back and want to go to 150 percent, because we will have the same stories?

I just hesitate to have a government start setting regulations. I do not think that either gentleman's corporations, who were represented before, would like it if you were trying to set room rates for them. They do not want to be taxed. What if you told them what they could charge for their rooms? Physicians have an obligation to the community to be fair and charge reasonable prices.

As an emergency physician, I can tell you that everyone in our group standardizes and goes by whatever the CPT code says. There is a coding system that is set up for emergency services, it is nationally recognized, and those are the fees that we charge. I do not have a government agency. What if you change those CPT codes on me? You say, well, we do not like that in Nevada so we are going to change everything that we have with regard to our fee structure. We have to look at a bigger picture here even though I am

certainly going to have sympathy for the people who have been billed exorbitant amounts.

My question is, why not address those individuals who charge that? In answer to Senator Washington's question, there are regulations with regard to where you take the patient. There are criteria and protocols that are followed. None of this has anything to do with money. What is being done has to do with what is best for the patient. I am sure the insurance would not make any difference if you were transported another ten minutes and you died during that transport because you were meeting your insurance. That is a slippery slope that none of us every want to go down.

Sitting on the Medical Advisory Board for SNHD are the medical directors and representatives from every EMS or transporting agency in Clark County; everyone has a say in this. There are debates and there are committees with regard to setting up protocols, deciding who goes where. None of this is done arbitrarily. It is done for the best interests of the patients. Though we will speak of this again, I have a problem when the government steps in and decides to tell people what they can charge or what they cannot charge for their services. Even though I understand that you may have been taken to someplace where you are not contracted, I would prefer that was dealt with on an individual basis; we certainly have enough attorneys in southern Nevada to handle those kinds of cases.

SENATOR WASHINGTON:
Under federal law, it is mandated that any patient who enters the ER must be treated under EMTALA. If this piece of legislation were enacted, in your estimation what would happen to those physicians or doctors who provide emergency medical services? Would there be a shortage or depletion? Would there be a migration out of this State? Can you give a scenario as to what might happen?

DR. CARRISON:
I would hate to do that. We all live with EMTALA as an unfunded government mandate. One of the other Senators was questioning what EMTALA means. Simply said, it means that every person who comes to a hospital with an emergency department is obligated to be seen. A medical screening must be conducted to determine if in fact that patient has an emergency medical condition, and if they do, they are treated.

I am not certain we would see an exodus of emergency room physicians. If we were talking about a different bill here today, yes, but in this particular bill, I am not certain we are going to see a huge change in our practice patterns. As a physician, when I hear a gentleman from a trust fund saying it is going up 12 to 13 percent a year, and I have not had a change in my wage in the last 10 years, then I am curious and wonder where it goes. The elephant in the room that no one speaks of is the insurance companies. They are the ones that seem to be profiting on this, one way or the other.

SENATOR WASHINGTON:
In the bill, S.B. 157, section 1, subsection 2, a physician providing services basically is capped at 200 percent of Medicare. The Medicare rate is pretty low. With 200 percent you have a small margin, and you are telling the Committee, and me, that you would not see a mass exodus out of this State, or a decrease in providers coming to this State, if it was capped at 200 percent?

DR. CARRISON:
I am saying I cannot predict that, Senator. I can just tell you that when someone says that, in the infinite wisdom of the federal government, they decided Medicare rates are fair, I disagree. They are currently not fair, and in a large percentage of cases they do not even cover the costs. So, with 200 percent we are setting a limit again. We should go by nationally recognized standards. From my standpoint, I can speak with expertise on the emergency services with the CPT codes. Those are what we charge, and if you have outliers in this community taking advantage of patients who are transported where they did not want to go, then those are the outliers that should be addressed, instead of trying to throw this government blanket over the problem.

SENATOR HORSFORD:
How would you propose to address it?

DR. CARRISON:
I would propose to address this on an individual provider's basis. We should identify these providers within our community that are clearly outside the acceptable standards of what we consider reasonable fees within the community. How many hundreds of orthopedic surgeons are in southern Nevada? Say 99 percent of them charge X, Y or Z dollars for a procedure. If you have that 1 percent charging 10 times what the others are of someone who as a patient had no choice, then we should address that individual.

The other fallacy I have heard today is that the patients have no choice. The patients do have a choice. If I do not like my doctor, I do not have to go to that doctor. Just because that person was brought to you as a patient, patients need to understand that they always have a choice. When they are conscious and their family is there, if you do not like your doctor, fire your doctor and get a doctor you like. That is within your purview as a patient.

SENATOR HORSFORD:
This issue has been before this Legislature before; this is not the first time and the problem continues to exist. You are right, there is a certain level of choice, but the reality in the ER case is there is no choice. That is what this bill and the arguments that we have heard thus far are seeking to address. I was asking you, specifically, how you would address that with those outliers as you frame the issue. Often, you cannot even get the data that supports these outliers. If the transparency is not there to identify who is contributing to the problem, how do you address it? In the meantime, people are being charged exorbitant fees that are outside of what is considered the norm.

DR. CARRISON:
I am a little confused by that, Senator. I am an emergency physician, and I know what my company charges. Again, it goes back to the CPT codes. Everybody here today is talking about exorbitant charges and there have been specific examples given of how a patient ended up with an exorbitant bill. I would like to know who else had an exorbitant bill? We are looking at this case by case. We have people reported to us as having had these bills, but I know there are thousands of other people who have had bills that are exactly the same for every emergency department that you go to in this community. Dr. Silver is also involved with a very large group of emergency physicians in the Valley who could also speak to that.

JULES SILVER, M.D. (Emergency Room Physician; Group Regional Medical Director, Doctors Medical Services):
We provide emergency physician services to five facilities in Clark County. To address some of the comments made by Dr. Carrison, it seems that the testimony we heard earlier by many of the insurance groups stated they were comfortable with the relationships they had with the hospitals. They seemed to point the finger at physician charges with some of them being quite exorbitant. The ER physicians working in a fixed world where all our fees are transparent do have contracts with most of the major employer groups here in Clark County.

From the testimony we have heard, it appears that most of these "grossly overcharged patients" are from attending doctors who pick up the patients from the ER and treat them in the hospital. That is something you should look at. I do not think this is a problem with the rank and file emergency physicians that do their shifts day in and day out.

SENATOR HORSFORD:
So if the rule is that people follow these charges, whether they are contracted or not, what is the opposition to setting the rate within that norm?

DR. SILVER:
In one aspect, suddenly you want to toggle this to Medicare. As Dr. Carrison alluded, Medicare is probably the lowest end of the spectrum. It would make more sense if you used "usual and customary" charges of the insurance groups, if they would come forward with a plan and pay typical reimbursement based on their average patient charge. That would be one way to do it.

In the wording that you presently have, you have used the term "what Medicare pays." It should be "what the Medicare allowable rate is" or "what is reasonable to Medicare," because there is some complexity there. You have the co-pay from the patient as well as the actual dollar amount that Medicare pays. The wording "allowable Medicare charge" makes more sense.

To address the issue of the 200 percent, I am not quite sure where that exists. You throw a dart and ask, "Who selected 200 percent?" That is something to be looked at. If you move that bar, perhaps that would be negotiable and reasonable for physician reimbursement.

SENATOR HORSFORD:
I appreciate that level of specificity because ultimately it is reaching a resolution that works. That is the type of specific information that would help us look at the options.

VICE CHAIR WOODHOUSE:
We are now coming back to Carson City. Presently, we have four speakers who have testified in favor of the bill, with two opposed. I am calling David Kallas and Bobbette Bond, then we will go back to those who oppose the measure. For those of you who are here and are interested, but not going to testify, if you

would like to go to Room 1214, that is now available as an overflow room. I shall return the chair to Senator Wiener.

CHAIR WIENER:
We have an extraordinary interest in this bill. We are going to take seven proponents and seven opponents, but we are not going to stop there. We have interest from the Committee to do subcommittee work on this. We have six other bills that are equally important to the Committee and people who are engaged with those measures as well. Senator Horsford, you seem to be quite interested. Would you be willing to chair a subcommittee on this? We will give it a thorough airing but we need to also consider those others who are here today for other measures. Would anyone else like to serve on a two-person subcommittee?. We have two members, Senator Woodhouse and Senator Horsford, who will serve as the subcommittee to hear this measure and to give it a thorough airing as the interest certainly dictates.

SENATOR HORSFORD:
Out of respect for those patients, if one of you would choose not to go, since we hear from you all the time, I would like to hear from someone who is directly impacted by the legislation.

CHAIR WIENER:
In southern Nevada, do we have two people who would like to testify on behalf of the patients' concerns? Please identify yourself and proceed with your testimony.

PATRICIA ALLEN (President, Health Strategies Inc.):
I am here today to assist the patient as patient advocate. I am a consultant for many health and welfare trusts in Las Vegas and Nevada, as well as a consultant to the HSC. With me today is Kelly Halloway. Mr. Halloway has a story regarding his experience with a non-PPO physician.

KELLY HALLOWAY:
My wife passed away in October 2007. She was 44 years old. In 2005, after several years of suffering, my wife's heart doctor referred us to a non-PPO doctor who admitted her to Desert Springs Hospital to have a tracheotomy. We did not realize until later that the procedure was put in place as a precaution if she needed to be on the ventilator. At the time, we had two insurances: my Teamster's Local 631 and her Medicare. The PPO doctor referred us, a PPO

hospital was used, and these physicians never told us they were not contracted with our insurances.

During my wife's hospital stay, there was a complication where the tracheotomy needed to be placed. Unfortunately, even if I had known the doctors were not contracted, I could not change doctors while she was having complications. Both of our insurances, Teamster's and Medicare, paid the bill that has the same rate as all contracted PPO doctors. The amount was considered substantial by Medicare, so Medicare cannot pay above and beyond what the Teamster's paid, which was minimal. If I had a PPO doctor, I would have had no out-of-pocket expenses at all. The doctor who put the tracheotomy in began to bill me the difference between the insurance payments and his escalated bill target. Within a few months of my wife's death in 2007, I received the first notice about the balance due. They have been calling and requesting payments. The Teamster's insurance and Medicare have paid in full and continuously told the doctor's office that they were paid the maximum that is allowed. A year after my wife's death, they began harassing me and threatening me. They demanded payment, as the debt she left behind was now mine, as Nevada is a community-property state. They threatened to bring me to collections, to garnish my wages, and asked me to go to my family and my children and ask them for money. They attached the county assessor's record of my home's worth through a letter. They asked me to sell my house or take out a second mortgage. They asked me to put the balance on a credit card.

I sought help from the Teamster's Local 631 insurance, the patient advocate who worked with my insurance, the union and now the Governor's Office for Consumer Health Assistance (OCHA). In conclusion, we did everything right in terms of our insurance, we trusted the doctors and we had two insurances.

SENATOR HORSFORD:
How much was the outstanding medical bill beyond what your insurances covered?

MR. HALLOWAY:
Right now, I believe it is $5,000.

SENATOR HORSFORD:
Is that an economic hardship on you and your inability to pay that?

MR. HALLOWAY:
Yes, sir.

SENATOR NOLAN:
Is that the balance remaining or is that the entire amount? If it is the balance, what was the entire amount?

MS. ALLEN:
The bill was approximately $7,500 for the emergency tracheotomy procedure and the complication that occurred with a physician afterward. The plan paid approximately $4,000 toward the $7,500. That was considered above and beyond the usual and customary fee. Medicare paid whatever they could to equal up to what they considered usual and customary for that procedure. There was $3,500 remaining. Since then they have added penalties, fees and interest. Since 2007, the balance owed now is just under $5,000 with that interest.

SENATOR NOLAN:
In your experience consulting with these individuals, are the requests seeking remuneration by means of selling their homes, taking out a second mortgage and those types of things made in writing? Are these things that individuals are telling you were said?

MS. ALLEN:
We had actual copies of the letters sent by the physicians to Mr. Halloway, which includes an actual copy of the Clark County Assessor's form on the value of his home. Health Strategies, as a consulting firm in Las Vegas and Nevada for almost 20 years now, probably had attempted to assist patients who had been caught in a similar situation. We have seen just about everything as far as attempts to collect. We have also seen the same physicians who will not negotiate or accept usual and customary, or reasonable payment, turn around and negotiate on one patient a fair and reasonable rate. We have also had physicians who have agreed to write off the balance, as in the case of Mr. Halloway, and then six months later actually refuse to accept a negotiated discount that they actually signed. We feel this bill would be very helpful.

I do not know if any of you have ever received what they call an explanation of benefits (EOB) but that is what the patient receives once they leave the hospital. It explains what the insurance will pay versus what the doctor is billing and their responsibility. It can be quite shocking to a family member who was

not aware that they had the wrong physician, or a non-PPO doctor taking care of them at the time of the emergency.

We feel that the 200 percent of Medicare is reasonable, as you will see in the packet from HSC, Exhibit D. Most physicians are accepting somewhere between 114 percent and 120 percent of Medicare on the high end when you contract, so accepting 200 percent for noncontracted physicians is more than reasonable. I also want to note that most physicians are very cooperative and wonderful when it comes to these situations, including the ER doctors that were up here at the table. Unfortunately, I have been involved for at least ten years with the HSC to avoid these situations where patients are being asked to pay above and beyond, up to billed charges.

We do not know of everybody who would like to tell you the numbers. When you are called by a collection agency you often just start writing checks to the physician, and this may be the same physician, or hospital, in Nevada, that does not accept a discounted arrangement. You just start making payments. Many of these patients, due to economic conditions, cannot afford to be making payments beyond reasonable amounts of bill charges.

SENATOR WASHINGTON:
Miss Allen, do you provide a service to patients who may feel that they have been charged exorbitant fees.

MS. ALLEN:
Yes, we are health-care consultants. We work for several health and welfare trust funds, as well as acting as the consultants for the HSC. Also, I co-founded the coalition ten years ago.

SENATOR WASHINGTON:
Do you charge a rate for your consulting services?

MS. ALLEN:
We charge a flat retainer rate that includes evaluating the trust fund, working on projects and one very small piece of it is for making ourselves available to members if they need some assistance with their bills or some other type of patient-quality advocacy.

SENATOR WASHINGTON:
So, there is a rate plus.

MS. ALLEN:
No rate plus. One flat rate per month for consulting services.

SENATOR WASHINGTON:
Then are there additional charges for services provided?

Ms. ALLEN:
Ninety percent of what we bill for is on a flat retainer or hourly. We do not charge separately for patient advocacy.

SENATOR WASHINGTON:
There were some other things that you mentioned, and I missed them. Could you repeat those?

MS. ALLEN:
Following are the services that we provide to clients: we monitor the managed-care vendors, we work with the plan and develop wellness, we help promotion activities and assist with pharmacy benefits. That is a long line of health and medical-related projects that we work on for our funds.

SENATOR WASHINGTON:
Is that all within the flat rate?

MS. ALLEN:
The only thing that would be charged separately is if we use a physician or nurse to do any medical reviews, then we charge for the physician's services.

SENATOR WASHINGTON:
Do you contract with any physicians, or is that your rate?

MS. ALLEN:
We contract with the physicians. We are an independent medical-review organization.

HELEN FOLEY (Nevadans for Affordable Health Care):
For the last ten years or so, we have been working on this. Senator Horsford is correct, it has been a very difficult situation. It does not just involve the ER, there are many situations where there is elective surgery; a patient will check and make sure they go to a contracted facility, with their contracted physician, and then find out that they have an anesthesiologist that is taking care of them. They never saw that doctor before, and then they get a great big huge bill from this physician who is not contracted with them. Through no fault of their own, they never even saw them. We believe that should not happen to the patient. Nevadans for Affordable Health Care worries about the affordability, the accessibility and the transparency of the service that is received. That transparency is definitely missing in this situation. Valerie Rosalin, R.N., with the OCHA, has hundreds of cases for which she has actually had to go to hospitals and physicians to try to negotiate. If she worked with the subcommittee, she could provide great resources about what is happening with doctors and with hospitalists at the different facilities where these problems are happening.

The insurance commissioners, both former and current, also have had advisory committees on this issue. I am sure, if requested, they would also participate in this. I encourage you to seek their counsel on it.

SENATOR HORSFORD:
We heard earlier about the protocols that the EMS community has in place. Are you aware of any protocols that the hospitals or physician groups have as far as whether they know a patient they are working on is covered by them, whether they have a contract with that insurance company or not or whether they make any attempts to find a doctor so that they do not have these costs that are beyond the contract? Or is that not something that is part of what happens?

MS. FOLEY:
We have heard horror stories where hospitalists come in, fully aware that they do not have contracts, still see patients and send them huge bills. We know when someone goes to a doctor's office, many times they will not even be seen if they do not have a contract. Yet, in a hospital, a lot of patients can be taken advantage of.

BOBBETTE BOND (Government and Community Affairs Manager, Nevada Health Care Policy Group):
I want to clarify we did not get time to go through the packets that were distributed, so I just wanted you to know what is in them, Exhibit D. Basically, when Tom Zumtobel was giving his presentation about why we thought that 200 percent of Medicare is a fair cost, that is in the packet and explains 117 percent is what most plans will contract with doctors. Their charges start at about 300 percent and 200 percent of Medicare is middle ground. This was not in any way intended to be punitive. We would like a solution. I appreciate the subcommittee idea so we can get to a solution that way.

Secondly, there is a letter with the packet. This is going to one of Senator Washington's questions from the Northern Nevada Care Coalition, a counterpart in the north (Exhibit E). They do not have contracts with all the hospitals, so they will probably have some information to show about the hospital issue with no charges. It is not our current situation but is their current situation. We would appreciate your time on that.

Finally, while I appreciate Dr. Carrison's discussion about CPT codes and the rate they charge, experience with bill charges is also in the packet, Exhibit D. Bill charges have increased almost 100 percent in the last 10 years. The Consumer Price Index (CPI) has increased 22.2 percent in the same time. The escalation of those charges, with no cap, is really the issue that we are trying to get to. Our experience is not that most doctors will bill the same price for the same code, not at all. It is all over the map. There are basically no rules. This is what I wanted to clarify. I really appreciate the Committee's time.

CHAIR WIENER:
We will take six more testifiers, in opposition, starting in Carson City.

DONNA JUELL, R.N., MBA, CMPE (Practice Administrator, Premiere Surgical Specialists, Reno):
See my prepared text I submitted (Exhibit F).

SENATOR HORSFORD:
On your second page, under the second bullet point, "… ONE set fee schedule for all physician offices … ." It states that in order for physicians to comply with Medicare, they must change their fee schedule to 200 percent of Medicare for all payors. Why is it okay for them to bill higher than that amount for individuals

who are not contracted, but they have a different fee schedule for those who are contracted? Is it just because someone shows up in their ER or they are a certified physician who does not have a contract?

MS. JUELL:
All physician offices have one set standard fee schedule. That is required by Medicare. That can be whatever the physician chooses, but it is one set standard fee schedule. It requires one tax identification number and a standard fee schedule. All of the other fee schedules are beneath that because they are contracted by PPOs or Health Maintenance Organizations for Medicare, so there is a set fee schedule and then there is what we contract for. If we are not contracted, then we charge our standard fee schedule. This bill says that our standard fee schedule has to be 200 percent of Medicare.

SENATOR HORSFORD:
Could there be multiple fee schedules based on contracted rates? I am asking for the person who is not contracted who sees a physician. Why is it okay for them to pay full bill charges? Is that inherently unfair for that individual just because they happen to show up at the wrong emergency room?

MS. JUELL:
Are you talking about patients that have no insurance or patients who have insurance?

SENATOR HORSFORD:
Either-or. In this situation, we try to address those who have no insurance in other legislation. I do not know if that is germane.

MS. JUELL:
There is the law that the hospitals discount their standard fees by 30 percent to the uninsured and most physicians' offices also do offer that discount. I have not seen the bills that we are talking about. For the most part in the north, my office is contracted with every insurance company that it is possible to contract with in the State. Most of the insurances that I am balance billing are California insurances that are not willing to commit to contract with me. That is for balance billing. If it ends up on the patient's bill, a lot of times our office does offer the patient a discount of what is left on the balance. The balance billing occurs if the insurance has chosen not to contract.

SENATOR HORSFORD:
I understand responsible hospitals and/or physician groups do that, but in case it does not occur, I agree with the beginning of your presentation. The trust between the physician and patient is to provide good quality medical care. That happens, but when you open the bill, like the gentlemen we heard from when his wife died, you end up having a bill that you cannot afford to pay. It just seems unfair and that trust needs to be continued throughout the process. We need to figure out some reasonable solution. It think it is an issue of how we create a fairness across the board.

SENATOR WASHINGTON:
In your opening statement, before you read your testimony, you did state that the patient does have some control in regard to the contract or noncontract costs. Can you elaborate just a little bit more on that? I tried to follow you through your testimony to see if you would pick up that theme, but it was not there.

MS. JUELL:
The point I was trying to make was that this is a very complicated problem we have. We certainly do have empathy for the patient who gets caught in the middle. There are several things we need to consider. We keep referring to those protocols and whether or not the patient has a choice about things. I have with me the chief of trauma surgery at Renown Medical Center, and he can answer those questions. If a patient is placed in an ambulance and absolutely does not want to be taken to the trauma center and states that he does not, at least in the north, he does not have to be taken to the trauma center. The rules may be different in the south.

Typically, we have those rules in place to protect the patient, because they are going to a facility that takes care of most of the particular problem, and they are going to get the best care.

SENATOR WASHINGTON:
On the second page of your testimony, Exhibit F, you indicated in the third bullet point that if the quality of patient care is not there and there is chaos and confusion in the billing environment, it may open up another legal avenue to see the physicians in court. Explain to me how that would work.

MS. JUELL:
It is hard to know how this bill will come out, when it will come out and what it is going to mandate. If it is mandating that the physician in an emergency situation can only charge 200 percent of Medicare, what about all the patients in his office and all the patients who are picked up from other places that do not fall under this? The billing office is going to have to be sorting out which patient belongs to what fee schedule. That could open another place for lawyers to sue physicians.

SENATOR WASHINGTON:
Ultimately, if you have a chaotic or confusing billing system, there are additional labor charges or administrative charges that may be tacked on to the bill charges, as well.

MS. JUELL:
I would tell you that our current billing system with all these codes and procedures, is already very confusing. We are looking at going to the International Classification of Diseases, Tenth Revision, which is going to further complicate things. For an office of three physicians, I currently have five billers to stay on top of the EOBs, all the contracts and all of the rules. It is a very complicated system, and I believe this bill will further complicate the billing.

SENATOR WASHINGTON:
On the first page, the fourth bullet point, Exhibit F, you talked about 200 percent. The previous testimony from Ms. Bond stated that the national average or standard was about 117 percent of Medicare. You just indicated that is not the national average, it is less, and some may charge outside of that 200 percent. Would you elaborate a little more?

Ms. JUELL:
I have no idea where she got her numbers. I can tell you that my contracts lie between 150 percent and 200 percent of Medicare.

SENATOR HORSFORD:
Depending on whose information you use on any given statistic, you get a different result. If your contract says between 150 percent to 200 percent, why is it unreasonable to accept 200 percent as this bill proposes for people who do not have a contract? Why should they have to pay more because you have a contract that pays you less?

MS. JUELL:
It comes down to a question of the contracting. The way you do business is to have contracts. This is interfering in the contracting business. I am not saying that 200 percent is necessarily bad for my practice at this point. The 200 percent is the moving target with Medicare. If you said 500 percent, would I be happier? Maybe, I do not know, but that is not the point. The point I was trying to make is that I do not think it is good for the Legislature to get involved in setting physicians' fees. We do not set fees for automobile mechanics or anybody else. It is difficult at a time when physicians are already scarce, overworked and stressed. It is a very bad precedent.

SENATOR HORSFORD:
I respect that opinion. I know that is the feeling of those in the industry; however, there is a public policy here because Medicare rates are set for a reason because the federal government is paying for that reimbursement rate. We hear from individuals like the person who is at risk of going bankrupt because he was charged the full-bill charges because his wife was served by a noncontracted provider outside the preferred provider network. That is a public policy discussion here, and we have to strike a balance. We have to protect those physicians and the medical community, and we need to do it in a way that is balanced with the interest of the patient as well. Thank you for your perspective.

SENATOR WASHINGTON:
Can you provide for the Committee an outline of how the contractual process works between you, the insurance company, the patient and the physician, so we can get a better idea of what we are dealing with as far as contracts and issues of concern. I am not one for legislating contracts, that is for the marketplace. If the marketplace dictates what can and cannot be paid, whether it is a provider, physician, or other stakeholders that may be involved in the medical health-care arena, I would like to see at least an outline, without the details, of how your contractual process works.

MS. JUELL:
I will provide that in writing to the Committee.

ASSEMBLYWOMAN HEIDI S. GANSERT (Assembly District No. 25):
I want to disclose that my husband works for Northern Nevada Emergency Physicians which staffs three of the four hospitals in Reno. I also work as an

independent contractor quarterly for them. I want to cast a different light on this. To me, the ER department is the safety net. It is the place where everybody goes when they have no other care. This is about access to care. Some people equate it to the fire department. If you think about the staff in the ER department, physicians and technicians, all these people are there just waiting for somebody to come in. People may show up or they may not show up, but you have to have levels and layers of staffing to be ready, and that is very expensive.

As far as the type of people that we see, it is well known that when you are presented to the ER you cannot be turned away. They see children with earaches, they see people with heart attacks and people who have been in car accidents. They see a plethora. In part of a discussion I heard earlier, they talked about protocol. One of the reasons there is protocol to go to certain hospitals is because certain hospitals have the facilities that are needed, be it a cardiac care center or a trauma center. In the trauma center you have all sorts of different specialties on call, and it is very expensive to do that.

Some of the people who are presented at the ER have insurance, some do not have insurance. Some are Medicare/Medicaid patients. We know right now, looking at our budget and the Assembly Committee on Ways and Means, we are at the 2002 Medicare schedule right now, even though there has been an update in 2007. Part of the reason that Medicare schedules are set is because of budget constraints. Sometimes it does not have to do with what care has been provided, it is because there is only so much money that the federal government, or in our case the Medicare budget, that the State government can spend. They back into these rates to try to get an amount that is enough to provide access to care.

I know we have a shortage of physicians and nurses in this State. We have heard from some pediatric specialties in the Ways and Means Committee about how difficult it is to provide access in Nevada because of the rates. My concern is that right now we are in a budget crisis, as are individuals who are losing their jobs. We are going to see more people go off of insurance. How do we balance all of this? There is a variety of people that you have to be ready to see in the ER; physicians, staff and equipment are necessary to make sure that you have the highest level of care. You need to see these patients, and again, it is a safety net. You take all comers in the ER, so it is reasonable to allow them to contract as they need to so they can provide these services.

JAMES WADHAMS (Attorney at Law, Jones Vargas; Nevada Hospital Association):
We are opposed to S.B. 157. Yes, this issue has been discussed in prior sessions, and quite frankly, we believe a great deal of progress has been made. Negotiations, as referenced by Mr. Zumtobel and Mr. Noonan, have taken place. All the hospitals in southern Nevada are contracted with HSC. That is because those parties have come together in good faith and have done precisely what this legislative body anticipated they would do, and have done.

There are several issues that come out of this that are much larger than this bill. This bill, in particular, page 2, line 8: "... by an ambulance ... " I would like to state parenthetically, in our handout (Exhibit G), we have identified in particular southern Nevada that 95 percent of ambulance deliveries are non-emergent. The various protocols that have been discussed, for example, of somebody being scooped up unconscious at a traffic accident, does not apply 95 percent of the time in an ambulance delivery. There is an opportunity for the kind of discretion to be exercised, as was discussed by prior witnesses, of directing where that person is taken. Patient direction is an overriding protocol.

The second critical element in this bill applies, in lines 11 through 14, to people who are insured. It does not apply to people who are uninsured. In Nevada, currently, the uninsured rate is probably close to 30 percent, given the unemployment numbers, the layoffs and the reduction in insurance purchasing. This only covers people who are insured, and it only covers people who are insured under a managed-care contract that has an emergency relationship with one hospital of any size in the State.

Just to illustrate the extreme, that could be Nye Regional Medical Center (NRMC). To have that contract with NRMC, they are entitled to the 200-percent cap at each and every other hospital, without the benefit of any attempt at negotiation.

Particularly applicable to the hospitals, we are required by federal Medicare law to maintain chargemaster compliance, a single set of rates that we charge everybody. We are permitted to deviate from that downward by negotiation with anyone else. We legally cannot charge more than the chargemaster. One of the witnesses said the CPI went up in the 27-percent range and the chargemaster has increased, but it cannot be more than that.

Part of the reason for that is the cost-shifting that was at the heart of Senator Horsford's question of why people are having different rates negotiating off of the chargemaster. Quite simply, it is discount based upon volume. If you have 300,000 members, they are going to have a lower discounted rate. If you had 700,000 members, you may have an even lower rate than that. That probably identifies also the major insurance programs in southern Nevada right now. Those who have a few hundred members will not get the same discount. Senator Horsford's question raises a fundamental problem of whether people should be charged different rates; should we allow discounting for volume? The problem with this particular element is that the hospitals with their health-care partners who pay these benefits and manage the insurance companies, which includes the HSC, have negotiated package pricing including ER and general hospital services. Again, all the hospitals in southern Nevada have entered into those negotiations and are in those contracts.

The insidious nature of this bill tends to be one in which we can legislate one component of that which has been negotiated in good faith. When the contracts come up again, there is one piece we do not have to negotiate. Quite frankly, is that a fair price? There has been some discussion of that in the questions and answers. I would suggest the answer to that is no. We have some data that has been handed out that suggests that Medicare really is second only to Medicaid in driving the bill charges higher, that is, the cost shifting. When the government programs pay less than the costs, the rest have to pay more. This is a complex question.

We look forward to working with the subcommittee and drive a little bit deeper. I want to commend those parties that, as a result of legislative efforts in 2005, really opened the dialogue between hospitals and payors and have produced contracts covering these services throughout Clark County. We would caution to being a little bit careful because the narrowness of this bill concept does not really get to the broader questions that have been raised by Senator Horsford, and they are certainly serious questions. The narrowness tends to benefit the insurers more than it does the individuals. The uninsured individuals are not benefitted at all, and worse, because of the cost-shift nature, they may actually pay their 70 percent, after their 30-percent discount, which will be of a higher number. It may be harmful to those who are not insured, but it benefits particularly the insurers of those other companies. I do not think that is the intent of this body. As this opens up into subcommittee discussion, we will be happy to participate and be happy to answer your questions.

SENATOR HORSFORD:
As you indicated, there has been tremendous progress between the hospitals and the various other stakeholders. What would you say, and we can get into more detail in the subcommittee, about the physician portion of this—how much does the contract that individual groups enter into with hospitals, carry down to the physician? Does that happen in every case? Are there contracts that people have with hospitals and then a noncontracted physician comes in and provides the service to the patient?

MR. WADHAMS:
That is an excellent question and it clearly opens up the area to which I was alluding. Within our facilities, we have certain physicians who are essentially there all the time. For example, in the trauma center we must maintain an existing standing cadre of people who can respond. Emergency rooms have to have 24-hour staffing; otherwise, hospitals are utilizing services of physicians who simply have staff privileges, not necessarily all of which are on call. The problem we have is that we have independent contractors, or physicians who are independent of the facility itself. When we enter into a contract as a facility with the HSC, it does not cover the seven physicians that might simply have staff privileges and occasionally take calls. In answer to your question, our contracts do not drive down to that level, and cannot.

SENATOR HORSFORD:
This issue needs to be explored further. People are saying let the market drive it, but if the market does not allow for those contracts to be entered into, then again ... God bless the hospitals, God bless the health purchasing groups that provide the insurance, but the patient that gets seen and ends up with a bill that is larger than it otherwise should be, or could be, is what I would ultimately like to get to. I appreciate the response.

CHAIR WIENER:
Mr. Welch, will you also meet with Mr. Wadhams?

BILL WELCH (President/CEO, Nevada Hospital Association):
I had some responses to some of the questions, but I will wait to do those with the subcommittee.

SENATOR NOLAN:
I was addressing other bills in other committees and was not here for the initial testimony on the bill, I came in at the tail end and got the pros and cons on it. I did not volunteer to be on the subcommittee for that reason, but if you are looking for another member… ?

CHAIR WIENER:
Senator Washington has volunteered.

WADE SEARS, M.D, (Nevada American College of Emergency Physicians):
I am currently President of the Nevada Chapter of the American College of Emergency Physicians. Today, I represent them and the safety net that we provide. As mentioned before, EMTALA is a federal mandate that requires us, as emergency medicine physicians, to see and treat every patient who presents to our facility. We do not have the luxury of refusing the patient. We do not have the ability to hang a sign that says, "We Will Not Care For You," in fact, we never close, never say no, never cannot see you, never cannot treat you, and we never stop caring for the citizens of Nevada.

Emergency medicine is a unique specialty. We see everything that walks through the door and we have to have extensive training to be able to provide those services. We make life and death decisions in a matter of seconds based on very limited evidence, the least of which includes insurance. This negative impact of S.B. 157 on emergency medicine physicians basically limits our ability to recover the financial exposure we have from upward of 30 percent to 40 percent of our uninsured patients. The downturn in our economy has increased the number of uninsured patients and even patients that are insured are no longer able to even meet their co-payments. The fact that we set a ceiling based on what is fair and customizable, for those patients that present, may not cover our expenses. In fact, the Medicare indices are a decreasing index. It has been held in abeyance, this index that has decreased over the last few years. President Obama's administration has mentioned that is where they are going to cut. So, 200 percent of Medicare, although you mention might be a fair and reasonable amount today, may not be a fair and reasonable amount in a year or two.

With the decreased index, one can guarantee that it is going to decrease our compensation as physicians and providers. That decrease will ultimately result in decreased physician coverage, and close the facilities like we have seen

throughout the nation, and specifically in California. It is essential that commercial health plans pay the EMTALA-obligated providers reasonable value for their professional services without the limitation set forth by this bill. Their payment by commercial carriers is essential for us as emergency medicine physicians to be able to cover the costs of caring for the uninsured and underinsured patients that we currently take care of.

Until we have a universal health-care program, whereby the reimbursement of rates, from all payors, cover the costs of providing critical emergency services, we cannot give heath insurance companies the right to ignore these uninsured patients. Senate Bill 157 gives insurance companies the right to ignore the uninsured. The 40 million uninsured lives that our safety net provides for is on the verge of financial collapse. We work on very thin margins. As you know, the coverage in California, because of balance-billing and bills similar to this, has forced hospitals to close and access to care for all in California to be greatly decreased. I would hate to see that type of access to care be something that was present in the State.

SENATOR HORSFORD:
I appreciate your service, Doctor, we understand from the physician perspective that it is becoming more difficult for you to do your job in the medical community, and that is one factor that we try to evaluate for public policy. I did have a question about the uninsured part of this as I did not understand where you were going with that part of your statement. Because of the current law that allows discounting of bill charges for uninsured, this bill does not address any of that, so how is this going to further affect the uninsured?

DR. SEARS:
By limiting the exposure, or by limiting the amount that we can charge health plans, it does not allow us to capture for the 40 percent of people that do not pay anything at all.

SENATOR HORSFORD:
That is a separate issue, and we will address that in disproportionate share hospital legislation that helps to reimburse hospitals. Maybe the hospitals are getting money that is not getting passed on to you, as physicians, and that is a whole other discussion we can have as a separate matter.

CHAIR WIENER:
Is this the first time you have testified before the Committee?

DR. SEARS:
Yes, in fact, it is the first time I have been to Reno and Carson City.

DAVID DEVALK (Chief Executive Officer, Reno Heart Physicians):
Reno Heart Physicians is a group of 21 of 45 cardiologists who work in Reno and Carson City. Ms. Juell did a good job of explaining the overview, but what everybody has missed so far is that this bill does not say 200 percent is a reasonable payment. It says 200 percent is a reasonable charge. That is not the problem. The charge is what the charge is, and as everybody stated, it does not really matter. I would wager to say, having just negotiated with Beech Street, which is the default PPO that comes in place when the culinary services unit contract does not apply because it is not a contracted facility, the charges fall back to Beech Street.

Here is how a contract negotiation goes with Beech Street: Beech Street sends a letter which says, "This is your rate, it will be this as of January 1, 2009, if you do not like it you can terminate; otherwise, this is the rate." It is not a negotiation. It is a national payor and they turn around and ramp that network on a contingent-fee basis through the culinary service unit. What I mean by contingent, is this: Kaiser Permanente does the same thing. They have software that actually goes through and looks at three contingent networks, and pays the claim based on the cheapest rate they can find. If you use the network and you are unfortunate enough to have a culinary worker come in and get a bill from a noncontracted doctor who is part of the Beech Street network, you will get Beech Street rates. The system goes beyond that with the Beech Street default; there is nobody at the other end to negotiate with. They just send the letter which says that is what you are going to get. This typically, in some cases, is even below Medicare. Office visit charges from our last Beech Street contract that I just finished looking at was actually 97 percent of Medicare.

You do not have a situation where the charge is a factor that you need to worry about. It is the payment that you need to worry about. I would wager to say that you can fix this whole thing. You would force insurers and doctors back to the table if you said if it is not a contracted patient, you have to pay 250 percent of Medicare. This would give incentive to insurance companies to not just unilaterally issue letters about what your reimbursement is going to be.

That would probably be a 60-percent to 70-percent increase over what they are paying right now. That would put us in a situation where a dynamic would occur that is very similar to what happened to the hospitals. The system would find a way to find equilibrium, whatever that might be. The charge has nothing to do with anything in medicine anymore. We are trying to find somebody who will pay us a reasonable rate so that when we do not get paid on three out of ten persons who come to the hospital, we can then pay our bills.

Currently, at Reno Heart Physicians, our hospital services render 29 percent of our bill charges and the office renders 62 percent of our bill charges. You do not need to be a financial genius to figure out that it would be a lot more lucrative to take the time devoted to doing hospital services and keep them in the office. That would cause the situation you were talking about before, whether access to care might go out, because anybody who is worried about paying their bills would have to spend more time in the office rather than spending time in the hospital.

It is a long, contracted billing, and I believe the villain here is the insurance company. Blue Cross, not to mention one by name, in their report to the shareholders are telling the shareholders that 59 percent of the premium went to medical losses. I know it is a publicly traded company and the shareholders are entitled to a rate of return, but I do not know why they get to keep 41 percent and figure that is okay. The villain here is the intermediary financing mechanism, it is neither the doctors nor the hospitals.

CHAIR WIENER:
A written testimony by Joseph Walls, M.D., in opposition to S.B. 157, has been distributed to members of the Committee (Exhibit H).

We will have a subcommittee chaired by Senators Horsford, Woodhouse and Washington. That will be posted and you will have another opportunity to appear. For the time being, we will close the hearing on S.B. 157. We will open the hearing on S.B. 302.

SENATE BILL 302: Authorizes certain agreements for the provision of medical care in certain hospitals. (BDR 40-982)

SENATOR DENNIS NOLAN (Clark County Senatorial District No. 9):
Senate Bill 302 is a health-care bill with some importance to both ends of the State, not only to our medical facilities but also to our communities as well. The Committee is well aware there are major medical facilities on our military installations: Mike O'Callaghan Federal Hospital, a full-service hospital, on Nellis Air Force Base; and the Fallon Naval Air Station also has a medical installation. This is a pretty innocuous bill, S.B. 302, which codifies into statute the ability for the military facilities to enter into a relationship with local hospitals for the purpose of allowing physicians who are licensed in another state to train primarily in the trauma centers with physicians and under the supervision of Nevada's licensed physicians.

The need for this is pretty obvious. On one hand, it will provide much-needed training to new physicians prior to tours of active duty and give them some experience, particularly in Las Vegas. Unfortunately, in Las Vegas, much of the urban trauma is seen there and the training and experience of those physicians would allow the opportunity to participate in the treatment. There is a benefit to the military. On the other hand, there is also a benefit to the hospitals in providing licensed, experienced physicians able to lend a hand in what is sometimes an overcrowded, very busy environment in our facilities as well.

COLONEL CHRISTOPHER BENJAMIN (Commander, Mike O'Callaghan Federal Hospital, Nellis Air Force Base):
I am the Commander of the Mike O'Callaghan Federal Hospital, which is a joint Air Force/Veterans Administration Hospital at Nellis Air Force Base. I am in favor of this bill. Before I begin, I would like to say that we at Nellis Air Force Base applaud Senator Nolan and his colleagues for their efforts to create a cooperative environment between the Air Force, county and state entities. Although federal statutes allow for the portability of state medical licenses for U.S. Department of Defense (DOD) medical officers, it does stipulate that such options will occur in authorized locations within the scope of federal duties in coordination with state licensing boards.

Senate Bill 302 will allow a hospital in the State to enter into an agreement with the armed forces which would define conditions of cooperation, specifying the scope and location in which the out-of-state licenses of military physicians would be honored. This would enable the UMC and the Air Force to forge an agreement to place military physicians at the UMC Trauma Center to hone their skills prior to deploying to Iraq and Afghanistan. The benefit to the armed forces

is clear. Experience working at a Level 1 Trauma Center prior to deploying into a combat zone ensures they will be prepared to handle the level of combat injuries they will face. Similar programs in Baltimore and Cincinnati have been very successful. Through such programs, combat medicine has made substantial progress. We have the lowest died-of-wounds rate in history. During this conflict, we have achieved a survival rate of 98 percent for anybody that makes it to a medical area with wounds. This compares to survival rates of 40 percent to 70 percent in wars within the last century.

As commander of a combat hospital in Baghdad, Iraq a few years ago, I had a chance to see this firsthand. Within days of arriving in-country, our team was faced with a mass casualty situation where we had five wounded soldiers basically dropped on us all at once. Our physicians did have the benefit of the type of training that S.B. 302 would provide those at Nellis, and because of this training they performed admirably. The combat environment does not afford us the luxury of spinning up teams in-country. The price of lack of currency is simply too high.

The benefits of S.B. 302 to the citizens of Nevada are also significant. The agreement between UMC and the Mike O'Callaghan Federal Hospital will provide Air Force physicians free of charge to work shifts in the Trauma Center. In addition to their experience in deployed skills, it will further enrich the educational environment that exists at UMC. The collaboration between military medicine and the civilian sector has a long history of successes. Techniques and discoveries from World War II through Vietnam have led to advances in medicine that U.S. citizens have been beneficiary of, while advances in the civilian sector today continue to save lives in the combat zone.

SENATOR NOLAN:
With Master Chief Barton's permission, I know that Dr. Carrison had been waiting originally for this bill and got caught up in the last one. He may have to go back to the Trauma Center at UMC, and I see him sitting down there alone.

CHAIR WIENER:
In the south, please identify yourself and proceed.

DALE CARRISON, D.O. (Chairman of Emergency Services, University Medical Center; Regional Director of Emergency Services, St. Rose Hospital):
I appreciate the opportunity to testify on behalf of this bill. This is an outstanding example of cooperation between the State, the UMC and our armed forces, particularly the Air Force. I have had the privilege of meeting with Colonel Benjamin before. I do not know Master Chief Barton, but share a similar respect for their military backgrounds.

This is a terrific opportunity for both sides. As you know, the UMC is a Level 1 Trauma Center chaired by Dr. John Fildes, current Chairman of the Commission on Trauma for the American College of Surgeons, which makes him the number-one trauma surgeon in the United States, if not the world. The benefit of this partnership is not only from an educational standpoint but it is a mixing. There are some recurring benefits for the Colonel; there are outstanding benefits for the men and women of the armed forces who will be allowed to come into the Trauma Center and train. If you look at this closely, I have no concerns with regard to licensing. The armed forces physicians are licensed physicians in a state, or the District of Columbia and in the United States of America. This bill would enable them to practice in our hospitals without getting a separate Nevada license. There is no reason for the State license. You have to remember, these men and women may come in for 30 days or 90 days, or they may be there for a year, depending on the level of training that they wish to be provided. This opportunity to share and cross train, as Colonel Benjamin mentioned, is unparalleled. In short, this is an outstanding bill. I compliment Senator Nolan and I certainly look forward to having a partnership with our armed forces, particularly Colonel Benjamin of the Mike O'Callaghan Federal Hospital, both from the active-duty Air Force standpoint and the Veterans' Administration.

FRED BARTON (Master Chief Petty Officer, Fallon Naval Air Station):
I am here representing the Commanding Officer, Captain Michael Glaser. I would like to say that both the U.S. Navy and U.S. Marine Corps support this bill. It is a quality-of-life issue for both the sailors and the families, and again, the Navy is in favor of this bill.

CHAIR WIENER:
Are there any others yet to come forward in favor or opposition of S.B. 302? I would love to move this measure today, but we are missing members. It will be on our work session tomorrow and Senator Nolan will give you the final tally

after we vote. I will now close the hearing on S.B. 302 and proceed with S.B. 303.

SENATE BILL 303: Enacts the Interstate Compact on Educational Opportunity for Military Children. (BDR 34-186)

SENATOR DENNIS NOLAN (Clark County Senatorial District No. 9):
We appreciate the Chair's indulgence with us on this. We have been coordinating a number of bills that we tried to bring together because these ladies and gentlemen from the military have hectic schedules and have traveled from Fallon today to try to take care of these all at once. With that, S.B. 303 is a bill which I was inspired to bring to the National Conference of State Legislatures, as I sit on a number of their different committees. This bill came before us and introduced the Interstate Compact on Educational Opportunities (ICEO) for the military children through the DOD. When I first heard of the intent of this bill, it made absolute sense to me in that Nevada should have this, not only in light of the number of military personnel and families that we have in and out, but all of us have friends who serve in the military who may have children. I know I do. My next-door neighbor is a Lieutenant Colonel with Nellis Air Force Base who recently returned from a nine-month deployment and was greeted by his wife and his beautiful little daughter.

The bill essentially codifies in statute the ICEO. The ICEO is a compact to establish some standardization and uniformity for those children of active service personnel who transfer across and in and out of state lines. It provides the educational standards and requirements for graduation for said students who come from one school to another. You can imagine how difficult the change must be. First of all, the kids have to move from one school to another, but add to that the trauma of finding out that your requirements for graduation from the state you moved from are not going to marry up with the state you are moving into. You either have to attend summer school, take additional classes or you are allowed to process at graduation but do not get your diploma until afterward. You really do not get to graduate with the kids you just made friends with. More importantly, we do want to make sure that the educational standards apply and the students who were graduating from our high schools meet at least the national criteria. That is what the ICEO does. There were some issues that we have been working on over the last several weeks that the State Board of Education had. We have ironed those out. There is an amendment in

the works that we have spent time on this afternoon with the DOD, Brenda Erdoes and the Board of Education.

We will identify the portion of the compact to be amended, but we will not spend a lot of time on it. It would make a lot more sense to get the amendment before we start entertaining questions, but we will speak to that. With that, Madam Chair, I might identify some of the witnesses to talk specifically about the bill and what it does.

CHAIR WIENER:
Legislative Counsel, Brenda Erdoes, has told me that she would be working with you on that, as well. Do you have any feeling as to when that might be ready?

SENATOR NOLAN:
Tomorrow morning. Ms. Erdoes stated she would have that done tomorrow morning.

Laura Crehan is with the DOD, State Liaison, Office of the Deputy Undersecretary of Defense, Military Community and Family Policy. She has traveled from San Diego to work with this and we have been in communication with her on this particular bill. I will step out of the way. Colonel Dave Belote is Commander of the 99th Air Base Wing and the Installation Commander for Nellis, Creech and the Nevada Test and Training Range.

LAURA CREHAN, ED.D. (State Liaison Office, Department of Defense):
I am currently a DOD State Liaison and I have also spent years with the DOD schools overseas, working as a teacher and principal with military children. This issue is near and dear to my heart as an educator as well as a DOD employee.

The DOD, in conjunction with the Council of State Governments, worked with groups and individuals representing legislators, educators, educational organizations and different associations over a period of two years to develop the Interstate Compact on Educational Opportunity for Military Children. A copy of prepared testimony is furnished to the Committee (Exhibit I).

MASTER CHIEF BARTON:
Thank you for the opportunity to speak in favor of S.B. 303 today. I am honored to serve as Command Master Chief Petty Officer at the Naval Air Station in Fallon. This position makes me the senior enlisted advisor to Navy

personnel in Nevada. On behalf of Captain Michael Glaser, Commanding Officer, Naval Air Station, Fallon, I would like to present the Navy support in the Interstate Compact on Educational Opportunities for Military Children.

In my role as Command Master Chief, I work with issues, concerns and complaints from our sailors and family members. The number-one complaint that I work with is their transfer on the base and their inability to work out school issues. I have been in the military for 28 years now, and have transferred 10 different times. Each time has been a challenge for my family, my children and me. We have moved from one state to another, come from overseas, and I deal with new school systems. Requirements from one state to another are different. My childrens' being able to get involved with sporting activities has always been an issue. This creates great stress for me and my family which should be unnecessary because it is part of military life.

Admiral Hearon, Commander of Navy Southwest Regions, who is in charge of installations in this region, including Nevada, has been behind the ICEO since its inception. He considers this to be a major retention issue. Military people who end up choosing to leave the military because of this will cause us to lose good folks. I ask for your support in this bill.

COLONEL DAVE BELOTE (Installation Commander for Nellis, Creech and the Nevada Test and Training Range):

It is my honor to testify on behalf of all the men and women, especially Air Force men and women, in southern Nevada. I have prepared and submitted a few slides (Exhibit J), and then I will share some personal stories to help drive the point home. Unless there is any doubt, I am very much in favor of S.B. 303.

I would like to highlight for the Committee that we have what we believe is a national treasure in southern Nevada, not only the 1,450 acres of Nellis Air Force Base, but the 2.9 million acres of the Nevada Test and Training Range. That combination of Nellis/Creech and the Range allows us to simulate any threat system that exists in the world today from a full Chinese threat, simulating the war over Taiwan, to a complete terrorist training camp set up in the area just south of Tonopah. Because of that, we have a tremendous reason to bring airmen of all ranks and all ages into this area, and as everyone has said, the school issue has become critical in retaining families.

I will highlight also for the community that Nellis and the Range brought a large economic impact of $5.1 billion in calendar year 2008. We have about 13,000 people on the payroll between uniformed military, civilians and contractors supporting us throughout Nellis/Creech and the Range. We know that in lots of places, $5.1 billion would be the only thing going. For southern Nevada, it is not a drop in the bucket. Critically, it is recession-proof dollars, and what we create for the State is a high-tech campus on the northern edge of the Las Vegas Valley, so we are proud to be here and because of what we represent. Because of the incredible capabilities out on the Range and at Nellis, we believe we will be here for a long time. Anything you and the Legislature can do to help our families will be very much appreciated.

As my two colleagues at the table have mentioned, we have issues of reciprocity, difficulties for transferring high school students to get to be on sports teams, to do things like model United Nations, Boys' State, Girls' State, you name it—any group of special programs, advanced placement courses and international baccalaureate. I know throughout Las Vegas there are about 10 or 12 special magnet programs, but the registration deadlines are February for all of them. If things work, as often happens in the U.S. Air Force, someone calls you up in April or May and says congratulations you are going to be at Nellis in two or three months. On the one hand, it is okay because you are transferring in the summer, but on the other hand, you have missed all of the deadlines necessary to give your children special consideration for those magnet programs. An incredibly difficult thing for kids who are already under the gun is trying to apply to colleges in different states and trying to build the foundation for their lives.

The Individual Education Plans for special-needs students can also create huge hassles for people who are moving around because so many states have so many different requirements. When a parent's number-one idea is to make sure that his or her child has the foundation for success that they need, it can create a great deal of stress on the military member and the family.

I am going to step away from the slides, and say, for better or worse, I am a poster child for both of those things that I have just talked about. My 20-year-old son, Drew, has autism. I have a couple on the Chief. In 23 years, my wife says I cannot hold a job; in 23 years I have moved 16 times. I am what we call a geographical bachelor. When I got this assignment to leave the Pentagon and came out to command at Nellis in May, because both my

20-year-old son with autism and his 17-year-old brother were rising seniors, we looked at all the issues facing us and we said, “We cannot move the kids right now, we cannot do it to either of them.”

In terms of Drew, his whole school program is about creating the foundation for an adult life. It is vocational experimentation. He was with a group of people who had watched him carefully for about two years. While I have come to Las Vegas and developed a great relationship with men and women in Opportunity Village, I did not have that relationship prior. I had no idea and it was very difficult to figure out what I could recreate in short order for Drew out here.

On the flip side, Mike is right now going through the college application process and he is on the total opposite end of the spectrum. Where Drew, by nature of his autism, cannot string three words together into a sentence, I have never been able to get Mike to be quiet. He has five out of six advanced placement classes, he is the secretary-general of the model he ran at his high school, he travels all over the state of Virginia doing things like that. I had no way of recreating that in short order. I honestly thought that I was going to have to choose not to be in the Air Force anymore and turn down one of the greatest assignments that I could have possibly dreamt. It was my beloved bride who sat at our kitchen table, and believe it or not, showed me the Command Screening Process which is all online now. We had the family laptop open over the Christmas holiday of 2007, and I thought she was going to say, “David, we cannot do this anymore,” and instead, she read the job description of the 99th Air Base Wing Commander, the Mission of the 99th Air Base Wing, and she said, “I cannot believe I am going to say this, you have got to take that job. That is everything you have ever dreamed of, that is what makes you who you are as a service member and you have to do it. We will make it work as a family.” I live in a little two-room suite, a bedroom, living room, and tiny kitchen. She and the boys are in a home that we own in northern Virginia. We are working through all of the family issues in trying to put everything into play to bring them out for the second year of my tenure, but that was a personal decision that we were able to make. It would have been just as valid a decision to say, “We cannot do that anymore.”

I am a native Virginian and am heartened that it was the governor of Virginia, where my kids and wife are right now, that today signed the Compact. It was excruciating. I have one more personal story about Mike. He was in Texas for

ninth grade. He smoked all of the Texas tests. He got the maximum permissible, the maximum allowable on the math test. We thought over the last three years we had wired everything, but the Texas and Virginia curricula were so difficult to mesh he had to repeat things as an eleventh grader that he would have taken in the ninth grade in Virginia, and vice versa. Three weeks ago, the guidance counselors called my wife and said, "Mike never did the history standards of learning in ninth grade, and if he wants a diploma he has to take a test tomorrow." She said, "Wait just a minute, we have been at this for three years." The counselor replied, "It is not too tough a test, who was Christopher Columbus, what was special about George Washington; he will walk in, take it, and be fine." I am 100 percent accurate that this is what my son was confronted with: go take a test tomorrow if you want a diploma in June.

This Compact would prevent things like that happening that would be a great benefit to the men, women and the families. People honor the Master Chief's and my sacrifice all the time. We appreciate the great words, but what our wives, children and our husbands do is what gets dropped out all too often. I ask your very favorable consideration of this bill, and I ask you to support the Compact.

CHAIR WIENER:
Thank you for sharing the humanization of issues before us in this Committee. As I often say, we are a Committee of head and heart. However our decisions may be, we use both very conscientiously. Are there any questions or comments?

DOTTY MERRILL (Executive Director, Nevada Association of School Boards):
The Nevada Association of School Boards represents the 17 school boards in our State, and all 107 members. We have been talking with Senator Nolan about this proposal for some period of time. He has been very gracious in connecting me with a number of individuals to talk about the Compact because, as an association and individual school board members, we do not have a lot of contact with interstate compacts. This has been a new adventure for us to learn about the issue of compacts as well as this particular Compact.

We have had some concerns and we have worked through a number of those concerns. We have learned in this process that there are many issues that face children in military families that we simply did not have an adequate

understanding of. A degree of frustration and tension can be created as students move from state to state and enter a variety of school districts in states and face new challenges. This is one that we have come to appreciate through this process. We have had some concerns about the way that the Compact will mesh together with our existing NRS, and as Senator Nolan has said, we want the statutes to be consistent with the Compact. We are working together on those.

We believe that we are on the right track here, and we look forward to further participation in the amendments. Thanks to Senator Nolan for raising this issue. We want to follow through with additional training and professional development for our school board members that gives them a heightened understanding of this issue, as well.

SENATOR NOLAN:
Ms. Merrill is one of those representatives who came to me. If only every lobbyist or representative showed up two weeks before the hearing, as soon as the bill came out, and said, "We have an issue with this and we want to work through it," as she did. We will come back with Dr. Crehan and work with the Legal Division. We will have the amendment ready maybe tomorrow, ready for work session, and be able to pass it.

DAN MUSGROVE (K-12 Inc., Education Management Services Company; McDonald-Carano-Wilson):
Education Management Services Company works with charter schools in school districts in 21 states and the District of Columbia. We are uniquely positioned to be able to come in and support Senator Nolan's bill because of the work that we do with military families across our charter schools and here at the Nevada Virtual Academy, which is one of our pilot programs. I cannot reiterate what has already been said other than the fact that the actual stories that the Colonel represented are exactly the reasons why something like this needs to exist.

One of the things that we have seen in our experience with these kinds of issues is the transfer of records that you have issues with, the course sequencing. The Colonel touched upon those kinds of issues. Obviously, the graduation requirements and exclusion from extracurricular activities is always a tough thing for these kids to have to deal with, as well as the parents. The redundant or missed exit testing is on point exactly. We just wanted to come to the table from a different perspective to say exactly what has been said. It is

impressive that Nevada wants to go ahead with this bill and get this on its books.

CHAIR WIENER:
Is there anyone else to come forth on S.B. 303? We will now close the hearing on S.B. 303 and reopen S.B. 325.

SENATE BILL 325: Requires hospitals to establish a program concerning methicillin-resistant Staphylococcus aureus. (BDR 40-42)

Senator Cegavske requested early in the hearing that we address S.B. 325. She had made the decision at the table to take no action on this; however, she has reconsidered and I bring it to the Committee with the request to turn this legislation into a resolution. We will bring the resolution back to work session and see it in draft form if that is alright with Senator Cegavske. We want it on the record that we are taking another direction.

SENATOR CEGAVSKE:
I forgot that Bobbette Bond wanted to say she supported one of my bills.

CHAIR WIENER:
We want it to go on record that Ms. Bond supports S.B. 325 which will be turned into a resolution, that it will come to a work session tomorrow, and if not, then next Tuesday.

MS. BOND:
I am excited to support Senator Cegavske's MRSA bill, S.B. 325, as MRSA is one of the three infections that we are trying to address in hospitals at this time, so I appreciate it. Senator Cegavske put this in over a year ago, she has been working hard on it, and we are excited that we get to see it.

CHAIR WIENER:
We will now close the hearing on S.B. 325 and move to S.B. 220.

SENATE BILL 220: Provides for the establishment of the Chronic Obstructive Pulmonary Disease Program. (BDR 40-1135)

ROCKY FINSETH (Managing Partner, Carrara Nevada; American Lung Association):
Thank you for bringing forth S.B. 220. Section 2 sets up within the Health Division the Chronic Obstructive Pulmonary Diseases (COPD) program, and section 3 allows the Division to accept gifts and grants to carry out the provisions of the act itself. The lung association, as well as GlaxoSmithKline, stands in full support of S.B. 220.

CHAIR WIENER:
As I spoke earlier on S.B. 157, this was a Committee bill, and Senator Cegavske will find this interesting in that it came as a request for a resolution. We found that it had more import to create legislation, and the Health Division was quite willing to address this because of the level of concern with COPD. This is, again, one of those that was requested of the Committee. I was more than happy to bring it forward, as I was with all the other bills that we have brought as Committee bills. Senator Breeden is having personal concerns with this issue as well in her family, so it touches our Committee in that way also. I might add that the idea of doing this is one of those "you never know where it is going to go but it is going to be good work."

Is there anyone else to come forward on S.B. 220?

MARY E. WHERRY, R.N., M.S. (Deputy Administrator, Health Division, Department of Health and Human Services):
In Nevada, COPD is the third leading cause of death for seniors 65 years and older versus the fourth leading cause of death nationwide. Early diagnosis and appropriate treatment of COPD can reduce inpatient hospital admissions and readmissions to only those with severe forms of the disease, reduce the associated financial cost and improve the quality of life for a person suffering from the disease. Currently, there are approximately 112,000 Nevadans with COPD. Prepared testimony is submitted (Exhibit K).

When we saw this bill, I asked the staff to look at it with regard to tobacco prevention. They contacted the CDC project officer. Interestingly enough, none of the other states have associated or incorporated COPD into their tobacco prevention, which I find unusual. It will present an opportunity to take existing resources and make a commitment to do all we can.

CHAIR WIENER:
We will close S.B. 220 which will probably be on work session tomorrow. Senator Cegavske has asked that we switch the order. The next bill is S.B. 290.

SENATE BILL 290: Authorizes patients of certain facilities to install electronic surveillance devices in the room of the patient. (BDR 40-852)

SENATOR BARBARA K. CEGAVSKE (Clark County Senatorial District No. 8):
Today's goal, in Nevada and across the nation, is to assist as many seniors and persons with disabilities in their efforts to live independently; however, a small segment of this population's needs are best addressed to the service provided in a hospital, long-term care or group-home setting. These individuals are many times the frailest. According to a recent new article, more than 4,700 people over the age of 60 were victims of abuse last year in Nevada. Unfortunately, sometimes this abuse is committed while an individual is a resident of one of the types of facilities I have mentioned. By recognizing the number of safe places in place to protect patients of hospice, long-term care, and group home facilities, this measure will provide added safeguards. The capabilities of monitoring from remote locations provides an additional sense of security for both the facility and the patients or residents. Senate Bill 290 seeks to allow for such monitoring in a way that respects the rights of each patient, the resident and their guardian facility.

For a moment, Madam Chair, I will let you know the reason this is important to me is I have a mother who is in a facility and has been for almost nine years. She is a victim of dementia, Alzheimer's disease and it is very difficult. She is in another state and I only get to see her twice a year. There was an incident where her hand was injured. We did not know what happened, and we did not know how it happened. She is in a very good facility, but nobody wanted to come forward as to what had happened and why. To this day, my mom, even with that illness, had remembered how to play the piano, and unfortunately, can no longer because of the damage done to her hand.

I thought to myself how wonderful it would be just to see her, so when Lillian Mandel contacted me and told me of her concerns, I told her I would love to be able to turn on my laptop and have a visual of my mom and her room, and just see her there. I also thought about the many family members who are concerned when they do leave their loved ones in a facility, and whether or not we would be able to monitor that at all.

That is why this bill came to be, and I do want to tell you that Robin Keith, President, Nevada Rural Hospital Partners, came to see me. I am very grateful to her. She talked to me about some of the issues that they thought could be presented. She does have three amendments that are very good amendments to add. I told her I was very supportive and appreciative because what she has done has made this a better bill for us. I would like to have her come forward, but I do appreciate all of you taking the time to listen to this information. It is something that we can work out again to make this good for everybody and all concerned. Again, the family is responsible for the equipment, the upkeep and all of the legalities taking care of the parent. My mom is in a private room, but Ms. Keith had brought to me some things that I had not thought of and so I am very grateful to her and these will improve the legislation.

ROBIN KEITH (President, Nevada Rural Hospital Partners):
Our hospitals have about 250 long-term care beds incorporated into their facilities, and thus our interest in this bill. Certainly, we appreciate the motivation for the bill and serving my relatives, as well. We do have a couple of concerns about the bill. One has come to my attention since I spoke with Senator Cegavske this afternoon. I have furnished a copy of my prepared text as to include three proposed amendments to S.B. 290, (Exhibit L)

The first amends line 5, page 1; simply insert the word “video.” We want to make it clear that we are dealing with pictures, not audio. The reason for that is the confidentiality of comments between doctors, patients, visitors, etc.

The second amends line 7, page 2 by adding after ... “patient or the guardian obtains any necessary permits, ensures that the installation meets all applicable codes.”

The third amends line 27, page 2 and strengthens the hold-harmless provisions for the facility. The facilities will definitely want to be cooperative with this but also have concerns that they are adequately protected.

Renny Ashleman, who represents the free-standing long-term care facilities in this State, brought to my attention and to yours, the fourth issue that has to do with how we might handle the instance where there are two people in the room. This bill provides for that and requires that their roommate signs a consent to have this camera in the room. Mr. Ashelman’s issue is what if that second person is not competent to sign that consent.

SENATOR CEGAVSKE:
Mr. Ashelman wants to make sure we had something that said it would be their guardian. If they do not have anybody, that would probably be the State. That is what we need to clarify. Those were the issues. I totally agree that we want to make sure all of that is covered.

CHAIR WIENER:
Thank you so much for holding up the building in Las Vegas, keeping everybody alert. Please state your name for the record, and proceed.

LILLIAN MANDEL:
I will give you a synopsis of what happened to make me realize what I feel has to be done in this State, and in this city. My mother was placed in a nursing home with loss of memory. In July, she had two abuse instances within a couple of days. The first one was where a certified nursing assistant (CNA) came in to change her diaper. She stuffed the diaper in her mouth to quiet her. A nurse happened to walk in and found what had happened and asked her to leave. I proceeded to talk with the administrator and head of nursing and they took care of it. Three days later, another CNA came in the evening and threatened that they were going to send her away because she had her friend fired. Now I was very irate, but calm in my presentation to them, but they could not prove that she really said that because it was, again, "she said, he said." I then decided I had to do something because these patients are not being treated very nicely when these things happen. I proceeded by pressing charges on the first CNA. She was arrested, she was sentenced, and now she can never work anywhere in the United States or in Nevada; I just found out today. With the second incident, I felt that I needed a camera in my mother's room and I needed someone who could help me get some kind of legislation going, and I e-mailed Senator Cegavske. She called me that evening and told me that she would definitely put a bill through, and here I am today. I have waited since 2:30 p.m. today, so I feel very strongly about this.

CHAIR WIENER:
We appreciate that level of engagement in government. Thank you for your perseverance and your commitment to the issue, demonstrating that this is a citizen Legislature, at many levels, and I would like to say that the citizen part is that we listen to people and act on what is important to them.

As there are no other witnesses, we will close the hearing on S.B. 290 and open the hearing on S.B. 286. .

SENATE BILL 286: Establishes provisions relating to early intervention services. (BDR 40-637)

SENATOR BARBARA K. CEGAVSKE (Clark County Senatorial District No. 8):
Today we are looking at S.B. 286. It relates to early intervention services for children. The mission of Nevada's Bureau of Early Intervention Services (EIS) is to identify infants and toddlers who are at risk for development delays or have development delays. The EIS provides services and support to families to meet the individualized development needs of their children, facilitates the children's learning and participation in family and community life through collaboration with the child's family, caregivers and service providers.

Early intervention services include assisted technology devices, audiology, family training, counseling, home visits, health care, medical services for diagnostic or evaluation purposes, nutrition counseling, occupational therapy, physical therapy, psychological services, service coordination, social services, special instructions, speech and language services, transportation services, vision, orientation, mobility services and others as needed.

Existing administrative regulations of the State Board of Health require the Health Division to charge and collect fees for early intervention services provided to an infant or toddler with a disability. Those fees may be developed on a sliding-fee scale. A summary of S.B. 286 requires the Health Division, within the limits of available money, to adopt and implement a policy for provisions of early intervention services to infants and toddlers with disabilities.

The measure also requires the State Board to establish fees for early intervention services, taking into account the financial circumstances of each family. The Health Division is required to charge and collect the fees in accordance with the schedule established by the State Board. The measure also requires the Legislative Auditor to annually evaluate the early intervention of services provided by the Health Division, and to report its findings to the Legislative Commission's Audit Subcommittee.

We have seen this bill before and heard it. There are some fiscal notes on it. There is an amendment that has come from Brian Patchett. We have tried to

rework the bill this time; working with all of the entities. Mr. Patchett took on the task. I am very familiar with Easter Seals' services. When my son was diagnosed as a severe asthmatic, we found out that he had hearing loss and needed some speech intervention at a very early age. Easter Seals was there for us and they did a magnificent job; I know of their services and I am very happy to support them. There are other providers and that is what we are looking for. We are looking for a choice for the families. The families need to be able to find something that fits for them. I am hoping that the people here today will come up, in the spirit in which this is given as a starting point, and that we can work together.

I do want to thank and would ask Karen Taycher to be the second speaker after Brian Patchett. I have worked with Ms. Taycher for years, she is with Nevada Parents Encouraging Parents, a wonderful program; I remember when she started out in her living room years ago. Ms. Taycher has brought to me several concerns and issues that we need to have addressed and talked through. I want to thank her for being proactive and being one that has reached out. I am very appreciative of that.

The other entities here, in opposition, I have not heard from at all. I do not know their issues and hopefully Mr. Patchett has been trying to reach many of these entities to see if we can work something out.

Again, this is something everybody talks about, it is something that we need to look at because it benefits the children and their families. I have had the pleasure of going to one of the Easter Seals events where parents were there and talked to me about the services. They are very happy, with tears in their eyes, being able to hold their children, including some with severe disabilities. They are willing to make that choice to work with Easter Seals, and they are very happy where they are. This is all about being able to obtain the services that are best for your child.

BRIAN PATCHETT (President/CEO, Easter Seals Southern Nevada):
I have furnished my written testimony today. I am legally blind and typed my testimony today (Exhibit M). I will amend it so it might end up being a little bit shorter.

As Senator Cegavske said, we are tying to create a system where we could have multiple providers in the community to offer choices for parents. We have a huge waiting list for early intervention. That is where this all started.

At the end of last summer and into the fall, we were facing another really big concern which was significant budget cuts that we have all seen. We were looking at $2 million to $4 million cuts in early intervention funding. That was going to dramatically impact children and their families.

There are three things that we are trying to get out of this bill, and it may not be perfect at this point. That is why this discussion in ongoing.

The third part of subsection 4 is, to me, the most critical part of this bill. One of the most frustrating things to me and many families has been trying to get accurate information related to who we are serving. I am not criticizing the Health Division or EIS, it is just the facts of what we have. Right now it is very difficult to find out exactly the costs, to find out exactly how much or what is being provided out there; it is very difficult to get that information. What we ask for in this bill is to get an independent evaluation, or audit, that would give us good information so we can make sound decisions as we go forward with providing the best quality services possible to children with significant disabilities. That is the spirit in which this bill has come back.

There is a proposed amendment (Exhibit N) and you have that before you. We are trying to address the fiscal notes. One was to try to work with something creative because we are looking at 4.5 full-time employees to be able to do a sliding-fee schedule, and the amendment talks about maybe contracting out for less. The final one is looking at hiring an auditor through the Legislative Counsel Bureau, and that would be very expensive. Maybe we could contract out with somebody else in a more cost-effective way.

To summarize my testimony today, the most critical thing that we can do is for EIS to find a way to provide the services that these families need. If we do not provide the services, from birth to three, it is going to get a lot more expensive and gets a lot harder to work with children. In Easter Seals we have an adult day program, for adults from 21 years and up, who have very significant disabilities. As I explain how we are trying to provide a recreation-based program for them, I cannot help but think if we had been able to provide quality

early intervention, we might have seen a completely different outcome for them as adults.

CHAIR WIENER:
When I was a young girl growing up in Las Vegas I was a Rainbow Girl with Easter Seals. Teams of us volunteered to work with a little girl, about 12 years old, who did not crawl; she went straight to walking. She missed substantial brain development. We took two-hour shifts to work with the little girl to force her to do things that she had skipped, like putting peanut butter on her lip to make her lick it off so she could develop certain motor capacity. We did this four or five times a day in two-hour rounds with that young child. I have great regard and respect for what the organization does and the use of volunteers.

KAREN TAYCHER (Executive Director, Nevada Parents Encouraging Parents):
No matter how we feel about this bill, no one is disputing early intervention is a valuable service. The Senator worked very hard last Session, and many of you have, to improve early intervention in Nevada. The Health Division and the EIS have also done a tremendous job trying to solve our problem. The fact is we still have a problem here in Nevada where we have 500 children on a waiting list for a service they need and cannot wait a long time because it is a birth-to-three service.

As I view this bill, I do not believe this bill will fix the problem that we are having with EIS. This bill has three parts. Part one is not mandated, saying that intervention is part of the Health Division. The second part is charging families a sliding-fee scale for the early intervention, and the third part, as amended, is a type of review of early intervention.

We have questions on three pages that Senator Cegavske has shared with you. We do not believe in its current form the bill will do anything to improve EIS. There are many questions that still need answers before Nevada creates a State fee, specifically for families who have children with disabilities.

I will ask you to please read through the very first line of S.B. 286 which talks of providing early intervention within the limits of available money. I do not believe that to be in compliance with federal law and strongly urge some research and validation on that before it moves forward. Since you have my paper (Exhibit O), I will stop here, but I will remain for questions.

SENATOR CEGAVSKE:
It is important that you highlight several areas. I know the hour is getting long but if we do not bring them up and have them discussed, they will get missed.

MS. TAYCHER:
Walking through the document, this bill has two fiscal notes. One of the notes is for Legislative Audit, and the advocates, for years and years, have wanted an audit of both the fiscal and the programs that are operated out of EIS. That was a positive that we saw. The second fiscal note is a guesstimate of what Nevada would be able to generate with the sliding scale and what the costs would be to implement a sliding-fee scale. Before we move forward on a sliding-fee scale for families, we need to understand where the revenue comes from for early intervention. Are we comparable to Connecticut's program? Before you copy someone's program you have to have all the elements in place or the program will not work like it does in Connecticut. I am not sure that Nevada's percentages are the same.

Also, there are questions about Nevada Check-Up and Medicaid. There are questions about Connecticut and does it have a much broader eligibility criteria than Nevada? There is a larger pool and different types of disabilities that certify early intervention in Connecticut. Some of Nevada's children do not get a direct service in a month. In Connecticut, when a child does not get a direct service, they do not pay the monthly fee. There is nothing in this bill to address whether they charge a family a monthly fee when they receive no service. The fiscal note does suggest that State employees will be doing the billing. Will private providers such as Easter Seals bill through State employees or will they have to hire their own billing people? There are questions related to who believes whose billing costs, and does the fiscal note really reflect the amount that it will take.

Another key component, in Connecticut, the insurance companies have to provide $3,200 a year for early intervention services to children with disabilities. We do not have that in Nevada. Again, we are trying to put something in place without all of the components. Maybe if we had that, it would make this bill work better. We do not know right now how much of our funds are projected to be generated by private insurance. If all of the providers are billing Medicaid, are they enrolled as providers in all the insurance companies? That is a key thing. If you are providing a service and you want to bill for it, you have to be enrolled with the people who are going to pay you back. My understanding is we are not utilizing all of the options that we have in our law right now to collect funds for

early intervention. Before we start charging families, we should spend time working on collecting the money that we need to collect now.

I would say now that families are not allowing EIS to bill their insurance, but we really want to see some data on that. How much money is Nevada losing by families not allowing billing of their insurance? In the law, I do not believe that service coordination can be billed, but it is not excluded in S.B. 286 as a service that will not be billed for. Bottom line is the fiscal note says we are going to generate about $235,000 a year. The cost of the audit is $101,000 and the cost for billing is $101,000. Our net to put this new system in place for billing families is $16,000 a year. I do not think that is going to get us to where we need to be to improve early intervention in Nevada.

SENATOR CEGAVSKE:
It is desirous to move forward and do something so we could have all these questions answered. I know that some of them are things that our staff will have to help us with. Being the last opportunity this week, I would ask if we could have all the parties work together. I would greatly appreciate it.

CHAIR WIENER:
Will you be sitting down with the parties to address concerns?

SENATOR CEGAVSKE:
I have been, and I will with the only ones who have come to me. It is hard to know who the others are if they have not come to me. I do not know who else there is.

MARY E. WHERRY, R.N., M.S. (Deputy Administrator, Health Division, Department of Health and Human Services):
I will veer just a little from your copy of my testimony (Exhibit P). Brian Patchett has said, "Well, we are going down this path, the ICC Committee has a subcommittee on Finance and they have been looking at every venue and opportunity that is being used across the United States to try to generate as much revenue as possible so that we can serve more children."

There are 15 other states that have established the family cost-sharing system with the early intervention programs. One of the things that we have discussed is that it is not just about the dollar, it is also about helping families to cost-share in the purchase of the services for their children. We send staff to

the home to provide services in a natural environment. We could probably collect data for you on how many times we go to the home and nobody is there. Staff has driven, sometimes hundreds of miles, and the families are not there. They have not called and they have not cancelled; they are just not there. There are other secondary gains to sharing in the costs of their health care.

With regard to where the revenue comes from in the EIS, this last year's budget was about $20 million; $15 million of that was State General Fund. Individuals with Disabilities Education Act provided about $4.3 million, the Maternal Child Health Block Grant was about $500,000 and the rest of it was Medicaid and Nevada Check-Up revenue. We did bill Medicaid and Nevada Check-up for all those children who are eligible. Medicaid and Nevada Check-Up children, I do not believe, according to federal law, would even be able to have a sliding-fee scale imposed upon them. I would doubt that they would even qualify when they are at 200 percent of the federal poverty level or below.

I would suggest that we take the Medicaid and Nevada Check-Up children off the table and look at who is left. We spoke with Mr. Patchett, who is working with Senator Cegavske on amending the bill. We would certainly be willing to look at any opportunity, whether it is employing state staff which we are not heavily vested in, or contracting with a third-party vendor to do the collections and operate the sliding-fee schedule; that is what they have arranged in Connecticut. We are more than happy to request information or request a proposal; whatever would be the most efficient, cost-effective venue for doing that with the State.

With regard to the audit, Mr. Patchett spoke to that. We had committed to using a contract starting this next fiscal year to go out and do a rate analysis. This is very important to us because our rates in the past have been set on the cost of doing business for the State. That is not always a good plumb line, so we have looked at the possibility of piggybacking on Medicaid's contract for actuarial services to be able to get an actuarial analysis of what the rates should be for those private-sector providers. We just completed a request for information to learn from the private sector and anybody willing to respond to this. We are conducting public workshops to get closure on it tomorrow on how should the State be operating EIS programs. What should the partnership with the private sector be? What should the role of the State be? We are open to looking at the whole gamut of this program, not just the sliding-fee scale.

We did do a survey of the families enrolled in existing early intervention programs and of the 105 respondents, 64 percent of them were reported to be at $45,000 or less, which for a family of 4 would be less than 200 percent of the federal poverty level. The remaining were above. We have 2 percent who are in the $125,000 to $150,000 range, with 3 percent making $105,000 to $125,000, 3 percent between $95,000 and $105,000 and 6 percent at $75,000 to $85,000. We do have families in the program who do have incomes and this was only families that self-reported. If we are not billing their insurance companies, the families are essentially getting these services for free. In today's economic environment and health-care deliverance system, that is a fairly atypical experience for just about anybody who is not on a publically funded program. Is this an entitlement program? Again, we are trying to look at every opportunity, looking at what other states have done to generate revenue, to serve more kids.

PAUL TOWNSEND (Legislative Auditor, Audit Division, Legislative Counsel Bureau): I am neutral on this bill, but I do want to discuss the fiscal note. The bill does require a Legislative Auditor to annually evaluate the EIS provided by the Health Division and to report on those to the Legislature. As discussed in the fiscal note, these evaluations would consist of performance audits to examine the efficiency and effectiveness of the resources being used by the EIS. Because they are conducted on an annual basis, I did feel obligated to note that I probably would have one position dedicated to performing this function. If the evaluations were performed with our existing staff, the impact would be a reduction in the number of audits completed annually by the Audit Division. The fiscal note also provides information on some of the travel expenses that would be required. We are your staff, we are here and want to work with you as best we can.

I do want to note that very rarely do we charge for an audit as we are funded by the Legislative Fund; I just put this expense in there, but it would then be included in our normal budget when we do the audits. There would still be some value perhaps in having a contract with actuarial study regarding the rates which, as Mrs. Wherry has indicated, would be more appropriate. Nonetheless, we are here, we will be excited to help out if we could on this. We would be doing the annual part of it forever. I am not sure if that is the best way to go, but we are happy to do whatever you would like.

SENATOR CEGAVSKE:
We appreciate your audit, you really do a good job. That is part of the subcommittee; we could call on you again.

CHAIR WIENER:
We are entertaining the work session on S.B. 286, by tomorrow or as soon as possible. Again, we need to resolve any concerns and we want to identify measures that might need to go to the Senate Committee on Finance as early as possible. My hope was by April 6 to get things identified so we can move them on and process them accordingly.

LISA ERQUIAGA (Executive Director, Northern Nevada Center for Independent Living; Strategic Plan and Accountability Committee):
I am the mother of a young man with a disability, and I come with three hats. The first hat would be to bring greetings from the Strategic Plan Accountability Committee (SPAC). They voted at Thursday's meeting and oppose this bill. The biggest part they oppose is the sliding-fee scale. I was happy to hear that Senator Cegavske said this is a starting point, because that is not something that we understood at SPAC. I will take that back to SPAC and let them know that it is indeed a starting point, and to be aware this is going to be ongoing.

I agree with the audit, a review of the program. But the sliding-fee scales were something that SPAC did not like. Some of the comments stated there were not enough details at this time, and when set in place there is no guarantee how high this will go and there is no stopping it. A lot of families do not have the means to pay the sliding-fee scale even if it is indeed $10 to $115. I saw that amount on the paper a few minutes ago; we did not have that information on Thursday at our meeting. The message from SPAC is that they oppose this.

I just want to give a little history of my son who was born with spina bifida and hydrocephalus in 1988. He just turned 21 years old. He was one of the first, at that time four months old, to be on the Katie Beckett Program. The Katie Beckett Program did not exist at that time in Nevada, it was a well-hidden program. That is where I got my start in all of this, and got thrown into the fire with Katie Beckett. I just wanted to share that this is not SPAC's information and it is not my center's information, it is my own personal information.

This needs to be delved into a little bit slower. In the early 1990s, the Katie Beckett Program wanted to charge a parental fee. Most of the people who

were in on that have long since retired, but at that time there was some talk about rich doctors and rich lawyers who were getting services for their children for free. It was very interesting because those rich doctors and rich lawyers never really showed up. We were not sure they were real. That was one of the tactics used, and the rest of us were trying to just make ends meet and get our children therapy and the care they needed at the different entities.

I need to caution everyone to think about the judgments that sometimes are made when you see where people live, how they dress and what they drive—all of those different circumstances that go along with that. Before we go into something like this, let us think about how the hostility toward Katie Beckett in the early 1990s caused a lot of hurt feelings and a lot of problems with a lot of people. I would hate to see that happen again.

CHAIR WIENER:
I encourage you to work with Senator Cegavske on your concerns. Sometimes a hearing brings out the voices that have not been calling. Senator Cegavske, you know the time limitations as well as I do for making a decision if the Committee chooses to move this forward.

SENATOR CEGAVSKE:
The one thing I am hearing that is coming out of this is that everyone is in agreement with the audit. If nothing else, if we provide that in this bill, we would be doing something not only that everyone agrees upon, but something that is probably very much needed. We could work that out with Mr. Townsend on how we could facilitate that. Everybody who is here, either for or against this bill, to bring to me the things you support in it, or you would like to see in it. The audit is number one, so if that were the only thing that came out of this I would feel very good about it, and if there are other issues in there that we could address, to make the system better, what we are trying to do is facilitate and do something for the children.

There has to be something besides the audit that will work. Maybe it is the language. If we need to rewrite it, I would be more than happy to work with that. Yes, SPAC is a very well-received group of individuals and I am thankful for their input. Sometimes we look at things in the negative and say we do not like it, but I was glad that you came forward with the things that you could support. That is how I would like to proceed.

CHAIR WIENER:
Is there anyone else to come forward on S.B. 286? We will now close the hearing on S.B. 286 and open the hearing on S.B. 319.

SENATE BILL 319: Revises provisions governing certain reports of sentinel events and related events. (BDR 40-828)

SENATOR SHIRLEY A. BREEDEN (Clark County Senatorial District No. 5)
I am bringing this bill before you on behalf of the Nevada Health Care Policy Group. My written testimony has been handed out (Exhibit Q).

SENATOR HORSFORD:
I would like to thank Senator Breeden for bringing the bill and having the strength to present it. Based on the situation that you have experienced, knowing that this was something you had proposed prior to your situation, speaks to the fact that this is about the people you represent and the people throughout the State who are affected by these types of events. The fact there is a personal situation that you experienced I expect brings to light all the more the reason why this matter is before us. I commend you on the bill and your strength over the last few weeks dealing with what you have been dealing with.

MS. BOND:
I am very happy that Senator Breeden agreed to try to work on sentinel events this Session. At the work group's beginning, they tried to figure out what would be an appropriate step in trying to strengthen our sentinel events reporting, activities and prevention. The State is also bringing forth a bill, A.B. 206. So, there is another bill out there on sentinel events. This bill might require some redrafting, first of all. One of the things we were trying to figure out is how we could address some key issues. Senator Breeden's request reached out to both HealthInsight and the Health Division because they are involved in several pieces of health-care quality now, so that we were not trying to structure something that would be duplicative or not appropriate.

ASSEMBLY BILL (A.B. 206): Revises provisions relating to public health. (BDR 40-858)

In conversations with them, they raised several issues that should also be addressed in an amendment, and we are very willing to do that. Specifically, we wanted to make sure, based on Senator Breeden's testimony, on literature and

what is going on nationally, that the State does require sentinel events reporting now. We know there is not a lot of regulation or a lot of reporting going on. While the State is requiring it, we thought we had to start addressing an issue called the "near miss" issue. We would like in this legislation, where we are requiring a near miss to be reported, an activity to control and prevent it happening again. If we cannot get there, we would at least like to see the State and the hospitals be required to work together to start figuring out how to define a near-miss and how to create a structured program to identify it quickly and fix it. The literature is showing near-misses are where the problems can be best identified and the best thing for your buck and the best piece of work. We wanted to bring the near-miss dialogue to the table. We feel very flexible about how it is approached. We would like this to be included in the sentinel-events program.

Secondly, we would like to talk about the CDC's National Healthcare Safety Network that has been going on for several years around the country. I am sure when HealthInsight testifies, and they know more about this than I, there is somewhere between 18 and 24 states now involved in the network. It is free for the hospitals to participate in, it is of no cost to the State and it is a national database. It seems, with our fiscal issues going on, like I need to move forward on health-care safety, to do something that is already a national benchmark or a national program, and not start off on something new. We are looking forward to having the hospitals participate with the State.

There are several different units that can be reported in the CDC's network. We are not proposing that all of those be in the bill, but it may be possible to work with the hospitals in the State and have HealthInsight identify which issue would be best to work on first.

In response to Senator Cegavske's bill on MRSA, we were thinking that would be a great first step to have the CDC reporting interstate networks as part of the national network reporting on MRSA and other medicine-resistant infections because those are the number-one preventable infections in hospitals right now. Last year there were 1.7 million of those 2 infections reported. That far outweighs the surgical-site infections going on in other areas. That would be our preference. But if the hospitals are already working on something or HealthInsight would suggest that there is something else that would be more appropriate, we would definitely want the flexibility to do that too. This is the long way of saying we are very flexible but we would like to move forward. We

do not believe that putting the hospitals in the situation where they have to drum up reports is useful. We would really like the collaborative programs so that things can move forward. One of the things that is very important to us is trying to figure out a way, if we cannot use the social security number on discharge forms, for the State and the hospital to collaborate on a unique identifier. The reason is the new UB-04 Forms that came out this year have removed the social security number from the data field. Because of that, nationally you no longer are able to track readmissions of the patient for an infection or some that could have started in a hospital, or something that did not get treated totally in the hospital if they are transferred to another facility. We have a problem now of not being able to line up vital statistics records and readmissions into a second facility without a unique identifier on them. That is one thing we really would like to see some progress on this Session.

The other thing that we are proposing is that if A.B. 206 is passed and an actual penalty assigned to not reporting sentinel events, which we strongly support, then we would like to see those hospitals and surgical facilities that are cited for non-reporting have that publically reported. We are not suggesting that sentinel events themselves be publically reported, though there are five states that admit to that. We would like to see how that program goes in the next Session and work with the hospitals to just get the reporting out. We will see what transitions through that. We would like to have the penalties for non-reporting be reported, because that is the best way to make sure the reporting starts.

MARK BENNETT (President/CEO, HealthInsight):
I am a member of the federal Quality Alliance Steering Committee which determines its priorities for measurement and improvement initiatives at the federal level. I have just a few comments that I would like to make about this bill and then turn the time over, with your permission, to Debra Huber who is our director of Transparency of Chartered Value Exchange Activities.

I would like to present four key messages. First of all, we at HealthInsight would strongly support the use of the National Healthcare and Safety Network (NHSN) tool. We believe this is a good model for gathering data, and as Ms. Bond has pointed out, it is free and available to hospitals. We believe this answers one of the difficult challenges that we will face in gathering information, particularly about infections, in a common way. The CDC has done a lot of work to prepare this, and we think the State should strongly consider

using this tool as they proceed in this area. This is very complex work and there are a lot of questions to be answered. We think standard tools will help us answer some of those.

Secondly, we have been using the NHSN with 12 hospitals in Nevada and a pilot project for gathering of data around MRSA. This is just beginning so we know something about how this process works. The main message from that is it is a very complex tool in and of itself, and requires a lot of work to implement. We would encourage the State to go slow in implementing the list in the bill as it is currently drafted. It is a very long list and has the risk of overwhelming the hospitals' ability to effectively use the tool and to make improvements. We think there should be some prioritization of that as you go forward.

Third, we have concerns about the provisions in the bill that talk about sentinel events, the reporting of near misses. There are, as Ms. Bond has pointed out, in the literature and in the practice of quality improvement, a lot of value in focusing on near misses as tools to prevent future errors and future mistakes in health-care. We believe as it is written in this bill, that we would be overwhelmed with a very broad range of reports, some of which would be useful and some of which would not. Many hospitals would end up doing potentially root-cause analysis paralysis, spending all of their time looking at their processes and none of their time delivering care. We would strongly encourage further discussions about how to limit that definition. The joint commission has a different definition which is narrower, or we would encourage a go-slow approach on near misses.

Fourth, we support the use of root-cause analysis as a tool to drive improvement and to ensure that mistakes can be corrected and future mistakes prevented. We have concerns about the ability of a mandatory reporting system to capture useful root-cause analyses. There is a tendency in any public reporting system for everyone to devolve to the least common denominator of doing analysis that is about satisfying the people they are reporting to rather than about understanding a process failure and building the system to prevent future errors.

That is a complex science, it is one we have worked on with hospitals and providers for more than 15 years now. We feel that it can be done, we support

its use, but we would suggest that you should be cautious about how much value you expect to get out of the initial root-cause analysis efforts as a result.

DEBRA HUBER, R.N. (Transparency Strategy Director, HealthInsight):
As Mr. Bennett said, we do support infection reporting and we do think that using the CDC network is a very strong and appropriate way to go. As part of this current contract that we have with Medicare, which began in August of last year, I have been working with the one hospital in Nevada that currently reports to the network to have them expand their reporting to this new MRSA module that just came out on March 13. We have also been working with 11 other hospitals that have volunteered to begin reporting to the network on the MRSA module, on 1 unit in the hospital. There are already voluntary activities going on.

I want to reiterate and make another couple of points about this network. Actually, it was developed almost two decades ago; it used to have another name and was put together and paid for by the federal government. It looks like a fine way with our fiscal problems. It allows for facilities of all sizes and locations to report, so it is not only the large hospitals that can report. Its purpose is to standardize definitions so that when we are looking at various reports they are very specific. That is so you can compare apples to apples and know you are looking at the same thing.

The real purpose of the network is to help us evaluate trends, to evaluate upcoming concerns and to help our providers evaluate the effectiveness of the interventions they have been putting in place to try to reduce infections, and that sort of thing. Those are all real positives, there. Despite those, it is also very important to be aware that to begin with, you have to get trained to join this network. The CDC estimates the minimum for each user to be 18 hours. It is online, it can be done at the individual's leisure, but they do say that it takes 18 hours to do that. In addition to just getting the training for the network and learning the definitions, you also have to do additional training for the new MRSA module, as well. That is only about an hour once you have completed it. This is just to let you know there is a considerable amount of time that is involved, and quite a learning curve because it is very, very specific about what you have to do. It does require monthly reporting, so again, this is something that generally the infection control practitioners accomplish.

As was mentioned, in the bill there are a large number of components of the network listed, and even more than that actually in the network that you can report. In each component, there are many, many metrics. I would really support our going slow, having a common understanding of what it is we really want to measure, where we want to focus our attention and then broadening out after that. One thing, for the new multi-drug resistant organisms within the one module, we sometimes think it is just MRSA, but actually there are five organisms, with many, many metrics within that. It is very, very broad and we would certainly support the reporting, narrowing our focus and going slow. It is very labor-intensive.

As Mr. Bennett remarked, I would echo his comments about the near-miss reporting and the use of root-cause analysis. It is most important to look at near misses, and using root-cause analysis can be very effective. Certainly, we want to know the contributing factors and to do those kinds of analyses, but as he said, often if it is a mandated kind of component and you are just trying to say, "We have completed this." It can become a paper exercise, if you will. Another important area, if we are going to use this and find value from it, is for the folks who are going to be doing the analysis to have the expertise, knowledge and experience to do it. I have taught a lot of root-cause analysis across the State and, frankly, we really do need the kind of expertise that many staff do not have in our facilities, to be able to conduct those in a way that will be valuable for us in the long run.

MARLA MCDADE WILLIAMS, MPA (Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services):
As you know, the Health Division currently administers the sentinel-events reporting system, so that in itself is not news, as has been testified to. As Ms. Bond mentioned, the literature indicates that analyzing these events provides opportunities to enhance the quality of care that hospitals and ambulatory surgery centers provide to patients. We also support use of the national health and safety network reporting system. It is an established system that 19 other states currently require hospitals to report to. In those states they do have the opportunity to access their data, as Mr. Bennett testified. Reporting through the existing surveillance system is a cost-savings to medical facilities and to the State because it is already a developed system and we do not have to go through and do a whole bunch of contract work to try to develop a new system. Providers will have access to consistent technical assistance and the benefit of an established peer group among other states that use this system. It

has the additional benefit of modules that can be targeted. One module now under development is dialysis.

In terms of analysis of the data and the reports that are required, the Health Division has proposed adding a bio-statistician to the Bureau of Health Care Quality and Compliance who would be available to analyze all of the Bureau's data. If this position is supported by the Legislature through out budget process, this work would be absorbed into the function proposed for that position. We also are coordinating a summit in July to provide opportunities for hospitals and ambulatory surgery centers, and others, to enhance their infection survey and analysis systems. We will be inviting the CDC and staff to participate in that summit.

CHAIR WIENER:
There is a bill processing in the Assembly; Ms. Bond had referred to it and we are aware of it as the Health Division's bill. Could you give us an overview of what is in that measure?

MS. MCDADE WILLIAMS:
The key provision, as it relates to sentinel events, is that it would impose a penalty for not reporting sentinel events. Right now, statutes do not have any penalties for not reporting a sentinel event. If it were discovered that a facility had a sentinel event that was not reported, it would allow a fine for that facility. Those are the major provisions related to sentinel events. It has the other enforcement that we had on the Saturday hearing discussions about clarifying our administrative authority and those other items that are in the bill.

CHAIR WIENER:
The Saturday hearing you are referring to was the hearing we had in Las Vegas, as the primary location, on hepatitis C, about the third week of the Legislative Session.

MS. BOND:
I forgot to talk about another key provision of this bill. This bill would require the sentinel events that are already supposed to be reported to the State Board of Nursing, the State Board of Osteopathic Medicine and the Board of Medical Examiners, be reported now, and would require those reports also go to the State, so that when sentinel events happen, and the boards know about it, the boards send out information to the State. The Health Division can then

coordinate the reporting of those, which has not happened up to this point. It is one of the gaps that was identified with the hepatitis C issues as a way for them to cross-refer and build communication patterns that are lasting, and fill in the holes.

CHAIR WIENER:
Are there any others who would like to come forward in support of S.B. 319, or to offer information, some of it for and neutral? Any opponents of S.B. 319?

TIM TETZ (Executive Director, Office of Veterans' Services):
Five hours ago, I started in this hearing with two bills I was pretty neutral on, and now I walk out of here tonight strongly in support of S.B. 302 and S.B. 303, neutral on S.B. 290 and have changed my mind 180 degrees on S.B. 319 in those time periods. We should have shorter hearings, then I can agree with everything. I stand before you today because S.B. 319 changes some things that we have. As you know, the Nevada State Veterans' Home is one of the premier veterans' homes in the State and a long-term care facility; it is a skilled-nursing facility. We are required by law to report sentinel events to both the Department of Veterans' Affairs and to what was the Bureau of Licensure and Certification, now named something else.

One of the first times I went to the Veterans' Home I sat in on a MRSA meeting and they walked me through this analysis. I learned later it was a root-cause analysis because they had a resident who was having a falling problem and had fallen several times. They were trying to figure out why the resident was falling. They explained that maybe he tripped over something; we will put a pad here; put up a rail; make sure he cannot move; advise him of all these things. At the end of it, I was just in awe that they had spent 45 minutes going over the fall of this one person. They eventually moved his bed down six inches. When I walked out of there, I remarked in my sometimes snide way, "Did somebody take into consideration that he is 88 years old and he has started to lose his balance?" They replied that they did take that into consideration, but how could we work around that? I just realized what a professional staff we have there and what they try to do.

When we look into this bill to address the near miss, and this has already been said, near miss is pretty loosely defined. A near miss could cover anything, including rolling out of that bed and not getting hurt. Now we meet to ultimately do a root-cause analysis perhaps on that, or tripping on shoelaces or something

else that happens when you are aged and no longer have the balance you had at 20 or 30 years of age. We have been, or might have been, in some ways exempt from this. When you look at section 4, long-term care facilities, or skilled-nursing facilities get wrapped into this reporting, because we do take more than 25 patients in a business day. Often it has been bantered about that this was for hospitals and surgical centers. This draws the skilled-nursing facilities in and would require the Nevada State Veterans' Home to participate in not only the federal program and putting these things together, but going on with the reporting of these near-miss situations.

In the scrambling of e-mails that I was sending awhile back, we will have to go back to the drawing board and submit an unsolicited fiscal note. But we are concerned that this is going to require us to do things we currently are not doing and add staff to do this, just because of the near misses.

Keep in mind that at the end of the day the Nevada State Veterans' Home wants to be the premier provider for care for veterans, spouses and Gold-Star parents. We will do everything in our power to do that. If that means requiring us to work with near misses and learning from those, we will, but we want it to be understood that right now we think we are doing a pretty good job and we are happy to improve, but it is going to be tough on us at times.

ERIN MCMULLEN (HCA Sunrise):
We are here to oppose the bill as it is currently written. But we are anxious to work with the sponsor, Senator Breeden, and the other parties involved to work something out that provides the best health care for the patients.

MR. WADHAMS:
Given the lateness of the hour, I will be brief. We have been on record on that Saturday hearing that was referenced a little earlier, in support of working on A.B. 206. We continue to support the general notion of using the CDC-based infection surveillance information. I will be happy to work on that. We do think there has to be a great deal of time spent to make sure that the protection of the identity, both for purposes of HIPAA and other federal identify protection, of individual patients is recognized, and sadly, rather than being a health-policy expert, I do happen to be a lawyer. I have read section 2 of the bill which causes me a great deal of excitement because a near-miss event is currently defined as "an unplanned event which is anything that did not result in any injury to a patient, but had the potential to result in an injury." That needs some

very serious, restricted definition, because as the gentleman from the Veterans' Home pointed out, this is everything from somebody simply stumbling on their shoelaces, somewhat proximate to a patient, as well as a patient having dizzy spells. It is way too broad and is problematic, but the basic concept of the system is something we ought to work on and hopefully this Committee can coordinate its work with A.B. 206 and we can end up with one bill that moves us along this pathway. We are opposed to the bill as it is written, but we are in support of the concept.

CHAIR WIENER:
Is there anyone else in opposition to S.B. 319? Senator Breeden, it looks like it will take some tweaking and some conversations with people. We will put this into a work group, not a subcommittee, and it would be nice to have it by Friday. We will give you until Monday, but Friday would be great. We will aim for Friday. We do have a work session tomorrow.

As there is no other business appearing before this Committee on Health and Education, this meeting is adjourned at 7:25 p.m.

RESPECTFULLY SUBMITTED:

Maureen Duarte,
Committee Secretary

APPROVED BY:

Senator Valerie Wiener, Chair

DATE: