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

Seventy-Sixth Session
May 9, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 1:54 p.m. on Monday, May 9, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/76th2011/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman Steven Brooks
Assemblyman Richard Carrillo
Assemblywoman Lucy Flores
Assemblyman Jason Frierson
Assemblyman Pete Goicoechea
Assemblyman John Hambrick
Assemblyman Scott Hammond
Assemblyman Pete Livermore
Assemblyman Mark Sherwood
Assemblywoman Debbie Smith

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Barbara Cegavske, Clark County Senatorial District No. 8

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Linda Whimple, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Morgan Baumgartner, representing University Medical Center of Southern Nevada
Kathleen Silver, Chief Executive Officer, University Medical Center of Southern Nevada
Gregg Fusto, R.N. Director, Trauma Services, University Medical Center of Southern Nevada
Jay Coates, D.O., Assistant Professor of Surgery, and Program Director, Trauma and Critical Care Fellowships, University of Nevada School of Medicine; and Vice Chairman, Trauma Department and Director, Visiting Resident Program, University Medical Center of Southern Nevada
Wendy Simons, Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services
Bill M. Welch, President/CEO, Nevada Hospital Association
Ed Guthrie, Executive Director, Opportunity Village
Brian M. Patchett, M.P.A., M.S., President/CEO, Easter Seals Southern Nevada
Lisa Foster, representing Northern Nevada Association of Service Providers

Chair Mastroluca:
[Roll was called.] We are going to start with Senate Bill 10 (1st Reprint), which is revising a process for approving an amendment to the license of certain medical facilities to add certain services.

Good afternoon, Ms. Baumgartner; it is nice to see you again.

Senate Bill 10 (1st Reprint): Revises the process for approving an amendment to the license of certain medical facilities to add certain services. (BDR 40-344)

Morgan Baumgartner, representing University Medical Center of Southern Nevada:

Thank you, Madam Chair. I also have Kathleen Silver and two of her staff physicians in Las Vegas. If it pleases the Chair, I will walk through the bill very quickly and turn it over to Ms. Silver to elaborate more fully on the ramifications of the bill and the problem that we are presenting here today.

Currently under statute, there are licensure requirements in addition to the general hospital license. There is a requirement if you want to add a service for trauma, neonatology, transplant, open-heart surgery, and burn treatment. Over the past few years we have seen patient volume decreasing in some of these areas. Patient volume—the number of patients seen by these services—is a very important criteria for maintaining patient outcomes, maintaining the ability to train residents, and keeping these programs viable and healthy.

Under current law, to get certification and licensure for these additional services, one has to submit an application and meet the regulatory requirements set forth by the Division of Health. Assuming you meet the licensure requirements, you are granted a license and then the Division monitors your license over the course of the year until license renewal. As we have seen these patient volumes decreasing, we have noticed that we need to take a step back and look at not only the licensure requirements that are being fulfilled by the actual applicant, but perhaps look more globally and more holistically at the other programs and services that are being impacted when new programs come online.

So we are proposing in Senate Bill 10 (1st Reprint) what we believe is a fairly simple way of addressing this potential problem. We would ask that through this bill, the Division of Health adopts regulations specifically related to patient volume and determining what an adequate caseload is. This is really an augmentation to the regulations that are already in place. Many of these services already have volume criteria that have to be met when applying for a license. We are not asking for anything new; we are just asking that if volume requirements have not been adopted yet for these particular services, that volume requirements in case numbers do be considered when looking at the regulations for licensure of these particular services.

The second important fix in this bill is that once these licensure and volume requirements are adopted, when a new service is submitted for licensure, we would ask that instead of simply seeing that all of the requirements for licensure are met by that particular program, that the Division also consider the volumes of other programs so that if another license for a particular service is approved, it will not cannibalize those existing programs or make those existing programs

suffer and thereby decrease patient volumes and the efficacy of those programs. The other important thing to know is that this bill does not require any new information to be collected by the Division. This is information the Division should have on file because it has already approved an application for the other programs and it has monitored the licensure status throughout the year.

I think that takes care of the quick overview of the bill. If you do not mind, I would like to defer to Kathleen Silver and her team to answer any additional questions or provide additional information. I would like to thank the Division for working with us as well as the Nevada Hospital Association in trying to come up with these new licensure requirements.

Kathleen Silver, Chief Executive Officer, University Medical Center of Southern Nevada:

Thank you for this opportunity to speak to you about S.B. 10 (R1). As Morgan indicated, one of the reasons that we proceeded down this path is that over the past few years there was a lot of growth and proliferation of new programs in southern Nevada. Many of the programs that were licensed to provide these services were doing fewer and fewer numbers. In many cases, the quality, efficiencies, and financial sustainability of the programs rely on volume. What we are hoping to do with this bill is to ensure on a going-forward basis that the programs that are here have enough volume to be quality programs, efficient programs, and because these are all resource-intensive programs, to remain financially sustainable.

We sent up a slide presentation for the Committee (Exhibit C) and I think it should be in your system. We just want to touch on a few of the programs that are specifically in this particular legislation. I will start by talking about open-heart surgery cases.

The first slide is open-heart cases by hospital. In the current licensing regulations, after a period of two years, hospitals that are sustaining these programs should be doing an average of 200 cases per year. Beginning in 2004 in southern Nevada, you can see that a number of hospitals were doing well above 200 cases. Over time, new programs came on board and as we look at 2010, there is really only one hospital that is significantly over the 200 mark, another one that is barely over the 200 mark, and the rest are beneath the 200 mark.

On slide 2 you see a trend line of average open-heart cases in southern Nevada from 2004 to 2010. In 2004, we were averaging 306 cases per hospital, going to a high of 324 a year later, and in 2010 we were averaging 177 per hospital.

Clearly, the added programs have not helped the individual programs by bringing additional programs on board. We are hoping that in the future before new programs would be licensed, the Bureau of Licensure and Certification would look at existing programs to make sure they are all meeting minimum standards.

I will now turn it over to Gregg Fusto. Gregg is the director of our trauma services. He is going to talk to you about some of the other programs.

Gregg Fusto, R.N. Director, Trauma Services, University Medical Center of Southern Nevada:

If we can continue onto slide 3 (Exhibit C), this shows the University Medical Center of Southern Nevada's (UMC) trauma admissions. We started as the lead trauma center; and if you look at our numbers from approximately 3,500 in 1998 to our peak in 2002, you can see where we are now. When the second of two centers opened up—one in 2005 and the other in 2007—we noticed a 20 to 25 percent drop in our caseload. Now with the economic bubble bursting, you can see our decrease is 49 percent. That is a big impact on a teaching institution.

Slide 4 shows our total transfers in. Our catchment area is 10,000 square miles and we get people from California, Utah, and Arizona. With the other two trauma centers coming in, we have noticed a 35 percent decrease in trauma transfers into our facility.

Slide 5 shows a 35 percent decrease in the total number of trauma field triage criteria patients. When we formed our trauma system, we made boundaries and we decided on trauma field triage criteria. If you just look at the number of patients that are in our system now, you can see where we started out at 4,736 and in 2009 it went down to 3,249. Again, UMC has had the greatest impact, because when the two trauma centers came on, it was the only system that actually suffered by giving up territory and patients. Now with our economy, it has noticed a 35 percent decrease, and that hurts UMC.

Slide 6 is an overall picture of UMC's trauma center patient volume that shows the highest volume of patients in 2003. You can see we are on a steady decline. Six years ago we were the only outside verified level II pediatric trauma center in the state of Nevada. Slide 7 is a Clark County School District enrollment history. You can see that the numbers have gone up drastically, and if you look at the next slide, we see a 58 percent decrease in volume of pediatric trauma admissions. When I say outside verification, that means the American College of Surgeons plus the state came in and reviewed us. It is an enormous process, backed by the administration and medical staff, but there is a lot of information and a lot of time that goes in here. We did not just hang

out a sign. We actually went through this verification process. Part of the verification says we have to have 100 pediatric patients per year. Last year we skimmed by with 108 patients. If the economy or other facilities open up and take more of our pediatric patients, we will not be able to reverify. Now we have two years, and we are trying. We are doing outreach and everything we can, but as you can see here, we have a 50 percent decrease. With the American College of Surgeons saying we must have 100 patients, and only having 108 last year, we are quite concerned.

Slide 9 shows a 52 percent decrease in pediatric transfers. You can see our peak was in 2003. Since we have formed a trauma system, we have pediatric trauma field triage criteria. The bad part is that the only ones that actually turn in data are the three trauma centers, so the only information that we could clearly and concisely get is from the three centers. On slide 10, you can see our decline from a peak of 179 patients to 108 patients this year.

If you look at the last line from the bottom on slide 11, it says, "Minimum No. of annual trauma admissions of children younger than 15 years." On the far right-hand column, pediatric level II, it says "100." We only received 108 patients last year. Again, we have done a lot of work and we would like to keep our pediatric trauma center. We think the citizens of Las Vegas, Clark County, and Nevada deserve it. We are coming to you for some help. Thank you.

Kathleen Silver:
I am going to turn the last slide over to Dr. Jay Coates. Dr. Coates is one of our trauma surgeons.

Jay Coates, D.O., Assistant Professor of Surgery, and Program Director, Trauma and Critical Care Fellowships, University of Nevada School of Medicine; and Vice Chairman, Trauma Department and Director, Visiting Resident Program, University Medical Center of Southern Nevada:
Slide 12, (Exhibit C), titled "Ex Laps Directly to OR," shows the patients who have come into our trauma center who have been severely injured or have life-threatening injuries, and have needed to go to the operating room. Usually a decision is made in under ten minutes to take these patients back. There has been a steady decline in those patients and this speaks to our ability to train residents.

I have been involved with the University of Nevada School of Medicine for ten years and we train three chief residents plus one fellow—now actually two fellows—a year. If you look at our high mark in 2004, we were getting about 60 cases per resident per year. Now the American Council of Graduate

Medical Education sets the standards, types, and numbers of cases that residents have to have through their training programs in order to graduate from that training program and be set for board certification. As you can see in 2009, our total cases out of the trauma center into the operating room were down to 160. We are dangerously close to losing the adequate numbers we need to train these physicians. In the last ten years, 50 percent of those residents have come out of our program and have remained and are practicing in Nevada.

The economic models that work for other businesses are not the same as those for health care, and more is not necessarily better. That is the reason all of the major cities throughout the country have started creating these centers of excellence, concentrating the care into certain centers. The literature and evidence shows there is a much better outcome, decreased morbidity and mortality associated with patients going through programs that have higher volumes versus those that have lower volumes. We have done a lot of hard work. We have a nationally recognized trauma center, and we would really like to be able to preserve the training program and the physicians that we are able to put out into our community. Thank you.

Assemblyman Goicoechea:
How many trauma centers are there that are causing that kind of reduction in your numbers?

Jay Coates:
Currently there are three trauma centers in Las Vegas. University Medical Center is a verified level I trauma center, Sunrise Hospital and Medical Center is a level II trauma center, and St. Rose Dominican Hospital is a level III trauma center.

Assemblyman Goicoechea:
It seems to me—and I realize you cannot go by a certified trauma center if you have a patient that needs some help—if you are the only level I trauma center, the majority of those cases would go there.

Gregg Fusto:
When we started the trauma system, the territories actually broke up into catchment areas. University Medical Center does have the largest part, but when it started it had the whole pie, and it knew it was going to take a hit. Initially it was 20 percent, and then maybe 25 percent when the third trauma center came on. With the economic issues that we are going through right now, we have had a 48 percent decrease in our volume. Our residents are not

getting the cases; we have 15 subspecialists on call every day. There is a big outlay, not only in money but in physician services.

Assemblyman Sherwood:
We touched on the trauma centers. How would this legislation, if we passed it, affect the surgery centers? If I am a physician and I specialize in cardiology and we are doing all of our surgeries at a surgery center as opposed to a hospital, does this impact the "niche boutique" surgeries or not?

Kathleen Silver:
This legislation would not have any impact on surgery centers or activities done in surgery centers. Most all of the services we are talking about—whether it be transplants, burn treatment, trauma care, open-heart surgery—need an acute care setting. You are not going to be doing it in a surgery center.

Assemblyman Sherwood:
I know we have passed legislation to set up UMC, and I think it is great what we have done so far. Would this restrict any physician access? If I am a physician and I am practicing in one area, am I now tethered specifically to UMC, if we did this?

Kathleen Silver:
No, that would have no impact. The physicians are privileged and credentialed at hospitals that they apply to. As it stands today in southern Nevada, you apply to any hospital that you want to have privileges at and, assuming you meet its criteria, you are granted privileges at that hospital. It would not have anything to do with this legislation.

Assemblyman Livermore:
My question goes towards patient choices. Can you tell me in the numbers you have shown here, how many of those are patients that have the ability to pay for the operations versus people who do not have the ability to pay? Can you tell me that in light of, I guess you might say, lost business?

Kathleen Silver:
We are talking about several different types of programs. As it relates to burn and trauma, and even to some degree the neonatal intensive care unit and open-heart surgery, we cannot not do those services based on pay source. So if a patient presents, we are going to take care of the patient first and ask about the pay source later. A transplant is actually a quasi-elective service, if you will. Everyone that gets a transplant—not only at our center, but at any center throughout the nation—has to be financially cleared first. Transplants are probably the one thing that has a 100 percent pay source. With everything

else, it is probably more relative to what your emergency department payor mix looks like.

Assemblyman Livermore:
I have been a patient at a hospital several times, and I have never admitted myself. I always got admitted by a physician. Why are physicians referring patients to other hospitals?

Kathleen Silver:
You are absolutely correct. Hospitals do not admit patients; physicians admit patients. What we are trying to identify through this information is a trend that has occurred over the past years as new hospitals came on board and new programs were started. There was a decline for all of us in those cases. If the growth had continued in southern Nevada, perhaps eventually the population would have kept up with the available supply. When the population started leveling off and even declining, the criticality of the services and the volumes that they needed came into question. By this legislation we are not attempting to unring the bell. The programs that are in place today we expect will stay in place. Before new programs are added in the future—looking prospectively—we want to make sure that some thought is given before new programs are licensed. We do not want to see added impact on the existing programs.

Assemblyman Livermore:
Thank you very much. That is what I understand the process to be, and I think you are right.

Assemblyman Hambrick:
Would this in any way cause those facilities that are currently licensed to have a concern—because of the lack of patients—that you are trying to dwindle down and decrease the number of facilities that will be offering these services? Are they safe?

Kathleen Silver:
They are certainly safe from the perspective of this bill. Where they are not perhaps safe is from the economic realities of what it takes to run some of these programs. It is quite possible that some of these facilities with declining volume and the added overhead that is involved with supporting these programs may decide electively that they do not want to be in that business.

Assemblyman Hambrick:
In section 4.5, you turn around and amend ". . . his or her license to operate a facility . . . ." University Medical Center is trying to have a health care conglomerate—I am trying to think of better words—but what you are trying to

do is what we approved a couple of weeks ago, and we all pretty much unanimously said what you try to do is to get the cream of the crop into our area. But on this one, if you have a board-certified and a fellowship physician come into the area—when you say his or her license, I am curious. Initially I thought this was a facility license, but you are also looking at individual licensure. So if you get a neonatal or burn unit specialist coming into the area, you are going to force him into going into a particular facility for licensure rather than opening up his own practice again.

Kathleen Silver:
Excuse me, I am not seeing where you are seeing that.

Assemblyman Hambrick:
Line 7 of the amended bill.

Kathleen Silver:
I see what you are reading: "A licensee must obtain the approval of the Health Division to amend his or her license to operate a facility before the addition . . . ."

No, we are still talking about a facility. We are not talking about individual physicians or other practitioners. This is still relative only to the facility license.

Chair Mastroluca:
I have a question, and maybe it is overly simple, so I apologize if it sounds naïve, but I would think that the hospitals, with the exception of UMC, are in business to make money. Obviously they have all said that the first thing they want to do is make sure they provide quality health care, but at the end of the day, they have shareholders to answer to. I cannot imagine that if these programs are not bringing in the money that they need to support themselves, that they would not continue to run these programs. So why would we tell hospitals that they could not run programs if they were actually making money?

Kathleen Silver:
I think the basic question is whether or not they really are making money on those programs, and it probably will take some time to determine whether or not they choose to remain in that business or provide that service line. Again, I think this bill is trying to look prospectively. Nothing was done to check the growth of these programs historically. Anyone who applied was essentially granted the license. We are trying to say is let us not let that continue to proliferate like that. Let us make sure that before we add new programs, the programs we have in place are sustainable and able to meet the standards as recognized both by the state and by some national authorities in some cases.

Chair Mastroluca:
Would they not just fall off by attrition?

Jay Coates:
We have seen this happen in a number of cities throughout the country. It is a little bit different economic model when you look at what hospitals do when they bring on product lines. The problem is that a number of outlying hospitals will bring on a product line—say open-heart surgery—and they know that they are going to take a loss for maybe a year or two, and then gain momentum as time goes on. The problem is that—and we saw this when I was practicing in Philadelphia—as these programs come on, they are barely keeping themselves above the watermark of doing an adequate number of cases to continue to be certified, yet they are diluting the population such that no center is really seeing the number of cases that it should see that would really make it a center of excellence. That is the inherent problem with what is going on with some of the cities, including Las Vegas. You are taking the experience of what is a limited resource. These programs are all incredibly labor-intensive programs. They are systems. They are not individual physicians. You will have doctors, respiratory technicians, specialized nurses, specialized floors, and specialized X-ray equipment. All of it is a big commitment from the hospital. You are diluting those individuals across several centers, none of which are having really excellent outcomes, maybe moderate outcomes. Again, the literature shows that the hospitals that do these the most do them the best. That is how you develop an academic medical center. That is how you really create a center of excellence: concentrate the care into a few centers that do these all the time.

Chair Mastroluca:
It begs the question—and because of all the hospital people in the room, I am going to make up a hospital name as to not show favoritism—so we will say ABC Hospital decides that it wants to become a center of excellence in one of these categories. Would it not be in their best interest to try and recruit the best doctors for that program to make that program stand out, such as with free-market competition?

Jay Coates:
Actually, what happens in that kind of market and what happens to that type of model is that you wind up having a brain drain. A lot of times it is not an altruistic motivation; it is a monetary motivation that brings on some of these programs because it is a known fact that with program X, program Y, throughout the country and different cities, that you can make a profit in your hospital. But again what happens is you wind up diluting the care. So instead of having a number of physicians at one facility with a dedicated team, you take

that team and kind of—imagine it is like the National Football League or the National Basketball Association. You have this incredible team that has won all of these championships and they do a great job. Well, everyone wants a piece of that. You take a piece of that out and now you have diluted that team. They are not as good as they were. All of the other teams may come up a little bit, but you do not have what you once had. You have a more mediocre environment than what you had previously. Again, that has been shown in both Philadelphia and Detroit when they have had deregulation of some of their centers.

Kathleen Silver:
I wanted to go back to your earlier question about the attrition of some of the programs. I do believe that if the population growth does not return or we continue to see a decline in population, and Las Vegas's economy does not bounce back, we will reach a point where some of these programs may decide that they do not want to maintain. I think that is part of economic reality we are dealing with today. I do think that to have a more thoughtful way of opening and licensing these services going forward only helps to protect all of the services that are currently in place.

Jay Coates:
The question I would ask every member of the Committee to ask themselves, if you were or your loved one were going to a center for a surgical procedure, and you look at southern Nevada and these pages, where would you prefer to go? I mean, do you want to go someplace that is doing ten of these a day, or someplace that does three a month? Thank you.

Assemblyman Livermore:
Are you saying that Las Vegas has an overcapacity of operating rooms, patients, or hospitals today?

Kathleen Silver:
Probably many of you saw the article that was in the *Las Vegas Review-Journal* recently about the amount of money that the hospitals in southern Nevada are losing on an annual basis. That speaks to two things: one is a certain amount of overcapacity in some areas where we have new hospitals and the community did not grow as expected; the other is, as was mentioned, because of the economy people have lost their insurance, lost their employment in many instances, and are putting off care or avoiding it altogether. So it is a combination of factors. It is not just saying that there are too many beds.

I think if our growth curve had continued we probably would have been just fine. But it did not, so we are here today with some hospitals that are lacking

the number of patients that they probably need to keep their head above water, and what you saw in some of those numbers were the hospitals losing money.

Assemblyman Livermore:
In examples I have seen, generally the free market works to correct that by one institution buying or merging with the other one and closing the facility. But, your proposal is legislating, to protect you from one of the two hospitals. Would you think that is the best approach to do it rather than allowing competition to do it?

Kathleen Silver:
What I think you see here is by virtue of the fact that we think all of the programs that are here and are existing need to remain. So we are not taking an anticompetitive stand. The free market actually brought us to this point, and if the free market were to continue and we were continuing to grow as expected, you would see a slightly different impression of what is going on here. But it did not, and the volume that was expected to increase with population and with time did not materialize. So we just do not want to see the mistakes of the past repeated in the future.

Morgan Baumgartner:
That concludes the testimony of UMC.

Chair Mastroluca:
Is there anyone else who would like to testify in support of S.B. 10 (R1) either in Las Vegas or Carson City? [There was no one.] Is there anyone in opposition to S.B. 10 (R1)? [There was no one.] Is there anyone neutral?

Wendy Simons, Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services:
The purpose of my testimony here today is to lend clarity from the Health Division's position. The Health Division is currently responsible for recognizing that a facility can provide the services as outlined in this bill. We do have regulations in place, some of which are modeled after standards from other national organizations. We would not need to adopt new regulations if the existing standards or current regulations already designated a specific number of cases to support the services which are already in place, for example open-heart surgery. As we review the existing standards and if they do not currently address the issue of an adequate number of cases in the community, we would work with the stakeholders to develop the necessary regulations. In conclusion, we have systems in place to implement provisions of the bill without any added costs. The amendment to the original bill removed the fiscal note. I am happy to answer any questions.

Assemblyman Hammond:
Just a while ago, the Chair had a great question, and I do not know if you can add any more clarity to it, and maybe we should ask the question again for those in Las Vegas. I am still not understanding. How does getting one, two, or three places and not letting the free market here sort of play out, how is that going to help—ABC Hospital, is that what you called it? We are going to call it the Scott Hammond Memorial Hospital. It would be great to have one team of specialists there and keep them all together, but what if one of the specialists wants to leave and start another practice somewhere else or go to another hospital? Do you keep him there? Do you force them to stay together so they can become specialists there? I do not understand the logic behind that. I would think that the market would bear that out after a while.

Wendy Simons:
From the Bureau of Health Care Quality and Compliance's standpoint, as was suggested by earlier testimony, it does not regulate where people or physicians go. This particular piece of legislation asks us to identify criteria that hospitals fit into, whether it is a trauma center, a neonatal intensive care unit, open-heart surgery, and organ transplant centers. In our regulation, those criteria would be specified with the industry partners pertinent to the number of surgeries that might be performed. So this particular measure takes it straight to regulations. I do not know if I gave you a complete answer, because we do not license people. We just license the facility.

Assemblyman Hammond:
I should have asked the question earlier when I kept thinking about it. I thought maybe you might have an opinion on it too, since you are probably concerned with the quality of health care as well. Thank you.

Assemblyman Hambrick:
I am trying to stay away from the fiscal aspect, but there was a fairly steep fiscal note. What was the thought process behind it? Why is it now being removed? What was satisfied? What caused it in the first place, and now what is causing it to be removed?

Wendy Simons:
When we did the initial analysis, we thought we would need additional staff, because we were not certain that it could be accommodated in a regulatory revision process identifying the particular nuances of each classification. That is what put the original fiscal note in. Once it was amended—by the way, that had to do with some of the extractions in the amendment—it removed the fiscal note, so now it is part of our normal process.

Assemblywoman Pierce:
It seems to me that there are more examples of regulated free markets in how we all live than there are examples of just a strict adherence to the ideology of free markets. We limit the number of taverns in Clark County, we have places in town where you can build buildings one size and places where you can build buildings other sizes. So the idea is that somehow we do that but we have some kind of concern that health care needs to follow this strict free-market ideology, what it means for all of us is that we end up with a community with 50 surgeons who have all done a particular surgery three times, so they are not too good at it, instead of a little bit of regulation so that when we can all go to surgeons who have done a particular surgery 300 times. I think that that is a good point to say that maybe unregulated free markets will not serve our community.

I, unfortunately, am a big consumer of health care and I do not take my car to a guy who has only changed a tire four times in his life. When I need surgery, I do not want to go to a doctor who has only done cancer surgery three times in his life. I want someone who has had a little practice and I think that that is what we are talking about. For me personally, I need to think about what is best for the community in Clark County and not some adherence to an idea that we do not demand in a thousand other ways that are less important in our community.

Chair Mastroluca:
Towards the bottom of the first page, line 9 where it talks about the Health Division determining whether there are an adequate number of cases, what constitutes an adequate number?

Wendy Simons:
For example, in open-heart we already have a specified number of cases from a start-up on up to an established open-heart surgery procedure. It is a national standard. Currently there is nothing in regulation. We would be working with other standards throughout the country to establish those numbers.

Chair Mastroluca:
So in open-heart surgery, what is the number?

Wendy Simons:
It says not less than 80 operations during the first 12 months, not less than 150 operations during the second 1- to 2-month period, and not less than 2 operations during the third year and each succeeding year. So in this particular regulation, there was the provision for allowing a start-up. We will be

seeking, with the other stakeholders, other nationally recognized standards rather than just establishing specifics.

Assemblyman Anderson:
This is just for amendments for new hospitals. We are not talking about getting rid of anyone's trauma center. We are just saying in the future we are going to take a look at this to make sure that the supply meets the demand. Correct?

Wendy Simons:
That is not specified in the bill. It would be carved out in the regulations as to the track that it would be taking.

Assemblyman Anderson:
But the general intent is that when making regulations in the future, we are just making sure that we are not creating too much supply if we do not have the demand.

Chair Mastroluca:
Mr. Anderson, I want to caution against us creating legislative intent. In this case I am just concerned that we could put something on the record that will cause problems down the road. So unless that is something that we see in the bill, which I do not believe it exists in the bill, I would rather not have that on the record.

Assemblyman Brooks:
Is this going to eliminate the competition amongst other hospitals in certain areas? For example, you have a heart surgeon who might be operating at UMC and another heart surgeon who is operating out of another hospital—ABC Hospital. Could this potentially deny us surgeons that are good surgeons, because of the fact that we have put a cap on the number of people who can get this particular type of license? I am asking if this could chase away good doctors from Nevada.

Wendy Simons:
I am not prepared to give you a theory as to what it might do to other surgeons or other health care. We know what we have established and what we have currently approved. Again, it would have to be carved out through the regulatory process.

Assemblyman Brooks:
So as an example, say you have 250 doctors and the number of people in the community would allow us to maybe generate 275 doctors. We would cap it at 275 doctors if we were to pass this legislation. Am I correct?

Wendy Simons:
No, actually, it does not have to do with doctors. In open-heart, it has to do with the number of procedures. It depends on how many procedures a particular physician does.

Assemblyman Brooks:
There are 50 open-heart procedures that are normally conducted in a day, and there are 50 that we are going to allow, or 100 that we are going to allow. How does it work?

Wendy Simons:
There is no cap. Currently the way the regulations are set—certainly for the open-heart piece—is you have to perform a minimum number per year. It does not say there is a cap on the number of procedures that could be performed per year, and that is for the particular open-heart designation.

Assemblyman Brooks:
Let me back up. This bill requires ". . . the State Board of Health to adopt standards for determining whether there are an adequate number of cases in the community to be served to support approving an amendment to a license . . ." or requirements of a health care professional or something of that case, ". . . and requires the Health Division to apply those standards in making a determination of whether to approve amending the license to add any such service." So if someone does open-heart surgery and there is some other type of surgery that this person could possibly do, you are only going to allow him to do it if we need it in the community. Is that what you are saying?

Wendy Simons:
I do not believe that is what the measure is saying. The measure is basically looking for nationally standardized criteria for approval of certain parameters to give an endorsement on a license. So as a bureau of the Health Division, we do not restrict procedures, but rather give recognition as an enhancement on their license for such services as intensive care of newborn babies, treatment of burns, et cetera.

Assemblyman Brooks:
Are we basically designating—for these particular categories—intensive care of newborn babies, treatment of burns, transplant of organs, performance of open-heart surgery, and trauma? We are saying we cannot designate other places as trauma centers if we do not need them, because they are not doing enough procedures in order to make them a specialist. Is that what you are saying?

Wendy Simons:
I am not saying that. The measure is saying that we are going to partner and work with the stakeholders to craft the necessary regulations. We are neutral on this. So let me back up and say that as a division and as a bureau we will work with whomever to accomplish the right thing.

Assemblyman Brooks:
I am just trying to understand the bill, so I appreciate you being patient with me. In other words, we would not have a trauma center at UMC and a trauma center at ABC Hospital, or a neonatology center at UMC and a neonatology center at ABC Hospital, correct? If there was only enough supply for one of those centers, there would not be a need to do four or five of them at four or five different hospitals.

Wendy Simons:
That enrichment on their license would be set by nationally recognized standards, not just us arbitrarily saying there is a quota that has been met. For example, the trauma centers that you just brought up, the Clark County Health District participates in the Las Vegas area on the designation of the level I, II, or III trauma centers. So I do not believe there are arbitrary quotas that are being set through this.

Assemblyman Brooks:
Okay. So there are no quotas being set. We are still able to have a trauma center at multiple hospitals and multiple doctors who might be professionals. Though they might not be on UMC's team, they can still be phenomenal doctors who have practiced their whole life and be at another hospital. They would still be able to compete in this market. But if we pass this, would that same type of competition still be able to occur? That is what I am asking you.

Chair Mastroluca:
Mr. Brooks, I understand where you are going with your question, but I do not think this is the right witness to ask that question of, because she is with the state, she is neutral, and I do not think she is prepared to answer that question. I would ask that you get with some of the hospital people and ask that question off-line.

Assemblyman Hammond:
My question was very similar to that of my colleague, Mr. Brooks. You are right; this is probably not the right witness. I understand that your intention is to make sure the right level of care is obtained in the state for the residents. Going back to the original question—and I believe it has a lot of merit to it, and I understand where my colleague is coming from when he is talking about the

free market—you are right. I probably need to ask the people from the hospital off-line. I will do that.

Chair Mastroluca:
I would encourage any of the members to do that. There are plenty of people who represent different hospitals in the room. Mr. Welch is always a great resource to make sure you are getting your questions answered.

Is there anyone else who would like to testify on S.B. 10 (R1)?

Bill M. Welch, President/CEO, Nevada Hospital Association:
The Nevada Hospital Association is neutral on this bill. We understand the sponsor's intent and desire for this legislation. I have heard a couple of questions and I am going to try to answer a couple of them and maybe try to add some additional clarity.

One of the reasons for the fiscal note being changed dramatically on this bill is that the bill has been amended and the intent of the bill has been changed to some degree. The bill originally required a certificate of need process to move any type of new services to be developed. That portion of the bill was removed and that is where much of the fiscal note was going to come from. However, for the certification and licensure of new services, particularly those that are defined in this legislation, it should be noted that the state has always used nationally recognized standards for the certification of those services. So this hospital is not going to be able to be a cardiosurgical facility, or it is going to be a trauma center based upon some made-up definition that they determined here. They have always looked to nationally recognized organizations that have established those criteria. That is the criteria that they have utilized. What this legislation is going to do is to formally acknowledge in our regulations the nationally recognized standards we have been utilizing.

Trauma center designation—it should be noted that in the State of Nevada, we have a trauma plan, and again, it is based upon national criteria. We have a trauma designation plan for Clark County specifically, and then we have a trauma designation plan for the balance of the state. It is not that anyone can choose to be anything on any given day. If they choose to become a trauma center, they are going to have to meet the criteria that are defined in that trauma plan, as well as meet the national standards. Much of what we are talking about today is putting into regulation the processes that are already being followed by the state to certify and license an organization. It just has not necessarily been in the regulations.

The last thing I would like to point out are the physicians who are performing these surgeries and treating the various specialties. I do not want people to leave here and think that because they are working at ABC Hospital they have only done three procedures. In most cases, the physicians have privileges at multiple hospitals. If they are a cardiosurgeon, they are not just performing surgery at ABC; they are probably performing surgery at ABC, UMC, and whatever other hospital that may have those services. I did not want there to be a perception that just because this hospital is only doing a limited number, that it means that the physician is only doing that number of procedures.

The fiscal note goes away because it is not a full certificate of need, but the certification standards and requirements that have been used all along by the state are now going to be put into regulation and they are not just going to be referenced by the State Board of Health. Hopefully that answers and clarifies some of the questions that I heard.

Chair Mastroluca:
Thank you very much for your explanation, Mr. Welch. I think it did help a little bit.

Assemblyman Brooks:
Thank you so much, and I apologize to the lady in the back, because you are probably the person that can answer this. It makes so much more sense now. Doctors do not necessarily have to be stuck to one hospital. They can travel around, and this is more of a designation so that we do not have a bunch of these designated trauma centers. That makes a lot more sense. If the doctor can go to ABC or UMC, then this bill sits very well with me by following the national standards. Thank you for the clarification.

Chair Mastroluca:
Is there anyone else who would like to testify on S.B. 10 (R1)? [There were none.] With that, I will close the hearing on S.B. 10 (R1) and move on to Senate Bill 293 (R1).

Senate Bill 293 (1st Reprint): Makes various changes relating to certain nonprofit organizations. (BDR 3-1011)

Senator Barbara Cegavske, Clark County Senatorial District No. 8:
Today we are going to bring Senate Bill 293 (R1) forward to you. It is intended to address a problem involving certain entities establishing nonprofit organizations for the purpose of competing with legitimate nonprofit company training centers. The bill accomplishes this purpose by ensuring the

organizations participating in these training programs are bona fide nonprofit organizations.

The bill requires nonprofit organizations to provide certain jobs and day training services or to operate certain rehabilitation facilities or workshops; and to be on file and in good standing with the Secretary of State as nonprofit organizations. Such an organization must also provide certain financial information to the Division of Mental Health and Developmental Services (MHDS) of the Department of Health and Human Services, or the Department of Employment, Training and Rehabilitation (DETR) as provided. Any nonprofit organization required to comply with the requirements of this bill may continue to participate in those training or rehabilitation programs until January 1, 2012. However, a nonprofit organization that is not in compliance on or before January 1, 2012 may not continue to participate in the program after that date.

That is just the 99-cent version of the bill that I want to give to you. I have two gentlemen here today who brought this idea forward to me. For total disclosure, I want you to know that I am on the board of Opportunity Village. Ed Guthrie will be discussing Opportunity Village, and Brian Patchett is here for Easter Seals. They will talk to you a little bit about why we brought this bill forward and what it means. I appreciate your support. If you do not mind, we will let them talk first and then see if there are any questions after that.

Chair Mastroluca:
That would be fine.

Ed Guthrie, Executive Director, Opportunity Village:
Opportunity Village is a nonprofit community training center in Las Vegas that provides assessment training and employment services to people with intellectual and other disabilities. [He read from prepared testimony (Exhibit D).] We serve about 1,000 people a month. Last year we served over 1,500 different individuals. We want to thank each of you for agreeing to hear this. The people with disabilities need champions to find jobs and to become active members of our community. Many of the members of this Committee have been those types of champions in the past, and we hope you will continue to be.

The reason we brought this bill together is because the State of Nevada has a program called the Preferred Purchase program. The Preferred Purchase program allows nonprofit organizations, like Opportunity Village, to sign contracts to provide goods or services to a state agency or a local government without going through a competitive bid process. The stipulation for the nonprofit is that at least 75 percent of the hours worked providing that service

or in that good would be done by individuals with severe disabilities. The purpose of the program then is to provide jobs for people with severe disabilities.

We are bringing this proposed bill to you because of some problems in a sister program at the federal level. There is a mirror image program at the federal level called the AbilityOne Program. There have been problems in the AbilityOne Program where there have been allegations that individuals have set up their own nonprofits that are controlled by an individual or a for-profit corporation rather than being a pure nonprofit corporation. The intent was to circumvent federal purchasing regulations. One or more of those individuals have been caught, and I know of one who was just sentenced to federal prison in Texas.

Each of these community training centers is required to be certified by either DETR, or by MHDS. We would like to have the agencies, as a part of their normal certification process provide to either MHDS or DETR a copy of their annual audit. In the annual audit of a nonprofit corporation, an independent auditor is required to test whether there is any excess compensation going to members of the board or officers of the corporation, and those tests would be outlined in the notes of the annual audit that would be provided by the nonprofit corporation. The nonprofit corporation would also provide its Form 990, which is its Internal Revenue Service (IRS) tax return that it is required to submit on an annual basis. In the provisions of the IRS tax return, they are also supposed to stipulate whether any of these relationships exist. We want to make sure that the public benefit is going to the individuals who are to be served, not necessarily the officers and board members of the corporation. That is the whole intent of the law.

Brian M. Patchett, M.P.A., M.S., President/CEO, Easter Seals Southern Nevada:
Madam Chair and members of the Committee, thank you so much for hearing this bill and for all you are doing to support folks with disabilities. I have been working in the disability field for more than 20 years, and as a person with a disability, I have been familiar with disabilities since I was seven years old. I think about the quality of service and the level of service that is delivered from an organization, and what it is that makes that organization a high-quality organization. I think of Opportunity Village as a high-quality organization as is Easter Seals Southern Nevada. I am a little biased there, because I am the Chief Executive Officer.

For me, it is a quality issue. It is making sure that the service being delivered is coming from an entity that is fully devoted to delivering that service. As I think about the service we provide, we have a community training center and some

very similar services to what Ed Guthrie talked about. This bill will help guarantee that those organizations that provide that service are nonprofit organizations that are accountable to our state government. I think about the IRS Form 990, which Ed mentioned. A few years ago, Form 990 was changed and made much more comprehensive. It takes a lot more work to fill out, but it also provides a lot better clarity and transparency so you know what a nonprofit organization is doing. When you look at that, and when state officials are looking at that, they can tell if the organization is truly providing the service from the standpoint that we want it to be done, as far as a quality nonprofit organization. I think this bill does that. It helps us to guarantee that the organizations providing the services are nonprofit organizations. I thank you very much for the opportunity to comment.

Senator Cegavske:
Committee members, just to let you know that we worked on this with the Secretary of State and Bill Bradley, so we really had it vetted from the original form, and that is why it was amended. It was just to make sure that we had it in compliance so they could effectively work with it. Thank you.

Assemblyman Frierson:
This sounds like a really great effort at addressing the problem that exists and that someone has already been prosecuted for. If a for-profit organization is doing this under the guise of a nonprofit to compete with an existing nonprofit, what is in it for them?

Ed Guthrie:
Let me tell you what happened in Texas. I was the chair of a national organization of nonprofits that supervised this type of effort on the federal level, and there was an individual who was running a nonprofit in Texas. He took no salary. Their "Ed Guthrie" took no salary. Instead, he had a management company that provided management services to the nonprofit for $3 million a year. The individual was also supposed to have 75 percent of the hours worked being worked by individuals with disabilities. Only 7.5 percent of the hours were worked by people with disabilities. The other hours were worked by able-bodied individuals. So this was a really strong profit center for the individual, and thank God the U.S. Attorney caught up with him and he has now been prosecuted for fraud. The gentleman's name is Bob Jones and he is serving time in a federal penitentiary in Texas. We want to make sure that that type of thing does not happen here in Nevada.

Assemblyman Frierson:
Who is paying this $3 million? Where is it coming from?

Ed Guthrie:
In a contract with the federal government. Normally in a contract with the state government, you have a competitive bid process. These types of organizations are exempted from the competitive bid process for the provision of jobs to people with disabilities. That is the only reason they are exempted. So they might come in higher than the lowest competitive bid, but the idea is you are paying that so that they can provide jobs for people with disabilities. In the case in Texas, the individual came in higher than the bid, but was not providing jobs to individuals with disabilities. He was lining his own pocket.

Assemblyman Brooks:
For that individual who was lining his own pocket, when he was paying 7.5 percent for people with disabilities, was the other 80, 60, or 70 percent—it just did not exist or was he paying someone else to do it?

Ed Guthrie
He was just hiring people off the street to do the jobs, so instead of providing jobs to individuals with disabilities, he was hiring able-bodied individuals and paying them but he was taking the excess money that he got because he was supposed to be hiring people with disabilities, and lining his own pocket.

Assemblyman Brooks:
So was he paying less money than he would have paid the individuals with disabilities? I am just trying to figure out how he was making money if he was actually still hiring those people.

Ed Guthrie:
If I am paying $10 an hour, I might be able to get away with charging $10.50 as opposed to $10 an hour. If the competitive price for this item is $10, the state might be willing to agree to pay slightly more than $10 an hour because I am providing jobs for individuals with disabilities. So let us say that you are willing to pay $10.50 instead of $10. Then I am taking the 50 cents and putting it in my pocket instead of taking the 50 cents per item and using it to hire people with disabilities. Does that make sense?

Assemblyman Brooks:
It makes sense. The only thing that would have gotten him in trouble was the fact that he is not hiring people with disabilities, but he is still paying out the $10 and pocketing the $.50, which would have been perfectly okay if they would have been people with disabilities. I am just trying to clarify.

Ed Guthrie:
Yes. The idea is that the purpose of these programs . . .

Assemblyman Brooks:
He is not fulfilling the purpose of the program, and this will hold him accountable.

Ed Guthrie:
Yes.

Assemblywoman Pierce:
Able-bodied people are able to produce more per hour. That is the other way this guy is making money—in volume.

Chair Mastroluca:
Are there any questions? [There was no response.]

Lisa Foster, representing Northern Nevada Association of Service Providers:
The Northern Nevada Association of Service Providers is a group of community training centers and related organizations that do similar work to Opportunity Village in the south. These northern providers want to support this bill. They really appreciate that it calls attention to the fact that there may be organizations that try to get away with some disreputable activities under the name of being a nonprofit and trying to serve people with disabilities when maybe they are not. So they support this bill and we appreciate the efforts of Ms. Cegavske, Opportunity Village, and Easter Seals.

Chair Mastroluca:
Is there anyone else who would like to testify in support of S.B. 293 (R1)? [There was no response.] Is there anyone in opposition to S.B. 293 (R1)? [There was no response.] Is there anyone neutral to S.B. 293 (R1)? [There was no response.]

Senator Cegavske:
Thank you, Madam Chair and Committee members. I really appreciate the opportunity to come before you with this bill, and I appreciate your support.

Chair Mastroluca:
Thank you very much for bringing this forward. Are there any other comments from the Committee on this bill? [There were none.] I will close the hearing on S.B. 293 (R1).

I will remind the Committee that on Wednesday we are going to have two presentations; one on sentinel events to prepare us for hearing the bill on sentinel events on Wednesday night, and another one on Kids Count data. There will be lots of information to take in.

Is there anything further from the Committee? [There was no response.] Is there any public comment? [There was no response.] With that this meeting is adjourned [at 3:12 p.m.].

RESPECTFULLY SUBMITTED:

_____
Linda Whimple
Committee Secretary

APPROVED BY:

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: May 9, 2011 **Time of Meeting: 1:54 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 10 (R1)	C	Kathleen Silver	UMC Presentation
S.B. 293 (R1)	D	Ed Guthrie	Testimony