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

Seventy-Sixth Session
June 6, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 3:38 p.m. on Monday, June 6, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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 K. Cegavske, Clark County Senatorial District No. 8
Senator Steven A. Horsford, Clark County Senatorial District No. 4

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Kevin Schiller, Director, Department of Social Services, Washoe County
Diane J. Comeaux, Administrator, Division of Child and Family Services, Department of Health and Human Services
Alex Ortiz, representing Clark County
Bobbette Bond, Director of Public Policy, Culinary Health Fund; and representing Health Services Coalition
LaShannon Spencer, Director of Public Policy and Advocacy, Catholic Healthcare West
Dan Musgrove, representing Valley Health System
Denice L. Miller, representing MGM Resorts International
Gina Polovina, representing Boyd Gaming Corporation
Kathleen Conaboy, representing Nevada Orthopaedic Society
Amber Joiner, Director of Governmental Relations, Nevada State Medical Association
Jeff L. Mohlenkamp, Deputy Director, Support Services, Department of Corrections
Bart Mangino, Legislative Representative, Community and Government Relations, Clark County School District

Senate Bill 371 (1st Reprint): Makes various changes concerning the protection of children. (BDR 38-3)

Chair Mastroluca:
[Roll was called.] We are going to start with Senate Bill 371 (1st Reprint) because we only have Senator Cegavske for a short amount of time, and we do not want her rushing off in the middle of this.

Senate Bill 371 (R1) makes various changes concerning the protection of children, and I happen to like this bill because it is something the Senator and

I worked on last session together. I am glad to see you have taken it to the next level.

Senator Barbara K. Cegavske, Clark County Senatorial District No. 8:
I would like to thank the Chair and Senators Leslie and Horsford for the hard work that has been put through on this, and I would really like to thank Kevin Schiller. If it had not been for him coming up with solutions for the language, we might not have gotten this to the point that it is today. So with your permission, Madam Chair, I am going to let Kevin walk through it. We are voting out Assembly bills in the Senate Committee on Finance, so I am sure you want me to get back there so I can continue voting. I really thank you again for all that you have done along the lines of this particular type of legislation, and I think this is going to be a wonderful bill overall for our children in the state of Nevada. I think we are really looking out for them and this is going to be a great piece of legislation. I would be honored if when we get to sign it, you would be over there at the Office of the Governor with us.

Chair Mastroluca:
Thank you very much, Senator, I appreciate that. Thank you for bringing this forward.

Kevin Schiller, Director, Department of Social Services, Washoe County:
To give you a little background, S.B. 371 (R1) originated as a bill that was specifically addressing the issue of not only psychotropic medications and psychiatric care, but also mental health. As the Senator previously indicated, one of the key areas that we worked on in the bill and kind of honed in on was the issue around psychotropic medications, which tends to be one of the most critical issues we deal with, with the hardest kids we serve. To give you a sense of the population in the child welfare system, we have somewhere between 100 to 130 kids who are in a higher level of care. A large percentage of those children in Washoe County require psychotropic medication to manage those issues.

One of the areas that we continue to struggle with is really tracking those medications appropriately, ensuring from an accountability perspective that doctors are talking to one another and that the children are being appropriately treated. While we have foster parents who are involved in that process, ultimately the agency is accountable. The Division of Child and Family Services worked with us a lot over the last year on a specific policy on psychotropic medications, so I want to credit them for working with us, as the counties, to come up with a policy. This bill is replicating some of that policy. There are two specific areas that are addressed: how psychotropic medications are administered and by whom, and the appointment of an individual who is legally

responsible for the psychiatric care of the child. As you will see, we are defining "psychiatric care" as psychiatric treatment services and resultant medication management.

Section 3 of the bill is requiring us as an agency to nominate the person who is legally responsible for the care of the child with the court, and the court ultimately has to approve that individual. One key area that I would highlight is that that individual can include an employee of the agency or the department. So if there was an internal staff member in my department, we would have to have the court approve that individual, who would subsequently be involved in training and the ability to manage that.

Section 4 is getting into the consent of the medications and requiring the individual who is appointed to be a part of the consent process, so we can make sure that is occurring. The other piece that I think is important is that as we move forward with the psychotropic medication, if an agency determines that psychotropic medication is required, the approval of that medication is going to be required by that court-appointed individual. It prohibits the administration of the medication without their consent or authority.

The other part that I wanted to highlight is that it allows us the ability to consent on an emergency basis. That would primarily relate to kids who we bring into custody and who are brought in on an emergency basis due to abuse and neglect, and if the child is on a current medication it gives us the ability to continue the use of that medication until such time as someone is appointed. It does not alleviate our responsibility for overall mental health and health care. As the Committee is aware, we are required to ensure the well-being of these kids in care specific to medication management, specific to mental health, and specific to health care in general.

This bill is allowing us to hone in on the psychotropic medication component and how it is managed. It ultimately holds us accountable as an agency. I will be the first one to tell you that we should be accountable because these are the toughest kids. On the other side of that, it is also going to require us to make sure we follow absolute procedure and protocols regarding how we administer those medications and how we work with the foster parent, the care providers, and also the parent.

Chair Mastroluca:
I want to ask you about the statement you just made regarding the responsibility. We had quite a few meetings in the interim about this issue, and where the ultimate responsibility of a child fell. I recognize that in Washoe County you obviously take your job very seriously and would take on

that responsibility, and in Clark County, I believe Mr. Morton would feel the same way, but when it comes to the rural areas, where does the responsibility lie? Does that now become the state's responsibility and then the state takes it on? How does that work?

Kevin Schiller:
Diane Comeaux, the Administrator for the Division of Child and Family Services, is here, so she can answer that. My interpretation of that would be that as an agency which provides child welfare services in the rural areas, they would ultimately end up having a staff member who would be appointed through their legal process to assist in the administration of psychotropic medications.

Diane J. Comeaux, Administrator, Division of Child and Family Services, Department of Health and Human Services:
That is correct; it would be the Division that would be responsible for it.

Assemblyman Livermore:
Just a couple of meetings before this, we had Court Appointed Special Advocates (CASA) Volunteers for Children here. I do not see any process of appointment for people who have the child's welfare at heart. Who is going to be doing that and who is going to do the appointment? How long is the process going to take before someone represents the child?

Kevin Schiller:
I think what you are asking is how long would it take once we have determined a child is on psychotropic medication?

Assemblyman Livermore:
No, not that. You take custody of a child. The child is under your jurisdiction. Who looks after the legal basis and protection of that child's rights?

Kevin Schiller:
In the child welfare system, the agency may have legal custody in almost all cases, but ultimately the system is responsible for the child. The court will have ultimate oversight on the agency and the child through mandated court reviews, and I would anticipate that this would be incorporated into all the mandated court reviews.

Back to your question about the treatment team, you can have a court appointed special advocate, a foster parent, and a guardian ad litem as this is listed. That team will ultimately have a responsibility in terms of the overall oversight of that child, which makes—for lack of a better term—a check and balance with us as an agency. In all those cases, 99.9 percent are basically

other people who are accountable for the well-being of the child aside from us. In our jurisdiction, these often include children's attorneys who are appointed to represent those kids, CASAs who are appointed to represent those kids, and the court will mandate reporting specific to the well-being and care of the child. The treatment team will ultimately do that.

Assemblyman Livermore:
On page 3, line 9, it says, "Upon nominating a person who is legally responsible for the psychiatric care of a child . . . ." Who is that and how long is it going to take?

Kevin Schiller:
I would anticipate upon removal of a child that we would have someone appointed if we did not. If there were medications that were already being administered to that child at the time we take custody, we would ultimately be asking for that authority in our protective custody hearing if we were aware of it. Beyond that, we would be doing it within a 30-day time frame through the court's disposition and process toward adjudication.

Assemblyman Livermore:
Is 30 days normal?

Kevin Schiller:
Yes, to go to court.

Assemblyman Livermore:
It would seem like even a criminal would have the right to an attorney long before 30 days.

Kevin Schiller:
In Washoe County we have some attorneys who are attempting to be appointed at protective custody, but the majority are appointed post protective custody. It is usually within about a week that we start seeing attorneys appointed and we have made a determination that we are ultimately going to petition.

Assemblywoman Benitez-Thompson:
In reading this, I really like it. I remember a colleague who I used to work with in the field who would say that when children need these psychotropic medications it can really get them stable.

To follow up on Mr. Livermore's question, although you would probably have to wait until that first court hearing to formally appoint a person, the minute the child was taken into custody, the agency and the social worker and the

caregiver—if they are going straight into a foster home—are usually sorting out and making sure the child is on a regular medication schedule. You are not waiting for them to go on a regular medication schedule if they already have one until the court comes in, correct? You are doing it right away; it is just that formal appointment in the legal process?

Kevin Schiller:
Yes, the minute we place a child into custody, we begin the intense process of assessing what those child's needs are and asking the parent about medical needs, which would include psychotropic medications and those types of issues. At the moment that we take custody of the child, even before a protective custody hearing, we have the authority to administer that medication. The key component would be once we have done that and moved forward, we will be responsible for making sure someone is appointed rather quickly on behalf of the department to oversee the medication management. If we became aware that psychotropic medication was a key element in the management of that child, I would have a qualified internal staff member attend that hearing, attend the process, and interview the parent.

Assemblyman Anderson:
It probably does not matter for the bill, but I am wondering why it is written this way. In section 3, subsection 1, it says, "If a child who is in the custody of an agency which provides child welfare services . . ." and then I look down to section 3, subsection 3, and it allows, "The person who is legally responsible for the psychiatric care of a child may be a parent or legal guardian . . . ." Why would you put that text in there about parent or legal guardian if the child is in the custody of social services?

Kevin Schiller:
Unless rights are terminated, the way that it currently works is although we have legal custody of the child, we are required and mandated to make sure that we are following up with the parent, specific to consent. So the best way I can explain it is when we do surgery on a child—as an example—although I have the legal authority to do that, I have to show efforts that I have gone to the parent and indicated what the need is. Even in this case, if the parent was opposed to that psychotropic medication and we had a difference on that, it would ultimately go to the court for final authority and decision point.

Assemblyman Anderson:
That explains it very well; thank you.

Assemblyman Brooks:
Can you give me a scenario? When we talk about psychotropic medication, we are talking about Xanax, anxiety issues, and schizophrenia that some of these kids have. Can you give me an example of how you would take possession of a child who was still in the legal custody of a parent or guardian, but you have him legally? Would it be the parent saying, "I cannot take care of this child anymore. He is driving me nuts." Are they submitting children to the agency? How are you getting them?

Also, taking these types of heavy duty medications can really have an effect on an individual. I am concerned about how long they are actually institutionalized as opposed to sent out to a different kind of home where they can get the kind of help they need and deserve. How long does that take?

Kevin Schiller:
Regarding the first question about how we take custody of these children, there are really three ways that can occur. One can be that I have a parent who is dealing with a child who has significant behavioral needs, and they do believe that they can no longer meet the needs of that child. One of two things can occur in that circumstance. There could be something that could occur through *Nevada Revised Statutes* (NRS) Chapter 432B in terms of neglect or inability to care, but probably more appropriately that would be from a voluntary agreement we reach with the parent for services so we could place the child into custody. The majority of the placements are the result of abuse and neglect where we would place the child into custody. I do not think we are going to see a large number of children who are already going to be on psychotropic medications of those types when we place. In fact, in terms of our demographics and what we see, we find in a lot of the cases that the children who are placed on those medications are children who have been in care for a period of time.

That leads to your second question, which is how do you move the child from an institutional setting? The closest thing we have to that is we would have treatment level foster care, or have the child in a shelter at Kids Kottage, and because of other legislation, we have to move those children as quickly as possible out of that congregate care setting into a foster home situation. So we are doing a pretty intense intake on that child, which includes a mental health assessment. He has to see a doctor or a pediatrician. If he has a medical home or an established pediatrician, we would get him to that established pediatrician. Once that has occurred, we do a thorough assessment to make a determination on next steps. It is really a combined effort to get the child into the least restrictive setting while at the same time making sure that if we need to

maintain medications, we can. Most of the time, as you said, they can be very detrimental, so we do not want to be stabilizing kids and treating kids with medication.

I think that is one of the key components of this is it is going to force the dialogue. We have seen instances where you have a pediatrician who may have prescribed some attention deficit/hyperactivity disorder medication (ADHD), and then you may have a psychiatrist over here and they have not communicated. We have seen issues where we have multiple prescriptions occurring and there is no central point for communications. We are really trying to address in this bill that someone is going to be responsible for that and ensuring it through procedures. Obviously, if the child is displaying significant behaviors, we want that child in a foster care setting in the least restrictive setting. We also do not want that to be at the cost of overmedicating the child. I think that is significant.

Assemblyman Brooks:
Would you give me the time frame if that occurs from institution to foster home?

Kevin Schiller:
It really depends on the circumstances, but I can describe it from the perspective of placement. Over half of our placements tend to be with relatives upon protective custody, so we try to get those kids to relatives even before that protective custody hearing. Those kids who may have significant needs—which is where I think you are going with that question—if they end up in our Kids Kottage program, as an example, we have a therapeutic component to that program, but we would use the assessment process and tend to try to move them within a matter of days into the least restrictive setting. The majority of our placements tend to be relatives now, and then relative foster care. What we are seeing in our congregate care setting, or in our shelter setting, is that those are kids who have been in the system for a longer period of time and who have treatment level needs, where they are having trouble in a foster home and moving up in the higher level of care system. I think we are averaging about 115 kids in that treatment level system. I looked today, and I think we have about 40 kids in our Kids Kottage with about 15 of those kids being more teenage kids, who are having behavioral issues, where they may have been in multiple foster homes.

Assemblyman Brooks:
So from an institution to a relative would be a matter of days?

Kevin Schiller:
In most cases, I believe, if the child is going to go to the Kids Kottage, as an example, which is a shelter facility.

Assemblyman Brooks:
I just need to know the time frame from an institution to the Kids Kottage and then the institution to a relative.

Kevin Schiller:
It is individually based. If we place a child into custody, we will have made that decision in most cases before we ever take custody of the child. So we do not want to move the child more than once. We want to move the child directly to the least restrictive setting. It depends on the circumstances.

Assemblyman Livermore:
I understand about Washoe County. What about a rural county?

Diane Comeaux:
We service the rural communities for child welfare and child protective services. Ours is very similar to Mr. Schiller's. When we remove a child, we typically try to place him or her with a relative if a relative is available. We have emergency shelter or congregate care, and we always try to move a child out of there within 10 days for placement.

Chair Mastroluca:
One of the questions I had in reading this, and with the bill we had last session that had some pieces in it regarding psychotropic medications, was about where the medical home of the child lies. In a traditional family, the parent is in charge of the medical home of the child. The parent generally knows where the child has gone for the pediatrician, where they have gone for a specialist, and what medications they are on. When you have a child in foster care, he could have gone to a doctor here and then transferred to another foster home on the other side of town and will now go to a different doctor. We have seen a tendency, especially with psychotropic medications, of them piling on top of one another. I would imagine that part of the purpose of this is to create some semblance of a medical home. Am I off, or is that something that is in this bill or something that is missing?

Diane Comeaux:
As a part of the policy that we adopted from the last session, we identify that as the responsibility of the agency which provides child welfare services. We have made some modifications to our Unified Nevada Information Technology

for Youth (UNITY) system to be able to better track medications and those kinds of things. Where we would keep all of that information would be in the UNITY system.

Assemblyman Hambrick:
I am going to try to tread very lightly because I know we are not the money committee. Washoe County put a significant dollar amount on this. Is that still valid?

Kevin Schiller:
No, it is not. The fiscal note was attached when the initial draft of the bill required the appointed individual for all mental health treatment, not just psychotropic medications. So what was happening was for any mental health appointment, which could be intake or an assessment for counseling, the fiscal note was attached to it based on the requirement for overall health care and mental health. Then what occurred through the amendments was getting it down to psychotropic medication, which has narrowed the population significantly. We also added in the ability of an agency representative to be court appointed and qualified versus having it be an external appointed individual.

Assemblyman Hambrick:
Has it been removed or greatly reduced?

Kevin Schiller:
Yes. From the perspective of where I sit in Washoe County, along with Clark County, we both believe that there is a minimal fiscal impact at this point.

Assemblyman Hambrick:
I know you cannot speak for Clark County . . .

Chair Mastroluca:
Mr. Ortiz, would you come to the table and take care of Mr. Hambrick's question?

Alex Ortiz, representing Clark County:
We testified in the Assembly Committee on Ways and Means that the fiscal note would be removed from our perspective as well, based on the way this bill has been redrafted or revised.

Chair Mastroluca:
Are there any other questions from the Committee? [There were none.] Is there anyone else who would like to testify on Senate Bill 371 (R1), either in

support, opposition, or neutral? [There was no one.] I will close the hearing on S.B. 371 (R1).

Committee members, we are going to jump to the work session because the hour is short and our Legal staff has to do a lot of work in a very short amount of time. We are going to hand out today's warmest copy of the proposed amendment to Senate Bill 115 (1st Reprint), which we heard yesterday at great length. I can walk you through the changes that were made between the conversations that we had yesterday and where the amendment stands right now. We will hear from folks who have worked on this bill. Most of them were in agreement about a half hour ago and hopefully no one has changed his mind.

Senate Bill 115 (1st Reprint): Provides requirements governing payment for the provision of certain services and care to patients and reports relating to those services and care. (BDR 40-192)

Chair Mastroluca:
The changes that were made in this amendment on page 3, in section 13, relate to the out-of-network hospital (Exhibit C). When someone presents to an out-of-network hospital that is in negotiations, there is a 12-month window that these provisions would apply to that patient as long as they are in contract negotiations and they had previously had a contract with the hospital. After 12 months it would go back to billed charges. We had a discussion yesterday about if it was 12 months, 6 months, half of the contract life, and we have fallen to 12 months.

I have one small change to page 4, section 13, subsection 2, paragraph (a). Yesterday we had conversations about the current schedule of fees and charges established by the Division of Industrial Relations (DIR). In discussion it was felt that costs could be better contained if we went to a percentage of billed charges. For emergent care it is 60 percent of billed charges, and for traumatic injury or trauma care it is 70 percent of billed charges. Your copies say 65 percent and that will be changed to 70 percent in the final draft.

At the bottom of that page in subsection 4, there is a provision regarding a cap that says that if the hospital's rates go up, there is a cap of 5 percent that they can raise the rates for the billed charges. That was something that both the hospitals asked for and the nonprofit providers agreed to.

On page 5, subsection 6, it says, "If an out-of-network hospital becomes aware that a patient is covered by a policy of insurance or other contractual agreement . . ." that the patient shall be stabilized and "transferred to an in-network hospital within 8 hours . . . ."

In section 22, this entire act will expire on January 1, 2018. It is a six-year period for this entire piece of legislation.

Risa Lang, Committee Counsel:
The only other thing you might mention is section 21.5, where it clarifies that this applies prospectively only for contracts that exist on or after the affected dates.

Assemblyman Livermore:
I can understand the reason for negotiations with a health care provider. But yesterday I believe all of us in this Committee received an email from Ms. Bobbette Bond, and she lists her Health Services Coalition. I believe this is just a process of shifting costs to health care providers, hospitals, and physicians, and I do not believe that is fair or equitable. I have a huge amount of sympathy for people who have out-of-pocket costs for health care. But if you look at some of the major corporations in the state of Nevada in this list, it is not a matter of them struggling to pay health care, as what I believe we heard earlier. I believe they have a moral and legal responsibility to pay their claims that a person who has a plan pays for.

Chair Mastroluca:
I would like to clarify that this is not about whether or not these groups should be paying for their clients or customers, but it is when they are in negotiations with the hospitals and that patient falls within that time frame. For example, say that the Health Services Coalition has an agreement with ABC Hospital and on December 31, that contract with ABC Hospital ends and they are negotiating but they have not come up with a new contract. During that time that they are negotiating, you, as a patient, who has gone to ABC Hospital in the past, is in an emergent situation and is transferred to ABC Hospital. It could be you were in a car accident and you did not have the ability to say, "No, I want to go to XYZ Hospital." You are transferred to ABC Hospital. During that time, technically you are not covered, and as a patient you would be forced to pay the entire bill. This is saying that because those negotiations are going on, in order to show good faith, this is an agreement between the hospital and the insurance company that as long as negotiations are happening, that patient will receive a different charge and in this case, 60 percent of billed charges is what the insurance company would be charged. The patient will still pay their same copay and they will not be forced to pay this entire bill. The goal is to never have to use this legislation. The goal is to say it is a much better deal for both parties to be under contract, and if the hospital and provider are under contract, you will never have to use this legislation. If for some reason they are not under contract and still negotiating, the patients will still be covered, and they

will still have the opportunity to receive the services at a price they can afford while the negotiations are going on.

Assemblyman Livermore:
My statement was not about patients. My statement was about this assortment of large insurance providers. I believe that you are toying with market dynamics. Negotiations come and go in all different arrangements of sorts and times and places. I believe that in this case, I am not going to support this bill because I believe this bill shifts the dynamics of the private market sector that should be allowed to continue to negotiate and compete and hopefully provide the best-priced health care. I am sorry to say that if a provider and hospital someplace cannot come to some agreement with that, that is insurance regulation. I do not think this policy that we are trying to do fits the market dynamics.

Assemblyman Sherwood:
Just for a point of clarification on section 13, subsection 2, paragraph (b), on page 4, line 8, is the 65 percent piece actually 70 percent now?

Chair Mastroluca:
Yes.

Assemblyman Sherwood:
Then the billed charges above that on line 2 says 60 percent. Was that also supposed to be 70 percent?

Chair Mastroluca:
No. It is 60 percent for emergent care, and 70 percent for trauma care.

Assemblyman Sherwood:
Then the rationale behind that is if you were to do this on your own, you would get, by statute right now, 30 percent off of billed charges. That is in law right now, correct?

Chair Mastroluca:
That I cannot speak to, Mr. Sherwood.

Assemblyman Sherwood:
We have heard a couple of times here that if you end up in a hospital and have billed charges they take 30 percent off the top. I am just trying to follow the rationale.

Assemblywoman Benitez-Thompson:
I want to make sure we are clarifying what the actual language is stating and the scope we are getting to. I know it is so hard when it is late in the day and with so many reprints and amendments coming in, but this language only applies—and if our Legal staff can confirm this—to nonprofits. Correct?

Risa Lang, Committee Counsel:
Yes, that language is in section 11 of the bill, and it limits it to only nonprofits.

Assemblywoman Benitez-Thompson:
Within that, the population that we are talking about are people who are currently insured. This is not any type of a negotiation in any way in which the people who are uninsured are affected. It is just insured folks who are paying out of pocket out of every paycheck.

Chair Mastroluca:
Correct. People who are currently paying their premiums.

Assemblyman Anderson:
I am pretty sure I will be supporting the bill and I want to thank the parties for working very diligently on this, and for the time the Chair spent on it. The way I look at it is that you have nonprofit health plans, and whether or not individual people who are insured are paying these charges, if the charges get too much—and it is based on someone going under in an emergency situation—and they do not know where they are going, and they go to the wrong place, that still puts pressure on health plans which serve people. I know that a lot of people in my district who work on the Strip really cannot afford it. They are working class folks, so I will be supporting the bill and if you would allow for it, Madam Chair, I would move to do pass as amended.

Chair Mastroluca:
I appreciate that, Mr. Anderson. We do have a few more comments and then we will come back to you. Thank you.

Assemblyman Frierson:
I wanted to at least make sure that our record is clear. There was an insinuation that we are talking about uninsured. I think that some of the discussion at the hearing made it clear that what we are trying to do—at least policywise—is acknowledge that these are folks who are trying to be responsible by having insurance, but because they are out-of-network end up with expenses that quite frankly in the community leave people homeless. But at the same time, the differentiation between traumatic and nontraumatic seems to—at least on a policy level—acknowledge that the traumatic injuries are more

expensive and a greater burden on the hospitals. In order to limit or mitigate the damages, they would be treated differently because they are much more expensive. I see it as a significant compromise to acknowledge both sides of the policy that was discussed at the hearing.

Assemblyman Brooks:
I think the email my colleague is talking about is the Health Services Coalition. There is a list of different insurance companies on there, and I just wanted to clarify that. I see MGM, City of Las Vegas, et cetera. I do not think all of them would qualify.

Chair Mastroluca:
They all belong to the Health Services Coalition, which is a nonprofit.

Assemblyman Brooks:
So the MGM would fit in there as well?

Chair Mastroluca:
They are self-insured. Their insurance is nonprofit.

Bobbette Bond, Director of Public Policy, Culinary Health Fund; and representing Health Services Coalition:
The Coalition itself is a nonprofit. All of the health plans inside the Coalition are self-funded. Not all of them are nonprofits, and right now we are trying to figure out who will and who will not be eligible inside those plans for these rates. But in the interest of moving forward, and in the interest of the benefit to the community of having a provision for nonprofit status, the entire Coalition signed off on this legislation.

Assemblyman Brooks:
Not all of those companies will be eligible, correct?

Bobbette Bond:
We are not sure.

Assemblyman Anderson:
A lot of the ones that are nonprofit have people who are really not high income earners, correct? So if you have a lot of pressure on a health plan because people have gone to the wrong place in an emergency situation, that can drive up rates for a health plan, correct? It says they only have to pay their deductible and everything else, if I remember correctly, but what happens is that people have to keep reevaluating their plan if there is too much pressure on them. Am I understanding that correctly?

Bobbette Bond:
I think the provision that was a little confusing yesterday in a lot of testimony was what happens to the patient in this bill. In this bill, the patient would pay their usual copays, coinsurance, and deductibles as though they were in-network, as though they landed in the right place. Then the plan has to pay the rate that is in this statute for everything else, so that the patient is held whole as though they went to the right place. This is an attempt to get a break off of billed charges, which really are not tied to costs. It is in between contracted rates and full billed charges, which is price but not cost. It is a middle ground.

Assemblyman Sherwood:
We heard testimony yesterday that your alliance already has contracts in place with every hospital in Clark County. If for some reason this did not pass, it would be a level playing field for someone like Anthem. I am looking at Anthem. They have preferred providers, which are in-network. They have nonpreferred, which are out-of-network. It is slightly more expensive for the patient, but because they are paying for the health insurance, the health insurance is negotiated to say, "Okay, if it is out-of-network, we will cover the difference. You will pay a little more but we will cover the difference." I want to make sure that you already have contracts in place.

The thing I am still struggling with, Madam Chair, concerns the constituents I represent who have United HealthCare, or Sierra Health and Life, or Anthem; why would they not enjoy the same benefit? For us to pick winners and losers is just not a good policy, and certainly not a principle that I think we want to get into.

Anyway, I just wanted to make sure that you are already under contract. That was the testimony that we heard, right?

Bobbette Bond:
Yes.

Chair Mastroluca:
I would like to have some of the folks who were in the negotiations come to the table to say whether or not they are good with this, and then we will move forward. We have the hospitals and then members of the Health Services Coalition.

Assemblyman Goicoechea:
This is more of a comment, and maybe I am oversimplifying the bill. This is all about if you have a traumatic injury, you are going to be transported to the

closest trauma center, you are going to be treated, and it is about who gets to pay the bill. Whether it is your insurance plan or the hospital, one or the other is going to have to eat it for the short term until that patient is transported. I think it ends up being all about equity. Someone has to pay the bill.

LaShannon Spencer, Director of Public Policy and Advocacy, Catholic Healthcare West:
We are very much in support of how S.B. 115 (R1) is currently written with your proposed amendments and we just thank everyone, and thank all of the stakeholders for being at the table drafting language that we can agree to. Thank you.

Dan Musgrove, representing Valley Health System:
Today I am representing the Valley Health System, which includes five hospitals in southern Nevada: Valley Hospital Medical Center, Summerlin Hospital Medical Center, Desert Springs Hospital Medical Center, Spring Valley Hospital Medical Center, and Centennial Hills Hospital Medical Center. I also represent Northern Nevada Medical Center in northern Nevada.

As you heard from my testimony yesterday, conceptually we have always had an issue with this as a policy, but I must say that this Committee, not ever seeing this issue before yesterday, certainly grasped it, asked excellent questions, and worked very, very hard with the leadership of the Chair to make this—in homage to the Chair—a bitter pill that I can down with a nice ice-cold Pepsi and it is not too bad. Thank you very much.

Denice L. Miller, representing MGM Resorts International:
I know you said you did not want flowery speeches, but since my knowledge of the actual technical aspects of the bill is very small, please permit me to offer a few flowery statements. Otherwise I will have nothing to say and I will just turn it over to Gina Polovina.

I would be very remiss if I did not express the thanks of MGM Resorts International, which is a member of the Health Services Coalition, to the hospitals, and the physicians that we have worked with over the past couple of days. This is a difficult issue. It is an issue of equity. It is not an easy one. We recognize that it is a difficult one for the hospitals. I can only say that we are extremely grateful that they were willing to talk to us. I know that perhaps we have not reached something that everyone likes, but they were great to work with and we thank them for those efforts.

Gina Polovina, representing Boyd Gaming Corporation:
I can only wholeheartedly echo those comments and extend our sincere appreciation on behalf of Boyd Gaming Corporation for the very candid and open dialogue with our partners.

Denice Miller:
If I may have one last point, and I apologize. I know we came in a little late, and I do not know if you discussed the proposed sunset. This is a difficult issue. It is one that has been around for many, many years. One of the reasons we suggested the sunset was to give all of the parties a comfort level with the fact that this gives us some time to show some good faith on both sides, to see whether it works, to address the situation, to gather some data, and to have some reporting to the legislative committees. Then in six years if this body decides that it should sunset, it sunsets. If we decide we want to take a look at it again and work with you, we are happy to do that. In six years, if I am still here, I will no doubt be regretting that I made the recommendation.

Chair Mastroluca:
My hope would be that in six years you come back and say, "You know what? We did not need this and we never used it." To me that would say that we did something right. Thank you both very much.

Assemblyman Hambrick:
We have heard from one side of the stakeholders. I think perhaps some of the witnesses we had yesterday may still have an opinion. I realize this is not testimony because it is a work session, but I just was not sure whether it was going to be all of those who may have had an opportunity to look at the amendment that may have other views?

Chair Mastroluca:
I would consider that. Would you like me to have Ms. Conaboy and Ms. Joiner come up?

Assemblyman Hambrick:
Perfect.

Kathleen Conaboy, representing Nevada Orthopaedic Society:
It may be that the negotiations between yesterday's meeting and today went very well and very smoothly, but we were not invited to those negotiations. We stand in opposition to the bill as written and as amended. It is fascinating to me. As I look at it now, it seems more and more like a contract negotiation,

not a piece of policy, and I am quite flabbergasted, quite frankly. For the record, we are in opposition to the bill.

Chair Mastroluca:
Were you part of the original discussion to use the Division of Industrial Relations Medical Fee Schedule as the basis for the rates?

Kathleen Conaboy:
We were at the meetings in the last session, in the interim, and in meetings with Senator Horsford and Senator Copening. We were not invited to Senator Copening's small group. Then we were invited to participate in an amendment. The use of the DIR fee schedule was not our idea. The Nevada Orthopaedic Society, as well as, I think, the Nevada State Medical Association, has always objected to any kind of a benchmark metric, especially if it is tied to Medicare, which is in flux at the federal level as we speak today.

Amber Joiner, Director of Governmental Relations, Nevada State Medical Association:
I am likewise surprised. This has been a stakeholder's process throughout in the Senate, and we have been at the table for all except the first set of meetings, and we were not invited to this one. So honestly I have not digested the amendment fully. Looking at it, it appears that most of the changes are related to hospitals and so our opposition to the bill would remain unchanged.

I would like to clarify, as Ms. Conaboy said, how this looks like a contract negotiation. We are talking about 200 percent, 115 percent; let us not talk about the DIR fee schedule—let us now talk about billed charges. For us, the frustration is about this concept of contracting by statute. The point was brought up that we do talk about contracts in law all the time. We do deal with homeowners' association (HOA) contracts, but the distinction that I would like to make, and the reason this is different, is that when we deal with things like HOAs in law, and we talk about finding contracts and how one party versus another would have to hold up their end of the bargain, you do have legislation relating to that. The difference with this is that this is setting a payment, an actual rate, an actual dollar amount in statute. The reason that is different is, if you look at, for example, HOA contracts, the last I checked, we do not have in law that an HOA can only charge a certain amount or that we do not set contract rates for a plumber to only be able to charge a certain amount. I just want to clarify that that is the difference. We are taking two private parties—a physician and an insurance company, or a facility and an insurance company—and you are setting in statute an actual rate of reimbursement and how much that person will be paid for their service. That is different than any

other legislation that this body has passed. Now this topic has been brought up, but it has failed, and we believe it is because it is a bad precedent to set.

The other key issue for us is still access. If physicians are not going to get reimbursed, they are not going to go on call to take over for the emergency room (ER) doctor. This bill excludes the ER doctors. Immediately following that, a patient will usually have to see an orthopedic surgeon or a specialist of some kind even before they are stabilized. So before they are stabilized and after they are stabilized, there are specialists all along the way, and we think that that could create a problem of access if physicians are not reimbursed in a way that covers their costs.

Assemblyman Frierson:
We actually did pass regulations on HOAs on what exactly they could charge. I certainly respect the notion that this is a unique situation and in some parties' opinion trampling or wandering into contractual terms, but that is what regulations do. I think it is a philosophical discussion about how far, and I certainly respect that. I think that there are ways that we regulate to try to protect folks and not necessarily reward bad or irresponsible behavior, but also not take action that is going to result in further complications and cost down the road. I think this is one of those areas. I know it is not an easy thing, and I know it is a difficult thing, especially for hospitals. It is unfortunate that not everyone was at the table and not everyone could agree. They are not always going to agree, but I just wanted to point that out. We had the example that we do sometimes regulate exactly how much folks can charge for certain services. I think it is a policy decision about how far we go.

Chair Mastroluca:
We have heard from the hospitals. We have heard from the insurance companies. We have heard from the doctors. I think we have covered all of the bases. I agree that this is not perfect, and I also recognize that what I have learned in my time in the Legislature is generally if you have something that everyone is just a little bit annoyed about, then it is usually pretty good legislation. You are not going to make everyone happy; no one is going to get their way, and I do not want everyone to get their way. I said yesterday that my goal in this first and foremost was to protect the patient. My second goal was to put something into the provision that said you have to negotiate and that neither side can drag their feet, and neither side can try to have a benefit over the other. The goal is negotiation. If the parties negotiate and the parties stay within contract, then this legislation should not be used. Like I said to Ms. Miller, it would be great for you to come back in six years and say, "We did not need this. We did not use it." That would be my goal.

With that, I will accept a motion to amend and do pass with the latest amendment.

> ASSEMBLYMAN ANDERSON MOVED TO AMEND AND DO PASS SENATE BILL 115 (1st REPRINT) WITH THE LATEST AMENDMENT.
>
> ASSEMBLYMAN CARRILLO SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMEN GOICOECHEA, HAMBRICK, HAMMOND, LIVERMORE, AND SHERWOOD VOTED NO.)

Chair Mastroluca:
We still have one more bill to hear.

Senate Bill 370 (1st Reprint): Makes various changes to provisions governing children who are placed with someone other than a parent. (BDR 38-909)

Kevin Schiller, Director, Department of Social Services, Washoe County:
Senate Bill 370 (1st Reprint) requires the board of trustees of each school district to adopt a policy specific to each elementary school in the district to develop an academic plan for kids who are in foster care and enrolled in the school. It has to be reviewed annually, and it must be developed with the goal of the child achieving academic success.

One of the key components is that when children come into foster care, there comes with it a trauma that is related to abuse and neglect. This bill is attempting to address maintaining a plan for that child. Many of these children have specific educational needs that need to be addressed as they come into care. It is also requiring the foster parent in those circumstances to obtain a written explanation from medical professionals—much like I was testifying about earlier regarding Senate Bill 371 (R1)—about the need for prescription medication of a foster child. It is also requiring that a copy of those specific explanations on medication management and treatment be submitted to the court.

Section 6 of this bill is getting into the Department of Corrections, and this is basically allowing that if the child has been placed with someone other than a parent, the parent may maintain contact with the child if the child is willing to maintain contact and the contact is not prohibited by law. It authorizes the prisoner to use approved telecommunications for the purpose of visitation, so those would be parents who are maintained in custody. It is allowing continued

contact between the parent and child when we are faced with issues of parents who are incarcerated.

I would highlight that in child welfare, as I have testified before this Committee, we average somewhere between 500 to 700 kids who are in foster care. This bill is trying to address the best interests of the child in terms of the educational component and maintaining contact with the parent. One of the pieces that you will note is that this bill requires us to notify the school when a child is placed in custody. So there is a requirement upon the agency to communicate directly with the school. I cannot speak for Clark County, but I can tell you that in Washoe County we have an existing database that we share between the school district and social services that we worked out with legal representatives of the school district, so we share that information and they are aware of kids who are in foster care. This bill is taking that one step further so that we not only have to communicate about it, but we also have to be provided with a plan. I would echo that it is similar to an individualized education plan, where you are sharing information about that child to ensure that educational needs are met.

Chair Mastroluca:
Thank you, Mr. Schiller. I appreciate you jumping in there and helping out.

Assemblyman Goicoechea:
I see a rather large fiscal note from the Department of Corrections. Has that been amended out or did they withdraw it?

Chair Mastroluca:
We are trying to address that right now. It is my understanding that it may have been affected by the amendment that was adopted.

Jeff L. Mohlenkamp, Deputy Director, Support Services, Department of Corrections:
In section 6, paragraph 2, ". . . if such equipment is available . . ." allows us to pull our fiscal note because it only says that we have to provide the videoconferencing when we have the systems in place to do so. As I testified before the Senate Committee on Finance, doing so might require us to engage a vendor who might then charge incarcerated individuals or their families a certain price in order to pass that cost along. I want to make you aware that that is a potential for us if we try to go forward with the video visitation capabilities discussed in the bill.

Assemblyman Frierson:
To my knowledge, attorneys do not have that access either. I would imagine if we are ever going to move towards videoconferencing that it is probably going to be a group effort. There are going to be a lot of folks who are going to have to be a part of that if we move in that direction. I certainly respect the fact that when you do not have the technology, you do not have it. I hope that we are able to move there at some point.

Assemblyman Goicoechea:
What you are saying is you interpret the bill as though you would not be required to put the equipment in place now. It would only be if you had it available.

Jeff Mohlenkamp:
Yes. We would interpret this as being permissive. It is mandatory but not until we have the equipment capability to do so, so we would only have a fiscal consequence if we could do this. I am telling you that we do not have the resources but in the next biennium we will look to having vendor-supported software that would allow us to do this. That would be at no cost to the state if we could arrange it.

Assemblyman Hambrick:
I have a question on section 8, but I will certainly bide my time for the Majority Leader, and hopefully will be able to come back for a question on section 8 in Clark County. I see a representative from the Clark County School District here, but I will wait for Senator Horsford to address the group.

Senator Steven A. Horsford, Clark County Senatorial District No. 4:
Thank you for your consideration of S.B. 370 (R1). The bill as amended is pretty narrow. The Chairwoman had a bill on kinship care, which was better, so we took out the provisions of my bill and went with her language. The only additional sections pertain to the academic plan requirement with the school districts. The justification for this is that children who are in the foster care system are the least likely to graduate from high school than any other group of young people. In part it is because they move from school to school when they are placed in different foster homes or group homes. It is an issue that I learned about when I was chairing the interim Committee on the Placement of Children in Foster Care, and heard directly from students who literally can be placed in five to ten different foster care placements, depending on the circumstances, particularly for older youth, which becomes a challenge.

The other provision which I know you were talking about deals with parents who are incarcerated to be able to maintain contact with their child to the

extent allowed based on availability of equipment. The provision of this bill comes from policies from the Children's Defense Fund, which has demonstrated that when a parent maintains appropriate contact with their child, it increases the child's ability to handle the parent being incarcerated, and once that parent comes back, they have a much better chance of integrating and restoring the relationship between the child and the parent. Of course, there need to be appropriate guidelines and policies in place to ensure that it is appropriate based on the nature of the relationship with the child and the parent. Those are the main provisions of the bill, Madam Chair, and I again appreciate your consideration of the measure.

Chair Mastroluca:
Thank you very much, Senator, and I appreciate you bringing this forward. I too watch closely the work of Marian Wright Edelman, founder of the Children's Defense Fund, and have received ideas from the work that she has done, which is why I appreciate you bringing this forth.

Assemblyman Hambrick:
I will give Senator Horsford an option. I do have some questions in section 8 if he would like to address those issues, or we could call in the Clark County School District. The questions are going to be somewhat indelicate.

Chair Mastroluca:
Let Mr. Mangino make his way up.

Assemblyman Hambrick:
We all know that youngsters who are in foster care have a lot of challenges, and that the vast majority of the challenges are not of their making. I have expressed occasionally that I sense that the school districts are not demanding excellence from our children. Occasionally some are allowed to coast. Because these youngsters do go to multiple foster parents, will the plan follow them from school to school to make sure they have some continuity in academia and that they know excellence will be expected of them as they go from elementary to middle school? We need to let these youngsters know that there is a way out of the environment that they are in, and excellence in education is perhaps the key factor in letting them escape that. If you could address how the plans will be drawn up, if they will follow the youngsters, or will each school draw up a different plan as the youngsters come to them?

Bart Mangino, Legislative Representative, Community and Government Relations, Clark County School District:
We appreciate the Majority Leader's willingness to amend the bill, because we feel that this plan would follow the student from school to school. As you may

be aware, with Superintendent Dwight Jones coming on board with the Clark County School District, one of his plans is to implement the growth model. That enables us to also monitor the student from school to school. We understand that transiency and continuity are a couple of the difficult pieces as far as the child is concerned. When you take a look at the things that are happening educationwise in the state of Nevada, in addition to the guidelines outlined in S.B. 370 (R1), you have common core standards, and you have the academic plan that would be able to follow the student from school to school. We do have the interim assessments. We also have response to instruction and intervention, which is a federal mandate that all schools have to implement at the elementary level. We additionally have many of the schools at the elementary level in the Clark County School District implementing different types of assessments and identifying where students are. We understand that our students come to us from a variety of backgrounds and it is our charge to address those identified needs. In order to identify those needs, there have to be assessments, and those are being implemented in many of our elementary schools.

Assemblyman Hambrick:
I would love to see the terms "mediocrity" and "complacency" eliminated from the vocabulary in our educational system. "Excellence" and similar words need to replace those. Kids have to understand that excellence is expected. They will reach it and they will get there. It is inherent in them.

Assemblyman Hammond:
When talking about the individualized education plan (IEP), Mr. Hambrick asked if that IEP is going to go with that child from elementary to middle school to high school. Of course, with the transiency rate the way it is, sometimes they go from elementary school to elementary school during the same year or the next year. I know that in dealing with foster care we are trying to keep the children in the same school no matter where they go throughout the valley in Las Vegas or in Washoe County. I understand that, but with the IEP in particular, are you planning on using this like a typical IEP, meaning that we are going to be updating it once a year, and that they will have an IEP at the end of their middle school year? I think that right before they graduate they have to update and have the input of the child. Are we going to do this like a regular IEP all the way around? Is that your interpretation of the bill the way it is written?

Bart Mangino:
What I would first take note of is the fact that it has moved from an individual education plan, because we do not want to confuse that with the federally mandated special education. What we have here is an academic plan. The

academic plan as outlined in the amendment does state that it is reviewed annually. When you take a look at some of the things that are currently happening in our elementary schools, at a minimum this plan is going to be reviewed during parent conferences that are held at the elementary schools. It is a program that has been in place for a long time.

Assemblyman Hammond:
That is what I wanted to hear. It is not the same. There is not going to be any federal mandate on it, or anything like that. You are saying you already have an academic team in place, someone who is going to be doing the work year to year? With an IEP, you usually have a coordinator who gets everyone together and figures out what core teacher is going to come in. You already have something in place for this academic team as well. Once you get these children on these academic plans, is there anything in the bill as you read it that would terminate the plan? As soon as they get back into the care of their parent, are they done with the academic plan or are they going to continue to go to make sure that perhaps there are no effects from what happened to them?

Bart Mangino:
My interpretation, having been an elementary principal for 13 years, middle school principal for 6 years, and high school principal for 4 years, is that whenever you are dealing with an individual student, the idea is that you are working with that child. It never ends. You are always looking at meeting the needs of those students and going back to the idea that we want that child to achieve as high a level as possible, and we are holding those standards high. The best opportunity for any child is education, and we want a quality education for them.

Additionally, what I would envision may differ, depending upon the school. Some schools are impacted more as far as foster children are concerned. For example, Bonanza High School has three group homes that feed into it, so as a result we have taken steps in that particular school to address the needs of those students that come to us. That is a revolving door. We try to keep those guys as long as we possibly can.

Assemblyman Hammond:
I agree with you. Every educator wants to make sure they are educating the child, but according to this bill, do you feel like it is your responsibility once you start the academic program that you have to continue it, even if they go back to the care of their parent?

Bart Mangino:
Absolutely. That is our responsibility. That child is our responsibility. The beauty of a plan for the child is that it will be a wonderful way of linking what has happened during foster care if they go back with the biological parent.

Assemblywoman Benitez-Thompson:
I know there is a lot of discussion going on with this bill, but to me it seems very simple, which is to ask the school district to put some thought into what they are going to do when a foster child enrolls in their school and enrolls in their classroom, considering the fact that children in foster care are coming with lots of different needs and abilities. You can have a kid who is going into first grade who has never seen a dentist or maybe has not had his shots. I think that all we are doing is asking the schools to think about how to address this population and it seems simple and good.

Chair Mastroluca:
Are there any comments? [There were none.] Is there anyone else who would like to testify on S.B. 370 (R1)? [There was no response.] I will close the hearing on S.B. 370 (R1). Do I have a motion for do pass on S.B. 370 (R1)?

> ASSEMBLYMAN FRIERSON MOVED TO DO PASS SENATE BILL 370 (1st REPRINT).
>
> ASSEMBLYWOMAN FLORES SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Senate Bill 371 (1st Reprint): Makes various changes concerning the protection of children. (BDR 38-3)

Chair Mastroluca:
We are going to work session the first bill that we heard today, Senate Bill 371 (1st Reprint) from Senator Cegavske. Is there any discussion on the bill? I will accept a motion of do pass.

> ASSEMBLYMAN ANDERSON MOVED TO DO PASS SENATE BILL 371 (1st REPRINT).
>
> ASSEMBLYMAN FRIERSON SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Chair Mastroluca:
I want to take a moment and thank everyone for their work. I know there were times where this Committee has had a lot of fun, and there have been times when this Committee has heard some very difficult things. I think that everyone has persevered. I appreciate it. Thank you for your patience with me as being a first-year Chair. I have learned a lot from all of you. I appreciate your patience and indulgence. I would also like to thank the folks who are here every week and for making my first session as a Chair quite special. I appreciate it.

Is there anything else to come before the Committee? [There was none.] With that and for the last time this session, the Assembly Health and Human Services Committee is adjourned [at 5:00 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: June 6, 2011 **Time of Meeting: 3:38 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 115 (R1)	C	Assemblywoman Mastroluca	Proposed Amendment