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

Seventy-sixth Session
March 8, 2011

The Joint Subcommittee on Human Services/CIPS of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Sheila Leslie at 8:04 a.m. on Tuesday, March 8, 2011, in Room 3137 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Sheila Leslie, Chair
Senator Steven A. Horsford

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblyman David P. Bobzien
Assemblywoman Maggie Carlton
Assemblyman Pete Goicoechea
Assemblyman Cresent Hardy
Assemblyman Joseph M. Hogan
Assemblywoman Debbie Smith

SUBCOMMITTEE MEMBERS ABSENT:

Senator Barbara K. Cegavske (Excused)

STAFF MEMBERS PRESENT:

Jennifer Byers, Program Analyst
Michael J. Chapman, Principal Deputy Fiscal Analyst
Laura Freed, Senior Program Analyst
Rex Goodman, Principal Deputy Fiscal Analyst
Wade Beavers, Committee Secretary

OTHERS PRESENT:

Phil Weyrick, Administrative Services Officer, Health Division, Department of Health and Human Services
Richard Whitley, M.S., Administrator, Health Division, Department of Health and Human Services
Mary Wherry, R.N., M.S., Manager, Public Health and Clinical Services, Health Division, Department of Health and Human Services
Joseph L. Pollock, R.E.H.S., Program Manager, Environmental Health Section, Public Health and Clinical Services, Health Division, Department of Health and Human Services
Tracey Green, M.D., State Health Officer, Health Division, Department of Health and Human Services
Marla McDade Williams, B.A., M.P.A., Deputy Administrator, Health Division, Department of Health and Human Services
Luana J. Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning, Epidemiology and Response, Health Division, Department of Health and Human Services.
Mary C. Walker, CPA, Carson City, Douglas County, Lyon County and Storey County
Jeff Page, County Manager, Lyon County Board of Commissioners
Lawrence A. Werner, P.E./P.L.S., City Manager, Carson City Consolidated City-County
Pat Whitten, County Manager, Storey County Board of Commissioners
Lisa A. Gianoli, LG Strategies, Ltd
Mary-Ann Brown, R.N., M.S.N., Interim District Health Officer, Washoe County Health District
Alex Ortiz, Clark County
Wes Henderson, Deputy Director, Nevada Association of Counties

CHAIR LESLIE:
I will open the hearing on the budget overview for the Health Division. I would like to begin with a discussion of the Health Statistics and Planning account, budget account (B/A) 101-3190.

HUMAN SERVICES

HEALTH

HHS-HD – Health Statistics and Planning — Budget Page DHHS HEALTH-23 (Volume II)
Budget Account 101-3190

PHIL WEYRICK (Administrative Services Officer, Health Division, Department of Health and Human Services):
For each account, I will discuss the major enhancements. The Committee has been provided with a copy of our presentation (Exhibit C).

The first major enhancement for this account is E-325 which requests funds for additional software and hardware systems which would support the Web-enabled vital records registration system.

E-325 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-25

This funding would come from the National Center for Health Statistics, rather than the General Fund.

The next major decision unit is E-710. This would replace two computers.

E-710 Equipment Replacement — Page DHHS HEALTH-27

This money would come out of the General Fund dollars allocated to the Trauma Registry and Sentinel Events programs. This would also pay for replacement of associated Windows software and peripherals, in accordance with the State's five-year Department of Information and Technology (DoIT) replacement schedule.

This account includes decision unit E-900.

E-900 Trsfr From Health Stat & Plan to Biostat & Epid — Page DHHS HEALTH-27

This would transfer the State Trauma Registry from the Health Statistics and Planning Budget to the Biostatistics and Epidemiology budget, B/A 101-3219.

HHS-HD – Biostatistics and Epidemiology — Budget Page DHHS HEALTH-90 (Volume II)
Budget Account 101-3219

On page 1 of Exhibit C, the Subcommittee will see an outline of the major consolidations which are proposed within the Health Division. The Biostatics and Epidemiology account will be new. We are trying to consolidate all of our biostatisticians and data personnel under a single supervisor, so that they can function more effectively. This will also improve our standing when applying for federal grants, as we will have a data section that can provide the information that is required for grant applications.

There are several transfers that we will discuss as we proceed through each account. A total of 19 employees are being transferred from 7 budget accounts.

In B/A 101-3190, unit E-901 transfers the Behavioral Risk Factor Surveillance System program which is a data collection program funded by federal grant money, to the Biostatistics and Epidemiology account.

E-901 Trsfr From Health Stat & Plan to Biostat & Epid — Page DHHS HEALTH-28

Decision unit E-902 is a request to transfer the Sentinel Events Registry from the Health Statistics and Planning account to the Biostatistics and Epidemiology account.

E-902 Trsfr From Health Stat & Plan to Biostat & Epid — Page DHHS HEALTH-28

Two positions, a human resource analyst and an administrative assistant, would be transferred by this enhancement. These positions are mostly funded with money from Health Care Quality and Compliance. This transfer involves about $17,000 in General Fund money.

Decision unit E-903 requests the transfer of a health resource analyst.

E-903 Trsfr From Health Stat & Plan to Biostat & Epid — Page DHHS HEALTH-29

This position is entirely funded with General Fund money.

CHAIR LESLIE:
The fees that are collected by the Office of Vital Records go into the General Fund, and not into this account. Please discuss the costs and benefits of that system. Should the fees be more directly funding this account?

RICHARD WHITLEY, M.S. (Administrator, Health Division, Department of Health and Human Services):
Those fees go into the General Fund and then are returned to us in authorized funding. They cover our costs.

CHAIR LESLIE:
Will there be a regular review of the fee schedule? During the Twenty-sixth Special Session, we made the determination that reviews of the fees had been neglected. We were lagging behind other states in the structure of our fee system.

The concern is that, as long as the fees have only an indirect impact on your agency, there will be little incentive to enact regular reviews of the fee schedule.

MR. WHITLEY:
The fee structure is in regulation. It has been several years since the fees have been reviewed and increased. They are now in line with fees in The Southern Nevada Health District and Washoe County. We have made a commitment to perform annual reviews of the associated costs of all of our fees. We will be able to make more frequent adjustments. Through the public workshop process, I, as the Administrator, can make appropriate changes in the fees.

This is part of an overall effort by our agency to determine the actual costs of all of our fee-funded programs.

CHAIR LESLIE:
Would there be any opportunities to leverage federal funding if we were to fund this account directly through fees?

MR. WHITLEY:
Not that I am aware of.

CHAIR LESLIE:
We would like to speak more with you on this issue at a later time. We need to determine if it makes sense to continue the indirect fee funding of this account.

MR. WEYRICK:
I will now discuss the budget for Consumer Health Protection, B/A 101-3194.

HHS-HD – Consumer Health Protection — Budget Page DHHS HEALTH-32 (Volume II)
Budget Account 101-3194

An overview of this account can be found on page 4 of Exhibit C.

The first major decision unit is E-690 which recommends replacing General Fund expenditures with county reimbursements. This would amount to $594,760 in fiscal year (FY) 2011-2012 and $586,759 in FY 2012-2013 county reimbursement funding. The Office of Consumer Health Protection will charge the counties that do not have health departments for inspection of food establishments, schools, jails, swimming pools and septic tanks.

E-690 Budget Reductions — Page DHHS HEALTH-36

The next enhancement is E-710 which would replace four desktop computers, two laptop computers and a docking station in accordance with the DoIT schedule for equipment replacement.

E-710 Equipment Replacement — Page DHHS HEALTH-37

This budget contains decision unit E-720 which is a request for an enhanced software program that would include a billing and permitting module.

E-720 New Equipment — Page DHHS HEALTH-37

It would also include the resulting maintenance agreement which would require $4,500 of General Funds in FY 2012-2013.

This account includes decision unit E-914 which would transfer a senior epidemiologist from Consumer Health Protection to Biostatistics and Epidemiology.

E-914 Trsfr From Cons Hlth Protection to Biostat & Epid — Page DHHS HEALTH-38

This would amount to a transfer of $90,153 in FY 2011-2012 and $91,177 in FY 2012-2013. This measure is part of a continuing attempt to relocate all epidemiology personnel and statistics personnel to the same budget account.

This account includes decision unit E-924 which would transfer two positions from Consumer Health Protection to Community Health Services, B/A 101-3224.

E-924 Trsfr From Cons Hlth Protect to Comm Hlth Srvcs — Page DHHS HEALTH-38

HHS-HD – Community Health Services — Budget Page DHHS HEALTH-140 (Volume II)
Budget Account 101-3224

This transfer would affect $142,365 in FY 2011-2012 and $144,735 in FY 2012-2013. This measure is intended to help in the management of public health preparedness activities in the rural counties. We felt that it was appropriate to transfer these positions to the Community Health Nursing program rather than to the Environmental Health section. Environmental Health personnel maintain a more mobile inspections process, while the Community Health Nurses are more stationary and are more able to participate in community activities and collaborate with the hospitals.

CHAIR LESLIE:
Please discuss the transfer of inspection responsibilities to the counties. Will we continue to perform inspections, but bill the counties? How will the billing structure be determined?

MR. WEYRICK:
We have a fee methodology in place for health care quality and compliance which is based on time and effort. Our intent was to utilize the same methodology for this account. We have inspectors who go to the numerous counties. We know the numbers of different types of facilities in each county. We know how long it takes our personnel to perform inspections.

Our goal is to develop similar methodologies so that we would be billing the counties based on the time and effort it would take to perform those facility inspections.

ASSEMBLYMAN GOICOECHEA:
If you are inspecting food establishments, do the counties have the ability to pass the costs on to the restaurants?

MR. WHITLEY:
That is correct. We currently bill for a portion of the cost to inspect. The model is implemented differently in Washoe and Clark Counties. Clark County charges the industry for the entire cost to inspect. Washoe and Carson City Counties offset the fee that is charged with county general funds. Part of the fee collection is achieved through a direct charge to the facility.

MR. GOICOECHEA:
As the counties receive these bills, would they have to adopt ordinances to determine the type of system they would use to generate payment? I would assume that most would want to recover all of the costs that they could.

MR. WHITLEY:
I would have to do more research, but I would assume that the counties would have to enact an ordinance in order to pass a charge on to the facilities.

CHAIR LESLIE:
Have you formally notified the counties that they will now be billed for these fees?

MR. WHITLEY:
We have engaged the counties. Some have responded that they are interested in trying to deliver the inspection services themselves. We are considering that possibility. We want the inspections to work, whether they are provided by the State or the local authorities. It would be our goal that, at some point in the future, there would be local health departments in every rural county or region. This type of discussion has been generated by the budgetary issues.

MARY WHERRY, R.N., M.S. (Manager, Public Health and Clinical Services, Health Division, Department of Health and Human Services):
Our concern is that, if some counties decide that they want to perform inspections themselves, the administrative costs then become the burden of the counties that do not. The costs will continue to go up in response to issues in the economy of scale. We will continue to hire staff and they will continue to travel to remote locations. If 7 of the 14 rural counties decide that they want to do the inspections their own way, the remaining counties will probably be the smaller ones who would have the highest burden of costs.

CHAIR LESLIE:
With respect to the quality of the inspections, I believe that the public should be protected no matter where they are eating. It is no small task to inspect a restaurant adequately. We only have three county health departments. Would you have to acquire resources to provide adequate training? Would you license the inspectors? Would you allow each county to deal with the problem alone?

MS. WHERRY:
There is a certification process for inspectors. The credentialing and education requirements for that certification are quite specific. Some of the highly qualified inspectors, with master's degrees in health related fields, have had a challenge meeting the certification requirements. You share a prudent concern.

CHAIR LESLIE:
In the urban counties, the local health departments inspect the restaurants. Do they also inspect food manufacturing facilities?

MS. WHERRY:
In the urban counties, the local health departments inspect many of the food manufacturing facilities. We, as the State, inspect all of the State facilities. For example, we do the food inspections at the University of Nevada, Las Vegas and the University of Nevada, Reno. There is a shared responsibility in some of those counties.

We have cost projections that affect Clark County. Those are costs that Clark County would have to absorb. The three urban counties will have some fees pushed down to them because of these types of shared responsibilities.

CHAIR LESLIE:
What kinds of inspections are required of facilities like the Hidden Valley Ranch factory?

MS. WHERRY:
We enforce labeling reviews. We do these for the cosmetic industry as well.

CHAIR LESLIE:
Would the State continue to pay for these labeling reviews?

MS. WHERRY:
That will be determined in negotiations with the counties. It depends on whether Clark County wants to become fully independent.

CHAIR LESLIE:
It seems that there is a significant amount of work to be done by July 1, 2011. What happens if a county is unable or unwilling to pay the bill? Is there a potential for this to happen?

MS. WHERRY:
We have proposed legislation that specifies that we would continue to perform the functions and that the counties would reimburse us.

The counties are supposed to have local health officers, but some of them do not. There are any number of things that could be a challenge. That would probably be a discussion where we would be speaking with the Interim Finance Committee (IFC) if we have problems. The bottom line is that we need to protect the public.

CHAIR LESLIE:
I agree. My concern is that we are dismantling a system that has been working. We are breaking it into smaller pieces. It is important to maintain the quality of the inspections so that people know that they are safe. I would appreciate it if you would keep our Fiscal Staff informed about your negotiations with the counties. It seems like a significant amount of extra work for the two of you to negotiate with each county to accommodate each particular situation.

Please go into further detail about the community health nurses. Is it true that Douglas County and Lyon County are choosing not to use the State Health Division for nursing services?

MS. WHERRY:
We have been in discussion with Lyon County and Douglas County.

Legislation was proposed in the last Session centering on regionalization of health services. In the end, it became a study bill. We had a number of meetings during the biennium and were able to make a recommendation to the Committee on Health and Human Services that that regionalization project be put on hold.

The initial movement toward regionalization originated with a desire on the part of Lyon County and Douglas County to partner with Carson City on a regional health authority. They wanted to build off of the work that the three had already been doing together in the areas of public health preparedness and epidemiology. We continue to have discussions on this issue.

Our goal is to eventually have regionalized health authorities throughout the State. We think that this would give the local areas more control over implementation of policy. This is the model for most states. Nevada is behind the rest of the country in that we continue to allow the State to be the provider of these services in the rural areas.

For this particular transfer, we are aligning the nurses with the public health preparedness activities, so that if we ever do become regionalized in that way, the counties can readily take over what the State has been doing.

CHAIR LESLIE:
That is an admirable goal, but I do not know how we will be able to afford it. Are you certain that this issue will be resolved before we close your budget?

MS. WHERRY:
No.

It will be a significant project for the counties to take on these responsibilities. My perception from conversations with Carson City is that it will take more than a few months to hammer out the details. If this is something that the counties decide they want to do, we will come to IFC and align the resources for that process.

ASSEMBLYWOMAN MASTROLUCA:
Please explain the county reimbursements for inspections. These would replace approximately $600,000 of General Fund money. How close are you to being certain of the fee structure for these inspections?

MS. WHERRY:
Fees will be charged based on the number of permits. We have a sense of the cost of each of these, whether it is a septic tank or a food establishment permit. We would be charging the counties what we currently receive from the General Fund. We took the total number of food permits among the counties and looked at the percentages. We then applied that number to all the permits in the county to come up with what we would provide in an invoice on a quarterly basis.

We plan for the first invoices to go out in June so that we could generate revenue to cover payroll for July 1, 2011. We would then bill the counties quarterly based on the number of actual permits issued.

The food establishment permit numbers are predictable. Numbers for septic and sewage inspections are down because of the reduced rate of construction in the rural counties.

ASSEMBLYWOMAN MASTROLUCA:
Is the projection for the $594,760 of replaced General Funds in FY 2011-2012 based on the amount that was spent on inspections last year? We are now in a position of billing the counties and there is the possibility that they might not pay. My concern is that we are backing into this number. Did you begin by trying to fill a $600,000 hole and then decide to fill it with these fees?

MS. WHERRY:
This number represents what we have been spending in the past. We are now passing those costs on to the counties.

The General Fund reimbursements we have received are reflective of our costs. Those expenses go into what it costs to permit an agency. No matter how we look at this, we would end up with the same result.

We are sending out White Papers and draft contracts to the counties within the next week. They will have, by county, the number of food establishments, school cafeterias, public swimming pools and other facilities for which we currently have permits. This would be an estimate. If these counties saw construction growth and there were new septic tanks to inspect, we would bill them for that activity.

ASSEMBLYWOMAN MASTROLUCA:
If a county chooses not to pay, this would leave a substantial hole in your budget. What is the backup plan?

MS. WHERRY:
That would become a legal situation. I do not have expertise in that area. According to *Nevada Revised Statutes* (NRS) Chapter 439, the counties are expected to have local boards of health and local health officers. A number of the counties are not compliant.

ASSEMBLYWOMAN MASTROLUCA:
Would those examples put holes in your budget?

MS. WHERRY:
I am not familiar with the consequences of that noncompliance. We would need a legal opinion as to whether we would need to take some action against the counties in these situations. I cannot answer your question.

ASSEMBLYMAN GOICOECHEA:
Are you saying that the Health Division presently inspects every septic tank in Nevada?

MS. WHERRY:
Some counties perform their own inspections of septic and sewage systems. Some counties do not. Some counties inspect the private systems, while the State inspects the commercial systems. It depends on which activities the county wants to perform.

ASSEMBLYMAN GOICOECHEA:
There are counties that do not even require building permits. I do not know how a large number of septic tanks would be getting inspected. I am trying to make the point that this system will not mesh well. I know of many septic systems, even in counties issuing building permits, that are not inspected by the local building departments. The State Health Division never inspects these systems. It seems that there is a lot of work to be done on this issue.

MS. WHERRY:
If we are not aware of a septic system, there is no way for us to know that we must inspect it. If we do not have a permit, we cannot bill for a permit. The main concern would be for the greater good of the people in terms of the potential for leakage into the ground water.

We would only be billing for permits that we know have been issued or need to be issued.

ASSEMBLYMAN GOICOECHEA:
Because I represent the rural counties, I know that there are many loose ends in these counties.

ASSEMBLYWOMAN CARLTON:
I worked in full-service kitchen food establishments for 30 years. Is the proposed fee system the same as the system you used previously or is this a new schedule?

MS. WHERRY:
This is not a new schedule. This is what our costs have been.

ASSEMBLYWOMAN CARLTON:
I would like to get a better understanding of this structure. For full-service kitchen inspections, you are basing the fees on size. There is a base rate of $200, with the addition of a seat charge. Have you charged by seating before?

MS. WHERRY:
Yes. It has worked in the past. Our 2008 fees are based on the numbers of seats.

ASSEMBLYWOMAN CARLTON:
I do not understand the relevance of a charge based on the number of seats. I have seen small kitchens put out a significant amount of food and serve a significant number of people in a short time. What logic was used in implementing the seating charge?

JOSEPH L. POLLOCK, R.E.H.S. (Program Manager, Environmental Health Section, Public Health and Clinical Services, Health Division, Department of Health and Human Services):
We base those fees on the number of seats because a larger facility, such as a buffet at a casino, would have a greater number of seats and a large full-service kitchen. There are some small facilities which consistently churn out great amounts of food that do not have any seats. They are charged a lesser fee. This is not a perfect system, but it seems to work. It captures most of the very large kitchens at the casinos.

ASSEMBLYWOMAN CARLTON:
What about the mobile food service units and the costs associated with their inspection? I would like to know how often you inspect these facilities, as we find them to be a large concern in Clark County. Are there enough resources available to inspect the steadily increasing number of these units? They move, so it might be more difficult to track them down.

If this is the basic scheme that you have used before, and you can raise the fees in regulation, then I suppose you could fall back on that as a safety net.

MR. POLLOCK:
The fee schedule provided to the Subcommittee describes State fees that are charged in the rural counties where we perform inspections. That service is provided by the county in southern Nevada, and I am not certain what inspection fees they charge.

In regards to our fees, we mandate one inspection per year for all mobile units. Ideally, the units provide us with a set schedule showing where they are located throughout the day so that we can catch them. We also inspect the depots from which they operate. This is a fairly thorough inspection. When we deal with particularly problematic units, which can happen, we increase the frequency of inspections as needed.

CHAIR LESLIE:
Seeing no further comment, I will move on to the account for the Immunization Program, B/A 101-3213.

HHS-HD – Immunization Program — Budget Page DHHS HEALTH-49 (Volume II)
Budget Account 101-3213

MR. WEYRICK:
This account is very straightforward. It contains decision unit E-325 which requests one position to run the Perinatal Hepatitis B program.

E-325 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-51

This unit is federally funded and is approved in the federal grant.

CHAIR LESLIE:
I want to emphasize the fact that this is a federally funded position. What percentage of births in Nevada are to mothers who are hepatitis B positive?

MR. WHITLEY:
I can provide that information to you at a later time.

CHAIR LESLIE:
Could you also provide figures about the transmission rates between mothers and infants? I am afraid that the Subcommittee does not have enough information about this issue to make an informed decision. I would assume that this is a good idea if it is being included in your recommendation.

MR. WHITLEY:
The other component of this measure involves an attempt to utilize the birth dose vaccine for hepatitis. This will require working with hospitals and gynecologists to vaccinate at birth.

In addition to addressing the problems of the mothers who may be positive, we are also seeking to establish a focused effort on achieving compliance with the standards for the birth dose vaccine for hepatitis in the hospitals.

CHAIR LESLIE:
I would imagine that all these measures work towards the goal of reducing the transmission rate.

Do you have a description of this plan?

MR. WHITLEY:
We do. It was contained in our grant application to the Centers for Disease Control and Prevention (CDC) which was approved. I can provide that to the Subcommittee.

MR. WEYRICK:
This budget includes decision unit E-710 which will replace one computer in accordance with the DoIT replacement schedule.

E-710 Equipment Replacement — Page DHHS HEALTH-53

CHAIR LESLIE:
Please discuss the progress that you have made in your performance indicators. I see that you project a 16 percent increase in the number of providers who are going to use the immunization registry. While we appreciate the progress you have made, we would like to know how you intend to achieve these goals.

MR. WHITLEY:
Over the past three years, we have made progress in improving our statewide immunization rates. In the national rankings for this category, we have moved from last among the states to 45th place. We have changed our focus. We are focusing on the immunization registry. We are focusing on accommodating portability, so that children can move around the State and use different providers.

We believe that we will see an increase in the number of providers because we are making a focused effort to enroll providers. We want to make it easy for them to acquire the vaccine. This effort to enroll providers is funded out of the CDC grant. We believe that a 16 percent increase in this area would be an achievable goal.

CHAIR LESLIE:
Why would providers not already be enrolled? Which providers are not enrolled?

MR. WHITLEY:
There are many new providers in this State which are not yet enrolled. We have an active program to enroll new providers, particularly pediatricians and federally qualified health centers, in order to benefit the underserved population. We had not previously had a focused program on enrolling new providers. Those that were interested would seek us out.

This process went hand in hand with the Immunization Registry. We provided training on how to utilize the Immunization Registry and how to order vaccines. There is a great deal of utility in these functions that make it a benefit to enroll physicians into the program.

Surprisingly, there are physicians who have opted out of enrolling because the storage of federal stock vaccine versus private stock vaccine has been a complicated issue.

We try to reengage those who have dropped out and those who have never participated.

CHAIR LESLIE:
Are more children being vaccinated, or is the focus more on getting the registry to work better? The registry was established by a bill that I sponsored. While I am happy that we have seen progress in this area, I would like to see more. We should try to improve our ranking to at least 25th among the states for statewide immunization rates. How are we going to achieve this?

MR. WHITLEY:
I believe that our path toward progress is lined out and I believe that the Immunization Registry will be a key component of that process.

A national survey is performed the same way in every state. It consists of telephone interviews with parents in which vaccination is verified, and then cross-checked with a clinic to ensure that there is a vaccination record. Before the development of the Immunization Registry, and the legislation that was passed to require it, the records were not kept in a standardized way. We believe that we have a higher rate of vaccination than is indicated because of historical shortcomings in our record-keeping system. This is evidenced by the fact that we do not see the rates of vaccine-preventable disease that we might expect from immunization rates as low as those reported.

Accounting for children's vaccination records has facilitated the cross-checking of school entry requirements. It has also helped in accommodating the transfer of immunization records as children move from one clinic to another.

CHAIR LESLIE:
Are we vaccinating a greater number of children?

MR. WHITLEY:
We are vaccinating more children, in addition to recording those vaccinations.

TRACEY GREEN, M.D. (State Health Officer, Health Division, Department of Health and Human Services):
There are several more things that we are doing to improve access and immunization rates. We are expanding efforts to enroll specialists. This group of physicians had not been approached as aggressively in the past. This would include gynecologists and oncologists. In addition, we are working on a Health Level Seven International interface that would allow physicians' electronic medical records to interface with the WebIZ program. This would facilitate interaction and would ensure that there is not dual entry into separate systems. We believe that this will encourage more physicians to enroll.

We are also examining the possibility of providing access for children. We are moving towards school-based services. We are looking at children who had previously been grandfathered into the system because of certain exclusions. For example, children may have moved and were allowed to forego their fourth hepatitis B shot. We have uncovered many of these grandfathered status implications, particularly in the urban counties. Our goal, by 2012, is to eliminate the grandfathering of immunization status throughout the State. We have been looking at moving health-based services back into schools. We want to train nurses within the schools to be immunizers. All of these measures will improve our immunization rates and improve access to the registry system.

CHAIR LESLIE:
This is an example of a State function that should not be left to the counties.

ASSEMBLYWOMAN CARLTON:
In the work that I have done with the Maternal and Child Health Advisory Board, I have seen that immunization has been a recurrent issue over the last decade. Doctors are saying they cannot afford to keep vaccines in their offices all the time. There is confusion between the groups receiving services for free and those receiving bills. This has been improved with the development of electronic registry systems.

When parents show up to enroll their child in kindergarten, they must show proof of immunization or their child will not be allowed to go to school. We do very well at that level, but we do not do well in providing vaccinations for

children below the age of two. We must figure out how to access that age group.

When I was a child, we lined up in the school gymnasium and received a shot in the arm. We all compared scars for three weeks. This was a regular occurrence in the springtime. Providing immunizations in the schools is great, but I would like to see emphasis on reaching children two years old or younger. I am concerned about that age group.

DR. GREEN:
We are working on a number of things related to that issue. We are working with nurses from the Head Start Program to start checking children early. Many of the nurses who are involved with Head Start are providing vaccinations for under-vaccinated children.

In addition, we have coalitions working directly with our Women, Infants and Children USDA Special Supplemental Food Program (WIC) organizations to uncover the children who are unvaccinated. These coalitions work to provide Saturday clinics for these children so their parents are not required to leave work. We work to target day care facilities and our WIC organizations to reach the zero- to five-year old population. This is part of our mission to improve our rates.

ASSEMBLYWOMAN CARLTON:
There have been discussions in the past about mandatory vaccinations for licensed day care. Can you update the Subcommittee as to the status of those discussions?

DR. GREEN:
I can provide you with that information at a later time.

CHAIR LESLIE:
You are recommending a transfer of approximately $1.57 million in Title XXI funding. What is the State match requirement? Are we sure that we have enough General Fund money to meet our match?

MR. WEYRICK:
That match requirement is for the Nevada Check Up vaccines. The funding for that comes from the Division of Health Care Financing and Policy. We hold the match for that in our budget.

That amount has been adequate in the past. Unless there is an unforeseen, dramatic increase in the caseload, this should continue to be adequate.

CHAIR LESLIE:
I would like for you to meet with our Staff at a later time and review that figure carefully. We are concerned that this is not a sufficient match.

As there is no further comment on this budget, I will now move on to a discussion of the WIC Food Supplement account, B/A 101-3214.

HHS-HD – WIC Food Supplement — Budget Page DHHS HEALTH-55 (Volume II)
Budget Account 101-3214

MR. WEYRICK:
An overview of this budget is located on page 6 of Exhibit C. This budget contains one enhancement, E-710. This would replace several federally funded computers in accordance with the DoIT replacement schedule.

E-710 Equipment Replacement — Page DHHS HEALTH-58

ASSEMBLYWOMAN MASTROLUCA:
Your numbers show that, in the month of September, WIC participation was down more than 5 percent. Is there any particular factor to which you can attribute this decline?

MS. WHERRY:
We have seen mild fluctuations in WIC program participation throughout the last two years. It has trended both upward and downward a few percent at a time. We continue to monitor these numbers. The caseload projections predict that we will continue to see growth in this program. We have significantly increased our outreach for this program. We are trying to get as many children covered as possible, particularly when so many families are struggling to pay for groceries.

I had the same curiosity about the figures when they were released. It seems odd to have a dip in participation during the holiday season. I do not think we have enough data to explain a relatively small, one-month curve like this.

ASSEMBLYWOMAN MASTROLUCA:
I am glad to hear that you are performing outreach activities. It is important to let families know that this is available.

MS. WHERRY:
It is important to reiterate a point made by Dr. Green. We are using the WIC Food Supplement program, not only as a vehicle to provide food, but also as a way to educate pregnant women and help provide additional services to children. We promote topical fluoride varnishes and immunizations. We have consolidated a WIC clinic with our nursing clinic in Pahrump. We also have a collocated clinic in Lincoln County.

We try to consolidate services wherever there is opportunity. We can bring a child in for an exam or we can assess them for developmental delays. We take every possible opportunity to make sure that the children are getting the best advantages for their overall health.

CHAIR LESLIE:
Are we still doing a mobile outreach program? I know that there was a WIC clinic in Sun Valley performing these services with mobile clinics.

MR. WHITLEY:
We do. St. Mary's Regional Medical Center is a WIC provider and they use a mobile clinic.

CHAIR LESLIE:
As there is no further comment on this budget, I will move on to a discussion of the account for Communicable Diseases, B/A 101-3215.

HHS-HD – Communicable Diseases — Budget Page DHHS HEALTH-60 (Volume II)
Budget Account 101-3215

MR. WEYRICK:
This budget contains decision unit E-250 which eliminates the HIV/AIDS program manager position.

E-250 Economic Working Environment — Page DHHS HEALTH-63

Originally, one-half of this position's funding came from a federal HIV Prevention grant, and the other one-half came from Ryan White grant funds. The administrator of the HIV Prevention grant has determined that they will no longer fund this position. As a result, it has been eliminated.

This budget contains decision unit E-710 which provides for computer hardware replacement.

E-710 Equipment Replacement — Page DHHS HEALTH-65

This unit is also 50 percent funded by HIV Prevention grant money and 50 percent funded by Ryan White grant money.

This budget includes several units that transfer funds to B/A 101-3219. The first is E-911.

E-911 Trsfr From Comm Diseases to Biostatistics and Epid Page - DHHS HEALTH-65

This unit transfers the hepatitis grant program from Communicable Diseases to Biostatistics and Epidemiology.

This account includes transfer unit E-912.

E-912 Trsfr From Comm Diseases to Biostatistics and Epid — Page DHHS HEALTH-66

This unit transfers the AIDS Surveillance program to B/A 101-3219. All the positions in this account are federally funded.

HHS-HD – Biostatistics and Epidemiology — Budget Page DHHS HEALTH-90 (Volume II)
Budget Account 101-3219

This account includes decision unit E-913.

E-913 Trsfr From Comm Diseases to Biostatistics and Epid — Page DHHS HEALTH-66

This unit transfers the federally-funded sexually transmitted disease (STD) program, including a health program specialist I position, to B/A 101-3219.

This account includes transfer unit E-921.

E-921 Trsfr From Comm Diseases to Biostatistics and Epid — Page DHHS HEALTH-67

This unit is described on page 8 of Exhibit C. This decision unit transfers a clerk position to the Interstate Communication of Confidential Records office in B/A 101-3219. This position is partially funded with Epidemiology and Laboratory Capacity for Infectious Diseases grant money and HIV Prevention grant money.

Lastly, this account includes decision unit E-926.

E-926 Trsfr From Comm Diseases to Biostatistics and Epid — Page DHHS HEALTH-67

This unit transfers the General Fund portion of the STD Program, which amounts to $7,380, to B/A 101-3219.

CHAIR LESLIE:
Your administration does a commendable job of managing these various accounts, but they may still be confusing to Subcommittee members. Please briefly describe these programs. I would like to hear more about the AIDS Drug Assistance Program (ADAP), the State Pharmacy Assistance Program and the Coordination of Benefits Program. In what ways do these services interrelate? I

would also like you to discuss your ability to meet the demands of the various caseloads.

MR. WHITLEY:
The HIV program is the most comprehensive federally funded programs we have. It provides assistance ranging from prevention to treatment. There is also a categorical grant that provides for surveillance and disease investigation. It is a complete program. We receive a federal grant that has base funding for support services as well as an earmark for medication services.

In the late 1990s, we saw the development of protease inhibitors for people living with HIV. Unfortunately, at that time we did not have enough money to add those medications to the formulary. The Legislature used General Fund dollars to fund an enhancement to ADAP that made available all medications that had been approved for treatment. The Ryan White grant program is a source of last resort. It is utilized when the people that are eligible for medication have no other pay source. In the past, there have been people who had jobs and health insurance but would lose their jobs. We found that it was more cost-effective to continue their health insurance through the provisions of the Consolidated Omnibus Budget Reconciliation Act so that we could cover their medication as well as reimburse for their medical care. This component of the program has helped us avoid having to implement a waiting list. We compiled a list of people who were in ADAP who also qualified for assistance under Medicare Part D and helped them make the transition between the two.

While, so far, we have been able to avoid the use of a waiting list, the need for these services continues to grow. We anticipate an 8 percent caseload growth, based on historical trends. There are some variables that need to be taken into account that are more difficult to predict, such as rates of job loss. I believe that we do a good job of taking these into account. About two years ago, we began receiving rebates from the pharmaceutical companies. This is a credit to our program staff who were able to identify that possibility and bring that money into the agency. We have been able to bring in some supplemental resources, including additional federal funding for ADAP, without demonstrating that we had a waiting list.

Acquiring this type of funding has always been a struggle for this program. In order to gain access to more federal funds, people must be waiting for service. Every time I have testified before this Subcommittee, it has been indicated to me that we should avoid letting service requests stack up. We do the best that we can, but at some point, we will reach a point where we will be using a waiting list. It is only at that point that we will be eligible for substantial increases in federal funding.

CHAIR LESLIE:
I understand that. It would be a horrible thing, however, to place someone on a waiting list for their medications in our pursuit of federal funding.

I would like to praise you for the job that you are doing, but I want to avoid sentencing HIV-positive people to a waiting list. If we need to do something to avoid this, I would like to know sooner rather than later.

You have indicated that the budget for this account is adequate and that your caseload projections are following historical trends. Has the condition of the economy factored into your numbers in any way?

MR. WHITLEY:
The economy continues to be a variable in our calculations, as it always has been. We could potentially see increases in our caseload as a result of economic fluctuations. If people are well enough to work, our wraparound services support them.

We will continue to report back to the Legislature on the status of this program.

CHAIR LESLIE:
We will move on to the budget for Health Facilities Hospital Licensing, B/A 101-3216.

HHS-HD – Health Facilities Hospital Licensing — Budget Page DHHS HEALTH-70 (Volume II)
Budget Account 101-3216

MR. WEYRICK:
The account contains enhancement unit E-325.

E-325 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-73

This unit requests a new office manager for the Carson City office. They have 26 professional staff there in a very busy office. It would be extremely helpful to have an office manager to assist in managing the high volume of transactions.

This next enhancement in this account is E-710.

E-710 Equipment Replacement — Page DHHS HEALTH-76

This unit would replace hardware according to the standard DoIT replacement policy.

The next enhancement in this account is E-720.

E-720 New Equipment — Page DHHS HEALTH-76

This unit would purchase an LCD presentation projector, some travel scanners and some other equipment. These would be used to enhance training capabilities. We do a significant amount of training for the various facilities around the State. This request is federally funded.

CHAIR LESLIE:
The regulations approving the fee schedule have been approved, although this was completed quite a bit later than I would have liked. Will your agency need a cash advance to get through the remainder of FY 2010-2011?

MR. WEYRICK:
The fee revenue is currently being collected. We had the original fee system in place in late October and early November. In January, the new fee increases were approved by the Legislative Commission's Subcommittee to Review Regulations. Following that change, we billed all the facilities for the differences

in those two amounts. We are currently seeing an acceptable flow of that revenue and of federal reimbursements.

I estimate that we will end the year with enough fee reserve that we will not need an advance from the General Fund.

CHAIR LESLIE:
That is good news. I did not realize that you were allowing people to pay the old fees but billed them for the difference once the regulation went into effect. That makes sense.

What would be an optimal reserve level for this account?

MR. WEYRICK:
We started the year with approximately $1.6 million in reserve. I estimate that we will have this same amount at the end of the year. The time and effort that were used to build that fee structure were based on what we needed to fund the authorized positions through this year.

We might finish with slightly more than that in reserve because we have had some vacancy savings. For a period of time, we were not sure that the fees would be approved, so we were leaving twelve or thirteen positions vacant.

CHAIR LESLIE:
Are you considering revising the fees in any way during the upcoming biennium?

MR. WEYRICK:
We have committed to the industry that we will review the fee structure every year. We are currently going through that process based on calendar year 2010 information and workload. We hope that, several weeks from now, we will have a clearer picture of where we stand, based on everything that happened last year. We will share that information with the Subcommittee Staff as it becomes available.

CHAIR LESLIE:
Are we keeping up with the inspections? Have we filled all of the vacant positions?

MARLA MCDADE WILLIAMS, B.A., M.P.A. (Deputy Administrator, Health Division, Department of Health and Human Services):
We have a priority workload. If someone registers a complaint and it becomes classified as an "immediate jeopardy" issue, it must be inspected within two days.

We have prioritized the rest of our workload. State mandates and statutory requirements take priority over our other responsibilities. We are keeping up with the priority workload. Because of limited resources, we have had to make certain judgment calls. In some instances, we have to assess performance quality from the previous inspection. We are weighing the performance of various providers against each other in order to determine which facilities are more in need of inspection and which are less likely to falter in performance. This will continue until we are fully staffed again.

CHAIR LESLIE:
How many vacancies do you currently have?

MS. MCDADE WILLIAMS:
We are currently recruiting for approximately 15 positions.

CHAIR LESLIE:
Please discuss the prelicensure training for facility operators. I know there has been an issue with the use of penalty funds.

MS. MCDADE WILLIAMS
When we issue a sanction against a provider, it goes into a separate, nonexecutive budget account. The health facility surveyors that we hire perform complaint investigations and ongoing inspections. We have separated some out to receive training in focusing on the new providers coming in. We are hoping that if we devote resources at that end, we will not have problems in inspections.

We find consistent violations at any number of different types of providers. We identify places where we can devote training resources from the nonexecutive budget report and then fund positions outside of our standard State employee workforce. We could, potentially, pull their licenses, but there would still be a

need for these placements. Our intent is to try to make all of our providers as successful as possible, and we want to supply them with targeted resources. With the training funds that we have in that nonexecutive budget, we can target positions that need the most training at any given time and allocate these extra resources.

CHAIR LESLIE:
It appears that, over the last five years, the penalty revenue has grown significantly, from $25,367 in FY 2005-2006 to $137,175 today.

MS. MCDADE WILLIAMS:
That is correct. This growth could be attributed, in part, to increased rates of inspection. The more we inspect, the more opportunity there is to find violations. In the past, the inspection schedule was not as aggressive as it is now.

CHAIR LESLIE:
There is a need to clarify NRS language pertaining to this issue. For the benefit of the Subcommittee, please explain that issue. I would also like to speak with you on this matter at a later time.

MS. MCDADE WILLIAMS:
When the statutes governing the inspection work of the Health Division were enacted, they were partially modeled on federal law. Chapter 449.163(5) of NRS dictates that our assessed penalty funds must go towards the facility responsible for the violation and to the affected patients at that facility. In reality, the investment of an individual fine into an individual facility will not affect the kind of overall change that is needed in all facilities. The language of the statute is impractical for our needs. We have proposed a statutory change that will allow the Health Division to use its sanction money for broader purposes.

We are working with a deputy attorney general who believes that the language of the statute is not as restrictive as it appears, but there can be many different interpretations. We would benefit by making it clear that we can use the money in that nonexecutive budget account for broader purposes.

CHAIR LESLIE:
We will be pursuing this issue in a policy committee.

This budget proposes to add an additional administrative assistant. Please describe the duties that would be performed by this position.

MS. MCDADE WILLIAMS:
Beginning in 2008, we made significant changes to the Bureau of Health Care Quality and Compliance. At that time, we identified a gap in complaint investigations. We were performing "immediate jeopardy" complaint investigations, but, in some cases, we were not doing our 10- and 45-day investigations at all. This issue became a priority for us. Complaints were being ignored.

We refocused the work of the office manager, who was an administrative assistant IV, to complaint oversight. We wanted to be able to more effectively triage the complaints as they came in. Before, complaints would be written up and then submitted to a supervisor to be assigned. Under the new system, we asked the person in this position to contact the relevant facility and complainant in an effort to resolve problems without formal on-site investigations. This was a time-saving measure, and it alleviated the workload for the inspectors. The position now functions more like an ombudsman.

Many times, particularly in nursing homes and hospitals, complaints are more related to communication issues than to flagrant violations of law. Our time is not well spent by going to these places and trying to help people communicate with one another.

This role has been taken over by the individual who was once the office manager. There is still a significant amount of work to be done at the administrative level. Without an individual in a dedicated office manager role, documents will not be processed and meetings will be missed. This office experiences an overwhelming and expensive workload, and the new position would be extremely helpful in replacing the other position.

CHAIR LESLIE:
It sounds as if the current administrative assistant IV is performing more paraprofessional work than is typical.

MS. MCDADE WILLIAMS:
That is correct.

CHAIR LESLIE:
As there is no further comment, I will move on to the budget for the Public Health Preparedness Program, B/A 101-3218.

HHS-HD – Public Health Preparedness Program — Budget Page DHHS HEALTH-79 (Volume II)
Budget Account 101-3218

MR. WEYRICK:
This account contains a number of decision units. The first is E-250.

E-250 Economic Working Environment — Page DHHS HEALTH-82

This unit proposes to add an administrative assistant position to provide support to the three professional staff in the primary care office. This would be federally funded.

This account also contains decision unit E-251 which requests two new health emergency preparedness evaluators.

E-251 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-82

These positions were approved by IFC in February. They are required by the federal grants to perform exercises and evaluations in support of the Public Health Preparedness Program. This decision unit also eliminates a public information officer position that was determined to be unnecessary.

This account contains decision unit E-326 which restores funding for the poison control program out of the federal preparedness grant.

E-326 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-83

This replaces General Fund money that had been cut from the program.

CHAIR LESLIE:
Are you certain that the federal government will fund the poison control program?

MR. WEYRICK:
We have been given assurances that they will. It was initially funded by this same federal grant in 2006.

CHAIR LESLIE:
That funding was then rescinded.

MR. WEYRICK:
I am not familiar with the history of this issue, as I was not working for the Health Division at that time. There were certain aspects that the federal government would not fund, but they have agreed to return funding to this particular part.

CHAIR LESLIE:
What kind of documentation do you have to prove they will reinstate funding?

LUANA J. RITCH, PH.D. (Chief, Bureau of Health Statistics, Planning, Epidemiology and Response, Health Division, Department of Health and Human Services):
The poison control line is an allowable expense. We have communicated with our project officer at CDC in an attempt to get their approval for funding out of our base grant. Within the last three to four years, CDC has focused this grant on early detection in communities. This could include detection of an outbreak of disease, illness, chemical exposure or other large-scale health hazard. The federal government came to the realization that poison control lines can be one of those early indicators and can be part of that early detection system within a community.

CHAIR LESLIE:
I am concerned that the federal government may come back to us and claim that we are supplanting this funding or that we are not meeting our Maintenance of Effort requirements.

MS. RITCH:
We have not asked them for an opinion on the issue of supplanting funding.

CHAIR LESLIE:
We should seek an opinion on that.

MS. RITCH:
We asked whether the base poison control would be an allowable expense.

CHAIR LESLIE:
I am concerned about this matter because of what happened the last time we sought out federal funding for the poison control program. We almost lost our poison control program. We had to step in through IFC and fund it with the General Fund. They may look at this proposal the same way this time around. We want them to fund it. I would like to see some assurances from the federal government that they will not be taking away this funding.

MS. RITCH:
We will send an e-mail today that will outline the history of this program as well as all the pertinent details.

CHAIR LESLIE:
Where does the nonfederal match for this program come from?

MS. RITCH:
The nonfederal match at the local level comes from the county health districts. They utilize county money that goes into the preparedness programs as match for the poison control program funding. Much of the service that the poison control line provides is to local communities.

CHAIR LESLIE:
Where does the match come from for the grant money?

MS. RITCH:
The majority of the match for the CDC grant comes from those same county health district funds. The match also includes some of the General Fund money that the Health Division is authorized to use for these purposes.

CHAIR LESLIE:
Please provide the Subcommittee with an outline of this funding so that we can double-check it to make sure we are meeting the General Fund obligation.

MR. WEYRICK:
There is $63,921 in B/A 101-3223 that could provide the match for this specific program.

CHAIR LESLIE:
I would like to talk about the new position in this account and the transfer of State Health Access Program (SHAP) funds to pay for it. Since SHAP is intended to manage chronic conditions, how is it appropriate to move this money into the Public Health Preparedness Program?

MS. RITCH:
This budget account is titled "Public Health Preparedness Program," but, as we have consolidated programs over the past four years, we have included some federal funding that works towards a broader range of goals.

One of those goals involved the funding of the Primary Care Office which acts as a core of health planning functions. Its duties include designating medically underserved areas and expanding outreach to serve these populations.

CHAIR LESLIE:
Are you saying that we need to rename the budget account because its name is no longer descriptive of the scope of its duties?

MS. RITCH:
That is correct. The SHAP grant is managed by the Primary Care Office which resides in this account.

CHAIR LESLIE:
Instead of stretching to make the terminology fit, perhaps we should change the name of the account. I am not sure what is required to do that. Please give some thought to making that change.

ASSEMBLYWOMAN CARLTON:
I would like to disclose that I worked for a primary care association for several years. I loved my job, particularly when working with the Primary Care Office on several issues. I have intentionally avoided discussing SHAP because of implications from my previous employment.

The program did not turn into a health insurance provider for seniors, as was intended. We had to acquire a waiver because we did not have any insurance companies in the State that wanted to partner with the State in this particular program. In the end, we were forced to develop another scheme to allow us to deliver these services to seniors. Can you tell me how many seniors are now being served?

MS. RITCH:
I do not have an exact number. We are currently involved in expansion efforts, particularly in southern Nevada. The most recent numbers that I can recall placed the number of seniors enrolled in the program between 400 and 500. This was before our current expansion efforts. That number has been increasing steadily. We currently have one partner who has been engaged in trying to reach this population. I will provide the current enrollment numbers to you at a later time.

ASSEMBLYWOMAN CARLTON:
Are the seniors bearing the costs of this program? Did it truly end up covering them or did they end up having to pay for part of it? Under the health insurance model, they would have ended up having to pay basic deductibles. I want to make sure that we are now in a position where the seniors are not being asked to contribute.

MS. RITCH:
The funding for the program is not only used to supplement the implementation of the project, but also to offset the participant's monthly membership costs

with the Access to Health network. The money also provides for a patient treatment fund which will minimize any burden on the individual.

This program is successful, in part, because we have an agency that works with every individual to look at how their financial management can help cover necessary health care. The program works differently for individuals who are working. This assistance is for people who may have retired and do not qualify for health insurance until age 65. The case managers work with the individuals to make sure that they participate in the process rather than passively receiving benefits. The financial burden is reduced, if not eliminated, when they qualify under SHAP.

ASSEMBLYWOMAN CARLTON:
The original program defeated the purpose of providing health care to seniors because we did not have any insurance companies that wanted to participate. That was very bothersome to me.

ASSEMBLYWOMAN MASTROLUCA:
I would like to discuss the new position funded by SHAP. Would that position replace a position in which you currently have a contracted employee?

MS. RITCH:
That is correct. We currently are funding, through the SHAP grant, a contracted administrative assistant. As we brought together the various programs, along with grant management, there was a need to have permanent administrative support on hand. Originally, we were receiving administrative support from other programs within the Bureau. The position supporting this area was eliminated through consolidation prior to the last biennium. It became apparent that we needed another administrative position to deal with the various functions of this office. We initially funded it as a temporary employee before realizing that we would need the position on a long-term basis. We are now asking to convert the temporary position into a State full-time equivalent (FTE).

ASSEMBLYWOMAN MASTROLUCA:
Is this a grant-funded position?

MS. RITCH:
Yes.

ASSEMBLYWOMAN MASTROLUCA:
In that case, there is no savings in changing from a contracted employee to a State employee. What is the justification from making this change?

MS. RITCH:
The advantages of changing the position over to a State FTE are in stability. In temporary, contracted positions that we renew every six months, we experience a high rate of turnover. If this were a State funded FTE, the potential would exist for splitting the funding in the future to allow General Fund support for the Primary Care Office. We have been very fortunate in obtaining our temporary employees at this level, but we would like more stability in this position. We have received tentative information that the current three-year federal grant will continue forward in some fashion. As with all federally funded positions, when the funds expire, the positions are eliminated.

CHAIR LESLIE:
We will move on to B/A 101-3219, Biostatistics and Epidemiology.

HHS-HD – Biostatistics and Epidemiology — Budget Page DHHS HEALTH-90 (Volume II)
Budget Account 101-3219

Please begin with a discussion of the overview explanation located on page 11 of Exhibit C.

MS. RITCH:
In creating this budget, we have moved programs that have been scattered across the Health Division into a single budget account. This completes the reorganization of the Division that began five years ago. We brought a number of biostatisticians and disease investigators into two units, Biostatistics and Epidemiology. In order for these programs to work more efficiently, we have consolidated supervision and grant management within this account.

CHAIR LESLIE:
Why is there still a biostatistician in the Health Facilities Hospital Licensing account?

MS. RITCH:
That position is located in this same unit. It is part of the Sentinel Events Registry. It is fee funded from B/A 101-3216.

MR. WHITLEY:
That biostatistician position was newly introduced into the Bureau of Health Care Quality and Compliance. The consolidation of positions under Biostatistics and Epidemiology is intended to provide data to communities to help them evaluate health outcomes. The biostatistician working for Health Care Quality and Compliance has two overarching duties. The first is to prepare an annual hospital report. The second is to pull data for our surveyors before they go out on inspections. This has been the more important of these two duties. This important role is more connected with this specific account.

CHAIR LESLIE:
Are the biostatisticians in B/A 101-3219 performing any data collection that would overlap with the work being done in other accounts, or do they focus primarily on analysis?

MS. RITCH:
The employees in these two units were formerly located in other budget accounts and other programs. They are now working as one unit. We have biostatisticians who collect data from our core data sets and prepare it. The epidemiology staff then uses that data to plan targeted interventions and prevention measures. There is no duplication of work.

CHAIR LESLIE:
I would like to hear more about the tuberculosis programs. I am concerned about the budget reductions in this area. What are your plans regarding passing these costs off to the counties? This issue involves the potential of a serious health epidemic.

MR. WHITLEY:
We have outlined the details of this budget shift in a bill draft request. The changes would remove State responsibility and place the responsibility with the county, much like we proposed to do with the environmental health programs. The counties would now be responsible for the cost of treatment of tuberculosis.

Currently, the State receives a CDC grant which funds testing, identification and disease investigation. No federal funds are dedicated to the treatment. In the urban counties, the State General Fund subsidizes the health districts in Washoe, Carson and Clark Counties to supplement the county contributions to treatment. Tuberculosis is a communicable disease that we have an obligation to identify. We must assure treatment. Currently, there is a shared responsibility for the ultimate assurance of treatment. If our proposal is approved, the law would be changed to make the counties responsible.

CHAIR LESLIE:
How do the representatives of the counties feel about this?

MR. WHITLEY:
They are not pleased with the proposal. It represents an added burden, in addition to already existing burdens. In the urban counties, the General Fund subsidizes less than what the counties already contribute to treatment.

CHAIR LESLIE:
The increasing burden on the counties could put us all in jeopardy of a major health crisis.

MR. WHITLEY:
This could potentially be avoided through strict monitoring at the State level.

CHAIR LESLIE:
What is the rate of incidence for tuberculosis in this State? Are there still problems with preventing highly resistant strains of the disease?

MR. WHITLEY:
Throughout the State, we average approximately 105 cases of tuberculosis a year. The majority of these cases are in Clark County. The more costly cases involve treatment of the drug-resistant strains. If the patient requires isolation and hospitalization, this presents more of a burden. The General Fund money that has been dedicated to tuberculosis treatment has not covered the costs of hospitalization and the treatment of the drug-resistant strains.

CHAIR LESLIE:
Are you certain that it is necessary to change the law in order to pass these costs on to the counties and reduce your budget?

MR. WHITLEY:
We have been working with a deputy attorney general on this matter. With advice from that office we have determined it best to make responsibility clear in law in order to avoid confusion.

CHAIR LESLIE:
I hope that we are not making a big mistake in passing some of these important responsibilities on to the counties.

MR. WEYRICK:
This account includes 20 transfer units which have, for the most part, been discussed in the context of other accounts. Decision unit E-691 eliminates approximately $7,000 that had formerly gone to the Community Health Nursing program for STD prevention. The expectation is that they can make up for those cuts with county funds.

E-691 Budget Reductions — Page DHHS HEALTH-96

CHAIR LESLIE:
We will now address B/A 101-3220, Chronic Disease.

HHS-HD – Chronic Disease — Budget Page DHHS HEALTH-108 (Volume II)
Budget Account 101-3220

MR. WEYRICK:
This account includes decision unit E-250 which eliminates seven federally funded positions from Nevada's Breast and Cervical Cancer Early Detection Program, also known as the Women's Health Connection (WHC).

E-250 Economic Working Environment — Page DHHS HEALTH-111

The intent is to replace those positions by contracting with an organization which could provide patient navigation, screening services and medical billings.

CHAIR LESLIE:
Why are these positions being eliminated? Are we saving money?

MS. MCDADE WILLIAMS:
The primary reason for eliminating these positions is to provide more comprehensive service to patients. The program only pays for breast and cervical cancer screening. If a patient goes to get these tests and is found to have another condition, such as diabetes or high blood pressure, they are told to go somewhere else.

CHAIR LESLIE:
Is this related to the Health Access Washoe County community health center program?

MR. WHITLEY:
We will be submitting a request for proposal (RFP) on this subject. The federally qualified health centers and other health care networks are all potential partners in this program. They have the ability to treat the entire person, rather than individual parts. This program is complicated because the outreach is targeted at women who do not currently have health care. When they are identified, they often have other health conditions. We are only able to screen for breast and cervical cancer. Treatment is available through Medicaid if they are diagnosed with cancer, but it is not readily available for the other health conditions. We are seeing more of this.

CHAIR LESLIE:
Would the RFP award all these services to a single organization or would you use different providers in different parts of the State?

MS. MCDADE WILLIAMS:
The RFP would require that the provider be able to administer services on a statewide basis.

CHAIR LESLIE:
Would I be correct in saying that the purpose of this decision unit is not to save money, but to provide better care for patients following screenings?

MS. MCDADE WILLIAMS:
Requirements are in place dictating that 60 percent of the approximately $2.5 million program funding be delivered specifically for the screening services. By contracting out these services, we can eliminate some of the infrastructure that we had maintained for performing administrative functions. This would allow for more money for screening.

If we contract these services out to someone who has the ability to negotiate rates with service providers, that will save even more money for screening, whereas, previously, the State was held to the Medicare rate.

CHAIR LESLIE:
I understand. Are the positions scheduled for elimination currently filled?

MS. MCDADE WILLIAMS:
They are not.

ASSEMBLYWOMAN CARLTON:
I am concerned that you will have trouble finding outside organizations interested in participating. They will be required to deal with patients who have no other outside resources. We will provide the screenings, but when it comes to the cost of the additional health care, there will be no other designated pay source and we will be asking the overstressed safety net to pay for this treatment in the long run. I am concerned that we will end up with a disjointed system for these women instead of true primary health care. I would like to see

more detail on the RFP. I would like some indication that we are not simply moving these patients from one place to another without providing holistic primary care.

MS. MCDADE WILLIAMS:
Our intent is to provide care. If we cannot find an organization that can come into the system and provide these services, then we will find ourselves back where we are today. We will continue to provide piecemeal services.

ASSEMBLYWOMAN CARLTON:
We should not simply settle for the first organization that shows up to provide service. If we cannot provide quality service to theses patients, we should keep them where they are and avoid putting them through a transition.

MS. MCDADE WILLIAMS:
We have no intention of doing that.

CHAIR LESLIE:
Please discuss the most important issues remaining in this budget account.

MR. WEYRICK:
Decision unit E-251 eliminates a management analyst position that was funded from three separate federal grants that are no longer supportive.

E-251 Economic Working Environment — Page DHHS HEALTH-111

Decision unit E-325 creates several additional positions that will be associated with the colorectal screening grant.

E-325 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-112

These positions have already been approved by IFC.

This account contains decision unit E-327 which moves the Preventative Health and Health Services block grant to B/A 101-3220 from B/A 101-3224.

E-327 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-113

That block grant is currently brought in on a federal revenue line for three to four different budget accounts. We would like to bring it in through a single budget account so that we can have more control over it. It will then be transferred out to the other budget accounts.

This account contains decision unit E-710 which replaces equipment in accordance with the DoIT replacement schedule.

E-710 Equipment Replacement — Page DHHS HEALTH-115

CHAIR LESLIE:
We will move on to a discussion of B/A 101-3222, Maternal Child Health Services.

HHS-HD – Maternal Child Health Services — Budget Page DHHS HEALTH-119 (Volume II)
Budget Account 101-3222

MR. WEYRICK:
This account includes several units transferring items to B/A 101-3219. These have been discussed.

Decision units E-520 and E-525 adjust funding alignment in order to accommodate federal grant receipts.

E-520 Adjustments to Transfer E-920 — Page DHHS HEALTH-122

E-525 Adjustments to Transfer E-925 — Page DHHS HEALTH-123

We cannot have two funding sources within the same revenue line. These transfers will justify these receipts so that we can receive federal funding.

This account contains decision unit E-710 which replaces three desktop computers in accordance with the DoIT replacement schedule.

E-710 Equipment Replacement — Page DHHS HEALTH-125

On page 17 of Exhibit C, there is a description of enhancement units moving items to B/A 101-3219, E-908 and E-909.

E-908 Trsfr From Mat Child Hlth to Biostatistics & Epid — Page DHHS HEALTH-125

E-909 Trsfr From Mat Child Hlth to Biostatistics & Epid — Page DHHS HEALTH-126

This account contains decision unit E-920 which transfers a position from B/A 101-3223 to B/A 101-3222 for the Core Injury Prevention grant.

E-920 Trsfr From Admin to Maternal Child Health Services — Page DHHS HEALTH-126

The Core Injury Prevention grant is located in B/A 101-3222 already, so we are trying to align this position with the correct budget account.

This account contains decision unit E-925 which transfers a health program specialist from B/A 101-3218 to B/A 101-3222.

E-925 Trsfr From Public Hlth Prep to Mat Child Hlth Srvc — Page DHHS HEALTH-127

This position will be funded by newborn screening fees. The fees are received into B/A 101-3222. The position is in B/A 101-3218.

CHAIR LESLIE:
Please address the increased General Fund appropriations for the Children with Special Health Care Needs Program. It appears that we have had lower than expected expenditures in that program over the past several years, and yet you are requesting more money. How does this fit in with Early Intervention Services? Is there overlap in these services?

MR. WHITLEY:
There is overlap in the provision of newborn screening, referral and services within Early Intervention Services. In the past, this program would buy medications for children with special health care needs. This would pay for components of health care, but we saw that those children were eligible for other services and what was really needed was more case coordination. We have been able to build efficiencies into the services that the State was providing through coordination of services rather than directly providing them. The General Fund is the match for Maternal and Child Health block grant. We leverage those dollars to support overall health of infants, from screening into the Early Intervention Services program.

CHAIR LESLIE:
For the current fiscal year, we appropriated approximately $213,000, and yet we have only spent approximately $35,000. Is this because of efficiencies?

MR. WHITLEY:
I would have to examine those numbers further before answering that question.

CHAIR LESLIE:
I would appreciate that. It may make sense to move this program into Early Intervention Services, or at least to coordinate the two.

MR. WHITLEY:
This is part of a larger view of the treatment required from newborn screening into referral to the Early Intervention Services. New policy is currently being discussed that would provide screening for all newborns in the State.

One of our challenges is that our capacity for specialty services resides outside of the State because of the screening. We see an opportunity to serve vulnerable children from birth to early intervention. We could maximize the usage of all the disparate revenue sources. In the Health Division we have been trying to engage partners throughout the State, particularly the State university system.

CHAIR LESLIE:
There seem to be several different ways that we are using birth projections to calculate the screening fee revenue and contract expenses. Rather than taking the time to discuss that right now, I would ask you to meet with our Staff at a later date on this issue. We should be using the same projection for all of our calculations.

We will move on to a discussion of B/A 101-3223, the Office of Health Administration.

HHS-HD – Office of Health Administration — Budget Page DHHS HEALTH-131 (Volume II)
Budget Account 101-3223

MR. WEYRICK:
This account contains decision unit E-250 which is a request to add three new positions to support financial management within the Division of Health.

E-250 Economic Working Environment — Page DHHS HEALTH-133

Management of the many budgets within the Division of Health is a very complex task. The Division receives money from 130 different funding sources, including 70 federal grants. We need these additional positions in order to execute complex budget execution and oversight. We are changing over to new, time-intensive fee calculation methodologies. We need to be able to monitor these fees and make projections.

CHAIR LESLIE:
In the last reorganization, we eliminated 13 positions from this account. Please explain why you are now requesting these additional positions.

MR. WEYRICK:
I was not working for the Division of Health during that reorganization. I cannot explain those eliminations.

MR. WHITLEY:
When we went through the rounds of cuts, we started with cutting supervisory positions rather than direct service positions. We consolidated our administrative services. The added positions will affect two program areas. The first involves our commitment to regulate industry. We now need an available skill set to perform regular analysis of those costs. The other program involves expansion of our early intervention services to the private sector. Our challenge revolved around waiting lists. We have expanded our service model and we now do not have a waiting list, but we are not certain that the actual costs we reimburse to the private sector have been analyzed in enough detail. We do not currently have the skill set necessary to perform this analysis.

CHAIR LESLIE:
Please provide a written description of the new positions, including an explanation of why you need budget analysts as opposed to administrative service officers. We are not opposed to providing you with the necessary resources to manage these complex budgets. We would appreciate a report containing more in-depth justification.

Please provide additional information regarding the reduction to funding for the Mammovan program.

MR. WEYRICK:
A description of that decision unit, E-600, is located on page 9 of Exhibit C.

E-600 Budget Reductions — Page DHHS HEALTH-135

This unit cuts $50,000 of General Fund money from the Mammovan project which was replaced with United Health Settlement funds. There was no reduction in total funding to the program.

CHAIR LESLIE:
Will we have access to the United Health Settlement funds in both years of the biennium?

MR. WEYRICK:
Yes.

CHAIR LESLIE:
Will that funding expire at the end of the biennium?

MR. WEYRICK:
Yes.

CHAIR LESLIE:
Does this program expend its entire budget every year?

MR. WEYRICK:
Yes. It is my understanding that this funding represents only a partial contribution to the expenses of the Mammovan. The operators of the program are spending more money than they receive from us.

CHAIR LESLIE:
Are there women on a waiting list for these services?

MR. WHITLEY:
We do not have that information, but we would be happy to provide it to your Staff at a later time.

CHAIR LESLIE:
Please provide additional information regarding the volume of need that exists for these services. I believe that we should be contributing to the program, but it appears that we are cobbling together this basic service. I am worried that our commitment will expire with the United Health Settlement money.

ASSEMBLYWOMAN SMITH:
I believe that in the pre-Session budget overview for the Health Division, we heard that the overall Mammovan budget would be reduced. Are you certain that the funding will be entirely replaced by the one-time settlement money?

MR. WEYRICK:
We are certain of that, yes.

ASSEMBLYWOMAN SMITH:
Is there a plan for what will be done to fund this program after the money expires?

MR. WEYRICK:
There is not.

ASSEMBLYWOMAN MASTROLUCA:
Please provide statistics on the volume of service that this program has provided since it was established. I would like to have more information available when we discuss alternative funding sources in the future.

MR. WEYRICK
I would be happy to provide the Subcommittee with that information.

CHAIR LESLIE:
I would like to discuss decision unit E-326 which describes the budget reduction for the poison control program.

E-326 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-135

Why are you splitting the contract expenses between two budget accounts instead of putting the federal funding into the Office of Health Administration account? It seems that this makes the budget more complicated.

MR. WEYICK:
We did not think of that when we were building the budget.

I would like to add that B/A 101-3218 contains no General Fund appropriations. It might have caused problems to move General Fund money into that account. We will discuss that at a later time.

CHAIR LESLIE:
With respect to the indirect cost assessment revenue, what will the reserve level for this account be at the end of the biennium?

MR. WEYRICK:
We have a new method of calculating indirect cost assessment revenue. We recently went through the process of recalculating our indirect rates for FY 2009-2010, as this process is retroactive. We are still becoming familiar with the new system. When we built the budget, our projections for the amount of money we would collect were too high. In the budget, the reserve appears large, but in reality it will probably be substantially smaller. We had about $1 million remaining at the end of FY 2009-2010, but my impression is that we will not have the numbers that are being shown. This may bring up some issues with the federal government.

CHAIR LESLIE:
We want to be sure that you do not have problems with the federal government. We also want to agree on the direction this account is going. Please work with the Subcommittee's program analyst on this issue.

We will move on to a discussion of B/A 101-3235, Emergency Medical Services.

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

MR. WEYRICK:
A discussion of this budget is located on page 20 of Exhibit C. The account contains decision unit E-251 which would increase the amount of emergency medical service (EMS) grants to the communities from budgetary reserves.

E-251 Economic Working Environment — Page DHHS HEALTH-152

This account contains decision unit E-325. This is a request for funds to restock the emergency support unit trailers.

E-325 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-152

Some of the equipment in the emergency response trailers is outdated or has deteriorated and should be replaced. This funding is provided only in the second year of the biennium.

This account contains decision unit E-326 which would replenish equipment in the training trailers.

E-326 Deliver Public Services Directly and Efficiently — Page DHHS HEALTH-153

CHAIR LESLIE:
The Subcommittee is more concerned with the larger issues in this budget account. Please discuss the budget reduction for the licensure and certification program and the plan to subsequently bill the counties.

MR. WEYRICK:
You are referring to decision unit E-690. It would replace General Fund money with county reimbursement funds.

E-690 Budget Reductions — Page DHHS HEALTH-155

We are in the process of developing a fee calculation methodology based on time and effort. We have completed a rudimentary beginning phase of those calculations. We will be using B/A 101-3216 as a model for this.

CHAIR LESLIE:
How do you determine the value for time and effort? Is it based on the number of emergency medical technicians (EMT) in the county or is it based on the population of each county?

MR. WEYRICK:
Initially, we proposed to base that number on the number of technicians and the number of licenses that are being issued. We have made some progress toward using the actual time figures for how long it takes to perform various services.

CHAIR LESLIE:
If an EMT lives in one county but works in another, or lives out of state and works here, how will you know what to bill each county?

MR. WEYRICK:
Currently, we are in the position of making that determination based on the county of residence where the license is issued. We will continue to work out these complications.

CHAIR LESLIE:
It seems unlikely that you will have these billing complications worked out by July 1, 2011, when you plan to start billing the counties.

MR. WHITLEY:
We are seeing a similar situation to what we presented in the Consumer Health Protection budget. Certain counties have expressed an interest in taking on this role. In the past, Washoe County has done this, although Clark County is currently the only county that administers this program on its own.

There are two components to this program. The first involves licensing the EMTs and the second involves licensing and regulating the service system. We are engaged in discussions with the counties, and we have seen that some are interested. This would present some of the same challenges that Ms. Wherry discussed, in that the costs would need to be shifted in response to potential regionalization of the services.

CHAIR LESLIE:
I see the same challenges and I have the same fears about chopping up a State-run system and delegating it to the counties. I believe that it will be difficult to realize efficiencies in these programs. It will be much easier for people to fall through the cracks. We need to know the details. You will need to keep us apprised of the situation because, as we discuss this budget, we will need assurances that the programs will not fall apart entirely. Please get back to the Subcommittee with further detail as soon as possible.

MR. WHITLEY:
We will not hand over to the counties programs that are in pieces and will not achieve the goals of protecting the public.

CHAIR LESLIE:
I am not trying to imply that the administrators of the Division of Health are irresponsible. I am concerned, however, that it might not make sense to handle this issue in this manner. There is no margin for error. We meet every two years. If we find out, six months from now, after we close the budget, that this measure did not make sense, we will be facing a real problem.

ASSEMBLYMAN GOICOECHEA:
My concern is that, in the rural counties, most of these are volunteer services. We have a number of attendants who are licensed, but most of them do not work as EMTs. I see the figures purporting that there are 3,800 licensed attendants across the State. I am concerned that, if the counties are asked to pick up the cost of these attendants, a number of them will be lost. We cannot afford to have that happen. We have ambulance services that are unstaffed. We have heard potential legislation that seeks emergency vehicle operators to drive them so that we can comply with the requirements that two people be available in the back.

We are struggling in the rural counties. We all drive across the State. At some point, if you need an ambulance, you will also need EMTs. I am very concerned about the continuous shifts of funding to the counties. At what level will the counties say that they cannot participate? They will begin paring these roles back in the rural counties. Whether it is $100,000 or $5,000, there will be things that we cannot afford. In that scenario, we will not have the attendants to keep the travelling public safe. I acknowledge that it is not the fault of the Division of Health. We are dealing with a very tough budget.

CHAIR LESLIE:
I share those concerns. We received a report several years ago detailing the poor condition of the ambulance equipment throughout the State. Were those equipment issues ever addressed?

MS. RITCH:
Several ambulances have been taken out of service due to equipment problems and shortfalls in personnel. We received money from a grant that aided in providing emergency medical services for children. This allowed us to buy new pediatric equipment.

CHAIR LESLIE:
Please provide the Subcommittee with a written report on the condition of the statewide ambulance fleet. I would like to compare it to the critical conditions from a year ago.

Please discuss the EMS training grant program. How many grants has the Division issued for training in the current biennium, and what were they for? If this would take a long time to explain, provide details to our Staff in writing instead.

MS. RITCH:
We will provide that in writing.

SENATOR HORSFORD:
In response to the concerns of Assemblyman Goicoechea, I have a question relating to policy. As a State, we have subsidized these rural services for quite a long time. That same subsidy from the State General Fund has not existed in Clark and Washoe County because the urban communities have the resources to provide many of these services themselves. I am concerned with the issue of balancing the concerns of the rural communities with the State revenue shortfall. We do not want to pull the rug out from under these rural communities. At the same time, we face the reality at the State level of being unable to provide these services without additional revenue. We appear to be talking around the issue based on the budget recommendations. We are not making the fundamental decision regarding whether the State subsidy for rural services should continue. I am not sure that it should continue. The rural counties cannot afford to do these things, and that will have long-term consequences for the people who live in and visit those communities.

I do not know what goal we are striving to reach. Are we trying to maintain the State subsidy? Are we trying to force the rural communities to build up their

capacity so that they can provide services? Will they need time to implement these changes, or are they all capable of making the transition on July 1, 2011? This issue needs to be settled from a policy standpoint before we decide which things are appropriate for the State to retain. There must be an implementation plan so that the counties can pick up these services effectively as they are transferred.

CHAIR LESLIE:
That is well said. I would like to add that the Subcommittee can use help in determining the State's role in funding these services. I am not certain that it makes sense to have 17 counties doing things 17 different ways. This is not simply an issue related to money problems. We must examine things from a structural standpoint.

ASSEMBLYMAN GOICOECHEA:
I would like to respond to the comments that have been made. We all understand that we are under budget constraints. I want to make certain, however, that the public and the Subcommittee understand that there will be deterioration in the quality of these services.

CHAIR LESLIE:
It would be terrible to be in an accident in rural Nevada without an ambulance or EMT to respond. These are important services. There are some things that are the State's responsibility, and we need to determine if this is one of them.

SENATOR HORSFORD:
I believe that we need a document that would specify that these are State mandated responsibilities. If we do not have this, then we should specify that these are responsibilities that the State has managed for the last 100 years, and, in order to shift paradigms, certain consequences of certain services are likely to be shifted.

Currently, we are focusing on a budget number in a spreadsheet that does not correspond to the impact on lives, services and support that will be felt. Some rural counties can afford to take these responsibilities on which, in my opinion, they should do. Other counties cannot, and there will be long-term consequences of that inability. This will affect our already poor standing in

comparison with other states in the provision of these services. We will become worse off rather than better off. I would like to see a level of specificity on key services that have been previously provided by the State.

MR. WHITLEY:
I believe that the provision of these services is our responsibility, but it is also a challenge. I believe that the possibility exists of examining all of the services that are provided in the rural counties. We serve the same people, whether they are mentally ill and have children who need to be immunized, or they need breast and cervical cancer screening. Absent the fiscal crisis, I would love the opportunity to examine the possibility of consolidating and coordinating services. We have met with county commissions in every rural county. We came back with ideas for ways to consolidate services and work together in a more efficient way. We would be interested in leading this type of discussion.

I think it is appropriate to put the allocation of these responsibilities in writing. We could then receive input from all the various State programs and put them together to show exactly where the limits of the rural counties' capacities lie. We need to know what kind of things we are investing in administratively. I would be very interested in assisting this kind of study for our Agency.

SENATOR HORSFORD:
There has been an ongoing discussion in the Government Affairs Committees in both the Senate and the Assembly concerning consolidation of services in and among local governments. Because the proposed budget shifts these responsibilities from the State to the rural communities, I believe that we should start by discussing these services first. We need a plan. We need all the assistance we can get from agency heads in facilitating this plan. Some of these services may be provided in a more integrated approach. This may take local agreements. This may take leadership from individual communities. We need this level of participation in order to move this consolidation from theory into practice. It will be a special challenge to accomplish this by the end of Session.

CHAIR LESLIE:
I concur.

I will now move on to a discussion of the budget for the Marijuana Health Registry, B/A 101-4547.

HHS-HD – Marijuana Health Registry – Budget Page DHHS HEALTH-158 (Volume II)
Budget Account 101-4547

Information on this budget can be found on page 21 of Exhibit C. I have a question about the performance indicators. Why is there a significant difference in the projected number of applications under Performance Indicator No. 5 and the number that we are using to project fee revenues?

MS. RITCH:
The performance indicators were entered into the system last summer. At that time, the projections for both performance indicators and the initial budget were based upon trends that we had been seeing in the Registry.

CHAIR LESLIE:
Will you see a 91 percent increase in fee revenue, as is indicated?

MS. RITCH:
We will not. During the fall of 2010, the Registry was receiving a high volume of applications from consultants who set themselves up to assist people in getting through this service. This affected our projections.

CHAIR LESLIE:
You are requesting three new positions, but your revenue projections are overstated. Please explain.

MS. RITCH:
We will only bring on new positions as we receive the revenue to support the activity. If the volume continues to remain relatively low, we will not bring on those positions until the revenue increases and the workload increases.

CHAIR LESLIE:
The Subcommittee might not approve those positions. We need to see a more thorough analysis of this proposal based on current data rather than speculation.

Please meet with our Staff at a later date and provide a revised report on this issue.

Is the Registry currently experiencing a backlog of applications?

MS. RITCH:
There is a backlog of approximately 700 applications.

CHAIR LESLIE:
Are those new applications or are they renewals?

MS. RITCH:
That backlog is composed of both renewal and first-time applications. The majority are new applications. We typically receive more applications for renewal in the spring.

CHAIR LESLIE:
Please provide the Subcommittee with specific details on those numbers at a later date.

This budget requests a program officer who would perform training for physicians, law enforcement and local health authorities. What type of training would that position be providing?

MS. RITCH:
The program officer would conduct training in addition to providing management over the Registry. The Marijuana Health Registry is currently staffed by one administrative assistant II.

The training was proposed in response to the frequent inquiries that we receive from law enforcement officials seeking information on the Registry and verification of patient status. We plan to develop a curriculum that would provide information to law enforcement on how the Registry works and how they can access information.

ASSEMBLYWOMAN SMITH:
I am concerned about the application backlog. I was under the impression that, if the Health Division does not meet the application time line, the client must be issued a provisional certificate. Is this true? How would that process be tracked and managed, if the Registry is already experiencing a backlog?

MS. RITCH:
The Registry is expected to meet established time lines. With the volume of applications that we have received and the staffing that we have been given, we are not able to meet those 30- and 45-day time lines. When an application comes in, we perform a criminal background check. If that comes up clean, we can then inform the applicant that they have been approved. That correspondence can be used by the applicant as proof of their approval until we can get the entire application through and set them up to get photo identification from the Department of Motor Vehicles. We try to provide temporary documentation so that the individual can participate in the Registry.

ASSEMBLYWOMAN SMITH:
Does the applicant qualify for the Registry once they have received that provisional documentation? I was concerned about the possibility that people might receive this provisional documentation before it is found that they do not qualify for the program, and then they are never reined back in.

MS. RITCH:
When we provide prospective patients with the record of application approval, this indicates that they have provided complete information and that they have a qualifying medical condition. The criminal background check takes time and is often pending at the time we issue the provisional documentation. The statute providing for the medical use of marijuana, NRS 453A, eliminates individuals from participation in the program only if they have been convicted of selling controlled substances. We have received only two or three applications a year that fall into this category. We have been granting the pending certification based on physician's statements and the completeness of the other information in the application.

If the criminal background check returns a disqualifying conviction, we revoke that provisional eligibility and do not issue a permanent Registry card.

ASSEMBLYMAN GOICOECHEA:
What are the fees associated with these renewal applications?

MS. RITCH:
The fee to receive an initial blank application is $50. To have that application processed, it costs $150. In each subsequent year, it costs an additional $150 to have a renewal processed.

ASSEMBLYWOMAN CARLTON:
I am concerned about the law enforcement and physician inquiries. Please explain the process by which these inquiries are made. Are they inquiring about patients who have legal prescriptions to use the drug?

MS. RITCH:
A licensed physician can recommend to an individual that they try marijuana for their qualifying health condition. The Registry receives notice of that medical certification. Law enforcement does not have access to our database. We respond to law enforcement when they provide us with a name and address of a person. We verify whether that person is listed in the Registry.

ASSEMBLYWOMAN CARLTON:
I am concerned with the implication that the Registry readily releases medical information. Law enforcement officers cannot call a standard pharmacy and ask if a person has a prescription for a Schedule C drug. Medical information is being shared with law enforcement with no basis for the request other than curiosity.

MS. RITCH:
The only time we discuss this information with law enforcement is when they have someone under arrest for possession. The person would inform the officer that they are listed in the Registry and the officer would contact us to verify that standing. This service attempts to avoid unnecessary jail time and seizure for patients properly enrolled in the program.

ASSEMBLYWOMAN CARLTON:
Do you have confirmation that these officers are engaged in lawful contact with patients at the time of the call, or is there the possibility that they could simply be phishing for information?

MRS. RITCH:
We would not be able to determine that. In the cases that we have handled, they are asking specific questions about the Registry status of specific individuals. We do not provide any health information to that officer. We simply confirm whether or not the person in question is included on our lists.

ASSEMBLYWOMAN CARLTON:
By providing confirmation, you are providing medical information.

CHAIR LESLIE:
Please meet with our Staff and provide additional information about the duties of the proposed program officers. There is some confusion regarding the purpose and justification for these positions, and I think that you need to reconsider whether you need them.

You are planning to transfer $700,000 from this account to the Division of Mental Health and Developmental Services, Substance Abuse Prevention and Treatment Agency. How did you determine this amount?

MR. WEYRICK:
That number was based on our projections from August 2010, when we were receiving a very high volume of applications. We believed that we could reasonably provide $700,000 while continuing to support the program and without depleting our reserve. We have seen changes in our revenue since then.

CHAIR LESLIE:
We need to see a revised figure for this transfer, based on your actual data. We need to know what this will mean for the child services that would have been benefitted by this amount, as they had built the entirety of this transfer into their budget.

In regards to decision unit E-720, you are proposing to use $68,070 of reserve funding to remodel the office used by the Vital Records staff. Why are we using this budget to do a remodeling project for another program?

E-720 New Equipment – Page DHHS HEALTH-161

MR. WEYRICK:
This was in conjunction with the addition of the three new positions. That office is a hodgepodge of different cubicles. In order to squeeze three more people into that space, we would have to remodel.

CHAIR LESLIE:
You may be rethinking this enhancement as well, as those new positions might not be available.

Please reexamine all the requests in this account and meet with our Staff to provide some better information.

We will move on to public comment.

MARY C. WALKER, CPA (Carson City, Douglas County, Lyon County and Storey County):
An outline of my testimony has been provided to the Subcommittee (Exhibit D).

I am here today, on behalf of the Carson, Douglas, Lyon and Storey County Commissions, to discuss the impact of the cost shifts to our counties that are proposed within the State Division of Health budget. There are four areas in the Division of Health budget which will monetarily impact our four counties. These are the areas of consumer health protection, medical care related to tuberculosis, medical care related to STD programs and emergency medical services.

These are not the only cost shifts proposed in the Governor's budget. It also proposes to shift the costs of the following services to rural counties.

- Elder protective services.
- Long-term care.

- Rural developmental services.
- Mental health courts.
- Youth parole services.
- Child protective services.
- Community juvenile justice programs.
- County youth camps.
- Mental health room and board.
- Pre-sentence investigations.
- The continuation of the 2.5 cent ad valorem tax sweep for the indigent funds.

This list does not include the additional costs or services that may be shifted to the counties by act of the Legislature.

In total, the costs to our four counties from the Governor's proposed budget shifts the amount to nearly $7 million a year for a total of nearly $14 million over the coming biennium. We have been given only a few months to prepare for this cost shift. This will have a tremendous impact on our small counties within a short period of time. We are very concerned. Frankly, we are stunned. Since 2007, our counties have already cut between 15 percent and 25 percent of their budgets. We are still in the process of cutting our budgets for next year. Lyon County, which was once the fastest growing county in the United States, is now one of the most economically distressed places in the Country. It has the highest unemployment rate in the State at 18.7 percent, in contrast to the 14.6 percent rate for the State as a whole. If the Governor's budget goes through as it is, Lyon County will have to lay off another 50 employees. Ten of these will be sheriff's officers.

We need to determine how we can balance our responsibilities to the citizens we serve with our responsibility to the State of Nevada.

Carson City and its adjoining counties, Douglas, Lyon and Storey, constitute the State's hometown. If there is a bomb at the Capitol, a fire at a State facility, an emergency at the Legislature or riotous crowd control problems, it is officers and emergency personnel from these four counties who respond. When the State lays off workers, these are the types of citizens who become unemployed.

In addition, State and county staff work hand in hand every day in this region. This has created a strong bond of partnership between the State of Nevada and our communities. Because of this strong bond of partnership, our four small counties believe that it is important to help the State as much as possible.

We agree with the Governor and the staff at the Department of Health and Human Services that there are certain services currently provided by the State which are typically the responsibility of local governments in other states. However, the current budget proposal leaves only two options for funding these services. Either the State can assess fees to the counties or funding will be eliminated. This approach limits the possibility of developing a more efficient and streamlined delivery system for these programs. We would like to discuss these issues with representatives of the Legislative and Executive Branches in an effort to determine the best approach for providing continued service to our communities.

JEFF PAGE (County Manager, Lyon County Board of Commissioners):
Since the Governor's announcement of his proposed budgetary adjustments in the State of the State address, the people of Lyon County have been very concerned. We have the highest unemployment rate in Nevada. We are the third most economically depressed county in the Nation.

We have worked with Carson City, Douglas and Storey Counties for a number of years. We have been discussing other things that we might be able to do as a four-county group that might reduce the impact of the absorption of these State services and benefit all involved. We have no firm answers at this point in time because we do not know exactly how things will look by the end of Session. The Department of Health and Human Services has worked very closely with my staff to determine what options we have.

I ask that we be given the freedom to collaborate with our neighboring counties. If we have to take on a service today because the State does not have the staff to provide it, we would like the ability to sit down with our neighbors a year from now, when the economy improves, and draw up a better system.

If the State ties our hands by requiring that we pay for these services without giving us any other options, this process will be much more difficult.

We, as the counties, understand that the State's budget problem is our budget problem. We are willing to work with the Governor and the Legislature to solve this problem, but we ask that we be given options for dealing with these situations when they fall to us.

CHAIR LESLIE:
It would be helpful to hear specifics on ways the State can help the counties better manage these problems.

MR. PAGE:
As we continue to go through this process, we will be more able to submit those specifics to the Legislature. As this is a complex issue, we are having to develop some very complex solutions.

CHAIR LESLIE:
You have also been given a very brief time frame.

Are you planning to close the Western Nevada Regional Youth Center?

MR. PAGE:
Lyon County has pulled its funding from the Western Nevada Regional Youth Center in response to budgetary problems. We have cut approximately $1.8 million from the total county budget in response to shortfalls. We have notified administrators that we will be pulling funding out of the facility on July 1, 2011, unless we can find a better way to manage the available finances.

CHAIR LESLIE:
It would be a shame to lose this important regional facility.

LAWRENCE A. WERNER, P.E./P.L.S. (City Manager, Carson City Consolidated City-County):
I concur with the sentiments of Mr. Page and Ms. Walker.

Carson City has been struggling with the problem of funding these programs if they should be passed on to us. We are restricted in our ability to seek out additional sources of funding. We may need to generate money from what are

currently restricted funding sources. We do not currently know that we will be able to absorb these costs within existing structures.

Senator Horsford made some valuable comments on the roles assigned to the State and to the counties. It would be extremely valuable to determine where the limits of the various capacities lie.

PAT WHITTEN (County Manager, Storey County Board of Commissioners):
I have heard one recurring concern regarding the provision of these various services. As a representative of the smallest county with the most limited resources, I can say that regionalization is the answer to our problems. Carson City is already capable of providing restaurant inspections. Over the last several years, we have been looking at things like regional EMS dispatch, animal control and other services that could be performed collectively better than individually. I assure the Subcommittee that Storey County considers its citizens to be Nevada citizens first and foremost. We have a direct responsibility to take care of our own as well as the over one million visitors who pass through Virginia City each year. It is through regional resources like this that we will be able to expand our options.

ASSEMBLYMAN GOICOECHEA:
I appreciate the benefits that regionalization would offer in this part of the State. The bottom line is that we have a number of rural counties across Nevada that coordinate as quad- and tri-county partners. If you were to take White Pine, Nye and Lincoln Counties, however, you would be dealing with a significantly larger area. I commend you for your ability to work together, but one size does not fit all, and we would struggle with implementing regionalized plans across the State.

LISA GIANOLI (LG Strategies, Ltd):
Today, I am representing Washoe County. I will provide some numbers about the impacts of the potential pushdowns and cost shifts.

Washoe County is currently in the process of reviewing the proposed pushdowns. In total, we will be seeing approximately $25 million in cost shifts and tax diversions in each year of the biennium. We will have to deal with these changes.

Regarding the proposed changes in the health program structure, it would cost about 0.5 cents of property tax to take these services over or to reimburse the State.

Our District Health Officer has been working with Legislative Staff. She will provide specifics about the implications of these changes. Currently, our fiscal analysts are making presentations to the Washoe County Commissioners regarding these impacts.

Before we had heard about the proposed pushdowns, we were looking at a 10 percent cut across the board for the county budget. If these shifts do occur, we will be experiencing a 25 percent cut to our budget of approximately $58 million in each year. We are concerned about our ability to work through these difficulties. We must try and absorb these changes in a cost-effective and efficient way. We need time to analyze these things to come up with the best solutions to the problems we will be facing.

MARY-ANN BROWN, R.N., M.S.N. (Interim District Health Officer, Washoe County Health District):
I have been working closely with the State on the three main areas that will become pushdowns to the counties. These are food inspection within higher education, medical treatment for tuberculosis patients and EMS. The short time frame and the uncertainty with which we are being asked to take on these responsibilities present a challenge. These are serious and important programs that will impact citizens. We are scrambling to plan and budget for these services by July 1, 2011.

The smallest of the three areas is the program for food inspection in higher education. I will not focus on that issue today. Tuberculosis treatment and EMS are the two more concerning programs that we will be asked to take on.

We currently receive CDC funding for the tuberculosis treatment service. This raises another concern in that half of our overall programs receive grant funding which is in jeopardy of being cut by the federal government.

If we are required to take on about $128,000 of the costs of medical treatment for tuberculosis, this will divert programming from prevention services. This is a step in the wrong direction, as prevention pays off in the long run.

The most difficult questions to answer concern EMS. The amount of money that we will be asked to provide for this service is constantly changing. Fees for EMS licensure and certification are very small. The program is inefficiently run. We would look at privatization of the training classes as an option for increasing efficiency. It is exciting to think of new ways to improve these services, but we are dealing with an incredibly compressed time frame. How should we create a brand new program by July 1, 2011, that will efficiently and effectively offer this service without putting undue impact on the County?

ASSEMBLYWOMAN SMITH:
We are dealing with a much more compressed time frame than is being discussed. Essentially, we are talking about getting these services organized only after this budget is finalized in the beginning of June 2011. This will offer about 30 days to make these decisions.

MS. BROWN:
This will be a difficult planning process to implement in a short period of time.

ASSEMBLYMAN GOICOECHEA:
The County's tentative budget is due on April 21, 2011. I realize that you can file an amendment after we submit the Legislature approved budget, but the point should be made that April 21 is not far off.

CHAIR LESLIE:
It is obvious that an amendment will be necessary.

ALEX ORTIZ (Clark County):
I would like to concur with the comments that have been made by Washoe County representatives. We are similarly frustrated by the limited time frame. We would like to be involved with all discussions about these issues, if possible.

WES HENDERSON (Deputy Director, Nevada Association of Counties):
The cost shifts that we have described today are only pieces of what has been described as the "bucket of burden" that is being transferred to the counties. We estimate that there will be a transfer of approximately $325 million in expenses to the counties during this Session.

Some of these programs are fee-based systems, and the State has the regulatory authority to raise these fees. This might be an option in mitigating the cost-shift to the counties.

CHAIR LESLIE:
As there is no further business, this meeting is adjourned at 11:00 a.m.

RESPECTFULLY SUBMITTED:

_____
Wade Beavers,
Committee Secretary

APPROVED BY:

_____
Senator Sheila Leslie, Chair

DATE: _____

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Date: March 8, 2011 Time of Meeting: 8:04 a.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Phil Weyrick/Division of Health	Division of Health Budget Presentation
	D	Mary Walker/Douglas County, Carson City, Lyon County and Storey County	County Impact Testimony