MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-sixth Session
May 3, 2011

The Senate Committee on Health and Human Services was called to order by Chair Allison Copening at 3:36 p.m. on Tuesday, May 3, 2011, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Allison Copening, Chair
Senator Valerie Wiener, Vice Chair
Senator Ruben J. Kihuen
Senator Joseph (Joe) P. Hardy
Senator Greg Brower

COMMITTEE MEMBERS ABSENT:

Senator Sheila Leslie (Excused)
Senator Ben Kieckhefer (Excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Marilyn Kirkpatrick, Assembly District No. 1

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Risa Lang, Counsel
Stephanie Robbins, Committee Assistant
Annette Ramirez, Committee Secretary

OTHERS PRESENT:

Thomas G. Chase, Chief Executive Officer, Nevada Health Centers, Inc.
Renny Ashleman, Nevada Health Care Association

Barry Gold, Director, Government Relations, AARP Nevada
Marla McDade Williams, B.A., M.P.A., Deputy Administrator, Health Division, Department of Health and Human Services

CHAIR COPENING:
We will open the hearing with a presentation about Nevada Health Centers.

THOMAS G. CHASE (Chief Executive Officer, Nevada Health Centers, Inc.):
I will start with Great Basin Primary Care Association. I would like to report they have three new board members and are in the final stages of selecting a new executive director. The balance of my comments will be related to Nevada Health Centers' (NHC) progress, challenges we are facing for the future, the federal budget and our hopes for partnership with the State. We receive a lot of American Recovery and Reinvestment Act (ARRA) stimulus funding. We were the fourth most funded health center in the country out of approximately 1,200 health centers. This started with what is known as Increased Demand for Services Grants (IDS) and is the only component of the ARRA funding related to what we could do with patients. We were funded nearly $1 million for two years to expand services we felt were necessary. We dedicated it almost exclusively to women's care in Clark County and a small amount to the homeless. The women's center was scheduled to close the same time as the stimulus funding was available. We directed almost all of the funding to obstetrics and gynecologic (OBGYN) services in Clark County. You have a chart, "IDS ARRA Stimulus Funding" (Exhibit C) that articulates the full array of what happened with the IDS funds. We saw 4,745 new patients, and 87.8 percent of those patients were uninsured. We incurred 16,660 patient encounters over a 2-year period. We are very proud of the accomplishments we had with respect to IDS. We are hopeful the funding will continue.

Our capital improvement program funding was nearly $2 million. We had five projects, and we reduced them to four projects. The most important project was a brand-new health center for the community of Carlin. It is a great partnership, and we used Community Development Block Grant (CDBG) funding. The City of Carlin donated the land, and that health center is slated to open June 7, 2011. Aside from that, we did quite a bit with the money. We purchased electronic medical record (EMR) upgrades, a new dental EMR system and electrocardiogram and pulmonary resuscitation equipment. We upgraded many of our systems, including our personnel system. We bought OBGYN equipment, put in a new voice override system for our statewide operations and

purchased brand-new video equipment and virtual memory and backup systems for our extensive computer operations. The $2 million came in at the right time for us to do all the things necessary to become meaningful users under the Information Technology Act.

The last part of the program for ARRA was the facility investment program. We were 1 of 85 applicants to win an award. We are building two new buildings and have broken ground in Las Vegas. We will break ground at Research Way, Carson City on June 1, 2011. The 2 centers together will have approximately 50,000 square feet. Clark County's facility will be 30,000 square feet and Carson City's will be 20,000 square feet. Both locations will provide for expansion, and we hope to add dental services sometime in the future. As a result of these two new buildings, we will save the cost of four leases.

The recession hit our operations forcefully. We started to emerge in November 2009, just as we were meeting our highest level of demand. At one point, we were serving 210,000 encounters a year, and we could not sustain that. It became clear, despite the demand, that we did not have the resources to accomplish that kind of aggressive goal. The third quarter ending in February 2010 was a very difficult quarter for us. If we had annualized those operations, we would have lost $2.2 million. We needed to take some drastic steps, and by the end of the year our loss was only $1 million. This year, after ten months, we are at a rate of earning $2.2 million. If I were to project this to May 2011, we would likely earn $2.6 million not including any of the ARRA funding.

The chart you have, "Annualized Encounters" (Exhibit D), shows figures from 2008 to now. Essentially, we are right where we were when I started. Overall, we improved in this period of time by $2.25 million because we took some hard steps. We reduced benefits, froze wages and salaries, completely overhauled our operations management group, adjusted service levels and hours, and closed several of our sites. We closed three school-based operations in Clark County. We also closed Child Haven, one of our homeless sites, and Bridger Health Center in Las Vegas. We are going to work closely with the State to determine how to recapture the losses of those populations. We have closed our mobile dental van in Clark County and our Incline Village and Gerlach operations. We could not service them efficiently and effectively out of Carson City. They were dragging down Carson City, which is one of our stronger health centers, and we could not let that happen. Between the high point in November 2009, and now,

we lost 67,667 encounters which is almost exactly 33 percent of our capacity. That was more than I had projected one year ago. The chart you have, "Payor Mix of Annualized Encounters" (Exhibit E), shows the patient mix, and it is back to where it was three years ago. We have had no major change in uninsured patients. We have had some improvement in Medicaid, but we have had some losses in private insurance, and our Medicare mix is virtually identical.

Our biggest challenge is the Medicaid mix for health centers which is the economic engine. We have 22 percent, and everyone else gets 37 percent. All other health centers in this Country operate on that economic model. We are operating on barely two-thirds of that, and that is the challenge we face. We cannot get funding to serve more patients because we do not get enough Medicaid patients to earn our way to do it.

We have other challenges. Over ten years we have never requested a rate increase from the State. We finally did in February 2009. As of January 2010, the State told us they did not think we were entitled to it. We have filed an appeal. We believe that will be a watershed event. The State health plan provides for it, we have had multiple changes within the scope of that plan, and we are entitled to a rate change based on those changes of scope. Last April, I outlined NHC's value equation for the interim committee. In that presentation, I explained what I just said about our basic economics. If we could increase our Medicaid mix by 10 percent, we would get about $2.5 million more in revenue, increase Medicaid encounters by 20,000 and sustain 28,000 uninsured encounters. We were not able to do that and lost 67,000 encounters in the interim 12 months. My report is a demonstration that the economics I was talking about are very real. We cannot sustain at the level we were, but we would like to do so. If the State were to invest another $900,000 in us, we would have about 67,500 encounters more than in the last 12 months. The cost of that, from the State's point of view, is $13.50 per encounter. Nobody can duplicate that. When any of those encounters convert into an emergency room (ER) encounter at the University Medical Center of Southern Nevada, the costs are probably at least $300. People who go to community health centers tend not to go to the ER. Nationally, it has been shown that health centers save the Medicaid program about four times the cost of the grant, and the Medicare program saves about three times the cost of the grant.

The federal budget is of interest to us because it creates even more uncertainty. With the last resolution for fiscal year 2010-2011, community health centers

lost $600 million of continuation funding. We were looking at the possibility of losing $1.2 billion, but we did not. We do not know how the Affordable Care Act funding is going to be affected. The trust fund was not touched by the continuation funding bill, but we do not know how we are going to move trust fund monies into continuation funding for regular operations for community health centers. At risk right now for NHC is $500,000 a year in IDS funding and an additional $1 million in what is called expanded services applications that we implemented in January 2011.

Finally, I would like to talk about the partnership NHC has with the State. We enjoy a very strong relationship with the Department of Health and Human Services (DHHS). We have operated the NHC Mammovan, participated in the hepatitis C crisis in Clark County and were integral in the administration and dissemination of the H1N1 influenza vaccine. The NHC has been involved in a wide variety of initiatives. We have worked with the Women's Health Connection, are the public health nurse for Elko County, are the emergency service for Eureka County, have done senior oral health care in Clark County and run mobile oral health care across the Interstate Highway 80 corridor in Nevada. Nevada Health Centers has had to turn down the opportunity to partner on the diabetes collaborative. We are looking closely at the screening, intervention, referral and treatment initiative that is coming down the pike. On an annual basis, we are the entity that delegates to the State authority to deliver vaccine for children. We are only authorized to do that for uninsured and underinsured individuals. We do not ask for a whole lot: we do ask for cost. The return is part of what our mission is about. Today, I find it difficult to believe we have a true partnership with the DHHS. I think it is predominately a one-way street. We do not believe we are a preferred partner or a preferred vendor. The margins derived from noninstitutional dollars provided by Medicaid for primary care are going predominately to Minnesota. What I question is the wisdom of not supporting the safety net in your state. It is my contention we have not been supported the way we need to be. We have not been able to deliver 66,667 encounters, and they can be lost permanently. This represents care for about 2.3 out of every 100 Nevadans. I am regularly asked to reaffirm our partnerships with the DHHS. I cannot continue to operate NHC as if the relationship with the State is strictly one-way. We have demonstrated our resolve and capability. These are uncertain times for us. The budget is going to be equally uncertain. I do not believe the Division of Health Care Financing and Policy (DHCFP), DHHS, perceives we are the partner that they want.

CHAIR COPENING:
I would like to call up Assemblywoman Kirkpatrick, our sponsor for Assembly Bill (A.B.) 533 and A.B. 535.

ASSEMBLY BILL 533: Provides certain financial protections for residents of group homes and similar facilities. (BDR 40-673)

ASSEMBLY BILL 535: Revises provisions governing the referral of persons to residential facilities for groups. (BDR 40-674)

ASSEMBLYWOMAN MARILYN KIRKPATRICK (Assembly District No. 1):
I was the chair of the interim study on Group Homes. These are two bills that came out of that study. I will start with A.B. 533. We heard that people were being asked to turn over their power of attorney (POA) to live in assisted living facilities and other group homes. We heard that when these people got into these situations and had turned everything over, they did not have any recourse. Mr. Ashleman has concerns because he wants individuals to get Medicaid funding as soon as possible, and a POA is the quickest way to do that. In *Nevada Revised Statute* 162A, which is the power of attorney chapter, it is either all or nothing. We have been working with Ms. Lang and Ms. Erdoes to come up with an amendment to address that situation. We were working on this late last night and would like to have the ability to bring it back before you. The point of A.B. 533 is to ensure that we are providing a safety net for the residents within these homes.

RENNY ASHLEMAN (Nevada Health Care Association):
This is an excellent bill, and we understand the need for it. The situation is that frequently residents in nursing homes do not have any family or guardian to take care of them, and the application process for Medicaid is a complex one. We become their authorized representatives and help them fill out the forms. Part of that process is the need to gather three months' worth of financial data, principally bank data. The banks will only give that data to us if we give them a special POA using their forms; these need to be signed by the patient. The challenge is to make sure we draw that as narrowly as possible so we do not defeat or damage the purpose of the bill but can accomplish our objective of getting the people qualified. Otherwise, it will need to go to the DHCFP, and they will need to do this. It takes us quite some time now to qualify individuals as it is, and if we have them assist us in this chase, it will take quite a bit

longer. I wanted the Committee to know what the problem is and that we are working on it.

SENATOR WIENER:
How long does it take from the start of the Medicaid application process until they receive funding?

MR. ASHLEMAN:
It all depends. Sometimes they come over from the hospital with the preparation and record keeping very well done. In that case, it is an ordinary process taking about 30 days. Typically, it takes a substantially longer period of time. It depends on how cooperative the financial institutions are and if there is family willing to cooperate. Some can drag on for months, and these are a concern. Eventually, a small percentage of individuals are not qualified for Medicaid, and you want to know that as soon as you can.

SENATOR WIENER:
In the case where patients have no one to assist them and you need to do that for them, is there a limited POA for this purpose?

MR. ASHLEMAN:
That is what we are trying to do. We are not trying to get a general POA because if one of our employees got hold of that and abused it, we would be liable. We are not interested in being in that position if we can help it. We have not had problems along those lines; however, it is quite possible. Each individual bank wants you to use their forms, and they are limited POAs.

ASSEMBLYWOMAN KIRKPATRICK:
There are some other states that have just a limited POA. In statute, there is no other provision other than all or nothing. How we craft the language is a difficult task. Ms. Lang has spent many hours on the telephone with Medicaid trying to figure out how this should work. Some extreme cases are when constituents have moved into a facility and turned over a POA, and then all of their assets have been cleaned out by the time they found out they did not qualify for Medicaid. This bill is to ensure that our elderly folks get a decent place to live.

CHAIR COPENING:
What do mean when you say their assets were cleaned out before they qualified?

ASSEMBLYWOMAN KIRKPATRICK:
I represent 41 group homes within my district and I have seen every worst-case scenario. I had a woman who signed into a group home and signed over her POA. It usually takes around 30 days for individuals to find out if they qualify for Medicaid. During this waiting period, the group home had recommended that she use a consultant who charged $1,500 to fill out the Medicaid forms. By the time the 30 days had rolled around, they determined that she had too many assets to qualify. During that time, they had charged the woman fees and assessments depleting all assets, except for her burial plot.

SENATOR HARDY:
Apparently there is a business that works with hospitals to get individuals qualified faster than DHHS has done. Have we looked at getting the group home out of the business and allowing someone else to do that so they do not have the perceived conflict of interest?

MR. ASHLEMAN:
Some of our institutions do use those folks and do employ them. Others who are fairly large have staff employees who do this. It is not cheap to do that. It is a lot cheaper to have us do it. Assembly Bill 533 is needed for several reasons. The actual abuse by the nursing homes has not been a problem, but assisted living has been a problem. We are the only state in the union where outside services do the qualifying. It is usually done by the state, but it is a matter of economics for Nevada.

BARRY GOLD (Government Relations, AARP Nevada):
I have written testimony (Exhibit F) that I will read.

CHAIR COPENING:
I close the hearing on A.B. 533 and open the hearing for A.B. 535.

ASSEMBLYWOMAN KIRKPATRICK:
Assembly Bill 535 came up because we had a lot of discussion about people being referred to group homes that were not licensed and were not proper facilities to house these people. I had a group home in my district that was a source of many problems and was closed down by Clark County. They opened back up the next day as a boarding house. There was a daughter in this district who wanted her mother to be in a safe place close to home. Her mother got some referrals that referred her to this unlicensed facility. Within a year's time,

this woman was beaten to death in that unlicensed facility. We want to make every effort possible to ensure that we are referring people to facilities that are following the standards of our State.

CHAIR COPENING:
This bill applies to a licensed medical facility or an employee of such a medical facility. This could be any private doctor's office, a State facility or a nonprofit facility. This bill would make it their responsibility, when making a referral, to be aware of the facilities that are licensed in the State, is that correct?

ASSEMBLYWOMAN KIRKPATRICK:
That is correct. We did have referral agency groups testify before us, and they thought this bill did not go far enough; however, we believe this is a good starting point. When you get a CDBG on a local level, it does not require you to have a business license, so you can get a grant to open up a referral business. We had this happen where someone got a CDBG, and they were referring people.

CHAIR COPENING:
How does an independent physician find out which facilities are licensed? Is there a place where they can check this out, or do they need to go through an investigative procedure to find out who is licensed?

ASSEMBLYWOMAN KIRKPATRICK:
The State has a very good Website, and it is the safest place to go for that information. The State does license the homes that comply with all the expected standards.

CHAIR COPENING:
I see where the State Board of Health is responsible for education to the public regarding this, which would also mean education to the medical facilities.

ASSEMBLYWOMAN KIRKPATRICK:
Our State Website has improved 100 percent in the last two years and is very easy to use. We also do report cards on the State Website so people can make determinations for themselves. Some of the things on a report card, just to give you an idea, might be that a facility's biggest infraction was having the temperature too high, by three degrees during the summertime, which is quite possible if you leave the door open in Las Vegas for a short time. So it is very

detailed. The Website also lists whether they were cited for missing fingerprints, documentation, etc.

SENATOR HARDY:
Section 1, subsection 1, of A.B. 535 alludes to a licensed medical facility. Then in section 1, subsection 4, it says " ... 'licensed medical facility' means: (a) A medical facility that is required to be licensed pursuant to this section ... " (b) "A facility that provides medical care or treatment ... ."

Am I looking at two different licenses? One is the facility that is referring and one is the facility that is getting the license. I want to be sure the license is applicable to what the facility is doing. For instance, you can have a business license in a city, but that does not mean you are licensed by the State to do something. Are we getting all of the appropriate licenses in this bill so that somebody does not say they were licensed in the city and did not think there was a need to be licensed by the State?

ASSEMBLYWOMAN KIRKPATRICK:
That is another bill we are trying to work on that determines those definitions. I may need to refer this to Ms. Lang. I believe that NRS 449 has to do with alcohol and different treatment centers, is that correct?

RISA LANG (Counsel):
Chapter 449 of NRS is for the medical and other related facilities and these are the general licensing provisions for those. *Nevada Revised Statute* 449.038 allows the board to adopt regulations to require licensing of other facilities that are not specifically listed in that chapter. This is an attempt to address all of the licensed medical facilities.

SENATOR HARDY:
We need to reference in section 1, subsections 1 and 4, that people need to understand even if they are licensed in the city, they still need to be licensed by the State to be on the State Website.

MS. LANG:
I am not sure I totally followed your scenario. This will cover all of the facilities that are licensed by the State under NRS 449.

ASSEMBLYWOMAN KIRKPATRICK:
I understand that you are saying because people will say on the local level I am not required to get a license. It is not very clear on the State level who has to have a license either. We have been working on another bill to list definitions for the local level, and the State level, so that we are consistent by county. There is also another bill that fines you heavily if you are not licensed. With all of these pieces in place, people will be aware to whom they are referring. We want to protect our good actors. We have several great referrals and homes out there. The money we spend going after the ones that are unlicensed, and trying to protect everyone else, could have been given to those good actors.

SENATOR HARDY:
Can we require a receiving facility to be on the Website; otherwise, they are not considered licensed? That would allow us to track the referring facility as being licensed.

MARLA MCDADE WILLIAMS, B.A., M.P.A. (Deputy Administrator, Health Division, Department of Health and Human Services):
All facilities that are licensed are on our Website. What I am unclear about is where the bill refers to medical facilities. This means hospitals and nursing homes. It does not cover the other facilities we license which would be: group homes, drug and alcohol abuse facilities and other dependent care facilities. Those facilities would not be held to this bill and could make referrals. The bill is saying that if you are a medical facility, or an employee of such a medical facility, you cannot make a referral to an unlicensed facility. It is implied you need to go to where the licensed facilities are listed, which is on our Website.

SENATOR HARDY:
Would it be wise to put in the bill, licensed by the State, as opposed to just licensed? We are trying to make sure the referring facility is licensed by the State. Is it possible to put in the bill, "refer a person to a duly licensed facility in the State," as opposed to just "a licensed facility?"

MS. MCDADE WILLIAMS:
Section 1, page 2 of A.B. 535 ,lines 5 through 13, states:

> ... a licensed medical facility or an employee of such a medical facility shall not: (a) Refer a person to a residential facility for groups that is not licensed or refer a person to a residential facility for groups if the licensed medical facility. (b) or its employee

> knows or reasonably should know that the residential facility for groups, or the services provided by the residential facility for groups, are not appropriate for the condition of the person being referred.

You could have assisted living facilities licensed as group homes that are not licensed as medical facilities. They could make a referral to an unlicensed facility and not be covered by this bill.

SENATOR HARDY:
I would like to refer to page 2 of A.B. 535, lines 7 and 8. The way I would like to have this read is "Refer a person to a residential facility for groups that is not licensed by the State."

MS. MCDADE WILLIAMS:
That would not hurt anything. It is implied in this statute that these are only State licensed facilities.

SENATOR HARDY:
I like implications that are very clear.

ASSEMBLYWOMAN KIRKPATRICK:
We can make it very clear.

MARSHEILAH LYONS (Policy Analyst):
For clarification; in section 1, subsection 4, a licensed medical facility is defined, and it refers to NRS 449.001 to 449.240, inclusive. Does that include all of the different facility types?

MS. MCDADE WILLIAMS:
That is good clarification, but if you look in that chapter under the license of a medical facility, you can see it is restricted to hospitals, nursing homes and a few other types. It would have been helpful to say "facility for the dependent and a medical facility," if that was the intent. We can work through that without any amendments.

CHAIR COPENING:
Was the intent of the bill to only put responsibility on medical facilities, or are there other facilities such as assisted living facilities we want to hold responsible to not refer to an unlicensed group home?

ASSEMBLYWOMAN KIRKPATRICK:
There are many nonprofit licensed groups that get vouchers from local governments through the CDBG that are referring to non-licensed group homes. We heard testimony from referral agencies, and they do not think we are strict enough because anybody could become a referral system. The intent was to ensure that people who are giving referrals are giving them to licensed group homes. Maybe we should use Senator Hardy's suggestion of the language "licensed by the State" to clarify it enough at this point. There are people who get paid to refer people to their own facilities. The referral agencies wanted to be stricter, but we need to start somewhere first, and I think this is the best way.

CHAIR COPENING:
Are we saying if an entity is not a licensed medical facility, we would not like them to be allowed to refer?

ASSEMBLYWOMAN KIRKPATRICK:
I do not know the answer. I think the intent was to ensure that people who are referring individuals anywhere should be held responsible for facilities to which they are referring them. If the State does not license them, that would not necessarily affect them, but there has to be a starting point, and I do not think you can specifically narrow it down at this point. Section 1, subsection 3 would allow a system to track violations, and we can find out where our loopholes are for the future. Maybe we need to do something different with the people who get the referrals. Maybe they need different training and education.

SENATOR HARDY:
I think we are going in the right direction.

MR. GOLD:
I have written testimony (Exhibit G) that I will read. In regard to what you have been talking about, look at section 3 of A.B. 535, which deals with referral agencies. There are also businesses that refer people to residential facilities, usually for a fee. If I am a referral agency and I refer someone to a facility, I get

a fee for that. A month or two later, it may be determined that facility is not right for this person, and now a new referral is made to a different group home and another fee is charged. That is why this bill is so important. It makes people think about being sent to an appropriate licensed group home.

CHAIR COPENING:
I close the hearing on A.B. 535. There being no other business to come before the Committee on Health and Human Services, the meeting is adjourned at 4:42 p.m.

RESPECTFULLY SUBMITTED:

Annette Ramirez,
Committee Secretary

APPROVED BY:

Senator Allison Copening, Chair

DATE:

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
	C	Thomas G. Chase	IDS ARRA Stimulus Funding
	D	Thomas G. Chase	Annualized Encounters
	E	Thomas G. Chase	Payor Mix of Annualized Encounters
A.B. 533	F	Barry Gold	Written Testimony
A.B. 535	G	Barry Gold	Written Testimony