MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-sixth Session
February 8, 2011

The Senate Committee on Health and Human Services was called to order by Chair Allison Copening at 3:34 p.m. on Tuesday, February 8, 2011, in Room 2149 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.

COMMITTEE MEMBERS PRESENT:

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

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Risa Lang, Counsel
Sherry Loncar, Committee Manager
Stephanie Robbins, Committee Assistant
Annette Ramirez, Committee Secretary
Shauna Kirk, Committee Secretary

OTHERS PRESENT:

Michael J. Willden, Director, Department of Health and Human Services
Harold Cook., Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services
Bob Bennett, Chair, Nevada Disability Protection Advocacy & Law Center
Marla McDade Williams, Deputy Administrator, Health Division, Department of Health and Human Services
Luana J. Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning and Emergency Response, Health Division, Department of Health and Human Services

P. Michael Murphy, Coroner, Office of the Coroner/Medical Examiner, Clark County
Gary Milliken, Southern Nevada Health District
Rebecca Gasca, American Civil Liberties Union of Nevada

CHAIR COPENING:
The Committee has been given a copy of the "Senate Committee on Health and Human Services Rules for the 2011 Session" (Exhibit C). If there are no comments or questions, I will entertain a motion to adopt the rules.

SENATOR KIECKHEFER:
What does "All votes will be considered open until the adjournment of the Committee meeting" mean? Will you explain that for me?

MARSHEILAH LYONS (Policy Analyst):
If a vote is taken earlier in the meeting and a member is not present for the vote, but comes back into the meeting, they are able to record their vote as long as the meeting is not adjourned.

> SENATOR WIENER MOVED TO ADOPT THE "SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES RULES FOR THE 2011 SESSION."
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> SENATOR KIHUEN SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

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CHAIR COPENING:
We will now have a presentation of the Committee Brief from Mrs. Lyons.

MRS. LYONS:
You have a copy of the "Committee Brief, Senate Committee on Health and Human Services 2011 Legislative Session" (Exhibit D).

CHAIR COPENING:
We will now hear from Mike Willden, Director, Department of Health and Human Services (DHHS) who has a presentation.

MICHAEL J. WILLDEN (Director, Department of Health and Human Services):
I will start with the "Presentation to the Senate Committee on Health & Human Services, Department Overview & Health Care Reform" (Exhibit E). We are organized into six different divisions. We also provide administrative support to the Office of the State Public Defender and the Nevada Indian Commission. You will see new functions or changes in the DHHS. One is child-care licensing. We are also proposing that the Governor's Office for Consumer Health Assistance be placed in DHHS. It will still be called the Governor's Office for Consumer Health Assistance, but we will merge several functions related to DHHS.

SENATOR KIECKHEFER:
All of the numbers you included were General Fund only. Have you evaluated what some of the total fiscal impacts are when you include federal dollars for the reimbursement rates?

MR. WILLDEN:
Yes. I did not bring that with me. I can e-mail that to you. The general rule when we are eliminating a General Fund dollar, particularly in Medicaid, is for every 45 cents cut, we will lose 55 cents. That is the matching ratio. In the past, for every State dollar we reduce, the State will lose a federal dollar.

CHAIR COPENING:
Regarding the cuts on page 35, Exhibit E, are there additional proposed cuts for these areas this biennium? The Anesthesia rates, Behavioral Health rates and Oxygen and Wound Vac Rental rates have already gone into effect.

MR. WILLDEN:
No. The 43 percent rate reduction was approved during the 26th Special Session for Anesthesia and is a carryover of that approved reduction. The Behavioral Health rate was discussed and approved through that 26th Special Session. It is not an additional rate reduction nor is the Wound Vac Rental. Those were implemented last summer and are being carried forward.

CHAIR COPENING:
Regarding State funding on page 38, Exhibit E, that you have eliminated, have you had a chance to identify any other organizations that can pick up some of these items being dropped? Can you expand on what we will be experiencing with the elimination of these programs?

MR. WILLDEN:
The first two are tuberculosis and the sexually transmitted diseases. We work in cooperation with the counties through the health districts on those programs. The hope is the counties will be able to fund these. There is some discussion that the statutes already require the counties to provide this type of service. If the State does not fund them, the counties are still required to provide them.

There are 14 staff members out-stationed in the Clark County Child Support Enforcement Agency. Again, if the County does not fund these positions, the Clark County Child Support Enforcement Agency would be operating without these 14 full-time employees, which may have an impact on the ability to collect child support for the custodial parents.

The Temporary Assistance to Needy Families (TANF) for emergency assistance are dollars that TANF sends to Washoe and Clark Counties to support the front end of the child-welfare system. Without these, the counties would have to put in more resources to fund the front end of the child-protective services system. We used to fund these at nearly quadruple the amount you see on page 38 a few years ago. Because the caseload has grown so much, more of the federal dollars have to be earmarked for caseload growth and less can be earmarked for child-protective services or emergency assistance. This would eliminate all TANF funds going to support those services.

The Community Juvenile Justice Program is funded by block grant dollars that go to the front end to support our probation departments to keep children out of the juvenile justice system. If the counties are not able to fund these programs, then roughly $1.4 million for programs that support keeping juveniles out of correctional care will have to be eliminated.

The last two on the list, page 38, eliminate funding for county camps. There are three county camps. Clark County runs Spring Mountain Youth Camp, which is approximately a 200-bed facility. The State supports 4 percent or 5 percent of that operational cost. The other two camps are China Springs Youth Camp and Aurora Pines Girls Facility in Douglas County. The State supports about one-third of the operating cost. Those are camps to which judges send juveniles for correctional care.

The last big number on page 38, Exhibit E, is mental health room and board. This would eliminate the room and board payments. If the counties probation

departments do not pay the room and board, providers may not accept children. These are children who go to different mental health residential-treatment centers. There is a mental health payment for billed medically necessary services and a room and board payment that is billed by the Division of Child and Family Services, DHHS.

SENATOR KIECKHEFER:
What options are the judges going to have for the juveniles if there are no camps to which they can go?

MR. WILLDEN:
We have pulled approximately 150 beds from use over the last 2 years. When we are full, the children will have to remain in the community or in detention.

SENATOR LESLIE:
During the 26th Special Session and the 75th Session, we made dramatic cuts, and there were concerns that children would not have access to these providers. What have you been able to document since that time?

MR. WILLDEN:
We have not seen widespread access issues. There have been concerns that we would not be able to get anesthesiologists to see children, and we have not seen that demonstrated. I checked on that every couple of weeks to see if there was a problem. I would like to thank the provider community, as they seem to step up and do it.

SENATOR HARDY:
I talked to people today from the China Springs Youth Camp and Aurora Pines Girls Facility. They talked about the difference between probation and parole. The county is in charge of probation when children are released, and the State is in charge of parole. Does the budget take into consideration the increase in the State's commitment for the parolees? Is that in the budget somewhere?

MR. WILLDEN:
If you look on page 38, Exhibit E, near the bottom, you will find what the State presumes to be the cost for parolee services. Again, the State would continue to operate parolee services. You can find this under "County Assessment for Services." The State would continue to operate parolee services with State

employees but would bill the county for that process. The budget does not contemplate a significant increase for parolees.

CHAIR COPENING:
The next presentation is on the "Health Care Reform" handout (Exhibit F).

MR. WILLDEN:
Health Care Reform was passed by Congress and signed into law by President Obama on March 23, 2010. On page 2, you will see that Health Care Reform targets that 19 percent of Nevadans who are uninsured. The goal is to get that portion of the population insured. Many of those will get their health care coverage through expanded Medicaid. Medicaid rules will change to allow those who are below 138 percent of poverty to be eligible for Medicaid. There will be a significant Medicaid expansion. The people in the uninsured portion will apply to the Health Care Exchange and purchase their health care with or without federal subsidies.

On page 4, Exhibit F, there is a list of 29 briefing papers that we have prepared over the last 6 months. There are many significant pieces on sections of the health-care reform legislation that all need attention and work. This is available on the DHHS's Website. I will highlight a few for you. This Committee will have to deal with a major health insurance exchange legislation.

"Payments to Primary Care Physicians" is a budget issue. Establishment of the "Eligibility Engine, Eligibility Engine Evaluation and Cost Estimate" will be presented to the Senate Committee on Finance. We have a $24 million project proposed to implement the "Eligibility Engine." "Prescription Drug Rebates" is a big issue in health-care reform. The health-care reform bill has a substantial section about fraud, waste and abuse, and those are identified by "Recovery Audit Contractors." The National Correct Coding Initiative promotes correct Medicare coding in claims.

On page 6, Exhibit F, you will find the "Implementation Timeline." The best source for tracking the timeline is the Kaiser Family Foundation Website, <http://www.kff.org>. It shows the provisions that have to be implemented year by year. We have 92 provisions to work through.

On page 7 is a list of provisions for fiscal year 2010. I will highlight a couple of them. First is the "Review of Health Plan Premium Increases." This is under the

Division of Insurance, Department of Business and Industry and there is a $1 million grant from the federal government for that. The Division of Insurance is currently reviewing the health-plan premium rate increase review process. "Medicaid Drug Rebates" is being processed. The "Medicaid Coverage for Childless Adults" is an option that has not been implemented early. The "Reinsurance Program for Retiree Coverage" is something the Public Employees Benefit Program has worked on. An application for federal money can recover some of that. The DHHS opted not to run the "Pre-existing Condition Insurance Plan" in the State and deferred to the federal government. There are only 56 enrollees in the "Pre-existing Condition Insurance Plan" for Nevada. I am concerned that Nevadan's are not accessing this Pre-existing Condition Insurance Plan. The DHHS has been working on these issues for the last year. We have a working group that meets every other Thursday to identify every opportunity we can to apply for a federal grant that may help us with implementation.

On January 1, 2013, the Secretary of the U.S. Department of Health and Human Services has to inspect or review each state's efforts in implementing provisions of the Patient Protection and Affordable Care Act (Health Care Reform), specifically, the American Health Benefit Exchange (Health Insurance Exchange). If we are not making adequate progress, the federal government will take over. It is our opinion that we do not want the federal government taking over. The Governor's position is to run a Nevada exchange. The Governor opposes Health Care Reform in a couple of areas. He believes the Medicaid expansion and the individual mandate are unconstitutional. He has been clear that we are on two tracks. One is the unconstitutional "yes or no track" that the Supreme Court will eventually hear, and the other is the "plan and implement track."

On page 13, Exhibit F, you will find more detail about the Health Insurance Exchange.

CHAIR COPENING:
We will open the hearing on Senate Bill (S.B.) 44.

SENATE BILL 44: Requires the Division of Mental Health and Developmental Services of the Department of Health and Human Services to adopt certain regulations. (BDR 39-448)

HAROLD COOK, PH.D. (Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services):
I am here in support of S.B. 44. I have a prepared statement I will read (Exhibit G).

SENATOR HARDY:
Does the bill do anything besides substitute the word "consumer" for "client" in chapter 433 of the *Nevada Revised Statutes* (NRS)?

DR. COOK:
There are two things in this bill. One is to change the term "client" to "consumer." The other is to provide for regulations to define eligibility for services.

SENATOR LESLIE:
Where is that defined now? Is it in statute?

DR. COOK:
Nevada Revised Statute 433.044 reads "Client means any person who seeks, on his own or her own or another initiative, and can benefit from, care, treatment and training provided by the Division, or from treatment to competency provided by the Division." That definition is broad. In practice, we attempt to limit services only to the most severely, persistently mentally ill population. We need assistance when, over time, the criteria can change. Income criteria can change, diagnostic criteria can change and residency criteria can change. We would like to have that specified in regulations so we have something to back up our decisions either to accept or deny services.

SENATOR LESLIE:
I thought it was in statute. I have always been told that you had to be severely mentally ill in order to get treatment.

DR. COOK:
It is in policy, and it is in practice. We would like to have the backup of having it in regulation.

SENATOR LESLIE:
Can you give us an example of where you have run into trouble, or is there an institution doing it differently?

DR. COOK:
Sometimes, we have individuals who seek services through the Division of Mental Health and Developmental Services, DHHS, who have insurance and are not income eligible. Their insurance is either inadequate with respect to mental health, or they have a large co-pay. They seek services through us to avoid the co-pay. We also have individuals who are not severely, persistently mentally ill. We are not set up well for other kinds of diagnostic criteria, one being traumatic brain injury. The State needs to provide treatment, but the Division is not set up to do it.

SENATOR LESLIE:
My concern is that we not use regulations to exclude people. For example, if the Division decides veterans can access mental-health services through the Veteran's Administration (VA), and therefore, by regulation, they may not be served by the Division. Yet in practice, sometimes they may, and sometimes may not, get services through the VA, depending on the discharge.

DR. COOK:
I would like to have it on record that we would not exclude veterans from service. Recently, a case came to our attention where several veterans in rural counties were unable to access medication services through the VA. It was a simple decision to provide them with the medication.

SENATOR LESLIE:
I am not implying that you do not want to serve veterans. However, I have seen the problem where veterans are told to go to the VA.

DR. COOK:
We would not disallow people from services if they need our services and do not have access to anything else.

SENATOR WIENER:
I understand you have had communication with Mr. Bennett. He considers some language here antiquated and that references to "mentally retarded" should be changed to "developmentally delayed." Is there a reason this and other wording references to restraints were not changed? Did you review other language in the bill to see if that might be updated as well?

DR. COOK:
We did not want to address the issue of seclusion and restraints in this bill.

SENATOR WIENER:
Is that one of those provisions and practices you would want to determine in regulation rather than statute?

DR. COOK:
No. We would not be addressing seclusion and restraint in regulation. That would not be an issue for us.

SENATOR WIENER:
I have concerns about regulations specifying circumstances under which a consumer is eligible to receive and not be limited to, care, treatment and treatment to competency and training. I am concerned about how broad that might be, and that you are asking it to be done in regulation. That would take us out of the process. Why do you want to expand through regulation and not through statute?

DR. COOK:
The basic issue is that criteria for services can change fairly rapidly. Changing statute is something that can be done only every two years. We have several programs for eligibility that are based on the poverty level. If the federal poverty level ever changes and the rules change, we would have to change the statute to accommodate the change in federal regulations. We would prefer to have this in regulation so that we can make those changes quickly.

SENATOR WIENER:
State statutes stay tied to the federal poverty level. I have concerns about how broad this discretion might be in regulation.

SENATOR HARDY:
I share the same concern. What are you not allowed to do now that we would be allowing you to do? We already have some mechanism for making regulations.

DR. COOK:
I am not sure I understand the question.

SENATOR HARDY:
Some things are done by policy and are not in statute. We will not change policy to put someone in a place they would not be were it not for regulation. I am struggling with the regulation and the statute regarding the provision "not limited to," and not knowing the process for making a regulation. How do you make a regulation now?

DR. COOK:
We would propose regulations to define someone eligible for services based on income and having a mental illness that falls within the range of severe and persistent. Not everybody would benefit from that kind of definition. We want regulation that allows us to let people know our admission criteria. That would provide some basis to allow the intake staff to make a determination whether or not someone is eligible for services. It does sometimes become a tug-of-war with families or individuals who demand services when we do not think they are eligible. We have nothing in regulation that backs up our decisions. This NRS is so broad it does not allow us, by law, to exclude anybody.

SENATOR HARDY:
I was concerned about how much you were going to do by regulation. But you are interested in protecting the Division from doing too much.

DR. COOK:
That is part of it. The intent is to define the kind of services we can provide and who would be eligible to receive those services.

SENATOR WIENER:
What is the motive to determine more specifically consumers for whom you would not deliver services? This may be "budget creep" and may not be in the best interest of the consumer.

DR. COOK:
I understand that concern. Mental Health and Developmental Services is in the business of providing services. If we make a restrictive definition, we will define ourselves out of business. We have a lot of dedicated clinicians who want to provide services. We have a service system that is designed to provide services to specific types of individuals. We would like to define eligibility for services to those kinds of individuals for whom we can provide services productively.

Mental health services for the severely, persistently mentally ill is a specific type of service.

SENATOR WIENER:
What is under current law that prevents you from doing what you are seeking to do?

DR. COOK:
There is nothing in statute that allows the Division to define the eligibility for services in regulation. We are asking for a specific statute that allows us to do that.

SENATOR WIENER:
Rather than going from legislation to regulation, would there be a way to work out statutory provisions that would have staying power and continuity so you could work from that in developing your regulations?

DR. COOK:
I would be willing to work on that.

SENATOR WIENER:
Maybe there is something we can agree on that gives you flexibility in regulations and allows us to put something in statute that gives it some shape.

DR. COOK:
If I understand it, you would like something in statute that would have the boundaries or parameters within which we would be able to create regulations. I do not have a problem doing that.

SENATOR WIENER:
If it is worth doing and has the continuity of care that we would all like to provide, then it is worth doing in statute and not at the whim of those who want to make major changes every time regulations are revised.

DR. COOK:
I have no problem with that kind of provision.

BOB BENNETT, (Chair, Nevada Disability Protection Advocacy & Law Center):
I am the Chair for the Nevada's Protection and Advocacy System for Individuals with Disabilities. I have a statement I have prepared (Exhibit H) and a document entitled "Bearing Fruit, Resetting Mental Health Priorities" (Exhibit I). I am not opposed to the term "consumer" in S.B. 44. However, in this context, we would be doing a disservice by leading towards greater prejudice and discrimination to those with mental illness. The term "client" has not been one to which those of us with mental-health issues have any objection. This may be overkill to change it here. The term "mental retardation" should be changed to "developmentally disabled." The people receiving services and their parents may not feel so alienated if they did not see the label "mental retardation technician" on the badge of an assistant.

CHAIR COPENING:
We will close the hearing on S.B. 44 and open the meeting on S.B. 52.

SENATE BILL 52: Revises provisions relating to vital statistics. (BDR 40-446)

MARLA MCDADE WILLIAMS, (Deputy Administrator, Health Division, Department of Health and Human Services):
With me today is Luana Ritch who oversees the Office of Vital Records. She will be presenting the bill.

LUANA J. RITCH, PH.D. (Chief, Bureau of Health Statistics, Planning and Emergency Response, Health Division, Office of Vital Records, Department of Health and Human Services):
I have a prepared statement that you have been given (Exhibit J). Attached to it is a proposed amendment to S.B. 52 and a proposed amendment to NRS 126.061 (Exhibit K).

CHAIR COPENING:
Will you review this bill section by section?

DR. RITCH:
In most cases, the changes reflect the modernization of vital records versus what was established in 1911.

Section 1 does not change. Section 2 changes the context "... inclusive, of this act have the meanings ascribed ..." to these definitions. In section 3 "Evidence

of Life" is a term in law. This adds to existing law a definition of "Evidence of Life" that is now currently standard medical practice. Section 4 is a change to the definition of "health authority." Throughout the vital records law, you will find it says "local health officer." This adds the definition of "health authority" to reflect the way vital records are now registered in the State, which is by health authority and by local health officers.

Section 6 clarifies the definition of the "pronouncement of death" to match current medical practice. Sections 8 through 14 reestablish in statute the duties and authorities of the Office of the State Registrar. These are functions we currently perform. This is codifying the language of those functions. In sections 15, 16 and 17 we wordsmith to modernize the language and eliminate redundancy.

Section 18 defines "Live birth" to bring the language in line with current medical practice. Sections 19, 20, 21, 22 and 23 all make modifications to the language to align with the model law as shown in my statement, Exhibit J. It retains language that is unique to Nevada. In section 24, subsection 3, we are adding "Produced electronically in accordance with the regulations adopted by the Board." That is one of the first instances in this where you will see the addition of electronic records.

Sections 26 and 27 add further definition to those activities in the Office of Vital Statistics and at the local level with registrars. This clarifies the roles of the agencies. The existing law is ambiguous in many of these details. We are adding further clarification language from the model law which then gives us or the Board of Health the ability to clarify further the procedures that support these actions. A lot of this has to do with the records and the information that goes into the records and who can authorize a change to any of that information. The existing law has often forced us to require people to get court orders and pursue other legal actions to change what should be a routine or administrative process.

Sections 28 and 29 make changes either to recognize our statewide system or changes to align with the model law. You will see changes such as changing the term "local health officer" to "health authority." Section 29, subsection 2, also clarifies that we provide training programs to promote the uniform application of procedures adopted by the Board in the enforcement of this chapter.

Section 30 makes changes and modernizes the language about an informant for purposes of the records. Section 31 deals with electronic records. Sections 32 through 36 contain cleanup language such as removing the term "vital statistics" and replacing it with the term "vital records" when we refer to the actual documents. "Health officer" is replaced by "health authority" in those sections.

Section 37 changes "health officer" to "health authority." Section 38 changes the law that we have been violating for many decades about providing a book to the county health officer to record births and deaths. We would prescribe a format. We now use an electronic system and no longer provide the leather-bound books. Section 41 eliminates cities that certify births. That is no longer a practice in the State. It adds a section related to language to comply with the domestic partnership statute.

CHAIR COPENING:
Is the strikethrough in section 39 moved to a different section, or is there a reason it has been removed?

DR. RITCH:
That is a strikethrough because it is redundant. We have language clarifying timelines in each of the individual sections.

Section 41 also addresses a birth certificate that is filed more than 10 days, but less than a year, after the birth of the child. The certificate cannot be marked "Delayed." A delayed certificate is used in an instance where a child is born on a ranch or a farm in a very remote area. Sometimes the births were not brought for recording until the child started school. That is a delayed birth certificate, and there is a separate process for that. This language clarifies that if it is filed within one year, it is not marked "Delayed;" it is late for other reasons. It allows us to keep a tighter control of issuing delayed certificates, and clarifies the evidence that has to be presented.

Sections 42, 43, 44, 45, 46, 47 and 48 all deal with modernization of language and address the issue of certificates being marked "altered" or "amended." It was common practice to record a certificate as altered or amended prior to electronic records. Indicated on the back of the certificate of record would be the reasons. However, with the increased use of a birth certificate for the purposes of establishing identity, what is on that certificate is very important.

Having "altered" or "amended" on the face of the certificate can cause problems when that certificate is taken to another state or sent in for a passport or for some other use. This language is to remove those circumstances where "altered" or "amended" is marked on the birth certificate.

Section 50 deals with a birth resulting in a stillbirth. It also clarifies when that event needs to be certified, and how, and within what time frames, to certify and provide the information to the Office of Vital Records for the registration of that event. It also clarifies fetal deaths and where they occur. This is to clarify who files the certificate.

SENATOR WIENER:
Is this also model language? If not, how does it differ?

DR. RITCH:
Yes. This is all model language from the national language. Some of this is also within existing State law and is consistent with other sections.

SENATOR WIENER:
What is it that we do now?

DR. RITCH:
A fetal death that occurs in a conveyance is sometimes mistakenly referred to a medical examiner for a determination when it is not necessary. We also had situations where a hospital would maintain what occurred in the conveyance was not "attended" and therefore an "unattended death." That is how it gets into that murky situation of having to be referred to a medical examiner or coroner. This clarifies that if a fetal death occurs in a moving conveyance and the fetus is removed from the conveyance in this State, or if the place of the fetal death is unknown, the fetal death must be reported in accordance with this section. The place where the fetus was first removed from the conveyance or was found shall be considered the place of death for the purposes of filing the report of fetal death.

Section 51 adds model language concerning particulars of the death or stillbirth certificate. The language in section 52 deals with the timeliness of reporting and the timeliness in providing information for filing a record. In section 52, subparagraph 2, is something that was not caught in the bill drafting. Section 50, subsection 2, paragraph (c), states "within 5 days after the birth"

resulting in a fetal death, a report must be filed by the medical examiner or coroner. There will be a request to change that to five days after completion of the investigation. We are not opposed to that. In section 52, subsection 2, regarding an inquiry being conducted by a medical examiner or a coroner, the five days did not get changed. It kept the 48-hour requirement for a facility, under normal circumstances and when not referred to a coroner. We would not be opposed to changing that to five days as well.

SENATOR HARDY:
Would these five days be in cases not involving an investigation? Would it be a straight five days?

DR. RITCH:
The coroner is bringing forward an amendment asking that the five days start at the completion of their investigation. If they do bring that amendment, we would not object to that.

SENATOR WIENER:
Would it be worthy of amending anyway?

DR. RITCH:
Yes. We are adding this language in here to tighten up circumstances where we have physicians who will not sign the certification of death. It causes stress on the families of the deceased and can have a serious impact on disposition of property and other legal matters when a death occurs. We have added language to tighten up on physicians in the cases of attended deaths. We understand that when a case is sent to a coroner, they may not be able to determine the cause within 5 days or within 48 hours. With an affidavit, we can still allow for the transport of remains and burial without having a death certificate. However, we want to keep the pressure on physicians through this language to provide the medical certification in those cases where they do know the cause of death or where they have access to the medical records and can make that determination.

SENATOR HARDY:
If a physician attends a fetal death and then goes on vacation before the three days go by for the death certificate to be given to him to sign, is there a provision for someone else to sign it?

DR. RITCH:
Yes. There is a provision later in this statute that allows for the medical director of that facility or others that are designated to sign. The pressure here to certify the deaths particularly deals with situations we have had where physicians have refused to sign because they are reluctant to determine the cause and do not want to go through the process of determination. We have had cases where physicians refused to sign a death certificate until the family of the deceased paid a fee or had some other financial arrangement made before they signed the certificate of death.

SENATOR KIECKHEFER:
Section 52, subsection 8 refers to a body that is believed to have died in the State but cannot be located. What kind of scenario would that be?

DR. RITCH:
This situation actually happens often. These are cases of people who get lost while hiking or die in plane crashes, fires and other circumstances were the body cannot be found. This subsection deals with creating a death certificate or recording that death certificate upon the order of a court to indicate that the individual is deceased. The death certificate issued must be marked presumptive, because we have had situations where family members have filed for a court order to indicate that an individual is deceased, only to have that individual appear alive and well. This still puts it under a court order, but we can put the language "presumptive" on the certificate.

Section 53 deals with timeliness of filing and who can file a certificate. In subsection 3 is language regarding cases that are under the jurisdiction of a coroner or medical examiner. There is a requirement that a coroner or medical examiner complete and sign the medical certification "... within 5 days after taking charge of the case." We would not be opposed to changing that to state "... within 5 days after the completion of the investigation."

Section 54 adds changes of the language from "probably" to "the death was most probably." That was a change from the model law. Section 55 deals with medical certification. There is a difference between medical certification and the certification of death. The medical certification is a statement the physician provides that certifies the cause of death. The certificate itself is a document that is produced after that information is entered into our electronic system.

Section 56 is cleanup language that, in most cases, deals with the local health officer, and it inserts "coroner" where it is appropriate. Section 57 deals with the duty of the coroner and the contents of the death certificate to be provided in order to certify that death. It includes the addition that the coroner or his deputy may certify the cause of death in any case which is referred to the coroner by the health officer. This is to make it very specific that coroners can make that pronouncement of death in cases where a health officer referred a case to them.

Section 59 changes "local registrar" to "health authority." Section 60 eliminates the word "county" because of the change to the definition of health authority. Section 61 eliminates the word "local," before "health officer." Section 64 deals with the changes concerning the health authority. There is one instance where "shall be accepted" is changed to "may be accepted." This deals with regulations pertaining to the place where the death occurred and the removal and burial permits that go along with the disposition of the remains.

Section 66 clarifies that the clerk of each county reports the number of marriage licenses issued.

SENATOR HARDY:
In section 64, is it purposeful that we insert "the health officer" on line 11 and strike "local" on line 13.

DR. RITCH:
Yes. Section 2 of the bill states that the health authority is the health officer of the health district, or his or her designee, or where none, the State Health Officer or designee. In some case, we have counties that do not have health officers appointed. We also have counties where they have appointed an individual who is not a medical doctor as their health officer. The change from "health officer" to "health authority" in section 64 deals specifically with burial permitting and disposition. The statement ... "basis upon which the health officer ..." is dealing with the individual health officer. That has to do with deaths due to infectious disease.

Section 67 changes requirements for filing any birth certificate by the State Registrar from more than four years to more than one year after the time prescribed. The Board shall prescribe in detail the proofs to be submitted. This is

to assure timely submission so we can keep our records updated. There are many other agencies that rely upon our records.

Section 68, subsections 1 and 2 show changes that deal with the amended, delayed or altered certificates of birth I referred to earlier. Subsection 3 delineates the process for delayed birth certificates as I described. Section 69 deals with amended or altered certificates. Section 70 has health authority issues. It determines who can have access to records and deals with issuing a death certificate that does not include the specific cause of death except in certain instances where it is requested. This is part of the model law and an attempt to address situations where individuals may have died from a socially stigmatizing condition.

SENATOR WIENER:
Subsection 4 of section 70 states "A certificate of death must not include the specific cause of death except that the specific cause of death may be included upon the request of …." My understanding is an authorized person can request that it not be included for specific reasons. This states that it will not be included unless requested.

DR. RITCH:
Yes. The cause of death will not be included unless requested.

SENATOR WIENER:
The example is that these would be requests not to include the cause of death because of possible social stigma.

DR. RITCH:
I may have misstated that. It is a privacy protection that is in the model law and is similar to the current birth certificate process. There is a medical section on the birth certificate that is confidential and not printed on the certificate that is issued.

SENATOR WIENER:
I can understand the request that it not be placed there. What would be the scenario in which someone would want the cause of death included?

DR. RITCH:
In some cases, we have individuals who need specific causes of death on a certificate for some type of legal claim. We often have people who are the immediate family of the deceased who are submitting claims related to downwind contamination and need a death certificate that specifies the causes of death to support their claims.

Section 71 has just one change, which deals with fees for vital statistics. It changes that language from "vital statistics" to fees for "vital records." Section 72 is a deletion of language that is included elsewhere. We are deleting subsection 6 because offices of vital records would often issue an abbreviated certificate that listed basic information about the birth and families would be able to use that information for enrolling their child in school. In today's environment under federal and state law, requirements of affirmatively establishing identity render those abbreviated certificates.

Sections 73 and 74 make changes for consistent language. Sections 75 through 81 all deal with monetary penalties increasing them to what is standard today, particularly penalties dealing with violations concerning burial permits. It changes violations concerning burial permits from $250 to a civil monetary penalty not to exceed $10,000. We are making those changes to put some teeth in the law. We have had instances where people have been either fraudulently producing burial permits or where burials are taking place without a permit. This allows us recourse that would result in a proper disincentive.

The proposed amendment, Exhibit K, clarifies section 11 of S.B. 52 to apply only to individuals who were born and adopted in a foreign country, and individuals who are obtaining a translation of a birth certificate from a language other than English. The second part of the proposed amendment modernizes NRS 126.061 advancing "artificial insemination" to "assisted conception" and accounting for instances where there is a donated egg so there is gender neutrality in how those donated items are handled.

SENATOR KIHUEN:
What is the rationale behind your amendment for section 11?

DR. RITCH:
There are instances in which we deal with foreign births. One is where a child is born in a foreign country and comes into this country with parents on a

U.S. passport or Visa, and the adoption takes place in this country. We can issue a birth certificate for that child with the documentation that they are legal. In the two other cases, a child who is born in another country and the adoption finalized in that country, their citizenship is not automatically granted. When the child is brought to this country, there are other processes that have to occur to establish citizenship for the child. In the first case of a foreign birth adoption, the citizenship is recognized as though the child was born in this country. In the second case, because it may be sometime later that the child is adopted in a foreign country, the adoption is under foreign statutes and law. The second case is what we are trying to address by stating even though we can provide a birth certificate, we cannot issue it as a regular birth certificate that establishes citizenship because it is in another language. The other situation we deal with is foreign birth certificates in another language that needs an English translation. We can provide a translated birth certificate, but it clearly states that it is not establishing U.S. citizenship.

P. MICHAEL MURPHY (Coroner, Office of the Coroner/Medical Examiner, Clark County):

We find several sections of S.B. 52 are of concern. We deal with approximately 14,000 deaths a year in Clark County. Approximately 10,000 of them will require a response from our office in some form. We will bring about 3,200 to 3,800 of those cases to our office for further investigation. As written, this would double or triple our intake of cases. We work hand-in-hand with physicians, emergency rooms and others throughout Clark County and adjoining counties. We provide services to ensure that when there is a death involving a fetal demise in instances where the mother is found to be under the influence of a narcotic or where there is alcohol fetal syndrome involvement, we are notified immediately. Our attending to, and responding to, every fetal death, would increase our caseload by 20 percent to 30 percent. The physicians who initially receive these cases act as our “stopgap” to ensure that if there is a case that needs our involvement, we respond. I have spoken with Dr. Ritch regarding this.

Our concern is with section 50, subsection 2, paragraph (c). We would like language that states “pursuant to local ordinance and/or State statutes” rather than say we would respond to everything. We would like language that says a report must be filed within 5 days from the completion of the investigation. The reason is that a typical investigation into a child death may take 90 days

to 120 days by the time all of the laboratory results are received. They are some of our most complicated cases.

The last item is in section 70, subsection 4. By Clark County ordinances and by State statute, it is the responsibility of the coroner/medical examiner's offices to determine the cause of death. I understand the purpose of the statute is to have the ability to issue death certificates without the cause in place, but death certificates and cause of death are a matter of public record, and the issue has been taken to the Nevada Supreme Court. Their response was that the cause and manner of death is public record as well as the time, date and the name of the person. In Clark County, it is known as the "County Death Register." The other issues are clearly not public record. Many medical conditions that people have had, such as plastic surgery, are not public record. I can understand the need or ability for those to request death certificates issued without that information. That ability should be there, but by statute you have to place it on the death certificate.

SENATOR WIENER:
Would you include the surgery information if it was part of the manner of death?

MR. MURPHY:
The cause of death is the immediate cause of death. There may be a list of medical issues that are related to the individual that dies, but we try to hold those causes of death to the immediate cause of death. If it is a gunshot to the head, that is the cause of death. The manner of death may be homicide, but we will not speak of gunshot wound to the head and say things such as "cancer" unless it directly relates to the immediate cause of death.

GARY MILLIKEN (Southern Nevada Health District):
The Southern Nevada Health District would like to have a clarification. We have met with representatives of the Health Division in order to confirm that nothing in this bill is intended to interfere or amend the local health authority's ability to administer and operate a vital records program in their respective jurisdictions and the ability to collect fees as determined by the local jurisdiction.

REBECCA GASCA (American Civil Liberties Union of Nevada):
We are in opposition to the bill. This issue caught our attention for several reasons. The abstract concept of this, in general, relating to reproductive

freedom, is a delicate matter. We are in support of the constitutional guarantee of privacy that women and their families enjoy. We have a concern with the definition of stillbirth and the twenty-four weeks of gestation versus the definition of abortion. By changing the certificate of stillbirth to a certificate of birth resulting in stillbirth convolutes the issue, and it is not clear if it is a certificate of birth or not. Clearly, stillbirth is not a medical definition. Fetal death is the actual medical term. That is used a few times in this bill but is not defined. It is based on the model language. Some states have decided to go with that language and some states have not because of clarity. Birth certificates are legal documents and are often used for identification purposes. However, Real ID is not currently in place in Nevada. In general, we are concerned that the terminology is not consistent throughout the bill. Stillbirth and live birth are defined, but throughout the bill we see the usage of the term "birth." We have concerns with section 3 of the bill. Any time there is a phrase such as "without limitation" it opens a statute to considerable interpretation. Section 80 might already be addressed in NRS 205.465 which makes it a felony to posses, sell or transfer any documents or personal identify information. We feel that it is more prudent for the Legislature to be looking for solutions that enhance public safety instead of creating duplicate laws. The federal law also covers this as well.

Finally, we had a concern regarding the term "willfully or with intent and purpose," but Dr. Ritch said she is amenable to having that clarified.

CHAIR COPENING:
Are there specific amendments you are proposing, and will you be submitting those in writing?

MS. GASCA:
I would be more than happy to do that. I just wanted to clarify the legislative intent for these changes. Most of it is to just clarify that this is not going to affect a woman's reproductive freedom choices.

CHAIR COPENING:
We will now adjourn the Senate Committee on Health and Human Services at 6:53 p.m.

RESPECTFULLY SUBMITTED:

Shauna Kirk,
Committee Secretary

APPROVED BY:

Senator Allison Copening, Chair

DATE:

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 8, 2011 Time of Meeting: 3:34 p.m.

Bill	Exhibit	Witness / Agency	Description
	A	Agenda	Agenda
	B	Attendance Roster	Attendance Roster
	C	Chair Copening	Senate Committee on Health and Human Services Rules for the 2011 Session
	D	Marsheilah Lyons	Committee Brief Senate Committee on Health and Human Services 2011 Legislative Session
	E	Michael J. Willden	Presentation to the Senate Committee on Health & Human Services, Department Overview & Health Care Reform
	F	Michael J. Willden	Health Care Reform
S.B. 44	G	Dr. Harold Cook	Prepared statement
S.B. 44	H	Bob Bennett	Prepared statement
S.B. 44	I	Bob Bennett	Bearing Fruit, Resetting Mental Health Priorities
S.B. 52	J	Dr. Luana Ritch	Prepared statement
S.B. 52	K	Dr. Luana Ritch	Proposed amendment to S.B. 52