MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-sixth Session
February 10, 2011

The Senate Committee on Health and Human Services was called to order by Chair Allison Copening at 3:30 p.m. on Thursday, February 10, 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 Ben Kieckhefer
Senator Greg Brower

COMMITTEE MEMBERS ABSENT:

Senator Joseph (Joe) P. Hardy (Excused)

STAFF MEMBERS PRESENT:

Risa Lang, Counsel
Marsheilah Lyons, Policy Analyst
Sherry Loncar, Committee Manager
Annette Ramirez, Committee Secretary

OTHERS PRESENT:

Kathleen Silver, Chief Executive Officer, University Medical Center
Gregg Fusto, R.N., Director of Trauma and Burn Services, University Medical Center
John R. Gosche, M.D., Ph.D., Chief, Division of Pediatric Surgery, Professor of Surgery, University of Nevada School of Medicine
Jay E. Coates Jr., D.O., Assistant Professor of Surgery, University of Nevada School of Medicine; Program Director, Trauma and Critical Care

Fellowship, Las Vegas; Vice Chairman, Trauma Department, University Medical Center; Director, Visiting Resident Program
Luana J. Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning and Emergency Response, Cancer Registry, Office of Vital Records, Department of Health and Human Services
John Pappageorge, Health Services Coalition
James L. Wadhams, Attorney, Nevada Hospital Association
George A. Ross, Hospital Corporation of America, Inc.; Sunrise Hospital & Medical Center
Dan Musgrove, Valley Health System
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Renny Ashleman, Nevada Health Care Association
Charles Perry, President, Chief Legislative Liaison, Nevada Health Care Association

CHAIR COPENING:
We will open the hearing with Senate Bill (S.B.) 10.

SENATE BILL 10: Requires approval for the establishment of certain services by a health facility in larger counties. (BDR 40-344)

KATHLEEN SILVER (Chief Executive Officer, University Medical Center):
I will speak about a demand analysis process for Clark County, specifically, trauma, burn, transplant, neonatal intensive care and open-heart programs. Some discussion will center around what happens with outcome and care when programs proliferate with little or no planning. We are not suggesting any currently existing programs would be changed in any way.

I have given everyone a copy of slides on your computers (Exhibit C). The first slide shows that 1,468 open-heart cases were done in the Valley for 2004, and we had 6 programs. In 2010, there was a total of 1,095 open-heart cases, and we had 9 programs. This is an inverse indicator of the need for additional programs. Volume is decreasing for a couple of reasons. Technology has changed, and there are more things interventional cardiologists can do that reduce the need for certain open-heart cases. Here is a situation where volumes are declining overall for everybody, and there does not seem to be anything to change that. The next slide shows the number of open-heart cases on average by facility using the same time frame, 2004 to 2010. In 2004, the average

number of cases per facility was 244, and in 2010, the average number of cases was just under 122. The trend line in the middle of the graph shows the requirement by the State for an open-heart program to do a minimum of 200 cases. Currently only one hospital in southern Nevada is doing over 200 cases.

GREGG FUSTO, R.N. (Director, Trauma and Burn Services, University Medical Center):
University Medical Center (UMC) has been in the trauma business for more than 20 years, and over that time we have gone from a level-three to a level-two trauma center. In 1998, we became a level-one trauma center, which is the highest level, and we are the only external validated level-one trauma center in Nevada. About six years ago, our pediatric center became a level-two trauma center, and it has been flourishing.

Now we will go through some of the slides (Exhibit D). The first one is "Clark County School District Enrollment History," reflecting the consistent trend upward of pediatric patients in the Valley. The second slide illustrates that UMC had a 58 percent decrease in total pediatric patients as new pediatric receiving centers came on board. The American College of Surgeons requirement for a level-two pediatric trauma center is 100 pediatric patients per year, and last year we had 119. If this rate continues, we will not be able to maintain our certification. Next, you can see UMC pediatric transfers have decreased by 52 percent. We have a "Pediatric Trauma Field Triage Criteria." This is the total number of pediatric patients in the Valley. This has gone down to 40 percent. If the trend continues and other services come, we will have to tell the people of Las Vegas there is no level-two pediatric trauma center.

JOHN R. GOSCHE, M.D., PH.D. (Chief, Division of Pediatric Surgery, Professor of Surgery, University of Nevada School of Medicine):
I came to UMC about four years ago. We are the only pediatric surgeons in the city that will take care of injured children. I am concerned about two things. We are about to get to the point where we can no longer be a verified center. When that happens, one of the few recognized pediatric trauma centers is going to disappear. There are 23 in the Nation, and we are the only one in the State. The other concern I have is that I am a surgical educator, and we train physicians and surgeons who can take care of the patients in the future. The problem is we are getting to the point where we do not have enough patients in these centers to train the future physicians adequately for our State. Many of the people we

train stay in the State and actually take care of our patients and our population. As we lose these patients to other centers, we are in serious danger of losing a real resource for the State. Our concern is if we do not do something to stop the expansion of services, this will be a big negative.

JAY E. COATES JR., D.O. (Assistant Professor of Surgery, University of Nevada School of Medicine; Program Director, Trauma and Critical Care Fellowship, Las Vegas; Vice Chairman, Trauma Department, University Medical Center; Director, Visiting Resident Program):
I would like to direct you to the last slide of your packet "Ex Laps Directly to OR," Exhibit D. This refers to patients who have come to our trauma center and people who have needed some sort of emergency abdominal operation. You can see from our high point in 2004 we have had a steady decline in the number of patients each year. The American Council for Graduate Medical Education sets a standard of how many cases residents should see in a given year for their training. For a chief resident, this is a minimum of 30 cases. I have four chief residents and two fellows whose requirements are about 50 percent above that. Somewhere between 200 to 250 cases are what I need in order to keep training these physicians. I have been involved in the program for ten years, and every year, at least one of our graduates has stayed to practice in either Las Vegas or somewhere else in Nevada. If these numbers continue to decline because of multiple services coming to the city, we are in danger of losing our certification and our ability to continue training the physicians that would stay in Nevada.

MS. SILVER:
An item I would like physicians to address is that the centers doing a lot of volume become centers of excellence. They have better outcome, better care delivery and more financial sustainability. Our effort is not to reverse what is in place now, but to put an orderly process in place going forward. We need to consider the impact to the existing programs before new programs are added.

DR. COATES JR.:
There is absolutely no question there is a strong correlation between volume and outcome. The centers that perform certain complicated medical procedures have a much better outcome. It really comes down to a simple question you could ask yourself. If you need a complicated medical procedure, would you want to go into a hospital that does one every-other week or one that does two or three per day? It is like anything else. Practice makes perfect. High-volume facilities see many more complications and many more variations. They are able

to take care of their patients and ultimately have better outcomes than facilities that only see a few patients in these certain subspecialties.

CHAIR COPENING:
Ms. Silver, could you please walk us through S.B. 10, section 1, subsection 2?

MS. SILVER:
The main changes to S.B. 10 happen in section 1, subsection 2. This language is directed at the counties with populations of over 400,000, particularly Clark County. The bill states there should be an evaluation done before any new programs are undertaken. It specifically does not allow the establishment of centers for the treatment of trauma, the transplant of organs, treatment of burns, performance of open-heart surgery and intensive care of newborn babies without first applying for and obtaining the written approval of the director of the Department of Health and Human Services. It further states that the Department shall not issue a new license or alter an existing license for such a service unless the director has issued such an approval.

On page 2, lines 32 and 33 of the bill, there is a modest change where we are adding "... or a service offered by a health care facility; ... ". This is built into a bill that currently applies to the rural counties. In the rural counties, it is directed towards facility expansion and construction, and there is a dollar amount attached to it. Ours in Clark County is purely programmatic and not designed to modify anything that is being constructed.

There are numerous references to service added on page 3 of S.B. 10.

SENATOR KIECKHEFER:
Section 1, subsection 2, paragraph (e) says "... The Health Division of the Department shall not issue a new license or alter an existing license for such a service unless the Director has issued such an approval." One issue I have is that the Health Division provides regulatory function over quality of care. If they find terrible quality of care violations, this could restrict them from being able to close a facility or take an action against that license for violations of quality of care they approve through the Bureau of Health Care Quality and Compliance right now.

MS. SILVER:
Do you feel the language does that by the way it is written?

SENATOR KIECKHEFER:
The Health Division does that, and it says you cannot alter their license, but they take actions on licenses all the time through regulatory purview.

MS. SILVER:
Perhaps we could modify the language so that it refers specifically to alter the license of a particular program.

SENATOR KIECKHEFER:
I understand what you are trying to do. I am just concerned the language would restrict their ability to take action against a facility performing poorly.

MS. SILVER:
Absolutely. We would not want to create that situation.

SENATOR KIECKHEFER:
I am also concerned about the criteria upon which the director shall make a decision whether or not this is appropriate. It seems very broad. Section 1, subsection 4, paragraph (b) cites the need for and the appropriateness of the project, financial feasibility and the effect of the project or service on the cost of health care. Is that an inappropriate level of criteria? It basically puts it totally at the discretion of a single person without any real guidelines. I am concerned about that.

MS. SILVER:
We would want to develop guidelines that would be used to assist the director in making such an assessment and perhaps would call upon the Nevada Hospital Association or an entity of that type to help develop that criteria. I think we could establish certain levels to work collaboratively with the Health Division to make that happen.

CHAIR COPENING:
I have a couple of questions on section 1, subsection 2 where you list the particular services. How did you arrive at these particular services where you require the Certificate of Need (CON)?

MS. SILVER:
There are a couple of reasons for selecting those services. In every instance, volume is required to ensure the program has good outcomes and is actually a quality program. Every one of these services relies on having the number of cases adequate to use in the practice of this particular area. The second part is the certification or external validation for the programs being tied to a certain volume. That is the reason for selecting these types of programs. Centers of excellence for kidney transplant must perform 50 transplants per year. In almost every case, the criteria are tied to a certain threshold for volume. That is why we chose these particular programs. These programs are also very resource intensive. They are expensive to operate, and you need to have the business to sustain them financially.

CHAIR COPENING:
Would that also hold true for your graph with the open-heart cases by the hospital which shows the *Nevada Administrative Code* requiring no fewer than 200 operations per 12 month period?

MS. SILVER:
Yes.

SENATOR WIENER:
Would we anticipate at some time in the future that you would be coming back to add to the list?

MS. SILVER:
There is nothing we would need to add now. Just to be very clear, this is not intended to close any existing programs.

SENATOR WIENER:
Should we look at this graph at centers that go above that required line? I am looking at open-heart cases, and only one is meeting the standard. Are you talking about this being something we look at prospectively with future hospital facilities opening up or future programs being brought into facilities? This could discourage it among existing hospitals.

MS. SILVER:
In that particular example, the State is not enforcing that criteria. This is a prospective approach to put an orderly process in place on a go-forward basis and not affect hospitals that are now providing the service.

SENATOR WIENER:
Is it possible the director could say the facilities are not performing, and services would not be approved because they are not delivering?

MS. SILVER:
The director actually has that authority now.

SENATOR WIENER:
Would this make the legislative intent a little stronger?

MS. SILVER:
We are not saying programs could not be added. We are saying programs would need to have an assessment or show a demand to be added. If this type of legislation is put in place, would it create a need for the director to require an assessment of existing programs? That is not our intent.

SENATOR WIENER:
Not all programs can sustain based on the demand according to all of the charts. And even though we are talking about being prospective, it is going to reshape the market based on legislative language you have given us.

MS. SILVER:
The economics of having programs that do not have a lot of volume would create a different situation as well. That has not happened in the southern Nevada market up to this point. I do not know if having this in a prospective manner would change the current market dynamic.

SENATOR BROWER:
You have said the intent is not to close existing facilities that are operating in these areas. What about existing facilities that want to expand or enhance services or otherwise invest? Is it the intent of the legislation to prohibit that or to require the director's approval?

MS. SILVER:
It would require a process that would be determined by the director to assess what level of demand exists either for that program to be expanded or for another program to be added.

SENATOR BROWER:
Would that apply even for an existing operation that simply wants to expand, enhance or invest?

MS. SILVER:
Let us make sure we are talking about the same thing. For example, a hospital now doing open-heart surgery and wanting to do open-heart surgery in the future would need to go through this process. If a hospital with an open-heart program wanted to expand its open-heart program—for example, they wanted to do ventricular assisted devices—that would not be affected by this legislation. We would not expect that because of this legislation.

CHAIR COPENING:
We might want to consider coming back with some clarifying language.

DR. COATES JR.:
I would like to make clear that the spirit of this is about health care provided to individuals in Clark County and Las Vegas. As we have demonstrated, there are thresholds set by national and international committees to say how many cases need to be done in a year for a center to be proficient. Medicine is not a typical economic commodity, and it is not like selling shoes or making hamburgers.

If you look at the history of regions, states and communities with CONs that have expired, more centers have begun offering services. This ends up driving up the price of medical costs. These are labor- and resource-intensive commodities and services we are offering. In a city like Las Vegas, there are only a certain number of trained nurses, respiratory technicians, etc. As more centers offer these services, you have a smaller pool to draw on to support them. This drives up the demand and price paid for those services. In the mid-1990s, Pennsylvania had CON legislation that expired, and they noticed over the next eight- to ten-year period the number of hospitals in the state performing open-heart surgery almost doubled from 35 to 62. The number of actual open-heart surgeries done in that state did not change. More centers

performed fewer surgeries, and what was significant was that there was a trend towards worse outcomes.

LUANA J. RITCH, PH.D. (Chief, Bureau of Health Statistics, Planning and Emergency Response, Cancer Registry, Office of Vital Records, Department of Health and Human Services):
I am presenting information about the Health Division's fiscal note on S.B. 10. The bill requires the establishment of a CON in Clark County. Nevada has not had a CON requirement for Clark County or Washoe County for many years. The bill presents the requirements for analysis of financial need, financial feasibility, analysis of need in the community and effects on the cost of health care of these services. The Health Division was not consulted on this bill, so the information we have in our fiscal note is based upon our read of intent and our attempt to try to put a cost to this. See my written testimony (Exhibit E). I would be happy to answer any questions the Committee may have.

SENATOR KIECKHEFER:
It is your job to administer CON in the rural counties, and there is probably not a lot of that going on. Are there criteria established in regulation now? Would you envision those same criteria being drafted through regulation, or would it be left to discretion?

DR. RITCH:
The requirements and the director's regulations focus on the rural counties, specifically on new construction. It is based on how expensive that construction may be. For example, one of our most recent CON applications was for an ambulatory surgical center in Fallon. The application was brought forward by the group proposing the surgical center and the hospital in Fallon. The process to examine the application was very simple; there were no other ambulatory surgical centers in Fallon, the hospital demonstrated a need to have additional surgical capacity in the community based on the transit times to Washoe County or Carson City. The thresholds were very clear as the project did exceed the $2 million threshold and there was financial feasibility for the project.

It is very clear in both statute and regulation that the present CON program is very narrow in its scope, and it is very narrowly applied. We have not had any new CON applications in four years. We believe this is because of the economy in rural Nevada and also because of population needs. To evaluate the complex services this bill proposes would require an extensive analysis by staff having

that skill set and individuals who have the ability and knowledge to assess medical need in the community and financial feasibility. Other factors also may come into play in a CON approval. This would require us to have full-time staff to do this. It is possible that the workload could be contracted on an "as-needed" basis, and perhaps we could pursue a Request for Proposal (RFP). We would have to rebuild an infrastructure to be able to complete these analyses which are much more in-depth than necessary to determine whether or not a small community needs a hospital.

SENATOR KIECKHEFER:
In terms of the extensiveness of the process, how long would you envision something like that taking if someone does want to come in and invest? How much of a time barrier would this create?

DR. RITCH:
We do not have an idea on that. Our current CON program takes about six months and sometimes longer. The current process requires we do an analysis and hold hearings in the community to obtain input for providing information to the director for making a decision on whether or not he should approve the CON. There are times when investors proposing a facility will come back with changes. We analyze the changes to decide if they need an amendment to their CON letter permitting them to make those changes. I have seen very complex proposals take at least six months, if not longer, and I have seen smaller ones take less time. It can depend on a multitude of issues and can be a lengthy process.

SENATOR WIENER:
Dr. Ritch, you had mentioned earlier in a testimony it has been about 20 years since we have had this program in place. In going back that 20 years, were we then doing it also in urban centers?

DR. RITCH:
We would have to do some research to find out how long it has been since the CON program was applied for in those two most populous counties. It could be much longer than that.

SENATOR WIENER:
Madam Chair, could Dr. Ritch work with staff to provide that? It would be nice to know the history and why we stopped doing it.

CHAIR COPENING:
Certainly, that would be fine.

Because of our economic situation, it seems costly that you would have to hire two full-time people to implement this program. Should this bill pass, it could create a deterrent for others to come in. It seems there is a lot of data about the need that already exists, and perhaps that part is not necessarily that time consumptive. Would you mind coming back and presenting some information about what it would cost if you had to contract these out and how many of these requests might come in? In a situation where numbers are so important to us in this Legislative Session, it would be helpful to have a more accurate accounting.

DR. RITCH:
We could look at some options. The fiscal note we submitted was based upon our experience with the CON in rural Nevada, as to the length of time and the administrative support. Our workforce could not absorb that, even if we only had one per year. We based these projections on four per year, and it does include revenue from a fee for covering expenses that already exists in regulation.

SENATOR WIENER:
What we need is information. This is more compounded than that because we have many hospitals providing many programs. How do you base this on four? I am seeing a bigger multiplier than that, and I would like to know what might be in front of us.

DR. RITCH:
We based it on four per year using experience with rural counties prior to the economic downturn that stopped a lot of projects. We looked at the volume we were getting over a period of time and with growth in those communities. We tried to estimate given the fact that the health-care system in Clark County has evolved in the past many decades. We were very conservative in our estimate.

SENATOR WIENER:
If one of these hospitals came to the director and wanted to expand its service and their volume is uncertain, would this be a consideration? Does that mean that since it is building on a service it already has, we may not need that expanded service?

DR. RITCH:
The CON program is a process to do just that. Part of the analysis in states that have CON is assessing volume, economy of scale and cost. Research is mixed on cost as to whether CON programs result in a health-care savings. The process we have for an application to expand is to apply for the letter of intent which gives us their basic outline. We review their proposal and inform them if it requires the full CON process. If it does require the full CON process, we require they submit many documents including their analysis, financial plan, and statement of need. We would analyze the data. Those are the processes we would put into place and put into the regulations.

SENATOR WIENER:
I have mixed feelings on this subject. I understand the merit of building something very strong so we get accreditation, certification, recognition and the ability to have the volume to produce the outcomes we are looking for. My concern is that if something happens and we only have one facility. I understand the argument for building a magnificent operation, and I want to see that. I also want to know we have access in other facilities as well. I am concerned that we become mega and there may be unintended consequences for only having one facility providing these major services.

CHAIR COPENING:
I want to have it entered into the record that we have received written testimony from Bobbette Bond, Director of Public Policy, Culinary Health Fund, in support of S.B. 10 (Exhibit F).

JOHN PAPPAGEORGE (Health Services Coalition):
I am submitting written testimony (Exhibit G). We mirror UMC's thoughts that the cost could become overwhelming in health care, and if we keep creating more trauma centers, more open-heart surgery centers and what is listed in section 2 of S.B. 10, the cost has to accelerate. There should be some method to control this, and I think a CON is a good way to do that.

JAMES L. WADHAMS, ATTORNEY (Nevada Hospital Association):
We have submitted a formal position paper (Exhibit H) which is helpful as a beginning for the questions being asked by several Committee members: did we do this before? why are we not doing it now? how did it work when we did it? Just to summarize, it was abandoned because it became very expensive. It can

go to the courts when someone who was denied certification wants to challenge the administrative process.

Our opposition to CON is not at all an expression of a lack of sympathy for the problems expressed by UMC. That is a serious issue needing to be addressed. The Nevada Hospital Association (NHA) is in the process of reevaluating the discussion points raised by UMC, and we will keep the committee apprised. Let me be very specific about the bill itself. Should this bill be processed as CON, it would need significant work. Senator Kieckhefer identified an excellent point needing clarification. Another one that was troublesome as I read this bill is, "... No person may undertake any proposed expenditure for the establishment of any of the following services ... ." This is going to sound trivial, but it says, "... for the treatment of burns ... ." This is something with which we will have to deal. The intention of this is to include certified, recognized, acknowledged burn centers. This language is far too broad. It could literally affect somebody taking a Boy Scout troop camping and receiving burn treatment medication for a Scout who fell into the campfire. That is clearly not what is intended. Another problem is with the language in section 3 that says "The provisions of subsections 1 and 2 do not apply to: ... a service offered by a health facility ... ." At least hospitals are clearly health facilities. There are others, so it arguably does not apply to hospitals. There are significant financial and policy issues raised by UMC, and NHA is fully in support of working with UMC to see that those are addressed.

SENATOR WIENER:
I am very sympathetic toward the challenges that UMC faces. Do you have something in mind that may be helpful?

MR. WADHAMS:
This is something that our chief executive officers and administrators need to discuss. As an example of an alternative, part of the issue may be the emergency service transportation protocol. Our population has not stopped growing, and, as all of us know, our retirees are still a growing portion of our population. When the economy rebounds, our service industry will rebound, and some diversification will occur. The NHA is meeting with UMC and the rest of its members to try to develop alternative ways of approaching this problem.

GEORGE A. ROSS (Hospital Corporation of America, Inc.; Sunrise Hospital & Medical Center):
Sunrise Hospital is also a large inner-city hospital in Las Vegas, and we sympathize with the problems UMC has. I want to thank UMC for going on record as saying they do not intend that this bill in any way inhibit or require a CON for the expansion, enhancement or investment of existing operations on these five services in health facilities. Our lawyers are concerned the bill as drafted does not make that clear. I want to express my willingness and desire to work with the Committee to develop some language making that clear.

CHAIR COPENING:
If parties can come together to resolve and bring forward amendments, it is better for us. Please continue to work together and see what we can come up with.

DAN MUSGROVE (Valley Health System):
I would like to point out Clark County Health District actually has a trauma designation protocol, and they still decided it made sense to add another trauma center. It was only 1 1/2 miles away, but there was a process, and a lot of factors went into it. When we talk about competition, we do not want to prevent new qualitative care to come in. Would a Cleveland Clinic come to town because they want to do the exact same things as our hospitals, but maybe could do it better? Let the market determine who does it better. That is what competition is all about. We want the quality to improve in our community, and I am not sure that is identifiable when you look at a CON process. That is why 20 years ago, we made a decision as a state to go in a different direction. I have asked to see if I can come up with some information for the Committee's review.

SENATOR LESLIE:
Have the hospitals in Las Vegas talked to UMC about the issues they have raised today? I hear what you are saying about the CON and I have heard these bills many times. I do not think this bill does what we need it to do; however, they raised some very important issues today and we do not want to lose that important resource. I would encourage you to talk to each other and see what you can come up with. It will be terrible for Las Vegas if we lose that trauma center and a lot of those resources.

MR. MUSGROVE:
It is an absolute necessity in our community to have a safety-net hospital. I agree we do not want volume to affect their designations and their ability to keep those standards, and maybe there is a way through the emergency transport protocols. I think this is an issue that needs to be worked out at a local level, and I volunteer my system to be a part of any talks.

SENATOR LESLIE:
I would be interested in any solutions. Maybe it is not a legislative solution, but clearly something needs to happen.

CHAIR COPENING:
We will close the hearing on S.B. 10 and open the hearing on S.B. 54.

SENATE BILL 54: Revises provisions governing the Fund to Increase the Quality of Nursing Care. (BDR 38-444)

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
This is an executive bill that seeks to lower reimbursements paid to skilled nursing facilities. We do not relish the opportunity to be here to talk about reimbursements to providers that serve Medicaid clients. We have numerous rate reductions being proposed that affect thousands of providers. This affects approximately 40 facilities throughout Nevada, and we understand there are concerns with it. I am here to talk about some of the changes we are proposing through this bill. To simplify my testimony, I would like to go through the two changes we are seeking in this bill (Exhibit I). This language precludes us from complying with federal requirements. Federal requirements may require a different methodology rather than us just reverting to 2003 reimbursement levels. The reason this has become an issue now is that there is a significant amount of litigation in the Ninth Federal Judicial Circuit about how states set Medicaid rates. Deletion of this language will allow us to comply with the provisions of the federal law.

CHAIR COPENING:
Can you explain how you are arriving at the revenue of $10,176,433? What are the actual dollar losses to these facilities?

MR. DUARTE:
The savings were calculated based on a reduction in the State General Fund portion of reimbursements paid to skilled nursing facilities. We call this the "base rate." The base rate is the portion of payments to these facilities that use the State General Fund as well as county matching funds to match federal dollars. There are other components of the rate. An enhancement is provided through the Nevada Medicaid State Plan through taxes levied against facilities. We use those tax revenues to match federal funds and reimburse facilities. We are not seeking to reduce that portion of the bill. We are seeking to reduce by approximately $20 per day the General Fund portion, where general funds and county matching funds are used to "match" for federal money. The current base rate is approximately $122 per day. The changes we are proposing in the Governor's recommendation of this portion of the *Executive Budget* would reduce the base rate to approximately $100 per day. Total reimbursement to the facilities would be reduced from approximately $183 per day to $163 per day.

CHAIR COPENING:
Will you repeat the numbers? You said the reduction to the reimbursement base rate to facilities was $20 per day, $120 is the current base rate per day and it is going to go down to $100 per day. What is the difference between $183 to $163 versus the $120 to $100?

MR. DUARTE:
There are two components to the reimbursements we pay to nursing facilities, and they are funded differently. One component we call the base rate is $122 per day on an average. General Funds are used as federal match for that payment, and we are looking to reduce that portion. There is an enhancement that is paid on top of the base rate and the match for that is funded by the facilities themselves through a provider tax program. We are not looking to reduce that portion through the enactment of this bill. It is really the State General Fund portion we are looking to reduce.

SENATOR KIECKHEFER:
Does a $20 General Fund reduction leverage up through a Medicaid match to a higher payment for the facility?

MR. DUARTE:
The $20 is total payment reduction.

RENNY ASHLEMAN (Nevada Health Care Association):
If the reductions do not go through in the money committees, this bill may not be necessary. I want to emphasize we are saying "may not," because we have not yet met with the division on the numbers, policy or wording of the bill. Of course we intend to do so. It is possible if the changes did not go through, some of this change in language may be needed. There may be better language. We are opposed to the reduction in reimbursement. The State put together a methodology of reimbursing us in 2001 and has never met the burden of that methodology. We have never been paid the amount of money Nevada said we should be paid, even with the enhancements of the provider tax. In 2003, we put a provider tax through to try to help the State at least partially meet the needed funding.

The understanding we had was, that what is in law today would be followed, and we would not suddenly discover we had been taxed in general to no benefit. To some degree, that will be happening to us if the budget changes envisioned here go through. In effect, we will be paying an unanticipated tax we probably would not agree with. I am not so naïve as to think that in Nevada's current budget crises this is not going to be on the table. I understand their need to reach out to various places. Our problem with doing that is it saves the State $10 million and by our calculations will cost the industry $30 million. We are not done with those calculations. When we have them, we will meet with the division to reconcile to the extent possible any differences in methodology on these numbers and conclusions. Then we will be sharing that with this Committee as well as with the budget committees. A consequence of the change is that five of our facilities have notified us they will be required to close if this goes through. This may to some degree cause a backup of discharges from hospitals. Since it costs more in general to keep patients in hospitals than it does to put them in our locations, the State will not realize the anticipated savings to the degree they think they will. The Ninth Circuit Court and Nevada may find they have potential legal problems with this, and it may not be possible to do it anyway.

CHAIR COPENING:
I would like to have Risa Lang, Committee Counsel, look into any legal ramifications that could possibly come from that.

CHARLES PERRY (President, Chief Legislative Liaison, Nevada Health Care Association):
Rather than come before committees and start talking about facilities closing, I wanted to get some hard data. I have letters from all of the applicable corporate entities operating in Nevada. If all of the proposed cuts, changes, reductions and the revenue happen, we will lose at least five facilities. Every one of the other facilities has indicated they will either altogether decertify their beds and get out of the Medicaid Program or they will severely limit their participation in the Medicaid Program. Closing five facilities will lay off at least 750 to 800 employees. Everyone says they are interested in access to care. If you want to look at access to care, then look what happens when facilities refuse to accept a Medicaid resident. When you do not have a pay source following your Medicaid coverage, you are in a pending status waiting for a Medicaid application to be processed. Then facilities are not going to take patients, and you are going to have people backed up in the hospitals.

SENATOR KIECKHEFER:
Medicaid is currently paying you a total average rate of $183 per day and proposing to reduce it to $163 on average. What is the average rate of a person who has private long-term care insurance?

MR. PERRY:
It is pretty much the same because the rates are based on acuity. I do not know exactly what facilities, private pay rates are. That is a matter of policy within the facilities. I can guarantee you they are not less than that.

SENATOR WIENER:
What would be the statewide Medicaid population in these beds?

MR. PERRY:
The average Medicaid populations statewide are in the neighborhood of 70 percent.

MR. DUARTE:
I have some statistics that refer to the numbers Mr. Perry is discussing. We only count Medicaid eligibles and not pending Medicaid, as a part of our census, and currently our census is exactly 60 percent of licensed beds.

MR. PERRY:
The private pay residents in skilled nursing facilities in Nevada pay the provider tax just like the Medicaid patient does.

MR. ASHLEMAN:
In representing some of these institutions as an individual attorney, I had access to the records of their private pay charges. For the ones I am familiar with, the private pay is substantially higher.

CHAIR COPENING:
I close the hearing on S.B. 54. There being no further business to come before the Senate Committee on Health and Human Services, the meeting is adjourned at 5:03 p.m.

RESPECTFULLY SUBMITTED:

Annette Ramirez,
Committee Secretary

APPROVED BY:

Senator Allison Copening, Chair

DATE:

EXHIBITS

Committee Name: Committee on Health and Human Services
Date: February 10, 2011 Time of Meeting: 3:30 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B.10	C	Kathy Silver	Open-Heart Cases by Hospital
S.B.10	D	Gregg Fusto, R.N.	Clark County School District Enrollment History
S.B.10	E	Luana Ritch	Written testimony.
S.B.10	F	Bobbette Bond	Written testimony
S.B.10	G	John Pappageorge	Written testimony
S.B.10	H	James Wadhams	Hospital Certificate of Need: Rural Necessity, Urban Expense
S.B.54	I	Charles Duarte	Written testimony