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

Seventy-Seventh Session
February 11, 2013

The Committee on Health and Human Services was called to order by Chair Marilyn Dondero Loop at 1:33 p.m. on Monday, February 11, 2013, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at nelis.leg.state.nv.us/77th2013. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Marilyn Dondero Loop, Chair
Assemblywoman Ellen B. Spiegel, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Wesley Duncan
Assemblyman Andy Eisen
Assemblywoman Michele Fiore
Assemblyman John Hambrick
Assemblyman Pat Hickey
Assemblyman Joseph M. Hogan
Assemblyman Andrew Martin
Assemblyman James Oscarson
Assemblywoman Peggy Pierce
Assemblyman Michael Sprinkle

COMMITTEE MEMBERS ABSENT:

Assemblyman Steven Brooks (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kirsten Bugenig, Committee Policy Analyst
Risa Lang, Committee Counsel
Terry Horgan, Committee Secretary
Macy Young, Committee Assistant

OTHERS PRESENT:

Elizabeth Aiello, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Misty Vaughan Allen, Suicide Prevention Coordinator, Office of Suicide Prevention, Department of Health and Human Services
Michael J. Willden, Director, Department of Health and Human Services
Amber L. Howell, Administrator, Division of Child and Family Services, Department of Health and Human Services
Alex Ortiz, representing Clark County
Michael Murphy, Coroner, Clark County

Chair Dondero Loop:
[Roll was called. Committee rules and protocol were explained.] I appreciate everyone's participation in our first meeting. The topic of health and human services can be complex, so I encourage all of you to ask questions throughout the session. We will now begin with our presentation of an overview of Nevada Medicaid.

Elizabeth Aiello, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
I am going to give you a presentation we are calling Medicaid 101 (Exhibit C). We will be talking about both Medicaid and Nevada Check Up. If you will refer to page 2 of my handout (Exhibit C):

> There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable tests within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

That quote is from a judge during a court case in 1994. I assure you that the situation continues. Since 2005, huge legislative actions in Congress have affected Medicaid—the Deficit Reduction Act of 2005; the American Recovery and Reinvestment Act of 2009, called the Stimulus Fund Act; the Children's Health Insurance Reauthorization Act, or CHIPRA, in 2009; and of course, the 2010 Patient Protection and Affordable Care Act, or health care reform. This is quite a difficult topic and we are just skimming the surface today, but I hope we can help you understand.

If you have seen one Medicaid program, you have seen one Medicaid program, because a person eligible in one state may not be eligible in another state. Services provided in one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. State legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.

People moving here from other states may become upset because our program is not exactly the same as the one they were used to. Starting with the stimulus funds from the American Recovery and Reinvestment Act, there is maintenance of eligibility, which does affect some of the flexibility we used to have concerning eligibility changes.

Many people say that Medicaid is a government-run health care program, but that is not correct. Medicaid is publicly financed, but it is not a government-run health care delivery system. Medicaid procures almost all our services in the private health care market through purchasing services on a fee-for-service basis. That means we enroll private physicians, hospitals, public entities, and others that meet the qualifications and want to be Medicaid providers. We pay for services through them or by paying premiums to contracted managed care organizations.

Page 5 (Exhibit C) contains facts from the Kaiser Family Foundation. [Ms. Aiello read from the page.] These facts demonstrate what a huge role Medicaid plays in the national system.

Chair Dondero Loop:
It is my understanding that about half of all births in Nevada are financed by Medicaid.

Elizabeth Aiello:
I think it is pretty close. I will get that exact number for you.

Turning to page 6 (Exhibit C), though the total cost for Medicaid programs increased rapidly during this economic downturn, this period demonstrated that Medicaid programs do control costs.

While Medicaid spending for medical services increased more than the medical care consumer price index, growth in Medicaid per-enrollee spending increased more slowly than medical care inflation, national health expenditures per capita and growth in private health insurance premiums.

The preceding reference is from the report by the Kaiser Commission on Medicaid and the Uninsured. Medicaid does work very hard to manage its costs while providing quality services.

Though Medicaid is thought of as a safety net that provides care for the neediest, it is a difficult task because current financing for the Medicaid system does not adequately account for the counter-cyclical nature of the program. In other words, when economic downturns occur, Medicaid enrollment increases greatly, but at the same time state tax revenues shrink during those downturns reducing the state's capacity to pay for the Medicaid program. When the state is doing well financially, enrollment in the Medicaid programs decreases.

The Medicaid program is a federal-state partnership, as demonstrated on page 8 (Exhibit C). [Ms. Aiello read the bullet points on that page.] An example of cost-effective optional services would be pharmacy coverage. That is an optional service, but if you do not cover pharmaceuticals, you will have much higher expenses for inpatient acute hospital costs. The federal government provides a template of services that must be provided and to whom. You must provide those services, and then additions may be made to both services and eligibility based on what the state wants to do.

The Division of Health Care Financing and Policy in the State of Nevada manages the Medicaid program and the Nevada Check Up program. Both are health care coverage programs that are partnerships with the federal government. Medicaid provides help to low-income families as well as aged, blind, and disabled individuals. Services are provided both through fee-for-service networks and through managed care networks in the Medicaid program. The Nevada Check Up program provides health coverage to low-income, uninsured children who are not eligible for Medicaid. It is a program that sits on top of the Medicaid program. Services are provided as fee-for-service and through the managed care network.

The general Medicaid rules are on page 10 (Exhibit C). Medicaid has to provide comparability of services. That means if you are on the Medicaid program, each

person is eligible for the medical services benefit package if he or she has a medical necessity. We cannot tell one person he does not get that service and tell someone else he does.

Everyone has free choice of providers. That means people in the fee-for-service network have free choice of providers among those enrolled as Medicaid providers. People enrolled in managed care also have free choice of providers. We must offer at least two managed care companies to choose between, and the program is statewide.

In our policy benefit, we have utilization management that encompasses items such as service limits. Those are similar to what most people probably have with their insurance companies such as X amount of services per item per year. There are utilization service limits as well as prior authorization requirements for some services, such as most of you probably have with your insurance companies. Prior authorization will determine whether it is a medically necessary service.

There is proper and efficient administration of the program. There is payment for services furnished outside the State when there is emergency coverage or needs or if the service is not available within the State, such as service to some catchment areas along the State's borders. There is assurance of transportation to medically necessary services for those who are unable to get to those services any other way. Our current transportation vendor is Logisticare.

Medicaid programs contain a program for children called Early Periodic Screening Diagnosis and Treatment (EPSDT). When a child has a medical assessment or preventative well-child check and an issue is identified, that child must be approved for all medically necessary services. In the well-child check there may be a review of those medically necessary services to identify them as being needed. Some of those services may not be services that are part of our base service package in Nevada's Medicaid State Plan, though they do need to be services that the federal government says are coverable.

Reasonable promptness means the decision for care must be made in a reasonable amount of time; and there are different time periods depending upon whether the problem is acute, emergent, or routine. If service should be denied through the utilization of management controls, terminated, or reduced from what was requested, the individual has to be offered a fair hearing that will go to an administrative judge if the individual wishes it to. A provider has a right to a fair hearing if the provider is denied the opportunity to be a Medicaid provider or is terminated as being a Medicaid provider. But it is the recipient who must ask for the service hearing if he or she is denied.

Page 11 (Exhibit C) lists both optional and mandatory services. This is not a fully inclusive list. That list is in our Medicaid fact book (Exhibit D). [Ms. Aiello read the services from page 11.]

Assemblyman Sprinkle:
Could you explain how you determine when someone qualifies for the optional services?

Elizabeth Aiello:
Once the optional services are added as state optional services, they become part of the State Plan. Everyone has the option for those services. Generally, we add services through the legislative budgeting process. For instance, the pharmacy benefit has been in the program for a number of years. I guess it was determined to be a cost savings by preventing hospitalization.

Assemblywoman Fiore:
Why is Medicaid not the provider for inmates?

Elizabeth Aiello:
That is a federal rule. When someone is in a state institution, the state must cover the cost of those services. The federal government will not pay for treatment in institutes for mental disease either. A lot of the rules occurred when the Medicaid programs and laws were passed. The federal government did not want to pick up costs for services the states were already providing in a lot of instances. Because Medicaid is a federal-state partnership, there are certain rules. Medicaid can cover the cost when an inmate is out of prison and in an acute care hospital for over 24 hours until that inmate is back in the prison.

Page 12 (Exhibit C) contains information regarding optional and mandatory coverage groups. Mandatory coverage groups will still be covered, but they are being changed and simplified under health care reform. [Ms. Aiello read the groups from that page.]

On page 13 (Exhibit C) is a graph showing Medicaid eligibility expansion and how things will be simplified. The first two columns cover all children 0 to 5 and 6 through 18 years of age. Those children will be covered up to 138 percent of the federal poverty level (FPL). Under the new eligibility rules, there is an automatic 5 percent disregard for income, so it really pegs to the 133 percent. Currently our programs have different income disregards. Pregnant women are up to 138 percent. Parents and caretakers will move up to 138 percent, and childless adults will also move up to 138 percent for Medicaid eligibility.

The Children's Health Insurance Program (CHIP) is our Nevada Check Up program which sits on top of the Medicaid program and involves children up to 200 percent of the federal poverty level. The different colors in the bar graphs reflect the fact that Nevada receives different match rates from the federal government, and those bar graphs indicate where the different match rates fall. As you can see from the eligibility demonstration, almost everyone is up to 138 percent of FPL. The aged, blind and disabled eligibility, and institutional nursing facility eligibility do not change at all from what they are today. Those stay the same.

Medicaid program flexibility is outlined on page 14 (Exhibit C). As I mentioned, it is a state and federal partnership. The federal government tells us the base things we must offer, and then the states can choose to develop the program above that in different ways, so states can establish their own eligibility standards. Those standards may rise higher than they are now, and even higher than under health care reform, but because of maintenance of eligibility, we cannot lower them. Adults must stay where they are until January 1, 2014, but then adult maintenance of eligibility is loosened on that date. Children's maintenance of eligibility goes until 2019, and those cannot be decreased or the state risks federal funding for the program.

You can determine the type, amount, duration, and scope of services above those mandatory services and there is no lock-in on any of those. As a state, we are able to set the rate of payment for services, though we have to prove that if we decrease rates there will not be access-to-care issues. The states have the freedom to administer their own programs.

On page 15 (Exhibit C) is a list of categories of coverage which include those aged 65 and over, the blind and the disabled, and those eligibility processes will remain the same. It was broken out differently for pregnant women and 0- to 6-year-olds because they had up to 133 percent of eligibility. Children ages 6 to 19 are only 100 percent. They are two different groups now, but they will all move up to the 138-percent threshold. Families with blood-related and/or adopted or dependent children in their homes are the final category.

Page 16 (Exhibit C) relates to waivers. States are allowed to develop waiver programs. They can waive some Medicaid rules, such as comparability, to provide additional services to certain sets of individuals. The largest number of waivers are for people who would otherwise be in institutions, such as nursing facilities and intermediate care facilities, or for persons with mental retardation-related conditions or intellectual disabilities. The waivers in those cases would be to provide those people with added services. In other words, we can add optional services that are not our base optional services. We can limit them to

certain sets of people who might have institutional levels of care or certain diagnoses and allow them to remain in the community. This is another set of services that is not for everyone.

Nevada has four waiver programs that are alternatives to nursing facilities or the Intermediate Care Facility for the Mentally Retarded (ICF/MR). They offer things such as supportive living arrangements, jobs, and day training which are alternatives for those with developmental disabilities and intellectual challenges. There is a home- and community-based waiver for the elderly at home that provides emergency response buttons, homemaking and companion services, or group living situations. We have a waiver for those with physical disabilities that has more attendant care than what the State Plan has, so it has some expanded services. There is also an assisted living waiver.

We have a 1915(i) Waiver. In that waiver we provide some services for higher need people including adult day health care, habilitation reintegration into the community for those with brain injuries, and day treatment or partial hospitalization services for people with chronic mental illness.

Chair Dondero Loop:
I have some questions about this page. Can you speak to the medical home model some states are implementing?

Elizabeth Aiello:
The medical home model is a program in which the primary care physician would provide a case management process. That process could include a number of services such as a pharmacist, dietician, nurse, and physician to create a Wellness Recovery Action Plan (WRAP) for that individual's needs. Health care reform allows for a health home that will also add in the social services of some of the home and community-based services and behavioral health. There are all kinds of different plans for the different models the states have. We are looking at applying to the federal government for a 1115 Waiver program to bring a care management organization as opposed to a managed care organization. That care management organization we are looking at would provide a care management process similar to a medical or health home to support those physicians who do not have the infrastructure to do an overall WRAP-care plan and to help with transitions out of hospitals to avoid readmits. Also in that 1115 Waiver we are looking to do some pilot health homes and medical homes, but that is not fully refined and not fully approved by the Centers for Medicare and Medicaid Services.

Chair Dondero Loop:
I also would like you to give me some background information on the Health Insurance Flexibility and Accountability (HIFA) waiver that expired last session. We need some waiver information in general.

Elizabeth Aiello:
The HIFA waiver was also an 1115 Waiver. A 1115 Waiver is terminology for it being a research and demonstration project. The federal government allows states to propose new, innovative ways to run Medicaid programs or to provide health care. The HIFA waiver was a certain type of research and demonstration waiver that the federal government allowed. They are not available any more.

The HIFA waiver was three-pronged. It provided premiums of up to $100 per month for adults under 200 percent of the federal poverty level who worked for a small employer, who needed help paying their premiums, and who were not already insured. That program ran for the five years of the waiver. At most we had ten people enrolled. The requirements in the legislation were strict enough that we could not find enough employers who met the definition of being small employers and who could pay the 50 percent.

The second leg of the waiver was for some hospital critical care payments that the Centers for Medicare and Medicaid Services would not approve in the original waiver. That was never implemented. The third leg was much more successful and we had to cap it. It brought the coverage for pregnant women from 138 percent up to 185 percent of the federal poverty level. The federal government's CHIPRA legislation no longer allows that in the CHIP program; and Medicaid eligibility itself, without a waiver, can be expanded up to 185 percent of the federal poverty level.

Assemblywoman Spiegel:
Are waivers for eligibility, service delivery, both, or neither?

Elizabeth Aiello:
Both. Waivers are allowed to waive the basic Medicaid requirements. Generally, waivers are to expand services but we have also expanded eligibility. Our eligibility for someone in an institution was up to 300 percent of Social Security Income (SSI). Before we got our first waivers, when people wanted to leave nursing facilities, they would lose Medicaid eligibility when they left. Those home- and community-based waivers were built so someone could be moved out of an institution, services could be put into homes, the person would maintain his or her Medicaid eligibility, and be where he wanted to live and the overall cost would be less than the institutional costs. Those are the home- and community-based waivers. The other waiver concerns a medical home and is

one of the research and demonstration waivers in which they let you propose all kinds of different things. We have been working over a year to get this one waiver, so they are not that easy to get.

To sum up, the HIFA waiver is not available anymore and the pregnancy expansion can be done under the regular Medicaid program. The employer-sponsored insurance, because of the way it was written in the legislation, did not move forward, but now those groups will have coverage under the Exchange or the Medicaid expansion most probably.

Assemblyman Hickey:
While this is not a money committee, we in this body are all aware of the large expansion which is likely to take place. With regard to innovative services and waivers, could you give us a little more background concerning what your office has done to anticipate this expansion? Some of our managed care operations now represent about 60 percent of the total Medicaid population. That may increase to 80 percent with possible inclusion of the aged, blind, and disabled. Is it not the case that most states have concluded that managed care is probably the best practice in terms of delivering services, as well as being as efficient and predictable with the state's finances. Would you let us know what we are looking at as we expand this program? Are you confident we are doing the things that will be best for the patients and taxpayers?

Elizabeth Aiello:
All of us at Medicaid are trying to build the program that we believe is the best program to do those things. We definitely have the same goals of quality health care for the best financial considerations.

We currently have managed care programs in our urban areas for basically our moms and kids. The rural areas do not have managed care, and our aged, blind, and disabled do not have managed care. We are expecting that the majority of families will go into the managed care organization. We may get some people who will fit into the aged, blind, and disabled, and with the expansion for adults going up to 138 percent, the projection is for managed care organization coverage to rise into 80 percent because of those new populations.

We also are developing the care management organization. We are looking at that as being the infrastructure, the care management WRAP for small physician practices statewide to help with developing care plans. It is similar to what a managed care organization would be, but we are developing the care management portion of it. They can develop care plans and the WRAP, and support that individual to get preventative care versus acute reactive care. We are going to study how that compares with the traditional managed care

organization where the price is in the cap. The folks who will be in that program will have chronic conditions or high needs such as the aged, blind, and disabled. We want to prevent readmits to hospital within seven days. In 30 days, we want to ensure follow-ups with primary care. You will hear from a lot of people that the highest rate of missed appointments is among Medicaid recipients. We are going to help them actually make it to their medical preventative care.

As to the decision across the country that managed care is the best entity, I think different states say different things. There have been a couple of states that have moved away from their managed care organizations. There are a lot of states that are moving to it. Because of tight budgets across the country, states have tried different things.

Medicaid funding is addressed on page 17 (Exhibit C). Medicaid gets federal funding for both its administrative operations and for its medical services. State or local governments must match that federal money. Federal funding is called federal financial participation (FFP), and it is to pay for medical services and also our administration. The federal medical assistance percentage (FMAP) defines the level of FFP provided by the federal government for our benefits. The administrative match is 50/50, but there are different matches for information technology (IT) services and other items, so you will hear many different matches.

Sources of funds, other than the state General Fund that match the federal government funds, come from intergovernmental transfers and from local governments. That money is matched bringing federal money to pay disproportionate share hospital payments. Those are hospitals that cover a disproportionate share of the uninsured and indigent and Medicaid caseloads. Intergovernmental transfers go toward upper-payment limit payments. That gives money to match federal money which increases payment to the hospitals from Medicaid levels to Medicare levels.

There is a county match program in which the counties match some or all of the nursing facility costs for people over a certain federal poverty level and the waiver program costs for some of those people. Intergovernmental transfers also help fund graduate medical education. Those transfers are coming from state and local entities and are being utilized at University Medical Center (UMC) right now.

Other local government funds include things called certified public expenditures. School districts and some social service agencies that actually provide services

will do time tracking and get an expenditure plan approved by the federal government which is used as the match.

We have a provider-fee program which we call a nursing facility tax. That tax is based on non-Medicare bed days. The facility pays a tax that goes into a fund that gets matched by federal dollars. The facility is paid back based on a complex formula that is a mix between Medicaid bed days and certain quality indicators.

I briefly mentioned the county match program. Effective July 1, 2011, this program was adjusted by the legislative session. It supports county care and the medically indigent by providing federal matching funds for individuals in hospitals, nursing facilities, and using home- and community-based services with incomes between 142 percent and 300 percent FPL.

Most other local government agencies, such as school districts and county social services, providing medical services and having a Medicaid contract fund the non-federal share of the Medicaid costs, and we transfer the federal match through to them.

On page 19 (Exhibit C) you will see our historical and projected caseload chart. Medicaid actuals are in blue. Projections in green are without health care reform; the dotted in the green is the mandatory portion of health care reform—in other words, the caseload growth we believe we would have for people applying for the health insurance exchange or Medicaid due to the mandatory insurance rules and who would enroll in Medicaid. The dotted purple line is what the Medicaid expansion up to 138 percent of the federal poverty level is projected to bring in.

The Nevada Check Up program is on page 20 (Exhibit C). It really is a wrap around the Medicaid program. For children up to 200 percent of the federal poverty level who are not Medicaid eligible, it grabs them and they become eligible for Nevada Check Up. It was authorized by Congress in 1997 and is Title XXI of the Social Security Act. It was funded for ten years. The program was reauthorized in 2009 and renamed the Children's Health Insurance Program (CHIP), but we call it Nevada Check Up here. Children have to be uninsured for at least six months. They can be ages birth through age 18, but they cannot qualify for Medicaid to be eligible for Nevada Check Up. The states get a higher federal match rate for their CHIP programs than they do for the Medicaid program, so the federal government is adamant that if someone is Medicaid-eligible that individual must go into Medicaid. Medical coverage in Nevada Check Up follows our Medicaid policy, except there is no nonemergency transportation in the program. Nevada Check Up has premiums based on

income level. The premiums are per-family and per-quarter and range from $25 to $80 per quarter per family.

Eligibility for Nevada Check Up is addressed on page 21 (Exhibit C). Currently in our Nevada Check Up program, families that have access to the Public Employees' Benefit Program (PEBP) are not eligible for Nevada Check Up. Originally that was a federal rule because they did not want states to shift state insurance coverage of children to the federal government. The federal government did not want to help subsidize it. In the CHIPRA legislation, the federal government removed that requirement. A family such as a single mother with three children, if she happened to work for the state, would not get the Nevada Check Up program at that income level. If she worked for any other employer, she could get on Nevada Check Up, but our policies in the program are still that the child does not have access to PEBP. Participants in our program must be United States citizens or legal residents for over five years.

On page 22 (Exhibit C) is a graph of the CHIP caseload.

Assemblyman Martin:
I have not heard you discuss the concept of the health care exchanges and how that might affect Medicaid. I think it is going to be beneficial that the health care exchanges come rolling in under the Affordable Care Act, but I would like to get your perspective. How do you think that might alleviate some of the costs under Medicaid as more people possibly shift into the health care Exchange as more affordable care becomes available?

Elizabeth Aiello:
I am not sure people will shift from Medicaid to the health care Exchange because Medicaid does not have any premiums or copays. We are looking at some cost-sharing items in our budget, but there are a lot of rules around Medicaid related to that.

It is my understanding that the health care Exchange would be similar to the CHIP program which sits on top of everything. There are a few levels of federal poverty that overlap. The health care Exchange starts at 100 percent of the federal poverty level. Medicaid goes up to 138 percent of FPL, so those individuals would be able to choose from an insurance product on the health care Exchange or the Medicaid product. To be honest, if I had that choice I would probably choose the Medicaid product, but someone else possibly would not if there were different physicians enrolled or different features.

The health insurance Exchange is another entity that will link with the eligibility engine. We believe that a lot of people who apply through the Exchange to see

if they can get insurance coverage, will be vetted by the eligibility engine. Some of those people or their children will qualify for Medicaid or Nevada Check Up, so families may be split between the different entities. That may make a difference.

Chair Dondero Loop:
We will be having a presentation on the health insurance exchange this coming Wednesday.

Assemblyman Oscarson:
Do you have any idea what the time frame for review of denials is for the recipient as well as for the provider? Also, is the Logisticare program available for the rurals, and do the rurals know about that program?

Elizabeth Aiello:
We have a time frame for addressing prior authorization. If it is a denial, the person who has been denied has a time frame within which he or she can request review. There are different time frames based on whether it is a physician peer-to-peer review or whether it has to go through a hearing process that would determine how critical the service is. People can ask for a hearing. Reductions have a different time frame. People can ask for continued service if it is a reduction or a termination versus a direct denial. The request for a service continuation must be made within a certain time frame. I can email you the time frames around all those requirements if you would like.

Assemblyman Oscarson:
Yes, I would.

Elizabeth Aiello:
Logisticare is contracted to provide nonemergency transportation services throughout the state and it is my understanding that they do. Is there a specific issue you want us to look at? They are a vendor for the state and do provide the service.

Chair Dondero Loop:
Any other additional questions from the Committee? [There were none.] Thank you for your information.

We will now open the hearing on Assembly Bill 29.

Assembly Bill 29: Creates the Committee to Review Suicide Fatalities. (BDR 40-307)

Misty Vaughan Allen, Suicide Prevention Coordinator, Office of Suicide Prevention, Department of Health and Human Services:

Thank you for giving me the opportunity to speak about something I believe will really assist in preventing suicide deaths in Nevada. The first goal of the National Strategy for Suicide Prevention is to promote awareness that suicide is a public health problem that is preventable. If the general public understands that suicide and suicide behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, the suicide rate can be reduced.

Nevada has historically held one of the highest suicide rates in the nation (Exhibit E). We currently rank number four. More than 500 Nevadans take their lives annually. For every one death by suicide, research shows that at least 25 other people will attempt suicide, leaving thousands of individuals, their families and their communities impacted by suicide behaviors. It is a problem that we see and deal with on the surface, which is terribly tragic, but what we do not know is the tremendous impact on our communities.

In a recent State Health Division report, Suicide Mortality in Nevada's Military Veterans, 2008-2010, shows that female Nevada veterans had a suicide rate three times that for non-veteran Nevada females. Male veterans had twice the suicide rate of non-veteran males in Nevada. The report also discusses the high rate of death due to motor vehicle crashes in Nevada for our veterans, and it is staggering. Nevadans in general across their life spans have a rate of 7.79 deaths in car crashes. Veterans have a rate of 27.7, or three times that number, in car crashes. I think a committee to review suicide fatalities could look at this number of potential hidden suicides. We do not know for certain, but the difference in numbers is staggering.

Other areas that could be better understood through the fatality review process are traumatic brain injury impacts and chronic traumatic encephalopathy. We do not fully understand the potential implications those injuries might have and their possible links to suicide deaths. I think a fatality review process would help us better understand that area for our returning men and women.

The system could be implemented across the life span in Nevada. A suicide fatality review committee would examine a sample of suicide fatalities to identify where systems or processes could be improved to prevent further tragedies. This suicide fatality review committee would draw on the knowledge of individuals from diverse fields. Information gathered by the committee, and any resulting recommendations to address any and all shortcomings in systems, would be shared among appropriate representatives of the courts, medicine,

social services, law enforcement, criminal justice, and other policy makers who might benefit from this insight.

Additionally, we have a benefit in Nevada in being able to model this process after our outstanding Child Fatality Review and Domestic Violence Fatality Review committees. I have been sitting on the Executive Committee of the Child Fatality Review Committee for several years and have grown to respect the recommendations that have come down from them to my office and that we have implemented across the years.

Assemblywoman Fiore:
You say Nevada has the fourth-highest suicide rate in the nation. What is the number of Nevadans committing suicide versus the number of our tourists committing suicide?

Misty Allen:
Our rates are for Nevadans. We have found that visitors to Nevada comprise 10 percent of our suicide deaths, and they are not counted in the ranking of fourth in the nation you are seeing. Suicides among visitors have averaged between 8 percent and 12 percent over decades.

Chair Dondero Loop:
Would you walk us through the bill, please?

Misty Allen:
Chapter 439 of the *Nevada Revised Statutes* (NRS) will be amended according to this bill. I want to highlight section 3 on page 2 that emphasizes the Director of Health and Human Services will appoint ten members to the Committee from specified disciplines. There is one provision to appoint anyone who the Director determines would provide assistance. That could possibly be a veterans-services-related or military-related individual who would highlight and emphasize their needs very well.

Section 4 on page 3 sets forth that the Committee would establish a written protocol to determine which fatalities across the state would be reviewed. The Committee shall not review any case in which litigation is pending.

Line 39 on page 3 highlights that we will coordinate with the existing Child Fatality Review team and the Domestic Violence Fatality Review team. They are models of success that are a real benefit to this prospect.

Section 5 highlights that we, like the Child Fatality Review Committee, can petition district courts in the issuance of subpoenas. We can also propose

recommended legislation concerning suicide fatalities in this state. This review gives us the opportunity to see where systems are working, possibly successfully, and highlight those, or where gaps might be occurring.

At line 38 on page 4, it states that we will make reports on the findings of the Review Committee and that everything found in the Review Committee will be confidential and privileged information. I cannot emphasize enough the importance of confidentiality throughout this process.

Section 8 amends NRS 439.513 to have at least one person to act as a trainer and networking facilitator in the state. The previous legislation outlined one person; we would like to increase that to at least one person. This other person would aid in training, public awareness, and networking outreach in all Nevada outside of Clark County where we currently have a trainer and networking facilitator.

Section 9 allows for the Department of Vital Statistics to share data. This is once again modeled after the Child Fatality Review and Domestic Violence Fatality Review committees.

Section 10 allows for the Office of Suicide Prevention to be added to receive statistics on deaths, similar to the Child Fatality Review and Domestic Violence Fatality Review committees.

Finally, I want to add that we have a clean-up amendment to add to this bill that would make certain the Office of Suicide Prevention is housed in the most appropriate place within the Department. The wording would change it from being housed in the Director's Office to being housed in the Department.

Chair Dondero Loop:
Has that been submitted?

Misty Allen:
That has not been submitted.

Chair Dondero Loop:
That needs to be submitted.

Assemblyman Eisen:
You made a specific point to emphasize that cases would not be reviewed if there was any litigation pending. We would like to know why. You also made reference to the fact that these reports would be confidential and privileged. I think they should be considered closed and not discoverable in a legal

proceeding to allow for open dialogue, but I would think that would obviate the concern about reviewing a case that might have litigation still pending.

Misty Allen:
The importance, as you agree, is that this is not about finger-pointing and blame. It is about discovering gaps in the systems or successes that we can promote. In Nevada, we have a high bit of stigma related to suicide and its deaths so we do not get timely information. Sometimes it is miscategorized because of that stigma. This review process allows us to get the most effective and representative information in a timely manner to find out if there are trends occurring. If we do not have that confidential statute, which I would recommend being based off the child fatality statutes and language, the collaboration across disciplines would not occur. They would not feel safe.

Assemblyman Eisen:
I served on the Child Death Review Committee in Clark County for more than a decade, and the very fact that those discussions are not discoverable allows for exactly the kind of open dialogue between members of that Committee, some of whom represent public entities and some of whom are private citizens, to do exactly what you are talking about. It is not about finger-pointing; it is about trying to understand what is going on. It is not even about any single incident; it is about trying to identify if there are things we can do on a large scale to decrease risk. I was just wondering why there was a particular concern about not reviewing cases that might have litigation if this is a completely separate process. I am concerned about things potentially getting delayed for years if that were the case.

Michael J. Willden, Director, Department of Health and Human Services:
This legislation is patterned closely after the Child Fatality Review process and the language here, even though the intent is the same, could probably be clarified in this bill. The Child Fatality Review statute is NRS 432B.407 and I can read subsection 5. "Except as otherwise provided in this section, information acquired by, and the records of, a multidisciplinary team to review the death of a child are confidential, must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding." That is the intent here, but I think that language is stronger.

In 2003 we created the Child Death Review teams. There was a lot of discussion about not having an investigative process occurring while there was litigation, and I think it is important to honor that.

Assemblyman Oscarson:
It is very important to us to make sure we identify what is causing these suicides and that we work together to make sure it does not continue to happen, and specifically at the current rates.

Since veterans are identified as being a specifically high population of suicides, why is a veteran not specifically identified as being someone you would appoint to this committee? I know you mentioned there being an ad hoc position, so to speak, on this committee.

Misty Allen:
At the time this bill was proposed, that entity was not identifiable. As we move forward in partnership with the Suicide Prevention Task Force for veterans, service members, and their families, that expert entity regarding suicide will be discerned.

Mike Willden:
We worked very closely with Executive Director Caleb Cage and that suicide report. It would have been my intent to make that appointment under item (j) at line 24 on page 2, and that can certainly be clarified.

Assemblywoman Benitez-Thompson:
Could you tell us a little bit more about the thinking behind including information from the child death reviews? I understand that this is modeled in a similar manner to the Child Death Review committees, but could you talk a little bit more for the legislative record about why their information would be relevant to the suicide prevention committee?

Misty Allen:
The Child Fatality Review teams discovered that suicides are the fourth-leading cause of death for our young people aged 10 to 14. We would cross-talk those deaths quite often and coordinate with the teams. I feel that because you have homicides and suicides with domestic violence, you are going to want to coordinate with that group as well.

Assemblyman Sprinkle:
Once a review is started, do you have parameters in place as to how long the review will take and when the findings would go out to the important agencies and others? The process needs to move forward and not drag on.

Misty Allen:
In section 4 of the bill it states that the Committee shall adopt written protocol setting forth procedures, and I believe that is where this will be determined.

Chair Dondero Loop:
Are there any additional questions from the Committee? [There were none.] Will you get that amendment; I would appreciate it. I see someone joining us at the witness table.

Amber L. Howell, Administrator, Division of Child and Family Services, Department of Health and Human Services:
We will work closely with Misty and her group. We have specific protocols around how long a local Child Death Review Team can review a case, how long they have to get that information to the Administrative Team, and then on to the Executive Team where the public awareness campaigns usually happen. Because we have been doing this for quite a while, we will offer everything we have already been through to mirror the same process. We can offer great assistance because of what we have been through.

For the record, it has been tremendously valuable to be able to review these fatalities, find the leading causes of death, and set up our public awareness campaign. It is a great policy to have in place, and we would be happy to help.

Chair Dondero Loop:
Any additional thoughts from the Committee? [There were none.] Now I will take testimony in support of A.B. 29.

Alex Ortiz, representing Clark County:
We have prepared a proposed amendment to the bill (Exhibit F), and have spoken with representatives of the Department of Health and Human Services about it. It is a friendly amendment, and they are in agreement with it. Our Clark County Coroner will talk in more detail about this amendment we are proposing.

Michael Murphy, Coroner, Clark County:
Our amendment is specifically designed to provide all the information I think is necessary for a healthy exchange of information. We have an Attorney General's ruling from 2002 that would prevent us from providing some of the information should it not be listed in statute. It is modeled after the Child Death Review which has been an extremely successful process. It does not allow for secondary dissemination of reports, so the items that we brought forward specifically address that.

The autopsy report itself, and many of the other reports, are considered public record but not open to the public. By doing this, it allows the Committee to be able to have access to all of those reports, specifically notes and investigative reports. What is most important about that is the autopsy report will provide

information about what has occurred. It will not necessarily give the information about how or why it occurred, so information about victimization suicide, ideation, and things of that nature which are extremely important, would be contained in the investigative reports. That is the reason to bring forth this particular language.

Chair Dondero Loop:
Are there any questions regarding the amendment? [There were none.] Is there anyone else in support of A.B. 29? [There was no response.] Now, testimony in opposition to A.B. 29. [There was no response.] Is there anyone who wishes to testify as neutral to A.B. 29? [There was no response.] Seeing none, I will close the hearing on A.B. 29.

Is there any public comment before we close the meeting or any comments from the Committee? [There were none.] Our next meeting is February 13 when we will hear information about the Silver State Health Insurance Exchange and the Nevada Health Co-op. This meeting is adjourned [at 2:53 p.m.].

[As promised by witness Misty Allen, (Exhibit G) was provided to the Committee after this meeting adjourned.]

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn Dondero Loop, Chair

DATE: _____

EXHIBITS

Committee on Health and Human Services

Date: February 11, 2013 **Time of Meeting: 1:33 p.m.**

	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Elizabeth Aiello, Dep. Admin., DHCFP, Dept. of HHS	Medicaid and Nevada Check Up Overview
	D	Elizabeth Aiello	Pamphlet about Nevada Check Up and Medicaid
A.B. 29	E	Misty Vaughan Allen, Suicide Prevention Coordinator, DHHS	Suicide in Nevada Fact Sheet 2012
A.B. 29	F	Alex Ortiz rep. Clark County	Proposed amendment
A.B. 29	G	Misty Vaughan Allen	Proposed amendment