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

Seventy-Seventh Session
March 25, 2013

The Committee on Health and Human Services was called to order by Chair Marilyn Dondero Loop at 1:36 p.m. on Monday, March 25, 2013, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, 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
Terry Horgan, Committee Secretary
Macy Young, Committee Assistant

OTHERS PRESENT:

Brian G. Brannman, CEO, University Medical Center of Southern Nevada
Jon Sasser, representing Legal Aid Center of Southern Nevada and Washoe Legal Services
Michael J. Willden, Director, Department of Health and Human Services
Alex Ortiz, representing Clark County

Chair Dondero Loop:
[Roll was taken. Committee rules and protocol were explained.]

I will now open the hearing on Assembly Bill 1.

Assembly Bill 1: Requires the Director of the Department of Health and Human Services to include certain requirements in the State Plan for Medicaid. (BDR 38-392)

Brian G. Brannman, CEO, University Medical Center of Southern Nevada:
I am speaking on behalf of Assembly Bill 1. Existing federal law requires a hospital to provide appropriate medical screening, or treatment to determine whether an emergency medical condition exists, if any individual comes to the emergency department needing care. This proposed bill would add a specific procedure, renal dialysis to stabilize patients with kidney failure, and the care necessary for the treatment of this emergency medical condition, to the schedule of emergency medical benefits for Nevada Medicaid beneficiaries. The Nevada Medicaid program defines emergency services as being situations in which a delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight, or hearing, injury to self, or bodily harm to others. Patients presenting to the emergency department experiencing kidney failure are dependent upon receiving renal dialysis in order to maintain life.

In the emergency department setting, physicians and health care providers have a legal and ethical responsibility to treat these patients with a stabilizing procedure—which in this case is dialysis. Currently, the Nevada Medicaid program does not recognize this procedure as life sustaining or as a defining stabilizing procedure. Their determination is that since the underlying condition, kidney disease, is chronic, the treatment is not emergent. As such, emergency

Medicaid reimbursement is denied. While kidney or renal disease can be a chronic condition similar to heart disease or diabetes, an individual can experience acute episodes which require immediate medical attention—a myocardial infarction, a diabetic coma, or a kidney failure in the case of renal disease. Emergency medical staff will provide the treatment necessary to stabilize the patient's condition and prevent death. In the case of kidney failure, the stabilizing treatment is dialysis. If a patient does not receive dialysis, organ failure will occur and death will follow imminently. Certainly, this would meet the Nevada Medicaid program's definition of an emergency service, just as treatment for a heart attack or treatment for an acute diabetic episode would be emergent.

In addition, the emergency department staff would be in violation of federal Emergency Medical Treatment and Active Labor Act regulations if they do not provide dialysis treatment to these patients. Medicaid reimbursement for dialysis has the benefit of including federal matching dollars. In the current environment, the entire cost of care for those people who are not eligible for coverage elsewhere is borne by the taxpayers via the county governments. Our proposal would entail an adjustment to the operating rules of the state Medicaid program to allow these patients to be covered under emergency Medicaid as is done in several other states.

Chair Dondero Loop:
Are there any questions, Committee?

Assemblyman Duncan:
Approximately how many emergent patients do you see each year? Also, you mentioned that other states had implemented this. How many other states have implemented this specifically for kidney dialysis? I realize this is not a money committee, but I am curious about what it costs you per year for doing these services.

Brian Brannman:
The precise number of individuals tends to fluctuate from year to year, but there have been about 100 to 109 individuals in the last couple of years. These are unique individuals who have shown up in our emergency department. That boils down to about 2,500 episodes of care. Some of these people were seen in the emergency room, sent to the dialysis unit on an ambulatory basis, and then discharged. About 400 or 500 of them tend to be so severely ill that they have to be hospitalized. The cumulative care for those two groups of people during fiscal years 2011 and 2012 cost us approximately $6.2 million. Medicaid reimbursement would probably be approximately $1.7 million. California and

Arizona have made changes to their plans that allow that payment, as have some other states.

Assemblyman Sprinkle:
How exactly do you define something as being emergent as opposed to something that is more chronic in nature?

Brian Brannman:
End-stage renal disease, diabetes, and chronic heart disease are chronic problems people are going to suffer with over a long period of time. At the point when a person's health is failing, for instance if dialysis were not delivered within a relatively short period of time—12 or 24 hours—you would be putting the person's life in jeopardy just as if the person had diabetic shock or was in a coma. A person coming in with acute myocardial infarction may have an underlying health problem, but he is now having an acute episode that is life threatening at that instant. As an aside, I am a hospital administrator and not a physician, but these people will show up with elevated serum potassium levels which can cause problems with heart arrhythmias, or creatinine levels that will cause problems, and at that point, they need emergent care.

Assemblyman Sprinkle:
Do there need to be more specific parameters in the language here that can define that? I have seen plenty of chronic renal failure patients, but it might not be emergent at that point; however, in less than 12 hours if they do not get dialysis, it could become life threatening. Would that help clarify and make things far more precise with this language?

Brian Brannman:
The definition we have said that the delay in treatment of more than 24 hours could result in severe pain, loss of life, et cetera. The issue is these patients obviously understand that they have an underlying disease and know if they are not dialyzed that they are going to have problems. They may present in our emergency department and already be in extremis. Sometimes they know they will deteriorate over a period of time, so they will sit and wait in the emergency department or in the parking lot until they are sick enough to be able to meet the criteria. That is a risky proposition and it is not good care. There are studies showing that people who do not have well-managed, end-stage renal disease have a life expectancy of less than five years. Are we going to wait until they are right at death's door before we do something? When these people present, if the lab values are such that it is clear they need to be dialyzed at that point, then they start the treatment.

Assemblyman Eisen:
Like my colleague, I am struggling with the three terms in section 2, subsection 1. Obviously, kidney failure qualifies if we are speaking about seriously bad, acute renal failure versus chronic renal failure. But exactly what do we mean by "stabilize?" The other part of that subsection that is tricky is that whole last phrase, "further emergency care necessary for the treatment of such kidney failure." Would the provisions here only account for the costs of the administration of dialysis and other management of the renal failure, whether that is fluid management or such? If a patient were to come in with renal failure and an infected foot, would it not cover those comorbid conditions? I want to be clear on what the scope of this is.

Brian Brannman:
The Medicaid folks who adjudicate the bills have to make a determination: was the foot problem comorbidity or was it also part of that whole episode. You end up with fractured bills a lot of times. It would have to be determined on a case-by-case basis what exactly the comorbidity was and whether it was related and life threatening. What we accumulated in our costs were purely those things related to the particular renal problem and whether there was another health problem that did not get picked up in our data.

Assemblyman Oscarson:
I had an opportunity to tour your facility over the summer and was very impressed with your staff and the efforts you put towards the health and welfare of folks in your area, so thanks to you and your staff.

The language in section 3, beginning at line 13, almost sounds as though you are anticipating or trying to put in a presumptive eligibility clause. I have heard that term kicked around, and it looks a lot like that to me.

Brian Brannman:
There is an amendment of section 3 proposed by Clark County that would eliminate that language (Exhibit C). Presumptive eligibility, since we have opted into the Affordable Care Act (ACA), is encompassed within that Act, so we have an amendment coming forward that would delete section 3.

Chair Dondero Loop:
That amendment is on the Nevada Electronic Legislative Information System (NELIS) and does state that.

Assemblywoman Fiore:
I have a question about the language on page 2, lines 29 through 32. It states that "a person who is determined not eligible for the Supplemental Security

Income Program must not be required to reimburse Medicaid for any expenses incurred by Medicaid in providing coverage to the person pending that determination." Are you amending that to "may?"

Brian Brannman:
That whole section would be deleted.

Chair Dondero Loop:
In the amendment that is being proposed, Clark County is proposing to delete section 3, the Medicaid presumptive eligibility provision. For clarification, the entirety of section 3 would be deleted.

How many people do we need to keep this part of the facility going? You probably do not need to include doctors and nurses, but is it a large staff?

Brian Brannman:
If we were just taking care of purely acute patients who were being managed somewhere else, we would need two dialysis units for a facility of our size. Because of the growth in numbers of these patients, we put in five stations to ensure people do not have to wait excessive periods of time, which would put them at risk. We do have other acute patients who may be in need of dialysis care besides the folks who show up in the emergency department, so we have five stations operating. That is done via contract; we buy this service from DaVita.

Chair Dondero Loop:
Are there any additional questions or concerns? [There was no response.] I will call forward anyone in support of A.B. 1.

Jon Sasser, representing Legal Aid Center of Southern Nevada and Washoe Legal Services:
We are in support of A.B. 1. Under federal law, these emergency services must be offered by the hospital. It is just a question of who is going to pay for them. Is it going to be paid for 100 percent by Nevada taxpayer dollars from county governments, or are we going to have the federal government pick up 60 percent of the costs by running these expenses through the Medicaid program?

The reason emergent care is so important as a category of Medicaid eligibility is that people who do not meet the citizenship requirements to be able to qualify for Medicaid still must be provided emergency care by the hospitals, and Medicaid still must cover that emergency care. If you label it "emergency,"

then the federal government picks up 60 percent of the cost; if you do not, then the county still has to provide the service and picks up 100 percent of the cost.

The group that meets the citizenship requirements under the Affordable Care Act will be covered after January 1, 2014, because now everyone under 138 percent of the poverty level will be covered. Today, they would have to meet the Supplemental Security Income Program (SSI) standards. That is why the presumptive eligibility idea was originally in section 3 of the bill. After January 1, 2014, everyone will be covered who meets the citizenship requirements for emergent and nonemergent care. For those who do not, they can only be covered under emergency care and this is the only way to get the federal government to pay a major portion of the bill. Of course that would require us to still pay 40 percent, so I assume that would create a fiscal note and the Committee on Ways and Means would have to take a look at it. I urge you, as a matter of policy at least, to support the bill.

Chair Dondero Loop:
Are there any questions for Mr. Sasser? [There were none.] Is there anyone else wanting to testify in support? [There was no response.] Is there anyone in opposition to A.B. 1? [There was no response.] Is there anyone neutral on the bill?

Michael J. Willden, Director, Department of Health and Human Services:
I want to provide information on the bill. In any legislation in which we are trying to have Medicaid pay for a cost of service, the first thing you have to have is a Medicaid-eligible client. Today we are talking about dialysis, so let us talk about how a person would be eligible for coverage of dialysis. If you meet any of the four categories of current Medicaid eligibility—U.S. citizen and eligible through any of the categories—you are eligible for the full scope of services Medicaid provides including dialysis.

The next category of eligibility is what we call lawfully admitted residents. Those are people who have immigrated to the United States and been lawfully admitted. They are banned from getting Medicaid for five years. That group of people is not eligible for Medicaid services except for emergency services. In that group are mostly people who are delivering babies or who have emergent acute conditions. These people present at the hospital, and we end up paying for them using Medicaid dollars.

The third group of eligibility is unlawful citizens or noncitizens. These are people who have not been lawfully admitted to the United States. They are also not eligible for Medicaid except for emergent services.

Then there is a fourth category of people who are United States citizens but do not meet the eligibility criteria. The basic example in that group is a childless adult. That is not an eligible category for coverage in Nevada. If someone in this category showed up at University Medical Center of Southern Nevada (UMC) or any other hospital needing dialysis, they would not be eligible for Medicaid either through regular Medicaid or as a noncitizen.

We probably should talk a little about section 3. One way to become eligible for Medicaid, if you are a childless adult or anyone else who has a disability, is to become SSI eligible. That can take months or years, so it is important to have a presumptive process—a fast-track process. Starting next January, that is not important because people in Nevada will be eligible as childless adults or as disabled individuals under other eligible categories rather than getting SSI eligibility. We concur that section 3 is not necessary and should be amended out of the bill. Who does that leave: noncitizens and those who are lawfully admitted but banned for five years, so Medicaid programs need to define what emergent services are for that group.

Historically, we have taken the position that dialysis is a chronic condition and not an emergent one. You certainly can put policies in your Medicaid program to support these individuals. Several states we have identified do provide for this. Arizona has been mentioned, and we have Illinois's and Hawaii's policies. Assemblyman Sprinkle asked how to define emergent versus chronic. You have to put a definition in your Medicaid policy that defines which emergent services you will cover. I can provide what Arizona and Illinois use.

Once a state has defined what an emergent policy is and a person has been cleared for an emergent dialysis, it does not mean all the rest of that person's dialysis will be emergent. In talking with the federal government over the last couple of weeks, it does not appear to us that this is a state plan requirement. Section 2 of this bill would direct me, as the Director, to include in the state plan this dialysis option. It does not appear to us that there is a box to check in the state plan to do this. The Centers for Medicare and Medicaid Services (CMS) has told us that, if the state wishes to do this, it is a matter of incorporating it into our policies, and then federal matching funds would be available. It is not a state plan issue; it is a Medicaid services or policy issue. The state plan is a large document. The boxes that are checked determine the coverage groups, and I do not think there is one in that document covering emergency dialysis.

Our fiscal note associated with the bill was compiled based on the presumptive eligibility approach. Depending on what you do with this bill, we will need to recalculate our fiscal note. We have had several meetings with Clark County

over the last couple of days, so we will need to update our fiscal note and get a new one.

Chair Dondero Loop:
Thank you to all the parties for working together. It makes it so much nicer for us. Does anyone have any questions or concerns?

Assemblyman Eisen:
As section 3 of the bill has been deleted, does that amendment also delete section 4, since the only change to existing statutory language proposed in section 4 is a reference to section 3?

Brian Brannman:
That is probably correct.

Alex Ortiz, representing Clark County:
Yes. In striking section 3, any reference to section 3 in the remainder of the bill would be stricken as well.

Chair Dondero Loop:
Are there any additional questions or concerns?

Assemblyman Duncan:
Mr. Willden, do we anticipate that people are going to be moving in and out of the emergent versus chronic categories? If so, how do we deal with that if this bill goes forward?

Michael Willden:
We need to define what an emergent service is. We have looked at four or five states' definitions, and it is my guess that we would probably pattern something after Illinois's language defining what an emergency condition is. I can paraphrase that language: occurs suddenly and unexpectedly; caused by injury or illness; requires medical attention; serious jeopardy to a patient's health; serious impairment to bodily functions. The language adds that once established, an emergent situation is limited. We would need to have a definition like that. It would be for a certain period of time. We would have to reevaluate the patient and go through the clinical criteria again to determine whether that patient was better or not, or if the definition had shifted to chronic care versus emergent care.

We have spent a lot of time talking about dialysis. As we all know, if you skip two or three days of dialysis, you are in huge trouble. I do not know where that fine line is. Once you start dialysis, particularly if it is an end-stage renal

condition, you are probably there for life. I do not know too many patients who get well enough to come off it, but there are other criteria. For instance, someone might have had a surgery and lost some kidney function and just need a couple of weeks of dialysis. At that point, it would no longer be deemed to be emergent and would need to be evaluated again if there is another presenting emergent condition. But it would not be a lifetime approval for dialysis. We will work to have a policy attached to the fiscal note that we resubmit so people can be clear concerning our policy associated with the fiscal note.

Chair Dondero Loop:
Are there any additional questions or concerns from the Committee? [There was no response.] Does anyone else wish to talk in the neutral position? [There was no response.] Does anyone else wish to testify on A.B. 1? Seeing none, I will close the hearing on A.B. 1.

Is there any public comment or any comment from Committee members? Seeing none, this meeting is adjourned [at 2:07 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn Dondero Loop, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: March 25, 2013 **Time of Meeting: 1:36 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 1	C	Alex Ortiz, Clark County	Proposed amendment