MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Seventh Session
February 12, 2013

The Senate Committee on Health and Human Services was called to order by Chair Justin C. Jones at 3:30 p.m. on Tuesday, February 12, 2013, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Justin C. Jones, Chair
Senator Debbie Smith, Vice Chair
Senator Tick Segerblom
Senator Joseph P. Hardy
Senator Ben Kieckhefer

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Policy Analyst
Risa Lang, Counsel
Joyce Hinton, Committee Secretary

OTHERS PRESENT:

Brian M. Patchett, President/CEO, Easter Seals Nevada
Michael J. Willden, Director, Department of Health and Human Services
Brian Brannman, CEO, University Medical Center of Southern Nevada
Emelina Quisumbing, M.D., CEO, FirstMed Health and Wellness Center
Maureen Cole, Administrator, Rehabilitation Division, Department of Employment, Training and Rehabilitation
Kristina L. Swallow, P.E., Engineering Program Manager, City Engineer Division, Department of Public Works, City of Las Vegas
Daniel Mathis, Nevada Health Care Association

Chair Jones:
The first topic of discussion is how to leverage State funding to obtain federal funding in health care.

Brian M. Patchett (President/CEO, Easter Seals Nevada):
I am a vocational rehabilitation counselor and a person with a disability. Leveraging State dollars to maximize federal funding is extremely important. Unfortunately, Nevada does not have the match monies required to draw down all the available federal dollars. In 2012, over $9 million in federal funds were left on the table for vocational rehabilitation programs. Nevada will continue to pass on millions of dollars until we find ways to provide the required nonfederal matching funds to draw down all the available federal dollars.

Additional funding would enable vocational rehabilitation to hire more counselors, serve more people with disabilities and help more of the disabled population become employed. I like the idea of working with the school districts to leverage some of their funds already used to transition persons with disabilities from school to work. Increased funds would allow us to provide new and more comprehensive services to youth with disabilities as described in the handout "Cooperative Agreements between state Vocational Rehabilitation (VR) programs and/or other state agencies and nongovernmental organizations to capture non-state match money in order to draw otherwise unused federal Sec.110 VR funds" (Exhibit C).

I am interested and happy to work with others to increase funding to serve people with disabilities.

Michael J. Willden (Director, Department of Health and Human Services):
The task today is to find ways to maximize federal revenue by looking for potential health care funding opportunities. The Department of Health and Human Services (DHHS) has done some things and will be exploring new opportunities. During my brief presentation, I will refer to information contained in the "Division of Health Care Financing and Policy, Medicaid and Nevada Check Up Fact Book" (Exhibit D).

Eligibility, pages 2-4 of Exhibit D, is a key component for leveraging funds. Nevada has historically been a low eligibility, or what some may call a "stingy" eligibility, state. We have not chosen many of the optional coverage groups offered for Nevada Medicaid. For example, we are 1 of 13 or 14 states that do not have a medically needy program. In that program, applicants spend their income down to become Medicaid eligible. Another example is coverage for pregnant women. Nevada covers pregnant women up to 133 percent of the federal poverty level. States can choose to cover women up to 185 percent of the poverty level. Choosing these options could bring in additional federal dollars but would require the State to come up with additional match monies. Whenever optional coverage groups are considered, the question is always where to find the nonfederal match.

When Governor Brain Sandoval decided to opt into the Medicaid expansion under the Affordable Care Act (ACA), most of the optional coverage groups became moot points. The ACA will grow the Medicaid population from 313,000 enrollees to 490,000 enrollees by the end of fiscal year 2014-2015. This will result in an additional $770 million of new Medicaid spending, of which $72 million will be State General Fund (GF) dollars.

States can obtain waivers from the federal government to waive eligibility rules or service packages or to do research and demonstration projects. Nevada has taken advantage of some waiver options to expand coverage and services. We operate four home- and community-based services waivers under section 1915(c) of the Social Security Act. These waivers provide expanded coverage for persons with mental retardation and related conditions, frail elderly, persons with physical disabilities and elderly persons living in assisted living facilities. We also have waivers on service packages for adult day health, habilitation services and day treatment, and a pending section 1115 waiver on managed care and care management.

Mandatory and optional Medicaid services are described on pages 4 through 6 of Exhibit D. Nevada could choose additional service options and increase the federal revenue for those services but would have to come up with the State match portion of the funding.

Another potential funding opportunity pertains to emergency services for noncitizens. Noncitizens are only eligible for emergency Medicaid services.

Kidney dialysis is one of the services frequently discussed. The DHHS is working with representatives from the University Medical Center of Southern Nevada to explore the possibility of leveraging federal funds for undocumented immigrants seeking emergency dialysis treatment.

The DHHS is continually looking for ways to take advantage of other people's money to leverage federal dollars in the Medicaid program. Those opportunities are ongoing, and new ones come along nearly every day. A substantial amount of federal dollars are brought into the State through the Disproportionate Share Hospital (DSH) program, the Upper Payment Limit (UPL) programs and the county match program described on pages 6 and 7 of Exhibit D. In these programs, the match dollars are 100 percent county monies; there are no State funds involved. Additionally, the counties pay a voluntary contribution on top of the nonfederal match that is reinvested into the Medicaid program. This amounts to approximately $85 million for each year of the upcoming biennium.

School health care program dollars can be used as match dollars. We are doing some of this now but could be more aggressive to expand our efforts in this area. The Nursing Facility Provider Tax program imposes a 6 percent tax in the long-term care system as shown on page 7 of Exhibit D. Those dollars are used to leverage federal dollars to make enhanced quality payments to nursing homes.

Certified public expenditures are used to leverage federal health care dollars when there are GF dollars available in other budgets. The Child Welfare Program is the best example of where this has been done.

Grant opportunities are ongoing. The grant application period is usually a small window in time—typically 6 weeks. As a State, we need to be prepared. This includes ready needs assessments, having all the possible data to support the grant requests and having partnerships intact. Most grants seek public/private partnerships and nonprofit involvement.

The ACA has two big opportunities in mental health resulting in substantial GF savings and increased federal funds. First, more people in the mental health population—an estimated 56 percent more—will be Medicaid eligible. We believe we can save about $30 million in GF accounts if we do a good job of referring this population to Medicaid payers, do a good job in Medicaid billing and have appropriate rate structures to bring in maximum federal dollars.

Another huge opportunity for bringing in more federal dollars for mental health is the Medicaid Institutions for Medical Disease (IMD) exclusion. The IMD exclusion affects people 18 to 64 years old in freestanding psychiatric hospitals. This population is not eligible for any federal dollars. Only the children and elderly are eligible. It is possible they could be eligible if the psychiatric facilities were licensed in a different way or the facility was not a freestanding psychiatric facility but rather a psychiatric wing associated with a hospital.

We have been talking to the Nevada Hospital Association and their subcommittee dealing with psychiatric hospitals trying to find opportunities where we can work through the IMD exclusion. Ten or eleven states have received grants to work on pilot projects that will be reviewed by the Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services. The hope is the IMD exclusions will be eliminated and replaced with new opportunities to obtain federal funding for these individuals. Absent that, we are looking for creative licensing and ways to associate freestanding psychiatric facilities with medical hospitals.

The DHHS is also exploring opportunities for leveraging the Indigent Accident Fund and Supplemental Indigent Medical Care Fund which are funded with the 2 1/2-cent property tax equating to $21 million.

Brian Brannman (CEO, University Medical Center of Southern Nevada):
The University Medical Center of Southern Nevada (UMC) is Nevada's safety net hospital (Exhibit E). It has 540 beds, a Level I Trauma Center, a Level II Pediatric Trauma Center and a transplant center. It is the primary teaching hospital for the University of Nevada School of Medicine. The UMC fits the mold of safety net providers and is comparable to any throughout the Country. The UMC treats the medically underserved indigent population and gives approximately $250 million of uncompensated care every year.

Despite the revenue received through the insured patients and commercial insurance, UMC requires a $60 million subsidy from Clark County. That number is not $250 million because we have some paying workload and are the beneficiaries of the DSH funding described by Mr. Willden. This fiscal year, we were able to reduce the Clark County subsidy to $30 million. Some of our operating loss was recovered by funds from the UPL Program—a tangible result of using Clark County money as the nonfederal match for obtaining additional federal funds.

We have been supportive of the Medicaid expansion under the ACA primarily because it provides a greater outreach to the underserved population in our community. However, there is a downside. With the expansion of insured individuals through Medicaid and through the Silver State Health Insurance Exchange, we will experience some increase in revenue. Unfortunately, the way the current program is structured, the DSH funding will begin to taper off in 2014-2019, and as a result, the DSH payment reduction will more than offset the increase in revenue from insured patients. If there are no further changes, we can potentially experience a $50 million reduction in our annual revenue.

We must pursue creative avenues to increase federal revenues such as the section 1115 waivers Mr. Willden discussed. We are examining collaboration possibilities with Clark County Social Service to use some of their indigent care funds.

Mr. Willden cited the dialysis patients as an example of uncompensated care for people ineligible for Medicaid and Medicare primarily due to their documentation status. They show up in our emergency rooms for dialysis and the cost of approximately $6 million a year is borne 100 percent by our county taxpayers.

We have discussed leveraging the Indigent Accident Fund (IAF) with Mr. Willden. There are many complications about how these funds are allocated and distributed. This could be a catch-22 situation with respect to proposals for increasing revenues. If the Medicaid reimbursement rates were increased, we would potentially be the beneficiary of funds being matched coming through the IAF. However, we must be careful this is not offset by reductions in the UPL program. In the end, there must be a net benefit.

We are hoping for discussions about how we can be more creative, and how we can avail Nevada citizens with additional federal funds that will help us with at least some of the issues.

Emelina Quisumbing, M.D. (CEO, FirstMed Health and Wellness Center):
I will be talking about how to leverage State funding to bring federal dollars into Nevada through the Federally Qualified Health Centers (FQHC) program (Exhibit F). The content of my presentation includes FQHCs, their impact, the opportunities for federal funding, why FQHCs are needed in Nevada and the Incubator Program. This information has been taken from federal and state sources about the FQHC.

The FQHCs are not-for-profit clinics that serve the underserved population. They are federally designated by the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services (HHS), and are otherwise called "330 Grantees" or "Community Health Centers." These centers must be located in or serve a medically underserved area governed by a board comprised of community members.

The FQHCs are intended to provide comprehensive preventive, primary health care and supportive services They must provide access to health care for all regardless of ability to pay, charge for services on a sliding-fee scale and meet federal performance and accountability requirements. The FQHCs must have governance, a mission and strategy, management and finance, and a clinical program. The clinical program must have a service delivery model, collaborative relationships to provide a continuum of care, adequate clinical staff and clinical systems and procedures in place. Additionally, the FQHCs must have sound management staff and structure, patient management systems, financial policies and a facility out of which it practices.

The benefits of having an FQHC status are access to federal grants to support costs of providing uncompensated care; access to federal grants to support costs of planning and developing a health care network or plan; prospective payment system reimbursement for Medicare and Medicaid patients based on actual cost of providing care; access to free medical malpractice coverage under the Federal Tort Claims Act, 28 USC sections 1346(G), 2671-2680; access to

the 340B Drug Pricing Program and Pharmacy Affairs under section 340B of the Public Health Service Act, created under section 602 of the Veterans Health Care Act of 1992; access to grant support and loan guarantees for capital improvements; right to have out-stationed eligibility workers on site; reimbursement by Medicare for "first dollar" of services, deductible is waived; access to Vaccines for Children Program, Centers for Disease Control and Prevention, HHS; and access to National Health Service Corp, HHS, provider placements.

Look-alike FQHC clinics meet all the requirements in section 330 of the Public Health Services Act but do not receive grant support or receive coverage under the Federal Tort Claims Act.

In 2011, there were 1,100 FQHCs nationally with 8,500 sites providing care to over 20 million patients. Of these, 75 percent were minorities, 40 percent were uninsured and 33 percent were children. Statistics show there was a reduction in health care disparities and improvement of patient outcomes despite serving a high-risk population.

The FQHCs are an integral source of employment and economic growth. The current system employs 138,000 people including 9,900 physicians and 6,900 mid-level providers. In 2010, FQHCs generated $20 billion in economic activity for low-income areas by providing employment and indirectly by purchasing goods and services.

The patients served by FQHCs had 5.8 out of 1,000 fewer hospitalizations. The FQHCs provide high quality care at the cost of $1.64 per patient per day. It lowers utilization of emergency visits and inpatient stays saving hospitals $1,600 per patient per day. It is forecasted that nationally, expansion of FQHCs under ACA will save $122 billion in total health care costs between 2010 and 2015, of which $55 billion will be savings in Medicaid.

The ACA established an FQHC fund that provides $11 billion over 5 years. This includes $9.5 billion to support ongoing FQHC operations to create new FQHC sites and to expand the delivery of oral health, behavioral health, pharmacy and services at existing sites. Additionally, $1.5 billion of these funds will be used for major construction and renovation of existing sites.

In 2011, $1.7 billion were awarded for FQHCs. Of this, $732 million went to 144 FQHC facilities for capital development, $900 million for ongoing FQHC programs, $40 million for 67 new FQHC sites and 129 planning grants. Quality improvement activities were funded for 900 FQHCs for $40 million.

In 2012, the ACA provided an additional $129 million for 219 new FQHCs to provide care to 1.29 million patients. None of these was awarded to Nevada. There was $629 million paid out for capital development to 171 FQHCs for renovation, expansion and construction to serve an additional 860,000 patients. Another $99 million was spent for facility improvements.

In 2013, almost $3.1 billion is appropriated under the ACA including $19 million for 25 new FQHC sites to serve an additional 21 million patients. The funding opportunity announcement (HRSA-13-228) was made about 3 weeks ago for the New Access Point, Health Resources and Services Administration (HRSA), HHS application. The deadline for applications is April 3, 2013. Nevada is encouraged to apply.

Statistics show Nevada is a good candidate for FQHC funding. Nevada has high levels of uninsured—estimated 22 percent of the population or 592,600 people. There is a high level of uninsured children, 134,300. Compared to the Nation, Nevada Medicaid is under enrolled—10 percent to 20 percent, respectively. Despite the need, Nevada is making few attempts to obtain this funding. No awards were made to Nevada during 2011 and 2012.

Nevada has two FQHCs with 33 sites serving 10 percent of the uninsured population—57,987 people. The capital development grants awarded in 2012 are illustrated on pages 23-25 of Exhibit F. Those highlighted in orange, including Nevada, received the least funding.

The barriers to FQHC funding in Nevada are lack of technical assistance resources; existing FQHCs have not adjusted to "competitive" environment; there is a lack of understanding about the value of FQHCs; and clinics, such as FirstMed Health and Wellness Center (FirstMed) that have interest, lack the budget to afford the indirect costs of care.

FirstMed Health is a not-for-profit clinic. We are structured around the FQHC model. There is a commitment to providing access to health care to all regardless of ability to pay. We have served over 6,000 patients in 2012 alone. We are the only clinic awarded an FQHC Planning Grant in southern Nevada. We have successfully identified our underserved service areas. We educate and advocate to address health care issues of those who have no ready access to care. We worked with State Senator Allison Copening in advocacy and collaborative efforts to develop more FQHCs. We worked with State Assemblywoman Irene Bustamante Adams to sponsor an Incubator Program. We believe FirstMed is a good candidate for FQHC funds.

The goal of the Incubator Program is to leverage additional federal funds through new FQHCs or FQHC look-alike clinics by helping organizations ramp up to meet the federal requirements. The components of the Incubator Program include planning grants, development grants, transitional operating support and capital infrastructure grants.

The Incubator Program Planning grant supports specific technical assistance activities key to successful applications. This includes organizational feasibility studies, board development, strategic planning and work plan development, needs and asset mapping, and basic training on FQHC requirements.

The development component includes support for development of organizational and collaborative capacities including grant writing, negotiating formal collaborative relationships and staffing.

The transitional support component helps to operationalize clinics to increase the likelihood of obtaining FQHC designation in the areas of medical supplies, salaries of key staff and informational systems.

The capital improvement component is to increase the infrastructure of the clinics in equipment purchases, management information systems, major renovations and purchase or lease of mobile units or temporary facilities.

The Nevada Incubator Program is patterned after the successful Texas Incubator Program. In 2003, their state legislation budget included $5 million per year for

the Incubator Program. As a result, the FQHCs more than doubled from 32 to 69, of which 28 became a FQHC through Incubator Grant Funding. This brought in $40 million a year in renewable ongoing federal funds to Texas. The lessons learned from the Incubator Program include consideration of support of funds that will increase capacities for clinics to apply for FQHC successfully; consider resources for the Primary Care Association (PCA) to increase capacity to provide technical assistance; consider working with the PCA to establish policies and guidelines; and use the PCA to address service area overlaps in urban areas.

FirstMed hopes to collaborate with local hospitals to decrease emergency utilization and decrease hospital costs of uncompensated care and readmissions. FirstMed requests a letter of support from this Committee for our application for the 2013 New Access Point funding. Finally, we request your support for passage of the Incubator Program.

Chair Jones:
Did Texas receive $40 million per year from a $5 million a year investment?

Dr. Quisumbing:
Yes. The Texas model was initially a 4-year project that started in 2003. In the first 4 years, they were able to build 15 new FQHCs. The Incubator Program is ongoing, and so far they have developed 32 new FQHC sites. As a result, $40 million per year in renewable ongoing federal funds have been brought into Texas through this FQHC program. This was used for developing new sites, capital development and expansion of services.

Chair Jones:
Is capital development about building new structures or modifying existing structures?

Dr. Quisumbing:
Capital development is mostly related to renovation and major construction.

Chair Jones:
Is Nevada getting fewer capital improvement dollars for FQHCs than other states?

Dr. Quisumbing:
Yes. In 2012, Nevada received $1.2 million in capital grant funding. As you can see on the illustrations shown on pages 23 through 25 of Exhibit F, most other states have done far better than Nevada. States that have a similar total population to Nevada, including Mississippi, Kansas, New Mexico and Utah, received at least ten times more capital development grant funding than Nevada.

Chair Jones:
I have two questions for Director Willden. First, what policy changes, if any, are needed to use additional State dollars to increase federal funding? Are there any existing programs with dollars that could be leveraged to help this cause?

Mr. Willden:
Regarding the policy changes, two items come to mind we cannot move forward without statutory changes. The first concerns the IAF. This has significant potential for leveraging dollars to increase federal funding. However, as Mr. Brannman from the UMC indicated, there are many sticky moving parts. As Medicaid rates increase, the gap between the Medicaid and Medicare payments is less, which then affects the UPL program. We have to be cautious about what we do, but if we do not change the statutes, there is no opportunity going forward. The second item is the private hospital UPL. As previously discussed in this Committee, there are statutory changes that must be made to get over some legal hurdles. If this is done, there would be opportunities to bring in additional federal dollars to benefit the private hospitals and the State.

The most significant issue I see is to continue focus on the mental health system. We have many State dollars in our mental health delivery system and very little federal money. The DHHS needs the staff requested in the budget to improve efforts in rate setting, billing and eligibility. We must continue to monitor, follow and push the federal government for changes in the IMD exclusion policy.

Chair Jones:
Mr. Patchett, do you have any thoughts on statutory changes or where we could best utilize our dollars?

Mr. Patchett:
I agree with Mr. Willden. He made some good points. In developmental disability services, we sometimes do not draw down all the available federal funds because we do not have adequate staff to ensure everything is billed correctly. In vocational rehabilitation, one of the best opportunities is working with the school districts to find ways to match those dollars. We should explore the feasibility of using money from nonprofits or foundations as the nonfederal match.

Mr. Brannman:
We must evaluate the inefficiencies in our delivery of care systems. Mental health is a prime example of an inefficient program that does not provide good patient outcomes. Our current system funnels the medically underserved and uninsured people through very costly inefficient emergency rooms. The UMC sees more than 100,000 people a year in our emergency department. This population needs to be assessed, and proactive steps taken to funnel them to the appropriate service delivery mechanisms. We need to reach out and bring the services to the people. Many dollars can be saved by putting clinics in schools and other public places.

If we continue to operate in the free fall system we have today, we will not have enough money going forward, especially considering the high number of individuals accessing the emergency rooms. We must think differently in terms of how we are structuring our system in Nevada. Nevada is still small enough to enable us to make some great improvements in our service delivery system.

Dr. Quisumbing:
I believe providing the community access to health care would make the biggest difference.

Senator Kieckhefer:
Is FirstMed an FQHC?

Dr. Quisumbing:
No, it is not. We are applying for the New Access Point grant that was recently announced.

Senator Kieckhefer:
Does FirstMed utilize the sliding fee scale set by the federal government?

Dr. Quisumbing:
Yes.

Senator Kieckhefer:
Is there ever a level where it becomes free to see a doctor?

Dr. Quisumbing:
We do not refuse services if patients are unable to pay. We ask them for proof of income. Patients pay between $20 and $100 depending upon their income level. We do not require payment from people whose income is below the federal poverty level.

Senator Kieckhefer:
Does the separate Medicaid reimbursement rate for services under FQHCs continue under the ACA?

Mr. Willden:
Yes. There are specific Medicaid reimbursement rates for the two Nevada FQHCs—Health Access of Washoe County and the Nevada Health Centers.

Senator Kieckhefer:
Do the FQHCs receive a higher Medicaid reimbursement rate?

Mr. Willden:
I believe it is nearly double what is paid to doctors in the community. Rural health care centers also have a different rate.

Senator Kieckhefer:
Will this be different under the ACA?

Mr. Willden:
No.

Senator Kieckhefer
I understand the prison population is not eligible for Medicaid unless they receive medical services outside the prison and stay overnight.

Mr. Willden:
Your statements are accurate. Six months ago the DHHS entered into an agreement with the Department of Corrections that allows providers to bill for Medicaid reimbursement for inpatients receiving medical services outside the prison.

Senator Smith:
Why is the dialysis service so outstanding in the emergent care discussion?

Mr. Willden:
Over $6 million in dialysis cost per year is incurred by UMC for noncitizens. This equates to around 2,200 visits. Medicaid will only pay for emergency services for noncitizens. There has been an ongoing debate about whether dialysis is considered a chronic or emergent service. These have been considered chronic services and therefore ineligible for Medicaid reimbursement.

Senator Smith:
Does Nevada have the ability to change the law on this?

Mr. Willden:
We have had recent meetings with county and UMC staff about this. My staff is doing in-depth research of the federal regulations and national literature. Once I review these findings, I will know whether Nevada can claim Medicaid reimbursement for these services. If it can be an allowable Medicaid expenditure, we will have to decide who pays the nonfederal match—the counties or the State.

Senator Smith:
Your agencies involve the public in working groups during the grant management process. Are you able to utilize some of those volunteers with the grant application?

Mr. Willden:
Yes. In the director's office, we have a Grants Management Advisory Committee. Some of the other divisions that issue grants have advisory boards. We leverage their knowledge wherever we can. We leverage our grantees' knowledge. We try to do everything we can to take advantage of grant opportunities. The Health Division, DHHS, has several advisory boards. These are volunteer, nonpaid advisors. We even use some grant writers in the community. We have had cases where our grantees will step up and write grants.

The difficulty in writing grants is about being ready. I cannot overemphasize that point. The DHHS does not miss knowing about a grant opportunity. If we miss grant opportunities, it is usually because we cannot provide the information in the short time frames allowed.

Senator Smith:
We have seen this same issue throughout the State. I have especially seen this in the education area. I am always wondering how to make this better.

Mr. Willden:
Most grant opportunities require a strategic planning process and a community needs assessment. There is not enough time to do these in the typical 4 weeks before a grant application deadline. Staff and ongoing efforts must be funded for building information databases, doing strategic planning and community needs assessments. When the grant application opportunity comes, the information must be readily at hand. We must be able to pluck, plug and submit the data required for the grant application.

Senator Smith:
This will be a discussion for another day in the budget hearings. We as decision makers need to help agencies find what they need to be prepared to apply for these grants.

Regarding people going to the emergency rooms rather than to their primary care physicians, I want to ensure we have a plan and the necessary funding to correct this problem.

Mr. Willden:
Education is essential as we expand Medicaid and health insurance to hundreds of thousands of Nevadans who have never had an insurance card. We must address outreach, education and access issues. A key part is making sure there are enough providers to access. That is why the FQHCs and the health centers play an important role. As pointed out by Mr. Brannman, we must improve the inefficiencies of our medical services delivery system and make the most efficient use of our dollars.

Senator Smith:
I have likened health care to dental care. Over the last several decades, our entire society has changed about dental care. It moved from not having access to having access and understanding the importance of going and knowing where to go. We can do the same thing with health care and will save money in the end.

Senator Hardy:
I am concerned about having enough providers to afford access to health care. When I consider the FQHCs, I wonder where we and all the other states are going to find adequate doctors and nurse practitioners. The graduate medical education and how it fits into the fallout of the ACA is another whole topic we have yet to discuss.

Mr. Willden:
There is a grant opportunity for three states to obtain some high-level technical assistance on access issues. The DHHS is submitting a grant application next week to compete for these funds. If Nevada is selected to participate, we will be able to bring some national experts into Nevada to help us with this.

Chair Jones:
I will now open the hearing for Senate Bill (S.B.) 54.

SENATE BILL 54: Revises provisions governing the operation of certain vending stands by persons who are blind or visually impaired. (BDR 38-370)

Maureen Cole (Administrator, Rehabilitation Division, Department of Employment, Training and Rehabilitation):
I have prepared testimony (Exhibit G) on S.B. 54. The first paragraph of the second page is replaced by the following material I presented:

> The fiscal notes filed to date do not indicate a fiscal impact on local or state government. The comments filed by the City of North Las Vegas reflect an older philosophy of the BEN program in which the program tried to negotiate a portion of the proceeds from the site that it was not going to develop if it were operated by a private individual. That policy has since been changed and in fact, the program has waived the priority of right for the blind vendors in that North Las Vegas site that was at issue.

Chair Jones:
Can you give me an example of how this is working in a particular location?

Ms. Cole:
The Caucus Deli located on the ground floor of the Nevada Legislative Building is an example. This snack bar is operated by a blind vendor in partnership with a local business. They do not pay rent. They pay a portion of their net proceeds into the Business Enterprises of Nevada (BEN) fund, Department of Employment, Training and Rehabilitation (DETR), which then funds the program in its entirety. The BEN is the only such program in the United States that does not receive state or federal funding. It is totally self-sufficient.

Chair Jones:
How many vendors are there in Nevada?

Ms. Cole:
There are 15 vendors at 29 sites.

Senator Hardy:
When you talk about set-asides, is there a list of things that are allowable charges?

Ms. Cole:
I do not have that with me today, but I can provide this information to the Committee. There is a list of permissible expenditures. By exclusion, anything not listed is not permissible.

Senator Hardy:
Is this a federal or State list of set-asides?

Ms. Cole:
It is both federally and State regulated. I will provide both lists to you.

Senator Hardy:
That would be helpful.

Kristina L. Swallow, P.E. (Engineering Program Manager, City Engineer Division, Department of Public Works, City of Las Vegas):
We support the efforts of the Bureau of Services to the Blind and Visually Impaired and Bureau of Vocational Rehabilitation and want to make sure their efforts continue to provide opportunities for employment for the blind. We also want to make sure the bill provides clarity so all public agencies know what can and cannot be charged.

Recently we had to seek a judicial determination for clarity on the existing law. The ruling said rent is not an allowable charge but utilities are. Each space is different and not all can be independently metered for all utilities. Consequently, in some cases utility and other facility charges are charged as a proportional share of the overall costs.

We do support the goals of the Bureau, and we do not oppose providing free space rent. Unfortunately, we also have customers—the taxpayers—who may

have concerns about our costs going up as a result of utilities, maintenance or security associated with these facilities if we are unable to charge a fee to offset those costs. As the bill is currently written, we will be unable to charge any fee to offset those costs. This may deter local governments from providing vending opportunities and jobs for the visually impaired and blind.

We do not have a proposed amendment with us today, as we needed to hear more from Ms. Cole, the sponsor of the bill, to understand the intent. We are willing to work with her and the Committee to find a solution to enable the Bureau to continue to offer job opportunities for the blind and the visually impaired without unduly burdening the agencies providing the vending space.

Senator Kieckhefer:
Do you recover a portion of the net proceeds based upon the contracts you enter into?

Ms. Swallow:
I do not believe we do, but I can verify this information and get back to you.

Senator Kieckhefer:
Could that be a way to recover the costs for the items you are concerned about?

Ms. Swallow:
I believe there would be a way, but I will need to do research and get back to you.

Chair Jones:
Ms. Cole, do the funds collected from the operators go into the BEN fund?

Ms. Cole:
That is correct. Each operator calculates the net profit, and then a portion of that is paid as set-aside to the BEN fund.

Senator Hardy:
Since the blind vendors are the ones who pay into the BEN fund, I suspect they would have a problem with this fund being paid to anyone who had not paid into it. Have there been any discussions about this?

Ms. Cole:
I do not think that conversation has happened because the expenditures that can be made from the BEN fund are limited by regulation. However, as mentioned earlier, in some locations where we can identify the incremental increase in utility costs, we can enter into negotiations with State or local governments to offset those by having the vendor pay that incremental cost.

Chair Jones:
We will close the hearing on S.B. 54 and ask that Ms. Cole and Ms. Swallow work together so that when we take this to work session we can come up with something that everyone can agree to.

Daniel Mathis (Nevada Health Care Association):
I want to comment on the matching federal funds and elaborate on Director Willden's comments. The skilled nursing facilities currently get a 6 percent match set by the federal government. There is an opportunity coming up in the federal Sequestration where they may consider lowering that 6 percent level for skilled nursing. This could result in a rate reduction for Medicaid rates for skilled nursing in Nevada.

Chair Jones:
There being no further business before this Committee, this hearing is adjourned at 4:48 p.m.

RESPECTFULLY SUBMITTED:

_____
Jackie Cheney,
Committee Secretary

APPROVED BY:

_____
Senator Justin C. Jones, Chair

DATE:_____

EXHIBITS				
Bill	**Exhibit**		**Witness / Agency**	**Description**
	A	1		Agenda
	B	4		Attendance Roster
	C	1	Brian M. Patchett	Cooperative Agreements between state Vocational Rehabilitation Programs and/or other state agencies and non-governmental organizations
	D	34	Michael J. Willden	Division of Health Care Financing and Policy, Medicaid and Nevada Check Up Fact Book
	E	3	Brian Brannman	University Medical Center of Southern Nevada
	F	38	Emelina Quisumbing	Federally Qualified Health Centers (FQHC)
S.B. 54	G	2	Maureen Cole	Prepared Testimony