MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Seventh Session
February 5, 2013

The Senate Committee on Health and Human Services was called to order by Chair Justin C. Jones at 3:32 p.m. on Tuesday, February 5, 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
Linda Gentry, Committee Manager
Joyce Hinton, Committee Secretary
Jackie Cheney, Committee Secretary

OTHERS PRESENT:

Michael J. Willden, Director, Department of Health and Human Services

Chair Jones:
The Committee has received three bill draft requests (BDRs) for consideration: BDR R-507, BDR 40-118 and BDR 40-529.

BILL DRAFT REQUEST R-507: Encourages the Department of Health and Human Services and the Insurance Commissioner to work with health care providers and insurers to develop a patient-centered medical home model of care. (Later introduced as Senate Concurrent Resolution 4.)

BILL DRAFT REQUEST 40-118: Revises provisions relating to background investigations for certain persons who work in facilities for long-term care. (Later introduced as Senate Bill 91.)

BILL DRAFT REQUEST 40-529: Makes changes related to the healthcare of newborns. (Later introduced as Senate Bill 92.)

SENATOR SEGERBLOM MOVED TO INTRODUCE BDR R-507, BDR 40-118 AND BDR 40-529.

SENATOR HARDY SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

Chair Jones:
I have given the Committee members a copy of the "Senate Committee on Health and Human Services Rules for the 2013 Session" (Exhibit C).

SENATOR SEGERBLOM MOVED TO ADOPT THE "SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES RULES FOR THE 2013 SESSION."

SENATOR HARDY SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

Marsheilah D. Lyons (Policy Analyst, Research Division, Legislative Counsel Bureau):
You have a copy of the "Committee Policy Brief, Senate Committee on Health and Human Services, 2013 Nevada Legislature" (Exhibit D). This document includes information about: the Committee; the number of measures considered during the 2011 Legislative Session; legislative subjects that typically fall within its jurisdiction; potential issues the Committee may consider during the 2013 Legislative Session; the schedule for implementation of the 120-day Session; contact information for persons representing State agencies and nonprofit organizations who may appear before the Committee; and commonly used acronyms related to health and human services.

During the 2011 Legislative Session, 77 bills, 56 Senate bills and 21 Assembly bills, were referred to the Senate Committee on Health and Human Services. A similar number of bills are expected this Session.

"Senate Standing Rule No. 40" outlines the jurisdiction for each standing committee within the Senate. The Senate Committee on Health and Human Services has jurisdiction over legislation affecting public welfare, mental health, and public health and safety. Exceptions include certain programs listed on pages 3-4 of Exhibit D.

The *Summary of Legislation 2011* includes summaries of measures passed in the last Session and is available from the Legislative Counsel Bureau's (LCB) Publications Office.

Some of the issues expected to be addressed during this Session are described on pages 4-7 of Exhibit D. Among these are the Federal Health Care Reform and Reauthorization Legislation, in particular the Patient Protection and Affordable Care Act (ACA).

Illicit drug use and abuse of prescription drugs are national concerns and have been a topic of discussion by the Nevada Legislative Committee on Health Care. Other concerns related to prescription drugs are discussed on page 6 of Exhibit D.

Health care quality and transparency have been issues over the past several sessions, and emphasis on continuing improvement is expected. Ten years ago, the Institute of Medicine (IOM) sounded the alarm about the widespread toll of medical errors in a report titled "To Err is Human." According to that IOM report, between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals alone. That does not include those who die from medical errors outside the hospital. Each session, this Committee considers improvements to safety and quality in hospitals and other medical facilities. We can expect legislation related to this topic.

Several high profile tragic events have put an emphasis on mental health across the country. Item 4 on page 7 of Exhibit D lists possible mental health topics that may surface in this Committee.

Chair Jones:
As you will learn in future hearings, mental health is something I care deeply about because it has touched both my family and my close friends. I discovered a book I highly recommend titled *Crazy: A father's Search through American's Mental Health Madness* by former Washington Post reporter Pete Earley. This book opened my eyes to the difficult issues that families face in dealing with mental illness, and the societal and structural problems that we face in treating those affected by mental illness. This Committee is expected to hear testimony related to mental health issues this Session.

Ms. Lyons:
As Chair Jones indicated, he has a particular interest in mental health, and nationally there is an interest in mental health. This Committee can expect many bills related to mental health. Some of the issues are: access to mental health care including insurance coverage for mental health care; mental health care professional shortage we in Nevada in particular are experiencing; improving the criminal justice system response to people with mental illness; review of procedures for commitment; community-based programs and support for persons with mental illness; and children's mental health issues.

Other state and federal issues that may be discussed in this Committee are managing the pharmacy benefit and overall cost of the Medicaid program; State oversight of long-term care and assisted living; childhood and adult overweight and obesity; health information technology and electronic health records systems; and unlicensed health care and health care workforce development.

Page 8 of Exhibit D lists important deadline dates. Senate bills must be out of this Committee by April 12, 2013, and either be referred to a money committee if they have a financial impact or sent to the Assembly if the Committee intends to do so. Without such action on or before that deadline, bills will die.

Some bills are marked exempt or eligible for exemption. When a bill is marked for exemption, it does not mean it is exempt while it is in this policy Committee. It will only become exempt when referred to a money committee. Some bills related to legislative issues are exempt for legislative business and will never be referred to this Committee. Even if a particular bill is eligible for exemption, it is still subject to the first house passage and all other deadlines.

Pages 8-11 of Exhibit D describe reports produced by LCB.

The Research Division, LCB, is available to assist the Committee and its members on any issue related to matters before the Committee. In addition, the Research Division provides information and assistance on a confidential basis to individual members of the Legislature on any topic.

Michael J. Willden (Director, Department of Health and Human Services):
I will begin by reviewing some of the highlights in the "Senate Health and Human Services Presentation/Departmental Overview" (Exhibit E). Page 2 illustrates the departmental organization. The Department of Health and Human Services (DHHS) is organized into six divisions: Aging and Disability Services; Child and Family Services; Health Division; Mental Health and Developmental Services; Welfare and Supportive Services; and Health Care Financing and Policy (also known as Medicaid). Additionally, the DHHS is responsible for the oversight of the Nevada State Public Defender's office.

Two pieces of legislation will be forthcoming that affect the organization of the DHHS. The DHHS proposes integrating services for people with disabilities along the lifespan into a single division. Services/programs now scattered over three divisions would be combined under one. The current Division of Aging and

Disability Services would receive and integrate five new budget accounts including Desert Regional Center, Sierra Regional Center, Rural Regional Center, Family Preservation Program and Early Intervention Services. The Suicide Prevention Office would transfer out of the director's office and be integrated within the Public Health/Mental Health Division. The Nevada Check Up eligibility function would transfer from the Division of Health Care Financing and Policy to the Division of Welfare and Supportive Services. This is where the other health care eligibility functions are located and would further efforts for the "no wrong door" initiatives.

Page 3 of Exhibit E shows a history of DHHS's full-time equivalents (FTEs) over the past decade. During the last 4 years when the economy was poor, DHHS lost FTEs. Staff numbers declined while caseloads rocketed. Consequently, case-processing time frames fell behind. Increased staff is requested for the upcoming biennium primarily because of the increased caseload activity resulting from the ACA and expansion of the Supplemental Nutrition Assistance Program (SNAP). Page 4 illustrates where the FTEs are located within the various divisions of the DHHS. The majority of staff is located in the Welfare and Supportive Services Division and Behavioral Health.

Page 6 of Exhibit E shows a side-by-side comparison of the funding distribution for the 2013-2015 biennium. If approved, the DHHS budget will increase by $1.2 billion for fiscal year (FY) 2014-2015. The general fund (GF) increases by only $136 million. Most of the increase is funded by new federal dollars related to the ACA.

The DHHS administers approximately 80 budget accounts. The detail about these accounts can be found on pages 8-10 of Exhibit E.

The federal medical assistance percentages (FMAP) determine the amount of monies Nevada receives from the federal government. The available funding is important to policy committees because as policies are created the cost for implementing and administering these policies must be considered. The projected FMAP shown in the table on page 12 of Exhibit E is inversely related to Nevada's per capita income. As a state's per capita income declines, the FMAP increases resulting in more federal dollars coming into the State. As the

chart on page 13 shows, Nevada's per capita income declined from 2009 through 2011, and although it has improved 2012 forward, it has remained below the Nation's per capita income. Going forward, Nevada is projected to improve at a slower rate than for the Nation. This keeps Nevada's federal matching percentage high. The FMAP for the last completed year, FY 2011-2012, was 55.05 percent. This is projected to improve to approximately 62 percent-63 percent for the 2013-2015 biennium. Millions of State Medicaid dollars are saved by shifting the costs to the federal government. The people newly eligible under the ACA are 100 percent federally funded FY 2013-2014 through FY 2015-2016. After that, the federal funding declines each year as shown on the page 13 chart.

Pages 16 through 39 of Exhibit E, titled "Nevada Data & Key Comparisons," contain global information about eligible populations and show how Nevada compares nationally with respect to some indicators. This document is maintained on the DHHS Website. I will highlight a few items that may be of particular interest.

As shown on Page 16 of Exhibit E, Nevada's age distribution is similar to the Nation as a whole. Nevada's racial mix differs from the U.S. average with higher overall percentages and faster growth for our Hispanic and Asian populations. Nevada's total minority population increased from 36 percent in 2002 to 47 percent in 2011. This represents a 10 percent increase compared to the Nation's increase of 5 percent for the same period of time.

Beginning on page 19 of Exhibit E, information describes populations living in poverty. As a whole, Nevada looks similar to the Nation.

Child Welfare data including maltreatment, fatalities, child protective services response times, average time in foster care and adoptions are displayed on pages 21-22. Nevada's children suffer less maltreatment per thousand than the Nation as a whole. The rate of maltreatment fatalities in Nevada is similar to the national rate—2.2 per 100,000 compared to 2.1 per 100,000. Our child protection agencies have a far better response time than the Nation—13 hours compared to 78 hours, respectively.

Nevada is not doing as well as the Nation in adoptions, page 22 of Exhibit E. The ratio of adoptions to those waiting for adoptions is 49 percent for the Nation compared to 42 percent for Nevada. However, if you look at the 10-year history for Nevada, there has been significant improvement.

The nursing home and community program information illustrated on page 23 of Exhibit E indicates the number of nursing facility residents in Nevada is 160 per 1,000 population. This is better than the national average of 251 per 1,000 population. Residing in the community is generally considered better than residing in a nursing home.

Presentation of health indicators begins on page 24 of Exhibit E. According to the Annie E. Casey Foundation, *Kids Count*—ten infant, children and teen indicators— Nevada's overall health ranking is poor. As shown on page 26, Nevada and the Nation as a whole, are getting more obese. The number of people with an infectious disease is significantly lower in Nevada than the Nation. Nevadans are 25 percent obese compared to 28 percent of the Nation as a whole. We are behind the Nation in vaccinations of children and flu shots received by seniors, page 27.

Page 28 shows how Nevada has been doing on preventative health care. Overall, Nevada is not doing as well as the Nation, but improvements have occurred in areas such as dental visits. Nevada has fewer primary care physicians per 100,000 population than the national average. As shown on page 30, Nevada's uninsured rate is approximately 22 percent while the Nation's rate is 15 percent.

Senator Smith:
What is the number of uninsured Nevadans?

Mr. Willden:
Nevada has 605,000 uninsured individuals. This is the second highest uninsured rate in the country behind Texas. About 207,000 of those are below the poverty level. Nevada's children are sixteen percent uninsured compared to 7 percent nationally.

The mental health and suicide indicators are located on Page 31 of Exhibit E. Nevada does not perform well in these areas. In a nationwide survey of mental health care conducted by the National Alliance on Mental Illness and reported in *Grading the States 2009*, Nevada received grades of F and D with an overall grade of D. Nevada's per capita mental health spending is half the national average, and our suicide rate is third highest in the Nation—20 suicides per 100,000 compared to 12 nationally. The suicide rate among Nevadans 65 or older is more than twice the average for the United States.

As shown on page 33 of Exhibit E, Nevada's Temporary Assistance to Needy Families (TANF) work participation rate is higher than the overall average for the United States—39 percent and 29 percent, respectively. Although Nevada is doing better than the national average, we continually strive to improve this statistic.

Data on Medicaid expenditures are contained on page 34 of Exhibit E. The first chart shows Medicaid spending per capita. Nevada's Medicaid spending is about half the Nation's per capita spending. Nevada spends $561 per capita while the national average is almost $1,200 per capita. This is not about Medicaid paying poorly. While that may be true in some cases, this statistic is more about Medicaid enrollees than the payment structure. For years approximately 7 percent of Nevada's population were Medicaid recipients. Today, about 12 percent of Nevadans are Medicaid recipients compared to 17 percent nationally.

There will be much discussion this Session about the DHHS Food Security Plan. Statistics about food insecurity in Nevada are provided on page 35 of Exhibit E.

Program participation rates by county are shown on page 38 of Exhibit E for the following: TANF; Medicaid; Nevada Check Up; SNAP; Women, Infants and Children (WIC); and Childcare. The counties with higher participation rates are highlighted in darker colors. The lighter colors indicate lower rates of participation. Provided on page 39 is information on socioeconomic and demographic indicators such as employment to population ratio, unemployment rate, median household income, persons below poverty, child poverty and uninsured.

Senator Smith:
Lyon County is ranked the third highest county in the Country with regard to stress. We hear a lot about the severe situation in Lyon County. With the exception of unemployment, these charts do not show Lyon County to be as bad as what we have heard. I am curious if you have any thoughts about that.

Mr. Willden:
I do not know why this is. Lyon County has one of the better county social services programs. I will look into this further and provide additional information.

Senator Smith:
Thank you.

Mr. Willden:
The DHHS administers hundreds of programs. An index of the more substantial programs is provided on pages 41-43 of Exhibit E. Brief program descriptions like the one illustrated on page 45 can be found on the DHHS Website.

Pages 47-55 of Exhibit E include information related to the implementation of the ACA and resulting Medicaid expansion. Included are data about the traditional Medicaid caseload growth, how FMAP will affect the financing, primary care physician rate increases, the ACA expansion caseload growth, administrative costs, specific information on the Disproportionate Share Hospital (DSH) program, impact on the Upper Payment Limit (UPL) hospital program, mental health savings opportunities and other saving opportunities related to the counties.

The uninsured population is 604,867 as shown on page 48. The pie chart on page 49 shows where the uninsured population falls in relation to income. The rate is expected to drop from 22.4 percent to 10.5 percent over the next 2 years. Medicaid and Nevada Check Up are expected to grow from 313,000 Medicaid recipients to approximately 490,000 Medicaid recipients.

Chair Jones:
Considering Nevada has one of the worst uninsured rates in the Country, do you anticipate the Medicaid expansion will bring Nevada more into alignment with other states?

Mr. Willden:
Nevada's uninsured rate is expected to improve 10 percent to 11 percent. Some states like Massachusetts and Hawaii are already at a 5 percent or 6 percent uninsured rate. That is more of an abnormality. Other states are planning to get their uninsured rate down to 8 percent and 9 percent. There are some populations such as noncitizens who will not be eligible. There will also be a population that chooses not to accept one of the insurance products and suffer the tax consequences. Others may choose to continue to be uninsured.

Senator Kieckhefer:
The title on the chart on page 50 refers to 100 percent of the federal poverty level. I thought the expansion was up to 138 percent of poverty.

Mr. Willden:
That is correct. The Medicaid expansion does cover people with income below 138 percent of the federal poverty level. We separated the groups into 100 percent increments. Everybody in the 0.0 percent to 100 percent piece of the pie—207,696 or 35 percent of the 605,000 uninsured—would be Medicaid eligible assuming they are United States citizens and want to participate. In the 100 percent-200 percent category, roughly one-third of those or 177,177 would also be Medicaid eligible. The breakdown for all groups was not shown on page 50; however, the DHHS can provide this information upon request.

Senator Smith:
It is good to understand what the federal poverty level incomes are to know how poor these people are.

Mr. Willden:
The chart on the bottom of page 51 shows the 2013 Federal Poverty Guidelines. A single-person household is considered to be in poverty if the annual income is below $11,490. A family of four is considered to be living in poverty if their income is below $23,550. The Medicaid expansion includes those with income below 138 percent of poverty. At this level, a single person household is eligible for Medicaid when the income is below $15,856, and a family of four is Medicaid eligible if the income is below $32,499 provided all other eligibility criteria are met.

The chart at the top of page 51 of Exhibit E illustrates where the Medicaid expansion applies. The blue bars are what Medicaid currently covers; the red bars are what Nevada Check Up covers; and the yellow bars show specifically where the new Medicaid expansion occurs. For the first time in Nevada history, beginning January 1, 2014, childless adults ages 19-65 can be Medicaid eligible, and this is where the majority of the growth in caseload will occur.

The caseload projections with the anticipated expansion appear on pages 52 and 53 of Exhibit E. The budget requests are based upon these forecasts. The Medicaid caseload is projected to go from 313,515 Medicaid eligibles to 490,103 by June 2015.

The presumptive Medicaid eligibility option available under the ACA is described on page 54 of Exhibit E. This will be a key issue legislators may have to tackle. There has already been one bill, Assembly Bill 1, introduced about presumptive eligibility.

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)

Nevada has never opted to do presumptive eligibility in the Medicaid program. The ACA includes a hospital option for presumptive eligibility. The DHHS has been working with the hospitals and the Nevada Hospital Association on a fast-track eligibility decision rather than a presumptive eligibility decision.

The 35 Decision Units in the DHHS's budget impacted by the ACA are identified on pages 55 and 56 of Exhibit E. Page 55 contains the mandatory provisions where the State has no options and page 56 the enhancement or optional Decision Units. In summary, the ACA will cost the GF approximately $72 million over the next 2 years and will bring in $768 million federal dollars.

Senator Kieckhefer:
Are we going to approve the optional Medicaid expansion solely through the General Appropriations Act and Authorized Expenditures Act, or are we going to see a policy statement from the administration about the expansion?

Mr. Willden:
It is simply budgetary. The Governor has opted in, and that is the message the DHHS has sent to the federal government. The DHHS will be making the necessary State Plan changes, and these 35 Decision Units will be submitted as part of the DHHS's budget for review and approval in the money committees.

Senator Hardy:
Please repeat what the ACA will cost Nevada and how many federal dollars it will bring to the State?

Mr. Willden:
It will cost an additional $72 million in State GF for the FY 2013-FY2015 biennium. Nevada will receive an additional $768 million in federal dollars.

The DHHS has done preliminary work with the state demographer and the University of Nevada, Reno's Economics Department, College of Business, on the impact of bringing in the new federal health care dollars. Implementing ACA could bring in 8,000 new health care jobs. The overall impact to the Nevada economy is significant.

A description of the Disproportionate Share Hospitals (DSH) program and diagrams of how the DSH distribution works is contained on pages 59 and 60 of Exhibit E. In the ACA, the national DSH pool of dollars drops from $11.3 billion nationally to $5.7 billion in federal fiscal year 2019. As the national funds shrink, Nevada's monies will likely shrink. The secretary of the U.S. Department of Health and Human Services has not promulgated final rules yet, but it is possible to see the highlight of what Nevada's impact might be. Nevada will be dealing with a decreasing pool of DSH dollars. The offset to DSH is the Upper Payment Limit (UPL) program run by the DHHS. Information about the inpatient and outpatient UPL programs is provided on pages 61 and 62. DSH concerns uncompensated care and which hospitals provide uncompensated care. The DSH payments are made based upon the disproportionate share different hospitals have. The UPL program is based upon how many Medicaid bed days a hospital provides. The UPL payments in simple terms bring the Medicaid payments up to what a Medicare payment would be. As DSH funds

decrease, the DHHS believes UPL will increase. This is because there will be more Medicaid eligibles and therefore more Medicaid bed days. In summary, uncompensated care, DSH dollars will be less and Medicaid bed days, UPL dollars, will increase. There is much analysis and work to be done by the funding partners to formulate how these programs operate.

The private hospital UPL program as described on pages 64 and 65 of Exhibit E was approved during the 2011 Legislative Session. It is not operating yet. The language in *Nevada Revised Statutes* (NRS) 433.354 and NRS 433B.220 must be revised to allow implementation of this program. Legislation will be forthcoming this Session.

Information about the Indigent Accident Fund/Supplemental Account Fund is provided on pages 68 and 69 of Exhibit E. This account is funded by the counties' 2.5-cent property tax. The State has swept this fund for the past 5 fiscal years, totaling more than $110 million to help in economic bad times.

The Governor is proposing that we no longer sweep this fund which will make it available for its traditional purposes starting in FY 2013-2014 and FY 2014-2015. The fund is expected to have approximately $21 million per year. The DHHS, the hospitals and the counties are working together to find a way to leverage these dollars to maximize the federal funding. We have a concept with general agreement that we will bring forth as legislation to turn $21 million into $56 million.

The DHHS bills of interest to this Committee are listed on pages 71 and 72 of Exhibit E. Page 71 lists the policy bills, and page 72 lists the budget bdrs. The DHHS will be working with legislators on these 14 bills along with legislation regarding the Indigent Accident Fund and Private Hospital UPL.

The DHHS Cliffs Notes on the Governor's recommended budget for the 2013-2015 biennium are provided on pages 73-85 of Exhibit E.

Senator Hardy:
Do we have complete information at this point to be confident about all the estimations in caseload and budget numbers for going forward with implementation of the ACA?

Mr. Willden:
There are still many unanswered questions from the federal government. The DHHS had to proceed with the best information available. We continue to see new proposed and final regulations. It remains a work in progress. The variability is the projected caseload. We are making our best estimates based on the information available. We have negotiation items with the federal government such as an outstanding Social Security Act section 1115 waiver request and unsettled issues concerning administrative financing.

Senator Hardy:
Is there any hope that we have administrative funding sharing opportunities with the federal government?

Mr. Willden:
There are various funding categories in administrative funding. Information technology projects are funded 90/10, federal/State respectively. Some training and other items are funded at 75/25, and general administration is funded at 50/50. The FMAP does not apply.

Senator Hardy:
Does early intervention involve any Medicaid dollars?

Mr. Willden:
Generally, the answer is no. Early Intervention Services can bill for a few Medicaid items. That program falls under Part C of the Individuals with Disabilities Education Act. Part B is schools and Part C covers the three populations the DHHS oversees. The federal government gives DHHS a $4 million grant infrastructure. The State must then contribute approximately $25 million per year to deliver services to approximately 3,600-3,700 youths. The services are provided as a joint effort by State staff and community partners. The Governor's budget includes a substantial GF increase so there will be no waiting list, and we will be able to keep up with the caseload growth.

Senator Hardy:
Does the State have to hire people to provide these services under Medicaid? Is this part of the ACA new staff funding?

Mr. Willden:
The DHHS employs 170 State staff to do parts of the service delivery in Early Intervention Services. There are no planned reductions or layoffs for this group of employees. The new money coming into this budget is being put into our community partners —people or organizations in the community that the DHHS contracts with to provide services to children and families.

Most new staff members, approximately 440, are in the Welfare and Supportive Services Division for the implementation of the ACA and resulting caseload growth. There is approximately 50 new staff members requested for Developmental Services caseload growth, specifically in southern Nevada.

Senator Hardy:
This would be a good time for me to disclose I am on the board for Easter Seals.

Senator Kieckhefer:
Is there anything in place to track medical care access for all these new Medicaid recipients once they come online? Currently, we get complaints about access.

Mr. Willden:
There are some general tracking tools in the Medicaid program. There will be a huge increase in the number of people with health care cards who will be trying to access primary and preventative care. As discussed, Nevada lags far behind, nationally, in the number of primary care physicians. If there are not enough doctors, we will have to look at scope-of-practice issues. The Governor's Workforce Investment Board and the Department of Employment, Training and Rehabilitation have established a Health Care and Medical Services Sector Council that is evaluating this problem. We are working with the Nevada System of Higher Education on studies to determine what we need to do. The DHHS is also applying for a national grant to help us with access planning. Health care access is a huge issue without an easy answer.

Chair Jones:
There being no further business before this Committee, this hearing is adjourned at 4:54 p.m.

RESPECTFULLY SUBMITTED:

_____
Jackie Cheney,
Committee Secretary

APPROVED BY:

_____
Senator Justin C. Jones, Chair

DATE: _____

EXHIBITS				
Bill	**Exhibit**		**Witness / Agency**	**Description**
	A			Agenda
	B			Attendance Roster
	C	2	Chair Jones	Senate Committee on Health and Human Services Rules for the 2013 Session
	D	24	Marsheilah Lyons	Committee Policy Brief Senate Committee on Health and Human Services
	E	85	Mike Willden	Senate Health and Human Services Presentation/Departmental Overview