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

Seventy-Eighth Session
May 11, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 2:17 p.m. on Monday, May 11, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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 www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblyman Nelson Araujo
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblywoman Amber Joiner
Assemblyman Brent A. Jones
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

Assemblyman John Moore (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Karen Buck, Committee Secretary
Norma Mallett, Committee Assistant

OTHERS PRESENT:

Paul Moradkhan, representing Las Vegas Metro Chamber of Commerce
Erin McMullen, representing Nevada Resort Association
Bob Beers, Private Citizen, Las Vegas, Nevada
Dan Musgrove, representing Southern Nevada Health District
Alex Ortiz, Assistant Director, Department of Administrative Services, Clark County
Rod Woodbury, Mayor-elect, Boulder City; Chairman, Southern Nevada Health District
Mason VanHouweling, Chief Executive Officer, University Medical Center of Southern Nevada
Mary-Anne Miller, County Counsel, Clark County District Attorney
Joan Hall, President, Nevada Rural Hospital Partners; and representing Nevada Rural Hospital Partners Foundation
Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services
Ellen Richardson-Adams, Agency Manager, Southern Nevada Adult Mental Health Services, Division of Public and Behavioral Health, Department of Health and Human Services
Michael Hackett, representing Nevada Primary Care Association
Nancy E. Hook, MHSA, Executive Director, Nevada Primary Care Association
Donald Farrimond, M.D., President, Nevada Academy of Family Physicians
Keith Lee, representing Nevada Association of Health Plans
Denise Selleck, representing Nevada Osteopathic Medical Association
Annie Hofstetter, Private Citizen, Reno, Nevada
Jessica Ferrato, representing Nevada Nurses Association

Chair Oscarson:
[Roll was taken. Committee rules and protocol were explained.] We will start today with Senate Bill 314 (1st Reprint). Erin McMullen and Paul Moradkhan will be presenting.

Senate Bill 314 (1st Reprint): Revises provisions governing certain health districts. (BDR 40-957)

Paul Moradkhan, representing Las Vegas Metro Chamber of Commerce:
Thank you for the opportunity to present this bill today on behalf of the Southern Nevada Forum priorities. As you know, this bill pertains to the District Board of Health governance and composition that currently exists with health districts in southern Nevada. The Metro Chamber helped facilitate conversations over the last 18 months with southern Nevada priorities regarding governance reforms, smaller government, and transparency. One of the bills that emerged was Senate Bill 314 (1st Reprint). Thanks to our cochairs of the committee, Assemblyman Tyrone Thompson and Senator Michael Roberson, for their dialogue and engagement on this bill.

This bill priority came out of the Southern Nevada Forum in those 18 months, resulting in over 20 community meetings and 4 major forums in the south. One of the common themes we heard from the broad base of stakeholders, business members, and elected officials was the need for simpler, more transparent and robust governance structure regarding the Southern Nevada Health District (SNHD). The bill focuses on reducing the Board composition from 14 to 11 by removing the alternates that currently exist. It also would create an advisory board for community engagement and provide flexibility for the qualifications of the chief health officer that allows the Board to have more authority over how the criteria is set. That was a result of the input we had from legislators and stakeholders on how this could be a more robust and engaging bill.

The business community—one of its largest customers—supports reform to the Health District. Our membership believes it is important to have a Board that is responsive to the needs of the business community and to have open, wide communication and engagement that is responsive to the constituents of the Las Vegas Valley. This bill does that. Erin McMullen will now walk through certain components of the bill.

Erin McMullen, representing Nevada Resort Association:
The Nevada Resort Association has worked together with the Las Vegas Metro Chamber of Commerce and the Southern Nevada Forum. If it is okay with you, I would like to briefly walk through the specific provisions of the bill and then explain why we support this bill. [Continued reading (Exhibit C)].

I want to go through a few reasons why we support this bill. As you may know from my testimony on another bill related to this matter, the gaming industry does have a representative on the District Board of Health, and we pay 38 percent of the fees—a big fee generation for the governance of the

Health District—and the other business representatives obviously pay another huge chunk of that as well. We would like to stay engaged and have some involvement on the Board. Lastly, we feel this will streamline the Board and provide some consistency. The removing of the alternates allows for consistent discussion—meeting after meeting—so that those members who have been involved in previous discussions will be there for the other discussions relating to various topics as well.

Assemblywoman Titus:
When we had the bill earlier in the session regarding the different layers of administration for the Southern Nevada Health District, I expressed some concern regarding the state being involved in it. I felt the District itself should decide its own best structure and how it would function best. I really appreciate this bill.

Erin McMullen:
We did take some of the concerns and issues that were raised in the previous hearing and tried to adopt them and evolve this bill to address them.

Chair Oscarson:
Seeing no questions from the Committee, Mr. Moradkhan, would you like to add anything?

Paul Moradkhan:
I am good.

Chair Oscarson:
Is there any testimony in support of S.B. 314 (R1) either here or in Las Vegas? [There was none.] Is there any testimony in opposition of S.B. 314 (R1)?

Bob Beers, Private Citizen, Las Vegas, Nevada:
I am not in opposition necessarily, but I understand when this bill was initially heard, there were questions about why we were contemplating the change in administrative structure. I can answer that, and I apologize that I was not here to testify the first time. I am not representing either the City Council or the Southern Nevada Health District in my testimony. However, I do serve as the Vice Chairman of the Board of the Southern Nevada Health District. In that capacity, I have served on the selection committee that was trying to find a replacement for the chief medical officer. Two years ago, as the Legislature was meeting, we paid a headhunter $25,000 and he came back and told us that the only person we could hire was the number-two guy at the Southern Nevada Health District. The problem that limited our candidate pool turned out to be a section in the law that says that the district health officer must be licensed to

practice osteopathic medicine in this state. It turns out that all licensed doctors who are interested in public health are already working in public health, so we had a catch-22. As I left that meeting with the headhunter's memo in hand, I called former Chairman Justin Jones of the Senate Committee on Health and Human Services and explained to him that the law was limiting us in whom we could hire. One fix would be to change the law from "licensed as" to "be licensable within 12 months as." That is how the law currently reads since it was changed last session to reflect that.

With that change, we can potentially hire up to a third of the chief medical officers in America when the sad time comes that we need to replace Dr. Joseph Iser. As a denouement to the story, the number-two guy declined the employment offer. Dr. Iser somewhat serendipitously drifted into our lives. It turns out he was the former Washoe County health officer and had become licensed in Nevada during that time. He was, in fact, eligible to be hired under the law as it existed prior to this change two years ago.

I hope that offers some clarity as to what the legislative motive has been in making these changes. In my opinion, the piece of this bill that further adjusts the governance structure to create two chief officers is likely not necessary anymore. We are a thinly funded organization by national standards, and it would dilute our resources for the citizens of the state for the provision of public health.

Chair Oscarson:
You stated initially that you are not necessarily opposed to the bill. Since this is oppositional testimony, should we list you as opposed or as neutral?

Bob Beers:
I would say I am opposed to this section of the bill. I personally believe the Board is a little large and unwieldy, but I leave that to your discretion. My understanding was there were questions about why we were seeking to make a change when the Committee met for the first time for this bill. That is why I wanted to explain the history of how it came about.

Assemblyman Trowbridge:
Councilman Beers, this approves a new position. Is that position funded solely by the Southern Nevada Health District or are there additional funds from the City of Las Vegas or Clark County?

Bob Beers:
The primary funding for the Health District is property taxes, and that is what we have to work with. This would consume some of those resources that we could otherwise spend providing services.

Assemblyman Araujo:
Councilman Beers, has the Board taken an official position, or is everyone on the Board testifying on his own accord?

Bob Beers:
The Board has not taken a vote on this particular bill. We did approve a legislative agenda before the session started, but that was before we knew that this particular bill had been drafted. The answer is no, the Board has not taken any position. I apologize, as I am not representing the Board. I am simply one member of the Board.

Chair Oscarson:
Has the Las Vegas City Council, the Clark County Commission, or the Southern Nevada Health District Board taken action on an agenda where they made a decision on this issue?

Dan Musgrove, representing Southern Nevada Health District:
Mr. Ortiz is in the room and might be a better source. I can tell you anecdotally that, in a Clark County Commission meeting, there was discussion on this bill during a legislative report that talked about support. There was no vote taken on this bill nor on the provision. It was simply a report that was given to the Clark County Board of Commissioners, although some of the members expressed some support of S.B. 314 (R1). I do not believe there has been any vote taken by any other city council that is part of the Southern Nevada Health District membership. However, during the report by the chief health officer to the Board in August, there was a discussion regarding legislative priorities as Councilman Beers alluded to. The number one priority was to keep the Southern Nevada Health District in its current form; however, there was no vote taken on an official position either on that priority. Our chairman, Rod Woodbury, has asked for the opportunity to discuss his personal position as the chair.

We appreciate Assemblyman Tyrone Thompson, Senator Michael Roberson, Erin McMullen on behalf of the Nevada Resort Association, and Paul Moradkhan on behalf of the Las Vegas Metro Chamber of Commerce for all the work that has come forward on S.B. 314 (R1). It has come a long way from the initial bill this Committee heard; however, our position is that we want things left the same. It would have a fiscal impact upon the Southern Nevada Health District.

To Assemblyman Trowbridge's question, we are funded through grants that we apply for and receive, and the property tax of 3.5 cents—our main source of revenue. This was not a budgeted item because there will be a new chief health officer position that this bill allows for and an advisory board that will have to be staffed for meetings that take place. We have an approximate $750,000 budget deficit that we are looking at for the next fiscal year. We would have to figure out a way to fund these additional positions.

Chair Oscarson:
Have you submitted a fiscal note?

Dan Musgrove:
We did on the Senate side because the bill was heard in the Senate Committee on Finance, which was interesting since it does not have any effect on state revenues. At that time, we did a fiscal note of about $30,000 for the Board and roughly $300,000 for salary and benefits for the chief medical officer. Those additional costs to the Southern Nevada Health District would impact programs.

Chair Oscarson:
For the record, I have asked Alex Ortiz to speak.

Alex Ortiz, Assistant Director, Department of Administrative Services, Clark County:
Mr. Musgrove is accurate in saying that the Clark County Board of Commissioners did discuss this issue during a standing agenda item to discuss legislative issues. There was some discussion about supporting this bill and this effort. Therefore, I signed in for support of this bill.

Assemblywoman Spiegel:
Because of the vast and diverse community health issues, I especially like having the advisory board involve a representative from each of the cities. Are you opposed to that as well?

Dan Musgrove:
There are already representatives on the Board of the Southern Nevada Health District from each city. The Board would lose an additional doctor that represents the minority community and two nurses; however, they would have an opportunity to fill those positions on the advisory board.

Assemblyman Sprinkle:
From the comments that were just made, and being an unbiased northerner, I find it interesting that we have a bill that directly affects the Board of Health

for the Southern Nevada Health District, and yet we cannot get a firm position from them. That would have been helpful instead of anecdotal stories.

Chair Oscarson:
Is there any other testimony in opposition?

Rod Woodbury, Mayor-elect, Boulder City; Chairman, Southern Nevada Health District:
There has not been any formal vote on the official position of the Southern Nevada Health District. However, I believe if we had a vote, it would reflect the legislative agenda that we adopted. We would be happy to take it to a vote if that is important to this Committee. In general, this is a well-intentioned bill. I testified before you earlier this session on Assemblyman Thompson's companion bill that was very similar. I will not belabor all the points I made in that testimony, but will touch on them quickly.

There is need for the head positions over the Health District to be combined into one. You do not want an administrator making an emergency decision on health issues based on financial constraints. The positions need to be combined into one or you will have unintended consequences if they are not. The financial impact has been discussed enough today.

The last time I was in front of you I discussed the idea "If it ain't broke, don't fix it." So far, I have not heard what exactly is wrong with the Health District in either Assemblyman Thompson's bill or this bill on the Senate side. I agree with Councilman Beers that the issue we were struggling with of finding a chief health officer has been fixed. That is not to say the health district is perfect and that we do not have problems from time to time; however, we do address those issues and work well together to fix them. Issues like the chief health officer have been addressed and that does not mean we have to totally revamp the constitution of the Board. If we knew the who, what, where, when, and why questions about what Senator Roberson believes are the issues, we could address them. For example, we need to know if they were raised five years ago or a month ago. Who can say if they have been addressed or not unless we know what the issues are. Although we have streamlined things, I did hear from Senator Roberson on the Senate side that there were delays in permitting, but he was very vague about what those delays were.

The issues under Dr. John Middaugh, who was the interim chief health officer about two years ago, were addressed and now we have a streamlined process for permits. Most of them do not even come to the Board. There is a preliminary administrative process that they go through. By the time they get to us, we only look at the ones that have particular issues raised by staff.

This is an example of another potential problem that we addressed in the past and resolved. To say there are current problems with the Health District is hard for me to address because I do not know what they are. I believe we work well together to make policy when regulatory provisions need to be changed.

To totally revamp the entire constitution of the Board of the Southern Nevada Health District is a knee-jerk reaction. Every legislative session I hear that the Legislature is broken and is having problems, but that does not mean you reconstitute the entire Legislature when that happens. My sister is in the Assembly and can testify to that. There are always issues that come up and people who do not like the way things are going. Councilman Beers, who is a former legislator, can testify to that. There are always perceived problems and yet we do not revamp everything. The Legislature is quite large as well, but that does not mean you cannot function within that system.

Frankly, I have not seen any Senators or Assemblymen who are sponsoring this bill visit our Board to figure out what the problems are, whether there is problem with the overall Board, or an issue with particular staff members. We already have systems in place where we divide and conquer some of these issues. We have an environmental health director, a legal department, and a nursing department. They work quite well in administering these things. I strongly believe that if you would engage in dialogue with us and investigate what the issues are, you would find that they are not systemic problems, but rather, minor problems that every governing body has from time to time that you address as they happen. That is the nature of the beast and why we have a governing board. It does not mean that there are such great problems that you need to reconstitute everything.

Our current chief health officer does both positions well, as Councilman Beers indicated. He is a great chief health officer and an able administrator. The system works. Our staff members are extremely devoted to their jobs and work well together in bringing to pass the things that need to happen—looking out for the health and safety of our community. It is a large, unique community that has casinos and the tourist industry, which makes us have to be responsive to those needs.

While there were good intentions, this bill—especially with respect to dividing the head position—will have a lot of unintended consequences that do not make sense. I implore you from the bottom of my heart not to make knee-jerk reaction changes without coming down to Clark County, investigating, and walking a mile in our shoes to truly understand the problems before you make sweeping changes.

On the issue of the advisory board, I believe the current constitution of the Health Board provides a measure of checks and balances. It is specifically designed to protect the interests of the industries and smaller jurisdictions. Right now, the industries have a voice on the health board. They include environmental health, nursing, nongaming, physicians, and gaming. Taking away the voice of nursing, nongaming, and the physician who represents the underserved and minorities is not necessarily a good idea. Those industries would not be represented anymore, even though they would be there in an advisory capacity; however, that is not the same as being on the Board.

The smaller jurisdictions also enjoy a checks-and-balances system. As a councilman representing Boulder City, and even though our voice is only half the size of Clark County and the City of Las Vegas, you will dilute the voice of the smaller jurisdictions if the size of the Board is carved down. That is our concern based on some of the issues we have had, especially with Clark County not wanting us to own property. This would not only affect Boulder City and Mesquite, but also some of the larger jurisdictions such as Henderson and North Las Vegas that have only one Board member instead of two. They, too, will lose their voice if the size of the Board is reduced. The Board would need only two extra votes instead of four or five to push through an agenda.

Chair Oscarson:
We have one of the cosponsors of the bill on this Committee and he will make some comments regarding your concerns. I agree that I do not know why the state is hearing an issue that is locally controlled. This began before I was involved, and I am amazed that it was not already worked out by the parties in southern Nevada and that it is now coming to the Legislature. I understand the Southern Nevada Forum also met on multiple occasions to discuss these issues. That is why the Las Vegas Metro Chamber of Commerce, the Nevada Resort Association, and other organizations are here discussing these issues that they feel are problematic without resolution. This is not an admonishment but rather factual statements of what I understand has been taking place. That being said, I will let Assemblyman Thompson respond to your statements.

Assemblyman Thompson:
Councilman Woodbury, we keep using the term "problem," but that is not the intent of this bill. The intent was to find areas needing improvement. When we began discussions about two years ago, we asked what the governance reform areas were that we needed to improve and build upon. The way in which the Southern Nevada Health District does business was discussed. This is not one Senator or Assemblyman bringing this bill forth, but rather the voice of numerous stakeholders. You stated that people have to ask questions. These are your customers—people who constantly work with you both internally and

externally. I want to say for the record that this bill is not punishment towards the Health District or saying that the District is a problem; instead, it is saying there is a grand opportunity for improvement.

Also, this Committee did its research. We looked at models that work and, for the record, we have a great model that is working for the state through our Department of Health and Human Services where we have a medical officer and an administrator. Therefore, we know this model works.

Regarding the advisory board and the regular board, we carefully vetted that process through as well. The reason we wanted to have the representatives from the cities is that it can either be a professional or a day-to-day customer. We need to have those perspectives because of the way southern Nevada is growing. I was not going to speak today, but knowing that you wanted to hear from the bill's sponsors, I asked Chair Oscarson if I could. I did not want to be adversarial but wanted to explain to you why we are bringing this bill forth.

Chair Oscarson:
Seeing no other testimony in opposition, is there any testimony in neutral either here or in Las Vegas? [There was none.]

Assemblywoman Titus:
I need a point of clarification regarding the fiscal note. One thing that greatly frustrates me is unfunded government mandates. According to this bill, there may be an unfunded government mandate, but when I look at the fiscal notes that were presented on the Senate side, Clark County introduced a fiscal note which said $0. Mr. Musgrove, you mentioned another fiscal note. Where is it?

Dan Musgrove:
We did submit one to the Senate Finance Committee based on the original version of Senate Bill 314 (1st Reprint), which did contain additional persons. This bill, in the first reprint, has only one new position and an advisory board. As we previously discussed, Clark County does not fund us. They just ensure we receive 3.5 cents per dollar of property taxes. It is up to us to budget that money. I can provide you with the amount of the additional salaries for that person and the advisory board. I testified to that earlier, but I am not sure what happened to that Senate fiscal note.

Assemblywoman Titus:
This bill is not a two-thirds bill as it stands now?

Dan Musgrove:
It has nothing to do with state resources.

Alex Ortiz:
We include the Health District's budget as part of Clark County's budget submission to the state. That is it; we do not fund them. Regarding the fiscal note, before and during session, the Legislative Counsel Bureau (LCB) sends us a request for a solicited fiscal note and we provide one. As a separate organization from Clark County, the Health District may or may not be set up the same way. If they are, they would receive a solicited fiscal note request from the LCB. That may be what happened here, or they may have the ability to submit an unsolicited fiscal note, which we do for old budget pieces. I hope that clarifies the question.

Assemblywoman Benitez-Thompson:
Last session we heard a couple of bills regarding the Southern Nevada Health District. There was a lot of consternation among all the parties then, and now again in this session. There seems to be a great deal of discontent. If Clark County had the ability to approve and set the budget of the Health District, we would probably see the fiscal note set up; however, I do not think that is anything the Health District would desire to have happen. That is one of the sources of contention that we talked about a lot last session on the record. Southern Nevada Health District is structured very differently than the State of Nevada, Washoe County, or the rural areas and how they structure their health systems, which has not been talked about this session on the record. It is meaningful for me when members who represent southern constituents bring a bill to address their concerns. I do not want it left on the record that this bill is about the state mingling in local business when it is the local representatives who are bringing this for their constituents.

Dan Musgrove:
I would like to clarify the fiscal note issue. I have already spoken to the director of the LCB, Richard Combs, about this. As a separate governmental agency, we are not a part of the fiscal note system, but I do not think they realize this. In years past, we were a part of their budget. I am working on it this session and will address it next session, so next time there are bills related to the Health District or health issues, we will have the unique opportunity to submit a fiscal note. However, we do not have one at this point. The information that I have given you is accurate as to what the impact would be on the SNHD.

Assemblywoman Dickman:
You stated that you get a certain amount of funding from the property tax, and I would assume it has been budgeted. Where would you find the money to fund the over $300,000 position?

Dan Musgrove:
It would impact programs, and we would have to eliminate some of them.

Chair Oscarson:
We just checked, Mr. Musgrove, and there are no unsolicited fiscal notes from the Health District.

Dan Musgrove:
I submitted them to the Senate Finance Committee. I will resubmit them to you, but again, it was based on the original bill. We would be happy to submit one for this bill in particular as to what it provides.

Chair Oscarson:
That would be prudent.

Dan Musgrove:
We will do that.

Erin McMullen:
I want to highlight that, in addition to the property tax that hopes to fund the District, it is also fee-funded from a number of the constituents, including the resorts, gaming associations, and other organizations. We pay about 38 percent of the fees to fund the Health District. I think the term "fiscal note" could possibly go either way in the sense that there are existing funds, and it is up to the Board to determine how they are going to manage them for salaries within the existing programs and funding for additional resources.

Chair Oscarson:
With that, I will now close the hearing on Senate Bill 314 (1st Reprint). [Submitted but not discussed is (Exhibit D).]

I will now open the hearing on Senate Bill 33 (1st Reprint). Mr. VanHouweling, the Chief Executive Officer (CEO) of University Medical Center of Southern Nevada (UMC) will testify.

Senate Bill 33 (1st Reprint): Authorizes the board of hospital trustees of a county hospital to hold a closed meeting under certain circumstances. (BDR 40-475)

Alex Ortiz, Assistant Director, Department of Administrative Services, Clark County:
Thank you for hearing Senate Bill 33 (1st Reprint). With me today is Mason VanHouweling, who is the Chief Executive Officer (CEO) of the

University Medical Center of Southern Nevada (UMC) in Las Vegas. He is our current CEO, but has also served as UMC's chief operating officer from April 2014 through December 2014 before he was promoted to CEO in December of 2014. He has not been in this position for very long, but has a good grasp of the health care issues that pertain to and affect Clark County and UMC. Mr. VanHouweling has worked in several not-for-profit and for-profit systems, agencies, and companies throughout his career of over 20 years. He is also an Air Force veteran with military hospital experience and is currently an Active Guard Reservist. Mr. VanHouweling will now present S.B. 33 (R1).

Mason VanHouweling, Chief Executive Officer, University Medical Center of Southern Nevada:
I appreciate the opportunity to review and summarize the major provisions of Senate Bill 33 (1st Reprint). The board of hospital trustees, which is referred to in the bill, and the Clark County Commissioners are one and the same as defined in *Nevada Revised Statues* (NRS) Chapter 450. The purpose of this bill is to allow a public hospital governed by NRS Chapter 450 to afford its governing body the ability to go into closed session to discuss the two provisions outlined in the bill. Section 8, subsection 3, states the board of hospital trustees may hold a closed session to discuss two issues. The first one is to provide a new health care service or to expand an existing service at the county hospital. A couple of examples would be acquiring a new robot surgery system to attract certain medical groups or patients, or purchasing telemedicine equipment to expand services to rural clinics and hospitals.

The second issue is the acquisition of an additional facility, or expanding an existing facility. Examples may include establishing a UMC outpatient facility at an off-site location, or purchasing or leasing a new building to move a UMC Quick Care facility to another location. I would like to stress that the bill still requires open public meetings for approval or any decisions of matters discussed in the closed session.

Section 8, subsection 4, further limits what can be discussed in a closed meeting and provides that the Board of Trustees cannot discuss change of ownership, management, or dissolving the county hospital. The bill only allows for expansion of services and facilities. Lastly, section 8, subsection 5, states that all minutes and supporting materials of the closed meeting must be made public.

While UMC operates in the public sector, it is a highly unique public entity, discernible from others by way of conducting business with competitors not subject to the Open Meeting Law. For example, private competitors have

a distinct advantage when it comes to adding a service with an aggressive timeline to obtain market advantage by keeping their plans from their direct competitors. Many states with public hospitals have passed similar laws to allow for closed sessions when it is necessary to deliberate initiating a new service or program or adding a new facility. If these plans were prematurely disclosed, it would create substantial probability to deprive an economic benefit to the public hospital. University Medical Center is facing ever-increasing financial challenges in order to stay viable and competitive within the hospital industry and owes the public it serves the best use of supplemental funding provided by county taxpayers.

We ask you to support Senate Bill 33 (1st Reprint) to allow UMC and other public hospitals in Nevada the ability to privately discuss additional services and potential growth to remain competitive in the community's healthcare system.

Assemblyman Gardner:
If we grant this exception to the Open Meeting Law, do you believe this will help the hospital do better work? What kind of advantages will we get if this happens?

Mason VanHouweling:
This bill would certainly help not only UMC, but other public hospitals in the state of Nevada. It is a very competitive environment. As I mentioned earlier, we are a unique public entity. In particular, we go head-to-head against 13 hospitals in Las Vegas. This allows us to have discussions about growth and expanding or providing a new service to the community. Any of those approvals or decisions would be made in a public setting with an open meeting. It allows us the format to have discussions with our Board of Trustees.

Assemblywoman Dickman:
For clarification, what is the purpose of the redefinition of taxpayers in section 6?

Alex Ortiz:
I believe that is just a conforming change through statute. Maybe Legal Counsel could assist us, but that is my understanding.

Mason VanHouweling:
Mary-Anne Miller is in Las Vegas and may be able to help with that question, as well.

Mary-Anne Miller, County Counsel, Clark County District Attorney:
Mr. Ortiz is correct. It is not a substantive change. It is just to make the language more consistent with other statute drafts.

Assemblywoman Dickman:
Does five years seem a little long?

Mary-Anne Miller:
Five years is the maximum amount of time. There is an additional provision that says five years or when the Board or governing body decides it is no longer necessary. Generally speaking, that will occur once a decision has been made to put it on a public agenda. Five years would be an unusual period of time to retain it, but it does put a limit on it so there will be transparency, even if they do not decide to go forward with a particular area of inquiry.

Assemblyman Jones:
I understand the idea of needing closed meetings, particularly for buying real estate or offering new services so that you have the competitive advantage and you do not have your ideas appropriated. However, five years seems far too excessive. I think two years, or even one year, should be enough to give you that competitive advantage. The whole purpose of the Open Meeting Law is to ensure transparency. If you make it five years, there is no real transparency there. I would like to see this changed to a maximum of two years.

Mason VanHouweling:
To reiterate Ms. Miller's comments, five years would be the maximum. Any decisions or approvals would go to a public meeting. At that point, it is to release that information. Some discussions about adding or expanding services may take three to five years. That is why that parameter was set, but when a decision by the Board of Trustees goes for approval, it would be public at that point. This bill allows us the leeway of five years because acquiring property or expanding services takes several years to vet out.

Assemblyman Jones:
I understand what you are saying, but if we are going to give you the right to violate the Open Meeting Law, I would want to say the time frame needs to be shorter. Five years is a very long time.

Assemblyman Thompson:
In your testimony, you said there are other public hospitals in our state. Can you share how many there are, and have you consulted with them about this bill?

Mason VanHouweling:
I believe it is seven.

Joan Hall, President, Nevada Rural Hospital Partners:
Yes, it is seven. They are: South Lyon Medical Center in Yerington, Grant General Hospital in Hawthorne, Battle Mountain General Hospital, Pershing General Hospital in Lovelock, William Bee Ririe Hospital in Ely, Humboldt General Hospital in Winnemucca, and Grover C. Dils Hospital in Caliente.

Assemblyman Thompson:
Are they in support of this bill as well?

Joan Hall:
Yes. Our hospitals are not nearly as sophisticated as UMC, but when we are purchasing property or looking to add a service, it is that competitive advantage that you lose when you have to talk about it in a public meeting.

Assemblyman Trowbridge:
My understanding of this bill is that it simply allows for the discussion of business strategies behind closed doors. We hear time and time again that government entities need to function like private business and not allow private discussions and closed door meetings about long-term objectives, such as programs you may offer or an acquisition of land. However, if I knew you wanted to buy a parcel next to UMC, I would go buy it first because I can move more quickly than you can. Then you can guess what I would do to the price. If you have a long-term plan, you need some time. When you talk about major capital development, five years is not an unusual length of time. Is that correct?

Mason VanHouweling:
You are exactly correct. The health care industry is very competitive, especially with the Affordable Care Act which has leveled the playing field for all hospitals. Since we are unique, the bill does allow us to discuss growing and expanding services in the public hospital setting. The example you alluded to has happened in the past and UMC has missed out on some opportunities. When we discussed expanding in a certain community, or looking at property, the prices seriously went up.

Assemblywoman Joiner:
I understand why you are doing this and I am sympathetic. However, we talk a lot about transparency issues, and I definitely have concerns. There are some words and phrases in the bill that I hope you can give me examples of. One is

"materially expanding a health care service." About how often do you plan to do this? When you look back five years from now, how many of those meetings would you have used this provision for?

Mason VanHouweling:
On your first question, materially changing a service could be looking at our hospital beds and expanding to a rehabilitation or skilled nursing facility or just expanding a service within our current clinic system. Another recent example is that we have been working with robotics medicine, which we have been looking at for several years. It is a new service line to the hospital, and there have been many discussions and decisions regarding it. As far as the frequency of the meetings, I believe it would be very limited. Many of our committee meetings are more like standing reports, and discussions related to adding services do not happen very often. Since UMC is a very complex organization and the highest level of care in the state of Nevada, we have just about every service. However, as technology changes and growth expands, we would then look at those opportunities for the hospital.

Assemblywoman Benitez-Thompson:
There was an example given off-line of UMC discussing purchasing land at an open meeting while a competitor was in the audience, who then went out to purchase the land first. We have a real-life example as it applies to UMC. For the other hospitals that are asking to be included, are there actual examples we can provide for the record? That would help me understand why we would make an exemption to the Open Meeting Law.

Joan Hall:
Yes, we have actual examples, including land. When I was the administrator at South Lyon Medical Center, we were looking at expanding long-term care. There was a vacant lot right across the street from the hospital. Because we were a public body, we talked about it in an open meeting and had the same thing happen to us. Others purchased the land and the price approximately doubled because they heard we were going to expand and they knew it would take us a long time. By then, they were willing to sell it to us, but at a higher price than we would have originally paid.

We have also had other issues in the rural areas. We often use a mobile magnetic resonance imaging (MRI) system. Many of the hospitals realized how many scans they were doing and decided it would be better for them to purchase an MRI scanner themselves. However, since we had to talk about it in an open meeting—and to go through the bidding process—the mobile service that our hospitals were using heard about it. Knowing how long it takes for

public entities to react, they increased the cost per scan because they knew they would eventually be losing business.

We have had the same issues with hospitals that were using mobile mammography services but were looking at purchasing a mammography unit. It just goes on and on. For us, the issues are sometimes smaller because we do not have the extensive services that UMC does, but we see those exact issues. Just talking about things can cause problems. Dialysis comes to mind. Often, rural hospitals discuss whether they can afford to have a hospital-based dialysis unit, or if it is better to offer that procedure from a free-standing service. To be able to have those conversations in private and to discuss what the possibilities are would be invaluable. The current way really limits you, as has been stated. Your competition is either in the audience or the meeting is on the front page of the newspaper. That allows other people who either have more money or can act more quickly to get there before you because they do not have to go through the process.

As was discussed a couple of hearings ago, anything that the rural hospitals want to do that costs above $2 million would go through the Certificate of Need process, and the public would know about it far before the five years. The examples I gave do happen, and this is an issue.

Assemblyman Thompson:
You mentioned a UMC Quick Care going into a community. I have been a public servant for 25 years, so I am always in the community getting their input. That is why I am concerned. Would you be amenable to an amendment that includes some public input from a few people, or something similar? For example, if you want to build a Quick Care facility in a community, you need to talk to people who live and work in that community. They may know bits and pieces that are important to the success or demise of your project. I am struggling with the five-year requirement for public knowledge. I have some real concerns with it being so cut and dry and want to meet this in the middle.

Mason VanHouweling:
I hope I can give you some comfort and reassurance that any decisions or approvals would always go through our hospital's governing body process. These are just the discussions to look at performance or market analyses to see if an idea is something the hospital would be interested in doing. At every meeting there is open public comment, an opportunity to discuss it and have it vetted out in an open forum, and closing comments. The bill is only about the discussions. If it is something we need approval for or to get into the contracting or decision phase, that is always in an open forum meeting. We have limited the language in the bill to existing services or to adding

services. We talk about differentiating, not changing management or ownership and not closing the hospital, but that would always be done in an open format and never in a closed meeting.

Assemblyman Sprinkle:
I was good with this bill up until the last conversation. What I am envisioning now is that there is going to be a meeting specific to what has been defined in this bill. However, these conversations are going to lead to a general decision of a direction to go, and then the public part—the open meeting part—is simply to have a vote. That is where my concern lies. At that point, decisions have already been made. The public's comments are not really going to matter because the meeting is just so we can have a public forum in which to take the official vote. I do not know if there is some way you can help alleviate my concern. I get strategizing and throwing things around the table to see if the idea is possible; however, at what point do those conversations lead to decisions? All of a sudden you have a quorum saying, "Yes, we can move forward" with no input from anybody else. When we are talking about taxpayer dollars, that is where the concern lies.

Alex Ortiz:
Mary-Anne Miller, County Counsel, would like to answer in response to Assemblyman Sprinkle.

Mary-Anne Miller:
I would like to draw the Committee's attention to the language in this revised bill. Section 8, subsection 3, says the board of hospital trustees may hold a closed meeting to "discuss." It does not include the word "deliberate." Those are two terms under the Open Meeting Law. The bill is written specifically to address Assemblyman Sprinkle's concerns. There is a difference between discussing by asking questions, and deliberating. Under Nevada law, deliberate means to discuss among the governing body toward a decision. As counsel for any of the governing bodies, I would say that once they got to that point, they have exceeded the scope of this bill. What this bill really seeks to do is to allow the staff of a hospital to present options, get feedback, and have discussions among the governing body to find out if it is an area that the governing body would like to staff in order to proceed. Because of the types of endeavors we are talking about, whether they go forward to a positive decision or not, generally requires the expenditure of some money. This would allow staff to get feedback and additional ideas before spending too much of the public's money. However, any deliberation and refinement would have to come at an open meeting.

Assemblyman Gardner:
Section 8, subsection 4, says subsection 3 must not be construed to authorize the board of hospital trustees to discuss certain things. Why is that language needed? My reading of subsection 3 says that they can basically only talk about two things in these meetings. Why would we need subsection 4?

Alex Ortiz:
During the hearing in the Senate Committee on Health and Human Services, there was concern that this bill and the change in the law would allow our board of hospital trustees to close services or change management through this process and not necessarily in the open public forum. The language in subsection 4 was added to the bill to further clarify that we cannot do that.

Assemblywoman Benitez-Thompson:
To make it clear for the legislative record, that was the intent of the amendments on the Senate side and is, hopefully, the intent here. Any meeting behind closed doors must be properly agendized. There is no exception to the Open Meeting Law regarding agendizing and closing a portion of a meeting, correct?

Alex Ortiz:
I will also defer this question to our general county counsel, Mary-Anne Miller.

Mary-Anne Miller:
The language clearly states that it is within the Open Meeting Law. It allows a closed meeting with proper notice pursuant to an open meeting, so the required specifics would have to be on the agenda. It would say they are going into a closed session to discuss one or two items in section 8, subsection 3, paragraphs (a) and (b). The public would know why a governing body was going into closed session. They would make a motion to go into the closed session and reconvene the open meeting when they came back out.

Assemblywoman Benitez-Thompson:
As a follow-up under subjects that can be discussed behind closed doors, I would think it would be employee issues, salaries, or hiring new professionals related to an expansion. Material expansion only means actual property acquisitions and footprints, correct? You are not talking about building a new wing or facility, are you? Does the staff personnel and staffing model go with it?

Mary-Anne Miller:
It is possible, through seeking direction from a governing body, it may ask questions along the lines of "Will this allow us to hire more people?"

Since expansion or addition is always involved with this language, there will not be questions of whether people will be laid off, but rather about additional staff since money is involved. They could include, "Will this mean more employees? Do you envision contracting it out?" Those kinds of questions may come up, but no decisions could be made.

Assemblywoman Benitez-Thompson:
For clarification, the distinction between hiring more employees versus contracting more employees could be contemplated. Is that part of your intent?

Mary-Anne Miller:
The governing body could ask staff in a closed session to investigate that and bring it back in an open session for discussion and deliberation.

Assemblywoman Benitez-Thompson:
I am trying to think of past bills that we have had regarding UMC. Would the Board be able to discuss the delivery model with the expansion of a new service? A couple of sessions ago, we had a heated conversation over a bill brought forth about changing UMC to a teaching or medical school. If you wanted to consider changes to the business model within an expansion, would that be something your Board could contemplate behind closed doors?

Mary-Anne Miller:
Something that wide in scope probably exceeds this bill.

Assemblywoman Benitez-Thompson:
It would exceed the intent of this bill then?

Mary-Anne Miller:
I believe so because it is so broad. If you look at subsection 4 that Assemblyman Gardner asked about, while it seems to be superfluous, it does give us an indication of legislative intent. If you are going to make major changes to a hospital, whether it is UMC or one in the rural areas, that should be done in an open forum.

Assemblywoman Benitez-Thompson:
It is good for the record to tighten it up a little, especially for some of us who are from counties up north where we have seen the Open Meeting Law get twisted and turned to mean lots of different things. It is important to make the definition narrow to serve the purpose. Otherwise, if you could drive a truck through it, people probably would.

Chair Oscarson:
Is there any additional testimony in support of S.B. 33 (R1) either here or in Las Vegas? [There was none.] Is there any testimony in opposition? [There was none.] Is there any testimony in neutral of S.B. 33 (R1)? [There was none.]

Alex Ortiz:
We would be willing to work with Assemblyman Jones on the five-year concern that he has.

Chair Oscarson:
That is not only prudent, but I will encourage Assemblyman Jones to meet with you and discuss it. Seeing no further testimony, we will close the hearing on S.B. 33 (R1). I will now open the hearing on Senate Bill 35. Dr. Green, Ms. Richardson-Adams, and Ms. Szklany are here to present.

Senate Bill 35: Ratifies and enacts the Interstate Compact on Mental Health. (BDR 39-330)

Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services:
With me today is Ellen Richardson-Adams, who serves as agency manager at Southern Nevada Adult Mental Health Services, and Chelsea Szklany, who is deputy administrator over Clinical Services for the Division of Public and Behavioral Health. Senate Bill 35 is intended to safeguard the well-being of mental health patients by honoring their rights to connect to and receive services in their home communities. It allows Nevada to participate as an interstate compact member with 45 other states for inpatient psychiatric treatment with another giving or receiving state. The Interstate Compact establishes uniform guidelines and standards with other participating states, but allows Nevada to retain its sovereignty. Currently, the states that are not Compact members are Arizona, California, Mississippi, Virginia, and Nevada.

Nevada is dedicated to providing quality services for individuals with mental health disorders. This bill would allow us to engage with other states that have adopted the Interstate Compact so that we can reconnect patients from outside of this state back to their communities, families, and support networks with smooth procedures for transitions based on national standards. In order for a relationship or a transfer to occur, there must be negotiation and discussion with hospital administration, medical staff, patients, patients' families, and patients' guardians. There must be a coordinated-care plan. This Compact is specific for inpatient psychiatric services to subsequent inpatient psychiatric services. In addition to that, there must be an agreement and

an acceptance by both the referring and receiving facilities. There is no fiscal obligation associated with this, and all of those issues are negotiable in the sense that whatever services are provided would be dependent upon the needs of the individual. However, there is no obligation to take on the cost except the cost to transfer to the state of origin by the referring state.

In Nevada, the chance to adopt this language gives us the opportunity, in essence, to obligate, but also to allow for those states participating in the Compact to come to the table for negotiation for both our patients and patients from other states. I can walk through the bill, or I would be happy to answer any questions.

Assemblywoman Titus:
Since California is not part of this Compact, it really does not help us very much. Are they considering joining? It seems to have stemmed out of issues such as bus tickets.

Tracey Green:
Yes, in fact, it did stem out of our issues surrounding an appropriate discharge. California is not interested in participating in the Compact, although we did discuss our participating.

Assemblywoman Titus:
Oregon and Utah have a compact already, but Arizona and California do not. Is that correct?

Tracey Green:
That is correct.

Assemblywoman Titus:
What is the advantage of the states not having one? Have they made a statement about why they do not want to participate?

Tracey Green:
I wonder if Ms. Szklany or Ms. Richardson-Adams may know of any reason they do not want to participate.

Ellen Richardson-Adams, Agency Manager, Southern Nevada Adult Mental Health Services, Division of Public and Behavioral Health, Department of Health and Human Services:
At this time, neither California nor Arizona have shared their reasons at the national level of why they are not participating.

Assemblywoman Titus:
It just makes good health care sense and good patient sense, so that is why I wondered if they had given an explanation.

Chair Oscarson:
Is there any other testimony in support of Senate Bill 35 either here or in Las Vegas?

Joan Hall, President, Nevada Rural Hospital Partners:
We think this bill makes good sense, and we are in support.

Chair Oscarson:
Seeing no other testimony in support, is there any testimony in opposition either here or in Las Vegas? [There was none.] Seeing none, is there any testimony in neutral? [There was none.] We will put this bill on a work session soon. I will close the hearing on Senate Bill 35. I will now open the hearing on Senate Bill 6 (1st Reprint). Mr. Hackett will present.

Senate Bill 6 (1st Reprint): Revises provisions relating to the delivery of health care. (BDR 40-63)

Michael Hackett, representing Nevada Primary Care Association:
Joining me is Nancy Hook, executive director for the Nevada Primary Care Association. Senate Bill 6 (1st Reprint) came out of the Legislative Committee on Health Care and would establish patient-centered medical homes (PC-MH) in statute. [Continued reading testimony (Exhibit E).]

With that, I would like to present an amendment to Senate Bill 6 (1st Reprint) that I have worked on with all of the stakeholders (Exhibit F). The reasons for this amendment are twofold. First, the way this bill was redrafted as it came out of the Senate created some concerns for us. Secondly, there were additional issues that were brought to my attention as it passed out of the Senate.

I would like to go through the amendment for you. The amendment does four things. First, it deletes section 20.2, subsection 1, paragraph (b). This is the provision that contained a threshold of 60 percent to seek status as a patient-centered medical home. It is our feeling that this provision is unnecessary because we are providing the definition of a patient-centered medical home already in the amendment. We also think the process by which a practice goes through the national accrediting organization to obtain the patient-centered medical home status eliminates concern.

The second provision would amend section 20.2, subsection 3, by deleting the language that is currently there and replacing it with new language. The reason we have this proposed provision is that, in discussions with Dr. Green and the Division of Public and Behavioral Health, it was brought to our attention that the State Board of Health does not have the authority to either establish an advisory group or to implement measures to assess the PC-MH model. Having said that, the new language would give the Department of Health and Human Services, through its Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease, the authority to establish an advisory group of interested parties and to study the PC-MH model. This would also be done in cooperation with the Nevada Commissioner of Insurance. To allow that to happen, we are also proposing to amend section 20.2, by adding subsection 6, to provide clarification in terms of who the interested parties are that could be part of this advisory group, and to amend section 20.2, by adding subsection 7, so that it is clear exactly who the advisory council is and has the meaning ascribed to it in NRS 439.515.

The next provision is to amend the definition of patient-centered medical home. What came out of drafting from the Senate side is not what we intended, nor what we presented in our conceptual amendment to the bill. Therefore, we have provided language that we feel is more specific and more accurately represents the PC-MH model of providing health care.

Finally, our last provision is under the definition of primary care practice. We are deleting the reference to obstetrics and gynecology (OB/GYN). It was brought to my attention again after this bill passed out of the Senate that OB/GYNs cannot actually seek status as a patient-centered medical home. They can attain status as a patient-centered specialty home, but they are not able to attain status as a PC-MH; therefore, we felt that including them in the definition for the purposes of this legislation as a primary care provider is unnecessary.

Assemblywoman Titus:
Is the federal definition 75 percent of the time that you spend in primary care versus 60 percent of the time? Why would you remove that from this bill?

Nancy E. Hook, MHSA, Executive Director, Nevada Primary Care Association:
We feel that the 60 percent is not necessary because the national accrediting bodies have set the standard for providing primary care services to 75 percent of a practice.

Assemblywoman Titus:
If you are abdicating to the national standards, maybe you should state that you recognize it is 75 percent of your time in primary care, as opposed to saying

60 percent. It should be clear in the amendment that we will follow national standards.

Michael Hackett:
It has always been our intention to defer to the national standards that the accrediting organizations require regarding their applicants. We never wanted to see anything in statute that would be more restrictive or looser than what those accrediting processes allow for. We would be happy to consider it.

Assemblywoman Titus:
For members of this Committee, a patient-centered medical home is something that we, in primary care, have been working on as a model for a decade. We think we have alternatives for providing good care in recognizing that a patient is looked at in a home, not only by the physicians, but by other support staff as well, such as nurse practitioners, physician assistants, educators, nutritionists, and diabetic educators. Developing a model that we can actually get reimbursed for is critical to solving the needs of our state when we do not have enough primary care providers. We have expanded our treatment of the patients we hear about all the time in our Committee on Ways and Means. It is very costly to provide Medicaid and services to our underserved patients and those who cannot get in to see someone. Developing a new model on how to give good, quality care is critical to our nation's survival in health care today. I am looking forward to more testimony.

Assemblyman Jones:
Is this bill with your amendment enabling legislation for a new type of care? Can you give me an example of who would use this? Is it like assisted living? What is being accomplished here?

Nancy Hook:
The PC-MH is a model of care based on the primary care and prevention activities that should be happening. There are two purposes for defining it in statute: one is to make sure that consumers who choose to be cared for in a patient-centered medical home or by a team from a PC-MH know that the practice meets certain national standards, as well as setting the foundation for looking at payment reform along the way. This kind of team-based care requires a change to the way we currently pay for care. We pay for physician and nurse practitioner visits, but not necessarily the services of the other team members that could make a huge impact on the health outcome of the patient.

Assemblyman Jones:
Is it a hospital that looks like a house? I am still unclear what a patient-centered medical home is.

Nancy Hook:
It is not a place. It is a model of care with 6 standards and 111 elements that have to be included. It is a new way of thinking about the practice of primary care.

Chair Oscarson:
Assemblyman Jones, if you think of hospice as a care model, this is a new model for primary care. The patient-centered medical home is somewhat of a misnomer.

Assemblyman Sprinkle:
You maintained the language "culturally effective." What does that specifically mean? Secondly, you completely took out section 20.2, subsection 3, but it was my understanding that it was the mandate for insurance companies to participate. Now, instead, you are putting together an advisory group to look at patient-centered medical home models. Could you go over those two things?

Michael Hackett:
You are referring to amending section 20.2, subsection 3. Is that the correct provision you are referencing?

Assemblyman Sprinkle:
Yes, it is.

Michael Hackett:
The reason we are replacing the provision in the bill is that, per Dr. Green, the State Board of Health does not have the authority to establish an advisory group of stakeholders or to implement a program to assess implement measures and study the patient-centered medical home model to see how effectively it is working to reach its full potential. From the beginning, as this provision was presented and amended in the Senate, it was never intended to address the issue of how to get to payment reform, which we obviously feel is a very important consideration in this. Understanding where Nevada is right now and, ultimately, where we want to be with patient-centered medical home legislation, we realize it is going to be at least a two-session process. However, we feel this legislation today, with this amendment, is an essential first step to get us where we need to be. I hope that answers your question.

Assemblyman Sprinkle:
Yes, it did. Could you explain the "culturally effective" language?

Nancy Hook:
"Culturally effective" is a term I am not particularly familiar with. It is usually "culturally appropriate," meaning people from a variety of different cultures and places in this world who do not necessarily understand the mainstream that is in the provision. For instance, if you are advocating for prenatal care, there are people who culturally believe that you do not need it. You need to understand their values and beliefs in order to advocate for them to start prenatal care early. It is ensuring you meet the patients where they are in terms of advocating for the health services they need.

[Assemblywoman Titus assumed the Chair.]

Assemblyman Sprinkle:
Is this stating that it will be accepted practice to take on other suggested forms of medicine that we may not consider mainstream in the United States, or is that what it is suggesting? If it is, I am not quite sure how we are going to get insurance companies to pay for it.

Nancy Hook:
No, it is not suggesting that we advocate for methods of care that are not considered appropriate within our credentialing process. It is understanding how to effectively change people's behaviors within their own culture or beliefs.

Assemblyman Thompson:
I want to go back to that question as well. Since Mr. Hackett is changing "culturally competent" to "culturally effective" and Ms. Hook mentioned "culturally appropriate," which terminology is correct? Is this the new term that we use? I do not want to lose what I have always known as "cultural competence." That has always been a goal in various communities. Also, I really have concerns, Ms. Hook, about your saying at the end of your testimony that you want to change some cultural behavior. Could you please clarify that statement?

Nancy Hook:
I believe "culturally effective" would mean working within the culture or language of patients in order to help them increase their knowledge to change attitudes and beliefs so that they would be more apt to do the things they need to do behaviorally to improve their lifestyle, such as to better their diet. You are familiar with "cultural competency." As an administrator, I am not culturally competent to deal with, for example, Hispanic mothers and African-American men, but I am culturally sensitive enough to know I need providers working for me that are competent. "Culturally effective" means making sure you have everything in place, so that you are effective in getting your messages across.

Assemblyman Thompson:
Are we downgrading by using "culturally effective" language versus "culturally competent"? I look at "culturally competent" as a more comprehensive mode, and I understand that you may not have that ability, but should that not be the goal to be "culturally competent"? I am just trying to understand the reason that language was taken out. I do not want us to lose the overall focus of what it means to be "culturally competent."

Vice Chair Titus:
Is that terminology in the federal model and is it clarified? Are cultural issues mentioned at all?

Nancy Hook:
It probably says "culturally and linguistically competent or sensitive." Both can be used, but I like "cultural competency" and would be happy to make that change.

Michael Hackett:
Assemblyman Thompson, it is really the decision of this Committee as to what term they feel is appropriate. If this Committee feels that "culturally competent" is the appropriate term, we would be happy to make that change.

Assemblyman Thompson:
We are looking to you as experts as well. I do not want to be the one to make this change because I am not in the health world every day. I am yielding to you to tell us what the appropriate term is. Of course, it is up to us to vote on this, but we want your expert opinion as to what is the best fit and terminology for this.

Vice Chair Titus:
For my benefit, I would like to see what the federal wording is, and you can bring that forward.

Assemblywoman Joiner:
I am looking at the Internet, and it is using terms like "a service that meets the cultural and linguistic needs of the patients." I do want to comment that this bill is such a long time coming. Thank you so much for sticking with it and finally coming with a bill. It sounds like everyone has worked together to come up with it. Nevada is behind the curve on so many things. This is a category where we really need to be stepping up and making this available to our patients. I have personally seen many constituents in situations where navigating the health care system is incredibly difficult. When you have

a primary care physician with a team of other folks communicating about a patient, it is a win-win situation.

Vice Chair Titus:
Could you clarify the fiscal note of $1.3 million on this bill?

Michael Hackett:
There should not be any fiscal note on this bill. It did not come out of the Senate with a fiscal note, so there should not be one going forward. Also, when I was presenting this amendment, I forgot to indicate that as part of this amendment, we are deleting sections 20.7 through 21.5 in their entirety. Those are provisions that would have authorized the Nevada Insurance Commissioner and the Nevada Division of Insurance to more fully explore the issue of payment reform. We have had a lot of meetings with the Division of Insurance as we presented the conceptual amendment to this bill in the Senate. It did not include those provisions. Somehow, they wound up back in the bill after redrafting. I wanted to say that for the record.

Vice Chair Titus:
Looking at the fiscal note on March 27, 2015, from the Department of Health and Human Services, it is still on here. Maybe Dr. Green could clarify that it has been taken off.

Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services:
Yes, that fiscal note was on the original version of the bill, but since it has been amended, the fiscal note has been removed.

Vice Chair Titus:
I wanted to make sure that was very clear. That was part of the stumbling blocks last session. Is there anyone wishing to testify in favor of S.B. 6 (R1)?

Donald Farrimond, M.D., President, Nevada Academy of Family Physicians:
I am a family physician in Reno, Nevada. I also perform rural emergency room work in public hospitals such as the one in Winnemucca. I am currently serving as the president of the Nevada Academy of Family Physicians (NAFP). I represent more than 500 family physicians in the state of Nevada. I would like to submit our support for the bill as it came out of the Senate as S.B. 6 (R1). I would like to support most of the amendment. However, the NAFP would like to see language defining "primary care." This is regarding section 20.2, subsection 1, paragraph (b). Sixty percent of time spent providing primary care is not arbitrary. This comes out of the Affordable Care Act. Furthermore, this bill is important in the same way that we talk about specialists

providing medicine. Many of our specialists are initially boarded in internal medicine. In internal medicine, you can provide primary care and stop there, or go on to additional specialty training and perhaps become a pulmonologist, a cardiologist, or a gastro neurologist. As family physicians, we believe people who are leading patient-centered medical homes should indeed be engaged in providing primary care during most of their work time.

I would like to address Assemblyman Jones' question about what a patient-centered medical home looks like. It is a difficult concept. We call it a home, but it is not a place. An example, as opposed to a description, may be more helpful. Currently, if you seek care for diabetes or another chronic disease, you may see a physician to be treated and prescribed a prescription, or perhaps given a laboratory slip. That is the end of your care. We call it episodic care. When we are dealing with patients at medical homes, we call it comprehensive and ongoing care. As a diabetic patient, you become part of a registry where your health is monitored monthly—or maybe every six months—to make sure you have had your diabetic eye examination. They make sure you have had the laboratory work you need for surveillance to make sure your kidneys are still functioning well. They check to see that you are actually performing well. You may even get a call from someone checking on you. These are some of the services that go into a patient's care. You may also have increased access through hours that are not customary, such as weekends, early mornings, and late hours. You may have access to your physician through texting or emailing.

These are things that currently, as physicians, we cannot offer because we do not get paid for that extra time. Part of a patient-centered medical home requires changes in reimbursement. That is where we always get stuck. For example, between 7:30 a.m. and noon, I can see perhaps 20 patients and spend 10 minutes with each one. Under the reimbursement changes, I might be able to see 10 patients and spend 20 minutes with them. As a physician and as a patient, both sides win. The bipartisan vote to do away with the Medicare Sustainable Growth Rate last month was 92 to 8. This brings in a new era in how we are going to be reimbursed as primary care physicians with the creation of MACRA, which stands for Medicare Access and CHIP Reauthorization Act of 2015. It has already authorized changes in reimbursement for Centers for Medicare & Medicaid Services, and will involve every state.

We are in full support of the initial bill, S.B. 6 (R1), and most of the amendment. We would not personally kill the bill or speak in opposition if this first subsection was not stricken. We believe that if we are going to make decisions for Nevadans to improve their care, we should make them based on facts and ideas

of what we want and what we want to see as outcomes. As a state that ranks thirty-ninth in health care outcomes and forty-first in determinants—meaning we are headed the wrong way next year—we have a lot that we can do. We can choose what we want to do. In the handout that I brought, the last four pages are outcomes of patients who are in medical home projects throughout the country that was released in 2012, which is the most recent data that we have (Exhibit G).

One of the problems in our state is getting providers to see Medicaid patients. If you look at Colorado after they initialized their patient-centered and alcohol models, their participation in the Children's Health Insurance Program, where doctors see children with Medicaid, rose from 29 to 96 percent. North Carolina has numbers that you can look at that show cost-savings to the state, which have grown every year from $60 million initially to over $400 million if you continue the projection. It was $382 million in 2010. This is a win-win for everybody. It is a win for the state fiscally, but more importantly as a primary physician, we see this as a win for our patients. We, the members of NAFP, are available if there are any ongoing questions during work groups.

Keith Lee, representing Nevada Association of Health Plans:
We are an organization of seven or eight of the primary health insurers in the state. Three of our members are also members of the Nevada Insurance Exchange in the state. We appreciate Mr. Hackett and working with him and Senator Hardy on this issue, which resulted in this amendment that is brought before you. We support the bill as proposed to be amended by Mr. Hackett's amendment. I would indicate that the model we have discussed here is the patient-centered medical home and is a model of practice. It is recognized by at least two of the members of the Nevada Association of Health Plans that currently have patient-centered medical homes in their portfolio, and what care they provide payment for. It is a method by which we incentivize good outcomes. The model of the PC-MH and members of my organization provide incentives for good outcomes. We think this is clearly the way we want to go. With the new payment models that are in process, that is what we hope to do.

Denise Selleck, representing Nevada Osteopathic Medical Association:
We are in favor of seeing PC-MHs finally come to the state of Nevada. This is something that we have watched some of our sister states do for almost two decades, and we have been lagging behind for a long time. As osteopathic physicians, our practicing physicians work on preventive health care and on keeping patients well. This will allow us to do exactly that and to do so in the patients' best interest. We are in support of this bill and look forward to it passing.

Annie Hofstetter, Private Citizen, Reno, Nevada:
I am a third-year medical student at the University of Nevada School of Medicine. I am speaking about the importance of patient-centered medical homes to the future of medicine and the impact this structure of health care will have on my future career as a family medicine physician.

During my time in medical school, I have begun to ponder what is happening to the human side of patient care that initially attracted me to medicine. As health care becomes increasingly more complicated by the multiplicity of players involved and an emphasis being placed on quantity rather than quality, I have noticed a growing divide between doctors and their patients, a lack of coordination of care and integration of services, and dwindling respect for patient's values, preferences and needs. And I truly believe patient-centered medical homes—which I will refer to as PC-MHs—are an integral aspect to solving this current dilemma in health care.

I have had the opportunity to work in an outpatient clinic on the school of medicine campus during by family medicine clerkship. This clinic is structured as a PC-MH. I was thrilled to be a part of an organized and systematic approach to each patient as a unique individual, where we specifically addressed the preferences, values, and needs of each patient and allowed our patients to take ownership of their own health. Further, our patients trusted the competency and efficiency of their caregivers. [Continued to read from written testimony (Exhibit H).]

Vice Chair Titus:
To add a personal note, sometimes I think I am an endangered species, so it is good to see that there are still people choosing family practice.

[Assemblyman Oscarson reassumed the Chair.]

Joan Hall, representing Nevada Rural Hospital Partners Foundation:
We are in favor of this bill. For the medical student, I have 14 rural hospitals that would love to employ you.

Jessica Ferrato, representing Nevada Nurses Association:
We are here in support of the bill.

Chair Oscarson:
We will go to testimony in opposition. Is there any testimony? I am not seeing any, so we will go to neutral testimony.

Tracey Green:
The state is neutral on this bill. I do want to add though that the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease is willing to create and house the advisory council, as well as collect the data as described in the bill.

Chair Oscarson:
Is there any other testimony in neutral? Seeing no one, we will close the hearing on Senate Bill 6 (1st Reprint). We will open up for public comment. Seeing no one, this meeting is adjourned [at 4:21 p.m.].

RESPECTFULLY SUBMITTED:

_____
Karen Buck
Committee Secretary

APPROVED BY:

_____
Assemblyman James Oscarson, Chair

DATE: _____

EXHIBITS

Committee Name: Assembly Committee on Health and Human Services

Date: May 11, 2015 **Time of Meeting: 2:17 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 314 (R1)	C	Erin McMullen, Nevada Resort Association	Written Testimony
S.B. 314 (R1)	D	John Packman, Nevada Public Health Association	Written Testimony
S.B. 6 (R1)	E	Michael Hackett, Nevada Primary Care Association	Written Testimony
S.B. 6 (R1)	F	Michael Hackett, Nevada Primary Care Association	Proposed Amendment
S.B. 6 (R1)	G	Donald Farrimond, Nevada Academy of Family Physicians	Written Testimony
S.B. 6 (R1)	H	Annie Hofstetter	Written Testimony