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

Seventy-Eighth Session
February 23, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 1:32 p.m. on Monday, February 23, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at 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
Assemblyman John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Karen Buck, Committee Secretary
Jamie Tierney, Committee Assistant

OTHERS PRESENT:

Richard Whitley, M.S., Administrator, Division of Public and Behavioral Health and Interim Director, Department of Health and Human Services
Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services
Julia Peek, Manager, Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Services
Cari Herington, Executive Director, Nevada Cancer Coalition
Stacy M. Woodbury, Executive Director, Nevada State Medical Association
Adam Plain, representing St. Rose Dominican Hospital System
Tom McCoy, representing the American Cancer Society and Cancer Action Network
Karen Beckley, Manager, Radiation Control Program, Division of Public and Behavioral Health, Department of Health and Human Services
Elisa P. Cafferata, President and CEO, Nevada Advocates for Planned Parenthood Affiliates, Inc.
Laura Hale, Manager, Primary Care Office, Division of Public and Behavioral Health, Department of Health and Human Services
Joan Hall, representing the Nevada Rural Hospital Partners Foundation

Chair Oscarson:
[Roll was taken. Committee protocol and rules were explained.] The bills we have today are from the Division of Public and Behavioral Health. I believe we are the first committee to welcome the Interim Director. We are looking forward to your presentation on the Division of Public and Behavioral Health.

Richard Whitley, M.S., Administrator, Division of Public and Behavioral Health and Interim Director, Department of Health and Human Services:
I will begin with a presentation (Exhibit C). We did a presentation for you a couple of weeks ago on our mental health system, but this is the rest of our division, which is the public health side. Starting on page 2, we are organized by direct administrative services, clinical services, regulatory and planning services, and community health services. Today we will focus on the regulatory and community health services. We separate the regulatory and community health services into two distinct areas because the functions are so different. On the community health side, we primarily fund communities through local partners, such as the local health authorities, to implement population-based services. On the regulatory side, we inspect, license, and certify health facilities and health professionals.

Turning to page 4, it lays the groundwork for public health. Public health is different from personal health. Personal health is health care that individuals obtain when they go to their clinician for care. Public health is really population-based health. It is delivered through policy and programs. The best example is immunizations, where there are requirements at different life events, such as entering school and being fully immunized. Population-based health tends to focus more on prevention and early intervention rather than traditional health care.

On page 5, what I wanted to do with this presentation is to put it in context. During this session, you will hear about the health care systems, especially with the Affordable Care Act and expanded Medicaid. I want to speak specifically to the role that public health plays in terms of the health care system. It really is a system, so there is no single cause of the problem in terms of access to health care and there is no single solution to it. It is important for us to go over what those components are and the role that the Division of Public and Behavioral Health plays.

The first component is clinicians. If we have a shortage of clinicians, it would seem obvious that we need our universities and colleges—both private and public—to produce more. It is more complicated than that. Each discipline has its own licensing board, its own rules on licensure, whether they offer reciprocity, and how that would be offered. It is a very broad landscape that is operationalized differently among each of the different licensing boards. An example that we found on the behavioral health side was with psychologists. We actually have a shortage of clinical psychologists. The universities were willing to produce more, but in order to have an internship, you have to be at an accredited site. We have only one accredited site in Nevada, and that is the U.S. Department of Veterans Affairs (VA).

The universities could produce more clinicians, but many of them were going out of state for their internships and, therefore, getting their jobs out of state. In the health care system, it is very important for us to look at the role of clinicians in terms of how we designate shortage areas, navigate the licensing boards, and the ability of clinicians to come into our state.

The other area is facilities. Facilities in our regulatory role range from hospitals to home health care agencies. You will see that we actually list all of the different facility types. It is important to note that the regulatory role that we play is not simply one of just inspecting for the sake of creating government bureaucracy to regulate a health care business. It is also to certify, on behalf of Centers for Medicare & Medicaid Services (CMS), these facilities so they can bill Medicare and Medicaid. For CMS to reimburse health facilities, they are required to be certified by CMS. Nevada has done a nice job combining state licensure with CMS requirements. Our statutes and regulations are in sync with CMS requirements so that we are not duplicating efforts or requiring facilities to jump through multiple hoops. In the last five years, we have integrated environmental health—the inspection of food safety in facilities—with the health facility inspection. We also regulate radiological health equipment and have integrated that inspection so we do not send multiple regulators at multiple times into a facility. We try to be organized.

There is still opportunity for us to make improvements. One of our challenges relates to fire safety. The local fire chief, the state fire marshal, and the requirements for Life Safety Code did not always sync in the past. We are working on making it easier for the facility, so if you are in compliance at one level, that should suffice for all. They should not have to duplicate efforts, which delays the start-up of these facilities. Health facilities have two roles: licensure and certification. Certification is required in order to bill Medicare and Medicaid.

The other area is reimbursement. How much is reimbursed and who can be reimbursed. Reimbursement is one of the challenges we have with health care in our state, especially since so many people are covered by an insurance product or Medicaid. Reimbursement often comes up, and a good example is social workers. Social worker interns are reimbursable by Medicaid. That is consistent throughout all of the disciplines, which is a pipeline for students graduating, employers hiring an intern—because they can bill for them—and hopefully they are staying in our state and serving in the various roles where social workers are required. Hospitals, long-term care, hospice, and various agencies require social workers. There is a nice pipeline into employment that includes reimbursement for interns. We continue to look at that and work with Medicaid on how that reimbursement works.

The other thing that comes up is the scope of practice. Some of the licensing boards have requirements that are not necessarily in sync with what the reimbursement is in terms of the standards of care. We are working with them so that the licensing function is relevant to reimbursement and supports those individual practitioners in multiple ways of compliance.

The final area is the geographical regions. We have shortage areas. In our Primary Care Office, we do calculations that designate health professional shortage areas. It is important because there are federal loan programs that pay off student loans for a whole variety of health professionals, including physicians, nurse practitioners, nurses, social workers, psychologists, and marriage and family therapists. Nevada underutilizes this program. We utilize this program less than any of the western states. Then we look at why. We get federal funds for designating underserved areas, but the federal grant does not adequately support the outreach to all of the colleges and universities and employers in our state. The loan repayment program is a three-year reimbursement and a good way of keeping people in our state. Members of our budget committee might note that we requested two positions to promote the federal loan repayment program for all clinical types, to both employers and colleges and universities. That is the health care system, as we see it, in terms of our regulatory role.

Starting with health facility licensing, as I said previously, we license and certify multiple types of hospitals and home health care agencies. The challenge we have in our regulatory role is that we get pulled in three directions. We have new businesses and expanding businesses—existing facilities that want to grow—that have opportunity, have done assessments, and see that there is a need in their community. They want our inspectors to go out and approve their expansion or new build. The CMS rules are that you have to be licensed and actually operating before you can be certified. A facility loses money when not up and running. There is a big demand for our inspectors to go out immediately to get the facility certified so they can begin billing Medicare and Medicaid. That is one big pull.

Another pull is our regular inspections. We have an 18-month frequency for most facilities, with the exceptions of ambulatory surgery centers and long-term care facilities. Several years ago, we had an incident in an ambulatory surgery center with exposure to hepatitis C. Based on the Nevada experience, CMS elevated the frequency—as did the State Legislature—to annual visits to ambulatory surgery centers.

The third pull on our workforce is consumer complaint. We get complaints from consumers who are either dissatisfied or have had a bad outcome in a health

facility. We investigate those. If you go to our website, under the Bureau of Health Care Quality and Compliance, you will see that we bureaucratically post those facilities and findings. They are not consumer friendly because we have integrated our state licensure with the same requirements that CMS has, so we do not have to duplicate efforts. We use the language of CMS and speak in terms of deficiency and substantiated or not. In order to participate as a health facility that is certified, they have conditions of participation. Those conditions of participation have required standards, and we inspect to those standards. If you are deficient in those, it gets noted and then you do a corrective-action plan. We have not done a very good job with consumers' complaints because we do not translate that very easily. Per our budget, we are moving this complaint piece back to the consumer. When inspecting complaints, our inspectors do not communicate well with the complainants. It is a little unsatisfying to just be told "unsubstantiated," so we are working on a stronger consumer voice in order to give feedback that is better received. We are also trying to help the consumer exhaust all remedies that exist in a facility rather than complain to the regulator. We check to see if they have worked through the process within the facility and received satisfaction. We have found that has been a benefit. We met with the Nevada Hospital Association and have worked through a nice process of making use of existing opportunities to intervene.

The important part of the licensing side is the competing priorities. As we have seen health care expand, we have also seen an increase in facilities, both new and remodels. Hospitals are doing some incredible things now under the hospital's license, like having offsite services. It is a business model that expands health care, and we are doing all we can to be supportive of that model. Some are because of reimbursement opportunities like the psychiatric hospital payment that has initiated interest. There are emergency rooms and ambulatory surgery centers offsite but under the hospital license. There are many requests to make use of the existing hospital's license to expand services.

Chair Oscarson:
Back up a little to when you were talking about the complaint inspections. Those are all very transparent now that they are all posted on the website. The public can see and access them whenever they need to. Is that correct?

Richard Whitley:
That is correct. I would add that we are trying to give the feedback back to the facilities. In the regulatory environment, many times things are done by single event. We did this with the complaints because there were a lot of unsubstantiated complaints. It is a reflection of something that is occurring

because of a consumer's complaint. Maybe it is customer service to give those back to the facility. They can look at themselves and see if there is room for improvement to help prevent the complaints. This regulatory environment is all fee-funded. The industry pays to be regulated. Our intent is to save funding for the facilities or to reduce the number of inspections.

Page 9 shows that we regulate the Emergency Medical Systems (EMS) in all counties except Clark County. Radiological health—page 10—is both equipment and some of the technicians, such as mammography. We have tried to integrate this because we have a hard time recruiting some of these specialty providers. We have hired some contractual staff—retirees—to serve as complaint investigators. It lends itself nicely to ad hoc work, allowing the state inspectors to do new business, expanding business, and regular inspections.

Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services:

I want to start by saying that the community health piece of our Division represents the diagram where we are looking at people health, as well as public health, and the integration of both. Ninety percent of community health is grant-funded. I want to take a moment as I go through some of these areas to really compliment staff for not only getting these grants because some are competitive, but also for implementing and assuring that these grants are carried out. Much of what we do is to fund our local partners to implement population-based services.

I will start with Maternal and Child Health (MCH) and elicit what is in some of these categories, who we serve, what some of these projects are, and then highlight some of the areas where we need work and where we have shown some real strides. It might be the most informational.

The MCH services focus on women of childbearing age, infants, children, and adolescents. The composition is the block grant, as well as a home-visitation program. A couple of programs are directed at adolescents in regard to both abstinence and contraception. I will highlight Rape Prevention and Education, as well as the Office of Suicide Prevention.

Through stakeholder investment and working with our local health authorities, as well as with the coalitions, the Association of State and Territorial Health Officers had a Healthy Baby President's Challenge where the goal was to reduce the number of low birthweight babies. I am happy to say that Nevada was one of four states that was able to achieve the 8 percent reduction in low birthweight. That is about reaching moms, communicating with new media types such as texting or social media, and trying to address the parents—mostly

the moms—on early prevention to prevent negative outcomes. When we look at our hearing program—which is a very important program—there are statutory requirements to assure that all children, before they are 30 days old, receive a hearing and screening assessment. We now have 97 percent of our babies getting hearing screenings before they are 30 days old. In addition, there are statutory requirements that babies who are screened and have a hearing deficiency of any kind must be referred and received services within six months. According to 2013 data, we received an 84 percent compliance once we identified and screened children and were able to get them to services. It is going to be our continued drive to ensure we can maintain those numbers statewide as we expand populations.

I want to spend a minute with the Office of Suicide Prevention. It is important to give you some shocking details about our state. In 2013, 19 percent of high school students had suicidal ideations, and 11.8 percent of them had attempted or reported that they had attempted suicide. This is very profound. The unfortunate thing is that we are sixth in the nation in suicide in children. It is very important for us to remember that, where we are sixth, we need to be fiftieth, and where we are fiftieth, we need to be first. The Office of Suicide Prevention has been working at all levels to address this problem. Last session, Senate Bill No. 164 of the 77th Session was passed, which required us to train all school administrators on suicide as well as bullying. Showing how legislation can improve that primary intervention and do some training for our school administrators, the Office of Suicide Prevention was established to look more closely at these suicides to address the root cause and the primary problems. I am happy to say that the Office of Suicide Prevention has educated 3,300 firearm owners, and has provided security locks for many homes. Our goal is to address them at the earliest point and to do prevention in early interventions, so we are not ultimately having to deal with children who have to address their mental health issues surrounding suicide. The Office of Suicide Prevention is also working directly with the coalitions and media. They staff the crisis call line, which is very important. They have made some strides and have expanded the program called safeTALK, recently expanding from the urban communities to the rural communities to include Storey County and Lyon County, and to address these problems head-on for a population effect while we work with our local health authorities.

Assemblyman Jones:
Suicide is obviously something we do not talk about, but when you say 11 percent actually have thoughts about or attempted suicide, that seems very high to me. Do you have statistics on how many kids actually commit suicide before the age of 18? This is often brushed under the carpet and not talked about, other than by these outreaches. Are there other ways to make it more

known? Are we trying to make it less talked about except through counselors? How does this work?

Tracey D. Green:
The way we identify this type of data is through the Youth Risk Behavior Surveillance Survey. It is a national survey under which certain populations are asked specific questions. It is done through the Department of Education. We are addressing the children through many different ways; one of which is through the screening that we now do. There are a number of programs looking directly at suicide prevention in schools. We have been working with The Children's Cabinet and Southern Nevada Health District doing suicide screening in schools—a screening called Signs of Suicide (SOS). Why do we not hear about it? It is something that is seldom talked about, but we are addressing it at many different levels to out the problem, and for early-on intervention. There is also a governor's project that we are working on trying to shift the system from crisis-treatment focused to prevention and early intervention. We will be addressing children earlier after adverse events that may lead them to be stressed enough to consider something like suicide.

Assemblyman Jones:
Do you have actual statistics?

Tracey D. Green:
I can get them for you.

Assemblyman Trowbridge:
I met with a group of home health care providers. They talked about their hours being cut back significantly and that they received a very low wage. Why is this happening with the increase in the number of people who would qualify? I hope there is a corresponding increase of funding available. Some of these people were from referral agencies that ranged from private firms to University Medical Center in Clark County. Would you share your thoughts on those matters?

Richard Whitley:
The barrier is not from the regulatory side, because they do not cap services. If you have the names of the organizations, I will follow up to find out what their reason is and to see if it is a reimbursement issue. Home health agencies are partnered to the appropriate discharge from a hospital. The idea is to reduce readmissions and to help support patients in their home. This is the trend. I would expect to see more support in that area. I will follow up more specifically to what their needs are if you have any names.

Tracey D. Green:
For the next category, I would like to speak a little bit about our immunization program. I have touched on some of these highlights with this Committee when I discussed our measles presentation. The immunization program comprises the registry, which we call Nevada WebIZ. A few things that you need to know about the registry is that 1,517 providers, 2,700 clinics, and over 3 million entries have been in our registry. It has become a great resource and is statutorily required for all clinicians who provide immunizations—to both adults and children—to enter into our registry.

The second, and probably one of the bigger parts of the immunization program, is the Vaccines for Children (VFC) Program. This program covers the uninsured and underinsured and Medicaid-eligible children. It covers American Indians and Alaskan Natives and works with the federally qualified health centers and rural health clinics. It is important to keep in mind that, because of programs like VFC, all children have the opportunity to receive immunizations.

That is the pay source; now let us look at the problem. The problem is how do we assure access and how do we assure reimbursement. A lot of people ask me what is going on with our current immunization rates. This year, we were forty-first in immunization rates. Last year, we were thirty-ninth. How does something like this happen? First, our overall population number has increased. Last year, we had a 65 percent increase in our population, and this year it is 66 percent. The other thing is, to backtrack a little, immunization rankings are determined by birth to 35-month-old children. How do we target that population, which would directly improve our immunization rates? Our laws surround day care facilities, but not all children under the age of 35 months attend them. Our laws surround universities and elementary schools. How do we target the populations in areas that will improve our overall immunization rates? I want to tell you about some of the approaches that we are using to target the children in the birth to 35-month-old group. Coordinating with our local health authorities, we are tracking where our high-risk poverty communities are. Using more of a grassroots, on-foot approach, how do we address the families that are in those communities? We will need to work directly with our coalitions and health departments and work with federally qualified centers to address children who are 0 to 35 months and also to address their parents. How do we educate that parent group? We are trying to target that population, while at the same time assuring that our day care facilities, schools, and universities are maintaining their records. I am sharing this information with you because it is a challenge for us to continue working to improve our rates. We are, in fact, improving rates to the credit of our program. When we compare ourselves nationally, we are improving and continue to improve. They are just improving more rapidly than we are.

Next, I want to touch on communicable disease programs. Communicable disease for us is primarily our HIV and AIDS program. This is really the Ryan White Part B Program. The HIV and AIDS program is about 75 percent medical support and 25 percent social service support. There are grants for assistance for housing and wraparound or case management services. One of our primary focuses now is to assist our HIV and AIDS clients to ensure they get their medications and to support copays and deductibles. At the same time, the HIV and AIDS program targets special populations where we might see an increase in either adolescents or African-American women. It is about prevention and early intervention, educating our entire population, and targeting the at-risk populations where we have seen the numbers starting to change. With our HIV and AIDS programs, it really is about the ground work. It is working with our coalitions, primarily to meet people where they are. Assemblyman Thompson has been working with us on how to get to places where individuals might be, not your regular nine-to-five job. We are going to be in parks, clubs, and places where active children, adolescents, and adults are. That is one of the areas that we are targeting with the HIV and AIDS program.

Assemblyman Jones:
I am looking at statistics. During the eighties, HIV was big everywhere; now we do not hear much about it. Do we have statistics on the number of people who have HIV in the state of Nevada?

Richard Whitley:
Yes, HIV is a reportable disease, so we have that. We have confidential testing in Nevada; some states have anonymous testing. We use a public health approach where you start with the person who is infected and then identify their contacts. We then go out and try to get them to be tested so they will know their status, and to prevent transmission. It is reportable, so we do have statistics.

Assemblyman Jones:
Do you know how many there are? I want to know what the magnitude of this problem is in the state of Nevada. Is it 0.1 percent, or is it smaller or bigger? Where are we?

Tracey D. Green:
What I can give you is the number of individuals enrolled in the program. We have 987 individuals enrolled, of which 584 are getting medication assistance or insurance assistance of some kind. I can get further information to see if that reflects the entire infected population.

Richard Whitley:
People are living longer because of the addition of medication. You referenced years ago when people were dying, which impacted the number of people living with HIV. HIV is a communicable disease with chronic characteristics. The treatment is keeping people alive. The focus of this program is certainly to prevent, because it is a preventable disease. Preventing transmission is the major goal, but once someone is infected—because it is reportable—following up and identifying why they are not in treatment is also a goal. In the case of HIV, treatment is prevention. If you treat someone, their viral load goes down, and they are less infectious. Getting them to comply with medication treatment is the centerpiece of the treatment side of this program.

Assemblyman Jones:
Earvin "Magic" Johnson, Jr. is well known and he is HIV positive. He still looks very healthy when he is on television and it is about 20 years later.

Assemblyman Araujo:
This topic of HIV awareness is very big for me because I was on the board of directors of Golden Rainbow for three years. This is dear to my heart. I am curious about the outreach that you referenced. When I think of an outreach, and because HIV is becoming such a nonissue for many people and no longer taboo, we really need to get creative. I would really like to hear about the ways you have been reaching out to schools and students and minority communities.

Richard Whitley:
It is an area where we could do better. HIV has been around for 25 years, and the only prevention funds we administer are federal funds. They come from the Centers for Disease Control and Prevention (CDC). Our tradition has been to fund the local health authorities, from federal government to state government to local government. It is not the role—and we have not played the role—of the state to do the outreach. Whatever puts a person at risk for HIV also puts them at risk for a lot of other things. Those determinants that put them at risk—substance use and homelessness—all bundle together. I am committed to looking at how we can take the categorical funding that addresses individual diseases, but are for a particular population of people, and to see how we can bundle that and leverage the federal dollars better. I take your question as a challenge. We have approached this in a similar way for a very long time. We knew we had to change the treatment side, but it has not been enough. It is also not enough to say that the program we fund is evidence-based. Who is providing it and can we leverage those dollars better to nonprofits rather than to government agencies?

Tracey D. Green:
I am going to move a little faster. Chronic disease, programmatically, is the area where we are going to see the most transition in our funding resources. This has been, essentially, the safety net for many of what we describe as "body part funding." I say that because there are breast and cervical screenings, colon cancer screening, comprehensive cancer screening, et cetera. It is parts of the human body that we are addressing through grant funding. With the Affordable Care Act, we are seeing many of these services being covered. Now, we will see a change in funding, and we are hoping this change will be more toward prevention of these chronic diseases as opposed to the actual diagnosis and treatment, which is the current direction. We have screened many men and women in Nevada for breast and cervical diseases and colon cancer for entire populations between the ages of 54 and 65. We are looking at programs that also address diabetes, community health workers, stroke and heart disease, as well as tobacco intervention and control. One of the areas where we will see a number of bills this session is the reduction of smoking in our state, including smoking in cars, exposure for children, the regulation of cigarettes, taxation, and the full gamut of bills on smoking. Obesity is another area where we look. Promoting school-based health centers and promoting school wellness are parts of this chronic disease section.

Next is Women, Infants, and Children (WIC). This is a supplemental nutrition program. It is a program that addresses pregnant women, postpartum women up to six months unless they are breastfeeding—then they get coverage for one year—and children under the age of five. These children have had a medical or clinical assessment that they are at risk for some kind of nutritional issue, whether overweight or underweight, anemia, small or large birth weight, or problems with pregnancy. They receive some additional dollars to assure they are getting healthy food. I say healthy food because WIC prescribes the types of food these children can get. They all fall in the categories of fruits, vegetables, beans, peanut butter, and the foods that we consider healthy for growing children and pregnant women. In addition, this program has the Electronic Benefit Transfer System (EBT), which is the benefit card system. The funding is loaded onto a card much like a credit card, so they can go to grocery stores and receive their food without being identified any differently than anyone else. This gets rid of the stigma. Addressing breastfeeding has been a big target and one of our successes as well. We are really promoting breastfeeding across the state.

We will spend some time on discussing the cancer registry and our biostatistics and epidemiology section when we present Assembly Bill 42 . The Office of Public Health Informatics and Epidemiology, for all of you who are interested in getting data or information, is a very busy place where we collect data.

We collect data on sexually transmitted diseases (STDs), HIV, tuberculosis (TB), and adult hepatitis. We have an epidemiology and lab capacity grant that looks at outbreaks, investigations, and surveillance overview. Most of these incidents occur locally, and they are handled locally, but the data is collected centrally. We also work with the School of Education to collect student-based data and with local health departments.

Finally, I want to talk briefly about consumer health protection. Consumer health protection—what Mr. Whitley was speaking to—is our food safety section that inspects food facilities in the rural areas. Washoe County and Clark County inspect their own food facilities, unless they are on a school campus, a jail, or prison. There are two new areas that are under consumer health protection that came from the last legislative session. One is the farm-to-fork bill. This is important because it expands the opportunity for farmers to actually prepare and serve food. We now have statutory authority to review the food that has been prepared. It is a very important movement to put nutritional food grown in our state on tables. The other is the cottage-food bill. This allows for a person, schools, or social clubhouses that manufacture small quantities of foods, to prepare prepackaged food that can be consumed or sold immediately to consumers. They have a limit of $35,000 a year and include things like nuts, bakery goods, and jams and jellies. It increases the opportunities for us to get fresh, healthy food to Nevadans.

At this point, I will stop the overview on community health. I want to say, as I go to the last page [page 13, (Exhibit C)], that things like our consumer health protection is reliant on our local health authorities, as well as the state. If you take a look at page 13 and look at public health prevention and early intervention, all of this starts at home. It starts with the communities at large. The authority lies with the specific communities: Southern Nevada Health District covers all of Clark County, Washoe County Health District covers all of Washoe County, Carson City Health and Human Services covers Carson City, and the State provides the oversight services for the rural areas. Our ongoing challenge is to move our entire state from the mode of crisis treatment to prevention and early intervention. That, with our local health authorities, is really our goal as we move forward in public health.

Assemblyman Jones:
I like the terms that you use: prevention and early intervention. Those terms are great; however, I am very holistic minded in my approach. I know that the definition of allopathic medicine is to treat the symptoms, while holistic is to treat the cause, then the symptom does not arrive. Type 2 diabetes is a very good example. Most type 2 diabetics can change their diet and it goes away, but, if they just take their medicine, they feel good, so they continue eating junk

food. In the system, how real is it that we look toward the holistic alternative methods as opposed to allopathic medicine?

Tracey D. Green:
That is an excellent question in the sense that it is our challenge. Our challenge is to move away from plugging and fixing or treating toward prevention. When we look at return on investment, when you look at prevention, the return is very far down the line. Most of us are driven toward treat it now and make individuals better; that is our primary focus. Looking at the Affordable Care Act, the opportunities that we now have for all of the preventive health services to be covered benefits, and the opportunity to focus on ensuring that those services are provided, we will see the downstream effects. I agree with you that our tradition is to go straight to treatment. It is our goal, as we move toward changing the system of services, to focus on assuring the preventive services are being provided.

Assemblyman Thompson:
How does the coordination occur with the state health versus the local health authorities? How close is the working relationship? Does everyone do his own thing, or does it work seamlessly throughout our communities?

Richard Whitley:
One opportunity we have is when we sub-grant federal funds to the local health authorities. We can be consistent statewide by putting standardized language in the contractual language to the local health authority. That is the easiest vehicle for that. The biggest challenge in this new environment of the Affordable Care Act with expanded Medicaid is that preventive health is reimbursable. With the exception of Carson City Health and Human Services, which has always billed effectively, we must figure out how the preventive health services that have been traditionally provided by local health authorities can be formally crosswalked to primary care. The goal is to get people in to primary care, not to send them across town to a health department to get their vaccine when they are already seeing the pediatrician. Getting vaccinated should be in the doctor's office. That is the real intent of the federal program. Our local health authorities are at different levels of maturity with the role of being formally tied to primary care, a natural partner of the federally qualified health centers in Las Vegas and northern Nevada. I would have anticipated some of these federal grants going away when the Affordable Care Act was approved, because the grants pay for some things that are covered by Medicaid. It is just a matter of time, so we really are trying to work with our local partners on how to maximize reimbursement. It is tying the system together so that consumers are not left navigating to go here for prevention and there for care, children go here and adults go there. It should be a seamless system.

Assemblyman Thompson:
I have seen this working, especially when you alluded to the HIV outreach. The state health department, local health departments, and community partners work together to say that this is the issue, we are going to boldly address it, and we will put all of our resources together. I see that as the simple model that we should be using with the different issues that we have.

Chair Oscarson:
I will open the hearing on Assembly Bill 42.

Assembly Bill 42: Revises provisions relating to mammography and the reporting of information on cancer. (BDR 40-331)

Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services:
We have before us Assembly Bill 42. There are two parts to this bill, and I am going to introduce section 1 and the issue surrounding section 1. I will then turn it over to Julia Peek to introduce the second portion of the bill.

As technology has advanced, the use of mammography machines solely for traditional diagnostic mammography really has become outdated. Many facilities now need the capability of using these radiation–producing machines for diagnostic intervention and therapeutic measures. Specifically, there are now opportunities to do directed biopsies utilizing mammographic machines. In addition, there is also the opportunity to provide chemotherapy by identifying and isolating certain tissues on a mammographic machine and then allow for radioactive treatment or cancer treatment to be done.

If you look at section 1 of the bill, the primary change for the portion surrounding mammography comes in section 1, subsection 3, paragraph (c), where it says that it is used exclusively to perform mammography. The first part of this bill is just to remove the word "exclusively" to allow for these new and up-and-coming treatment opportunities with mammographic machines.

Julia Peek, Manager, Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Services:
Nevada Revised Statutes Chapter 457 outlines the reporting and tracking of all cancer cases in Nevada. Assembly Bill 42 is going to make several changes to improve our registry operations. Many of the changes, as you can see, are just updating language and making changes to align us with national standards. The most substantial change comes on page 4 of the bill, section 4, and that is about the underreporting that we have in Nevada. We spoke with health care

providers—those folks who are required to report—and they said that one of the challenges is that we charge $8 a case for the facility when they abstract their own case. We are the only state that does that. That creates a hardship on facilities. We are requesting that that fee be removed. Instead, we have developed an administrative fine. Right now, if a provider facility does not report, they are guilty of a misdemeanor, potentially a fine, and possible imprisonment. We would like that to be just a fee. In A.B. 42, we are requesting that fee. We determined that, by removing that fee and adding a fine, we have to include a fiscal note on the bill, but we think it will be cost neutral. I wanted to mention that since you will see it.

One of the major ways we determine if a case has been reported is by dual reporting. We do it for communicable diseases and chronic diseases. If we received a pathology lab and we did not get a provider reporting that lab on a case report, we would know that they did not report that case, and we would follow up with a warning letter and then, potentially, a fine. That data is used locally. Federally, they will look at the type of treatment that people with cancer are getting, the number of cases, incidence, prevalence, et cetera. It is very important that the data is complete.

Assemblyman Thompson:
Right now, with HIV, if a positive is detected but not reported, what is the fine? How does that work?

Julia Peek:
We do get that HIV-positive detected, and the penalty is similar to the way it is written for communicable diseases. It could be a misdemeanor, but we could also do an administrative fine of $1,000. We threaten to fine, but normally the providers will report once they know we have identified a case. It is not a large issue.

Tracey D. Green:
The process by which it occurs currently is that there are two parts to the report. The first part comes from the lab and the second part would come from the provider who ordered the test. The current law is written that there is a fee charged when the provider reports it. That is not for HIV; we are talking about communicable diseases and cancers. This bill addresses that piece. For HIV, Ms. Peek was speaking to the "not reporting" element.

Assemblyman Thompson:
What are we doing on that end? You are changing it from a misdemeanor with a potential fine to just a fine. Where will that money go? Will it go toward

more community outreach to get the mammogram van out into the communities where it really needs to be? Where does that money go?

Julia Peek:
Right now, we are not making as much as we used to when we were abstracting the other cases. On the average, it was about $100,000 a year. That is used as a maintenance effort for our CDC grant. That money is currently going toward the Nevada Cancer Coalition, which has representation here. They did a presentation and a conference for certified cancer registrars. We do education on how to code cases. It is very technical. We also use that money to fund a contract with Westat, which is a federal organization that helps us abstract those cases. We spend a great amount of money on data collection and quality, so there is not much left.

Assemblyman Thompson:
I know we are a policy committee, but I was talking about money. I have very close family members and close friends who have passed away due to breast cancer, and early detection is so important. If this bill is going to help on that end and ensure we get the proper reporting, this is a good bill.

Assemblyman Jones:
At the beginning of the first section, you mentioned it was to remove the word "exclusively." It seems like you are saying that you can diagnose it and do a biopsy on the spot and do targeted treatment all in one whack now. Also, what does "neoplasm" mean?

Tracey D. Green:
Neoplasm is cancer. Specifically, it is the abnormal tissue in cancer.

On your first question, it is the opportunity to perhaps, at some point, provide that triad of services. Currently, the way the process works is that you would use the mammography machine for its traditional use, but subsequent services could be provided if there was the ability in the law to use the machine for alternative resources. We do not, today, have the capacity to do all in one, but that could be the trend for the future.

Assemblyman Hambrick:
In full disclosure, my wife is a 20-year cancer survivor. In your statement, you said that the information comes from the labs and providers. So far, what I am not hearing about is the physicians. It is very important in our family's case, because my wife was diagnosed.

Tracey D. Green:
I am sorry for not being clear, but the providers would be the physicians. The primary would be the actual laboratory result from the specimen, but the provider would be the physician who either performed the biopsy or ordered the test.

Assemblyman Hambrick:
I appreciate the clarification.

Assemblyman Sprinkle:
I want to get back to the reporting. I am looking at the section that gives all of the types of information that is collected. At the very end, section 5, subsection 2, talks about research. This is very personal information, so what kind of oversight is there with the information that is being given? How do we know that the information is protected? Who exactly, other than someone performing research, is going to have access to this information?

Julia Peek:
A lot goes into our determining if we are going to release data. Most of the data we can do in-house, so most of the time there is just a request for statistics. We can provide that without ever releasing information. In *Nevada Administrative Code* 457.140, we have a process by which researchers can request the data, but they have to provide a great deal of information to us. They would not get identifiable information at any point. They would need to justify why they need a certain level of information. Then it would probably go through our state biostatistician and epidemiologist. We would have to see the results of the research before we would allow them to release that information publicly.

Assemblyman Sprinkle:
You just said in your statement that there is no identifiable information, but I see where it says, "Prescribe other information to be included in each such report, for example, the patient's name and address . . . other neoplasms in the patient's family, and the places where the patient has resided" [section 3, subsection 3]. That is all pretty identifiable information.

Julia Peek:
I am sorry that is not clear in what you are reading. That is what is reported to us. Those two sections are next to each other, but what is provided to us is from the laboratory, physician, or hospital. If a researcher asks questions, that is when we would de-identify the patient and give the researcher the minimum amount of information that they need.

Assemblyman Sprinkle:
I thought that was getting too close to that information.

Assemblyman Trowbridge:
In section 4, subsection 4, you eliminated the fine of $1,000 and further punishment of up to six months, and replaced it with an administrative penalty that you stated would be cost neutral. What would we gain by having one part taken out and another put in if it is going to have no fiscal impact? Are we just changing words for fun? What are we doing?

Julia Peek:
In order to get that $1,000 fine, we would have had to go through the court system and have them fined as a misdemeanor.

Assemblywoman Spiegel:
At the end of the bill, section 6 says that we are repealing NRS 457.075 and I am guessing that is because the Nevada Cancer Institute closed in 2013. I wonder if there is a reason why we are not naming another facility as the official cancer institute in the state.

Tracey D. Green:
At this point, I do not know the answer, but I am not familiar with another institute that would be considered a Nevada cancer institute or could be considered.

Assemblywoman Benitez-Thompson:
I believe many of the hospitals have a type of cancer institute that is affiliated with them, although they do not use that name, but there is not a central one anymore.

Tracey D. Green:
That is correct.

Assemblywoman Benitez-Thompson:
I have a question on the proposed new fee structure. You are going to put regulations in place to adopt the fee structure. Do you imagine it being a progressive fee as violations happen? One violation would be this much money and two would be that?

Tracey D. Green:
Exactly, starting with a warning letter, then sequentially based on history.

Assemblywoman Benitez-Thompson:
The bill will go into effect in July 2015 and will probably take up to a year for regulations to all be sorted out. Do you imagine that, coming into the next legislative session, we should have more comprehensive data? Is that your goal, a two-year process to get the reporting levels where they should be?

Tracey D. Green:
Yes. We would anticipate getting the regulations going within a year, and then, hopefully, have at least a six-month data set for the next session.

Assemblywoman Joiner:
It sounds like you said the fee is prohibitive and that other states do not do that. How do we compare to other states in our return rates? How many do you think we are missing? Is it possible to get to 100 percent? Are other states getting there? I am curious how we compare and what you are hoping to get to.

Julia Peek:
The way we do cancer data is different from communicable diseases. The CDC sets a number that they think we should receive, which is 14,000 cases a year. They issue standards if you can get that many. We are getting about 11,000 a year. They think we are missing 3,000 cases, and they determine that based on population and number of reported cases, using their algorithm. We are hoping to capture the 3,000 cases that are out there. We do not know where they are. It could potentially be a dermatology office where there is not necessarily a provider report or a pathology lab report. We are not sure, but we hope that, by making this change, we will be able to get providers to report more openly. For clarification, that fine would, hopefully, cause them to report. Right now, what we do is charge the hospital and abstract the fees. They are two different processes.

Assemblyman Gardner:
My understanding is that this requires health care providers to provide information to the Department. If that is true, do we know what kind of cost that will be to the health care providers?

Julia Peek:
It is not very expensive. They would need to complete a short, one-page form and send it to us. With the Health Information Exchange, if they choose to go with that method and have their data shared electronically, we are looking at

getting access to that information, and then they would not have to report it to us. It could potentially be free if they go through the Health Information Exchange.

Chair Oscarson:
I see no other questions from the Committee. We have some folks that want to speak.

Cari Herington, Executive Director, Nevada Cancer Coalition:
I am testifying in favor of Assembly Bill 42. This has been more than a year-long collaborative effort between the Division of Public and Behavioral Health, hospitals, providers, and researchers across the state. As you have heard, this bill updates and aligns NRS Chapter 457 with national standards and is designed to improve the quality, quantity, and validity of our cancer data. We use this cancer data, or our health officials use it, and our medical professionals use it to address cancer across our state. We use the information to identify cancer risk; improve screening, diagnosis, and treatment; evaluate the care of people living with cancer; and characterize leading trends in cancer incidence, survival, and mortality among our state's residents.

Cancer data is also used to make public health decisions, to maximize the effectiveness of our very limited public health dollars, and it helps guide our cancer prevention and control efforts. Ultimately, we hope to be saving lives.

As you heard, we currently lack quantity and quality, meaning we are not compiling a true picture of our total cancer burden. We feel that we are missing cases. This clearly impacts our state's ability to identify cancer trends and allocate our resources for prevention and care and quickly address any cancer developments.

We wholeheartedly agree with everything that was shared. As you heard, A.B. 42 will update and align us with national standards. Nevada has not met the national gold standard for reporting cancer data in three of the past five years. Assembly Bill 42 would increase our ability to collect such data, remove the barrier to cancer reporters, take away the fee that is additional to expenses already incurred by many of our law-abiding health care facilities who already train qualified registry professionals to properly report in compliance with NRS Chapter 457, and it can be prohibitive to our smaller providers. It changes the penalties for nonreporters. To our knowledge, we have not actually enforced penalties for nonreporters to date. Changing this to an administrative penalty would, hopefully, provide the impetus to follow the law and properly report all cancer data. Nevada Cancer Coalition is honored to be part of the statewide collective effort on A.B. 42. The passage of A.B. 42 strengthens

Nevada's ability to accurately and more swiftly address cancer, both for those battling this disease today, and as an effort to eliminate cancer for future generations.

With that said, I bring forth a friendly amendment (Exhibit D). As we stated earlier, this bill is a collaborative effort of the Division of Public and Behavioral Health, hospitals, providers, and researchers across the state. As Dr. Green mentioned, there are two parts to the bill. One piece was developed with the radiation control program, and the cancer data component with the Office of Public Health Informatics and Epidemiology. We merged the two since both items reside in NRS Chapter 457; however, some of the language was inadvertently dropped along the way. We sincerely apologize for missing it prior to the bill's introduction. We appreciate your consideration of this friendly amendment.

The mammography portion essentially strengthens the language that Dr. Green mentioned. The change in the administrative fine corrects the provision ensuring the funds; supports the Division in accordance with other statutes regarding administrative sanctions for medical facilities and other related entities and the disposition of money collected, such as what is outlined in NRS 449.163, and speaks to what Assemblyman Thompson mentioned about using the fines and fees to appropriately promote cancer prevention.

Assemblyman Gardner:
I have one question about the amendment. Regarding the second part, previously, the administrative fee went to the General Fund, but now it is going to go to the prevention, screening, and diagnostic services for breast cancer. Is that going to go back into the Division's coffers? I am hesitant that someone can administer a fine and then use it for their own benefit. I am concerned that they are both in the same location.

Cari Herington:
It is my understanding that a number of the fines stay within the Division and are used for the benefit of public health. To be clear, these fines are fairly limited. They range from $10,000 to, maybe, $20,000 a year. In 2012, we collected $21,500, in 2013 we collected $10,800, in 2014 we collected nothing, and in 2015 we collected $20,000.

Chair Oscarson:
Is there a process or a mechanism for how you actually use that money?

Richard Whitley:
We do not actually use any of our fines in the way that was described for outreaches. The fines that we keep actually go back into quality improvement in the facilities. This would be a stretch from what our current practice is in our regulated entities. Right now, if we impose a penalty and collect it, it goes back into improvement in the industry that we collected the fee from, not for enhancing programming. It would be a new function for us.

Chair Oscarson:
Are there any other questions from the Committee? [There were none.] I will accept any other testimony in support of the bill.

Stacy M. Woodbury, Executive Director, Nevada State Medical Association:
We want to go on the record in support of the bill.

Adam Plain, representing St. Rose Dominican Hospital System:
We would echo Ms. Woodbury's comment and say me, too.

Chair Oscarson:
Is there any other testimony in support? [There was none.] Is there any testimony in opposition?

Tom McCoy, representing the American Cancer Society and Cancer Action Network:
You might ask why the American Cancer Society is taking opposition to A.B. 42. I want to make it very clear that this is a very narrow opposition; it is so narrow it is only one word. It is the word "exclusively." Basically, what A.B. 42 has in section 1 is an off-label approach to treating other aspects of cancer. That is the problem that we have with the bill. There is no published literature that weighs the risks or benefits or effectiveness of using mammography for anything else other than breast cancer screening, and that is a problem that we feel has not been addressed in this bill. Historically, the American Cancer Society worked with the developers of mammography years ago in developing standards. We worked with the American College of Radiology coming up with standards and guidelines. We were involved with the Mammography Quality Standards Act—which is still the law today—which establishes standards and guidelines by which reporting is done and the consistency and notification aspects across the country. Our concern is that we have the potential for uses that have no standards or guidelines, and we are taking a product that is designed for a specific purpose and taking it off label.

I looked at information on radiology and the information from the American College of Radiology and the Radiological Society of North America, and they

described a mammography unit. I wrote down their explanation of a mammography unit. They said it was a rectangular box that houses the tubes in which x-rays are produced, and that the unit is used exclusively for x-ray exams of the breast. I think the word "exclusively" is in there for a reason, and I do not think we are at a point where that word should be taken out of our statutes. We are in full support of the Cancer Registry. We would urge you to eliminate section 1 and stick with the Cancer Registry, which is the initial understanding of this bill that I have been working on for some time.

Assemblywoman Spiegel:
Do we have enough mammogram machines in Nevada for Nevadans to get screenings for breast cancer? I am trying to determine if we have the capacity to expand the use of the machines that we have in this state.

Tom McCoy:
I do not have information on the actual number of units. As of October 2014, there were 63 certified sites in Nevada—facilities that have one or two machines. My concern is similar to that. Women, and the public at large, are focused on using mammography for breast cancer screening. We are concerned that we will lose sight of what its purpose is if it is going to be used for other things.

Chair Oscarson:
Your question is answered on page 10 of the presentation. It says there are 67 mammography facilities.

Assemblyman Jones:
If the machines could be more comprehensive, and do more to effectively eradicate breast cancer, why would you object to that? Is your only objection that you think they will lose sight of the screening aspect if it is more comprehensive and does more?

Tom McCoy:
We are not talking about that. What we are talking about is the expanded use that goes beyond screening and diagnostics. They mentioned the term "therapeutic," but there are no guidelines. This is new territory. Mammography machines were designed for one purpose, and that is what they should be used for until other uses have been evaluated. I work for an organization that is evidence-based, and everything we do is evidence-based. There is no evidence to support what is being proposed in section 1.

Assemblyman Thompson:
Do we have any evidence or information from other states that they have done this?

Karen Beckley, Manager, Radiation Control Program, Division of Public and Behavioral Health, Department of Health and Human Services:
Yes, we do have data. We did a national survey of all other states and got 30 responses, of which 22 allow this. There are five states that are looking to go that direction, because it is a change in the industry. We use AccuBoost, which is the name of a company that uses mammography machines in conjunction with therapy machines, which is what we are proposing to allow. It is not that we are taking the machine to use for providing therapy; it allows us to use it in conjunction with something else.

Assemblyman Thompson:
Mr. McCoy, I echo what some of my colleagues are saying. It is strange for the American Cancer Society to come in opposition. If you were to work with the Department of Health and Human Services to get that evidence-based information and data, would you feel more comfortable with the language of the bill?

Tom McCoy:
Right now, we do not have the same data that the state agencies may have. I contacted our people in Atlanta—our science division and our cancer control people—and they found no published literature that weighs the risks, benefits, and effectiveness. Therefore, we take the position that this is not in the best interest of Nevada's patients.

Assemblyman Thompson:
Or does it just mean that we would be the first? We would be setting the standard.

Tom McCoy:
I take issue with what they are proposing; the standards have to be set. There are national standards that must be followed for mammography now. That is the Mammography Quality Standards Act. There are no standards that I know of on the removal of exclusivity that would allow these mammography machines to be used for other purposes.

Karen Beckley:
This AccuBoost system is not changing standards for mammography. It is taking a therapy machine—of which there are standards of how it has to operate and be used—and regulating it in conjunction with mammography.

We cannot use that mammography machine for anything other than screening, unless we get rid of some of the verbiage against using it in conjunction with this other machine. We have regulations in place for both devices, and we need the ability to use them together.

Tracey D. Green:
This is an industry request for expansion of the use of the mammography machine. We are also happy to work with Mr. McCoy to provide him with the information that we have, as well as the studies from other states that have expanded the utilization of mammography machines to see if we can work with him on some of his issues.

Chair Oscarson:
When you get together, spell out the allowable uses in regulations. Since you have to do regulations for that anyway, maybe you could put that in this piece of legislation or another where it would go and see if we can do that. I do not want to narrow you down too far because we only meet every two years. I want to make sure you have the tools in your toolbox to utilize services as technology improves and things go forward. What I am hearing from Mr. McCoy is that he needs to see some evidence that there is viability in that because I, like the rest of my colleagues, cannot see why Mr. McCoy, who is a reasonable man, opposes something that would help detect cancer. That does not sit well. The two of you need to get together and discuss this and identify those things that are a problem. That might be an option if you are amenable to that.

Tracey D. Green:
Absolutely.

Tom McCoy:
Yes. We will get together and talk.

Chair Oscarson:
If you want me to be a part of that discussion, I will be happy to participate as well.

We will now go to neutral. Is there anyone wishing to testify?

Elisa P. Cafferata, President and CEO, Nevada Advocates for Planned Parenthood Affiliates, Inc.:
We are neutral at this time. I am trying to get more information from those folks who set the standards in our health centers. Generally, we do not offer mammography. We just do the physical exams and refer women for further

services. We are trying to get more information that I can bring to you later. To clarify some of the discussion, they were actually talking about two sets of standards. There are standards that the state establishes for the use of these machines, and then there are standards that are set by the American Medical Association for protocols and treatments when we find diseases. They might have been talking about different standards, where we might have studies in one area but not another. Hopefully, we will be able to provide more clarity as we go forward and learn more about this.

Chair Oscarson:
Any information that you can provide to those two entities would be helpful and appreciated.

Is there anyone else neutral? [There was no one.] I will close the hearing on A.B. 42.

We will open the hearing on Assembly Bill 39.

Assembly Bill 39: Removes the cap on the application fee for the Physician Visa Waiver Program. (BDR 40-328)

Laura Hale, Manager, Primary Care Office, Division of Public and Behavioral Health, Department of Health and Human Services:
We administer the J-1 Physician Visa Waiver Program, which allows us to recruit international medical graduates to work in our shortage areas around the state in exchange for the waiver of their usual requirement to return to their home country after they complete their residency. Assembly Bill 39 would remove the $500 application fee cap for that program. In 2009, the Legislature increased administration and oversight of this program due to documented abuses in southern Nevada where these physicians were required to work outside of designated areas and to work extensive hours, on threat of deportation. In the six years since then, we have worked very hard to improve technical assistance and oversight of this program. That sets the foundation for assuring that these physicians are going to be treated fairly. To the extent that we have happy physicians working in this program, they serve as great ambassadors to recruit additional J-1 physicians into our state.

The $500 fee for applications does not meet our costs for any of our reviews. There is a range of costs that are incurred for the application depending on the type of application. We estimated about $1,300 in costs for the most recent application that we completed this month. There is quite a range depending on whether it is a primary care physician or a specialist. Increasingly, we are seeing more specialists and hospitalists, which require more time for our review.

We do more data collection on those. They often work at multiple sites, which means we have to do more site visits to ensure program compliance.

Another new aspect that we are seeing is third-party contractors. A group of physicians will contract to work in private sectors. They do not necessarily oversee that site, which means they have to do some coordination with a hospital and look at how all of the components are implemented. When the program began it was focused on primary care, but with all of the changes in environments, we are seeing a lot of different types of applications. In response, we sometimes have to do more negotiating with applicants, including the third-party contractors or hospitalists.

Giving us some flexibility on that cap to differentiate among these types of applications would help us support the program's sustainability. By no means do we intend to create a barrier, as Mr. Whitley testified earlier. We realize that we have a huge shortage of providers in our state, and every program that we administer within the Primary Care Office is intended to bring in more physicians. The elements that we are trying to support ensure that we have a fair process in bringing more people into the program. We also have language within our regulations that the fee can be waived entirely if any type of hardship can be demonstrated. This particular program, the J-1 Physician Visa Waiver Program, is also known as the Conrad 30 Waiver Program; each state gets 30 slots each federal program year to fill. States that routinely fill all 30 slots charge far more than $500. For example, Texas fills those 30 slots within the first two months of the program. They charge between $2,500 and $5,000 per application. We are not looking at that much in Nevada, but we are looking to support our ability to administer that program.

Assemblyman Thompson:
On page 2, section 1, subsection 2, paragraph (b), starting on line 6, you want to delete "not to exceed $500" and add "a reasonable." Will there be caps mentioned in the regulations? I am concerned about the subjectivity that could occur. It is like going to purchase a car and asking how much the car is; you want to see the tag of how much it costs. You do not want the price to change each day. Also, with the subjectivity, it can potentially block certain people. Tell us why we would go more general when we have something specific.

Laura Hale:
Our intent is to put this in regulation. We would specify a differentiation for specialists or hospitalists compared to primary-care physicians. We would have that flexibility to do it in regulation. The third-party contractors are new, and neither our regulations nor our policies are designed to manage that type of request. We have had a lot of questions come up, and there have been a lot of

back and forth negotiations taking place. Having flexibility to manage that through regulation would be easier than putting it in statute and not anticipating what can be anticipated.

Assemblyman Thompson:
You used the term "negotiation." Why would there be a need for negotiations for this program? Why is there not a set cost?

Laura Hale:
The negotiations would not be the fees. The negotiations depend on the type of data they need. Typically, our regulations and policies are developed around a facility. It is usually the facility that is hiring, and they report to us how many people, or patients, came in over the last 12 months. Of that number, how many pay by Medicaid, Medicare, or use the sliding fee schedule? When it is a third party like this contractor, and he does not operate the hospital, they want to report on their contracted providers also. If it is a specialist who is going to multiple facilities, they could not identify only the numbers for that one facility; they would have to look at multiple facilities. Shift work also came up in a recent application. The person they wanted to bring on would work 12-hour shifts, seven days on and seven days off throughout the year. One of the components of both the federal requirements and our state requirements is that you must have equitable treatment for these J-1 physicians. They cannot be treated differently from a United States citizen who is a physician. We ensure they get sick leave and vacation leave, which was not accounted for in the contract. We review the contracts. The contract said that this person who works seven days on and seven days off was getting time off. We wanted them to document that the physician was getting leave time equal to what someone who worked a regular shift would get over a year period. It is about that comparability. Since we have not worked with contractors in the past, this is new for us and our policies were not designed this way.

Assemblyman Araujo:
If I understand this correctly, some cases will take longer than others. Was there a specific reason you did not want to list a specific new cap?

[Assemblywoman Titus assumed the Chair.]

Laura Hale:
It was about the flexibility of doing it in regulation with the changing environment. I would not have anticipated the issues that we saw in this recent application. There are many new things. Under the Affordable Care Act, there is a lot of change, including how doctors practice. We want to be able to

change with it. Our intent is not to create barriers; we want to bring more people in. We want to sustain the program.

Assemblyman Sprinkle:
I am also having an issue with "reasonable," as opposed to something more defining. Could you, for the record, give me a definition of what reasonable means to you?

Laura Hale:
What we had in mind was that specialists and hospitalists would now be a $1,000 fee, and that does not cover all of our costs. It would allow us to do a site visit to ensure compliance and be able to meet with the physician to ensure he or she is comfortable with his or her working arrangements.

Assemblyman Sprinkle:
That comment did not give me much. For me to feel more comfortable about this bill, you would need to define another upper limit and say "up to" like the language that is in there now, except that you are expanding it beyond the $500. Further in the bill, it talks about where the money goes. It goes into your account through the State Treasurer, rolls over, and never makes it to the General Fund. I am assuming, since you are asking for this change, that the account is completely used every year. Do you anticipate, with the changes that you are requesting, that this will now expand that account at the treasury, and that you will have surplus funds at the end of the year?

Laura Hale:
It did not get a fiscal note attached to it because the number is so small. Right now—and for a long time following the abuse issue—we would only have two J-1 applicants per year at $500. We are talking about $1,000 a year. In the recent years, where we have tried to improve the technical assistance and the program oversight, we have four to seven applications come in each year. Of those, maybe half are primary care, which would stay at the $500 level. Maybe half are specialists or hospitalists, and now third-party contractors, where we would look at that increased rate of $1,000. Even adding that up over time, it is such a small program it would not meet the level that would require a fiscal note; it is miniscule. Traveling to Las Vegas and doing site visits costs about the amount of the application.

Assemblyman Sprinkle:
That brings me back to my concern at the very beginning that we are saying reasonable, and who knows what that number could be. There could be a flush account all of a sudden. I personally would be more comfortable if there was a limit, as opposed to reasonable.

Assemblyman Trowbridge:
Perhaps we could address this issue by some additional language in the regulations where it currently says, "a reasonable application fee," and say "not to exceed actual costs associated with processing the application." That would stop it from being a moneymaker and eliminates that provision.

Assemblyman Jones:
I concur with my colleagues that, without some type of limitation on the cap of the fee, there is no way I could support the bill.

Assemblywoman Benitez-Thompson:
Where the concern comes from—and I do not think anyone will challenge the fact that you have costs—is that I have seen regulations come through where other bodies wanted to remove a cap, but they could not tell us why or what the new fee structure would be. That makes people nervous. Some departments and agencies are better than others at managing their fees. I do not think you have to go through regulations just because it is such a small population. It will cost you more to develop the regulations than it will to actually collect the money. You are at the point that you need to define a couple of things, then you will be in a much better spot. The department has a lot of fee-schedule examples to pull from and good people to help you.

Vice Chair Titus:
You said that you had four or five applications last year?

Laura Hale:
In the current cycle, we have had two, and we have two more pending. Last year we received four, and the year before we had seven.

Vice Chair Titus:
How many J-1 visa doctors are practicing in Nevada at this time?

Laura Hale:
Currently, 18.

Vice Chair Titus:
According to the existing statute, the money in the account may be used to cover the costs of administering the program and for training and educating J-1 visa physicians and employers. What kind of education do you have for them?

Laura Hale:
We have a website that is basically a 101 for both employers and physicians. Basically, we ask them to review it before the physician begins employment. It goes through all of the federal and state requirements and the rights and responsibilities for both parties.

Vice Chair Titus:
Is there any cost for maintaining the educational program?

Laura Hale:
There is an outreach. As the regulations change, we have to update that material. We also do site visits. One of the requirements is that materials be posted for clients to identify that a sliding-fee schedule is available, that Medicaid and Medicare are accepted, and that they may not be refused service on the basis of their ability to pay. That comes with the federal program.

Vice Chair Titus:
Is this fee in addition to the cost of licensure? Is this an application fee?

Laura Hale:
Yes.

Vice Chair Titus:
In addition to the almost $800 that they have to pay to be a physician, they also have to pay an additional application fee just to go into the J-1 visa program. Is that correct?

Laura Hale:
Actually, the fee can be paid by both the employer and the physician.

Vice Chair Titus:
Basically, are you documenting their qualifications with this fee? Are you looking at where they did their training, what college in Russia they went to, or what other country they happened to leave from? Is that what you are doing in your application process?

Laura Hale:
That is part of the requirements. There are many documents that are required by the U.S. Immigration and Customs Enforcement as part of that application. The state is designated to review those and then send a letter of support. We review the application and ensure all of the federal requirements are part of it. We review the contract to ensure it meets state requirements, including things such as a limitation on how many hours the physician is to work.

We do not want abuse issues like we saw back in 2008 and before. We conduct a public hearing for review, and so our applicant and employers have an opportunity to ask questions. Different stakeholders in the community participate in those public hearings. We conduct an outreach by way of site visits, making sure the physicians are comfortable with the work environment and that they are not being required to work outside of a designated area.

Vice Chair Titus:
This cannot be done through a phone call?

Laura Hale:
We are in compliance upon receipt of any compliance report from the employer and the J-1 physician, but there is a big difference between completing a form and faxing it, and talking with a person. When I first came to the program in 2010, we had a complaint and went to talk to the physician about it. The employer did everything possible to create a barrier to us talking with that person. She finally came to talk to us during her lunch time so that she had the freedom to express her concerns with the employer.

Vice Chair Titus:
I share the concerns of my colleagues who have asked about a cap on the fees. Many health care workers who come from all over the world to fill spots for us frequently are inundated in the application process with attorney fees and other costs just to get here. I would hate to see another barrier to qualified folks coming to work and serving areas where we are so desperately in need.

Is there anyone who would like to testify in favor of A.B. 39?

Joan Hall, representing the Nevada Rural Hospital Partners Foundation:
I am supportive of J-1 physicians. As you know, in my tenure as an administrator, I hired four. You are correct; it is a very onerous task for both the facility and the physician. It is also very expensive for both. I share all of your concerns about the cap; however, I also know how much work has to be done for the whole process. Initially, J-1 physicians were a rural recruitment tool, then it opened up to urban underserved areas. It was much easier when it was rural. It was easy to control for the Primary Care Office. When it got to the urban centers, there was a lot of competition and need for those doctors. That is where the abuse came in. We support the program.

Stacy M. Woodbury, Executive Director, Nevada State Medical Association:
I am also a member of the Primary Care Advisory Council that approves the J-1 visa applications. I go through the documents that these people have to

provide to get accepted into the program. We believe it is an important way of putting providers in places in this state where we need the help. Our concern was that the fee not be so high that it hinder entry into the program. We need these people, and we need to fill these spots.

Vice Chair Titus:
Are there any questions? [There were none.] Is there anyone else who would like to testify? [There was no one.] We will close the hearing on A.B. 39. Is there any public comment? Seeing none, we are adjourned [at 3:36 p.m.].

RESPECTFULLY SUBMITTED:

_____
Karen Buck
Recording Secretary

RESPECTFULLY SUBMITTED:

_____
Karyn Werner
Transcribing Secretary

APPROVED BY:

_____
Assemblyman James Oscarson, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 23, 2015 **Time of Meeting: 1:32 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Richard Whitley Department of Health and Human Services	PowerPoint Presentation on Division of Public and Behavioral Health
A.B. 42	D	Cari Herington, Nevada Cancer Coalition	Proposed amendment