MINUTES OF THE
SENATE COMMITTEE ON HUMAN RESOURCES AND EDUCATION

Seventy-third Session
April 4, 2005

The Senate Committee on Human Resources and Education was called to order by Chair Maurice E. Washington at 1:35 p.m. on Monday, April 4, 2005, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4401, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Maurice E. Washington, Chair
Senator Barbara K. Cegavske, Vice Chair
Senator Dennis Nolan
Senator Joe Heck
Senator Bernice Mathews
Senator Steven Horsford

COMMITTEE MEMBERS ABSENT:

Senator Valerie Wiener (Excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Chris Giunchigliani, Assembly District No. 9

STAFF MEMBERS PRESENT:

Leslie K. Hamner, Committee Counsel
Marsheilah D. Lyons, Committee Policy Analyst
Cynthia Cook, Committee Secretary

OTHERS PRESENT:

Jay L. Parmer, LogistiCare Solutions, LLC
Scott Scherer, Hale Lane Peek Dennison and Howard Law Firm

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Human Resources
Chris Szymarek, LogistiCare Solutions, LLC
Phillip D. Nowak, Social Services Chief, Division of Health Care Financing and Policy, Department of Human Resources
Diane G. Buckley, National Patient Advocate Foundation
Raymond McAllister, Professional Firefighters of Nevada
Bill Welch, Nevada Hospital Association
Gary E. Milliken, American Medical Response
John M. Myers, City of Las Vegas
Brian Rogers, Vice President of Operations, Southwest Ambulance
Rory Chetelat, Emergency Medical Services Program Manager, Clark County Health District
Bradford Lee, M.D., J.D., M.B.A., State Health Officer, Health Division, Department of Human Resources
Michael J. Willden, Director, Department of Human Resources
Fergus Laughridge, Committee on Emergency Medical Services, State Board of Health, Health Division, Department of Human Resources
Brian Burke
E. Joe Cain, Regional Emergency Medical Services Authority
Robin Keith, Nevada Rural Hospital Partners Foundation
Ann Lynch, Health Corporation of America
George A. Ross, Health Corporation of America
Robert A. Ostrovsky, North Vista Hospital
John Domansky, North Vista Hospital
Michael R. Alastuey, University Medical Center
Lacy Thomas, University Medical Center
Chris M. Bosse, Washoe Health System

CHAIR WASHINGTON:
We will open the hearing on Senate Bill (S.B.) 401.

SENATE BILL 401: Makes various changes concerning provision of certain transportation services to recipients of Medicaid. (BDR 38-1395)

JAY L. PARMER (LogistiCare Solutions, LLC):
I represent LogistiCare Solutions, LLC. We are here in support of S.B. 401. LogistiCare entered into an agreement with Nevada Medicaid in October 2003, to provide nonemergency transportation brokerage services on a capitation

basis. We work with existing providers and create a network to offer transportation for Medicaid and Nevada Check Up (Childrens Health Insurance Program) clients. During the past 17 months we have encountered several challenges.

SCOTT SCHERER (Hale Lane Peek Dennison and Howard Law Firm):
The issue is to have providers of nonemergency medical transportation be regulated by the Department of Human Resources, rather than the Transportation Services Authority (TSA). The bill authorizes the Department of Human Resources to contract directly with a broker, a provider of transportation services, a common motor carrier or a contract motor carrier. The director of the Department of Human Resources will adopt regulations specified in the required qualifications. The requirements must include insurance equal to that required by the TSA and a program of safety inspections done in conjunction with the TSA. We are suggesting that transportation service providers continue to provide the same or higher level of security. Federal law mandates the provision of transportation to the Medicaid population. Section 2 of the bill is a housekeeping measure to include in the existing appropriation the provisions of section 1. There are exemptions existing under current law. Page 3, line 39, states a nonprofit carrier of elderly or disabled persons is not required to obtain a certificate of public convenience, but is not exempt from inspection by the TSA to determine whether its vehicles are safe. Providers of transportation for the Medicaid population need this exemption because not all Medicaid clients are elderly or disabled. We would like to suggest one amendment to the bill (Exhibit C).

SENATOR CEGAVSKE:
Does the bill allow or prohibit the taxicab companies from submitting a bid for this service?

MR. SCHERER:
There is nothing in the language to prohibit the taxicab companies from bidding on this service. LogistiCare is a brokerage; they do not actually provide the transportation. Most of what is being provided is through taxicab companies.

SENATOR CEGAVSKE:
I am concerned about the costs of this service.

MR. SCHERER:
The federal rules require a system of cost control to be put into place. LogistiCare follows the rules and they do provide a cost-control mechanism.

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Human Resources):
Under the terms of the contract, LogistiCare is a broker of nonemergency transportation services for Medicaid and Nevada Check Up clients. We did a competitive procurement for these services. Any entity that met the qualification in our request for proposal (RFP) was encouraged to submit a bid. There were four bids received. We pay LogistiCare a $3.18 per-person per-month rate to provide all nonemergency transportation services. Prior to LogistiCare, we struggled with trying to get transportation services for our clients, particularly those who lived in North Las Vegas and outlying areas.

SENATOR CEGAVSKE:
All of the people enrolled in Nevada Medicaid and Nevada Check Up are included in the monthly rate. What is the total enrollment?

MR. DUARTE:
The total enrollment is 170,000.

SENATOR HECK:
Am I correct that this is not what is known as paratransit service?

CHRIS SZYMAREK
I am the director of operations for LogistiCare. Although we use the public system, this does not affect the paratransit system.

SENATOR HECK:
You have testified there have been problems. Could you please clarify those problems?

MR. PARMER:
LogistiCare has contracts in ten states to provide nonemergency transportation services. Nevada is the only state where LogistiCare is regulated by an entity other than Medicaid. We have encountered some cultural differences between the TSA and the regulating of a Medicaid service. Most of the problem seems to be because the TSA likes to license carriers using a "one-size-fits-all" common

carrier application. We are trying to get to the point where we can have an expedited process in order to reach out to one contract carrier to provide only nonemergency Medicaid transportation. There are nonprofit organizations that have vehicles which are not fully utilized. Given the demand on the taxicab companies in Las Vegas, it is difficult to dispatch them in a timely manner. We are trying to get an expedited application process whereby we can get more carriers into the network.

The clients we serve are ambulatory patients, people who are going to regular medical appointments.

MR. DUARTE:
We support this bill. The intent is to assure services are readily available for clients in the Las Vegas area. We would like to provide language to include Nevada Check Up in the bill.

SENATOR CEGAVSKE:
Is the funding for this program all federal money?

MR. DUARTE:
The program is a medical service that is reimbursed at the medical federal-matching-assistance percentage.

SENATOR HECK:
As the broker, if you are using a taxicab service, are you charged the meter rate?

MS. SZYMAREK:
We pay metered rates.

SENATOR HECK:
If that is the case, how is there a cost savings? A patient calling for a taxicab could be reimbursed for the fare.

MS. SZYMAREK:
There is probably not a cost saving, but there is a need for the public to have a better service. With the taxicab companies we often have patients waiting three and four hours. Mentally ill patients are unable to wait that long without any help.

PHILLIP D. NOWAK (Social Services Chief, Division of Health Care Financing and Policy, Department of Human Resources):
As a part of the federal approval process, there is a stipulation of structure by which we must demonstrate cost-effectiveness relative to the previous situation. It was difficult to monitor. There is not a regulated tariff, and a broker does negotiate direct rates that may be advantageous relative to a one-by-one trip-based rate. We see that in out-of-state travel. If a child needs to go to Los Angeles, by arrangement and interaction with carriers, we found the broker to be advantageous.

SENATOR HECK:
You mentioned that you are requesting Nevada Check Up clients to be included in the program. Does the 170,000 figure include those beneficiaries?

MR. DUARTE:
Yes, it does.

MR. SCHERER:
This exemption would allow some nonprofit carriers to provide transportation services and a per-trip rate could be negotiated.

DIANE G. BUCKLEY (National Patient Advocate Foundation):
I am in favor of S.B. 401. When a client leaves a medical facility or a doctor's office, they may have an order for additional laboratory tests or a prescription to be obtained immediately. In northern Nevada, the patients are scattered over a large area. When a client has an appointment, it may be out of their area of residence. Some of the clients have wheelchairs and problems walking, and not all personal-care assistants are allowed to go out of the area. These clients often need transportation services because many times they do not have personal transportation available. I am concerned with the carriers that may be used in the program and the type of vehicles to be used. I worry about timeliness and safety constraints.

CHAIR WASHINGTON:
We appreciate your concerns, and I believe most of them are addressed in the bill. On page 2, it states: "The Director may adopt regulations concerning the qualifications of persons who may contract with the Department to provide transportation services ... "

MR. DUARTE:
The regulations to be adopted will be consistent with those in our contract with LogistiCare. We will be glad to work with Assemblywomen. Buckley on strengthening the language in the contract.

SENATOR HORSFORD MOVED TO AMEND AND DO PASS S.B. 401.

SENATOR HECK SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR WIENER WAS ABSENT FOR THE VOTE.)

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CHAIR WASHINGTON:
We will open the hearing on S.B. 458.

SENATE BILL 458: Makes various changes concerning time within which person who is transported to hospital is transferred to place in hospital where he can receive services. (BDR 40-1321)

RAYMOND MCALLISTER (Professional Firefighters of Nevada):
We have reviewed the bill. To the best of our knowledge, all of our concerns have been addressed. We would like to have put on record that if there is an entity outside of Clark County that wants to participate, there will be a fiscal note. If a fiscal note will jeopardize the life of the bill, we would request it to be specific to Clark County, because they have agreed to pursue this.

SENATOR NOLAN:
The Clark County Health District has informed me that the tracking of time is currently being done. Why is this being left in the hands of the State when the county is better equipped to do this?

BILL WELCH (Nevada Hospital Association):
The thought was to have a standard throughout the State. We understand the only county interested in this issue is Clark County. However, to have a tiered standard is a concern to us. It would give the impression there is a different standard of care expected in various parts of the State. It is spelled out in the

bill how a county might opt out if they were not interested in the process. There was no opposition to the provisions of the bill during the work session.

CHAIR WASHINGTON:
Would you please verify that S.B. 458 does not provide for a fine if a hospital does not transfer a patient within 30 minutes of arrival?

MR. WELCH:
There are not any penalties in the bill.

SENATOR NOLAN:
This bill relies on a good-faith effort for a number of entities to make it work. I believe those efforts will result in reducing overcrowding in emergency rooms (ERs). If the effort does not seem to be working, there is no remedy except to return to the Legislature in two years. Is there some immediate remedy if there is a unit not making a good-faith effort in this area?

CHAIR WASHINGTON:
Let me address your question. This agreement has been worked out between the hospitals, the firefighters and the emergency-response population. The three parties agree. There is now a definite time of 30 minutes in which a patient is to be transferred to an appropriate place in the hospital. There is a reporting mechanism to determine if time is being lost, and the cause and effect of the time being lost. The bill gives an opportunity to review the report and determine if additional measures are needed.

SENATOR NOLAN:
If there is noncompliance, does the bill provide for a remedy?

CHAIR WASHINGTON:
This collaborative agreement does not provide for any fines or penalties.

MR. MCALLISTER:
This problem developed over a period of time and it probably cannot be fixed in one year. The reports will allow us to identify many problems. When a triage system is in place that will enable us to drop off patients, when a new hospital comes online and when the mental health facility opens, we should show a reduction in time at the hospital. The fact that the system will report to the Legislative Committee on Health Care on a quarterly basis should encourage the

hospitals to comply. The media follows these hearings and the results will be reported in the press.

SENATOR HECK:
I would like to commend all those who came together to craft this solution. I understand a county has the ability to choose not to participate in the study. The 30-minute time frame is in statute and applies to all counties.

MR. WELCH:
It is important to understand we now have a defined time that is accepted by all parties, a defined standard of reporting and a committee that will have equal representation. We are all interested in one outcome, and that is for the patient to receive prompt and effective services.

SENATOR CEGAVSKE:
It seems this bill is penalizing the hospitals. What kind of an impact will the 30-minute requirement have?

MR. WELCH:
It should be noted that the hospitals had over 270,000 patients brought to the hospital ERs in 2004, of which 70,000 were delivered by ambulance. The challenge is to triage all patients who are presented. Under federal law, we are obligated to triage and evaluate a patient to determine whether or not they require emergency care. This is going to be difficult, but for the first time we have a standard. There are hospitals who believe they have met that standard. The challenge in the past has been how to measure the time. This bill now gives us a specific format and definition on how to measure the time. We know we will not meet the standard all of the time. We hope this will help to provide to the Legislature the cause of the backup of patients in the ERs. I believe this will help identify whether or not the concerns with the overwhelming load of mental health patients and the uninsured population who pursue primary care through the ERs are the reasons for the backlog. One of the requirements of the measure is that a document be filled out for every patient and an explanation as to why the patient was not transferred to the appropriate place within 30 minutes.

SENATOR CEGAVSKE:
I would prefer to see a time of 60 minutes for transfer to the appropriate place after the person is delivered to the hospital.

CHAIR WASHINGTON:
The 30-minute time period for transfer is a national standard.
SENATOR HORSFORD:
Are the emergency medical service providers under a time frame to deliver a patient?

GARY E. MILLIKEN (American Medical Response):
We have a response-time requirement of 8 minutes and 59 seconds.

SENATOR HORSFORD:
The requirement is based upon the average time within the industry. If you exceed the requirement, you are fined. I do not feel another study is necessary. The problem for quality patient care needs to be addressed now. That should be our priority. I appreciate the cooperation between the entities but I do not understand where the incentives are for the hospitals to comply. If the Emergency Medical Services (EMS) providers have to meet a transport-time requirement in a growing town, why can we not hold the same level of accountability for other partners in the system?

MR. MCALLISTER:
There has been some disagreement about when patients are actually transferred. One hospital contends it is taking place in 20 minutes. Our data shows it is taking place in 88 minutes. The difference is, when we go to sign in a patient, a hospital representative will meet us within 20 minutes and designate the bed assignment for the patient. However, the assigned bed may not be vacant and we are required to wait. We have reports whereby various responders are staying at the hospital and not doing what they are supposed to be doing. This will help clarify all of that. A specific check-in method, perhaps a time clock, will be implemented. When the patient is actually transferred to a bed, the hospital representative will sign off and enter the time. The 30 minutes is a national standard and a starting point for us. This will help to find the hospitals doing the most effective things, and it sets a beginning point for ways to improve the system.

JOHN M. MYERS (City of Las Vegas):
The hospitals and the EMS came together to deal with this crisis. The reasonable solution is a winning situation for all involved. The study will help to determine the causes of not meeting the 30-minute time frame. Everybody

wants something done during this current Legislative Session, and it would be tragic if this bill is not implemented.

BRIAN ROGERS (Vice President of Operations, Southwest Ambulance):
As the vice president of Southwest Ambulance, I would like to echo Mr. Myers' comments from the private side. We do have a national standard and are required to respond to calls in a certain period of time. We believe we are "in field goal range" with all of the cooperation between the parties.

SENATOR MATHEWS:
Have models from other cities the size of Las Vegas been looked at? Denver has a system that seems to work.

MR. WELCH:
We have looked at many models from other cities and states. There are many models being looked at. We are trying to eliminate diversion and a color-code system in Clark County. There is a combination of different issues and other factors that come into play.

SENATOR MATHEWS:
Did you not find any models similar to Las Vegas?

MR. WELCH:
In the short period of time we have been working on this bill, we found a number of models. To come to a truly effective system for the process requires more than a brief review.

SENATOR MATHEWS:
I thought diversion had been reviewed before this Legislative Session. If we looked at it previously, why have we not looked at models?

MR. WELCH:
The Clark County Health District has reviewed many strategies on hospital overcrowding. Many variations of diversion have been tried, and this is not the first time this issue has been reviewed.

CHAIR WASHINGTON:
As we have looked at this issue several times, there have been a number of items. Among them are: dealing with the population growth, lack of quality

medical staff, a decreasing number of hospitals and emergency departments, the implementation of federal requirements, seasonal diseases, an increase of seriously ill patients, the lack of specialty-care resources and the lack of providers to treat indigent Medicare and Medicaid patients.

SENATOR MATHEWS:
There are things that are predictable. My concern is that we have been discussing this for a long time. There are some things we cannot keep putting off. We need a solution and if there are successful models to review, that should be done.

SENATOR HECK:
Overcrowding is a nationwide issue. There is difference between Las Vegas and the rest of the nation. The nation is experiencing the closure of hospitals and loss of infrastructure. Clark County cannot build hospitals fast enough to keep up with the growth. There may be best-practice models; they are not applicable to the situation in Clark County. The 30-minute time frame may not be the best for the hospitals and the EMS providers; it may be what is best for the patient.

SENATOR CEGAVSKE:
For the record, I absolutely want what is best for the patient. Having specific staffing for a specialty service is still a problem.

RORY CHETELAT (Emergency Medical Services Program Manager, Clark County Health District):
The Clark County Health District supports the bill. We would like to be actively involved in the development process, and would like to know that the Health Division of the Department of Human Resources will be actively involved to assure the quality of the data. We would also like to work closely with the Health Division to define the advisory committee.

BRADFORD LEE, M.D., J.D., M.B.A. (State Health Officer, Health Division, Department of Human Resources):
This bill requires the Health Division to do numerous things for which it is currently neither funded nor staffed. There is a fiscal note attached which amounts to approximately $401,000 the first year and $300,000 the second year. The overall cost of instituting the program, performing the data collection and analyzing the results will be significant. The biggest challenge will be to get it done by the defined sunset date of 2006.

SENATOR NOLAN:
What was the fiscal note for Clark County to perform this function?

MR. CHETELAT:
We have not been able to determine the fiscal impact. Some of the information is not clear, such as in what format the information will be transmitted. We believe we can limit the fiscal impact on the Clark County Health District if we can fit this into our existing advisory system.

SENATOR NOLAN:
If you are able to receive the information in an easy format that could be transferred electronically, would you expect to add additional staff?

MR. CHETELAT:
Based on the information provided, if it can be kept simple and in an electronic format, I believe for the 18 months of this study it could be handled without additional staff.

CHAIR WASHINGTON:
It is essential to have a reporting mechanism to analyze the data.

MICHAEL J. WILLDEN (Director, Department of Human Resources):
I am willing to review with staff and the Clark County Health District to see if there are some joint resources, but I do not know with what existing staff I could do this. As I understand the fiscal note, assuming the counties other than Clark County opt out, then the fiscal note would be lower.

CHAIR WASHINGTON:
I agree with the parties involved. We do not want this bill to be lost. I suggest you go back and work on the fiscal note. See if a number can be developed with which we can work.

SENATOR HECK:
Has there been any indication from the counties whether they may or may not want to participate?

FERGUS LAUGHRIDGE (Committee on Emergency Medical Services, State Board of Health, Health Division, Department of Human Resources):
I have not had personal conversations with the health officers, but providers in Washoe County indicated there is some concern with wait times.

SENATOR HORSFORD:
If the Clark County Health District feels they can work within the entire infrastructure on these issues, perhaps we can take out the Health Division and give the responsibility to the county. This issue is too important to become muddled with fiscal notes and procedures. The folks at the Clark County Health District know what the issues are; they have been dealing with them. If they have the resources and are willing, we should change the language to allow them to work with the hospitals and their EMS.

CHAIR WASHINGTON:
I would agree with you, but the reporting mechanism is required for the interim study in order to proceed further. I am asking Mr. Willden to come up with a fiscal note within the Department of Human Resources for the first biennium so we can get this off the ground.

SENATOR MATHEWS:
Are we talking about another study?

CHAIR WASHINGTON:
It is not a study. It is the tracking information derived from the reporting by the hospitals. The money is to pay for staff.

MR. WILLDEN:
The fiscal note prepared by the Health Division is for hiring five staff members and purchasing a software system to collect the data over a two-year period.

CHAIR WASHINGTON:
I stand corrected. It is to provide information for the study of information for causes of excess waiting in the hospitals and corrective measures or actions that can be implemented to alleviate the excess waiting.

SENATOR MATHEWS:
I continue to be concerned that this issue is once again being studied. We have had at least three Legislative Sessions to look at this situation.

SENATOR NOLAN:
We should amend this bill to allow the State the ability to delegate these responsibilities to a county for the purpose of conducting the study and to provide a copy of their summary documentation to the State. If the county is charged with collecting the data, they will find the most reasonable and inexpensive way to do so. The last thing we should do is put a fiscal note on this bill.

CHAIR WASHINGTON:
I do not believe the bill needs to be amended. Section 2, subsection 11 states if only one county participates in the study, the Health Division may delegate its duties to the county.

SENATOR NOLAN:
I believe what we need to do, in order to avoid a fiscal note, is to say it is our intention to hand this off to the county and have the county agree.

DR. LEE:
We would have no objection. At this moment, no county has indicated they wish to participate. Each county health officer, hospital, operator of an ambulance or fire-fighting agency must agree in writing that participating in the study is not necessary.

CHAIR WASHINGTON:
I believe this can be done.

SENATOR NOLAN MOVED TO AMEND AND DO PASS S.B. 458.

DR. LEE:
The Health Division would be glad to review the summarized data submitted by Clark County and report to the appropriate committee. Analyzing every case, as stated in the bill, will take considerable effort. I applaud Clark County for being able to do so without added staff.

SENATOR HECK SECONDED THE MOTION.

THE MOTION CARRIED (SENATOR WIENER WAS ABSENT FOR THE VOTE).

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SENATOR HORSFORD:
I do support the motion. I want to clarify there is not a fiscal note.

CHAIR WASHINGTON:
That is correct. We will open the hearing on S.B. 280.

SENATE BILL 280: Provides that person alleged to be mentally ill who is being detained under emergency admission must be detained in mental health facility. (BDR 39-1131)

SENATOR BARBARA V. CEGAVSKE (Clark County Senatorial District No. 8):
The bill provides that a person alleged to be mentally ill must be detained in a mental health facility. The bill attempts to address a problem that occurred when a daughter called the police about her mother. The mother was taken on a Legal 2000 hold, a legal mechanism whereby a public or private mental health facility or hospital is to hold certain individuals on an emergency basis in order for those individuals to be psychiatrically evaluated, and put through the system based upon the recommendation of the daughter. The mother was held for several days, and it was later determined she should not have been held.

ASSEMBLYWOMAN CHRIS GIUNCHIGLIANI (Assembly District No. 9):
We thought this issue had been decided in previous legislation. Senator Cegavske and I were trying to narrow the issue so that people were truly being screened. In some instances, people were being reported wrongly by a family member who did not want to deal with them. We question whether Legal 2000 applications are being treated in a different manner than other admits. Some concerns that arose are whether the initial examination is occurring during the first 72 hours, and if the case manager says the client is being screened and should not have been maintained, what happened? Those are the questions we did not get to in the drafting of this bill. If we can get answers to those questions, we may be able to determine whether it is an enforcement issue or if we need to refine the bill.

MR. WILLDEN:
I have not had the opportunity to review the situations in depth. Generally, the process is if a person is brought in on a Legal 2000, they have been identified by law enforcement or an emergency medical technician and are taken to the hospital. There is a medical clearance process which takes up to two hours. On a Legal 2000, admission can be with the signature of a physician, psychologist, a social worker, a registered nurse, a marriage and family therapist or other authorized professionals. The patient is seen by a psychiatrist or a psychologist. The patient is then held under the legal-hold process and normally transferred to Southern Nevada Adult Mental Health Services for observation and evaluation during the 72-hour period. The goal is to stabilize with medication, and then discharge the patient to the community with a treatment plan. Those who cannot be discharged are transferred to an inpatient facility. I am not sure about the intent of the bill.

SENATOR CEGAVSKE:
I believe we have informed you this bill is not what was intended. If you feel you need to review these cases, I believe the individual I referred to would talk to you.

MR. WILLDEN:
I will be happy to review the cases you have mentioned and work with a committee of advocates.

ASSEMBLYWOMAN GIUNCHIGLIANI:
I would like to make sure, in your review, that the Legal 2000 was properly signed by an authorized person. This may just be an issue of how current procedures are being implemented.

BRIAN BURKE:
I am an attorney working for Nevada Disability Advocacy and Law Center. We are glad to assist in the process with Mr. Willden. Statutes state a family member can recommend emergency admission, but they must petition the court. A judge then gives an independent evaluation. I have submitted some comments that I would like to be a part of the record (Exhibit D).

E. JOE CAIN (Regional Emergency Medical Services Authority):
I would like to present an idea for an amendment to the bill. It would add language to allow for transportation by a different type of carrier that does not

fit into one of the three categories mentioned. That would be a nonprofit authority that is in the business of medical transportation. It might lower costs. The Regional Emergency Medical Services Authority has a lower cost than regular ambulance services. If the circumstances warrant, it would make sense to add such providers.

CHAIR WASHINGTON:
If you would present your amendment to staff, it will be considered. We will now open the hearing on S.B. 281.

SENATE BILL 281: Revises provisions governing payment to hospitals for treating disproportionate share of Medicaid patients, indigent patients or other low-income patients. (BDR 38-42)

CHAIR WASHINGTON:
Disproportionate Share Hospital (DSH) is a federally-mandated program intended to provide special payments as extra compensation to hospitals that serve a large portion of Medicaid and other low-income patients for the higher costs associated with their treatment. Over time, the program has also come to be considered as a way to protect access to care for vulnerable populations. While federal law allows states great flexibility in determining how to structure their DSH programs, there is no requirement limiting participation to public or to private hospitals. Most hospitals that receive DSH payments nationally receive it based on a formula calculated using the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries added to the proportion of total hospital days provided to Medicaid recipients. The bill's formula mirrors this; however, every state's formula differs in detail. The analysis shows that a very significant portion of Medicaid and Supplemental Security Income (SSI) patients treated in Las Vegas are treated in private hospitals, principally North Vista, Sunrise and Valley. For example, Health Corporation of America, the parent company of Sunrise Hospital, booked approximately $26 million in bad debt and charity costs in 2003 and $32 million in 2004. Of Nevada's indigents receiving hospital treatment, Sunrise treats 28 percent. To target virtually all of the DSH adjustment money in Clark County to one hospital ignores the costs incurred by these other hospitals, all of whom are then pressured to raise costs to their other customers' insurance plans to cover the revenue shortfall.

The number of indigent patients treated at the private hospitals reflects the continuing demographic evolution of neighborhoods. As their neighborhoods

contain more and more Medicaid and SSI-eligible patients, so will these hospitals treat increasingly greater numbers and proportions of them, placing them under greater and greater cost pressure. Given the ever-changing demographics of neighborhoods and the states' interest in making sure that its poorer and vulnerable populations have full access to quality health care, it is important that those hospitals treating them receive some compensation for these costs. It is also important that whatever formula is used be one that automatically adjusts payment distribution as a hospital's patient mix changes. As one hospital's proportion declines and another's increases, the former should receive less and the latter more of the DSH adjustment. Rather than have to come before the Legislature every few years and change the law to reflect these demographic changes, it would be more efficient and equitable to adopt a formula, such as, but not limited to, or similar to, the one suggested in S.B. 281. When dealing with the public's money for an important public purpose in a program that provokes considerable controversy, as the DSH payment distribution in Clark County does, it seems clear that whatever formula is used should be as simple and transparent as possible. Following such an approach will assure taxpayers and voters that money is definitely being used in accordance with the purpose for which is it originally appropriated.

MR. DUARTE:
The Division has historically not taken a position with respect to the DSH legislation. I have provided a spreadsheet to you to show the impact of the bill on rural hospitals (Exhibit E). The current program establishes certain funding pools. This bill changes the formula used to fund the pools and it reduces the number of pools from five to four. There is a negative impact on small rural hospitals. Any change of the funding for the rural hospitals has an impact on the facilities.

CHAIR WASHINGTON:
The impact deals with the demographics of the rural communities whether the Medicaid or uncompensated-care population increases or decreases.

MR. DUARTE:
That is correct. In order for the rural hospitals to maintain a core-service array, they need to maintain funding. If the funding level is reduced, it can have an effect on their ability to sustain core services.

CHAIR WASHINGTON:
I believe the intent was not to reduce their funding. We are prepared to amend that portion of the formula.

MR. DUARTE:
With respect to the funding of pools A and B shown in the exhibit, the biggest impact is to Clark County. In terms of the intergovernmental transfer (IGT) program, University Medical Center (UMC) is estimated to show a net loss of $49 million. It is a significant impact to that facility.

CHAIR WASHINGTON:
Let us make it clear that the IGT is actually from the county itself, not specifically from the UMC.

MR. DUARTE:
That is correct. The IGT is an interlocal agreement with the county, not with the hospital.

SENATOR HECK:
You state there is a potential negative impact to some of the rural hospitals with the new formula. Is that related to the percentage of uncompensated care they provide, or is the DSH payment helping to sustain them?

ROBIN KEITH (Nevada Rural Hospital Partners Foundation):
The uncompensated care provided by the rural hospitals is approximately $12.5 million annually. The DSH funds under the existing formula amount to approximately $3.5 million. We are not talking about a subsidy in excess of costs, but one that is far below the actual costs.

CHAIR WASHINGTON:
The net loss for rural public hospitals is $233,425 and for rural private hospitals $339,685 over the biennium. Our intent is not for the rural hospitals to have a net loss, and we shall adjust the formula accordingly.

ANN LYNCH (Health Corporation of America):
We are supportive of the bill. This is not a hospital-directed issue; it is the will of the federal government to take care of people who are unable to care for themselves.

GEORGE A. ROSS (Health Corporation of America):
When we look at the DSH program it is important to remember the federal government initiated it for two reasons: to compensate the hospitals that treat a disproportionate number of the vulnerable members of the population and to provide that population with access to medical care.

CHAIR WASHINGTON:
There is some impact to North Vista Hospital.

MR. ROSS:
The bill mirrors the concept the federal government uses. The provider impact analysis (Exhibit F) illustrates the proportion of uncompensated care the hospitals provide.

SENATOR MATHEWS:
Is the University Medical Center required to match any money?

MR. DUARTE:
The IGT which funds this program is provided by the county through an interlocal agreement. The funds come from Clark County, not the UMC.

MR. ROSS:
It is important to point out the federal government did not distinguish between public and private hospitals. In Clark County, the UMC is not the only hospital that provides uncompensated care. A formula should not fix the allocation in stone, but absorb and reflect the changes in demographics and patient mix. The distribution should be equitable and fair. The formula in the bill is fairly simple and understandable.

CHAIR WASHINGTON:
We looked at net impact over the biennium for Sunrise Hospital which shows a gain of approximately $19 million.

MS. LYNCH:
We were as surprised as everybody was, because our intent was not to hurt the rural hospitals. The original bill indicates Sunrise Hospital should be left intact. Also, our intent was not to do harm to the UMC. Sunrise Hospital was included in the formula previously and then removed from the formula last year. It is not that Sunrise Hospital wants the money, but as a facility that takes care of an

increasing numbers of indigents, we feel the tax dollars should follow the patient. One problem with the formula is the size of the hospital. Sunrise Hospital has increased to 700 beds. The more beds that are added, the lower the percentage is in the formula. That is where the adjustment needs to be. The federal government has an upper payment-limit program which offers funds to government hospitals. The only eligible hospital in the State is the UMC. Sunrise Hospital sits in the middle of an area in Clark County with the densest population and the highest crime rate. Sunrise serves the patients coming from the Cambridge Clinic, which is run by Clark County.

CHAIR WASHINGTON:
In reviewing Exhibit E, I see Sunrise Hospital received no compensation through the DSH program this year. Over the next biennium, the compensation is estimated to be $19 million. Is that a reflection of the demographics within the area of the hospital?

MS. LYNCH:
That does reflect the current composition of Sunrise Hospital.

SENATOR MATHEWS:
Sunrise Hospital provides care for the Las Vegas Strip entry-level employees. Is that correct?

MS. LYNCH:
We have many illegal aliens and unemployed people in addition to those you mentioned. The chief industry in the area is probably the sale of drugs.

ROBERT A. OSTROVSKY (North Vista Hospital):
It is very important for the Committee to understand our position. The DSH payments are for uncompensated care. The suggestions of how to distribute the payments are many. Should it follow the Medicaid usage of the hospitals? Medicaid is compensated care. The interim study did not look at Medicaid. It looked at uncompensated care, of which North Vista Hospital has a great deal.

JOHN DOMANSKY (North Vista Hospital)::
I am the chief financial officer of North Vista Hospital. According to the quarterly reports to the State, the hospital provided almost $33 million of uncompensated care in 2004. Additionally, the hospital pays specialty physicians for emergency room coverage in the amount of $2 million.

MR. OSTROVSKY:
Our current DSH payment is approximately $85,000 per month. We struggle to service the population, because our hospital lost $1.25 million last year. As a percentage of overall costs, North Vista Hospital spends a large amount of total revenue on uncompensated care.

CHAIR WASHINGTON:
Based on the formula in S.B. 281, the money follows the patient. Is it correct the formula improves the position of North Vista Hospital?

MR. OSTROVSKY:
There is no question the bill provides a financial gain to North Vista Hospital. The question is whether or not we want that gain at the expense of the UMC. If our emergency room were to close, the UMC would be overwhelmed. Although we would love to have a windfall, we do not want it at the expense of the UMC.

CHAIR WASHINGTON:
I believe you are saying the gain is fine as long as it does not jeopardize the UMC. Our concern as policy makers is to provide quality care to the patient. If the patient is accessing your hospital, the UMC or North Vista Hospital, we want to make sure those funds get to that hospital to care for that patient. Valley Hospital will have a net gain of $27 million.

MR. OSTROVSKY:
When we say we would love to be out of the DSH program, it is because we are trying to create a hospital that is more attractive to paying patients.

MR. DOMANSKY:
In the first year of ownership, the company has invested approximately $11 million for new imaging equipment and information systems. Currently, there is an investment of $14.5 million of capital expenditure.

MICHAEL R. ALASTUEY (University Medical Center):
Disproportionate Share Hospital is a federal program providing a fixed sum of money to each state, each year. Currently the allocation to Nevada exceeds $43 million annually. To receive this money, the federal government requires a minimum match of $35 million. Counties pay in approximately $55 million, and that enables the State to retain approximately $20 million. Without the match

paid by Clark County there would not be a Nevada DSH program. Senate Bill 281 would be devastating to southern Nevada taxpayers. We believe the share for the UMC must be protected. Distribution of DSH funds has always been debated. In 2003, all the participants agreed to live by an interim study to determine a long-term method by which the DSH funds could be allocated. The 72nd Legislature recognized the interim study, adopted the findings and passed a new law codifying the improved method of allocation. Despite the completion of a valid study, Sunrise Hospital wants to send the funding into a crisis costing Clark County taxpayers over $90 million for the next two years. There are tax impacts because the UMC is a public tax-supported hospital.

CHAIR WASHINGTON:
This study was not generated by Sunrise Hospital. The numbers being reflected are from the Division of Health Care Financing and Policy, Department of Human Resources.

MR. ALASTUEY:
I wanted to point out these figures were not from the UMC. The hospital periodically requires taxpayer support in order to stay in business. Approximately two years ago the amount was $38 million. It is estimated to be $15 million this year. Any loss to the UMC constitutes an additional need for Clark County taxpayer dollars.

CHAIR WASHINGTON:
The bill shifts dollars from the UMC to North Vista Hospital and Sunrise Hospital. How does that constitute additional Clark County taxpayer dollars?

MR. ALASTUEY:
I would suggest any impact of this size indicates we are beyond the realm of shift. We are in an area of loss. There would be two options: increased taxes or the reduction of other programs within Clark County.

CHAIR WASHINGTON:
Referring to the IGT amounts, I do not see an increase of taxpayer dollars.

MR. ALASTUEY:
What I am referring to is the change from a biennial gain for the UMC of approximately $30 million to a loss of approximately $68 million. The method for determining the hospitals in Nevada to which DSH funds should be allocated

is for net uncompensated care. There have been all manner of definitions of uncompensated care, sometimes including individuals who do not bring their own pay source, but a governmental one. The 2003 interim study found the best measure to indicate a hospital's uncompensated care is net of all governmental pay sources. The study specifically mentions net uncompensated-care percentage and could not recommend the continuation of Sunrise Hospital on the program. Medicaid and SSI patient days should not be used to determine which hospital receives DSH funds. Of all the hospitals in the study, the UMC incurs the highest percentage of costs on behalf of uninsured patients. The net benefit to hospitals can continue to be distributed based upon populations in Clark, Washoe and other counties. I have testimony about changing demographics. The bill currently in place provides that if a hospital shifts from having low uncompensated-care costs to relatively high uncompensated-care costs, they too could eventually qualify for DSH funding. All of the changing definitions and alternative numbers are to divert your attention from the fact that some hospitals have low net uncompensated-care costs. Any formula change from the current method simply takes from tax-supported the UMC to enrich out-of-state shareholders. If you divert tax money from a tax-supported entity, you either reduce services or provide more tax support. There was testimony attesting this would align Nevada's definitions with the federal definitions. In fact, the federal government does not name a DSH payment for a specific hospital. If they did so, why are you considering this bill? This bill puts the prerogative where it ought to be, at the state level. The prerogative was exercised in 2003.

CHAIR WASHINGTON:
University Medical Center received $80 million in fiscal year 2002. North Vista Hospital received approximately $1 million and Sunrise Hospital did not receive any funds. If their uncompensated care costs are reflective of their demographics, should they not receive more DSH payment for those patients?

MR. ALASTUEY:
I do not know where that figure came from. I believe you may be referring to the $70 million that the UMC received. Of that amount, the UMC has deposited most of that with the IGT account and received a net benefit of approximately $15 million. The amount mentioned for North Vista Hospital is their net benefit. Sunrise Hospital did not receive a benefit. If the definition of uncompensated care is based on Medicaid, SSI and other kinds of patient days, the DSH dollars to the hospitals rendering the care are actually reimbursing the hospitals twice.

The current methodology says the payment is to be based on patients for whom no payment is received from any source.

CHAIR WASHINGTON:
How would a hospital get paid twice?

MR. ALASTUEY:
A Medicaid-patient day is a compensated-patient day. If 20 percent of a hospital's utilization is for Medicaid patients, then roughly 20 percent of the revenue would be from the Medicaid program. The true measure of uncompensated care is that patient day for which no compensation is received.

SENATOR HORSFORD:
Do we have the information that shows uncompensated-patient-care costs by volume of patients? The information we have could be confusing.

MR. ALASTUEY:
That information is gathered by the State.

CHAIR WASHINGTON:
Can you give us the federal and State definition of DSH.

LACY THOMAS (University Medical Center):
I am the chief executive officer of the UMC. The State does prepare a quarterly report from certified data submitted by the hospitals showing all uncompensated care. If the care of a patient is compensated in any way, that is not considered uncompensated care.

CHAIR WASHINGTON:
Is the care compensated through government programs?

MR. THOMAS:
When we say compensated care, we mean the patient has a source of payment for their care. Whether that equates to the price charged by a hospital is not necessarily relative. If there is any payment source, then the patient is not considered uncompensated.

SENATOR HORSFORD:
Exhibit E shows revenue. Is this chart for uncompensated or compensated patient days?

CHAIR WASHINGTON:
The formula used in the chart is based on S.B. 281.

SENATOR HORSFORD:
Based upon these formulas, are these uncompensated days?

MR. DUARTE:
The formula is based on the methodology that is proposed in S.B. 281. That formula is primarily the percentage of Medicaid utilization to total bed-days and the percentage of SSI bed-days to the total Medicare population served by those hospitals. Both of those are compensated by Medicaid.

SENATOR HORSFORD:
Mr. Alastuey said the definition of DSH, according to federal standards, is based on uncompensated days. Is that correct?

MR. DUARTE:
I do not believe that is what Mr. Alastuey said. I believe he said he discussed the results of the Nevada study on DSH.

MR. ALASTUEY:
I believe there is a distinction on qualification. The federal government provides a definition of DSH compensated hospitals as those hospitals permitted to receive DSH payments. You are not required to provide a DSH payment to any of those hospitals. That is why I am saying that you are exercising your State prerogative.

CHAIR WASHINGTON:
Currently, there are five pools of qualifying hospitals and the bill proposes four pools.

SENATOR HORSFORD:
Is the State dictate based on uncompensated care?

MR. ALASTUEY:
That is the decision that was made in 2003 and the decision with which we recommend you remain.

SENATOR HORSFORD:
Before any decision is made on this bill, we need a spreadsheet that shows what the allocation is, based on uncompensated days.

MR. DUARTE:
The spreadsheet in Exhibit E that we provided the Committee does show a comparison of the two methodologies. What we have been discussing is the net impact associated with the different methodologies, and the last column shows the net impact for fiscal year 2006.

SENATOR HORSFORD:
You are saying the net impact is caused by making the language changes that are proposed in S.B. 281.

MR. DUARTE:
Yes, there are two major changes that result in the shift of dollars between facilities. The first is the qualification for a DSH payment, which is based on federal language. The second change is how the pools are funded and how the hospitals are distributed within the pools. The two changes result in the net impact shown on the chart.

SENATOR HORSFORD:
I believe we need to hear the reasons we need to change the negotiation that was agreed upon in the 72nd Legislative Session. This policy change affects where the State is today and will be in the future. New hospitals are being planned in Clark County. I would like to know why this policy change is so imperative now.

CHAIR WASHINGTON:
We heard testimony earlier that because of the dramatic demographic and density changes, the bill reflects those changes. The formula has been simplified by stating the dollars will follow the patient to the hospital that provided the uncompensated care.

SENATOR HORSFORD:
I just want to be assured the methodology follows the true definition of uncompensated care. We have needs in Clark County that will probably worsen. It is my understanding the DSH program is supposed to pay for care provided by a hospital for which they have not received any compensation.

MR. ALASTUEY:
We worked hard with the Legal Division of the Legislative Counsel Bureau (LCB) to try to craft a tax-relief package. Going forward, I think we must be cognizant of conserving tax dollars. University Medical Center is against any change that will have such a negative impact on the hospital.

MR. THOMAS:
We want to reiterate that the UMC serves residents of Clark County, regardless of their ability to pay. As such, the residents in Clark County are aware that the doors of the UMC are always open and the services are always available. We embody the definition of disproportionate share. We believe S.B. 281 will do a serious disservice to the residents of Clark County. The study that took place during the 72nd Legislative Session completely evaluates the need for DSH as it currently exists. We remain the only hospital in the State of Nevada which has a statutory obligation to take care of anybody, regardless of ability to pay. We remain committed to provide the highest quality of care to the residents of Clark County.

CHRIS M. BOSSE (Washoe Health System):
We participated in the interim study concerning uncompensated costs and watched the changes implemented in the 72nd Legislative Session. We stand by those decisions and believe the DSH funds should be distributed to facilities not compensated for the care they provide. There are concerns with the DSH funds following patients for whom the hospital has been paid.

CHAIR WASHINGTON:
The intent of the bill is to make sure the funds are distributed to the facilities not being compensated for care.

MS. KEITH:
It has been noted in the bill that the formula is based on Medicaid inpatient days. Rural hospitals have a great deal of uncompensated care in the outpatient

realm. The current formula takes that into account; the suggested formula does not.

CHAIR WASHINGTON:
We will ask Mr. Duarte to revisit the formula to make sure the rural hospitals are compensated for outpatient days.

MR. DUARTE:
I am uncomfortable trying to revise language in S.B. 281. We did not sponsor the bill. We will be glad to provide the Committee with analyses.

SENATOR HECK:
It is assumed every hospital will provide some level of uncompensated care. These funds are to reimburse hospitals that provide a disproportionate share of uncompensated care. The multiple pools seem to diminish the total amount of money. Each hospital should be reimbursed for the amount of care provided. Numbers provided by the rural hospitals indicate they were reimbursed 25 percent of their uncompensated care, and North Vista Hospital was reimbursed 3 percent.

CHAIR WASHINGTON:
The pools are necessary to keep some hospitals whole.

SENATOR HECK:
The question I asked earlier was if the money is being used to subsidize core services at rural hospitals. This is not the perceived intent of DSH funds. The money is meant to provide funds to hospitals that provide uncompensated care.

CHAIR WASHINGTON:
If we did not keep various hospitals whole, some of the doors might close. That is the reason for the pools. The federal government gives the states the flexibility to create formulas to make sure the funds get to the hospitals.

SENATOR MATHEWS:
Tax packages often focus on helping to keep the rural counties whole.

CHAIR WASHINGTON:
We will close the hearing on S.B. 281. There being no other issues before us today, this meeting of the Senate Committee on Human Resources and Education will now adjourn at 4:55 p.m.

RESPECTFULLY SUBMITTED:

Cynthia Cook,
Committee Secretary

APPROVED BY:

Senator Maurice E. Washington, Chair

DATE: