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

Seventy-Ninth Session
March 17, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 12:49 p.m. on Friday, March 17, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chairman
Assemblywoman Amber Joiner, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Richard Carrillo
Assemblyman Chris Edwards
Assemblyman John Hambrick
Assemblyman William McCurdy II
Assemblywoman Brittney Miller
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

Assemblyman James Oscarson (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Megan Comlossy, Committee Policy Analyst
Mike Morton, Committee Counsel
Kailey Taylor, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Joseph L. Pollock, Deputy Administrator for Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
Paul Shubert, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services
Leticia Metherell, Quality Improvement Team Lead, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services

Chairman Sprinkle:
[Roll was called. Committee rules and protocol were explained.] We will have a work session for a few bills today. We had a late change. We are going to pull Assembly Bill 113 from the work session; it is not ready to be heard.

Assembly Bill 113: Requires an employer to make certain accommodations for a nursing mother. (BDR 40-7)

[The bill was listed on the agenda and in the exhibits but not heard.]

Is there anything from the Committee before we get started? [There was no response.] We will open up public comment now. [There was none.] We will now open the work session.

Megan Comlossy, Committee Policy Analyst:
The first bill on the work session is Assembly Bill 65.

Assembly Bill 65: Revises provisions relating to medical care for indigent persons. (BDR 38-438)

This bill was sponsored by this Committee on behalf of Clark County and heard in Committee on March 8. [Read from (Exhibit C).] For a county whose population is 100,000 or more (Clark County and Washoe County), Assembly Bill 65 authorizes the county commission to use money from the indigent medical fund to provide supplemental payments to public hospitals in the county that are eligible for such payments. For a county whose population is 700,000 or more (Clark County), A.B. 65 allows the county commission to make grants to any public hospital in the county for the construction or acquisition of capital assets and the renovation of facilities. One amendment was proposed at the hearing by Clark County to section 1, subsection 5. This amendment clarifies that the allocation is on a fiscal year basis.

Chairman Sprinkle:
Are there any questions or comments on this bill? [There were none.] I will now accept a motion.

ASSEMBLYMAN CARRILLO MOVED TO AMEND AND DO PASS ASSEMBLY BILL 65.

ASSEMBLYMAN McCURDY SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMAN OSCARSON WAS ABSENT FOR THE VOTE.)

Assemblyman Hambrick will take the floor statement.

Megan Comlossy:
Moving on to Assembly Bill 205 in the work session document (Exhibit D), which revises provisions relating to cremation.

Assembly Bill 205: Revises provisions relating to cremation. (BDR 40-649)

This bill was sponsored by Assemblyman Nelson Araujo, Assembly District No. 3, and was heard in Committee on March 8. Assembly Bill 205 expands the definition of cremation to include "alkaline hydrolysis," which is a water-based process for reducing human remains through the use of alkaline chemicals and agitation. This bill makes certain fee and penalty provisions applicable to this type of cremation. In cities and towns where existing zoning laws limit the location of a crematory, the bill exempts a crematory using only alkaline hydrolysis. Finally, conforming changes are made to other sections of the law to account for differences between the two types of cremation.

Two amendments were submitted at the hearing, which are included. The first amendment was by the sponsor, and it gives discretion to a local board of county commissioners to exempt crematories using an alkaline hydrolysis from zoning restrictions. The second amendment was submitted by the Division of Environmental Protection, State Department of Conservation and Natural Resources, to require operators to provide advance notice to the Division before the purchase of any equipment and to ensure compliance with water pollution controls.

Chairman Sprinkle:
Are there any questions or comments about this bill from the Committee?

Assemblyman Carrillo:
I know the bill sponsor is not here at the moment, but he did reach out to me regarding my concern about the Ohio legislation. They tried to pass this, but never followed through on it. I am okay with that.

Chairman Sprinkle:
Are there any other comments? [There were none.] I will now take a motion.

ASSEMBLYMAN THOMPSON MOVED TO AMEND AND DO PASS ASSEMBLY BILL 205.

ASSEMBLYMAN YEAGER SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMAN OSCARSON WAS ABSENT FOR THE VOTE.)

Assemblyman Edwards will take the floor statement.

Megan Comlossy:
The last bill for the work session (Exhibit E) is Senate Bill 92 sponsored by Senator Hardy, heard in Committee on March 10.

Senate Bill 92: Revises provisions relating to the Task Force on Alzheimer's Disease. (BDR S-270)

Senate Bill 92 makes permanent the Task Force on Alzheimer's Disease, which was set to expire by limitation on June 30, 2017. No amendments were proposed to this measure.

Chairman Sprinkle:
Are there any questions or comments on this bill? [There were none.] I will accept a motion.

ASSEMBLYWOMAN TITUS MOVED TO DO PASS SENATE BILL 92.

ASSEMBLYMAN EDWARDS SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMAN OSCARSON WAS ABSENT FOR THE VOTE.)

I will take the floor statement for this. That is the end of the work session. At this point, we will open up the hearing on Senate Bill 71.

Senate Bill 71: Revises provisions relating to medical facilities and facilities for the dependent. (BDR 40-183)

Joseph L. Pollock, Deputy Administrator for Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services:
With me today in Las Vegas is Paul Shubert. He is chief of the Bureau of Health Care Quality and Compliance. Also with me in Carson City is Leticia Metherell. She is a supervisor within the bureau. Quickly, I will go over the highlights of S.B. 71 and then open it up to questions.

Section 1 adds "hospice" to the definition of a medical facility. Section 2 removes the word "residential" from the definition of a psychiatric hospital. Section 9 adds "a psychiatric hospital that provides inpatient services to children," to *Nevada Revised Statutes* (NRS) 449.119. This will require background checks for all staff that work at these facilities. Section 10 delineates how often background checks at a psychiatric hospital that provides inpatient services to children must occur. Section 14 is a modification to licensed facility sanctions. Section 15 allows the Division to suspend or revoke a license if disqualifying offenses against a licensee or applicant are found. Section 16 modifies the unlicensed facility sanctions.

We included a handout (Exhibit F) on our licensed sanctions. It is a breakdown of how those sanctions are changing. From our initial look, you would think we are increasing the fees associated with these sanctions; however, what we are trying to remove is the per-patient-per-day requirement to fine these facilities, which was resulting in astronomical fines. We think that the proposed language, which sets a per-incident fine, is better. That concludes my prepared remarks.

Chairman Sprinkle:
Thank you for that overview. Are there any questions from the Committee?

Assemblyman Yeager:
I noticed that on the sheet with the fines you provided, you have indicated that you are going from a per-patient to a per-incident fine. You said that was to avoid astronomical fines. When I first look at the sheet, the fine structure as it currently exists seems to make a lot of sense. Could you provide more background on why you think the current per-patient fine is not working and why a per-incident would lead to greater compliance?

Joseph Pollock:
We found that rather than achieving compliance with the large fines, businesses were going out of business. Rather than lose these facilities, we would rather ensure compliance. I can have Leticia or Paul talk about any specific instances where we have seen this and where our inspectors in the field are stuck. If you mark it as a deficiency, you are forced into an astronomical fine, which may not always match up with the offense. We have this structured severity scale that we would like to use. With the new language, we think we get better compliance.

Paul Shubert, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services:
Let us say that a facility of 600 or more patients has a sprinkler system that has not been reviewed or inspected as often as it should have been. That single citation, under the current statutes, would require at least a $1,000 fine per-patient in the hospital because all of the patients would be affected. That would be a $600,000 fine for a single violation where no one was actually harmed. I do not know if that illustrates the problem, but I am happy to address additional questions.

Leticia Metherell, Quality Improvement Team Lead, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services:
I wanted to mention that this applies to all of our facility types, including our very small businesses. It includes home screening programs to residential care programs that only have two residents. It also applies to our smaller group homes that have maybe four or five residents. You are looking at $1,000 per-patient-per-day: That is just one violation. It is possible that they will have five violations. When you start adding up those numbers, it is hard to see how those smaller businesses are able to absorb those costs.

Assemblyman Yeager:
Thank you for the follow-up. I certainly understand the example given of a sprinkler system. That makes sense. My concern is when we look at severity level 4, scope 3, essentially you are talking about substantial probability of harm that is widespread. My question there is, Would you be opposed to leaving some discretion in there if the harm we are talking about or the condition impacts a number of patients that there would be an ability to give a fine per patient? It looks like if we look at severity level 4, scope 3, you would be limited to $5,000, even if it was something that greatly harmed a number of patients.

Leticia Metherell:
I wanted to mention that we also have other abilities to sanction. We have abilities to do bans on admissions and partial bans on admissions which, of course, affects the facility fiscally. We have banned admissions at facilities, including a hospital. That obviously hits the bottom line. We can also do temporary management where we put in a temporary manager. We can do monitoring visits; we can do other things in addition to the monetary sanctions to assure compliance. I just want you to be aware of that, but I did hear your concern.

Assemblyman Yeager:
I was just wondering, particularly when you look at the chart that was provided, severity level 4, scope 3, would be a very serious violation that is widespread. The proposed language indicates a $5,000 maximum per violation. I was wondering if there might be a willingness to look at allowing the discretion to give a $5,000 fine, or whatever the amount be, per patient in those more serious cases—the ones that are more serious than a sprinkler that has malfunctioned.

Joseph Pollock:
We would be happy to look at that as an alternative. I think we would be open to that.

Assemblywoman Benitez-Thompson:
A lot of my questions were along that same line. I was going to ask if you could talk a little about the number of times that fines are imposed. I think we have two different things going on in medical facilities. We have bigger, more established, hospital-like facilities. Then we have the small residential homes for groups. For some reason I thought that, at some point, we had two different fine schedules in statute. Maybe they have always been the same, but at

least it seems that when it comes to the residential homes, there was talk about increasing those fines. We discussed the fine structure and made changes to those fines. I believe that one of the concerns was there were not enough teeth. Health Care Quality and Compliance did not have enough teeth to go in and actually close homes when we heard about horrific abuse events that were happening and did not have the ability to ride someone out of town when we needed to. Could you talk a little about what the fines have been like in the past couple of years? Has the teeth provision worked?

Paul Shubert:
We have a whole scale of fines that have occurred over the past several years. It has been since 2009 that we have had the legislation. We had the ability to increase those fines on a per-patient basis. In any given year, we have facilities that have egregious violations that we assign fines to. Our intent is always to get the facility into compliance with regulations and allow them to continue providing services in compliance with the regulations. It is not necessarily to put them out of business, although there are those circumstances where a facility is not cooperating and is not making changes or improvements that are necessary to ensure they are protecting the patients or residents in those facilities. We do have other opportunities to get them into compliance or to revoke licenses if we have to. Certainly that is not our first intent, but when we decide that things are going downhill and a situation is not safe, we take those actions. I could certainly provide you additional information regarding the numbers of fines that we have imposed in the last several years.

Assemblywoman Benitez-Thompson:
I think that would be helpful. Could you get me the number of facilities that you have had to close as well? I remember there was an issue about the ability to shut down a licensee and a bad actor. It sounds like we have course-corrected, perhaps too much.

Assemblywoman Titus:
I need some clarification on the bill's language. Under section 1, you add a program of hospice under the definition of medical facility. Then you refer to that multiple times throughout the bill, "and section 1 of this act," all the way down. Then at section 8, subsection 2, there is an apparent need to define a psychiatric hospital that provides inpatient services to children. That is broken out multiple times throughout the text. Why did you not want to put that into section 1 when you added to the definition of medical facility? I need an explanation of the difference and the reason it could not be added under hospice.

Leticia Metherell:
In the first section, the programs for hospice were added through our regulatory process, so they were never entered into the definition of a medical facility. There are things in the bill that apply to medical facilities that do not apply to a program of hospice, such as administrative sanctions. The bill adds them into the appropriate areas related to that medical facility piece. The psychiatric hospital is completely different because it is adding it to

NRS 449.119, which is the background check section. It allows background checks to apply to the psychiatric hospitals. They are two completely different things and have different purposes.

Assemblywoman Titus:
Along that same line, there are already definitions in there of psychiatric hospital. Is the need to address services to children separately because of the Medicare component? Why did you separate that out and designate the children component?

Leticia Metherell:
When you look at the definition of NRS 449.119, it says that a medical facility that provides residential services to children must conduct background checks. There was no definition of residential services in either statutes or regulations. There has been a lot of conflict on whether it applied to inpatient children. This clarifies that it applies to inpatient children. They do get background checks.

Assemblyman Thompson:
I have a question in section 16, subsection 2, where it says, "If the Division believes that a person is operating a medical facility . . . ." What criteria do you use? I am sure the obvious is an expired license, but what are some other factors where you may believe that they may not be operating accordingly?

Paul Shubert:
This is common language. It was in previous statute. When we are investigating whether a facility is operating without a license, we look at the statutory language in its simple form, and then we do the test of whether a facility is actually meeting that statutory definition. For instance, the definition of a residential facility for groups indicates that it provides food, shelter, assistance, and limited supervision to infirm and aged individuals. Upon entry of that type of facility, or unlicensed facility, we would look at what they are providing and see if they are actually providing food. Of course, shelter is provided for the residents living in the home. We would look at assistance and see whether they are assisting with medications or assisting with bathing or other services that are needed by those residents. For supervision, we would determine whether there was someone onsite at the facility providing supervision to the residents. We have different tests for different types of facilities to determine whether they are actually meeting the statutory definition. That is an example of the type of investigation we would do.

Assemblyman Thompson:
Using that same scenario, at what point would you issue the cease and desist order? Do you investigate first and then issue? Or, do you issue and then investigate?

Paul Shubert:
If we are going to take an action against the facility, we have to do a proper investigation, which would mean that we are actually entering the facility. However, we do, upon receipt of information about some particular situations of unlicensed operation, provide

correspondence to the proponents of the facility and ask them if they feel like they are meeting the criteria for licensure. There are certain circumstances when we use that. In all circumstances where we are actually issuing a cease and desist notice, we conduct a proper investigation.

Assemblywoman Benitez-Thompson:
My questions are regarding section 1. When we add the hospice programs into a medical facility, does that impact a program differently if they are a hospice program attached to a hospital versus a hospice program that is free-standing?

Leticia Metherell:
If they are licensed as a program for hospice, regardless of where they are located, they would meet the medical facility requirement. We also have facilities for hospice that are already considered a medical facility. They would not be impacted because they are already a medical facility.

Paul Shubert:
I would say that we have both circumstances. You have a brick-and-mortar hospice that we have the ability to sanction. All of the things that apply to medical facilities already apply to them. It is only in the situation where we have a facility that is licensed as a program of hospice, so it could be operated out of a hospital or even out of an office building. They are only offering the services of hospice, not an inpatient facility. We want to make sure that we can apply all of the sanction abilities and other things to ensure compliance.

Assemblywoman Benitez-Thompson:
I am surprised that does not exist already. Has there been a problem you have run into? It sounds like you have greater ability to come in and do quality control in the ones that are part of a hospital, but the ones that are free-standing you cannot. Is there no nexus through NRS to go in to those?

Leticia Metherell:
For the administrative sanction piece, that is correct. We have, through statutes, the ability to add facility types through regulation. Unfortunately, when we do that, they are not added to the medical facility statutes.

Assemblywoman Benitez-Thompson:
It does look like there are regulations for sections 1 through 5. Is the intent that the regulations that are in place would follow this statute or would you need to develop them? We talked about the licensing standards; would those reference existing regulations or will there be new standards that will be put in place?

Leticia Metherell:
We have everything in place. I do not foresee doing anything new for the hospice programs in regard to licensing, just the regulations we come up with for the administrative sanction piece that applied to the other ones would apply here.

Assemblyman Edwards:
Could you talk about the licensing process and what is involved? What do we get at the end of it?

Leticia Metherell:
As part of the licensing process, we have to submit an initial application that requires programs of hospice to have background checks and other articles. There are different criteria that we collect for that. Then we do an onsite inspection to ensure they are in compliance with all of the statutes and regulations. Once we are assured they are in compliance with the statutes and regulations, we issue a license. If they are not, we have them submit a plan of correction until we feel comfortable that they are in compliance.

Paul Shubert:
The only thing I would add is that, as part of the application process, we collect several documents and information from the applicant regarding the business entity, ownership, and anyone with 10 percent or more ownership in the entity. There are articles of incorporation and governing body bylaws. When we do our inspection, the facility has to be in full compliance with statutory requirements and substantial compliance with regulatory requirements. Once we have determined that is the case, we can issue that license.

Chairman Sprinkle:
Are there any other questions? [There were none.] We will open testimony in support of S.B.71. [There was none.] Is there anyone in opposition? [There was no one.] Is there anyone neutral? [There was no one.] Are there any closing comments? [There were none.] Thank you for bringing this bill to us. We will close the hearing on S.B.71. Is there any public comment? [There was none.] This meeting is adjourned [at 1:22 p.m.].

RESPECTFULLY SUBMITTED:

_____
Kailey Taylor
Committee Secretary

APPROVED BY:

_____
Assemblyman Michael C. Sprinkle, Chairman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Assembly Bill 65, dated March 17, 2017, presented by Megan Comlossy, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is the Work Session Document for Assembly Bill 205, dated March 17, 2017, presented by Megan Comlossy, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Senate Bill 92, dated March 17, 2017, presented by Megan Comlossy, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is a document titled "Scope and Severity of Administrative Sanctions," submitted by Kirsten Coulombe, Deputy Administrator of Administrative Services, Division of Public and Behavioral Health, Department of Health and Human Services, presented by Joseph L. Pollock, Deputy Administrator for Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services.