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

Eightieth Session
March 27, 2019

The Committee on Health and Human Services was called to order by Chairwoman Lesley E. Cohen at 1:33 p.m. on Wednesday, March 27, 2019, 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/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Lesley E. Cohen, Chairwoman
Assemblyman Richard Carrillo, Vice Chairman
Assemblyman Alex Assefa
Assemblywoman Bea Duran
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblywoman Connie Munk
Assemblywoman Rochelle T. Nguyen
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblywoman Michelle Gorelow (excused)
Assemblyman John Hambrick (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Christian Thauer, Committee Manager and Secretary
Alejandra Medina, Committee Secretary

OTHERS PRESENT:

Jesse A. Wadhams, representing Nevada Hospital Association
Bill M. Welch, President and CEO, Nevada Hospital Association
Joanna Jacob, representing Dignity Health-St. Rose Dominican Neighborhood Hospitals
Chris Bosse, Vice President of Government Relations, Renown Health
Dan Musgrove, representing Valley Health System
Mike Draper, representing Elite Medical Center
Helen Foley, representing Nevada Assisted Living Association
Sarah M. Adler, representing National Alliance on Mental Illness Nevada

Chairwoman Cohen:
[Roll was called. Committee policies were explained.] I will go ahead and open the hearing on Assembly Bill 232.

Assembly Bill 232: Makes various changes to provisions governing hospitals. (BDR 40-158)

Assemblywoman Rochelle T. Nguyen, Assembly District No. 10:
I am here to present Assembly Bill 232, which requires certain hospitals to participate in Medicare programs as a provider. It also eliminates the designation of general hospitals and addresses some other related matters.

As to the background of this bill, Nevada, like other parts of the country, has seen an increase in the number of microhospitals. Microhospitals differ from general hospitals and urgent care centers. The marketing of these microhospitals has led to some confusion on the part of residents and our own constituents when they are seeking appropriate care. This measure seeks to provide greater clarity to patients by ensuring that a facility that promotes itself as a hospital meets certain requirements.

Joining me now are Jesse Wadhams and Bill Welch, who will provide more information and detail about the bill and what it does.

Jesse A. Wadhams, representing Nevada Hospital Association:
I would like to thank Assemblywoman Nguyen for taking over this piece of legislation and this Committee for considering it.

I have learned to never call any bill simple. I will say though that A.B. 232 is pretty straightforward in its goal. All short-term, acute care hospitals in Nevada should be certified by the Centers for Medicare and Medicaid Services (CMS). Assembly Bill 232 does this in section 2 by mandating that all hospitals must "enter into an agreement with the United States Secretary of Health and Human Services . . . to accept payment through Medicare." In section 21 [subsection 1, paragraph (b)] of the bill it is specified that all hospitals need to "Enter into such an agreement as soon as practicable."

All Nevada hospitals get licensed through the state. This bill mandates certification through CMS or CMS-recognized entities. Centers for Medicare and Medicaid Services or CMS-recognized certification will require hospitals to accept Medicare and Medicaid as a payment source. By accepting payment and participating in these programs, all Nevada hospitals are made to comply with the federal law known as the Emergency Medical Treatment and Labor Act (EMTALA). Broadly speaking, EMTALA establishes that if I present to a hospital emergency room, I will get examined, triaged, and receive medical care and treatment to the extent needed for my stabilization—without any regard to payment and thus without my having to fear being turned away for any reason.

Let me point out that this bill is not intended to be anticompetitive in any way. We welcome the fact that competition has increased in recent years, with several new hospital openings in southern Nevada, and with the new hospital that will open in Reno shortly. We think competition makes us better, as it provides more access to care and forces our facilities to compete over patients.

Assembly Bill 232 is to ensure that, at the end of the day, the playing field is fair for all competitors in the market. The bill codifies my expectation that when I show up at a hospital in the emergency room, I do not have to fear being turned away for my potential inability to pay or for showing up as a government payer. Examination, triage, and needed medical care without regard to payment or the potential of being turned away is the upshot of what this bill will ensure. Mr. Welch will answer any technical questions, but that is the bill in a nutshell.

Chairwoman Cohen:
I will open it up for questions from Committee members.

Assemblyman Carrillo:
Thank you for bringing this bill forward. What would be considered a critical access hospital?

Bill M. Welch, President and CEO, Nevada Hospital Association:
A critical access hospital is a federal designation primarily for rural community hospitals that are sole community providers. The designation provides for assurance that those hospitals, which would otherwise be likely to be vulnerable and unlikely to be sustainable financially, will be reimbursed at cost level for both Medicare and Medicaid patients. It is meant to ensure that rural hospitals can be financially viable.

Assemblyman Carrillo:
Regarding the acceptance of payments through Medicare—and I cannot remember whether this really pertained to Medicare or Medicaid—I believe I have heard earlier during this session that the amount that is being paid is not sufficient, especially for private hospitals. Is this creating more of this issue?

Bill Welch:
The issue that has been shared with you by the hospital community concerns the inadequacy of reimbursement for services through Medicaid. Medicaid reimburses us below the cost level. This legislation does not impact or change that. By becoming designated critical access hospitals, facilities gain the certainty that they will be reimbursed at cost level. The bill states that all short-term acute care hospitals must be Medicare participating and thus be also accepting Medicaid's payment as payment in full. The bill ensures that they are not able to balance bill the patient for the difference anymore.

Assemblyman Thompson:
I would like to get some further clarification on whether this legislation is also meant to include a neighborhood quick care center.

Jesse Wadhams:
No, it does not. It is meant for short-term acute care hospitals.

Assemblyman Thompson:
Is certification, the goal of this bill, a lengthy process? Will that present a hardship to the hospitals that have to be in compliance? Medicare and Medicaid processes usually take a long time. Can you share some information about the burden this will mean to these hospitals?

Bill Welch:
It would be false if I said it was a simple process. It is not a simple process. But it is not a difficult process either. The overwhelming majority of all short-term acute care hospitals in this state are currently CMS-certified regarding their ability to participate in Medicare. There is an application process. Primarily, that requires hospitals to comply with certain federal regulations. It is not that difficult to go through that process.

Assemblyman Thompson:
During the application process, would these hospitals still be able to operate as long as they show good faith and due diligence towards entering the process of becoming certified? Or how does that space work between having to apply for the certification and obtaining the actual certification? Does that process take quite a while?

Assemblywoman Nguyen:
If you look at the very last page of the bill, section 21, subsection 1, paragraph (b), it says that these facilities shall "Enter into such an agreement as soon as practicable after that date." The bill designates January 1, 2020, as "that date." It is the date by which an application for an agreement has to be submitted.

If there are concerns about the length of time it may take hospitals to obtain CMS certification, we are willing to talk to anyone coming forward about a possible amendment. The important thing about this bill is that we get on top of this problem. We only meet every other year. These types of facilities have emerged in other states already, and many of these

states have been able to address them quickly. The bill assures that Nevada, too, addresses them from early on.

Assemblywoman Titus:
I wish to make a general comment. I do not know any other business besides health care where you are mandated to accept certain payments. For example, gas stations—you have them on every corner and so you can choose to go there or not based upon your decision of whether or not you want to pay their respective rates. The government does not step in and say to gas stations, We are only going to pay you a nickel for a gallon of gas and you must accept this card of ours. That is just an observation.

My first question concerns section 2, under which you have excluded—probably with the intent to help them, though I am not sure about that—rural hospitals and critical access hospitals from having to enter an agreement with the United States Secretary of Health and Human Services. I need some clarification on what this section is meant to really do. Is the agreement a hospital "shall enter" with the United States Secretary of Health and Human Services meant to address EMTALA violations? I would like to know why you chose to specifically cite 42 U.S.C. § 1395dd in this section.

My second question concerns the fact that we, as rural hospitals and critical access hospitals, are already CMS-certified and do already contract with Medicare and Medicaid. I need some clarification why you carved out the rural and critical access hospitals in that section, as I am not sure what the intent behind this carving out is. I think the intent is to help these hospitals, but I am not sure if that really helps or not.

Jesse Wadhams:
I will take the question concerning the critical access and rural hospitals first. Critical access hospitals are already getting their certification from CMS, as you pointed out. The bill does not change that. The carving out in this section is just meant to ensure that rural and critical access hospitals are not caught up in this, but only the short-term acute care hospitals. That is the intent.

Bill Welch:
Please keep in mind that there is currently no requirement in Nevada law obliging any hospital to become CMS-certified and/or Medicare-participating. Our focus is on short-term acute care hospitals. To receive the designation of "critical access hospital," facilities are federally required to become CMS-certified and therefore Medicare-participating. Hospitals are not eligible to become critical access hospitals and take advantage of an improved reimbursement rate unless they become Medicare-participating and CMS-certified. I hope this answers your question.

Assemblywoman Titus:
It answers my question only partly, but thank you for that. Correct me if I am wrong as concerns the general purpose of this bill and the situation it is meant to address. We all know that Medicare and Medicaid do not reimburse at cost level. So a business could come in and,

to stay viable, refuse to accept any patients on whom it would lose money. The hospitals that have already been there before, however, are CMS-certified and offer Medicare and Medicaid services. These incumbent hospitals are now losing out because the newly incoming satellite hospitals only accept cash or cash payments or other reimbursements. These new hospitals make a profit and maintain a business by taking the paying patients away from the established hospitals that would need them so desperately for their economic survival. Am I correct that this is the issue the bill seeks to address?

Bill Welch:
Yes, you are correct. We want to make sure that all hospitals have the same responsibility to meet the needs of patients who present. As a layperson, if I see a sign that says, This is a hospital emergency room, I expect that I will able to present myself, that I will be triaged and treated if necessary, regardless of my ability to pay. We think that all short-term acute care hospitals in the state of Nevada should have that same role and responsibility.

Assemblywoman Titus:
My next question concerns section 9. Am I correct in my understanding that the bill addresses hospitals only and not, as I would call them, "Docs-in-a-box," such as the Walmart Stores and the freestanding small clinics where folks can walk in and be seen? As concerns Docs-in-a-box services, it seems to me that our citizens clearly understand what they are, and that they are meant for urgent care, for temporary care only: you have a cold, you can receive the services while you are shopping. There is no illusion that you are going to get an X-ray or go to a real hospital. Am I correct that this bill is not meant to undermine these urgent care or walk-in clinic-type of models? Instead, what you want to do with it is to ensure that the consumer or the patient or the citizen of the state or outside of our state has a clear understanding of what the services are that are being offered when walking into a facility—am I correct?

Jesse Wadhams:
You hit on it exactly. It is the expectation that when I walk into an emergency room, I get emergency room services. That is exactly what we are trying to guarantee.

Assemblywoman Titus:
Along that line, I have some further questions relating to section 9. I am concerned about the elimination of the term "general" hospital. I am not at all a television watcher, but I know that there was a show called *General Hospital*. That relates to my question, what, really, is the general public's expectation? Does every hospital now have to be a specialty hospital? Why are you not allowing a hospital of the type that we all grew up with to be called a general hospital any longer? Why does it have to settle down in one of the categories listed in section 9? That is my main concern.

Jesse Wadhams:
The intent is to make all hospitals the same, if they offer that suite of services—medical, surgical, and obstetrical. Psychiatric is actually carved out as a specialty. The issue with the term general hospital is really that it is a naming convention for facilities that offer multiple

services. As I have seen it in the law, it appears as a distinction without a difference. Section 9 would clarify that all hospitals are the same.

Assemblywoman Titus:
Yet clearly, all hospitals are not the same. And that is what this bill is about. I am thus wondering about these distinctions. As you, I am sure, are aware, I am a practicing physician at South Lyon Medical Center. We call it the hospital, but it is designated as a medical center. Different hospitals do different things. At one point we offered obstetrical services; we did surgeries before; right now we are more of a medical thing and a long-term care hospital. In other words, there are many hats that we wear and have worn. I am concerned that by eliminating the terminology of general hospital, it does not allow latitude and flexibility anymore to change things: maybe do surgery again, offer obstetrical services, or other services? How specific should we really get? Sometimes, using the term community hospital or general hospital is really not a disadvantage. I am thus curious why the bill wants to eliminate that particular use of designation.

Jesse Wadhams:
Again, the intent there is that a hospital does not seek a general hospital license versus a medical hospital license. It would seek a hospital license. And that is what we are clarifying.

Assemblyman Assefa:
Section 21, subsection 1, paragraph (a), requires all hospitals to be compliant by January 1, 2020. How many hospitals in our state—what percentage of hospitals—are currently not compliant?

Jesse Wadhams:
I understand that at this point there is only one such hospital.

Assemblyman Assefa:
As part of your response to the Assemblyman from District 17 [Tyrone Thompson], I first heard the term short-term acute care hospitals. There are facilities out there that look like hospitals, but they really are not because they would not treat everybody. Instead, patients need to prove that they are capable of paying for the care they are receiving before the providers actually see them. Are these hospitals or facilities—or whatever they may be termed—also required to be compliant by January 1, 2020?

Bill Welch:
This law will only apply to medical hospitals licensed by the state of Nevada. Some of the facilities that you are referring to are urgent care centers. They do not need to be licensed by the state of the Nevada. They are quick care facilities as the ones Assemblywoman Titus just mentioned. There are also other types of medical facilities that do not require licensing by the state of Nevada. Our focus is specifically on hospitals licensed by the state of Nevada as medical facilities that have an emergency room. We want to ensure that patients, when they present themselves to a facility, are understanding what they are entering.

Assemblyman Assefa:
They should then not advertise themselves as hospitals, but as quick cares.

Bill Welch:
Should they be advertising themselves as hospitals without having a hospital license, I think the Bureau of Health Care Quality and Compliance in the Division of Public and Behavioral Health, Department of Health and Human Services, would have the authority to intervene and require them to no longer refer to themselves as a hospital.

Chairwoman Cohen:
To be clear, they do not have to be in compliance by January 1, 2020, but just have to have applied. Are there any other questions from Committee members? [There was no response.] We will move on to hear testimony in support.

Joanna Jacob, representing Dignity Health-St. Rose Dominican Neighborhood Hospitals:
I would like to offer our support and some clarification regarding the discussion of today, specifically with respect to what has been called the microhospital model. I know some of the Committee members were able to tour the smaller acute care hospitals that Dignity St. Rose has opened up in the last year. They are fully licensed, though smaller in stature. Technically they can be seen as a microhospital. There was some discussion about whether or not we accept government payment. We are fully licensed, CMS-certified, and we do take Medicare and Medicaid. I just wanted to clarify that for the record. We consider ourselves community partners. There are a lot of Medicaid- and Medicare-eligible people here in the state who need care. And we want to be seen as a valuable community partner. I just wanted to clarify that. We are in support of A.B. 232.

Chairwoman Cohen:
I think there is also a concern as to what happens when there is an accident and people think, "This is a hospital," and they come running to the facility with someone in tow who is in dire need of medical care. What do your microhospitals do at that point? Are they able to treat them?

Joanna Jacob:
I am happy to give you an anecdote. For example, we had four facilities—one in Blue Diamond, and one in North Las Vegas—that treated 17 victims of the October 1, 2017, shooting, including gunshot victims, crush victims, and car crash victims. We are part of the integrated health care system. We are integrated into the Dignity system. We are staffed by board-certified emergency physicians. It would be the same thing as walking into an emergency room. Anything that we are not able to do, because it would require a different level of care, we transfer either within our system or at the patient's choice to another facility. This procedure is similar to what other hospitals do. That has happened, we had to transport some patients to a higher level of care that we were not able to provide at the microhospital. If you have a stroke or heart attack or those types of things, then you will have to go elsewhere.

Chairwoman Cohen:
The 17 victims whom you treated, how did they get to your hospital—was that by ambulance or was there someone driving around to drop an injured person off? Blue Diamond is close to the location of the shooting, so I can see someone getting there from the Strip. Obviously, North Las Vegas is not the closest place—hence my question.

Joanna Jacob:
I would like to be given the opportunity to supplement, because I do not have the information as to how every single victim arrived at the hospital. I did speak with the hospital manager yesterday. She indicated that some of the victims arrived—as so many people did—in cars. There was a real crisis at that time. I believe that there may have been some patients who arrived by ambulance. Some of them were at other facilities, and because we had such a crisis on that day they were able to self-transport to our facility. I will be glad to provide you more information on that.

Chris Bosse, Vice President of Government Relations, Renown Health:
I am here in support of A.B. 232. We believe that this bill goes a long way in ensuring that patients presenting to hospital emergency rooms will be taken care of adequately, and will not be turned away or be financially devastated down the road because, for whatever reason, the hospital decided to bill the patient instead of Medicare. We think this potential change in statute is the right answer to protect patients in Nevada.

Dan Musgrove, representing Valley Health System:
We are a statewide network of hospitals. We have six hospitals in Las Vegas, one in Pahrump, and one in Sparks. We also have two freestanding emergency rooms with emergency departments.

To your question, Madam Chair, I think that the public has become pretty smart about the difference between an emergency room and an urgent or quick care. To piggyback on what Ms. Bosse just said, the public has a right to expect that when they go into a hospital and are in need of emergent care, they will find a full-service hospital. It may be smaller in stature and may not have the rooms that a freestanding hospital has. We at Valley Health System always have the ability to transfer to a hospital for a longer stay. But if anyone comes into a hospital and is in need of emergent care, if the sign says, Emergency, there should be an expectation that the public can get that kind of care, and that it will be all-inclusive care. That is one of the things that this bill helps to ensure. It sets a standard that helps the public to understand what they are getting when they are walking into the door of any facility which is pretending to be or advertising itself as a hospital.

Assemblywoman Titus:
You mentioned something, Mr. Musgrove, that I believe is really important to have clarified. The issue is not necessarily that there are freestanding hospitals, microhospitals, or freestanding emergency rooms. You do not have to do everything at every single hospital location. In fact, only a few hospitals do so; many hospitals have a specialty that they focus on and then they transfer somewhere else for other services. The key component here is that

you, Dignity Health, and others, have a connection to other facilities so that you can offer comprehensive treatment. You have an arrangement to make sure that patients get the treatment they need, whether it is in your facility or not. This model is able to offer comprehensive treatment in a network of facilities as opposed to being a facility that is truly autonomous with no connections that would allow for it to make sure that patients get the care that they need. Am I correct?

Dan Musgrove:
You are absolutely correct.

Chairwoman Cohen:
In southern Nevada, do we have anyone in support? [There was no one.] Is there anyone else in support in Carson City? [There was no one.] Is there anyone in opposition to A.B. 232?

Mike Draper, representing Elite Medical Center:
You can probably guess, we are that one hospital. We are opposed to A.B. 232. We understand the overarching purpose of the bill. But we do not think that this bill is a solution to the problems that have been presented today. Furthermore, we are one of a few, if not the only, hospital this bill would affect. We feel much of this bill is based on misinformation, protectionism, and a lack of understanding of what Elite Medical Center is—or other hospitals like us.

We represent a new business model which is starting to pop up all over the country. Elite Medical Center opened last July on Harmon Avenue just off the Strip in Las Vegas. We are a state-licensed, 22-bed, state-of-the-art hospital with digital X-rays, in-house emergency labs, and CT scanners. We offer emergency care, in-patient services, pediatric emergency services, full-service radiology, and a litany of other services. We are proud that almost every patient who visits Elite Medical Center sees a physician within ten minutes of arrival, if not less. We are not an urgent care facility, as we are open 24 hours a day, seven days a week, and we have a full-service emergency room. Likewise we are not a full-service hospital, as we do not provide surgery or intensive care as traditional hospitals do. When we see patients who need these types of services, we transfer them to other hospitals that are capable of accommodating their needs. We have over 60 employees and 9 contracted physicians who we think are some of the best in their profession in southern Nevada.

We opened in Las Vegas with the primary purpose of expanding the patient base in southern Nevada. We do so by providing high-quality emergency services to the millions of visitors traveling to Las Vegas each year. Too many times we have heard stories of visitors cutting their trip short due to an accident or illness. Forced to seek medical care, they too often make the decision to return home. Almost a year in, we are proud to say that we think we have changed this. More than 80 percent of our patient base is from outside of Nevada, and our relationship with the gaming resorts has been very positive. While most of our patients have been tourists, we are proud to have served hundreds of Nevadans in the short time since we have opened.

It is our fear that this discussion came to surface because, in our efforts to open and provide high-quality patient care, we did not do a good job communicating to the community, to the other hospitals, and to our elected officials about who we are and what our business model is predicated on. So let me briefly start that process today. As I mentioned, we are licensed by the state of Nevada in the same way as every other hospital. While Elite Medical Center is not certified through CMS, we are still subject to EMTALA. The federal EMTALA law requires anyone coming to an emergency department to be stabilized and treated regardless of their insurance status or ability to pay. If there are concerns about facilities like Elite Medical Center and how we treat CMS patients, maybe the solution is better found in our reporting our matrices and patient demographics on a regular basis. When it is determined that a patient is not experiencing a true medical emergency, we redirect that patient as necessary. This can include sending the patient to an urgent care facility or a private care practitioner. We even go as far as to call and make those follow-up arrangements for the patients. We call this "EMTALA plus."

Our examinations do not require long waits and waiting rooms, but occur in minutes. We value our patients' time and health, and refer to this, as I said, as EMTALA plus. After a patient has been seen by our physicians, Elite Medical will submit a claim to insurance providers on our patient's behalf. Under the Patient Protection and Affordable Care Act of 2010 and EMTALA, insurance carriers are required to process claims for emergency services at a rate at least equal to the highest of the plans in network, out of network, or prevailing Medicare rate. We purposefully made the decision not to be part of Medicare and Medicaid because of the inherent burdens that participating in a federal government program can add to quality care and efficiency. The trade-off, though, is that by not participating in CMS, we offer a significant amount of free care, since we cannot turn anyone away. Nearly 30 percent of the care we provide is free, uncompensated care. That is a trade-off we knowingly and willingly made, so that we could offer our services more efficiently and nimbly.

I would like to point out that, by offering 30 percent free care, we are actually providing an economic benefit to the Medicaid and Medicare programs, as this means that we are not drawing from Medicare and Medicaid budgets for any form of reimbursement for this care. We factored this trade-off into our business model and readily accepted this as a cost of doing business in a more efficient and nimble manner, and with the patient in mind. Forcing hospitals to participate in CMS does not improve patient care or address billing issues, but adds burden and regulation that can impede innovation, care, and expediency.

We have been engaged with the Clark County Commission over the last several months, as well as other stakeholders, working to address this issue. We respectfully ask to be included in the discussions moving forward on this bill to work together to establish policy that provides real patient protection while allowing for innovations in patient care. Today, Elite Medical is the only hospital that is being affected by this. We have not had any discussions with any of the proponents of this bill. For those reasons, we are opposed to A.B. 232. With the litany of other bills that have been introduced this session regarding hospital and insurance billing practices in patient care, we ask that this issue be examined closely and more robustly before it moves forward.

Chairwoman Cohen:
Thank you, Mr. Draper. Since you are on Harmon Avenue, if October 1 had happened when Elite was open, would those patients arriving from the shooting have been triaged and stabilized? What would have been the process? I think the concern that a lot of people have is that when October 1 happened, people did not wait for the ambulances. They saw people who were injured, put them in the back of their truck, and drove down the street. They went to the closest spot. Since you would have been the closest spot, what would have happened?

Mike Draper:
We take this question very seriously. As much as we all wish that the October 1 event did not happen, we certainly wish we were around when it did happen. We think we would have been able to play a positive role that would have improved the quality of outcomes on that evening. We estimate that we could have helped save three lives that night. We are a small 22-bed facility. But we are prepared to accommodate natural disasters as well as tragedies on the Strip. We take that location very seriously. In fact, one of the things we proposed to the Clark County Commission is that, regarding the statutes relating to microhospitals or acute care hospitals, one of the requirements should be, just as it is for big hospitals, the ability to triage, to stage, to do those kinds of things during an emergency. That part really does not have any role with CMS or Medicare or Medicaid, but is a policy that we think would be very important for hospitals to have. We are prepared to do that. We take that very seriously, even to the point that we are capable of landing a helicopter.

Chairwoman Cohen:
I appreciate that, and I understand that you are not a health care professional—but what is the plan? I understand it is a small, 22-bed hospital. I am not expecting you to fill the 22 beds, but there would have been dozens of people who probably would have been driven directly there. Would they have been triaged and then sent on to the trauma center? Can you give us more of those types of details? What would have happened? What does the emergency plan look like?

Mike Draper:
We do have an emergency plan in place for events like that. Obviously, I do not think anyone can anticipate an emergency of that magnitude. And certainly, our facility is limited by the number of staff whom we have on hand as well as its relatively small size. In that case, we would have triaged as many incoming patients as possible. We have established relationships with other hospitals in the region to which we would have transferred those patients as needed—if we had so many that we could not triage all of them, or if the triaging determined that the magnitude of the injury was such that we could not treat it. But as concerns the details of the plan, I am speaking a little bit above my pay grade.

Chairwoman Cohen:
Is that something we can have access to; could you forward that to us?

Mike Draper:
Yes, I can.

Assemblyman Assefa:
This facility on Harmon Avenue, is it designated as a hospital by the state of Nevada?

Mike Draper:
Yes, it is. We are licensed by the state of Nevada as a hospital. We offer 24-hour, seven-days-per-week emergency services. We have a full-service emergency room as well as 22 inpatient beds.

Assemblyman Assefa:
Will you treat anybody who walks in the door without their having to prove that they are capable of paying for the services they receive?

Mike Draper:
The short answer is, yes, Assemblyman Assefa. The topline overview of our process is that if you are a patient who walks into our facility and you are presenting with emergency symptoms—for example, you are having heart pain and think you may be having a heart attack—you are given a screening immediately. Most of our patients see a physician within three minutes. They are given a screening immediately to determine the diagnosis. If it is determined that you are indeed suffering a heart attack and it is not, say, heartburn, then you are treated. The paperwork is done on the back end. If you are a Medicaid or Medicare patient, you are treated for your heart attack. We do not balance bill. We do not bill the patient—a Medicare or Medicaid patient—at all. We never bill a Medicare or Medicaid patient. We give that work away or, if it is determined that you are not suffering from a heart attack but just from heartburn, and you are a Medicare or Medicaid patient, we will tell you, Look, we could treat this, we could give you medication and do whatever we need to do, but it is going to be charged at out-of-network rate. Alternatively, you could go to the urgent care that is right down the street to get your $50 heartburn medication, and we are happy to make the necessary arrangements for you.

Assemblyman Assefa:
What happens if I am not able to pay for the care? I understand that during your testimony you said that 30 percent of your care is for free. How do you stay in business?

Mike Draper:
I am speaking here on behalf of a client's business model, which is obviously somewhat proprietary, but if it grew to 40 percent, at some point the business model could not handle the amount of free care provided anymore. Thirty percent is right in the range within which they projected they would be doing it. It was the trade-off they made to avoid not having to hire the staff that it would take to administer Medicare and Medicaid. These programs are so burdensome in terms of processes and staff that it is actually cheaper to provide free care than it is to be part of them.

Assemblyman Assefa:
Are ambulances able to bring patients to you, and can you care for those patients brought to you?

Mike Draper:
Yes, we have an ambulance bay. We do work with American Medical Response (AMR). The challenge is that AMR is really good at knowing what we do well and what we do not do well. Most of those patients who require an ambulance end up at other hospitals such as the University Medical Center. But, yes, we do have an ambulance bay and all of the same things that any other hospital would have.

Assemblyman Assefa:
Is the facility certified as an emergency medical services facility with the Southern Nevada Health District?

Mike Draper:
It is not—you know what, I have got to make sure I understand that right. I am going to have to follow up with you on that. As I understand it, the facility is currently going through that process with the Southern Nevada Health District. I have to follow up and make sure that I confirm that.

Assemblyman Assefa:
I would appreciate it if you could give me some more details on that.

Assemblywoman Munk:
Let us say I am a visitor. I am on the Strip. There is an emergency. I am unconscious. We show up at the Elite Medical Center. You do not know what type of insurance I have or if I have any. After you start helping me—I may now be in the emergency room—you find out that I am on Medicare. Do I get the full bill then, less the 30 percent that you are saying is free care?

Mike Draper:
If you are on Medicare, you do not see a bill at all. We do not balance bill. We write off whatever the remaining charges would be that are not covered under EMTALA or an insurance provider.

Assemblywoman Munk:
So, do you send me a bill or do you just write off the whole amount?

Mike Draper:
We just write off the whole amount. However, as you know, with insurance companies you see a statement before you see an actual bill. I have no idea if you actually see a statement.

Assemblywoman Munk:
I am specifically talking about Medicare.

Mike Draper:
I cannot imagine that you will see a statement, but I do not know that for sure.

Assemblywoman Titus:
I appreciate your testimony. I think it answered a lot of our questions, in particular as I have not been down there and thus do not know what your hospital in Las Vegas looks like. My question concerns your billing practices. We write off a lot of Medicare and Medicaid patients at my hospital, too, by the way—whenever it costs more to bill than we could ever collect. For example, I make house calls for which I never bill because it is just not worth the process of collecting. Writing off is something all hospitals do for certain care. Another question I have is, when patients come and they pay cash, do you give them a discount? I know many facilities do. I know you cannot do price-fixing in health care, but I am curious—is your rate comparable to other stand-alone facilities such as Dignity Health Centers? I am just curious how your price structure is, as far as you can share this information.

Mike Draper:
I am glad you are asking that question. Yes, we do offer a cash rate that is a discounted rate. We have shopped that rate to make sure it is competitive. I have a chart that I am happy to provide to every member of the Committee that shows that we are level in many areas. In some areas we actually beat the cash prices of some of the other facilities. In other areas we are more expensive. All these differences are within the realm of our being competitive.

Assemblyman Hafen:
I am confused and I hope you can help me with this. You said you do not actually bill the patient. Let us say the insurance of a patient has a $10,000 deductible. You are not going to bill against that deductible?

Mike Draper:
First of all, there is a clear difference between an emergency and a nonemergency situation. For emergency situations, if you are insured, EMTALA requires the insurance company to pay whatever the higher rate is for the respective in-network or out-of-network care. If it is not an emergency situation—and we have plenty of patients who do not have an emergency, and we tell them, You are subject to your insurance company as we are out of network—and assuming that you have a deductible, that is really where a lot of the causes of our patients' unhappy billing stories come from. This is really because of the deductible. We cannot do anything about the deductible. That is your agreement with your insurance company. If you have a $6,000 deductible and you still have $3,000 remaining on that, you will see a bill for $3,000 because that is what your deductible is, and there is nothing we can do about that.

Since we are out of network, part of our billing practices is that we call on patients' behalf and negotiate with the insurance company. We send none of our patients to creditors. Rather, we call and negotiate and fight the insurance company with and for the patient. We have had several of those patients who asked us to continue to engage in doing that, and we do. Hopefully, that provided some clarification.

Assemblyman Hafen:
Yes, I was just under the impression that some plans had a fee also in the event of an emergency. Maybe $10,000 is too high, maybe it is only $500, but I just did not know if you went after that or if that is billed through the insurance company. But I think what you are telling me is that you never go after any of that.

Mike Draper:
For cases of emergencies, that is correct.

Assemblywoman Duran:
If I went to your facility and I needed care, what would happen exactly? You would ask me for my insurance, which is the Culinary Health Fund; you would tell me that you are not in my network; and you would tell me that I have the responsibility of paying—or what is the process?

Mike Draper:
If it is an emergency or you are presenting with emergency symptoms, it does not really matter whether we are in network or out of network. We would have you undergo medical screening and determine if you are indeed having an emergency. If it is not an emergency, at that point you will go through paperwork. All our paperwork clearly identifies that we are out of network. Our front desk staff has been trained to identify that we are out of network and make sure you are aware of that.

Assemblywoman Duran:
So you are telling me that you will screen me first, and tell me—before I fill out any paperwork—This is not an emergency; this is what you have. In other words, you basically give me some type of diagnostic treatment. Do you charge the patients for diagnosing and screening them?

Mike Draper:
If it is clearly not an emergency, we will not screen you until you have been through the paperwork process. If you are having emergency symptoms and present, for example, with heart pains, but it turns out that you are just having heartburn, at that point we will tell you, This is not an emergency, and then we start the paperwork process.

Assemblywoman Duran:
So you will see me first before I do the paperwork. I am just confused by the fact that I go in and you ask me, What are your symptoms? Then, after I answer, you will check me, and I later go back and fill out the paperwork?

Mike Draper:
Most of the patients who come into Elite are presenting with emergency symptoms. First and foremost, we need to establish if it is an emergency or not and how urgent the treatment needs to be. We firmly believe in not letting paperwork get in the way of the treatment. If then, at that point, after we screened you, we establish that you are not having an

emergency, we will start the paperwork process—after we have determined that you are, for example, only having heartburn, are not an emergent case, and thus not subject to the federal laws an emergency would fall under, such as EMTALA and the Affordable Care Act.

Assemblywoman Krasner:
How many patients does Elite care for every day in its hospital beds? What is the average?

Mike Draper:
We see approximately 20-30 patients per day. To date, we have seen somewhere between 5,000 and 6,000 patients since we opened in July. We hope that number gets up to around 50-60 per day. But I am speaking here on behalf of the client's business plan, so I am sure I am not aware of all the specifics. Currently we are seeing 20-30 patients a day, which is somewhere within the range of what we anticipated seeing at this point.

Assemblywoman Krasner:
I think you said you have 22 beds. But you just stated that you are seeing 20-30 patients per day. How many are inpatients and how many are just being seen and then released?

Mike Draper:
I do not have specific numbers on this, but I am happy to get them to you. The vast majority of our patients do not end up staying overnight. About 80 percent are tourists, and they are usually treated and then, hopefully, get back on their vacation.

Chairwoman Cohen:
Thank you for answering our questions. Is there anyone else who wishes to come forward in opposition? [There was no one.] Is there anyone else who wishes to come forward under neutral? [There was no one.]

Assemblywoman Nguyen:
Thank you for your thoughtful questions. At the end of the day, the intent of the bill is to make it clear to tourists from out of state as well as to the constituents who live near this microhospital facility that this is not a traditional hospital or medical center in the way that we normally understand it. A lot of times, when people are coming to these types of facilities, they are presenting with heart pain, broken bones, or similar emergencies. They might not be in the right state of mind to be able to fill out paperwork. You do not want a situation in which you present at a facility like this and it turns out that you are not covered or that it does not provide the care that you need and that you therefore have to wait—even though time is essential in this moment. I am glad that the facility is willing to organize transport to another location. But in other instances, you may have to find another location yourself. I think that is an important thing to keep in mind. I have met with Ms. Fisher [Susan Fisher, formerly representing Elite Health Medical Center] regarding this and I look forward to working with Elite Health and other representatives to see if we can make this better.

Chairwoman Cohen:
With that, we will close the hearing on A.B. 232. I will open the hearing on Assembly Bill 252.

Assembly Bill 252: Revises provisions relating to providers of community-based living arrangement services. (BDR 39-656)

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27:
Assembly Bill 252 deals with the subject matter of community-based living arrangements. During the 2017-2018 Interim, I had the pleasure of serving on the Legislative Commission's Audit Subcommittee as Chair. The subcommittee heard a number of audits that our legislative auditors brought forth. I will say that serving as Chair of the Legislative Audit Subcommittee has probably been one of the most legislatively satisfying committee experiences that I have ever had. The work that is done on that subcommittee by our auditors is simply amazing.

During this past interim we did some very significant work to tackle a big problem in our community, which is the quality of our community-based living arrangements. In particular, two audit reports have gained publicity and notoriety for their contents and have spurred a number of bills to address the results of these audits. I am here today to bring forward a piece of legislation that I think will address some of the most egregious findings in these audits. We have uploaded the highlights of two specific audits to the Nevada Electronic Legislative Information System: Legislative Auditor report number LA18-13 (Exhibit C) regarding community-based living arrangement homes; and Legislative Auditor report number LA18-24 (Exhibit D) regarding residential services payments.

What are community-based living arrangements? Their primary clients are Nevadans with a mental illness who are underinsured or uninsured, and whose conditions have resulted in interactions with law enforcement. We are not talking about all mentally ill persons, but only about mentally ill persons who have come to the state of Nevada health facilities because of their interactions with law enforcement. Community-based living arrangements are residential placements for those who can live in the community as opposed to more restricted environments such as Lakes Crossing Center for mentally disordered offenders.

Let me give you some legislative history about what has been happening with these types of homes, and why we are here today. In February 2014, the Division of Public and Behavioral Health within the Department of Health and Human Services, issued standards for mental health supportive living arrangement services (SLAs), which established the operational structure of community-based living arrangement (CBLA) homes. Back in 2014, we had just one nomenclature of SLAs that would talk about the types of population that we would serve. You will see that in the definition of community-based living arrangements, we talk about those who are mentally ill and at present also those with a developmental disability. I will be proposing an amendment to take this mention of those with a mental disability out so that we are talking specifically about the mentally ill within these homes.

In 2016, a *Reno Gazette-Journal* article featured a provider of 13 homes which all had closed their doors (Exhibit E). The clients had to be relocated, which was very disruptive to them and to their families. These families reached out to complain to the newspaper about that situation. Subsequent reporting revealed that the owner had not been paying rent on his home, and the clients were living in squalor. The squalor piece was especially appalling. Many of us legislators felt compelled to take action. During the 2017 Session, there were two specific pieces of legislation that came forward from those reports. Assembly Bill 46 of the 79th Session created a mandate for a certification process. Essentially, the Department of Health and Human Services had to create a process that would define criteria and qualifications for persons to own and operate a CBLA. Most of the language said that those had to be developed by regulation.

Assembly Bill 343 of the 79th Session required an interim study to review and evaluate the funding and the rates for the Southern Nevada Adult Mental Health Services and their payments to CBLAs. However, when our auditors looked at it, we realized that the scope of the audits needed to be much larger for a complete picture. We thus included all Northern Nevada Adult Mental Health Services. That is how we ended up with the residential services payments audit.

The highlights of the audits you have in front of you [(Exhibit C) and (Exhibit D)] are the result of the work of the auditors during the 2017-2018 Interim. I will walk you through the bill now and explain to you where each piece of A.B. 252 is coming from and why I feel we are justified putting it into law. As section 1 of the bill makes clear, the bill amends and concerns *Nevada Revised Statutes* (NRS) Chapter 433, the mental health chapter.

Section 2, subsection 1, states, "Each person employed by a provider of services" has to be able to speak the language of the clients. The audits found that there were people working in the homes who were not at all able to communicate with the clients. Legislative Auditor report LA18-13 on the community-based living arrangement homes states on page 22 [Assemblywoman Benitez-Thompson read from page 22 of the full report]:

> For 11 of 20 (55%) CBLA homes inspected in southern Nevada, the staff member identified as the caregiver spoke little to no English, the language of the clients living in the home. If caregivers are unable to communicate, clients may not receive the services they need, and those for which the State is paying. Caregivers are responsible for tasks that necessitate client interaction such as administering medications and supervising client activities. In addition, in one home, we were informed the caregiver had recently undergone surgery and could not leave her bed. Because of significant communication barriers, our discussion with the caregiver was translated by a friend visiting the caregiver.

What we see existing in statute and the basis on which I modeled this language is in NRS 433.269. There is a requirement for proficiency in English language for social workers, psychiatrists, psychologists, and registered nurses in order for them to be able to do their

work. We want the staff in the homes to be able to speak the language that a majority of clients in the home speak. I am not going to say specifically that the staff has to speak English. If the majority of the clients are non-English speakers, then we need to have staff in that home who can communicate with them. Remember that this communication is about medications and daily habits, and that we are reimbursing for these services. We need assurances that this communication can happen.

Section 2, subsection 2, says, "A child under 18 years of age must not reside in a home operated by a provider of services." This subsection has also been put in as a response to Legislative Auditor report LA18-13. I am going to quote some findings of the report on page 21 so that you get an idea why this subsection is in the bill. [Assemblywoman Benitez-Thompson resumed reading]:

> During our inspections of CBLA homes, we observed young children of the caregivers living in 2 of 37 homes . . . For the home in which the child's mother was not present, we observed the 3-year-old child running around a filthy home in his underwear and being loosely supervised by clients living in the home. A female client identified herself as the babysitter and indicated the mother was the live-in caregiver at the home, but worked another job during the day.

Community-based living arrangement homes are for the mentally ill who have come to us through law enforcement. We think it is best to put in statute that the children of the caregivers for this community cannot be living there also, and that the clients—who are recipients of state services—cannot be their babysitters.

Section 2, subsection 3, defines what "A provider of services shall" do. Paragraph (a) specifies that the provider of services shall "Provide each recipient of services with access to licensed professionals who are qualified to provide supportive and habilitative services that are appropriate for the recipient." We really need this in place because the goal is to provide services to this community. What we found was that none of the clients living in the home were receiving any kind of rehabilitative services. That piece just was not happening, and it is the intention of this paragraph to change this. The Division of Public and Behavioral Health (Division) is piloting the use of occupational therapists and other types of professionals in the homes. We will see this expanding and happening. Before, however, we were not having skilled individuals in the home helping the clients.

Paragraph (b) requires providers of services to "Post prominently in any home . . . in which services are provided a sign with the telephone number that may be used to make a complaint to the Division concerning the provider." Complaint hotlines also exist in other types of group homes that are operated within the state. The intent underlying this paragraph is that family, friends, or anyone who walks into the home gets to know a number that can be called for complaints and concerns. The Division will then have a process in place according to which representatives will come out and investigate these complaints or concerns.

With section 3 we are moving towards the requirements that the Division has to have. Subsection 1 states, "The Division shall establish, for each recipient of services whose services are provided pursuant to a contract between the provider and the Division, an individualized plan for the provision of services." Once an individualized plan is in place, it has to address two things per section 3. The first is that specific case management services are to be provided by professionals to address the client's primary diagnosis of mental illness or other diagnoses that these professionals establish. The second concerns the supervision component. Every client is different and, with individualized plans in place, each has a different mix of case management versus just supervision that is being provided in the home. We need a plan that details out what this person needs and what the state is obligated to provide. One such obligation is just basic supervision, to make sure that the clients are safe in their homes, themselves, and to others.

Section 3, subsection 2, defines that "A contract between the Division and a provider of services . . . must include a provision requiring the provider to comply with an individualized plan." If you want to be a person who hangs out a shingle running a community-based living arrangement home, you have got to agree that part of what this home does is allow for the provision for these services within the home.

Section 3, subsection 3, establishes that, "If the Division determines that it has paid the holder of a certificate with which the Division has entered into a contract an amount that exceeds the amount required by the contract, the holder shall reimburse the amount of the overpayment to the Division." This subsection is a response to the findings of Legislative Auditor report LA18-24 on CBLA homes. As you can see by reading the second sentence of the Audit Highlights' Summary, the findings show [Assemblywoman Benitez-Thompson read from (Exhibit D)]:

> We estimate the Division was overbilled about $1.5 million in fiscal year 2017. These overbillings resulted from providers billing for more hours than were recorded on staff service logs and payroll documents, and billings for duplicate services.

Most of this report goes on to talk about these overpayments. I quote page 11 of the Legislative Auditor report LA18-24:

> Our review of monthly bills found providers billed multiple times for the same hour of staff time worked. For 27 of 45 (60%) monthly home payments tested, providers' staff recorded the same date and time performing services to multiple clients in the same home, or between homes operated by the same provider.

We need to be able to have a second look at billing records and, in case of overbilling, to claw that money back. The expectation should be that if we have overpaid a provider, those dollars will be reimbursed to the state.

Section 4 specifies, "The Division shall: Arrange for an annual financial audit." In the coming months and—given that this change will be a process and take time—years, the Division will be changing the way these homes are paid. Right now, the billing system literally consists of paper logs. Our auditors reviewed hundreds of thousands of handwritten paper logs by the hour and sometimes even by 15-minute reporting requirements of what staff is doing and what they are providing. As you can imagine, it is onerous for the CBLA staff to do it this way. It is also onerous for our staff to review. Therefore, right now the Division is talking about going to a daily rate. That will help a lot. But until we get to that point, we need ongoing financial oversight if for some reason that plan is delayed or we need more time to implement this daily rate-type of system, which will be easier to track. We would thus like the Division to continue on with some type of financial audit process and be able to reconcile all of those paper records to ensure that we do not have ongoing overpayments to the homeowners. We are also, with this section 4, building into our legislative budget ongoing audits of the Division and of Medicaid, and will increase the number of auditors solely dedicated to Medicaid and public behavioral health and health and human services issues. We want to make sure, as the Legislature, that we are having ongoing conversations about these issues.

I am turning now to section 5, subsection 1. "The Division shall not renew a certificate if: The provider of services has refused or failed to reimburse any overpayment." If we have an error in billing, we will give you time to correct it, and we will give you time to pay it off, but if you flat-out refuse and say you are not going to pay for it, then you just cannot be this kind of provider. Furthermore, per subsection 2, if "the holder of the certificate has failed to correct any practice required by the Division to comply with state law or regulations," which means if we go out to your home to investigate it and we see filthy, unsanitary conditions, and the provider proves unable to correct those, then the certificate shall not be renewed and, in fact, should be removed.

I will now turn to section 8, which concerns what the providers have to do to obtain certification. The main takeaway from this section is about the training provisions. Once again, this is speaking to the quality of the staff in the homes. We have seen staff who really have no knowledge of the client base that they are working with. I say this as a licensed social worker who has been working in this field now for nearly 15 years. I have to do 30 continuing education units every 2 years. A lot of this education goes into understanding this population. Interacting with people living in community-based living arrangement homes is inherently problematic, and it is only through education that social workers can work with them effectively and be diligent service providers. My expectation is not that someone who is living in a home doing basic supervision needs to be an expert in the mental health population, but that person needs some basic understanding of who this population is that they are interacting with. They need this both for their own safety and well-being and for the safety and well-being of the people living in the home.

I move now to section 8, subsection 1, paragraph (b), subparagraph (3), where it specifies that if you are going to own and operate a CBLA home, then you are required, before you get

your certificate, to have mandatory training in Nevada labor laws. Legislative Auditor report LA18-13 delineates on page 22 to 23 concerning employment practices in those homes:

> These concerns include the quality of care provided to clients and potentially oppressive working conditions that may circumvent labor laws and payroll requirements. For example, during our audit, we also visited the offices of CBLA providers and reviewed provider records. For 3 of 11 providers, payroll records were not provided for the caregiver who was in the home during our inspection. . . . we have serious concerns with the working arrangement of caregivers living in CBLA homes, and potential circumvention of labor laws and payroll requirements.

Some of the staff has, in fact, been found to not be paid a minimum wage. The homeowner argued, I am paying for their room and board, so that should be part of it; I am letting them live here. So we have a lot of work to do with these owners to make sure that they are in compliance with the labor law. We will do this at the front end of the process now. Before they get the certificate, they need to have this training to ensure that they are in compliance with labor laws.

Section 8, subsection 1, paragraph (b), subparagraph (4), requires applicants to post a surety bond in the amount of two months' operating expenses and to have that amount placed into escrow. Once again, this is a reaction to the audits—more specifically, Legislative Auditor report LA18-24, which highlighted the lack of financial solvency of these homes as a major problem. We thus decided that, as a bare minimum, we need to know that these homes have some operating cash in escrow so that we know they are going to pay their rent. This was also the issue that initiated the newspaper articles and resulted in the closing of multiple homes.

Section 9 establishes that the Division needs to do a walkthrough of the home before they approve the home. The initial audit included 2,000 pictures of homes that were not in great condition, but filthy. We want a walkthrough at the beginning of the process so that we can lay eyes on that home and determine the quality of the home from the outset. An amendment that you are going to be seeing coming to this bill concerns the definition of CBLA services in NRS 433.605, section 1, as individualized services: "Provided in the home, for compensation, to persons with mental illness or persons with developmental disabilities." The way we are going to need this to read is, "to persons with a primary diagnosis of mental illness," and then strike "developmental disabilities." What gets them through the door is mental illness and interactions with law enforcement. Whatever else they come through the door with, we will empower the Division to help with individual case plans. But we do not want to mix our developmental disability community and our intellectual disabled community with our mental health community. The planned amendment makes sure that both are separated. I am open for questions.

Assemblywoman Titus:
There is a need for bringing this forward given the horrendous conditions in some of these homes. I appreciate your sticking with it, bringing it forward, and using the good information and data from the Audit Subcommittee on what the issues were and how to change the situation.

I have some questions, starting in section 2. I think it is important that persons employed by a provider speak the language of the clients. However, based on what we have heard in testimonies on other bills and issues, I am concerned that the reimbursement for the providers in the home is such that it raises the question, Who are you going to find to replace them? Will the homes be able to stay open if they cannot find the personnel to take care of these clients in these homes? This is a real issue. The reason why these personnel have taken these jobs is that they have, perhaps, limited skills, and so cannot get a job somewhere else. Are they going to be able to staff these facilities given the newly envisioned language requirements? Will we have adequate supply of personnel?

Assemblywoman Benitez-Thompson:
That is a wonderful question. We have got to make sure that we are clear on the record about something: Money is not the problem here; lack of funding is not the problem. We are reimbursing these homes in a healthy and generous way. In no way should it be said that there are no dollars available for the community-based living arrangement homeowners to hire the staff that is necessary and provide the services that are necessary. Some of these homes are making a good deal of money, and we are not seeing those dollars—which are state dollars—flowing to the people who are living in the homes through the provision of qualified staff. I thus wish to make sure that when we are talking about resources, we all know that the resources are there. We just have to push harder to ensure that the owners are hiring the right type of personnel.

There are two different kinds of services that are going to be provided at a home. There is going to be staff living in the home who are providing basic supervision. This type of staff in supervisory roles does not necessarily have to comprise licensed professionals. Instead, they should consist of employees who have been trained and educated about who the clientele is. And they should be able to communicate with that clientele. Then there are the actual licensed providers who are coming in to do the more specific work with the clients, such as occupational therapy. I think that if we push on the homes, and I believe we have every reason to, and formulate the expectation that they will hire better staff, they will change. We as the Legislature have not contemplated saying, Well, these homes are not working; we are not getting the product we want, so we are going to take this money back or away. We are leaving the funds there, but we have to have high expectations about what is happening in the homes.

Assemblywoman Titus:
I think that was an important clarification, that we try to get better quality within the homes, and that we are willing to support that, as a state. My next question concerns section 9. I am absolutely supportive of inspections prior to issuing a license; however, is there enough staff

to do that in a timely manner? I am always worried about what is happening after the initial inspection—how often will these homes be inspected again? To get the license, everybody is wearing that white coat, everything is clean, and everything looks great. But then, when there is no follow-up, what happens six months, one year, two years down the road? Will there be a follow-up, and are sufficient staff levels available to make that happen?

Assemblywoman Benitez-Thompson:
One thing that happened directly after the Legislative Auditor reports came out, the Division of Public and Behavioral Health asked the Bureau of Health Care Quality and Compliance, which regulates other medical facilities, Will you help us in the regulation of these homes? We realized that there was a potential conflict. We also had asked our workers, who desperately need to place clients into these homes, to be the ones evaluating the homes, and potentially say that they are not good enough and need to be closed down. As a result of that realization of this potential conflict, there has been that shift to the Bureau of Health Care Quality and Compliance for the fulfillment of the more regulatory approach towards the homes. A lot of homes were closed as a result of this shift. I will let the Division talk to whether these inspections are too burdensome to accommodate. But I think that we are at a place where we need to make that happen.

A second measure I want to point out in response to Assemblywoman Titus's question is that, since we put a hotline into the bill, we are creating the ability for clients to initiate complaints. The expectation is that once these complaints come in, staff goes out to look at the home. Then, if we find that there is not enough food in the home, or the windows are broken, we can respond to that.

A third point in response to the question is that we will continue working with the Division to ensure it has the necessary regulation for the certification process in place, and that the certification process includes that aspect of checking back to ensure that everything is in place in a home.

Assemblywoman Titus:
For clarification, the mechanism behind becoming reviewed again will not only be complaint-driven, but there will be some automatic review. The problem with the hotline is, frequently folks do not know what they should complain about or the clients are not of the capacity to know that something is not right. I just want to make sure that there is some assurance that there will be some sort of review again, independent of a potential complaint that would also trigger an inspection.

Assemblywoman Benitez-Thompson:
That is correct. The Department of Health and Human Services will be able to answer more specifically as to with what frequency the homes will be reviewed. There was a hearty conversation about the certification process itself producing better owners, and about going back into the homes to check. I suggested that they ought to be recertified every six months, so that we are in every home twice a year. It turned out that this would have set an unrealistic expectation. We would have fallen out of compliance with it. But I believe that

the Division will testify that it sends inspectors out to all of the homes following the audit, and it since put processes in place.

Assemblyman Carrillo:
My question concerns section 7, subsection 1, and more specifically the striking out of "or persons with developmental disabilities." Is the intention here to have the community-based living arrangements kept strictly separate from facilities for individuals with developmental disabilities?

Assemblywoman Benitez-Thompson:
Yes, that is correct. The intent is to clarify who can live in what kind of group home based on the distinction between, on the one hand, those who are mentally ill, who come to the state through law enforcement, and, on the other hand, those with a primary diagnosis of developmental disability or intellectual disability, for whom the supported living arrangement homes are intended. We want to avoid mixing these two populations.

Assemblyman Carrillo:
My other concern is regarding unlicensed homes. I believe there was a case, approximately a year ago, in which a lady was discharged from the hospital and went to an unlicensed group home facility where she apparently passed away. Will the bill help track these unlicensed homes and address these practices?

Assemblywoman Benitez-Thompson:
You bring up such an important point, Assemblyman Carrillo. Some of the first work the Division had to do back in 2014 consisted of figuring out whether these homes actually existed. Remember that all of these homes used to be unlicensed before we took action. We cannot just say, please come and tell us if you are operating an unlicensed home. Then everyone raises their hand. As I remember it, the Division looked at persons receiving different kinds of payments. If there were more than three state payments in one spot, the Division sent people out to see whether this was a group home. This is how the process of licensing and regulating these homes started.

Presently, NRS 433.615 gives the Division the ability to seek an injunction against provision of services without a valid certificate. I thus believe that, as it stands right now, the Division has the ability to say, You look like a group home, but you do not have a valid certificate to be a group home; the Division has authority to take action against that. If I am interpreting that wrong, let me know. I think the issue is more that we have to become better at working with the community so that people understand what it means to be a licensed home, and how those licensed homes are really better than unlicensed arrangements or more informal arrangements that are out there.

Assemblyman Assefa:
My question concerns section 5. The audit you referred to identified that overbilling has resulted in about $1.5 million in damages. If the applicant or licensee refuses to comply with our requests to reimburse us for overbilling, what is the consequence? Are we currently just

saying, OK, you have refused to give us our money back, and we are just not going to renew the license of your certificate—or do we have other legal avenues we can pursue to go after that money?

Assemblywoman Benitez-Thompson:
One of the reasons for us to require the homes to post a surety bond and place it in escrow is that the dollars sitting there will allow us to claw something back if we need to. We had ongoing conversations about that question with the Division. The auditors shared the audit results and their concerns with the Attorney General's Office. However, these are state dollars, not Medicaid dollars. There is thus not the ability there to investigate Medicaid fraud. Ultimately, where we landed is to say that the best practice is to make sure that we have owners who have a better understanding of how to manage their own businesses. We are supporting them in that because ultimately we want them to succeed. We do not want to come in with the heavy hand of law—though in a couple of instances the Department has, and rightfully so. But I will let them speak to whether there is a specific dollar amount they are able to claw back or not.

Assemblyman Assefa:
In section 8, the bill requires the applicant "to post a surety bond in an amount equal to the operating expenses of the applicant for 2 months." Can the state go after that surety bond, legally, in case that a provider has been found to overbill?

Assemblywoman Benitez-Thompson:
If I am incorrect in the assumption that we could go in to claw back these dollars held back in the surety bond, then someone with a legal degree, please let me know. It is, however, also important that we make sure this provision is being implemented, and we will follow up on this with the Department with the intent to ensure that everything that it takes to get that certificate is actually happening. There was also debate about whether it should be two or three months of operating expenses. Three months seemed a little too expensive. That is how we ended up with two months.

Assemblyman Assefa:
As a friendly amendment, I would like to be added as a sponsor of the bill.

Assemblyman Hafen:
My question concerns section 2, subsection 1—the requirement of the demonstration of verbal and written proficiency. My grandfather's first language was not English. He became bilingual years into his life. But he had a very thick accent. I could fully understand him, but a lot of people could not. My concern is, bilingualism is a good benefit in a number of our communities. I do not want to hinder that. I wonder if the requirement of "Each person" in that subsection is not too limiting. I do understand where you are coming from and the situation described in the reports, but I do not want to discourage the hiring of bilingual individuals who could be a benefit, maybe not to the majority of the recipients, but to some of them. I wonder if you could explain a little bit further the requirement that "Each person"

would have to "demonstrate verbal and written proficiency" to me and ease my concern regarding this formulation.

Assemblywoman Benitez-Thompson:
I have been thinking about the written part of that requirement, and we could perhaps let that go. The verbal part, though, we have to have. There are three options we have in this respect: One is the option to not have the mandate in there. That would mean that we do nothing to correct the concerns that were noted by the audit. We would have no way to ensure that the dollars we are paying for caregivers result in the provision of adequate services to the clients in the home. That is probably the least best option.

The second-best option would be to copy the provision in the statutes in NRS 433.269 where it lays out the requirement of demonstrated proficiency in English. But in particular in a context such as Clark County, where so many different languages are spoken, that might not be the best option. You might have a group home there in which the majority of clients are Spanish- or Mandarin-speaking. We as a state would do best by being able to service them in those languages.

The best option I can see is thus to say that staffers must have proficiency in the language the majority of the people whom they are working with speak. Our legislative intent is to ensure that vital communication between the people working in the home and the clients whom they are serving is flowing.

Chairwoman Cohen:
There are not a lot of people working in these homes, and it is a very hands-on job, correct?

Assemblywoman Benitez-Thompson:
Yes, these homes tend to have three to four staff living in them. Some of the bigger ones get up to about seven staff living in there. This is for the supervision aspect of these homes, for which these homes have employees living with the clients. The minimum seems to be two to three, but we are certainly not talking about hundreds or even tens of employees.

Assemblyman Carrillo:
May I be added to your bill as a sponsor?

Assemblywoman Benitez-Thompson:
Yes, absolutely, right now we have the members of the Audit Committee listed as sponsors of the bill; they heard almost seven hours of testimony between the two audits. I would also like to thank the Division for entertaining all our questions.

Chairwoman Cohen:
Is there anyone in Carson City or Las Vegas who wishes to come forward in support of the bill?

Helen Foley, representing Nevada Assisted Living Association:
We represent the large and small group homes. We could not be more pleased with this legislation. Since the horrible *Reno Gazette-Journal* article in 2016 that talked about the squalor, we have been screaming and yelling to our lawmakers to please do something about this terrible situation. Both of the audits that came through this last time—the financial one as well as the one concerning the conditions of those facilities—were just jaw-dropping, disgusting, and very shocking. I appreciate the work that you, Madam Chair, did during the 2017-2018 Interim, with your Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs, along with the outgrowth of Assembly Bill 131 which just passed this Committee on March 8, 2019. Many of the issues dealing with community-based living arrangements—and what you heard from Assemblywoman Teresa Benitez-Thompson about what the Department of Health and Human Services is doing to try to regulate them—are codified in that legislation.

However, since there are so many community-based living arrangement bills out there, one thing I believe you will have to do is align them. I know of a few inconsistencies between them. For example, a bill proposed by the Audit Subcommittee still talks about the certificate that homes receive, whereas A.B. 131 discusses homes as actually having full-fledged licensure. All would be falling under NRS Chapter 449, so there will have to be a gathering of the minds at some point between the two houses to resolve this conflict. But it is a wonderful bill, which reflects how thoroughly the Assemblywoman has investigated this, and how she put her heart and soul into it.

Sarah M. Adler, representing National Alliance on Mental Illness Nevada:
The dismal, squalid, and harmful conditions in which the mentally ill have been living in Nevada cannot be overstated. Nevada's mentally ill population deserves the expectations and standards laid out by the Majority Floor Leader, Assemblywoman Benitez-Thompson. We truly appreciate her work and her vigor. We also appreciate the work and vigor of the Legislative Auditors and the Legislative Audit Committee who have followed through with this bill so well.

We say yes to the common language. Individuals with mental illness have a hard enough time communicating even without having someone there who does not speak their primary language. We also say yes to the rehabilitative services in the bill. We, the National Alliance on Mental Illness, believe in recovery and the opportunity for improvement in quality of life. That is, however, only going to happen if a client is living in an environment of engagement. To have a specific focus on rehabilitative services is truly fantastic.

We say yes to the telephone feedback and complaint line. What we really want in these living environments is a climate of mutual accountability. Having that complaint line phone number prominently placed in the home gives those who are in the home—family members, support, or those providing rehabilitative services—the opportunity to report unacceptable conditions and creates that oversight loop that Assemblywoman Titus was referring to.

We say double yes to billing accountability. There is not an extra dime of funding available for mental and behavioral health in our state. The number mentioned, $1.5 million, would fund year one of the Medicaid IMD [Institutions for Mental Diseases] exclusion, which is a goal of the mental health community in our state. Overall, we are very thankful for this bill and we are in support.

Chairwoman Cohen:
I see no other support. Is there anyone in Carson City or Las Vegas who wishes to come forward in opposition to the bill? [There was no response.] Is there anyone in Carson City or Las Vegas who wishes to come forward as neutral? [There was no response.] The Majority Floor Leader signals to me that she will waive her closing remarks on the bill. With that, I will close the hearing on A.B. 252. I will open for public comment. Is there anyone wanting to come forward in northern or southern Nevada? [There was no one.] Do any of the Committee members have any comments? [There was no response.] The meeting is adjourned [at 3:24 p.m.].

RESPECTFULLY SUBMITTED:

_____
Christian Thauer
Committee Secretary

APPROVED BY:

_____
Assemblywoman Lesley E. Cohen, Chairwoman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a document titled "Adult Mental Health Services Community-Based Living Arrangement Homes," highlighting Legislative Auditor report # LA18-13, published by the Audit Division of the Legislative Counsel Bureau, dated January 17, 2018, and presented by Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27.

Exhibit D is a document titled "Adult Mental Health Services Community-Based Living Arrangement Homes, Residential Services Payments," highlighting Legislative Auditor report # LA18-24, published by the Audit Division of the Legislative Counsel Bureau, dated October 29, 2018, and presented by Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27.

Exhibit E is page 1 of the copyrighted article "Erratic oversight left mentally ill living in squalid Sparks home," authored by Anjeanette Damon, dated February 25, 2016 (updated February 29, 2016), published by the *Reno Gazette-Journal*, and presented by Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27.