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

Eightieth Session
April 10, 2019

The Committee on Health and Human Services was called to order by Chairwoman Lesley E. Cohen at 12:34 p.m. on Wednesday, April 10, 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
Assemblywoman Michelle Gorelow
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:

Assemblyman John Hambrick (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27
Assemblywoman Maggie Carlton, Assembly District No. 14
Assemblyman Jason Frierson, Assembly District No. 8
Assemblywoman Shea Backus, Assembly District No. 37

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Richard Whitley, Director, Department of Health and Human Services
Maya Holmes, Healthcare Research Manager, Culinary Health Fund
Tom Clark, representing Nevada Association of Health Plans
Chelsea Capurro, representing Health Services Coalition
Stacie Sasso, Executive Director, Health Services Coalition
Jim Sullivan, Legislative Representative, Culinary Workers Union, Local 226
Marcia Turner, Chief Administrative Officer, University Medical Center, Las Vegas, Nevada
Alfredo Alonso, representing UnitedHealth Group
Eileen Moynihan, Private Citizen, Las Vegas, Nevada
John Tessee, Private Citizen, Dayton, Nevada
Ryan Uhlmeyer, Private Citizen, Reno, Nevada
George Ross, representing Hospital Corporation of America
Michael Heil, Principal, Healthworks
Katie Roe Ryan, Director, Public Policy, Dignity Health-St. Rose Dominican
Jesse A. Wadhams, representing Nevada Hospital Association
Dan Musgrove, representing Valley Health System
Bobbette Bond, Senior Director of Health Policy, Unite Here Health
Hanna Olivas, Private Citizen, North Las Vegas, Nevada
Nick Vassiliadis, representing Anthem, Blue Cross Blue Shield, and Blue Shield Healthcare Solutions
Philip Ramirez, Chief Compliance Officer, Prominence Health Plan
Dean Polce, Private Citizen, Las Vegas, Nevada
W. Bradford Isaacs, M.D., President, US Anesthesia Partners-Nevada
Kanani G. Espinoza, representing Boyd Gaming Corporation
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Maria Jimenez, Private Citizen, Las Vegas, Nevada
Nelson Lucero, Private Citizen, Las Vegas, Nevada
Jessica Ferrato, representing American College of Emergency Physicians
Lindsay D. Knox, representing Nevada Orthopedic Society; and Nevada State Society of Anesthesiologists
Alex Ortiz, Assistant Director, Department of Administrative Services, Clark County
Bill M. Welch, President and CEO, Nevada Hospital Association
Joanna Jacob, representing Physicians for Fair Coverage
Damon Haycock, Executive Officer, Public Employees' Benefits Program
Cam Scott, Government Affairs Manager, Nurse-Family Partnership

Joelle Gutman, Government Affairs Liaison, Office of the District Health Officer, Washoe County Health District
Sarah D. Larrabee, Private Citizen, Henderson, Nevada
Romina Lizaso, Private Citizen, Las Vegas, Nevada
Kristen Krisyna, Private Citizen, Las Vegas, Nevada
Jessica Lagor, Private Citizen, Mount Charleston, Nevada
Cassia Lopez, Private Citizen, Logandale, Nevada
Emily Tuttle, Private Citizen, Las Vegas, Nevada
Clarissa Luna, Private Citizen, Las Vegas, Nevada
Shanna Martinez, Private Citizen, Las Vegas, Nevada
Janine Hansen, State President, Nevada Families for Freedom
Ross E. Armstrong, Administrator, Division of Child and Family Services, Department of Health and Human Services
James Oscarson, Private Citizen, Pahrump, Nevada
Trey Delap, Director, Group Six Partners
Graham Galloway, representing Nevada Justice Association
Lindsay E. Anderson, Director of Government Affairs, Washoe County School District

Chairwoman Cohen:
[Roll was called. Committee policies were explained.] We will take the bills out of order. We will hear Assembly Bill 471 first, followed by Assembly Bill 317, Assembly Bill 430, Assembly Bill 340, and Assembly Bill 469. We have a very full agenda, which also includes a work session. I will open the hearing on Assembly Bill 471 and invite the Majority Floor Leader, Assemblywoman Teresa Benitez-Thompson, to present the bill.

Assembly Bill 471: Revises provisions relating to supported living arrangement services. (BDR 39-178)

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27:
You have before you a two-section bill that is only half a page long. Its meaning, however, is significant. The bill is brought forward in response to the March 19, 2019, Performance Audit of the Department of Health and Human Services Aging and Disability Services Division's Supported Living Arrangement Program [Legislative Auditor report number LA20-06, (Exhibit C)]. You have already heard a lot on different audits during this legislative session, such as on the audit on the Community-Based Living Arrangement Program. This bill and audit report specifically concern the Supported Living Arrangement Program.

The good news is, we had a very good audit. This program is doing great things, and is serving the people who are in its purview very well. The one thing, however, that we do need to address is in Appendix A of Legislative Auditor report LA20-06, and is a legal opinion [page 19, (Exhibit C)]. The question therein raised is whether the statutes, as currently written, are allowing the Division to service the people in a holistic way. After six pages the legal opinion establishes: No, our statutes are not empowering the supportive living

arrangements (SLAs) to address all of the person's needs. If a person is walking into an SLA with an intellectual or developmental disability, the SLA can only offer a care plan around this intellectual or developmental disability; it cannot address any secondary diagnoses such as any other mental health problems. The SLAs are, however, trying to address secondary diagnoses nonetheless—and we want them to do that. The bill brings about a change in statutes to allow these efforts to continue to happen.

Section 1, subsection 3, states, "The holder of a certificate to provide supported living arrangement services may provide such services to any person with a primary diagnosis of an intellectual disability or developmental disability, including, without limitation, such a person who has a secondary diagnosis" in the area of mental health. The SLAs can then service both of those diagnoses. That is what we are trying to do. I will accept any questions that Committee members may have.

Chairwoman Cohen:
Committee, do you have any questions? [There was no response.]

It is a brief and important bill. We worked on this a lot during the 2017-2018 Interim, trying to resolve these issues for people in our community who need extra assistance in their living situations and daily lives. We appreciate your bringing the bill forward.

Is there anyone who would like to speak in support of Assembly Bill 471 in Carson City or Las Vegas? [There was no response.] We will move to opposition—is there anyone wishing to come forward in opposition? [There was no one.] Do we have anyone in neutral? [There was no response.] I see that the Majority Floor Leader, Assemblywoman Teresa Benitez-Thompson, waives her final statement. I will close the hearing on A.B. 471 and open the hearing on Assembly Bill 317.

Assembly Bill 317: Revises provisions governing the licensing and operation of certain medical facilities. (BDR 40-1034)

Chairwoman Cohen:
We do have an amendment, which was uploaded on the Nevada Electronic Legislative Information System (Exhibit D), and I believe we are going off of the amendment completely.

Assemblywoman Maggie Carlton, Assembly District No. 14:
Yes, this is one of those amend-as-a-whole bills. I will go through the two conceptual amendments (Exhibit D) and take questions after each one of them.

As far as the first conceptual amendment goes, I was so thrilled when we received the *Executive Budget* and it turned out that the Governor included the Consumer Health Protection Bureau within the Office for Consumer Health Assistance, Department of Health and Human Services. We have been talking about establishing this as a patient protection bureau over the past years. There is an appropriation that goes along with this inclusion.

Knowing that this bureau is going to need to take a look at how things in health care happen in the state, we wanted to be able to get the best data possible.

So many times, particularly concerning health care, it is hard to get the actual data. Often, we have to decide on bills, maybe not on pure anecdote, but on the basis of insufficient information. Nevada has gotten much better in this respect over the years. I believe that this first conceptual amendment will really help the bureau to be able to get the data that it needs to address some of the concerns that I am sure a number of you have heard in relation to health care in the state.

The first conceptual amendment actually came from Colorado. The legislative declaration that went along with it was so good that I felt it would be good to share parts of that with you. We really do want more accountability and more transparency in our health care system. Being able to look at the costs is very important for consumers in order for them to be able to make health care decisions. Having the identifiers this bill proposes would generate the necessary information—including, perhaps, the costs associated with seeking services.

The amendment is geared towards the off-campus facilities—or what we have been calling in the Legislature the free-standing emergency rooms. It has been noticed that often, these off-campus facilities use the same identifier for billing purposes as their affiliated hospital or organization. Being able to have a distinct identifier for each one of those off-campus facilities would give the bureau, this Committee, and others who are interested in this issue, real data on what is actually happening. The bill would require all the off-campus facilities to get this identifier.

It has been brought to my attention by a number of persons that there are a lot of services that are done ancillary to the hospital and off-campus. We are talking about labs or blood draws and things along that line. I understand there are concerns. I am more than happy to meet with anyone who wishes to bring forward these concerns to make sure that the bill meets the different needs. We do not want to get a separate identifier for every small service that gets provided ancillary to the total treatment. But we do want to have an identifier for those off-campus facilities so that we can actually understand what is going on. That is the crux of the discussion that I have had surrounding conceptual amendment number one. I abbreviated this discussion greatly. I would be happy to share the four pages of testimony with anyone who would like it.

Chairwoman Cohen:
Committee, do you have any questions? [There was no response.] Up until now, what we heard about the bill is that it is about getting proper data.

Assemblywoman Carlton:
It is asking the individual facilities to have an identifier that would be put on the medical bills. This would allow the Consumer Health Protection Bureau to move forward based on a basis of sufficient data and knowledge. It would also allow this Committee, when it has

conversations about some of the issues that arise around billing and cost, to have an identifier and thus a proper information base.

Chairwoman Cohen:
I am seeing no questions. Please move on to the second conceptual amendment.

Assemblywoman Carlton:
I owe the Committee an apology for the second conceptual amendment, as it is somewhat incomplete. I wanted to get something in writing to the Committee within the right time frame and so was not able to include everything that needs to be discussed in relation to it. My testimony will, however, clarify how it all fits together.

I have had many conversations on the issue of trauma designation of medical facilities. The concerns I heard on this issue relate to the Southern Nevada Health District not making its decisions regarding trauma designation based on an adequate community needs assessment.

In 2005, trauma designation moved from the state to Clark County. I believe that we need to bring the state back in again to ensure that shortage areas are adequately identified and developed according to a two-tier evaluation process. The second conceptual amendment proposes that the American College of Surgeons' Needs Based Assessment of Trauma Systems should be applied to evaluate whether trauma designation should be granted to an applicant. This would, however, only be a small portion of the two-tier process this bill envisions. It would concern the initial evaluation of the applications hospitals would submit to the state.

While researching how the needs-based assessment envisioned by the second conceptual amendment could be conducted, we actually read some of the minutes of the meetings of the American College of Surgeons. It became apparent that their goal is to produce a pragmatic and relatively simple tool that could be applied to the data that is currently available. The tool is constructed to aid the assessment of the number of trauma centers needed in a specific geographical region—so-called Trauma Service Areas (TSAs).

The key part I was not thoroughly aware of until I learned more about it is that this assessment tool is not meant to also be the designation tool. The American College of Surgeons' Needs Based Assessment of Trauma Systems presumes that the need is to be evaluated and established on the TSA-level—which could range in size from a small county to a multi-state region—while the trauma designation should lie at the state level within the Department of Health and Human Services and its trauma board. The board would look at what we call Health Professional Shortage Areas (HPSAs).

For HPSAs, we have a process in place that actually works. We apply it for federal loan repayment; for federally qualified health centers and where they will be located; and for J-1 visa physician placements. We already have a system set up in the context of which we could look at an area and decide, Is that a trauma—for lack of a better term—desert? Is there an area in which we really need to place a trauma designation? The state would have the

responsibility to look at it and use data to figure out what is needed. If there is a request for a trauma designation, there are four components that would be considered in this assessment tool. The applicant would bring that to the state, and then the state would look at it and then it would send it back down to the Health District.

There have been issues that people have brought forward to me about the health districts' role in this. Not long ago, there were a number of applications that were placed. They were not approved, and after that, it was discussed that the Southern Nevada Health District would do a community needs-based assessment so that it could look at southern Nevada holistically as far as trauma goes. It is now 2½ years later and that community needs assessment still has not been done. There are trauma applications in the queue right now. It is kind of antithetical. You may think, The more trauma the better—but that is not necessarily true for the different areas. There are experts here who can explain that in detail and walk you through these arguments. It was also a hard thing for me to wrap my brain around, how trauma designation actually works. It is a very fine balancing act to make sure that there are the right services in the right place for the right level of trauma so that patients are taken care of. That golden hour is very important. We have heard that about heart attacks, strokes, and a number of different emergencies that can happen. The concerns that were brought forward to me were that, in order to address this issue, bringing the designation of trauma areas back to the state level could help resolve the problem.

In closing, to put the facts on the table, this would take local politics out of trauma designation. Those do not belong in trauma designation. This allows for a measured, thoughtful, and consistent approach to decision-making when it comes to designating trauma. We would conduct a statewide needs-based assessment, and we would look at it and then decide what needs to be done. There would also be statewide evaluation and statewide reporting. This body would be able to go to the state and ask, "Where are we with this? What do we need? Where do we need to go?" I have a lot more information for you, but in the interest of brevity I will stop here. I realize that the second conceptual amendment will probably need more language to build that state piece in. I will be more than happy to work with staff to make sure that the second conceptual amendment delineates very clearly a two-stage process to make sure that the public is protected.

Chairwoman Cohen:
We will take some questions.

Assemblywoman Duran:
How will the state determine whether the counties need more trauma designations?

Richard Whitley, Director, Department of Health and Human Services:
We would recommend to Assemblywoman Carlton that we be allowed to make regulations to establish the criteria and work with stakeholders. That is typically how we conduct our regulatory oversight of health facilities, including hospitals. Assemblywoman Carlton mentioned one variable being the American College of Surgeons; however, data is the other variable. We are constantly getting additional data. We would want to develop those

regulations in a public forum with all the variables considered. We also have other states that have used various criteria that we would look at to see what their successes were.

Assemblywoman Duran:
Is there any data collected that you have now and utilize in making any of these determinations?

Richard Whitley:
The first part of the bill laid out one problem that we confront. We are seeing more hospitals looking to have off-site emergency rooms. That data does not get collected. A hospital could have an emergency room 30 miles away from the actual hospital, but the data that is collected only shows that hospital. I think the first part of this bill will help us with having a better understanding of what the access issues are concerning emergency rooms.

Assemblyman Thompson:
My question relates to the idea of utilizing the American College of Surgeons' Needs Based Assessment of Trauma Systems. Was the University Medical Center (UMC) certified by them? Would UMC not be considered the baseline for our state? If we now went with another certifying organization, would that not skew our quality? Who was it that certified UMC?

Richard Whitley:
The state served in that certifying role when UMC gained trauma designation. The American College of Surgeons did revise its criteria in 2011. As a state, with our regulations, I believe that we do have to be nimble enough to change as well when standards change nationally. The criteria do not look the same as they did back when UMC was certified. The intent cannot be to look backwards and look at the existing trauma centers and the designations. It is the going forward that this bill is concerned with, and the concern is that we want to have a better understanding of what the need is.

Assemblywoman Carlton:
I would like to add that UMC became a trauma center long before 2005. It was, however, only in 2005 that the change was made from a total state to a local control-based designation process.

Chairwoman Cohen:
Do I understand it correctly that the American College of Surgeons' Needs Based Assessment of Trauma Systems is the generally accepted standard that has been used? It is not that 30 states use a different standard and we are using one that no one else is using, correct?

Richard Whitley:
That is correct, this is the standard. I was only pointing out that this standard has changed. It was revised in 2011.

Assemblywoman Carlton:
I believe they are currently in the process of another reevaluation of the standard. They are constantly updating and moving forward as issues arise within the health care field.

Chairwoman Cohen:
Do we have any other questions? [There were none.] Is there anyone in support who wishes to come forward here in Carson City?

Maya Holmes, Healthcare Research Manager, Culinary Health Fund:
We are strongly in favor of Assembly Bill 317 and of having the state have a very clear and vigorous role in identifying shortage areas and assessing the need for trauma expansion. It is critical for Nevada to have an effective, financially stable trauma system based on identified and verified community needs, which ensures that our patients get the right care when they need it. This is an incredibly important step because in southern Nevada, right now, there is an effort to nearly triple the number of trauma centers by adding low-level trauma centers. Just a few years ago, there were three applications for low-level trauma centers. The Health District found that there was no need and rejected those applications.

Now we are back a few years later, and despite the Board of Health having asked in 2016 for a community-wide assessment, it has not been done. We think there is a critical role for the state in this, because trauma centers are so vital to ensuring the health, safety, and well-being of residents and visitors. At the same time, a flood of trauma centers could really undermine our system. Trauma centers need a certain level of patients not only to be financially viable, but also to really assure quality patient outcomes. The higher the number of patients trauma centers see, the better experience the trauma teams have. If you oversaturate the system, you can negatively impact that volume.

Finally, on the issue of the unique provider identifier for health care facilities, we are very much in support. This is really an important transparency and reporting requirement that other facilities such as hospitals and ambulatory surgery centers already provide. We would like to see it extended to these offsite facilities. As payers, this will generate incredibly important information to which we can direct our members to make sure that they are receiving the most appropriate and affordable care. We also think that all of this is vital information for the state to have in its ability to analyze health care costs and access. We are very excited about the Governor's commitment to patient protection and the plan to develop a patient protection commission. This information will be really important and invaluable to that body.

Tom Clark, representing Nevada Association of Health Plans:
Speaking specifically to the first conceptual amendment (Exhibit D), I would like to reiterate exactly what the bill sponsor spoke to, but add that requiring a unique National Provider Identifier will provide more transparency around exactly where those health services are being delivered, and specifically the costs of the services that are delivered in those unique locations.

Chelsea Capurro, representing Health Services Coalition:
I do not want to repeat what has already been said; we are in support.

Chairwoman Cohen:
We will now go down to Las Vegas.

Stacie Sasso, Executive Director, Health Services Coalition:
The Health Services Coalition is in support of the establishment of state regulation around the expansion of existing trauma systems in Clark County to create a two-step process for trauma designations. The regulations that currently exist in Nevada to ensure the careful creation or expansion of trauma centers is limited. While additional trauma centers sound like a good idea in theory, they would pose risks to the entire state by placing existing facilities at risk of saturation.

There are also very limited physician specialists in Nevada. Expanding trauma centers without proven need will create coverage issues in area hospitals and other established centers that are currently meeting all the need in Clark County. This is also true for both on-site coverage as well as on-call specialists. It will be helpful to have a process in place according to which the state has the ability to review the system as a whole as concerns its demonstrated need, rather than individual neighborhoods.

The American College of Surgeons' tool referenced in the proposed amendment should be one part of the process. The state should be determining if there is a capacity shortage before a neighborhood is evaluated. This step is missing today. If a shortage is determined, the county could then be able to move to identify solutions. Ideally, in my own opinion, based on reviewing this over the last year, a request for a proposal-type process would be ideal to determine if capacity is available. Your support of this legislation is critical to protect the state of Nevada's current trauma system.

Chairwoman Cohen:
We will now go back to Carson City to hear further testimonies.

Jim Sullivan, Legislative Representative, Culinary Workers Union, Local 226:
The Culinary Health Fund is the health fund that services our 60,000 members. We are a member of the Health Services Coalition. We fully support this bill for all the reasons that my colleagues just laid out.

Marcia Turner, Chief Administrative Officer, University Medical Center, Las Vegas, Nevada:
I am here in support of the conceptual amendments Assemblywoman Carlton has laid out. We appreciate your time and consideration in this matter. Trauma care is very complicated. It requires a carefully coordinated, systematic approach to making sure that we can work together and meet all the community's needs. We are honored to be part of the Southern Nevada Trauma System and to be working with our partner trauma centers in the south. We

are actively involved in all the discussions that have been going on, and we would like to continue to be involved and be a resource in any way that we can to your Committee.

We agree that the American College of Surgeons is a great resource. It is our understanding that they are in the process of continuing to update their tools. I think that is a really important piece of it. There are also neighborhood nuances that we need to make sure we take into account so that changes to the system are done in the most effective way and without compromising what already exists. We believe that a two-tiered system is a great idea, and having the folks of the state involved is also a really good idea. We need to conduct the most thorough analysis of the data available to determine whether or not there is a need. If there is any level of trauma designation already present, we need to use that data to establish how many trauma centers we need, where they should be located, and what will be the process of determining where the patients are delivered for care. We would recommend a proportionate distribution. But again, we stand by to help in any way that we can.

Alfredo Alonso, representing UnitedHealth Group:
We support Assemblywoman Carlton's attempt to bring more transparency into the process of trauma designation. Obviously, there are a lot of unknowns right now in the health care industry, and we believe that this helps immensely. We are also in support of the second conceptual amendment, as we are very much for the thorough and thoughtful manner in which this bill suggests to look at this issue across the state.

Chairwoman Cohen:
I see no one else in support for A.B. 317. We will move to opposition.

Eileen Moynihan, Private Citizen, Las Vegas, Nevada:
I have been a trauma patient, so I am speaking from that grassroots level. I will put a human face on what trauma is about. Two years ago—the year I turned 72—I fell off a ladder coming down from the roof of my home and landed in a bunch of rocks. That led to the breaking of my radius, ulna, right wrist, and three fractures on my right femur.

I was very impressed with the immediacy of the 9-1-1 response. When I was placed in the ambulance, I was fortunate that I was still able to talk and make my own decisions. I asked where they would be taking me. They said, based on current trauma criteria, they would need to take me to UMC. I knew I would receive outstanding medical care at UMC, but there was one thing they could not provide for me because of the distance from my home. I would not be able to have what has been established to be a very significant factor in good outcomes: the presence of friends and family—the support system that is needed if you go through the surgeries, the in-patient rehab, and the following care that is required. Because I requested to go to MountainView Hospital, which is just less than two miles from my home, they said I needed to sign a paper—which was fine with me. I was able to do that.

My concern is that we have many people in northwest Las Vegas who are seniors, who are very susceptible to falls—which I understand is definitely in the purview of a Level III trauma designation. For many of them, they would not have the understanding that I had of

my ability to request to be taken some place else. Beloved neighbors of mine, for example, are both in their eighties. If he were to fall, she would not be able to drive to a farther hospital to be there for him. For that reason, I am encouraging people to try to look—if you do not mind the analogy—with the eyes of your heart at specific people, your loved ones, and not just at the common good. If you were either in the role of supporting a patient who had a trauma or you yourself suffered a trauma, how important would it be for you to be able to be seen and provided care within that golden hour in a place that is more readily accessible to your family?

Chairwoman Cohen:
Thank you for sharing your story. Just to be clear, are you in opposition of the bill or in support?

Eileen Moynihan:
I am in opposition because there are so many things in place already right now. For example, at MountainView Hospital, where I have volunteered for several years, they have been in a four-year process, and when the College of Surgeons made their visit in January, they saw that everything was already in place. My concern is that, if we try to go back and revisit the gathering of data and apply new tools—even though there are so many things already in place—it will slow down our ability to have Level III trauma centers closer to the areas where there is an already established need. My concern is thus that we need to be expeditious as well as wise.

Chairwoman Cohen:
Thank you for clarifying that.

John Tessee, Private Citizen, Dayton, Nevada:
I am a retired Nevada Highway Patrol Association trooper. I am here in opposition of the bill. I spent the first few years of my career in Tonopah. As you know, that hospital is closed. I witnessed many tragic accidents. Some people never made it off the road and some people made it in an ambulance to that hospital where they could be stabilized and flown out. That hospital is not there anymore. How is this bill going to serve the people in rural communities, where you have a 3½ hour drive to the next hospital with a trauma center or a 1½ hour flight—45 minutes here and 45 minutes back? I cannot imagine how many lives were saved in that hospital. I know there were lives saved. I witnessed it, and I think that this bill takes away the possibility to allow that to happen—and not just for the citizens in the area, but also for the travelers—the people who travel to and from Las Vegas involved in crashes or accidents or any mishaps out there. You are a long way from anywhere in most of Nevada, only a few places of population. I stand in support of all first responders and oppose this bill.

Ryan Uhlmeyer, Private Citizen, Reno, Nevada:
I have first-hand experience with trauma care in Nevada. On December 21, I was involved in a very serious car crash. I was taken to the trauma center in Reno and treated for my injuries. I feel very fortunate to have been so close to a hospital equipped to handle any injury

I sustained. It is scary to think of what would have happened if I had been critically injured in a more rural area of Nevada.

Putting trauma care further out of reach for the people who need it, as A.B. 317 would do, would make Nevada even worse off in comparison to the rest of the nation. Assembly Bill 317 would put unnecessary restrictions on the establishment of new trauma facilities, and this would put people's lives at risks.

Today, you have the opportunity to help people who are less fortunate and who are in crisis. You can oppose A.B. 317.

Chairwoman Cohen:
Director Whitley, could I ask you to come forward again to answer more questions?

Assemblywoman Titus:
I think people are using trauma designation Levels I, II, and III incorrectly. Would you be able to explain what these different designations mean? It is my understanding that we only have one Level II trauma center in northern Nevada, Renown Regional Medical Center. In southern Nevada, we have only one Level I trauma center and then there are several Level IIs. We are a trauma center in my little rural hospital. The law states that first responders have to take patients to the nearest facility for stabilization and then get them to the appropriate Level I or II center if that is indeed needed. I think people are not understanding that this bill does not prevent the first responders from taking patients to the closest facility. Could you clarify that for me?

Richard Whitley:
I think you clarified it perhaps better than I could. Trauma centers work in concert with the emergency medical services which take patients to the nearest facility. The example that was just given in public testimony shows that people can certainly go to an emergency room and will be assessed and then can be transferred to the higher level.

Assemblywoman Titus:
Thank you for that. I just want to make sure that people understand that the rural emergency rooms can and do deal with trauma on a daily basis. This bill does not exclude that. What this bill is attempting is to assess what the trauma needs are, and to establish whether and where we need another Level I trauma center—or do we need a Level III center? What are the needs of the community? This bill would not prohibit any of the currently existing solutions or people accessing care. Quite to the contrary, I think the bill is trying to make sure people have appropriate care and access.

Richard Whitley:
That is correct. I understand that the role the Department of Health and Human Services would play is to provide regulations that specifically define what that need looks like. When a request is made to add additional trauma level sites, we need to be able to base this on the need that exists. This concept works quite nicely, as Assemblywoman Carlton mentioned,

for workforce shortage areas in the areas of health care, primary care, and federally qualified health centers. It actually works opposite to the way that has been insinuated in some of the previous testimonies. We are designating areas that really are in need by doing that assessment. We are not waiting for industry to perhaps come in and make their request to add a new facility or to bring in additional workforces. I see this working in a similar way with respect to trauma designation.

Chairwoman Cohen:
I see no one else wishing to come forward in opposition to A.B. 317 in Las Vegas or Carson City, so we will move to neutral. Does anyone wish to speak in neutral to the bill?

George Ross, representing Hospital Corporation of America:
We are neutral. I want to express our definite appreciation to the sponsor for essentially limiting the original version of A.B. 317. We think that would have been really problematic as far as supplying adequate access to health care. Regarding the new version (Exhibit D), the second conceptual amendment has some issues that need to be further discussed. I have Michael Heil with me, who has forty years of experience across the country in every aspect of trauma care, ranging from analysis to administration. I would like to have him make a few comments.

Michael Heil, Principal, Healthworks:
[Michael Heil also submitted a presentation (Exhibit E).] I have been asked by Hospital Corporation of America to come and share some of my experiences in trauma system planning and operation throughout the last 20 or 30 or 40 years. My experiences include regions as diverse as Alaska, where I helped to write the trauma system plan for that state, Colorado, and Florida—a very eclectic look at the United States and how the various systems work.

I would like to focus, first, on one particular region that I think this Committee might find instructive, which is Sacramento, California. That region happens to be amazingly similar to the southern Nevada region in terms of population, size, and other dimensions. What I would like to call your attention to is that—although there are a lot of good tools that people are developing—I have come to believe that the best and simplest way to understand demand and supply is to look at one simple ratio, which is the ratio of population to the number of Level I plus Level II trauma centers.

I can speak more about why the Level I and Level IIs result in the best ratio. The southern Nevada region has a ratio of 1,150,000 inhabitants per trauma center. That is the total population divided by the two centers—a Level I and a Level II center. The United States average is about 650,000 inhabitants per trauma center. So what we really see is a clear empirical indication that there is a shortage in the southern Nevada region when compared to the U.S. average. Interestingly, the Reno area happens to be right at the U.S. average of about 700,000 inhabitants per trauma center. The southern Nevada region is thus an outlier by national standards, with a relative undersupply of trauma centers. There are only nine other states in the United States that have a greater undersupply. I think the shortage is even

more exaggerated than it might appear because of the rapid population growth right here in this state; the tilt to older individuals; and the influx of visitors. That makes this shortage really bigger than it might appear today.

Let me say a word or two about Sacramento. Over the last 20 years, Sacramento has developed and now has the same population as the southern Nevada region. Originally, there was only one trauma center, downtown at the University of California, Davis (UC Davis), Medical Center, which is a Level I trauma center. Today there are four university medical centers at UC Davis and three Level IIs. Initially people were really concerned about too many trauma centers. But today we find it to be a very stable system. All four trauma centers are financially and, most importantly, clinically, stable and successful.

Katie Roe Ryan, Director, Public Policy, Dignity Health-St. Rose Dominican:
I had provided a letter of opposition to the Committee last Friday (Exhibit F), but based on the current conceptual amendments, we are now in neutral. I wanted to clarify that on the record.

Jesse A. Wadhams, representing Nevada Hospital Association:
We appreciate Assemblywoman Carlton's explanation and the proposed amendments. In concept they sound like something we could probably be supportive of. We just obviously first want to see the underlying language. We look forward to working with her to help develop the underlying policy.

Dan Musgrove, representing Valley Health System:
We have two facilities in southern Nevada that have put in applications to the Southern Nevada Health District for trauma designation. I want to thank Assemblywoman Carlton for changing A.B. 317. We are neutral at this point, and echo the comments of the Nevada Hospital Association. We want to see what the bill shakes out to look like. Obviously, we need to make sure that the community is well-served.

Assemblywoman Carlton:
We have hit that deadline mode and you are working from concepts that are constantly evolving. I apologize for that and will make sure that we get the best language to you. I commit to making sure that part one and part two of the conceptual amendment all get put together for you, and I commit to making sure that folks are aware of what we are trying to do.

As far as some of the opposition that came forward is concerned, I am not sure whether it was against the first or second conceptual amendment—or if it might have been with the original bill and the 30-mile designation therein. That is something that had been brought up to me by Assemblywoman Titus when the bill was first released. The story of losing our facility in Tonopah was also heartbreaking to me. I worked with former Assemblyman James Oscarson [Assembly District No. 36] on trying to save that facility for over a year because it is very important to that area of the state. Unfortunately we were not successful.

I totally understand these concerns and I know that our first responders need to have a place to go to. Going forward, I am happy to talk to them.

When we are having conversations about Level I and Level II designations, it is important to clarify that most applications that have been submitted are for a Level III trauma designation. There is a very fine line that goes from emergency room care Level III to trauma designation. Making sure folks understand that is important. I understand that young lady who had her 72nd birthday just two years ago—I have found myself in a situation with a heart condition and a daughter who was ill. Knowing that the hospital is within just a couple of miles or so and that the paramedics can get you to the appropriate level of care, if needed, is very important to all of us. We would never want to slow that down. We also understand that this needs to be a thoughtful, deliberate, data-driven process so that trauma rooms do not end up in more affluent areas only and not in an area that really needs them. We want to make sure that they are placed strategically to serve everyone within the community. I commit to working with folks going forward on this issue so that the state and the county can work together to get this issue addressed.

Chairwoman Cohen:
I will close the hearing on A.B. 317. As Assemblywoman Carlton just said, it is that time in session. We will have to deviate from the road map I gave at the beginning. We are now going to hear Assembly Bill 469 and welcome up the Speaker of the Assembly, Assemblyman Jason Frierson.

Assembly Bill 469: Revises provisions governing billing for certain medically necessary emergency services. (BDR 40-704)

Assemblyman Jason Frierson, Assembly District No. 8:
Assembly Bill 469 concerns what has become commonly known as surprise billing or balance billing. I want to state at the outset that this bill reflects conversations I had throughout the past entire legislative interim about taking the patient out of the negotiation process for bill charges in emergency rooms. There has been a great deal of work that I have been able to monitor over the past 1 1/2 years in this context. It is a complicated area, but we have been making more progress on the issue of surprise billing than we have made in this state in probably over a decade of discussing it. I joined in on that discussion to make sure that we put something in writing and to ensure that the stakeholders came together and found a viable solution. As I said in other hearings, if everybody is moderately annoyed by it, it probably is a good thing. We have come up with a structure that does not make any stakeholder completely happy, but it does protect patients, and that is what we set out to do.

Overall, the problem is the following: third-party health care payers are responsible for providing members with access to appropriate quality care at reasonable cost. This is accomplished by engaging in contractual partnerships with hospitals, physicians, and other providers. These partnerships are critical in order to keep premiums and rates affordable for employer-sponsored plans and individual policy holders. The respective insurance contracts provide agreed-upon rates that are substantially discounted. As the market place dictates,

sometimes payers are fortunate to contract for discounted rates with all hospitals in the community and physicians practicing at those hospitals. But sometimes, business negotiations fail and prevent payers from contracting with all hospitals or physicians.

The standard practice in the majority of benefit plans requires the member to obtain non-emergency care through contracted physicians of preferred hospitals. The payments for services in care are the agreed-upon contract rates. In emergencies, the member presents at the nearest hospital, and that might be out of network. In these instances, the patient is billed at a rate that is substantially higher than the contractor rate for services provided by an out-of-network hospital or provider. Health insurances may only cover a small portion of the cost—or none of the cost at all. Under those circumstances, the patient is financially vulnerable, even if they have health insurance.

Assembly Bill 469 seeks to address that problem. I will go through how it does so now. First, the bill prohibits an out-of-network provider who provides medically necessary emergency services to a person covered by a policy of health insurance from charging the person an amount that exceeds the copayment, coinsurance, or deductible required by their policy. This is the fundamental purpose of A.B. 469, to make sure that, if you have insurance that has costs spelled out, you are taken care of. We let the providers and payers deal with how to resolve the difference. It also requires an out-of-network facility, under the aforementioned circumstances, to notify the third party that provides coverage for the patient that the patient is receiving services at the facility. And it requires this facility to transfer the covered person to an in-network facility no later than 24 hours after the person's emergency medical condition is stabilized. We obviously do not want to compromise the safety of a patient, but when it is safe to do so, we want to ensure that costs are minimized by transporting patients to an in-network facility.

The bill also establishes a basis for payment under two different scenarios. For providers in network or who were previously contracted within the last 24 months, the bill requires that the third party pays—and the provider accepts—compensation for those services within an amount based on what would have been paid for the services under the most recent contract between the third party and the provider. The third party will pay 108 percent of the amount if they are less than 12 months out of network, and 115 percent if they are more than 12 months but less than 24 months out of network.

I realize that is a mouthful. Essentially, if a third-party insurer is in contract, it will pay the contracted rate. If they are out of contract for a year, they are going to pay 108 percent of what the previous contracted rate was. If they are out of contract between one and two years, they pay 115 percent of what their contracted rate was.

What we are trying to do here is create an atmosphere where there is encouragement to enter into contracts. There needs to be a basis for out-of-network emergency charges. Everybody has a certain level of expectation about what the charges are going to be. In the spirit of keeping the patient out of all of this, we are trying to create a scenario in the context of which contracts are encouraged. For providers who have never been in contract or are beyond that

two-year period of the last contract, the third party is required to make a final offer of payment to the provider for the medically necessary services. If the provider does not accept that offer, the parties are required to submit to binding arbitration. I did not know that term—as I am a football player, not a baseball player—but this is what is called a baseball-style arbitration where basically one party makes an offer, the other party makes a counter-offer, and if they cannot resolve their differences, they go to arbitration.

Once again, this is designed to encourage folks to enter into contracts. To be clear, this measure also applies to providers of health care, hospitals, and independent centers of emergency medical care that have not entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance. However, this bill does exempt critical access hospitals and does not apply to a person covered by a policy of insurance sold outside of Nevada.

I cannot emphasize enough the amount of work and collaboration amongst all stakeholders that have gone into the bill. I believe we have come closer than ever to something that is workable since this issue has been raised in Nevada. I know that everybody has been at the table and has been able to express their concerns. The bill is not ideal for anyone, but it is great for the patient. That is what we set out to do.

There are a couple of conceptual amendments that I expect and do consider to be friendly. I know that there is a set of technical amendments that I know are necessary, which will be discussed by the hospitals. There is also the concept that there will be a reporting mechanism on whether or not providers are dropping out, whether or not they are terminating contracts. We are going to assess the effectiveness of what we are trying to do here. I consider this request to be a friendly amendment as well. I do expect there to be continuing conversations about this challenge and how it is best resolved. We are, in my opinion, far too close to walk away from the opportunity to take the patient out of the middle here. That is what we set out to do over the past two years.

I would also like to acknowledge Assemblywoman Carlton. She sweated a lot on the field on this issue and worked really hard over the years. This largely reflects what she has done in previous sessions. I applaud again the stakeholders who came together to have these conversations. There may be a few outstanding issues that we need to resolve. I am confident that we will get there. I am welcoming the collaboration, and I look forward to getting this done in short time and moving a measure that will protect patients.

Chairwoman Cohen:
Would you like to take questions now, or do you have more people presenting?

Assemblyman Frierson:
I am happy to take questions to the extent that I am able to answer them on a technical level. I will certainly be able to answer questions about the intent of the bill and the nature of the discussions leading up to where we have come. I know that the payers and providers are

both here today. I would let them answer the technical questions, while I will take any questions on the intent of the bill.

Chairwoman Cohen:
If someone is being transported 24 hours after having been stabilized in an out-of-network facility, who pays the cost of the transfer? That can be very pricey.

Assemblyman Frierson:
I will phone a friend on that. I believe there are stakeholders here in the room who will absolutely be able to answer this question.

Assemblywoman Titus:
Thank you, Assemblyman Frierson, for bringing the bill forward. It did take a lot of work, and I would like to express my appreciation for all your time and to all the stakeholders coming to the table to make this bill happen. I think it is important.

I know you want to take the patient out of this mix. However, as a provider, you really cannot totally insulate the patient. Specifically, in section 6 of this bill, you talk about somebody presenting to the emergency room. I appreciate this component, because if somebody shows up to our emergency room with chest pain that might only be indigestion, we determine it is not an emergency. But the patient thought it was an emergency. Frequently, the payment gets denied because it was not a true emergency. I just want to acknowledge the importance of this component. If a patient thought she or he had an emergency, comes to the emergency room, but we, the medical caretakers, determine it was not really an emergency, frequently the payment gets denied. That clarity is critical for helping us out on that end and getting those situations paid.

Assemblyman Frierson:
That is a valid point, and I think there is actually another bill drafted to address that specific issue—I believe it is Assemblywoman Carlton who has been working on that issue. There is a bill to deal with that separately from the billing issue that is addressed in this piece of legislation—even though I would agree, the two issues of surprise billing and the issue you raised are related.

Assemblyman Hafen:
Thank you, Assemblyman Frierson, I think this is a very important issue. Concerning the proposed reporting aspect, would that report then come back to this Committee at the next legislative session? When would that report be put together and presented to us?

Assemblyman Frierson:
I would prefer to let those folks who are familiar with the language of that amendment speak to that because I do not have the amendment yet. I believe that is an agreed-upon conceptual amendment to allow for reporting back—whether it be to the Legislature or the Legislative Commission throughout the legislative interim. The point is for us to be able to have information on the impact this policy is going to have so that we can monitor and adjust.

Assemblywoman Gorelow:
What if there is a fourth party? For example, another insurance company like car insurance, becomes primary and the medical, secondary. Is that accounted for in the bill?

Assemblyman Frierson:
I will let the persons who represent these entities answer this question. It sounds to me like that is more like a personal injury issue with respect to litigation, whereas the bill is about emergent care.

Assemblywoman Gorelow:
I was talking about emergent care, when someone enters an emergency room after a car accident. In this situation, the car insurance may become your primary insurance. But then, after your $1500 or $2000 is taken care of through the car insurance, it should revert to a secondary medical insurance—though it sometimes does not revert to the secondary insurance at that point. I was wondering whether the bill forces the involved insurers and the provider to work that out in the back room.

Assemblyman Frierson:
I will let the folks who are in the weeds on the practical aspects of the bill answer that question.

Chairwoman Cohen:
We will ask supporters in Carson City and Las Vegas to come up to answer the technical questions.

Bobbette Bond, Senior Director of Health Policy, Unite Here Health:
I am the Policy Director for Unite Here Health nationally, which in Las Vegas is the Culinary Health Fund. We are responsible for providing benefits for 130,000 members and their dependents in Las Vegas. We are also part of the Health Services Coalition. Mostly, we want to thank Assemblywoman Carlton for kicking the ball and doing all the work last session to get a bill through that was then vetoed by the Governor. We had an earlier version of this same result in 2011, when we tried to pass a bill that would have resolved these issues. We are very excited that we are so close on this legislation, and we really appreciate the Speaker, Assemblyman Frierson, picking this bill up and making sure that it saw its way through the entire Committee. We are very supportive; we have an issue with one section of the bill that we are hoping to continue to work with the Speaker on. We hope that the conceptual amendment on that piece of the bill comes back to you soon. We are very happy about the rest of the bill.

As to the questions that have been raised, I will start with the issue of paying for a true emergency versus a non-true emergency. I do not believe that specific issue is handled in this bill. Assemblywoman Titus, I understand what you are asking about, but I think that is a different set of issues. This bill is meant to get the patient out of having to pay non-PPO [Preferred Provider Organization] rates which are often way beyond in-network rates. There

is progress, but I cannot say that every insurance company is going to do about true versus non-true emergencies.

To Assemblywoman Gorelow and your question about medical insurance payment—third- or fourth-party payment—I think this will depend on which sections of the *Nevada Revised Statutes* are included in this code, and whether this code is extended to all sections. If it is, then the patient is going to be held harmless regardless, but I am not sure who pays what in the solution. It could be that it works out in the back. In this situation, our expectation is that the patient is held responsible only for their in-network cost share regardless of how we cook the sausage.

Chairwoman Cohen:
I was wondering about the cost of transportation, 24 hours later, when the patient has been stabilized and is transferred. Who is paying for that?

Bobbette Bond:
The way it works in the rest of our industry is, if the hospital requires a transfer—sometimes they cannot take care of the patient with all the services the patient needs—they would be responsible for that transfer. But if they are caring for the patient, stabilizing the patient, and then notify us that the patient is out of network, it is on the payers to pay for the transfer of the patient to an in-network facility.

Chairwoman Cohen:
We are not anticipating that this is a bill that the patient gets, correct?

Bobbette Bond:
The patient will be paying the copay for having an ambulance, but not anything relating to out-of-network billing.

Chairwoman Cohen:
Are we capturing situations in which you go to the hospital and the hospital is in network, but the hospital contracts with a provider who is out of network? Is that being captured in this so that people are not getting those bills that can sometimes be exorbitant?

Bobbette Bond:
Assemblyman Frierson has ensured that this bill will be comprehensive. As written, and with the conceptual amendment, both facilities, including the free-standing emergency rooms that you are hearing about—Elite Medical Center facility—and the physicians who are caretakers inside the hospital but out of network, will have to find a solution. We have a lot of cases in which the patient is in network. The patient goes to a hospital in network, but the doctor and anesthesiologist or any other doctor is not in network. This bill is addressing this situation.

Chelsea Capurro, representing Health Services Coalition:
[The Health Services Coalition submitted, but did not discuss, three documents with background information on "surprise bills," which will become part of the record

(Exhibit G), Exhibit H, and Exhibit I).] I would like to echo Ms. Bond's comments thanking the sponsor and all the groups that have come together to work on this. It is not an easy topic. We still have some work to do, but this is as close as we have ever gotten. The number one goal is to get the patient out of the middle. The second goal for us is to encourage contracting on both sides.

Chairwoman Cohen:
We will go down to Las Vegas to hear more support.

Hanna Olivas, Private Citizen, North Las Vegas, Nevada:
I am testifying today in support of A.B. 469. I had to visit a hospital emergency room for pneumonia in August 2018. We paid $100 out-of-pocket that day and we were later told we still owed $250 more just for our copay. Three months later, we received a bill for over $800. I was very upset and disappointed because even though I am battling a rare and incurable blood cancer, we have always stayed on top of our medical bills.

I started receiving phone calls daily asking when we could pay our $800 bill. I asked to set up an arrangement and was told I could split it into two payments, the first one being right then and there. I laughed and hung up. Since this happened, we have been sending in $25 a month on our own and are still receiving phone calls. This entire situation has been stressful and sad.

I support A.B. 469 and ending surprise balance billing. Nevadans should not risk medical debt, and we need to do everything we can to reduce excessive health care costs.

Stacie Sasso, Executive Director, Health Services Coalition:
I am representing 25 employer and union self-funded health plans in southern Nevada, covering roughly 280,000 covered lives. We are in support of the concept of A.B. 469. Since there is no patient protection policy in place right now, this is a step in the right direction to make sure that the patient is taken out of the middle, and to prevent patients from facing medical bankruptcy. Medical bankruptcy is oftentimes the result of accessing care in an emergency situation and then later finding out that the provider was not in network. When you are in those situations, you are not stopping the provider at the bedside to say, "Hey, are you on my insurance? What is my financial obligation going to be at the end of this?" You are worried about getting better. Being thousands of dollars in debt as the result of your health care is a problem that needs a solution. We appreciate Assemblyman Frierson's hard work and look forward to continuing to finalize details and get to a resolution that is helpful for all parties involved.

Chairwoman Cohen:
We are going back to Carson City to hear more support.

Nick Vassiliadis, representing Anthem, Blue Cross Blue Shield, and Blue Shield Healthcare Solutions:
We also would like to thank Assemblywoman Carlton for all her hard work, and Assemblyman Frierson for jumping straight into it headfirst and getting down in the weeds and trying to help us figure out how to do this correctly. We are very much in support of this bill. We thank everybody for the hard work that has gone into it. We also recognize that there is still a lot of hard work to be done before we will get across the finish line. We are committed to that effort.

Alfredo Alonso, representing UnitedHealth Group:
We also commend Assemblywoman Carlton and Assemblyman Frierson for all the hard work. This bill has been a decade in the making. Clearly, it is not an easy, but a very difficult, task. Everyone in this room can probably tell you that this is the closest that we have ever been to finding a solution. We thank the parties and everybody who has been involved in this, and we hope to continue to be involved. There is some language that still needs to be massaged. Ultimately, questions such as, what is a contract, will be important to flesh out because some agreements are contracts, some are letters of understanding. Once this is completed, consumers in Nevada will be much better moving forward.

Philip Ramirez, Chief Compliance Officer, Prominence Health Plan:
On behalf of our 32,000 insured Nevadans and their families, and our 200 employees in Reno and Las Vegas, we stand in support of A.B. 469 and all the hard work and dedication the bill represents. While the language does require more work in our opinion, we encourage this Committee to support the goals of this legislation to better manage emergency health care costs and provide greater financial security for families in the state of Nevada.

Chairwoman Cohen:
We are going down again to Las Vegas.

Dean Polce, Private Citizen, Las Vegas, Nevada:
I am an anesthesiologist with US Anesthesia Partners in Las Vegas. I stand in support of A.B. 469 and agree with most of the comments made so far. In the last ten years, our group has provided the supermajority of anesthetics in the state—not just for critical care, but also in pediatric, obstetrical, and cardiac care. In that time we have never submitted an out-of-network bill to a single individual. This bill would not harm anything that is currently in place, which seems to be working the supermajority of the time, whereas previous attempts have really threatened our emergency services capabilities.

I understand very well the hardships associated with receiving an out-of-network bill. My wife was waiting for a kidney transplant a year ago. She received a bill from an anesthesiologist for 14 acts of Medicare. That is totally inappropriate and I condemn all that, like my colleagues and partners do, and would appreciate continuing to work on this bill with anybody on questions they may have.

W. Bradford Isaacs, M.D., President, US Anesthesia Partners-Nevada:
We represent 160 providers both here and in Carson City. We are in network. We believe in "in-network," and are opposed to the practice of out-of-network billing that is a business model. I would also like to point out that Nevada is now probably ranked number 47 in terms of doctors per capita. When you compare the rate of reimbursement for physicians in Nevada versus like-minded states—be it South Dakota, Wyoming, North Dakota—we have issues with linking this to any type of Medicaid reimbursement. Thank you for this bill; we are fully in support of it.

Chairwoman Cohen:
We are going back up to Carson City.

Kanani G. Espinoza, representing Boyd Gaming Corporation:
We are in support of the purpose and intent of A.B. 469. Boyd Gaming Corporation has approximately 12,000 employees in Nevada and insures about 14,000 employees and families. Our employees and their families should have security and peace of mind knowing that an emergency medical visit will not place their family in financial jeopardy. We understand additional work is required on this bill, but we stand in support of its goals and encourage this Committee to allow the bill to move forward.

Jim Sullivan, Legislative Representative, Culinary Workers Union, Local 226:
Surprise bills from hospitals and doctors are a major concern for working families. Patients are being charged outrageous amounts with a non-contracted hospital or user contractor facility that gets care from a non-contracted doctor. This is a growing issue that must be addressed because patients have little or no control over where and who will care for them in an emergency situation. Surprise bills can bankrupt working families, and this is wrong. Limiting how much hospitals and doctors can charge in these situations will protect workers and all Nevadans from price-gouging, and we believe that A.B. 469 does just that. Lastly, I would like to point out that five of my union brothers and sisters came down from Reno because this is such an important issue. [Union members in the audience were standing up to be seen.] That is all of our "me toos" on the Culinary Workers Union's testimony.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
We are here in support of the bill. Assemblyman Frierson mentioned that this is a bill that people support with moderate annoyance. We are here in support with moderate annoyance.

This is a bill that is related to patients who are seeking emergency care. I think it is important to remind the Committee that physicians who are treating in emergencies are bound by ethics and also by the Emergency Medical Treatment and Active Labor Act, also called EMTALA, to treat the patient without any consideration for their ability to pay and whether or not their insurance has chosen to contract with that provider. In that context, I would like to mention that we have three goals when we look at a bill to eliminate out-of-network billing. First, we want to make sure that we are protecting patients when their insurance fails to cover them in an emergency. Second, we want to provide for a reasonable, fair payment to our physicians for the services that they have already provided to those

Nevadans who are in a time of need. Third, we want to protect the market so that the bill does not unnecessarily advantage one side or the other.

You heard how it is important to protect patients from high bills and medical bankruptcy. The other way to protect patients from high bills is to ensure that we have robust networking systems and that we are encouraging the insurance industry to continue contracting at the greatest level with the broadest safety net. We have not supported bills like this in the past because they have not provided those three things. We do believe that this bill—although imperfect—does provide for those three things as it is currently written and introduced with the technical amendment and the agreement to have a study. We think it protects patients; we think it provides for a reasonable payment; and we believe it protects markets.

On the one hand, it will require physicians to go through arbitration in order to collect a fair payment for a service they have already rendered. This process is hard on doctors. Doctors want to be doctors. They want to treat patients and they do not want to be lawyers. I am a lawyer; I work with doctors, and they do not want to be me. They do not want to be bill collectors, and they do not want to spend their time in arbitration. They want to focus on the patient, which is what their ethics and EMTALA require them to do.

On the other hand, we also do not want this arbitration model to incentivize the insurers to drop our contracts. That is why those provisions about holding this in place for two years are so important. All this does is protect those who have already agreed, who have already been contracted. It protects them from any dropped contracts in those first two years. We believe that, while imperfect, this bill accomplishes the policy objectives that our membership has and that we believe you as policy makers should have as well.

Chairwoman Cohen:
We are going back up to Las Vegas.

Maria Jimenez, Private Citizen, Las Vegas, Nevada:
[Maria Jimenez testified in Spanish and was translated by Nelson Lucero. She was not able to finish her testimony but submitted it in writing (Exhibit J).]

Nelson Lucero, Private Citizen, Las Vegas, Nevada:
I am testifying today in support of A.B. 469. When I started to get sick, my husband took me to urgent care. On the first visit to the urgent care, I was bleeding and the doctors said nothing was wrong. On the second visit to the urgent care, I was still bleeding a lot, but the doctors did not know where the bleeding was coming from and so they sent me home again. On the third visit to the urgent care, I was bleeding and throwing up blood. The urgent care called an ambulance and I was taken to the hospital. As soon as I got to hospital, I was put on an IV and had to get blood transfusions because I had no blood left in my body. I stayed in the hospital for three to four days before I was discharged. My husband told me that, while I was in the hospital, a lot of doctors came and visited me.

The next month, I started getting calls about bills for various doctors who had attended to me while I was in the hospital. The bills are for different amounts for each doctor, and they add up $7,000. My husband and I support A.B. 469 and ending surprise balance billing. We think that the law needs to change so that patients like me are protected.

Chairwoman Cohen:
We are going back up to Carson City.

Jessica Ferrato, representing American College of Emergency Physicians:
There are more than 500 emergency physicians who are part of our association. Emergency departments in Nevada service 1.5 million patients every year statewide. We are here in reluctant support of A.B. 469. What I mean by that is that we have some doctors who are hesitant on this solution and not quite there yet, but we have enough support to be able to move forward and express our support today.

This issue is one that impacts every single emergency physician and will have a significant impact for patients. I want to start by thanking Assemblyman Frierson and Assemblywoman Carlton for their work and diligence on this issue. This bill commits to a solution that is first and foremost protecting patients. It is fair, preserves the market, and creates tension for both parties to maintain their contracts.

Emergency physicians are the safety net so many Nevadans rely on in their greatest hour of need. They see each patient, deliver expert care, and are blinded to the insurance status at the time the care is rendered. This care is mandated by federal law and it is also their moral duty. Emergency doctors are subject to EMTALA—which has been mentioned earlier—a federal law that requires them to take every patient that comes through the door regardless of their ability to pay. We see this bill as a fair, market-based solution that we can support. It protects patients and maintains stability in the market. We urge your support.

Lindsay D. Knox, representing Nevada Orthopedic Society; and Nevada State Society of Anesthesiologists:
I would first like to thank everyone who worked on this during the legislative interim. Most importantly, I want to thank Assembly Speaker Frierson for his efforts. Orthopedic surgeons care for two types of patients. In emergent situations they fall under EMTALA and care for the patient regardless of their ability to pay. They also must provide additional care after the emergency situation has ended. For this reason it is a priority for orthopedic surgeons to be in contract.

The members of the Nevada Orthopedic Society strive to always be in contract. However, in the instance one of them has to provide care for an out-of-network patient, they have worked diligently with that patient to make sure that they are not financially harmed. At the end of the day, our primary goal is to provide the best care for our patients and to keep them out of the middle of any billing discussions. While the bill is not perfect, we believe this creates the necessary tension for both sides to remain in contract, which will ensure quality care for our patients.

Alex Ortiz, Assistant Director, Department of Administrative Services, Clark County:
As a member of the Health Services Coalition, I am here in support of this bill. We insure over 20,000 lives through our network.

Chairwoman Cohen:
Seeing no one else in support, we will move to opposition. Do we have anyone who would like to come forward in opposition to A.B. 469? [There was no response.] We will move to neutral. Would anyone like to come forward as neutral?

Jesse A. Wadhams, representing Nevada Hospital Association:
I want to thank Assembly Speaker Frierson and Assemblywoman Carlton for all of their efforts in keeping this bill moving forward and folks at the negotiation table. As you have heard, this bill reflects months—if not, as in the case of Mr. Vassiliadis and me, generations—of work. No bill is perfect. This bill does a couple of things that we do appreciate: it incentivizes keeping folks in contract and it keeps the patient out of the middle. We are neutral on the bill because we do want to continue to work on the technical amendments and continue the discussion Assemblyman Frierson mentioned. To the extent that there are additional technical questions, Mr. Welch is here to provide any additional insights the Committee may need.

Bill M. Welch, President and CEO, Nevada Hospital Association:
I, too, would like to thank everybody who has been working hard throughout this process. I remember that it was in 1999, my first legislative session in this role, that this bill was introduced for the first time. This issue has had a long journey. The one thing I would like to add is that we want to make sure that the patient is protected. This bill ensures that not only providers, but payers are also held to a standard on how we resolve the matter of how their medical expenses are covered.

Assemblyman Frierson did indicate that there will be some technical amendments. I am happy to review those with the payers. I have reviewed them already with the physician community. I believe there is consensus on the technical amendments I have brought forward. I cannot speak to some of the technical amendments I heard referenced today, but I can speak to the ones that I think further strengthen this bill and further protect the patient, as it is intended.

Chairwoman Cohen:
Yes, but please do so briefly.

Bill Welch:
The bill refers to deductibles, coinsurances, and copays. The intention has always been that the patient would be protected to the level of in-network copay, coinsurances, and deductibles. We believe the bill needs to be corrected so that it does, in fact, state that it is for in-network copay, coinsurance and deductibles. Otherwise, out-of-network copays, coinsurances, and deductibles could potentially be involved.

The bill also states that providers could charge not more than for the deductible. The intent is that the hospitals cannot collect more than the authorized in-network copay, coinsurance, or deductible. These sums would be collectible directly from the patient. Any other payment would have to be between the provider and the payer.

An additional technical amendment concerns the discussions among all parties over the last year as to what happens when a patient presents with an emergency and is stabilized. This discussion led to the agreement that it was the payer's responsibility to facilitate the transfer of the patient to an in-network provider in their system. We, the hospitals, do not always know who is an in-network hospital for the payer. The payers have agreed to that being their role. Once the patient is stabilized, they facilitate that transfer.

Finally, we agree with the idea that studying this issue would be desirable. This is a very complex issue and we have proposed that information should be collected on all claims that were facilitated through the provisions of this legislation, and an annual report provided [by the Department of Health and Human Services] to this legislative body or the patient protection committee that the Governor is going to be creating.

I believe that all the parties I have talked to are in agreement about these technical amendments.

Joanna Jacob, representing Physicians for Fair Coverage:
We are a nonpartisan, multi-specialty alliance of physician organizations working in this state, other states, and nationally on this issue. Our goal is to improve patient protections and to end the surprise insurance gap that we have discussed today. We have been part of this infamous working group. We were at the table with the other provider representatives and our insurer partners to try and work on this legislation. We are dedicated to three core principles to end surprise billing: strong patient protections; fair reimbursement to protect access to care; and transparency for the patient as concerns pricing and their insurance coverage.

Though transparency is not really fully addressed in this bill, there has been a lot of work done on this over the years in Nevada through our insurance provider directories. We are hoping that with the reporting that Assemblyman Frierson mentioned today, we will get some data and be able to see if we can take further steps towards enhancing transparency. We are in support of the technically amended version Mr. Welch just discussed. Our member physicians—you have heard this from the other group—want to be in contract and in network. They want to practice medicine and provide that care in emergency settings.

We concur with Ms. O'Mara's comments: a stable contract provides predictability of revenue for any organization. We are just asking for fair and timely payment for those services. As other speakers have indicated, this bill is not ideal, but it is a start. And I think it is a really good start. I concur with what the insurers said. I do believe that we are the closest that we have ever been to a solution, and that is a very important place to be. Compromise is

essential in an ever-changing health care setting. We are hoping, as we take this first step and get the reporting and the data on this solution, that we can keep working on this.

We like the protections for patients in sections 6 and 9 which address medical necessity and the "prudent layperson" standard. This is important for patients; it takes them out of the middle, which is our number one objective. When a reasonable person believes that they are in an emergency situation, and that emergency is medically necessary, they are protected, as Assemblywoman Titus mentioned. When someone is having an emergency in Nevada, we do not want that person to be thinking about insurance coverage. We also appreciate the approach taken in section 14, which lays out the out-of-network payment structure that the Speaker has proposed.

We know there is going to be continued dialogue on this, which is why we are neutral today. The sections about arbitration processes are a compromise; importantly, we take the patient out of the middle, and provide a process and a timeline for the payer and the provider to determine fair compensation. We believe that is a step in the right direction. We will continue to be at the table and work on this issue.

Damon Haycock, Executive Officer, Public Employees' Benefits Program:
Public Employees' Benefits Program (PEBP) covers state and local employees, retirees and their families. About 50,000 covered lives are in the two plans that we manage. We also outsource to a fully insured HMO [health maintenance organization] plan. I am here today to testify in the neutral position. There are a couple of concerns. We want to make sure that everyone understands that we want to protect patients as well. We detest balance billing; it does not do anybody any good. I am not going to reiterate what everyone else has said about it today and throughout the last decade. However, taking the patient out also means that billing becomes a tango dance between the provider and the actual payer, of which PEBP is one.

One aspect of the bill that gives us a little bit of concern is the guarantee payments of 108 percent of the contract within the first 12 months, and then 115 percent if it is between 12 and 24 months. In the way that it is drafted, if a provider group decides to terminate the contract with the hospital, the very next day they get an 8 percent increase. That is just the math of it. I recognize that there has been a lot of negotiation, that there has been a lot of work that has been done. We are not here to become a speed bump in this process. We recognize the moderate annoyance everyone has to bear, but we are here to make sure that our folks are protected. Thinking about the math of it, as good stewards of taxpayer dollars, we, PEBP, have to reveal to all of you what the potential cost increases would be to the programs, since it is the citizens' legislature that funds us.

Dan Musgrove, representing Valley Health System:
I have always wanted to say this in front of a committee: I am passionately neutral on this bill. I have been in this building as long as Mr. Welch, but I have not always worked on this issue. Only from 2003 on, when I became the representative of University Medical Center in in Clark County, did I start working on it.

We are so glad that the stakeholders worked so hard over the interim session. One of our Executive Vice Presidents over the entire system, Karla Perez, was a part of all those negotiations over the legislative interim. We appreciate the leadership that Assemblyman Frierson took on when we lost the key component to those negotiations. We support the technical adjustments that Mr. Welch has provided to you. We absolutely believe it is important that the patient is protected. The patient should not have to pay out-of-network fees when it is not their fault that they were transported under an emergency situation. I think that is absolutely key along with the transfer situation. Again, we want to thank this Committee and all those who have worked on this in the years that have passed. I hope it can be processed. It will hurt us a little bit. But that is what we want to do, get this done and put away.

Marcia Turner, Chief Administrative Officer, University Medical Center, Las Vegas, Nevada:
We are neutral on this bill. We support the concepts, and we look forward to helping in any way we can with the technical discussions that will be ongoing.

Chairwoman Cohen:
Seeing no one else in neutral, I will ask our committee counsel to answer the question regarding third-party insurers.

Karly O'Krent, Committee Counsel:
I am happy to look into this further. With regard to the question concerning third-party insurers, in the bill, "third party" includes any insurer that arranges for the provision of health services [section 11, subsection 5]. So if an auto insurer is arranging for the provision of services, this bill would apply to them.

Chairwoman Cohen:
With that, I will close the hearing on Assembly Bill 469. I will open the hearing on Assembly Bill 430.

Assembly Bill 430: Establishes a family home visiting system to provide support to new parents. (BDR 38-1001)

I invite Assemblywoman Backus up when she is ready.

Assemblywoman Shea Backus, Assembly District No. 37:
We have handed out an amendment to each of you today (Exhibit K). Initially, Assembly Bill 430 started out implementing a family visitation program. It was a little broad and so I want to take us back and then move forward to where we want to go.

Originally, when this bill was conceived, I was a proud cosponsor with Assemblyman Frierson. It was meant to find a way to assist expecting mothers who may be at risk of having to go to the Division of Child and Family Services within the Department of Health and Human Services once their child comes into this world. The goal was to ensure we have

healthy and successful families. The bill was quite broad, and I am sure you have received numerous emails concerning A.B. 430. To clarify, this bill is not intended to violate anyone's Fourth Amendment rights in any way. It would be purely a voluntary program.

However, we were also getting a lot of pushback from stakeholders on other questions. Who will oversee the implementation of the bill? Who is it intended to benefit? How are you going to outreach to the designated beneficiaries? How are you going to know who these people are?

At the end of the day, we bring before you a request to have the interim Legislative Committee on Child Welfare and Juvenile Justice conduct a study so that we can get the answers to these questions. The good news is, there are a lot of federal programs out there. We could tap into the financing these programs provide to benefit our youth. This is where it has come to with our stakeholders. The proposed amendment reflects this state of affairs.

Section 1 lays out what that study would be about and that it should result in a report. The idea is that in case we do need legislation in order to better benefit from federal programs and funding opportunities, this report will tell us and allow us to get that legislation in place next session. We have a lot of programs in our state that do home visits. In Clark County they have the capacity to have 240 families enrolled.

Cam Scott, Government Affairs Manager, Nurse-Family Partnership:
We are a nonprofit, evidence-based health program with nearly 40 years of evidence showing significant improvements in the health and lives of first-time moms and their children living in poverty. Ultimately, we are about breaking that cycle of poverty by impacting two generations at the same time. This concept was developed as a home-visiting program. In southern Nevada we have a site that has eight nurses doing home visits, with a current capacity of serving up to 240 families, as was mentioned by Assemblywoman Backus.

To illustrate what we do, I have just recently participated in a case conference in southern Nevada. One of the nurses brought to us a story of a young mom who was about to have her first child. The mom was living in a home where there were clearly drugs around. She was living in that home with her mother, who was doing drugs, and also with other folks in the home who were doing drugs. We put the new mother in the driver's seat. The nurse asked her, "What do you want?" The mom answered, "I do not want to become like my mom. I want you to help me to not follow the same path."

One of the most significant things in this was how much this nurse home-visitor was working with her colleagues to try to figure out: How can we help this new mom find the housing that she needs to be in a safe environment for her and her child? It was just so heartwarming to see these nurses invest in these lives. What is most important is that we have been implementing this in different states for 40 years with randomized controlled trials and other studies demonstrating and documenting success. This is an evidence-based program, and I would just like to mention a few of these quick statistics that we have shown in our trial outcomes:

- 48 percent reduction in child abuse and neglect;
- 56 percent reduction in emergency room visits for accidents and poisonings;
- 50 percent reduction in language delays of children at the age of 21 months;
- 67 percent less behavioral and intellectual problems at age 6;
- 82 percent increase in the months employed on the side of the moms;
- 61 percent fewer arrests of the mother; and
- 59 percent reduction in child arrest at the age of 15.

This is just to give you a sample of some of the results that we have demonstrated. To reiterate, this is a voluntary program. In fact, it must be voluntary for a mom to participate in this. There cannot be any force or coercion at all. The moms have to be willing to participate. The nurse comes in to support their pregnancy, to make sure they have improved pregnancy outcomes, improve child health and development outcomes, as well as improved self-sufficiency outcomes, so that they can provide for their family in the long term.

The evidence shows that this kind of program can put a family on a completely new trajectory, breaking that cycle of poverty. We have one site in Las Vegas in Clark County, but we have heard folks in Washoe County say they would love to have the same program there. We are very encouraged to see this bill trying to move the state in that direction. We would love to be a resource in whatever way we can.

Assemblywoman Backus:
We are happy to answer any questions.

Assemblywoman Titus:
Thank you for bringing this bill forward. There certainly is some need for identification of our at-risk families and our at-risk children. There is also however a lot of concern about the invasion of privacy and family rights, et cetera. I have a copy of your amendment here. When we are talking about section 1—and I am comparing that with section 1 in the original bill—there are not the typical green strikeouts. Are you proposing to entirely delete the bill that we have here and use just this proposed amendment (Exhibit K)?

Assemblywoman Backus:
Yes, absolutely, that is what we are intending to do. We used the purple double strike-through on the entire bill. We substituted what was there before with a legislative interim study pertaining to the program the bill originally envisioned in order to secure some information before we move forward. The intent is not to make anything mandatory or violate anybody's rights. The hope is that people will want to participate voluntarily in order to help their children succeed.

Assemblywoman Titus:
I think I heard you say that this would be a self-referred program. How would you identify the families that could participate, and who is going to identify them? Would it be the Committee's job to have that discussion: Who are we identifying? How are we identifying

them? Should the interim study really be about focusing on specific families rather than on the more basic questions such as: What is the problem? How do we even know who to interact with? Where can we best serve folks? I am concerned about doctors potentially becoming responsible for the identification. Are they supposed to say, "Hey, I have a mom here in need of services?" I am already mandated to report so many things. I always worry about identification and who is targeted by a program—these types of questions.

Assemblywoman Backus:
The intent was to look at this on a macro scale. The state of Indiana served as a model for us. Indiana has conducted a relatively comprehensive analysis of these questions, which serves as the foundation when moving forward on laws such as this for home visiting programs, as well as trying to move in compliance with the Family First Prevention Services Act, which is a federally funded act in which Title IV-E funds are being dedicated to hopefully prevent the removal of children due to abuse and neglect. It is really a study on a macro level to get all of the stakeholders together to find out: How to identify? What families are we looking at? And where could these families go and connect to services? I was talking to Mr. Scott about what they do. I asked him, "How do you find the families that you help?" He explained that sometimes they partner with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and with other services to get Nurse-Family Partnership services to those who need them the most.

Chairwoman Cohen:
Is there anybody in Las Vegas or Carson City who wishes to come forward in support of A.B. 430?

Joelle Gutman, Government Affairs Liaison, Office of the District Health Officer, Washoe County Health District:
I would like to thank Assemblywoman Backus for meeting with me and hearing our concerns. Originally we were not sure where this program would be placed, whether it would be with Washoe County or with the Washoe County Health District. We were concerned about how we would implement it. But we fully support the concept and we support the bill as amended. As the Assemblywoman said, the Washoe County Health District offers family planning services and WIC. And we think that we potentially could be a good source for referrals and a partner and stakeholder of the study and program.

Chairwoman Cohen:
Is there anybody in Las Vegas who wishes to come forward in support of A.B. 430? [There was no response.] I will ask for any opposition in Las Vegas and Carson City to come forward. We will start hearing opposition in Las Vegas.

Sarah D. Larrabee, Private Citizen, Henderson, Nevada:
I do have to modify my opposition slightly due to the amendment. [Sarah Larrabee spoke from written testimony (Exhibit L).]

I represent myself, my sons and daughters, and future grandchildren. I am currently testifying that I oppose A.B. 430. Before I move on to my personal testimony, I would like to refer the Committee to the currently listed fiscal notes for several agencies, indicating that the impact will be high. These state and local agencies are already underfunded, understaffed, and with extensive caseloads.

Chairwoman Cohen:
Madam, I am sorry, but this is a policy committee. We are just addressing the policy issues. If the bill continues on, its fiscal implications will be considered in the Assembly Committee on Ways and Means.

Sarah Larrabee:
I will move on to my personal experience in regard to home visits. I have two experiences. [Sarah Larrabee continued speaking from (Exhibit L).]

While serving in the United States Air Force, I was stationed overseas in England where there is a national healthcare system. My spouse worked in the local economy and paid into the National Health Service (NHS). I decided that I was going to use the local services and experience this socialized medicine for the pregnancy and birth of my first child. I also signed up for a new parents course provided by the military's equivalent that was based on section 1, subsection 1(a) of this bill before it was struck through. Home visits were what drew me to their new parents program. It was completely voluntary.

The home visit from the new parents program was a social worker specializing in early childhood development, and her job was to look for "probable cause." I received no support and no resources. I got nothing out of it. Her visits were confusing and generally left me feeling extremely inadequate as a new parent.

The NHS includes home visits as part of their standard maternal care after the birth of any child from their medical providers which are midwives. These midwives are trained in postpartum care of mother and child.

The difference between the two programs is, one was set up very similar to this bill and one is standard maternal care done by a midwife or nurse or a lactation consultant. I am very grateful for the NHS home visits as part of my standard maternal care. I received the support and care that every woman, not just first-time parents, receive.

My point to this matter is, this bill and the way you are going about it creates more of a government oversight of my medical issues and my children when it should be between me and my healthcare provider. This is something that our society needs to start looking at. We need to look at our community healthcare providers, not mandated government oversight.

Romina Lizaso, Private Citizen, Las Vegas, Nevada:
I am here in opposition to A.B. 430. As a mother and as a community support provider, I am very relieved to see the deletion of section 2 (Exhibit K) that would have crossed the Fourth Amendment rights of citizens here in Las Vegas, and in Washoe County as well. I would encourage the Committee to look into continuity of care for maternal aid—not only postpartum, but throughout pregnancy, and possibly even before as well. I think that financially, fiscally, that would encourage families to look for support—if they had better access before they had their babies, instead of making something mandatory that would force home visits.

I understand that now, with that strikeout of section 2, this is merely looking into a study. I still would like to encourage you to rather look into continuity of care instead. Like I said, as a community support provider here in Las Vegas, I have personally seen and experienced that when mothers provide support to one another; it results in a more personal and better experience for those new mothers. My last comment would be that I encourage the continuity of care instead of requiring home visits.

Kristen Krisyna, Private Citizen, Las Vegas, Nevada:
I was opposed to A.B. 430. I appreciate the amendment that has been submitted. As far as this would be a voluntary service—which the bill originally did not state, as it was instead very broad and somewhat intrusive—I think this really needs to be highlighted. The program's idea to tackle certain risk factors is a good thing; but if it is not voluntary, we are crossing major lines and leaving the door open for exploitation of your interpretation of risk factors versus somebody else's. I appreciate the amendment, and that is all I have to say.

Jessica Lagor, Private Citizen, Mount Charleston, Nevada:
I represent myself as a mother and a community support provider. I was just made aware of the amendment. Everything I had planned to say I had to scratch out. However, section 1 is still very troublesome to me and the fact that section 2 is a proposed striking—well, I am not sure whether that can come back or not.

We have programs in place for families to seek support. We are very concerned about postpartum depression. We are very concerned about mothers who are overwhelmed and families that are struggling, and maybe are taking it out on their children—or their children are struggling because of that. We have a wide variety of community outreach programs already in place that are not in the *Nevada Revised Statutes* (NRS). These are voluntary programs. Realistically, we are very concerned that, when you are writing or amending a bill, using the word "voluntary" seems like an oxymoron. These things do have to be enforced, so who are you enforcing? Is it going to be an enforcement for participation or an enforcement for the workers to provide the services? I am concerned about those details. Just the idea of a study alone confuses me with section 2 being struck out. I am concerned about data mining. Am I giving you consent to study my family? What would be the purpose of the study if section 2 is not going to be a thing in the first place? These are my concerns.

Cassia Lopez, Private Citizen, Logandale, Nevada:
I am from Assembly District No. 36 and I am representing myself and my family. I am against the bill for the reasons mentioned by the speakers before. My biggest concern now, with the second part of the bill being struck, is that we do not need this study to be done if we do not want the rest of the bill to pass next session or any other time. What is the point of doing this study if we are not going to be okay with the bill?

Emily Tuttle, Private Citizen, Las Vegas, Nevada:
I host a mother's support group here in Las Vegas. We are supporting pregnant mothers as well as new mothers and mothers of older children. We encourage partners to come as well. I would like to emphasize what has previously been said about the opposition to section 2 and how I appreciate it is now crossed out. I would like to encourage legislators to look on Facebook or online to find our programs, which are free and available to them. I am opposed to such programs being in NRS and legally prescribed. I feel it should all be voluntary and not written in a bill.

Clarissa Luna, Private Citizen, Las Vegas, Nevada:
I am here as someone who was born and raised in Las Vegas, in Clark County. I am also a new mother of seven months and a community support provider. I know that there are resources in the community that exist and I do see postpartum depression within my peer group and know that with this continuum of care and model that has already been preexisting within the community, mothers can get help. I understand that there are medical resources that we would then refer them to, as we can only emotionally and physically support mothers.

But I do want to oppose A.B. 430 that is now an amendment. I do so for the same reasons as my peers before have invoked in their opposition. It is my opinion that it is the parents' decision whether they want to enroll in a program and how we raise the children. Otherwise, the privacy of our homes is being endangered.

Shanna Martinez, Private Citizen, Las Vegas, Nevada:
I am here to represent myself and my family. As was already stated, we are definitely relieved that section 2 has been stricken or is proposed to be stricken—and we hope that it will for sure be stricken. However, section 1 is still an issue because it establishes a study that is not needed—unless section 2 or something like section 2 is going to be brought forward at another time. There are existing resources already. There are so many resources out there that are voluntary, free, and I think the main issue is that there needs to be a lot more awareness that they are available. They are available. There is really no need to even do a study. Who will participate in this study? Who will be studied? That all seems vague. That is the issue. What is the point of the study if legislation is not being proposed after collecting the data?

Chairwoman Cohen:
Is there anyone else wishing to come forward in opposition? [There was no response.] A number of written testimonies in opposition have been submitted by private citizens via

email and will become part of the record (Exhibit M). Also, additional testimony in opposition was submitted by the Nevada Homeschool Network (Exhibit N). Do we have anyone in neutral wishing to testify?

Janine Hansen, State President, Nevada Families for Freedom:
We were originally very concerned about the content of this piece of legislation. I had the opportunity to meet with Assemblywoman Backus last evening. Our issues with the bill were resolved through the striking out of the portions of the bill about which we were very concerned. The Assemblywoman's explanation of what she wanted to do with the study was satisfactory.

We will remain interested observers, though. We do want to help young mothers who are in at-risk situations. There are a lot of volunteer organizations that can do that. I think making these mothers aware of these resources would be a positive thing. I want to tell Assemblywoman Backus how I appreciate her responding to our concerns. I do not think she ever had the intention of how this bill came out in the first place. I really appreciate her talking to me about it. We did let our people know so that they will not be upset about what is going on.

Ross E. Armstrong, Administrator, Division of Child and Family Services, Department of Health and Human Services:
We would like to express appreciation to the Assemblywoman for listening to our concerns about the initial draft of this bill. The trauma to children and families of a removal by a child welfare agency is profound. We are preparing to embark on the next chapter of child abuse prevention with the passage of the Family First Prevention Services Act at the federal level. For the first time, we will be having access to true federal resources to help with the prevention of that removal and that trauma for that family. We are not there yet. We will be doing a lot of work in the next legislative interim to make sure our system is ready for that. This study fits in well with these efforts and may help us in figuring out how a home visiting plan or program may fit in with our entire child-serving system.

Chairwoman Cohen:
Our state agencies work very hard to help families in Nevada. Are there places where there are missing gaps, where families are not getting the services that they would like to receive?

Ross Armstrong:
There are always gaps. Sometimes these are geographically based. A lot of times those have to do with emerging issues and trends in our families, as our definition and how we view a family changes. We are having a much bigger, broader vision of what a family is, which is wonderful. There are certainly gaps. The study would help us identify these. The Division of Public and Behavioral Health, Department of Health and Human Services (DHHS), currently oversees a program similar to this that is voluntary. Figuring out where, across all of our DHHS agencies, we have the resources to bring to families is a challenge. A lot of times it is about that connection to a family, figuring out that the family is in need and then connecting them to the appropriate resource to help them thrive.

Chairwoman Cohen:
Is there anyone else who wishes to come forward under neutral? [There was no response.]

I would like to clarify—when we do studies in the Nevada Legislature, no one is forced to participate in the studies. Studies are voluntary, they are also presented and held in committee meetings open to the public and open to public participation. Bill presenters, please come up for brief concluding remarks.

Assemblywoman Backus:
I want to thank the opposition that came up against the first version of the bill, which did not reflect our real intention. The idea of the study is to generate valuable insight and comprehension of the resources that are available. With that, I would ask the Committee to pass this on to the interim Legislative Committee on Child Welfare and Juvenile Justice, which, I do want to mention, is open to the public and is voluntary.

Chairwoman Cohen:
I will close the hearing on A.B. 430. I will go ahead and invite Assemblywoman Titus and Mr. Oscarson to present Assembly Bill 340.

Assembly Bill 340: Makes various changes concerning the acquisition and use of opioid antagonists by schools. (BDR 40-849)

Chairwoman Cohen:
If Assemblyman Hambrick is listening, we hope you are doing well and we are sorry that you are not able to participate with us today. We are sending you our best wishes.

Assemblywoman Robin L. Titus, Assembly District No. 38:
I represent Assembly District No. 38, which is most of Lyon County and all of Churchill County. I am honored to sit here representing Assemblyman John Hambrick who is representing Assembly District No. 2. We are presenting Assembly Bill 340 for your consideration.

I can assure you that Assemblyman John Hambrick and his wife are watching. He is following right along, and he is truly sorry that he cannot be here.

Assembly Bill 340 is a bill that will allow public and private schools to address the issue of opioid overdose in the school population. This bill does not mandate the school to carry opioid antagonists, but it gives them the ability to obtain, store, handle, and transport opioid antagonists. It also exempts them from certain liabilities when the use is necessary and certain conditions have been met. It establishes storage, handling, and transportation requirements. And it requires a reporting to the Department of Health and Human Services of doses administrated by authorized personnel each school year. That is the brief summary of the bill. I will turn it over to former Assemblyman James Oscarson, who has worked hard on tackling the opioid crisis.

James Oscarson, Private Citizen, Pahrump, Nevada:
I am a former Assemblyman from Assembly District No. 36. I am pleased to be here to present A.B. 340, which authorizes public and private schools to obtain and maintain opioid antagonists under certain conditions—and please remember: the bill does not require schools to maintain opioid antagonists; it just gives them the option.

I am here today at the request of Assemblyman Hambrick who, as you know, is unable to be here. Assemblyman Hambrick sends his best regards and he certainly misses seeing each of you every day.

Before I review the specifics of the bill, I would like to provide a bit of context. Many of you may remember Assembly Bill 428 of the 79th Session. That bill, in its introduced form, looked very much like the bill before you today, A.B. 340. The 2017 legislation was amended to authorize a pharmacist to furnish an opioid antagonist without a prescription—under certain circumstances. In addition, the 2017 bill prohibited the development of standardized procedures and protocols that would prevent a pharmacist from dispensing an opioid antagonist without a prescription.

Here we are again, two years later, with greater knowledge of the importance of opioid antagonists—drugs like naloxone [hydrochloride], also known as Narcan—and the successes we have seen in reversing opioid overdoses with these antagonists. Here we are again, two years later—with nearly 100,000 lives lost nationwide since 2017 from opioid overdoses—asking for the simple authorization to allow schools to keep opioid antagonists on hand in the event of an overdose.

The past two years have seen a nationwide trend toward authorizing the use of opioid antagonists in schools. While we do not have exact data, we know that at least one dozen states, including Connecticut, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, New York, New Mexico, Rhode Island, and Tennessee, have statewide or school district-specific programs allowing the use of opioid antagonists in schools. As recently as last week, a similar bill in Oklahoma—Senate Bill 85, which passed unanimously in the Oklahoma Senate—received final committee approval in the second house and is on the verge of being approved in its assembly. We are seeing incredible movement on this issue across the United States, and it is time to take this important step forward here in Nevada. I hope you agree.

If there is a silver lining in all this, it is the fact that opioid overdose deaths have remained flat in Nevada between 2016 and 2017, the latest year for which we have data. According to the Office of Analytics in Nevada's Department of Health and Human Services ["Nevada Opioid Surveillance 2010-2017"], there were 387 opioid-related overdose deaths in Nevada in 2016, and 388 in 2017. Of these deaths, 34 were in the 15 to 24 years of age group in 2016; 37 deaths were reported in this age group in 2017. What we do not know about this age group, however, is how many overdoses occurred at schools and how many of those deaths could have been prevented had an opioid antagonist been available for use, in an

emergency situation, at a school. That said, I would argue that if even one young life can be saved, the passage of A.B. 340 is worth it.

With this background, I would like to take a moment to briefly review the primary components of A.B. 340. First, the bill authorizes a health care professional who is authorized to prescribe an opioid antagonist to issue an order allowing a charter, private, or public school to obtain and maintain an opioid antagonist on campus. This order is permitted, regardless of whether a person at the school has been diagnosed as needing the antagonist. The measure sets forth the specifics of the order and declares that the health care professional shall not be subject to disciplinary action solely for issuing such an order. Assembly Bill 340 provides additional protections for the health care professional by declaring that he or she is not liable for any error or omission concerning the acquisition, administration, possession, or provision of an opioid antagonist maintained by the school under the order. Liability exemptions are also extended to pharmacists who dispense an opioid antagonist or who transfer an order to another pharmacist at the request of the public or private school.

With regard to administering and storing an opioid antagonist at a school, A.B. 340 models its use and storage much like that of EpiPens, which are already permitted for use in schools. School nurses or other designated employees at the school may administer an opioid antagonist maintained at the school to any person believed to be experiencing an opioid-related drug overdose. The governing body of any charter or private school and the board of trustees of each school district must adopt a policy to ensure that emergency assistance is obtained each time a person at the school experiences an opioid-related drug overdose. Also, a policy must be adopted requiring notification of the parent or guardian of a student who is administered an opioid antagonist.

Finally, much like the protections afforded to health care professionals and pharmacists, A.B. 340 extends exemptions from liability to the school, school district, employees, and others affiliated with a school from certain damages relating to the acquisition, administration, possession, or provision of an opioid antagonist or EpiPen, which is not resulting from gross negligence or reckless conduct.

Madam Chairwoman and Committee members, this concludes my presentation. I urge your support of A.B. 340. I know there are others here today who also wish to speak in support of this important legislation.

Chairwoman Cohen:
Thank you for pinch-hitting for Assemblyman Hambrick. I did not think that Mrs. Hambrick would be listening. We are of course also sending our best wishes to Mrs. Hambrick and hope that she is doing well.

Assemblywoman Nguyen:
You mentioned the programs schools already have in place for EpiPens or allergic reactions. Does the bill model the same liability waivers and information that is included in the respective sections on these programs?

Assemblywoman Titus:
Yes, it does, and it actually almost mirrors, if not models, what happens with the EpiPens. The important point here is that schools do not have to do this. This is an optional program. Some districts may find that this is something they need, others may feel that this is not something they would want to deal with—just as with the EpiPens.

Chairwoman Cohen:
My concern is that in a lot of schools there is no nurse on staff full time. I know the bill allows for someone else to be designated, but I am a little bit concerned about that person not necessarily having the proper training and medical background.

Assemblywoman Titus:
When Narcan was first available, the concept of an opioid antagonist available not only for schools—which this bill addresses—but for families and friends emerged. When the prescription opioid is originally given, there is a policy and a program that the pharmacist already has in place before she or he dispenses it. This whole program is not about having to be a health care professional. To administer Narcan, one does not have to be a first responder. One just has to be there at the time. We are encouraging it not to be limited to a health care professional.

Chairwoman Cohen:
Without the health care training, how do you know it is an opioid overdose?

Assemblywoman Titus:
You have to have some basic understanding of what an overdose might look like as opposed to, for example, a diabetic condition. If there is a known diabetic child, this kind of information about medical conditions should be known, and you would have to know the difference. You are absolutely correct with your question. Narcan can be prescribed to a family member or given to the patients themselves when they pick up their prescription for the opioid. It is in the same bag. It is not specifically limited to a health care professional to give Narcan. However, you do have to recognize what an overdose may look like—and that is what that training is about. Before they dispense Narcan, the training teaches you what the signs of a possible overdose are. There is some risk involved. You have to have certain knowledge. It would not just be anybody who would be able to administer this in the schools. That is why the bill says that the schools will have to develop a program, and they will have to get in some education and understanding and accordingly determine who has access to that Narcan.

Assemblyman Thompson:
The bill lists three types of schools: public schools, private schools, and charter schools. It seems that every one of these school types' protocol is a little bit different when I am reading through it. When it comes to who can administer, who can be trained, it seems that for charter schools there are different requirements and guidelines than for public schools. Can you shed some light on that?

Assemblywoman Titus:
Some of the public schools will have a school nurse, whereas the charter schools frequently may not have one. That is just an observation and I cannot address the details of the actual wording.

James Oscarson:
Those are discussions that can be had with Assemblyman Hambrick. In my presentation I referenced that the governing body of any charter private school and the board of trustees of each school district must adopt a policy to ensure that emergency assistance is obtainable. I think that sets the stage, if I am not mistaken, for them to be consistent or not consistent. Assemblywoman Titus is exactly correct when she says that many of the private schools and charter schools may not have a nurse. The training component is thus something important that could be provided by a physician that works with the school. That would be my hope, and I believe that there could be some standardization across the school types. At the same time, there are some differences in the ability of these school types to have staff.

Assemblywoman Nguyen:
I did not see any of our various school organizations having signed in either in opposition, support, or neutral. Have you had much input on this bill? Did you collaborate with them to see what their concerns are on this?

Assemblywoman Titus:
I was not part of the negotiations in the initial drafting of this bill. I, therefore, do not know to whom Assemblyman Hambrick reached out. I do know, however, that when we did the EpiPen bill, there were many folks at the table from all the different school districts.

James Oscarson:
I did see a couple of letters that expressed concern that schools could be forced to have this product. I think we clarified that. It is not a mandatory program, but an optional one. Usually, when programs are optional, there is not much pushback.

Assemblyman Assefa:
Could you take us through the genesis of this bill? How much overdosing is happening in the schools so that this is necessary? It definitely does not hurt to have it, but do we have data that show this is necessary?

James Oscarson:
Let me repeat very quickly from the Office of Analytics report I just referenced: According to the Office of Analytics in Nevada's Department of Health and Human Services, there were 387 opioid-related overdose deaths in Nevada in 2016, and 388 in 2017. Of these deaths, 34 were in the 15 to 24 years of age group in 2016, and 37 deaths were reported in this age group in 2017. What we do not know about this age group, however, is how many overdoses occurred at schools.

We do not have the 2018 data yet. We do not know how many of them happen in schools. We believe one is far too many. I hope that answers your question.

Assemblyman Assefa:
Are you saying that you do not know if any of these deaths occurred as a result of overdose on school properties?

James Oscarson:
That is correct, we are not aware that any of them happened or did not happen on school properties. We do not have access to that data at this point.

Assemblyman Thompson:
Following up on the question Assemblyman Assefa raised, do we have some type of preventative campaign included with this? I understand and totally get it when you argue that one death by overdose is too many. If we do not know the number, is this bill going to address any type of prevention?

James Oscarson:
There are campaigns such as "Say No to Drugs" and others going on consistently in schools. I know that this even goes down to lower-level grades. This particular bill does not address that educational component. You would hope, however, that this would be another tool in the toolbox to help assist confronting opioid overdoses. In the system we live in today, it is important to have every tool available in the toolbox to address these concerns.

Chairwoman Cohen:
I will now invite everyone wishing to testify in support of A.B. 340 in Las Vegas or Carson City to come up.

Trey Delap, Director, Group Six Partners:
One of our policy objectives this session has been to reduce barriers to recovery from addiction. Death is a barrier to recovery from addiction. The idea of this bill—continuing from last session on—is a good one and should be part of a general harm-reduction strategy. It was already mentioned that a number of states have this empowering legislation for their schools. The National Association of School Nurses also endorses this. They consider themselves on the front line of public health. They are also, in many cases, the first responders.

If you go to the Southern Nevada Health District and you attend a 20-minute training, you can get an overdose kit. This kit includes Narcan nasal spray. This is part of the Opioid State Targeted Response grant, paid for by the federal government. This program started in March 2018. Since then 1,729 people have been trained in the use of the Narcan kit. They have issued 6,367 kits out in the community. The reason why I am bringing that up is—although it is not related specifically to the schools—any member of the community who wants to get access to Narcan can get it.

We would certainly support that Narcan can be obtained anywhere, and we hope that the measure will reduce the number of opioid-related deaths in Nevada. The statistic has remained static. I also want to mention, on the federal side, the Bureau of Indian Affairs asked their health service officers to start carrying Narcan. They are often first responders. The Department of Veterans Affairs realized that co-prescribing Narcan when there is an opioid treatment was important as well. There is also an organization in southern Nevada, Trac-B Exchange, which is a needle exchange that has Narcan available. They estimate that at least one person per day asks for treatment or help with opioid abuse disorder. These are all very encouraging developments. I urge your support of this bill.

Chairwoman Cohen:
In the case of minors, does an opioid overdose mimic any other medical conditions?

Trey Delap:
The training that you will get tells you that, if there is a suspicion of overdose, you should first call 9-1-1, then administer the Narcan. If the person is overdosed, it will work. If the person is not overdosed from an opioid, it will not work and it will have no other effect. The administration of this does not require any judgment. What you are, however, asking about is the other part of this bill, which deals with the Good Samaritan Law and immunities. That law was passed in 2015.

Chairwoman Cohen:
We will move on to opposition.

Graham Galloway, representing Nevada Justice Association:
Let me begin by saying that this is a good bill. The goal and intent of this bill is worthy and excellent. But it is not a perfect bill. It is not perfect because it provides gratuitously and without any real justification immunity to everybody who comes within the terms of this bill. This is troublesome. The cornerstone of our civil justice system is that everyone should be accountable for their actions. This bill does not do that. It gives individuals a free pass if they are negligent in the distribution or application of these antagonists. I have not heard anything today which at any other point would justify this radical change in our civil justice system.

What is it that you want from this bill? You want people who are going to distribute and use these antagonists to be at their best. This bill does not do that or foster that. In fact, it sanctions or allows for incompetence. It waives any negligence on the part of any of the

actors involved under this bill. Bill Belichick, the head coach of the Super Bowl Champion New England Patriots, said it best. He said to all his players, "Do your job." If you do your job diligently, you do not have to worry about litigation, being sued, responsibility, accountability. We are big proponents of the distribution of these antagonists to anyone and everyone who is going to use them correctly. That goal should not be at the expense of one of the core values of the civil justice system, which is accountability, responsibility, and liability. Unfortunately, we have to be in opposition with the immunity language that is in the bill. If the immunity language is withdrawn, we would be enthusiastic, happy supporters of the bill.

Chairwoman Cohen:
I am seeing no one else in opposition. We will move to neutral.

Lindsay E. Anderson, Director of Government Affairs, Washoe County School District:
Many of the things I was going to say have already been addressed. I will not reiterate them. We are here in the neutral position because what the bill envisions is enabling and not required. I do want to reinforce that in the Washoe County School District we have roughly 100 school sites, and we have approximately 30 registered nurses who serve those schools. We do not have a medical professional in each school building. We do have what we call clinical aides in each school building. But I want to make clear, they are not really trained medical professionals in any way. They do receive some training about how to handle medical situations, but they are not educated as medical professionals.

Way back in 2013, I worked for many hours with then-Senator Debbie Smith on the epinephrine requirement [Senate Bill 453 of the 77th Session]. Stocked epinephrine is a mandate in our schools, whereas this bill is permissive. I cannot miss the opportunity to say how much we wish we had a school nurse in every single school building and how important that would be to meeting the health needs of our students. At this point, however, we do not have that. I cannot say that my district would take advantage of this program. I will also not reserve any fiscal comments on the cost of stocking this at each school. But because it is permissive, at this point we do not have a particular concern in terms of a mandate.

Chairwoman Cohen:
Are there any more questions? [There were none.]

James Oscarson:
I certainly understand the concern Mr. Galloway brought forward. I think one of the key points he mentioned in his testimony was the word "responsibility." When you are responsible, sometimes you do things to be responsible and take care of concerns and questions that arise. Seventeen hundred kits have been distributed in Clark County in addition to 6,000 that have been made available. While I cannot speak for other people, I would much prefer myself to err on the side of caution and save the life of a young man and face my maker that way. I appreciate the opportunity to testify, and I appreciate Assemblywoman Titus in her diligence as one of the sponsors of this bill. Normally, I would

ask that you pass this bill. But I will go as far as begging you to please pass this bill. I hope you see the importance of it, as I have over the last four years.

Assemblywoman Titus:
I appreciate your question. It is not an easy task and we are talking about a medication. Everything needs to be discussed. I appreciate the Nevada Justice Association coming up with their concerns. One of the hallmarks of this bill is stated in the preamble that it is "An Act . . . providing immunity to certain persons for acts or omissions relating to the acquisition, possession," et cetera. The Justice Association did come up with an amendment moments before we met today. I do not feel I am in any position to accept that without Assemblyman Hambrick really thoroughly vetting that amendment because they added in the term "unless negligent" before each chapter. I was concerned that would change the whole spirit of the bill and I have had some concerns about that. That does not mean Assemblyman Hambrick would not accept that. That is still open, as I am here as his surrogate today.

Just as a point of clarification and to piggyback on what Mr. Delap said, the risk of administering Narcan is negligible except that people are usually very angry with me when I do give them Narcan. They go through an immediate withdrawal and that is not a good feeling. If somebody shows up with some other medical problems we do not know about, while we are trying to figure out what that is, in an emergency response we give Narcan. If that person has overdosed, it does work right away. If it does not work, obviously, we will work on other things too. That is the beauty of Narcan and this whole process. Thank you for your thoughtful questions

Chairwoman Cohen:
I will close the hearing on A.B. 340.

Regarding the bills that were heard today, if you are an interested party and you are thinking of submitting a proposed amendment, please get those to us as soon as possible, but by no later than 2 p.m. tomorrow. Please make sure that the bill sponsor knows that you are providing us with a proposed amendment, and do let us know if it is a friendly amendment. "Friendly" means that the sponsors have agreed with moving forward with your amendment.

We will now move to our work session. We will remove Assembly Bill 339 from the work session.

Assembly Bill 339: Revises provisions relating to wages paid to certain persons who participate in job and day training services. (BDR 39-104)

[Assembly Bill 339 was agendized but not considered.]

Marsheilah Lyons, Committee Policy Analyst:
The work session documents have been made available to the Committee and the public in copy and electronic form on the Nevada Electronic Legislative Information System. The first bill in the work session document is Assembly Bill 66.

Assembly Bill 66: Provides for the establishment of crisis stabilization centers in certain counties. (BDR 39-486)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit O).] Assembly Bill 66 requires the Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS), to establish a center to provide crisis stabilization services in each county whose population is 100,000 or more, currently Clark and Washoe Counties. The Division is authorized to enter into a contract with a provider of behavioral health services to provide crisis stabilization services at the center. The measure defines "crisis stabilization services" to mean behavioral health services designed to: (1) de-escalate or stabilize a behavioral crisis or reduce the concerning or disruptive behavior associated with acute symptoms of mental illness or the abuse of alcohol or drugs; and (2) avoid admission of a recipient of services to an inpatient mental health facility or hospital.

An amendment was proposed by Charles Duarte, Chief Executive Officer, Community Health Alliance, and Chair, Washoe Regional Behavioral Health Policy Board; and Dorothy Edwards, Regional Behavioral Health Coordinator. The proposed amendment replaces the original bill and includes the following provisions:

1. It defines a "crisis stabilization facility." However, there is a correction I have to the work session document (Exhibit O) concerning the definition of "crisis stabilization facility." Crisis stabilization facility does not refer to "a new facility type," but to a "psychiatric hospital" under *Nevada Revised Statutes* (NRS) Chapter 449, "Medical Facilities and Other Related Entities."

2. A "crisis stabilization facility" must:
   a. Be accredited by one of two specified national accrediting bodies.
   b. Be operated pursuant to established administrative protocols and evidence-based protocols for treatment and documentation.
   c. Deliver crisis stabilization services in the manner prescribed.
   d. Employ credentialed peer support providers.
   e. Use data management tools to collect and maintain certain information.
   f. Be able to perform medical clearance.
   g. Accept all patients regardless of:
      i. Their ability to pay;
      ii. Behavioral health acuity level;
      iii. Type of admission pursuant to NRS 433A.120; and
   h. Not exceed a maximum of 16 short-term crisis beds in any unit incorporated in the crisis program.

3. Authorizes DHHS to enter into a contract to provide crisis stabilization services after consulting with the appropriate regional behavioral health policy board.

4. Defines "crisis stabilization services."

5. Authorizes DPBH to accept gifts, grants, and donations to establish crisis stabilization facilities.

6. Requires DHHS to:
   a. Designate "crisis stabilization facilities" as Medicaid essential community providers; and
   b. Amend the State Plan for Medicaid to appropriately reimburse crisis stabilization facilities for service.

Chairwoman Cohen:
Just for clarification, this amendment is friendly. It was submitted by the Washoe Regional Behavioral Health Policy Board. Are there any questions?

Assemblywoman Titus:
Do we encourage the state to subcontract with a private entity to create these stabilization centers? The original bill seemed to mandate the state to create these centers. I was quite concerned about the state going into the business of having these crisis stabilization centers. I have not had the chance to fully vet what appears to be a new bill. I am hesitant here.

Marsheilah Lyons:
As I understand it, this would allow the state to contract with private entities to create these facilities.

Assemblywoman Titus:
But at the same time, the amendment would not mandate that each county must have a stabilization center. It is enabling that the local entities may establish and contract, and it authorizes them or requires them to designate them in a way so that Medicaid would then pay for the services they offer—is that correct?

Marsheilah Lyons:
Yes, it would be optional to the counties.

Chairwoman Cohen:
I will be looking for a motion to amend and do pass.

ASSEMBLYWOMAN NGUYEN MOVED TO AMEND AND DO PASS ASSEMBLY BILL 66.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblywoman Titus:
I will support this in the interest of the concept, which is good. I will let you know if I have some concerns afterwards and need to change my vote.

Chairwoman Cohen:
I am seeing no further discussion on the motion.

> THE MOTION PASSED. (ASSEMBLYMAN HAMBRICK WAS ABSENT FOR THE VOTE.)

I will assign the floor statement to Assemblywoman Gorelow.

Chairwoman Cohen:
We are moving on to Assembly Bill 150.

Assembly Bill 150: Authorizing certain adopted children to enter into an agreement to receive services and payments from an agency which provides child welfare services. (BDR 38-453)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit P).] Assembly Bill 150 authorizes a child, determined to be a child in need of protection, and adopted before reaching 18 years of age, to enter into an agreement with the agency that provides child welfare services. The measure further requires such an agreement to specify that while the agreement is in effect the child is: (1) entitled to receive services from the agency and to receive monetary payments directly or to have such payments provided to another entity; and (2) is required to comply with a written plan developed by the agency to assist the child in transitioning into independent living.

The bill requires the agency to develop such a written plan for the child. The agreement terminates upon a determination by the agency that the child is not in compliance or making a good faith attempt to comply with the written plan. The measure also provides for the termination of such an agreement if the child so requests or on the date the child reaches 21 years of age. The agency, with the consent of such a child, is authorized to request and examine a credit report of the child and assist the child if an inaccuracy is discovered.

An amendment has been proposed by Denise Tanata, Children's Advocacy Alliance. The amendment replaces the language in the measure by:

1. Requiring the Department of Health and Human Services (DHHS), to plan for and prepare a state plan amendment to formally extend the foster care program to age 21, allowing youths who are in care at age 18 to voluntarily remain in foster care up to their 21st birthday.

2. Authorizing Nevada to extend foster care to youths up to age 21 by:
   a. Requiring the Division of Child and Family Services (DCFS), DHHS, in collaboration with the local child welfare agencies, social services, children's attorneys, and other key stakeholders, to establish a plan, apply for, and implement a Title IV-E Extended Foster Care Program in Nevada; and

b. Requiring DCFS to establish a decision unit for the IV-E Extended Foster Care Program and submit it to the 81st Legislative Session.

3. Requiring DCFS to report certain information to the Legislative Committee on Child Welfare and Juvenile Justice by no later than October 2020.

Chairwoman Cohen:
Are there any questions by Committee members? I am seeing none. I will accept a motion to amend and do pass.

ASSEMBLYMAN ASSEFA MOVED TO AMEND AND DO PASS ASSEMBLY BILL 150.

ASSEMBLYMAN THOMPSON SECONDED THE MOTION.

Is there any discussion on the motion? I am seeing none.

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

I will ask Assemblyman Assefa to handle the floor statement.

We will move on to Assembly Bill 232.

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

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit Q).] Assembly Bill 232 requires each hospital, other than a psychiatric, rural, or critical access hospital, to participate as a provider for Medicare. Therefore, each such hospital would be required to: be primarily engaged in providing diagnostic and therapeutic services or rehabilitation services to inpatients; and if the hospital has an emergency medical department, provide certain emergency medical care. The bill eliminates the designation of a hospital that offers services in at least medical, surgical, and obstetric categories as a general hospital and removes references to general hospitals. By removing that designation, certain provisions will apply to all hospitals. Specifically, those provisions concern: (1) the referral of a patient to certain surgical hospitals in which the referring physician has an ownership interest; (2) state assistance to publicly owned hospitals; and (3) the provision of inpatient care to persons with a mental illness or an intellectual disability and the responsibility to pay for certain care provided to such persons.

There are no amendments for this measure.

Chairwoman Cohen:
Are there any questions by Committee members? I am seeing none. I will be looking for a motion to do pass.

> ASSEMBLYWOMAN DURAN MADE A MOTION TO DO PASS ASSEMBLY BILL 232.
>
> ASSEMBLYWOMAN MUNK SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblywoman Titus:
I respect all of the members who have put this bill forward. I understand their intent. But I am very concerned about the bill mandating that businesses sign with an entity. I think it is definitely unfair practice. I will not be able to support this bill.

Chairwoman Cohen:
Are there any other comments? I am seeing none.

> THE MOTION PASSED. (ASSEMBLYWOMAN TITUS VOTED NO. ASSEMBLYMAN HAMBRICK WAS ABSENT FOR THE VOTE.)

I will ask Assemblywoman Nguyen to handle the floor statement.

We will move on to Assembly Bill 252.

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

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit R).] Assembly Bill 252 removes the reference to persons with developmental disabilities from the definition of the term "community-based living arrangement services" (CBLAS), thereby prohibiting the holder of a certificate to provide such services from serving persons with developmental disabilities unless the holder also holds a certificate to provide CBLAS. The bill requires a person employed by a provider of CBLAS, for the purpose of supervising or providing support to recipients of services, to be proficient in the language spoken by a majority of the recipients to whom he or she provides services. The measure also prohibits a child under 18 years of age from residing in a home operated by a provider. A provider is required to provide each recipient of services with access to licensed professionals who are qualified to provide supportive and habilitative services.

A provider is required to prominently post a sign with the telephone number for making a complaint to the Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS). The bill requires DPBH to establish an individualized plan for

each recipient of CBLAS. The bill requires a provider of CBLAS to reimburse DPBH for any overpayment for a bill submitted to the Division on or after January 1, 2017. The bill prohibits DPBH from renewing the certificate of a provider who has failed to provide such a reimbursement or make certain corrections required by the Division.

The measure requires an annual independent financial audit of each contract between DPBH and a provider and removes the requirement for such audits, effective on October 1, 2023. The State Board of Health must adopt regulations prescribing required training and continuing education for an operator of a provider of CBLAS and certain employees. Further, an applicant for a certificate is required to take certain actions to ensure that, if the applicant becomes insolvent, recipients of services from the applicant would continue to receive such services for two months at the expense of the applicant. The Division is required to conduct an investigation before issuing a certificate to provide CBLAS; and as part of the investigation, inspect any home operated by the applicant in which the applicant proposes to provide services.

An amendment is proposed by Assemblywoman Benitez-Thompson. The amendment:

1. Removes the annual financial audit requirement by deleting section 4;

2. Clarifies in section 7 that a holder of a certificate to provide CBLAS may provide services to any person with a primary diagnosis of a mental illness, even if the person has a secondary diagnosis other than a mental illness; and

3. Adds Assemblymen Alex Assefa and Richard Carrillo as sponsors.

In addition, conforming changes to *Nevada Revised Statutes* (NRS) 433.607 are necessary:

NRS 433.607 Certificate required to provide services; exception.

1. Except as otherwise provided in subsection 2, a person, government, or governmental agency shall not provide services without first obtaining a certificate from the Division.

2. A natural person who has not been issued a certificate but is employed by the holder of a certificate may provide services within the scope of his or her employment by the holder. This was added to NRS by 2017 Statutes of Nevada, Page 1406.

Chairwoman Cohen:
Are there any questions by Committee members? I am seeing none. I will ask for a motion to amend and do pass.

ASSEMBLYWOMAN NGUYEN MOVED TO AMEND AND DO PASS ASSEMBLY BILL 252.

ASSEMBLYWOMAN DURAN SECONDED THE MOTION.

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

I will ask Assemblyman Carrillo to handle the floor statement.

Chairwoman Cohen:
Committee members, do you have any comments or questions? [There was no response.] Is there anyone wishing to come forward under public comment? [There was no response.] We are adjourned [at 3:39 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 Legislative Auditor report number LA20-06, titled, "Performance Audit on the Department of Health and Human Services Aging and Disability Services Division Supported Living Arrangement Program," published by the Audit Division of the Legislative Counsel Bureau, dated March 19, 2019, and presented by Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27.

Exhibit D is a proposed conceptual amendment to Assembly Bill 317, presented by Assemblywoman Maggie Carlton, Assembly District No. 14.

Exhibit E is a copy of a PowerPoint presentation titled "Trauma System Design for State of Nevada and Southern Nevada Health System," dated April 10, 2019, presented by Michael Heil, Principal, Healthworks.

Exhibit F is a letter dated April 10, 2019, authored by Eugene Bassett, Senior Vice President of Operations, Dignity Health, and Kim Shaw, Chief Operations Office, Dignity Health-St. Rose Dominican, in opposition to Assembly Bill 317, submitted by Katie Roe Ryan, Director, Public Policy, Dignity Health-St. Rose Dominican.

Exhibit G is a document titled "AB469—Nevada Patient Protection from Surprise Bills," from the Health Services Coalition, submitted by Maya Holmes, Healthcare Research Manager, Culinary Health Fund.

Exhibit H is a chart titled "Average Billed Charges Per Adjusted Inpatient Admission," from the Health Services Coalition, submitted by Maya Holmes, Healthcare Research Manager, Culinary Health Fund.

Exhibit I consists of a number of charts of top inpatient and outpatient categories billed in Nevada, from the Health Services Coalition, submitted by Maya Holmes, Healthcare Research Manager, Culinary Health Fund.

Exhibit J is written testimony submitted by Maria Jimenez, Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 469.

Exhibit K is a proposed amendment to Assembly Bill 430, presented by Assemblywoman Shea Backus, Assembly District No. 37.

Exhibit L is written testimony dated April 10, 2019, submitted by Sarah D. Larrabee, Private Citizen, Henderson, Nevada, in opposition to Assembly Bill 430.

Exhibit M is a compilation of letters in opposition to Assembly Bill 430.

Exhibit N is a letter dated April 11, 2019, to members of the Assembly Committee on Health and Human Services, authored by Elissa Wahl, Chair, and Matt Alder, Vice-Chair/Treasurer, Nevada Home School Network, in opposition to Assembly Bill 430.

Exhibit O is the Work Session Document for Assembly Bill 66, dated April 10, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit P is the Work Session Document for Assembly Bill 150, dated April 10, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit Q is the Work Session Document for Assembly Bill 232, dated April 10, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit R is the Work Session Document for Assembly Bill 252, dated April 10, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.