MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eightieth Session
April 29, 2019

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 4:12 p.m. on Monday, April 29, 2019, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

COMMITTEE MEMBERS ABSENT:

Senator Pat Spearman, Vice Chair (Excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27
Assemblywoman Lesley E. Cohen, Assembly District No. 29
Assemblywoman Connie Munk, Assembly District No. 4
Assemblywoman Rochelle T. Nguyen, Assembly District No. 10

STAFF MEMBERS PRESENT:

Megan Comlossy, Committee Policy Analyst
Eric Robbins, Committee Counsel
Vickie Polzien, Committee Secretary

OTHERS PRESENT:

Sarah Adler, National Alliance on Mental Illness
Helen Foley, Nevada Assisted Living Association

Jeanne Bishop Parise, Nevada Assisted Living Association
Margot Chappel, M.S., Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
Lisa Foster, State of Nevada Association of Providers
Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Serena Evans, Policy Specialist, Nevada Coalition to End Domestic and Sexual Violence
Chris Bosse, Renown Health
Joan Hall, Nevada Rural Hospital Partners Foundation
Elisa Cafferata, Planned Parenthood Votes Nevada
Joanna Jacob, Dignity Health – St. Rose Dominican Neighborhood Hospitals
Jessica Ferrato, American College of Emergency Physicians
Izzy Westerman, Associated Students of the University of Nevada
Marlene Lockard, Nevada Women's Lobby
Jesse A. Wadhams, Nevada Hospital Association
Bobbette Bond, Culinary Health Fund
Chelsea Capurro, Health Services Coalition
George Ross, Sunrise Hospital and Medical Center
Todd Ingalsbee, Professional Firefighters of Nevada
Dan Musgrove, Valley Health System
Mike Draper, Elite Medical Center
Patty Holden, CEO, Elite Medical Center
Eric McLaughlin, M.D., Elite Medical Center

CHAIR RATTI:
I will open the hearing on Assembly Bill (A.B.) 252.

ASSEMBLY BILL 252 (1st Reprint): Revises provisions relating to providers of community-based living arrangement services. (BDR 39-656)

ASSEMBLYWOMAN TERESA BENITEZ-THOMPSON (Assembly District No. 27):
I am here to present A.B. 252 for your consideration. Over the Interim, I chaired the Legislative Commission's Audit Subcommittee. I was especially interested in the Community-Based Living Arrangements (CBLA). There were a series of audits completed to address several issues. One would be the conditions of a CBLA and what was happening in terms of resident care. Another was how the State pays for these homes. I will be referencing Legislative Audits LA18-13

(Exhibit C) and LA18-24 (Exhibit D) throughout my presentation of the individual sections of the bill.

There has been a considerable amount of media attention about the state of our CBLA homes. In past Legislative Sessions, we made a step forward in terms of quality and getting these homes on the map, knowing they exist and creating a process for certification of the homes. We now have information from these audits to help us better understand the direction in which we need to move.

Section 2 of A.B. 252 puts in place a requirement that each person employed in the home demonstrate verbal and written proficiency of the language of the majority of the residents in the CBLA. The conceptual amendment (Exhibit E) would match language we see in *Nevada Revised Statutes* (NRS) 433.269, which is a proficiency for English for those who hold a certain type of degree and work in a medical setting.

A theme we saw throughout the audits was the inability of the staff to communicate with the clients in the home. There was no way the clients in the home were having their needs met when the staff could not communicate with them. The staff could not keep track of medications or make actual notes as they were not able to communicate in the language of the residents. We saw this in several sections of our audits. It is important we have a language proficiency to ensure records coming to us are accurate, and there is an exchange of information happening with the clients in the home.

Section 2, subsection 2 of the bill states a child under the age of 18 must not reside in the home. This was seen in audit LA18-13 on page 21. During the inspections there were young children observed living in 2 of the 37 CBLAs. An example on page 21 showed:

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

The clients we are talking about only coming to the CBLA because they have had an interaction with law enforcement. These folks are more than likely not

the best choice for your childcare options. The purpose of the CBLA needs to be for the clients in the home, and other arrangements made for child care. The Division of Public and Behavioral Health (DPBH) did work to address this and was one of the first things tackled once the audit was published. We want to ensure we draw a bright line in statute that these CBLAs are not intended to have young children in them, and the clients are not intended in any way to serve as caregivers.

Section 2, subsection 3, paragraphs (a) and (b) provide for a pilot process regarding the licensed professionals qualified to provide support in these homes. Another theme we saw throughout these audits showed there were people hired to be in the homes with no qualifications, knowledge or skills sets required for managing the CBLAs and interacting with the clients in the home. This population of client is a very difficult one to work with. We wanted to ensure these homes were for rehabilitation and not a warehouse where we put people without any type of supportive services in place.

Section 3 of the bill states the DPBH needs to create and provide case management services, and clearly define supervision hours versus case management hours. If law enforcement is having an interaction with these clients, there are behavioral and compliance problems that are happening. We need to have a case plan with case managers who are able to tend to these clients. Each client will have a different level of need. Perhaps they do not need eight or nine hours a day of intensive case management; they may only need four to five hours. The remainder of those hours would be supervision hours. As a State, we need to be able to track when someone is getting case management services versus when they are getting supervision services for a clear distinction between what the services are and who is providing them.

Section 3, subsection 3, based on audit LA18-24, pages 11 through 13 speaks to an overpayment made to a CBLA. We need to have language in statute allowing the State to collect that overpayment once it has been identified. For those who followed the audit, there were a lot of overpayments made.

Section 4 of the bill was deleted by amendment in the Assembly. We were asking to have financial audits done so we would not continue to have the overpayments and systemic issues we found in the audit. It made more sense for the Legislature to continue with the audits. In another budget piece, we are

allowing the addition of two auditors for the purpose of keeping tabs on programs to protect the public.

Section 5 lists the reasons a CBLA should not receive a certificate to operate. If you have had a corrective action plan from problems identified in a CBLA and they have not been corrected, you should not be issued or have a certificate renewed.

Section 7 of A.B. 252 creates or changes the definition of the CBLA. We want to be clear about who is coming into these homes. We want to ensure it is a person who has a primary diagnosis of mental illness, which is covered in section 7.5, subsection 3. This person can have a secondary diagnosis that will also be addressed. The primary reason for their care is for the mental illness and the interaction with law enforcement. Once we get them in the home, the individualized plan and case management services will address all of the persons' identified issues.

Section 8 comes from information in audit LA18-13, pages 23 and 25. We have owners and employees in CBLAs who have a lack of knowledge about the clients they are attempting to serve. We need to enhance their education and knowledge of the clientele they are working with. This is a difficult population for those who are licensed, have taken extensive courses and know how to interact with this population. We want to see the people caring for this population become more knowledgeable about the traits, diagnoses and behaviors they may come across.

Section 8, subsection 4 requires an applicant to post a surety bond for the expenses equal to 2 months of operating costs. The first problem brought to the communities' attention was one of the owners became insolvent because they operated several homes. They closed overnight, leaving us with clients who needed services. We want to make sure people have the ability to operate and finances exist when there is an issue. Second, if we overpay them and we need to recoup the overpayment, we need to know there is money being held where the State can recover some of those funds.

Section 9 states before issuing a certificate for a CBLA, the DPBH can perform an inspection of the home to make sure the home is safe and in good condition. We had over 2,000 pictures of homes in filthy, unsanitary conditions seen in

audit LA18-13. It is common for other health care facilities that an inspection is completed before clients are allowed in the home.

The overall goal was to address the most egregious concerns we found in the audits and those coming from the DPBH in terms of practices, to ensure the corrections were made to NRS.

SENATOR HAMMOND:
The question I have is in section 2, subsection 1 with regard to whether there is a time frame for when you want to staff these CBLAs?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
Audit LA18-13, page 22 it states:

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

This is a big problem. The legislative intent is that we need people working in the home who can speak the language of the clients living there. You asked about a specific time frame for staffing the home. I hesitate to give one because I would say it is unacceptable that it is not happening right now, or that it would not happen on passage and approval of this piece of legislation. I also know it would not be practical. We would need to have ongoing conversations with the DPBH to make sure that when our auditors are going back into the homes we are able to have a line in statute of what should be happening. We must have the ability to communicate so we can address this issue moving

forward, and our auditors can continue to report whether or not homes are moving in the direction of compliance.

SENATOR HAMMOND:
I see where you may not want to have a specific time frame, but at the same time, one is needed. I see two ways of this happening. You find caregivers who speak the language of the clients in the home, or you change the majority of the clients residing in the home so you have someone who speaks the language.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I believe that to be true and would be comfortable discussing a good benchmark with you. We would not come back to address the NRS for another two years, so it might be reasonable to say we have a benchmark within regulations addressed. My goal would be to expect real progress in six months. Our auditors have a schedule of when they follow-up on audits.

CHAIR RATTI:
To be clear, we have an amendment that has been replaced with the one you provided which will align the language pursuant to NRS 443.269. What the bill states is to "demonstrate verbal and written proficiency in the language spoken by a majority of the recipients". The amendment states "the ability to communicate in English". Is it one or the other, or both?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
Per NRS 433.269, the administrator shall not employ anyone who is unable to demonstrate proficiency in the oral and written expression of the English language. My intent would be that these homes shall not employ anyone who cannot demonstrate or have the ability to communicate in English. I do not think written proficiency makes sense here. We have the question of what does written proficiency mean and then what does the test and metric look like. Most important would be verbal communication, and that is where I would focus my attention.

CHAIR RATTI:
The focus is the verbal communication in English. Are there any requirements for the language of the residents?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
We are going to remove that. By default, we end up with mandating those who can speak two languages. I believe we should focus on the first language and contemplate that further down the line as we become more sophisticated with these homes.

CHAIR RATTI:
Should we be considering the patient who does not speak English should have access to the services of a translator on a regular basis?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I think it makes sense to have access to services in a client's language or to have a translator available.

SENATOR HARDY:
You have 11 out of 22 caregivers who do not speak the language of the clients in the home. How many of the 11 caregivers will have to seek other employment because of this?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
There have been some changes as the DPBH has been working with the CBLAs to correct the issues identified in the audits. Our auditors will periodically go back to the CBLAs to check the progress being made. My hope would be that within a year's time we look back and know that 100 percent of the caregivers are able to speak the language of the clients they are serving. Writing that as a legislative intent, or as a firm NRS rule has been difficult to navigate. I would expect in two years we should be able to contemplate a hard and fast rule.

SENATOR HARDY:
From a medical standpoint, "you have a right" to have a translator. A CBLA is not a medical facility so they are not under the same obligation of providing a translator who is not a family member or friend. I understood you to say it is not so much the language the person speaks as it is the language we are going to use, which is English.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
We have a few different options. The least would be to do nothing and not address this. The next would be to have a hard and fast rule that ideally you speak the language of the client in the home, and the client has access to

someone who speaks their language. I do not know how prudent it would be to have us put this in statute right now. The third option would be to start with the mandate that the caregivers can communicate in English, so when the auditors come for a review of the home, the caregivers have that skill set.

Of the options we have, the best step forward is to look at the language that currently exists in statute in NRS 433.269 and say we have a precedent to use moving forward.

SENATOR HARDY:
Is there anything that speaks to making these regulations and heading in that direction?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
Section 8 is regarding adopting regulations without limitations. If that does not apply to section 2, then we could look at that happening. There is language in A.B. 252 giving the authority to promulgate regulations. I will check with your Committee legal staff to make sure that will apply to section 2 as well.

SARAH ADLER (National Alliance on Mental Illness):
The National Alliance on Mental Illness supports A.B. 252. We appreciate the legislative auditors for assembling these horrific findings. Every component of this bill is important. Residents will be safer, be supported in their recovery rather than warehoused, and money will be spent with benefit, not misused.

I have a godson who lived in seven different CBLAs where he barely survived in unacceptable conditions. In one home, multiple times a week he had to be the caregiver for another resident who would have epileptic seizures.

HELEN FOLEY (Nevada Assisted Living Association):
This is an issue we have been concerned about for the past several sessions. We are proud of the action that has been taken. People are not safe in many of these facilities. This bill goes a long way in trying to resolve the problem.

As Ms. Adler mentioned, one of the issues is that the caregivers in these homes for 24 hours are not skilled. Maybe some residents do not need supervision for 24 hours, but others do. Residents of the home end up being responsible for others when they all have mental illnesses making it extremely difficult. It is not

safe for our most vulnerable populations. The Nevada Assisted Living Association supports A.B. 252.

SENATOR HARDY:
Are you suggesting this be redefined to have skilled caregivers in the home 24 hours a day, 7 days a week?

MS. FOLEY:
Not necessarily. It depends on the level of care required by the individuals living in the home. There has to be much closer attention paid by the State to peoples' vulnerabilities and where they are placed. The budget Subcommittee found people would come in with specific specialties to provide services, and perhaps there was no food in the refrigerator and this issue was not addressed. They only took care of their services and many of these kinds of problems went unnoticed. Some clients will need 24 hour care and others may not. It is going to be a process the State will need to actively play a role in determining, which is not currently the case.

SENATOR HARDY:
What do we call 24 hour supervision if it is not at the CBLA?

JEANNE BISHOP PARISE (Nevada Assisted Living Association):
I am a licensed residential facility administrator in Nevada. I am also the Co-Chair for the Assisted Living Advisory Council. What we are mapping out is a continuum of care. I have an endorsement for my facility for mental illness that requires additional training in oversight. These are prevalent throughout NRS 449 relating to licensed residential facilities for groups. We have to operate 24 hours a day, 7 days a week for those diagnosed with a mental illness, requiring this 24/7 supervision.

Sometimes in a CBLA you have someone who does well, is rehabilitative and only requires daytime monitoring. They might also go out for a sheltered workshop session or something along those lines and only need an eight hour certified medication technician who sets up their medications and provides supervision in that way.

Our facilities with the mental illness endorsement and 24/7 care have a 16 hour medication technician certification.

CHAIR RATTI:
There are the types of facilities you are talking about that provide the 24 hour care, and if that client needs 24 hour care, that is where that client should be referred. This bill requires an individualized plan for the provision of services. This would imply where there is an assessment and specifically states in section 3, subsection 1, paragraphs (a) and (b):

> A description of the case management that must be provided to the recipient and a designation of the entity responsible for providing those services; and
> the hours during which the provider of services must provide supervision and support to the recipient.

These facilities are short of the 24 hours, but this bill states each individual resident must have an assessment and plan of care. That plan of care would specifically state they need this many hours of supervision and support services.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
Specific to Senator Hardy's question, right now the CBLA services have clients living within the mental health statutes, and NRS 433.605 defines what the community-based living arrangement service is and who it is for. This bill proposes to change the population, but also states the CBLA be designed and coordinated to assist such persons and maximize their independence.

This bill will better define what the "assist such persons" is through clearly defining the type of skilled services they are going to have provided. These services could be provided by an occupational therapist or licensed social worker, or someone who is in the home simply reminding them of their medications and perhaps does not need intense rehabilitative services. Right now, these plans are just starting to live. With statute, we will say all of these clients will now have these types of plans.

SENATOR HARDY:
So there will be a CBLA, a CBLAB, and a CBLAC depending on the requirements that are needed.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
No, there will only be a CBLA with the defined group of the mentally ill who have had interactions with law enforcement. There are other types of homes,

such as the supportive living arrangement (SLA), but for now we are only talking about the mentally ill who have had interactions with law enforcement.

MARGOT CHAPPEL, M.S. (Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services):
Currently, an individual has a case management plan which will indicate whether they need 24 hour care or a certain number of hours of supervision. In one home you may have 1 person who needs 24 hour attention and another 3 individuals in the same home who do not require that level of service.

We are in the process of working toward a daily rate. One of the things we have been talking about is licensing the CBLA homes at different tier levels. One home may be qualified for just those who are less intense in their needs, and one that houses all who need 24 hour care. That is not firm, but something we are considering. Today we have CBLAs with a population requiring a variety of different needs. We like the idea of having the home well-integrated with people who require different needs. This lends itself to more of an inclusive environment and being person-centered.

CHAIR RATTI:
It is very easy to get confused about all of the different group home environments because there are so many. What we are talking about are those that are in NRS 433. Ms. Chappel, yours are not in NRS 433, correct?

MS. CHAPPEL:
That is correct, ours are referenced in NRS 449.

CHAIR RATTI:
You support this because in NRS 449 there is a regulatory process and more protections and you would like to see some of those similar things for NRS 433 types of organizations, correct?

MS. CHAPPEL:
Yes. The Legislative Counsel Bureau (LCB) Audits found there was some crossover into our area as opposed to keeping the CBLA distinct.

SENATOR HARDY:
If I owned a CBLA, I would not want an integrated model as I might be accused of having someone take care of someone else who was less able. Then again, with an integrated model I would have to keep track of all of the different types of individuals as opposed to one model and one need; one reimbursement level which would make the auditor's job much easier, as well as the caregivers. I would like to know what I was responsible for and meet the criteria at the same time without having to bring in a caregiver for only one person, but one that could handle several people.

CHAIR RATTI:
I agree with Senator Hardy. I am also concerned about smaller communities and rural communities that may just have one group home, and within that group home they may need to be able to handle all tiers due to the number of patients they are caring for.

I am appreciative of the good work of the Majority Leader to follow-up on the audit and make sure we are, letter by letter, line by line, addressing the audit. I know the Department of Health and Human Services (DHHS) has put in an effort to make sure we are making progress toward a better State.

CHAIR RATTI:
I will close the hearing on A.B. 252 and open the hearing on A.B. 471.

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

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I am here to present A.B. 471 for your consideration. This bill is also coming from a performance audit completed during this Session and released within the past month. It is the audit of SLAs from the Aging and Disability Services Division of the DHHS. The Audit had a good outcome; however, at the back of the audit, Appendix A, page 15 you will see a legal opinion regarding SLA providers serving individuals with a mental health diagnosis.

The question posed was, are SLAs empowered by statute to care for folks for more than just their developmental disability or mental illness? This bill looks to empower the agency to care for the entire needs of the person. By definition, first and foremost, the SLA would be for the population that has a primary

diagnosis of a developmental disability. If they have a secondary diagnosis of mental illness, such as depression, they are empowered to care for all of their needs.

LISA FOSTER (State of Nevada Association of Providers):
I represent the State of Nevada Association of Providers in support of A.B. 471. Our membership includes the majority of SLA providers in Nevada.

DENA SCHMIDT (Administrator, Aging and Disability Services Division, Department of Health and Human Services):
When we got the audit results, we were concerned with the legal interpretation. This clarifies the legislative intent and allows our providers to continue these critical services. We stand in a neutral position to A.B. 471.

CHAIR RATTI:
I will close the hearing on A.B. 471 and open the hearing on A.B. 131.

ASSEMBLY BILL 131 (1st Reprint): Revises provisions governing facilities and services for adults with special needs. (BDR 40-170)

ASSEMBLYWOMAN LESLEY E. COHEN (Assembly District No. 29):
I am here today to present A.B. 131 for your consideration. During the 2017-2018 Interim, I was the Chair of the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs. This bill will improve the quality of services provided to adults with special needs.

During the Interim, the Committee received testimony concerning services for adults with special needs, and in many cases the testimony was alarming. For example, we received a presentation from the staff of the LCB Audit Division about the findings of an audit on CBLAs. The purpose of the audit was to determine whether controls for monitoring such living arrangements are adequate to ensure the safety and welfare of adult mental health clients.

The findings and recommendations of the audit were issued in January 2018 and were troubling to say the least. In addition to its general duties, the Committee also carried out a study on the standards of training for persons who are not providers of health care, but who provide care to clients. This study was required to be carried out through passage of A.B. No. 299 of the 79th Session.

This study consisted of two components determining standards of training for persons who are not providers of health care but who provide care to clients, essentially looking at training for unlicensed workers. That would not, for instance, be the Certified Nursing Assistant who is licensed and has training. It would be training for others in a facility who are not licensed to help someone in and out of a bus, to bathe, to get dressed, etc.; physically helping clients in determining whether they need training and what that training would be.

The second component of the study was to consider the creation of a competency evaluation each person must take and successfully complete following training.

Based on the findings of A.B. No. 299 of the 79th Session study, and testimony received relating to CBLAs, the Committee approved A.B. 131 to improve services for adults with special needs.

Assembly Bill 131 relocates the provisions from NRS 433.605 regarding CBLA services under NRS 449, medical facilities and other related entities, to provide accountability for CBLA services to consumers.

The bill states that a CBLA be licensed, regulated and monitored by the Bureau of Health Care Quality and Compliance of the DPBH of the DHHS.

Section 10 provides a recipient of CBLA services with the same rights as recipients of services from other facilities for the dependent.

Moving CBLA to NRS 449 would also provide that entities must meet all requirements other facilities, hospitals, agencies, programs and homes must meet under NRS 449, such as background checks.

For example, sections 5 and 6 prohibit a person from operating or providing services as an employee or contractor for such entities if that person has been convicted of a crime. In addition, the bill states that providing false information in connection with the required background check is a misdemeanor. These are the sections that require a two-thirds majority vote for the measure to pass.

Sections 1 through 9, 12, 13 and 15 make conforming changes relating to moving the CBLA under NRS 449.

Section 4 of the bill requires an employment agency that contracts with persons who provide nonmedical services in a home to obtain a license from the State Board of Health. It clarifies that this requirement applies when the contracted services are provided in this State, regardless of where the agency is located.

During the Interim, concerns were expressed that certain non-licensed, out-of-state internet employment agencies are actively placing personal care aides in residences in Nevada and not complying with all of the State requirements.

The Nevada 2-1-1 program is addressed, because pursuant to NRS 232.359 the DHHS is required to establish and maintain the program. This program is a Statewide information and referral system that provides non-emergency information and referrals to the public concerning the health, welfare and human and social services available in the State. During the Interim, the Committee heard it was difficult for the public to find licensing information about facilities. Section 11 of the bill requires the 2-1-1 program to specify the licensing status for all entities licensed under NRS 449.

This section also requires the DHHS to review and update the information at least quarterly. The reason for looking at this was the concern about people touring a facility and seeing a city business license, then thinking the facility was fully licensed, inspected and vetted by the State when it was not.

Section 14 of the bill requires the Interim Committee to continue the study started under A.B. No. 299 of the 79th Session.

CHAIR RATTI:
The first bucket of the four you have discussed is relocating NRS 433.605 to NRS 449 to ensure those CBLAs licensed under NRS 433 have all of the accountability that exists in NRS 449.

The second bucket is trying to capture employers who are placing personal care attendants in Nevada with the employers being located out of the State to ensure they follow the same compliance.

The third bucket is ensuring we have the licensing information available and updated quarterly, so when people are calling 2-1-1 they can obtain the licensing status of the facilities they are calling about.

The fourth bucket is to continue the study, ensuring we are doing more analysis on the competencies for unlicensed providers.

SENATOR HARDY:
How many CBLAs are there that are affected by the transfer of the CBLA from NRS 433 to NRS 449? We have CBLAs that deal with law enforcement; how many other CBLA types are there?

ASSEMBLYWOMAN COHEN:
Currently, there are 21 licensed CBLAs in northern Nevada.

SENATOR HARDY:
How many categories are there?

MS. CHAPPEL:
There is one licensure type for the CBLA. If you are referring to the previous testimony, the license for a residential facility for groups is a separate type of facility. They do get a mental health endorsement as was stated. They can have clients who have mental illness in those homes, but they are not CBLAs. That is a separate single stream licensure.

CHAIR RATTI:
Section 3 references a list of 9 facilities for the dependent and this makes CBLAs the 10th that would have the same accountability as all of the other 9 listed to accomplish what is provided for in NRS 449.

The underlying philosophy of this part of the bill is if it looks like a group home and acts like a group home, we should treat it like a group home and it should have similar accountability.

MS. CHAPPEL:
That is correct.

SENATOR HARDY:
Does this bill deal with having an individual care plan for the client in the home such as in a CBLA?

ASSEMBLYWOMAN COHEN:
I believe all case managers have some sort of plan for each resident in all group home settings and they would all probably look different. The case management for those living in a half-way house for recovering alcohol and drug abusers would be done by whomever their staff is. The clients with mental illness would each have their own plan to meet their needs.

CHAIR RATTI:
My understanding is that this is something our LCB Legal Division will reconcile, but that there is no conflict between the two bills we have heard today that would strengthen the case management specifically for the CBLA population. Also moving it into NRS 449, both would still live if these bills were to pass.

ERIC ROBBINS (Committee Counsel):
That is correct. We would most likely put the information from A.B. 252 into NRS 449 and it would just apply to the CBLA. They would be enforced by the Bureau of Health Care Quality and Compliance with regard to requirements specific to other types of facilities governed by NRS 449.

MS. FOLEY:
The Nevada Assisted Living Association supports A.B. 131. We believe it makes more sense to have CBLAs under the same statutory regulations of NRS 449. The CBLAs are the only ones that have been left out besides the SLAs, which are entirely different and doing an excellent job. The problem child has been the CBLA and we believe the DHHS can work much better to ensure this happens.

Payment is another issue that should be looked at carefully and perhaps tightened up through regulation.

MS. BISHOP PARISE:
I concur with Ms. Foley.

MS. ADLER:
National Alliance on Mental Illness supports A.B. 131.

ASSEMBLYWOMAN COHEN:
I have a chart from DHHS that breaks down the group housing spectrum of care that I will provide the Committee.

CHAIR RATTI:
I will close the hearing on A.B. 131 and open the hearing on A.B. 124.

ASSEMBLY BILL 124 (1st Reprint): Requires a hospital or independent center for emergency medical care to provide certain information to a victim of sexual assault or attempted sexual assault. (BDR 40-591)

ASSEMBLYWOMAN CONNIE MUNK (Assembly District No. 4):
I am here today to present A.B. 124 for your consideration.

Assembly Bill 124 is a resource booklet intended to provide the sexual assault victim with practical information after a sexual assault. It does not provide legal or medical advice; however, it gives the victim of sexual assault a lifeline. It is also a resource to answer questions when a victim presents at a hospital emergency room or clinic anywhere in Nevada.

I am bringing this bill forward as I have worked as a sexual assault counselor performing rape kits on victims. I am also sharing with this Committee that I have a family member who was gang-raped, taken outside of town and dumped like a piece of trash along the roadside. As a family, we had no information at the time on who we should contact for counseling or what to expect.

Currently, Nevada law does not require emergency rooms, hospitals or clinics to provide information or emergency contraception to these victims. For example, if a victim presents in Ely, Tonopah, West Wendover or Lovelock, those hospitals are not equipped to perform rape kits, nor do they have the information in writing for the victim. We only have a few areas in the State that do perform rape kits through a Sexual Assault Nurse Examiner (SANE).

This brochure will be Statewide and organized by region. Again, this is a resource tool for all hospitals and clinics to help them better treat and serve victims of sexual assault. The booklet will include medically and factually accurate information concerning emergency contraception and prophylactic antibiotics, and other services such as counseling, clinics and other facilities specializing in servicing victims in their area. It will also include a list of locations that provide testing for a sexually transmitted disease (STD), contact information for law enforcement, or an opportunity to meet with an officer to file a complaint.

I have been working with the Nevada Hospital Association, Renown, University of Nevada and emergency room doctors to produce this pamphlet.

SERENA EVANS (Policy Specialist, Nevada Coalition to End Domestic and Sexual Violence):
Because of the traumatic nature of sexual assault, victims may not be receptive or able to retain any verbal information given to them. Providing victims with written information will allow them to review and revisit the information when they are more willing and receptive.

Currently, victims are only receiving information about follow-up medical care concerning emergency contraception, prophylactic antibiotics for STDs or sexually transmitted infection prevention and community resources when they are visiting a sexual assault forensic medical exam location.

There are currently only six locations in the State that provide forensic medical exams. However, not all victims choose to undergo a forensic medical exam and may choose to seek care at the nearest hospital where they will not have contact with the SANE nurse or an advocate who are often the ones who provide this information.

In addition, information received by victims may also be inconsistent and change from one location to the next throughout the State.

This bill simply aims at creating continuity among all hospitals to direct services to vital resources in their community. It will require all hospitals to provide accurate and consistent written information to victims of sexual assault, and will ensure all individuals receive helpful information that may assist with their health and healing following an assault.

ASSEMBLYWOMAN MUNK:
We were able to secure pamphlets that are being used from several states. Some states hand out information on paper, other states provide pamphlets. We are thinking this is a simple, easy way to provide information for the victims of sexual assault.

CHRIS BOSSE (Renown Health):
Renown Health supports A.B. 124. As an industry, this bill will ensure that we can consistently serve sexual assault victims. The development of a tool by

region which provides information once they leave a facility, along with local resources, is vital. Dr. Frey, one of the medical directors of the emergency room in Reno was not able to attend this hearing today, but is appreciative of the efforts of this bill and understands the importance of consistently providing information to these vulnerable patients.

JOAN HALL (Nevada Rural Hospital Partners Foundation):
The Nevada Rural Hospital Partners Foundation supports A.B. 124.

ELISA CAFFERATA (Planned Parenthood Votes Nevada):
Planned Parenthood Votes Nevada supports A.B. 124.

JOANNA JACOB (Dignity Health – St. Rose Dominican Neighborhood Hospitals):
Dignity Health - St. Rose Dominican Neighborhood Hospitals supports A.B. 124.

JESSICA FERRATO (American College of Emergency Physicians):
The American College of Emergency Physicians supports A.B. 124. I would also like to include the Nevada State Medical Association supports A.B. 124.

Victims of sexual assault often come to the emergency room seeking refuge and help, most by walk-in and unfortunately all too often, they are alone. It should be noted most triage processes have specific questions designated to identify victims of violence and abuse even if that is not their chief complaint. The American College of Emergency Physicians believes A.B. 124 provides a comprehensive approach to the sexual assault victims both during and after emergency care, and seeks to minimize any chance of an accidental omission of important information or care.

If passed, this bill will enhance the awareness of the importance of having a unified and consistent approach to sexual assault victims in Nevada.

IZZY WESTERMAN (Associated Students of the University of Nevada):
I am a student of the University of Nevada, Reno; a Senator Representative of the College of Liberal Arts and member of the Associated Students of the University of Nevada (ASUN).

In March, an ASUN resolution written by Senator Mika Alvarez was passed in support of A.B. 124, which would improve the medical treatment experiences of the victims of sexual assault. According to the University of Nevada, Reno

2016 Sexual Conduct and Campus Safety Survey, 8 percent of the students who participated self-identified as victims of physical and sexual assault or rape.

The University of Nevada Student Health Center is only open during the hours of 8:00 a.m. and 5:00 p.m., and is closed on weekends and holidays. Emergency contraception is most effective the earlier it is taken and A.B. 124 would ensure victims of sexual assault were not only provided with options for this emergency contraception, but also any educational information necessary to handle the trauma they have endured.

Students I personally interact with have been afraid to go to hospitals after their assault when the Student Health Center is closed. There is a negative stigma that accompanies merely telling anyone, including health care professionals. This deters them from obtaining the proper medical attention they need.

The students of the University and I believe A.B. 124 will provide a positive experience with the health care system victims need and deserve.

MARLENE LOCKARD (Nevada Women's Lobby):
The Nevada Women's Lobby supports A.B. 124.

CHAIR RATTI:
I will close the hearing on A.B. 124 and open the hearing on A.B. 232.

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

ASSEMBLYWOMAN ROCHELLE T. NGUYEN (Assembly District No. 10):
I am here today to present A.B. 232 for your consideration.

This bill requires certain hospitals to participate as a provider in the Medicare program and eliminates the designation of general hospitals and some other related matters.

Like other parts of the Country, Nevada has seen an increase in the number of free-standing emergency room hospital-type facilities that are less traditional than we are accustomed to. These differ from general hospitals and urgent care centers.

We have seen that the marketing of these facilities has led to confusion on the part of residents seeking appropriate care. We are hoping A.B. 232 seeks to provide greater clarity in statute to these patients by ensuring these facilities promoting themselves as hospitals meet certain requirements.

The facilities we are talking about are not contracted with the Centers for Medicare and Medicaid Services (CMS) and cannot bill Medicare or Medicaid. Since these facilities do not participate with CMS, they are not bound by the federal Emergency Medical Treatment and Labor Act (EMTALA). This is a federal law requiring anyone coming into an emergency department to be stabilized and treated regardless of their insurance status or ability to pay.

I do not believe any of these facilities are not doing this; however, since they do not contract with any health insurance, they leave patients responsible for the cost of any out-of-network care. They rely on the Affordable Care Act (ACA) provision that requires health insurance providers to reimburse all emergency facilities and providers on an in-network basis for emergency services. If they charge higher than what the insurer would pay in-network providers, they would balance bill the patient.

JESSE A. WADHAMS (Nevada Hospital Association):
Assembly Bill 232 has one operative section, which is section 2 that states a hospital, other than a psychiatric hospital, critical access or rural hospital, shall enter into an agreement to accept payment through Medicare. This would mean all Nevada hospitals must be willing to accept payment through Medicare.

Section 21 states a hospital shall enter into an agreement as soon as practicable. By accepting the terms of Medicare participation, a corresponding obligation is triggered, which is the compliance with federal EMTALA. Broadly speaking, EMTALA means if I present myself to an emergency room I will be examined, triaged and provided any necessary medical care to stabilize my condition without any consideration of my ability to pay. I cannot be turned away because I cannot pay or am covered by Medicare or Medicaid.

Nevada does have a similar provision in NRS 439B.410. We believe federal EMTALA is imposed as an obligation of being a Medicare participant. The most significant difference of federal EMTALA and NRS 439B.410 is the charges for those covered services are specifically limited to the Medicare allowable amount.

There may be some ambiguity as to whether or not federal EMTALA is currently imposed either through regulation or statute. Certain provisions of EMTALA are self-referential, inasmuch as having on-call physicians are imposed because the hospital is Medicare participating. Rather than having that ambiguity and arguability in State law, we believe it should be the responsibility of the policymakers at the Legislature to impose the participation and obligations of participating in Medicare.

We do not believe this bill is anticompetitive, but we do welcome competition believing it makes us all better. In addition to a new hospital being built in northern Nevada, there are a number of new facilities that have been built in recent years, including several micro-hospitals that have opened in southern Nevada. We believe this bill is ultimately about a fair playing field and codifying the expectations for when someone presents to a hospital that they receive a hospital experience.

SENATOR HAMMOND:
Do you know of any hospitals not treating patients according to EMTALA?

MR. WADHAMS:
I am not familiar with complaints that may or may not have come to the DHHS. We do think we want to clarify any ambiguity as to whether or not federal EMTALA does apply.

ASSEMBLYWOMAN NGUYEN:
Whether or not there are any actual complaints, the ambiguity of not doing this is you may now have a player that is complying as it is in their business model. However, it does leave the door open to those players that might see this as a loophole and be able to get the payment through the ACA where they are able to get reimbursed for emergency services. There may be complaints in the future, so it would be prudent to clear up the ambiguity to ensure our NRS is in compliance with the federal statute.

CHAIR RATTI:
Would it be fair to say this has been a growth industry in other states so the intent is to close that ambiguity before we have significantly more players in this market?

MR. WADHAMS:
Yes. To the extent that there is ambiguity, and that other players may not be good participants in the market, we ought to clarify it.

SENATOR HARDY:
You stated that federal EMTALA is different than Nevada NRS, as federal EMTALA does not require the freestanding facilities to charge more than what Medicare or Medicaid pays.

MR. WADHAMS:
As I understand, one of the differences between federal EMTALA and NRS 439B.410 is that federal EMTALA would limit the amount that is chargeable to a Medicare patient to the Medicare allowable charge under federal EMTALA.

SENATOR HARDY:
Are you saying there is someone who is charging more than what Medicare or Medicaid would pay?

MR. WADHAMS:
They could under the ambiguity.

SENATOR HARDY:
Should this go into effect on January 1, 2020, what becomes of the facility currently in business? Does that ruin their property and make us liable for property taking?

MR. WADHAMS:
I cannot answer that question. That would be a question for the operators and owners of the business.

CHAIR RATTI:
We have heard other bills where we are changing the licensing requirements on existing businesses. The question would be if we are changing the licensing requirements significantly enough.

If our goal is the mechanism of requiring participation in Medicare, but the real goal is to have compliance with federal EMTALA, mechanically why did we not just add that they were required to follow federal EMTALA in the law?

MR. WADHAMS:
There are different ways to ultimately "skin the cat." Section 1867(a) of the Social Security Act imposes specific obligations on Medicare participating hospitals that offer emergency services. I understand it to mean you participate in Medicare and get the payment mechanism, but the obligation is EMTALA. It is basically a contract, the benefit and the bargain.

SENATOR HAMMOND:
You are saying there may be some ambiguity, but right now there is no evidence there is anyone who is not complying with EMTALA. I understand there is an obligation because they are attending to those patients. They are just not charging the Medicare rate for the services that are rendered.

If we add a law to clarify that EMTALA needs to be obeyed, that is one thing. In this bill, I believe you are asking to ensure they change their business practice and make sure they bill Medicare when they do not want to. Perhaps they just want to treat the patient but not necessarily charge those rates.

MR. WADHAMS:
We do want the policymakers to set the policy, but as I understand with participation in Medicare and Medicaid you do not need to charge them. You need to be willing to accept the payment Medicare allows if you participate.

ASSEMBLYWOMAN NGUYEN:
You will hear testimony from the opposition and perhaps other hospitals. At the end of the day, every single hospital is participating in Medicare and Medicaid in Nevada with the exception of the one potential, and others potentially coming into the market. This is a national trend where there are other state legislatures setting policies on how they want to handle these non-traditional hospitals and freestanding emergency rooms.

This clarifies and makes it an even playing field. It makes it understandable for the patients and our constituents that are going to these facilities thinking they are going into a hospital to be treated and be charged a fair rate.

SENATOR HAMMOND:
Are you saying there are other states that have done this to ensure their place in the market and passed laws stating every hospital needs to be participating in

Medicare and Medicaid through the U.S. Department Health and Human Services?

ASSEMBLYWOMAN NGUYEN:
I am not sure they have done it the same way Nevada has, but they have set statutory policies on how these particular facilities are being regulated. I will look into that further for you.

CHAIR RATTI:
There are some states where none of these freestanding facilities are opening and some where many are opening based on the NRS environment of those states. Coming back to us with some clarity on this would be appreciated.

ASSEMBLYWOMAN NGUYEN:
I would be happy to do that for you.

BOBBETTE BOND (Culinary Health Fund):
I am the Policy Director for Unite Here Health, which in Nevada is the Culinary Health Fund, supporting the intent and goal of A.B. 232. From our prospective, I cannot answer the technical questions raised here today with regard to EMTALA. We believe this bill provides an opportunity to even the playing field in an elegant and simple way, particularly from our member experience perspective and patient confusion and clarity.

We are interested in clarifying any confusion so facilities that open up are playing by the same rules. There is a different kind of model being created where there is confusion in the market. We are hoping the confusing issues that are side effects of this new market are clarified, and our patients understand what they will experience when they go to an urgent care versus an emergency room.

SENATOR HAMMOND:
Perhaps you have heard stories from some of the patients who have visited these facilities. When they go in they do not know how they will be billed, eventually receiving a bill higher than was expected. Presumably they go in not knowing or being told about how they will be billed. Maybe we can level the playing field by letting patients know this is a different type of facility and what the charges they will be billed will look like. Is there something we should know about this that we do not know?

MS. BOND:
The reason this issue is on our radar is that we have patients who feel they are going to an emergency room because the sign reflects that. That facility is not treating the emergency room as a normal emergency room, and the patients have to be transferred to a hospital for true emergency care.

We also see that patients believe they are going to an urgent care facility and are treated, but the bill reflects emergency room costs at a much higher rate than an urgent care facility. We also have patient complaints and appeals due to this. We have had at least 20 appeals from patients being told the facility is contracted with and accepts the Culinary Health Fund insurance when they arrive. There is confusion about accepting insurance versus contracting with insurance.

We are collaborating with the hospitals to see if this bill will help to stabilize this new market.

CHELSEA CAPURRO (Health Services Coalition):
The Health Services Coalition supports S.B. 232 and believes this is a first step at leveling the playing field. There has been confusion for some of our members when they go to certain facilities and are unsure of the experience they will have.

GEORGE ROSS (Sunrise Hospital and Medical Center):
Sunrise Hospital and Medical Center supports A.B. 232 and echo Ms. Bond's testimony.

I had a personal experience with a similar situation on vacation in a different state. I am on a Medicare Advantage plan and the facility I visited would not accept the plan. I ended up with a $375 bill when all was said and done for what would have been the equivalent of a doctor's office visit.

MS. BOSSE:
Renown Health supports A.B. 232.

I would like to attempt to address Senator Hardy's question relative to property taking. My understanding of being Medicare participating is that going forward with the next round of licensure, the organization would have an opportunity to become participating. This would require Medicare certification. They would

have the opportunity to do what many other micro-hospitals have done in the community, which is go through that certification process. Dignity Health is the poster child for this and they offer full hospital services in their micro-hospitals. The organization currently operating in Las Vegas would have an opportunity to do this as well. As long as they have an opportunity to become Medicare participating, they should.

Relative to EMTALA, if you go to the CMS website and review Medicare participation, EMTALA applies in conjunction with participating in Medicare. I do not believe it applies otherwise. Once you become Medicare participating, federal EMTALA applies.

As an industry, I have been involved in meetings with Elite Medical Center since they came to Nevada. What I hear time and again is the industry's concern about the patients and making sure the patients understand what general services they are going to receive when they go to a hospital. They want to ensure the patients feel safe, understand how they will be billed and the financial implications. I think the industry has primarily come together for that reason. We feel strongly that we want to be part of the solution and have our patients trust us. Adopting this policy will allow us to better support our patients.

SENATOR HARDY:
What you are saying is a hospital should be a hospital. In order to be a hospital you have to meet certain criteria with respect to the number of beds available and what your census is. Federal EMTALA means you have to accept anyone and everyone who comes through your door and treat them to the best of your ability as opposed to how many people you have in beds. If a facility wants to call themselves a hospital they should look at the terms defining a hospital. This bill is basically a definition of a hospital.

MS. BOSSE:
I would agree with what you have said but would add that the bill adds to the definition of the hospital license. I do not think they are exactly the same, because so far we have given a hospital license to someone who does not meet these requirements. I think we are asking to add the component that will meet the objective you are describing.

SENATOR HARDY:
Is this bill trying to add the definition and requirements of what a general hospital should be?

MS. BOSSE:
I would agree with that.

SENATOR HARDY:
So your emergency rooms in the micro-hospitals actually have patients they treat who occupy beds?

MS. BOSSE:
Yes, they do. The stories you hear from other organizations is that there is a significant demand for them. It would not be a stretch to see rather quickly that all services would be utilized in the Las Vegas market, which is quite busy.

TODD INGALSBEE (Professional Firefighters of Nevada):
The Professional Firefighters of Nevada support A.B. 232 and agree with what has been said.

In an emergency, we need to be concerned when we have people going to what they believe to be an emergency room to be treated for an emergency and they cannot be treated when they reach the facility. As we know, in most emergencies time is of the essence.

SENATOR HAMMOND:
Do we know they are not receiving emergency services? It is one thing if someone arrives at a facility and it is not quite an emergency and they are told they might be better treated and have significantly lower cost if they go somewhere else. But if it is an emergency, and they are not treating the patient, that is a problem.

MR. INGALSBEE:
If the facility is marketing themselves as an emergency room, they are required to treat certain issues and have the facilities and staffing to accomplish those things. In a stand-alone facility, if they are not under the same compliance, I would guarantee they do not have a cardiologist physically in the building although they may be on call. I am not certain. If you advertise you provide emergency care services, you should be providing emergency care. The only

person hurt is the patient who went to the facility not knowing the treatment they would or would not receive.

DAN MUSGROVE (Valley Health System):
I believe Senator Hammond and Senator Hardy have reached what we are trying to prove here and that is the expectation of what a hospital is. Senator Hammond talked about a new name. Perhaps this is what we need for this kind of facility. Today, what we want to say is if the Legislature agrees a hospital needs to meet certain standards, we will put that in statute. As a legislative body, if the one facility that has been licensed under a standard that perhaps was not as all-inclusive as we think it should be, they have the ability to meet that standard and we will welcome them into our community.

It is those three or four facilities that we know of in other states we want to ensure meet a standard so the public has the expectation Ms. Bond spoke about. To ensure her members understand the difference between an emergency room, an urgent care, a primary care facility and hospital so when they seek care they will receive the care they are expecting. We want everyone to have that same expectation, and do not believe we are limiting anyone's ability to accomplish this.

MIKE DRAPER (Elite Medical Center):
As the only business currently operating in Nevada affected by A.B 232, we are very much in opposition to the bill. We are not in opposition in continuing to address many of the very real problems and issues you have heard today, such as balance billing, patient dumping and surprise billing. We are also concerned with these issues.

However, this bill does not address any of these issues. This bill is simply an attempt to eliminate a new, innovative business model to protect a long institutionalized industry.

I have provided an overview and fact sheet (Exhibit F) on Elite Medical Center to give you a look at what our business entails.

Elite Medical Center opened in June 2018. It is a state-of-the-art, 22 bed hospital operating just off the Las Vegas strip. Elite Medical Center has more than 60 full-time employees and emergency room trained nurses. Additionally, Elite Medical Center contracts with nine full-time, board certified physicians.

Our services include: emergency medical care, in-patient medical services, pediatric emergency services, sports injury treatment, concussion assessment, full-service radiology and lab services in an emergency room that is open 24 hours a day, 7 days a week. It is not an urgent care, as it has a full emergency room nor is it a full-service hospital, as it does not perform surgery or have an intensive care unit.

It is true that Elite Medical Center does not contract with Medicare and Medicaid. However, this absolutely does not mean we are not seeing and treating Medicare, Medicaid, Tri-Care and indigent populations or patients. In fact, it would be illegal for us not to do so. This was a conscious business decision allowing us to avoid the cumbersome process that is the Medicare and Medicaid program, and focus more of our resources on patient care.

Despite what many are saying, we are subject to EMTALA. While federal law does indeed state that EMTALA only applies to those participating in the Medicare and Medicare program, this legislative body saw fit to put into Nevada statute that we are not allowed to turn away anyone during an emergency situation regardless of their ability to pay. Furthermore, Nevada law refers to and states we are also subject to the tenets of EMTALA.

We have heard LCB's opinion that echoes the spirit of this law that all hospitals, regardless of their participation in Medicare and Medicaid, are subject to the tenets of EMTALA. We received an email from the Attorney General's Office that states they also see it as any hospital operating in Nevada that has an emergency room is subject to EMTALA. We are subject to EMTALA and cannot turn away patients based on their ability to pay.

Over the past several months, we have had many conversations with elected officials and key stakeholders, and each one included some sort of mischaracterization or falsity about Elite Medical Center and/or our business model and practices. We will take much of that responsibility. We should have had these conversations much earlier and taken a more proactive approach to introducing ourselves to the community.

Regardless, over the next month as you deliberate this bill and other issues regarding hospitals, it is important we are all operating from correct information. We have heard that we are operating without a license; that is incorrect. We have the same license as every other hospital in Nevada.

We have also heard we are turning away patients and this is illegal and untrue. Rather than participate in Medicare or Medicaid as many physicians in medical practices around the Country do; we write off the work. It is cheaper for us to do this than it is to participate in those cumbersome and burdensome federal programs. To date, of the more than 5,200 patients we have seen, 30 percent of the work has been uncompensated care.

As a small hospital focused on patient experience, our business model is predicated on directing our resources toward our patients and staff rather than the huge administrative requirements of Medicare and Medicaid. It is true we are out-of-network with all insurance providers, but this is not entirely by choice. Simply put, we do not have close to the negotiating power of the big hospitals in Nevada. In fact, like many other medical practices in Nevada, we have been flatly told "no" by several insurance plans in the State when it comes to contracting with them. Rather, we commit to our patients to negotiate with their insurance companies on their behalf, and have a very good track record of success.

We do not engage in the practice of balance billing and have the same concerns around this practice that you do. While we cannot address specific bills due to HIPAA restrictions, I must stress that for many of our patients they do not see a bill from the facility. However, the physician group with which we contract might send them a bill. We have nothing to do with their billing; it is an independent group with which we negotiate contracts. Some of the negative billing stories you have heard are very likely because of the confusion around facility billing compared to hospital and physician group billing.

We understand and agree there are serious problems such as access, balance billing and surprise billing which need to be addressed. However, A.B. 232 does not address any of these things. If participating in Medicare or Medicaid did anything to address balance billing, it would not have been and continue to remain a major issue in Nevada over the last several years. If participating did anything to address surprise billing or out-of-network billing, none of the other hospitals in Nevada would have this issue as they all see large numbers of out-of-network patients.

We cannot and are not turning away Medicare and Medicaid patients. Participating with them does not solve that problem. Simply put, the only thing this bill will accomplish is to end this business model. The past couple of

months, I have had conversations with several elected officials who have compared us to Uber, and that we are a newer, more agile model attempting to enter into a long entrenched space.

While this might be true in some ways, there is one way it is different. Elite Medical Center made a sizable investment of $20 million in their facility. They employed more than 60 people, had all of the appropriate licenses and opened a year ago in a completely legal fashion, all before starting to operate in the State. They did not come back to the State and ask to create policy or ordinances around their business model. They established a newer business model in order to serve a niche population in our State.

We have heard there could be concerns about others opening up after us. We also share the same concerns, both from a competitive standpoint, as well as it is the right thing to do from a patient focused standpoint. We are happy to be part of that solution. It would be very simple for us to strengthen what we currently have in statute. We have the ability to do this right now.

PATTY HOLDEN (CEO, Elite Medical Center):
I have submitted testimony (Exhibit G) in opposition to A.B. 232. I grew up in Las Vegas; we moved there when I was four years old. I began my health care career as an EKG technician. I am passionate about patient care and always have been. I have registries as an invasive cardiac specialist and a respiratory therapist. I know what it is like to care for patients. I can guarantee the staff at Elite Medical Center has the same passion and runs the facility that way. We do not turn patients away whether you are a bum or a billionaire. You come to that facility and you will be seen by a physician within ten minutes.

CHAIR RATTI:
I want to clarify your role Ms. Holden. Is Elite Medical Center operating in multiple states or only in Nevada? And are you the CEO for the entire company or just the facility in Nevada?

MS. HOLDEN:
This Elite Medical Center is the only one in Nevada. The company does own free-standing facilities and hospitals in Texas. I am the CEO only for the facility in Nevada.

SENATOR HAMMOND:
Someone has to have a new model and new technology. There is always a new way to do things and think outside the box. However, I am not unsympathetic to some of the concerns we have heard today, such as surprise billing, emergency use and the idea of what an emergency is.

We have heard testimony today that there are times when you may not be accepting a patient. Is there a clear definition of what constitutes an emergency? Maybe this is the biggest concern for most. Is every hospital taking a patient according to EMTALA and are you obligated to follow this?

MR. DRAPER:
While Ms. Holden is the CEO of Elite Medical Center in Nevada, Dr. McLaughlin is a managing partner for the Nevada Elite Medical Center, as well as a partner in the parent company. He will be able to answer the questions as they relate to other states. There are a number of things that have been discussed today. Participating in Medicare and Medicaid does not address what has been discussed. Even if those things are happening, this bill does address them.

We have heard here and in Clark County that we are not a real hospital. I have met with nine emergency physicians and a staff of people who take offense to that statement. If that is what we are talking about and defining what an emergency is, or defining what these hospitals should or should not do, we are not addressing that in this bill. We continue to get side-tracked on what this bill accomplishes.

ERIC MCLAUGHLIN, M.D. (Elite Medical Center):
There is no clear definition of a medical emergency. Some definitions will include the phrase "life- or limb-threatening." It might be defined as what threatens a human life or limb or a female in active labor. These are the definitions EMTALA specifically refers to, the kinds of individuals the federal government wanted to make sure did not get turned away. Some people may not be able to express the condition they are in when they arrive at the hospital, because they are unable to breathe.

Trying to categorize an emergency in one simple definition is difficult. There is a 90 percent overlap between the symptoms you might feel that could end up non-emergent and the symptoms of something that might become a life-threatening emergency unless they present to an emergency department. In

the emergency room a competent, board certified emergency physician can determine if those symptoms put them on track toward non-emergent or a life- or limb-threatening emergency. Unless they get to the emergency room and are seen in a timely manner the outcome could be unfortunate.

We see and evaluate every patient who walks through our doors for the potential of a life- or limb-threatening emergency. Only a doctor can do that.

CHAIR RATTI:
There is a definition in statute for an emergency.

MR. ROBBINS:
Nevada Revised Statutes 439B.410, subsection 5, paragraph (b), subparagraph (2) requires each hospital in this State to provide emergency services and care, and to admit a patient where appropriate, regardless of the financial status of the patient. It defines emergency medical condition to mean:

> ... the presence of acute symptoms of a sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in, (I) placing the health of the patient in serious jeopardy. (II) Serious impairment of bodily functions; or (III) serious dysfunction of any bodily organ or part.

This definition is based on a definition of a similar term found in federal law.

CHAIR RATTI:
To be clear, the license your facility holds is under that statute and the expectation would be by that definition you are able to address that situation.

MR. DRAPER:
That is correct.

CHAIR RATTI:
What happens if a patient with a serious cardiac event needing immediate intervention enters your facility? Do they get treatment there or do they need to be transferred?

DR. MCLAUGHLIN:
Every one of our facilities, including Elite Medical Center in Las Vegas, has the ability to respond to every life-threatening condition that may come into the facility. We offer the life-saving stabilization and treatment any kind of patient could need, including cardiac arrest, stroke and acute surgical conditions. We are able to stabilize a patient and appropriately transfer when the patient needs additional services we do not have at our facility, much like many small hospitals in the area.

CHAIR RATTI:
You have 22 beds available. Can you give me an example of who would be admitted and who would be transferred?

DR. MCLAUGHLIN:
Those admitted would be anyone who meets the qualifications of being able to remain in the hospital. The bucket that is 97 percent of everything else in emergency medicine will stay; about 3 percent of the patients we see are ultimately transferred. Those who stay will have difficulty breathing that is not caused by something that requires surgery; chest pain that is not an acute heart attack; abdominal complaints and infections of the body and the skin. There are hundreds of different cases we see that we can manage on an in-patient level.

SENATOR HAMMOND:
I am sympathetic when we talk about surprise billing. I have previously been out-of-network. We were told we would be billed so were aware of that, but shocked at the amount of the bill. What is the process you adhere to for letting patients know they may be charged more than what is expected, and that it may be the physician that is billing them rather than the facility? Is there a protocol that is followed?

MR. DRAPER:
The short answer is yes. Our patients are notified and fill out paperwork to the effect that our facility is out-of-network. This is an important question, but regardless of this question, A.B. 232 does not address that. The federal government would not recognize us if we attempted to bill these patients. We are not billing these patients regardless.

Surprise billing is an important question, but one all hospitals face. They all see out-of-network patients. We all face the same problem. We have a similar

process to what all hospitals do with regard to how they address out-of-network billing; there are a litany of stories. This is where a lot of the discrepancy comes. There are stories of patients going to a hospital that is in their network and are perhaps seen by a neurologist that is not in their network. They will get a bill from that out-of-network physician group that is higher than what they would expect. Without addressing the physician groups in addition to the facilities, this will continue to be grappled with around the Country. As this bill relates to some of the stories that have been heard, the physician group might be the billing entity, not the facility.

SENATOR HARDY:
The ambulances do not drop off patients to your facility?

DR. MCLAUGHLIN:
That is correct. At this time, we do not receive in-bound ambulance traffic.

SENATOR HARDY:
If you do charge for Medicaid services, you can be prosecuted for not charging everyone the same amount. You cannot be a partial Medicaid or Medicare provider. You cannot bill some and not others. You bill everyone or no one.

DR. MCLAUGHLIN:
That is correct. I do not want our facility to participate in any illegal behavior.

SENATOR HARDY:
What is your hospital average daily census? In order to be a "hospital" you need to have more than two patients?

DR. MCLAUGHLIN:
We have less than two patients at this time. Yes, you have to have two or more patients.

SENATOR HARDY:
Are there regulations in Nevada for free-standing, not attached to a hospital, emergency rooms?

MR. DRAPER:
There are no regulations in Nevada. They have not addressed this issue. Other states have addressed this issue and are addressing micro-hospitals and

free-standing emergency rooms and the like. We have also not found another state, not saying one does not exist, that has forced all of their hospitals to participate in Medicare and Medicaid.

SENATOR HARDY:
It looks like you have three options. You can become a hospital, you can ask to be grandfathered in or create a new category of hospitals.

MR. DRAPER:
We also see those as three options. Right now, we cannot meet the requirements of accreditation for Medicare and Medicaid. Most small hospitals or free-standing emergency rooms in other states cannot meet those requirements. You have to have two or more in-patients as your daily census and we do not have that. Our model was not built around that.

Elite Medical Center picked Las Vegas, Nevada for a reason. We saw a niche in tourists that was not being filled and decided to open the facility close to the strip. They purposely picked a location two miles from the closest hospital. The idea was not to compete with the hospitals. It was to add and increase the footprint of health care services in southern Nevada. If the concern is about who is coming in behind us, we are fine with being grandfathered in.

The ideal solution would be for us to commit to the hospitals in the community and the Legislature that we are happy to work with some kind of comprehensive legislation over the next two years that addresses our type of facility. A solution that addresses some of the concerns whether they are real or not, or addressed by this bill or not, in that policy.

CHAIR RATTI:
You have a two-patient census; what did you say the requirement was for CMS? Are you meeting that requirement now?

MR. DRAPER:
The requirement is two or more to participate with CMS and we are not meeting that at this time. Our average in-patient census is under two.

CHAIR RATTI:
You have only been open since June. Is it reasonable to think you will meet that census, and if not, why do you have 22 beds?

DR. MCLAUGHLIN:
We built a hospital hoping we would be able to fill 22 beds. We were surprised when the volume we saw did not meet our expectations. We were disappointed we did not have more patients in those beds. We would expect that as our emergency room department volume increases as our relationships with the community physicians' increase, we will begin to see the practices that would fill those beds.

CHAIR RATTI:
If you are just under two now, it is not unrealistic to think you are going to meet that standard in the near future.

MR. DRAPER:
We hope that is correct. We based our $20 million investment building the hospital on that expectation. Not to get lost is what goes along with meeting the criteria of Medicare and Medicaid. It was addressed in the Assembly by the proponents of the bill what a cumbersome process participating can be. I spoke with a physician last week who has a four-person pain management practice. He has 35 employees and said he has to have 10 employees for every physician.

CHAIR RATTI:
Does getting certified with CMS mean you have to actually bill Medicare or you just have to get certified?

MR. DRAPER:
It does not mean we have to bill Medicare, but to be certified has administrative requirements that are burdensome. The only way we can compete with the larger hospitals because we cannot get the negotiated rates they have, is to figure out how to be more nimble. One of the ways to do this is not dealing with the administrative burden. Our physicians have more freedom to focus on patients than work on the paperwork required by CMS.

CHAIR RATTI:
The administrative burden of CMS participation is the ongoing billing process. The certification is a one-time event that requires some updating every so often. What does it take to get certified with CMS? What is the administrative burden?

DR. MCLAUGHLIN:
I am not an expert in CMS participation. I am told by advisors and counselors the process to become certified is lengthy and burdensome.

CHAIR RATTI:
It is a one-time up-front cost once you are participating. Is there an ongoing cost?

Dr. MCLAUGHLIN:
It is a one-time cost to participate. The Centers for Medicare and Medicaid has said the on-going administrative burden of compliance is burdensome and outdated. It is the on-going maintenance of CMS accreditation that is difficult.

CHAIR RATTI:
I would like more clarity on what the burden is. Everything we have heard is in reference to the act of billing, and most of that compliance comes back to whether you are billing correctly once you are certified.

MS. HOLDEN:
There is a list of conditions CMS calls "conditions of participation" that are extremely detailed. There are numerous policies, procedures and steps that have to be followed on a routine basis, including a large amount of documentation as well as a number of committees that must be present in each facility that participates. This adds additional staff taking physician time away from treating patients to meet those conditions.

CHAIR RATTI:
Mr. Draper made a comment about a portion of patients being out-of-network which is a challenge for all of us. All of your patients are out-of-network, correct? And, if so, why is that your business model; why not contract?

MR. DRAPER:
That is correct, we are completely out-of-network. That part of the business model is not entirely by choice. We have been told flatly by several major insurance plans in this State they will not contract with us. I have spoken to several physicians and medical practices, granted they are not hospitals, who have also been told the same thing. There are several insurance plans that, due to our size and lack of negotiating power, will not contract with us. A lot of insurance companies will simply not talk to us.

CHAIR RATTI:
I heard testimony that it was about meeting EMTALA and a rate cap, and that there is a rate benefit to patients if you are CMS certified. You are subject to the EMTALA rules at the federal level, and when a patient comes in and has that out-of-network billing experience, the most they can be charged is aligned with the Medicare rate. Is that your understanding?

MR. DRAPER:
In the conversations I have had with various consultants, the cap is set for Medicare and Medicaid patients and EMTALA does not apply to the out-of-network cap that the other patients are experiencing. The out-of-network cap is only important if we were to bill Medicare and Medicaid patients.

I am happy to ensure that answer is correct and that cap does not apply to out-of-network billing.

CHAIR RATTI:
My major concern is that the Medicare and Medicaid cap becomes the effective cap across the system. If I am a patient, a particularly thoughtful patient, and go where I know I will be in-network, I have protections. If I am a Medicare patient, I should have protection no matter where I go. When I come to your facility, what protections are there for me to ensure the rate is not significantly different from anywhere else I would go in the community?

MR. DRAPER:
As a thoughtful patient, and one familiar with the billing process, we have ensured our prices are in line with other facilities. The pricing is not an egregious price for the facility and again, not pricing for the physicians. This is the unfortunate part of this issue. When a patient goes to a facility that is in or out of network, and treated by a physician who is not contracted through the hospital or emergency room, the patient is subject to their billing.

As I understand through Elite Medical Center's attorneys and others, the Medicare and Medicaid cap does not apply to out-of-network patients.

DR. MCLAUGHLIN:
We have a cash price list we refer to as our prompt pay pricing such as all other hospitals have for the patients who elect not to have insurance coverage. We

have made sure this pricing is in line with other hospitals and is a fair rate for all patients who choose to come in for treatment.

CHAIR RATTI:
Is this pricing transparent and published?

DR. MCLAUGHLIN:
It is published in front of the patient when they come in for care. They are presented with the pricing for their care prior to receiving the care and medical screening is complete. We do not talk about money until it is proven the patient does not have an active emergency.

CHAIR RATTI:
You stated you have nine emergency rooms you choose to contract with? Are you stating the higher prices are due to the contract physicians you choose to contract with?

DR. MCLAUGHLIN:
That is correct.

MR. DRAPER:
As we talk about surprise billing, something well-documented across the Country, we are talking about when someone goes to an in-network facility and sees an out-of-network physician. Some of the stories you have heard could be from patients who have never received a facility bill but did receive a bill from the emergency physicians.

CHAIR RATTI:
Is every physician in your business model out of network?

MR. DRAPER:
It is an independent contracted group who can contract within the networks they are participating with. As it stands right now, they are all also out-of-network as they are working for a small facility. They do have the ability to contract on their own; we do not have the ability to force them to contract with anyone we tell them to. As the contractor, we can encourage them to engage in some of the same practices we do.

CHAIR RATTI:
Is your pricing comparable to market rate by choice or because you have to? Is there anything in law that is making you charge the prices you are charging?

MR. DRAPER:
To my knowledge, this is part of our business model. It is by choice we have chosen to have the pricing where it is to be fair and available to all patients.

CHAIR RATTI:
I am troubled by the fact that we have spent a lot of time on different bills attempting to build a Nevada philosophy to push folks to contract between payers and providers and try not to have us, as a Legislature, in the middle of that. It does not appear to me there is anything in your business model that is an incentive for you to contract for a payer source. If you can just charge the out-of-network rate, why would you ever contract with any payer?

MR. DRAPER:
We are talking about creating a level playing field. If we get even close to remotely the same rates from any insurance company, or get them to sit down and have a conversation with us, then we are talking about a level playing field. We would love to contract with payers; we just cannot get the comparable rate that would allow us to be competitive in the market. If we are talking about participating in Medicare and Medicaid as that being the catch-all for this, I am not sure that is a level playing field. That is our concern.

There is nothing in State law that dictates pricing. We would be happy to have the discussion about creating a micro-hospital bill and policy, and blaze our own path doing something to address this business model that is percolating around the Country.

CHAIR RATTI:
In Texas, where you have a larger scale due to the amount of facilities there, do you contract with any payers?

DR. MCLAUGHLIN:
In Texas, we do not currently contract with any payers; however, we have in the past.

CHAIR RATTI:
It is a core part of your business model not to contract?

DR. MCLAUGHLIN:
It is a core part of our business model to succeed in our business. When we reach out to contract with insurance providers they will either not talk to us or give us rates that are so low they are unsustainable and not comparable to what they are paying the hospital emergency rooms. They will not disclose to us what they are paying other emergency rooms in the area.

We welcome a free and fair environment in which to practice. We simply want to survive at business as we feel that what we provide patients is excellent.

SENATOR HAMMOND:
According to EMTALA, you have to provide patient care when there is an emergency and we have defined what an emergency is according to NRS. The only way to ensure you are complying is when someone comes into the facility and you have an emergency doctor on staff. Is it your practice to have someone on staff 24/7?

DR. MCLAUGHLIN:
That is correct. We have board certified physicians capable of handling any emergency on staff 24/7.

SENATOR HARDY:
One of the challenges I have with your 22 beds is who is going to fill them. If you do not have a medical staff for specific specialties and are looking to have conversations with payers to bargain with for contracting, you need to have some kind of medical staff to do that.

How many of your patients get admitted elsewhere as you do not have an in-patient practice?

DR. MCLAUGHLIN:
We are currently transferring between one and two patients a day because they need services we do not provide, such as surgery or need a lengthy in-patient intensive care unit.

CHAIR RATTI:
Of the one to two patients you transfer, how many actual patients do you see a day?

DR. MCLAUGHLIN:
We currently see 25 to 30 patients per day.

MS. HOLDEN:
I would like to address the fact that we are in the process of getting accredited by a nationally recognized organization who surveys every year. We are that focused on patient safety and quality. We are also in the process of getting contracts for consulting physicians to interpret or be of assistance to our in-patient hospital list. We have recently signed a cardiologist and are working with a pulmonologist. We are looking to work with additional specialists to be a resource for them.

ASSEMBLYWOMAN NGUYEN:
The opposition mentioned an opinion from the LCB that states "therefore it is the opinion of our Office that it is unclear whether NAC 449.331 makes federal EMTALA, which is 42 CFR 489.24 applicable to hospitals in Nevada that do not participate in Medicare." There is some ambiguity there that came out of the LCB.

Additionally, they had mentioned they were providing an email received from the Attorney General's Office. My understanding was this was not a formal opinion. Typically formal opinions on the law are requested through a government or state agency. It is also my understanding this was more of a casual conversation that took place in a very brief email.

Someone had talked about wanting everyone to know this was a hospital. They openly admitted they do not receive incoming emergency room vehicles and that their emergency room bay is an out-going bay transporting those 1 to 2 of their 25 live patients out of that facility to the other hospitals in the surrounding area.

We are talking about the patients who come in that may be in a position where they are in a crisis and are not thinking about where they need to go. They are on the strip and search Google for the closest emergency room and this facility pops up. They may end up not being an emergency after being stabilized after

the first ten minute encounter. The facility will then need to call 911 or another emergency service to have the patient transported to either an urgent care because they do not want to pay the cash price, or to a facility that will accept their insurance. Therein lies the confusion. I believe A.B. 232 will bring clarification to our law and put policy into effect so that organizations like this can comply with what everyone else does.

CHAIR RATTI:
I will close the hearing on A.B. 232.

For the record, Senator Spearman is out of town and will not attend the meeting.

Remainder of page intentionally left blank; signature page to follow.

CHAIR RATTI:
Seeing no further business, we are adjourned at 6:48 p.m.

RESPECTFULLY SUBMITTED:

Vickie Polzien,
Committee Secretary

APPROVED BY:

Senator Julia Ratti, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	5		Attendance Roster
A.B. 252	C	1	Assemblywoman Teresa Benitez-Thompson	Legislative Audit Repot LA 18-13
A.B. 252	D	1	Assemblywoman Teresa Benitez-Thompson	Legislative Audit Repot LA 18-24
A.B. 252	E	1	Assemblywoman Teresa Benitez-Thompson	Proposed Conceptual Amendment
A.B. 232	F	2	Mike Draper / Elite Medical Center	Elite Medical Center Overview and Fact Sheet
A.B. 232	G	2	Patty Holden / Elite Medical Center	Letter In Opposition