# MINUTES OF THE
# SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

## Eightieth Session
## April 5, 2019

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 4:12 p.m. on Friday, April 5, 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 Pat Spearman, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

**GUEST LEGISLATORS PRESENT:**

Senator Nicole J. Cannizzaro, Senatorial District No. 6
Senator Dallas Harris, Senatorial District No. 11
Senator James Ohrenschall, Senatorial District No. 21

**STAFF MEMBERS PRESENT:**

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

**OTHERS PRESENT:**

Stephanie Woodard, Division of Public and Behavioral Health, Department of Health and Human Services
Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Jennifer Jeans, Washoe Legal Services; Legal Aid Center of Southern Nevada
Joan Hall, Nevada Rural Hospital Partners

Greta Seidman, Nevada HAND
Angela Quinn, FirstMed Health and Wellness Centers
Kimberly Mull
Andy LePeilbet, Military Order of the Purple Heart
Michael Roach, American Legion; United Veterans Legislative Counsel
Joe Tinio, Adult Residential Care Providers of Nevada, ECHO
Ron Sumbang, Adult Residential Care Providers of Nevada, ECHO
Tina Angat
Steve Spentzakis, Minds Matter
Thelma Balingit
Liz Angat
Heidi Gustafson, Foundation for Recovery
Helen Foley, Nevada Assisted Living Association
Jeanne Bishop Parise, Park Place Assisted Living

SENATOR RATTI:
I will open the work session with Senate Bill (S.B.) 266.

**SENATE BILL 266**: Provides for the establishment of the Mental Health First Aid Program. (BDR 39-550)

MEGAN COMLOSSY (Committee Policy Analyst):
I will read the summary of the bill and amendments from the work session document (Exhibit C).

CHAIR RATTI:
I will entertain a motion on S.B. 266.

SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED S.B. 266.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 315.

**SENATE BILL 315**: Revises provisions relating to public health. (BDR 40-581)

MS. COMLOSSY:
I will read the summary of the bill and amendments from the work session document (Exhibit D).

CHAIR RATTI:
I will entertain a motion on S.B. 315.

SENATOR SPEARMAN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 315.

SENATOR HAMMOND SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 362.

**SENATE BILL 362**: Revises provisions concerning the placement of persons with dementia in a residential facility for groups. (BDR 40-611)

MS. COMLOSSY:
I will read the summary of the bill and amendments from the work session document (Exhibit E).

CHAIR RATTI:
I will entertain a motion on S.B. 362.

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 362.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 370.

**SENATE BILL 370**: Revises the State Plan for Medicaid and the Children's Health Insurance Program. (BDR 38-966)

MS. COMLOSSY:
I will read the summary of the bill and amendments from the work session document (Exhibit F).

CHAIR RATTI:
I will entertain a motion on S.B. 370.

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 370.

SENATOR HAMMOND SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will close the work session and open the hearing with S.B. 425.

**SENATE BILL 425**: Requires the Director of the Department of Health and Human Services to amend the State Plan for Medicaid to provide certain additional home and community-based services. (BDR 38-919)

SENATOR NICOLE J. CANNIZZARO (Senatorial District No. 6):
I am here to present S.B. 425 for your consideration. This bill seeks to amend the State Plan for Medicaid to provide certain additional home and community-based services.

Having a safe and stable place to call home is critical for every Nevadan. Unfortunately, achieving this goal is more difficult for individuals with long-term disabilities. These include those with serious mental illness (SMI), those with intellectual or developmental disabilities, frail elderly populations, the chronically homeless and other vulnerable populations who have low or no income.

Individuals with long-term disabilities often rely on federal programs for support such as Supplemental Security Income or Social Security Disability Insurance. This income is generally insufficient to fully cover the cost of food, housing, medicine and other expenses. Unless these individuals receive rental assistance or live with other household members who have additional income, they will likely experience difficulty finding affordable housing.

In Nevada, community-based housing models provide housing in different levels and types of supportive services to certain individuals with SMI, intellectual disabilities or those who are frail and elderly. While housing model populations served and funding mechanisms vary, each provides a bed in a home in the community for individuals with similar disabilities.

In the past, some of these congregate care living situations have received significant attention. News stories have described horrific living conditions. Audits by the Legislative Counsel Bureau have come to varied conclusions. While certain types of housing arrangements were found to have dismal conditions with serious deficient unsanitary and unsafe conditions, others were found to be providing homes generally clean, safe and in good repair.

We need to look at housing support services available to individuals either as part of, or separate from the housing models, possible funding mechanisms and other ways to improve services.

From a legislative perspective, this work began last Session. During the 2017-2018 Interim, the Legislative Committee on Health Care studied the congregate living and community-based support services available to individuals with mental health conditions. The study included a comprehensive review and evaluation of the rates the State pays to group homes contracting with Southern Nevada Adult Mental Health Services through the Division of Public and Behavioral Health and Department of Health and Human Services (DHHS).

The resulting report highlights a number of key issues. We found the existing system of housing and supportive services for individuals with SMI is neither built around nor operated in the best interest of the individuals who are often placed in housing models not based on their needs, but on availability of beds. Housing providers are more likely to serve individuals who require a high number of service hours and are financially disincentivized from helping clients progress

to their highest level of independence, which corresponds to fewer service hours and lower reimbursement.

The report identifies the disparity between the funding mechanisms available to help serve individuals with different types of disabilities. For example, the State currently receives federal funding through what are known as Medicaid 1915(c) waivers to support the intellectually disabled and frail elderly populations, but not for those with mental illness. The report also shows available funding, as well as existing regulatory and reimbursement structures, impact the quality of housing and services received.

The Legislature is working to address many of these issues through at least six bills proposed this Session. Certain bills address the results of the audits line by line. Others address unlicensed facilities, and still others aim to address problems with the existing licensing and regulatory structures for these congregate care living arrangements.

Senate Bill 425 specifically focuses on expanding federal funds the State receives to assist with housing and supportive services to better serve these vulnerable populations. It requires the Director of DHHS to preserve a Home and Community Based Services Benefit, 1915(i), from the federal government to enhance funding for home and community-based services. One of the goals of the benefit is to improve home and community-based services for the vulnerable populations needing it most. Based on recent audits and reports, many Nevadans with SMI could see significant improvements in quality of housing, care, services, and life with this change.

STEPHANIE WOODARD (Division of Public and Behavioral Health, Department of Health and Human Services):
I will present an overview of Supportive Housing and Tenancy Supports (Exhibit G).

The concept of supportive housing and tenancy supports is not new to Nevada. It has been worked on for several years. It has been one of the priorities coming out of the Governor's Interagency Council on Homelessness and identified as a key strategy needing to be considered for additional funding. In addition, we have engaged the Centers for Medicare & Medicaid Services (CMS) in what is called an Innovator Accelerator Program. We partnered with them and received

intensive technical assistance to determine what types of tenancy supports and supportive housing would be most appropriate for Nevada.

When we talk about homelessness in this context, we are looking beyond the current Housing and Urban Development (HUD) definition for chronically homeless. The chronically homeless definition used by HUD is considered relatively restrictive as an individual would have to be homeless for up to 12 months. By using a different definition, we can begin to provide services for individuals before they reach a period of chronicity. We believe this is important for a number of reasons, not the least of which is to provide those supportive services to assist individuals in regaining housing relatively quickly, or those at risk for losing their housing.

When we began to develop the concept for the 1915(i), we had to determine the target population we wanted to identify as beneficiaries for this program. We worked with all Continuum of Care Programs (CoCs), north, south and rural, to include the populations in the homeless housing queue. This system is typically called the Homeless Management Information System (HMIS). When we pulled the information from the three CoCs to determine what homelessness currently looked like Statewide, we saw there were a number of different individuals across different types of housing supports. This gave us a good baseline of the number of individuals a program like this could potentially touch.

We engaged the CoC in meaningful discussions to identify which currently homeless individuals would most benefit from a program of supportive housing. Each CoC provides a vulnerability assessment of individuals entering into the system, looking at a number of factors. The Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) is used in northern and rural Nevada. The Community Housing Assessment Tool (CHAT) is used in southern Nevada. These tools are used to help determine not only vulnerability, but also prioritization for individuals in need of housing, additional case management and supportive services.

We needed to identify individuals with certain types of vulnerability index scores to target these scores, breaking them into tiers. We identified Tiers II and III for being the target population; Tier I is individuals with relatively low scores. Tier I individuals typically do not have a high rate of issues, vulnerabilities or disabilities and would benefit from services, not specifically supportive housing. Tier IV individuals tend to be higher on the vulnerability indices scores, as well

as have multiple issues or disabilities, likely being too great to provide them with a program like supportive housing.

In this instance, the VI-SPDAT and CHAT vulnerability assessments will be used as the screening tool. It is not going to be the ultimate element to determine whether or not someone qualifies for this program.

It was also necessary to look at the types of individuals in the housing queues in the HMIS, looking at the prevalence of disabilities by different types of disabilities. We have quite a few individuals with physical and developmental disabilities, chronic health conditions, human immunodeficiency viruses and mental health and substance abuse issues. In previous discussions, the target populations were only those with behavioral health disorders. We felt we needed to expand that population to identify individuals having other disabilities, such as intellectual or developmental disabilities, who could also benefit from supportive housing services.

We are talking about tenancy supports, housing case management or coordination of care when we talk about supportive housing. Tenancy supports include outreach and engagement to homeless individuals, helping them develop applications for housing, as well as developing service plans for them to successfully maintain tenancy once they achieve housing.

Coordination of care is what we would consider part of the lynch pin of what is provided in supportive housing as it offers an opportunity for individuals with multiple needs to have care coordinated across different systems. This could include health care and behavioral health, as well as address many of the social determinates of health we know can continue to interrupt an individual's process to successfully maintain housing.

Supportive housing is an evidence-based practice implemented in both large and small jurisdictions and counties, having time to research and generate data supporting its use. It has an impact on the cost of care for individuals who are homeless. A study found supportive housing is no more and sometimes less costly than not providing supportive housing in certain areas. It can have an impact on lower bed days related to psychiatric admissions, as well as incarcerations. It can lower overall health care costs of individuals participating in supportive housing.

SUZANNE BIERMAN (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
These issues have been the subject of conversation for a number of years. We have a timeline outlining the Division of Health Care Financing and Policy (DHCFP) efforts to address the issues and develop additional services.

In 2018, the DHHS held a Housing Summit in Reno addressing the housing crisis and worked on developing a plan to support those most vulnerable. By 2018, the Regional Behavioral Health Policy Board had been established. One of the recommendations made was to provide the 1915(i) benefit funded by Medicaid to help address the issue.

In 2018, when the DHCFP was working together with the Governor's Office in putting together the budget, these services were ultimately included. The DHCFP also has a decision unit in our current budget that would fund these services for the next biennium.

In 2019, proposed legislation required the Director of the Statewide Program for Suicide Prevention to create a State Plan option to provide tenancy support. It will also provide additional information on our process in working with CMS to obtain and get these services approved and implemented. In March, a working group drafted an amendment which will be submitted to CMS. Stakeholders have been involved in this process and there have been meetings with the CoC group for draft input. In July, we plan to hold a series of public workshops to discuss the concept with stakeholders and solicit feedback on the Program.

Following the workshops, there will be a series of public hearings once we have a developed State Plan amendment and proposed changes to the Medicaid Service Manual. We anticipate holding the workshops in September and October of 2019. Finally, we plan to submit the State Plan amendment that would add these services to the Nevada Medicaid State Plan by the end of September 2019. We look to implement the Plan in January 2020.

SENATOR HARDY:
What will be the cost of this plan?

MS. BIERMAN:
The DHCFP budget for the upcoming biennium for all funds has been projected at $3,227,000 for Fiscal Year (FY) 2020; the State share being approximately

$621,000. For FY 2021, $6.5 million with a State share of $1.3 million. All of this is included in our current proposed budget.

CHAIR RATTI:
Is it possible this could be used to fund caseworkers who would be working to move folks out of perhaps a tent city arrangement to get them housing? Could this be used for folks with a serious mental illness who may be at risk for losing their housing?

MS. BIERMAN:
This would provide wraparound services allowing people to find and maintain housing.

CHAIR RATTI:
Are there specific services for the possibility of funding case managers for community organizations or intervention work on the potential list of possibilities?

MS. WOODARD:
I believe care coordination and outreach are services that would be reimbursable under this model.

JENNIFER JEANS (Washoe Legal Services; Legal Aid Center of Southern Nevada):
Washoe Legal Services and the Legal Aid Center of Southern Nevada support S.B. 425.

JOAN HALL (Nevada Rural Hospital Partners):
Nevada Rural Hospital Partners supports S.B. 425. I was involved in the Regional Behavioral Health Policy Boards during the Interim. This came up as an issue time and again. We believe this would be a great solution to a large problem.

GRETA SEIDMAN (Nevada HAND):
Nevada HAND supports S.B. 425. I will read from my written testimony (Exhibit H).

ANGELA QUINN (FirstMed Health and Wellness Centers):
I am the CEO of FirstMed Health and Wellness Centers, a federally qualified health center in Clark County. We are in support of S.B. 425.

In 2018, we served 25,000 individuals, 40 percent of the clients being primary care and behavioral health recipients. Out of those 25,000 individuals, 2,500 indicated housing and security was their biggest concern. These are folks who are homeless, living at Catholic charities or couch surfing. To date this year, to date, we have seen 67 young adults between the ages of 16 and 24 coming to us for mental health services. Housing was their core issue. This bill will begin to solve some of the problems.

I have five individuals I pay general revenue for supportive services as part of our three-legged stool of supportive services, behavioral health and primary care. With Medicaid funding to offset the cost, I can put those funds into housing and more direct services for clients rather than salaries.

SENATOR SPEARMAN:
How are we getting this information to veterans, as well as emancipated or homeless youth?

MS. WOODARD:
We need to continue to consider this question as we develop the 1915(i). We are going to be pursuing several public hearings where we will have robust discussion on how we not only operationalize the 1915(i), but how we will get the word out so people know these services will be available to them.

SENATOR HAMMOND:
Would you be developing policies around how to provide the information, and is there a priority?

MS. WOODARD:
This is all part of the discussion we need to have. We have the vulnerability indices already used by the CoC which do an amazing job, as well as many of the nonprofit organizations providing housing support now. It is, at this time, not a reimbursable service.

The CoCs are doing street outreach and have coordinated entry so individuals who do touch social services, and may have an issue with homelessness or housing insecurity, are currently being brought into the system. We do not want to re-create the wheel, we want to optimize the systems already in place and provide an additional funding stream so the services can be reimbursable.

We have many agencies and organizations Statewide that have been doing this for quite some time.

CHAIR RATTI:
Would it be accurate to say this is not a new program, but a way to fund the work that has been done, leveraging it with federal dollars? If you are serving that population and able to bill Medicaid, you would be able to build programs to serve that population using this Medicaid waiver.

MS. WOODARD:
That is accurate.

CHAIR RATTI:
I will close the hearing on S.B. 425 and open the hearing on S.B. 483.

**SENATE BILL 483**: Revises provisions governing the Statewide Program for Suicide Prevention. (BDR 40-1163)

SENATOR DALLAS HARRIS (Senatorial District No. 11):
I am here to present S.B. 483 for your consideration.

In 2017, 627 Nevadans took their own lives; that is nearly 2 people per day. This figure represents a higher death rate than those who die from an opioid overdose, which we call an epidemic. It represents nearly three times the number of individuals who die by homicide. Preventing suicide is, therefore, everyone's business. This bill builds on a lot of the same premises expanding the list of these people to whom training of suicide prevention must be provided.

Existing law creates the Statewide Program for Suicide Prevention in the DHHS. The Program is required to provide training programs for suicide prevention for law enforcement personnel, providers of health care, school employees and others interacting with those at risk of suicide. Senate Bill 483 will include family members of those at risk of suicide in the list of people to whom such training must be provided. In addition, the bill requires the Coordinator of the Program to establish a program of free suicide prevention training for family members of those at risk of suicide. This includes training, recognizing and productively interacting with people at risk of suicide and how to refer such individuals to suicide intervention and prevention professionals.

I want to help veterans and this bill does not contain the word "veterans". However, when I reached out to a few of the veteran advocates visiting today, they are already heavily using this program. The veterans would like to be able to use it for free, and increase the use for everyone. This is one of their top recommendations on what can be done to help their community.

The more people who know how to recognize and assist a person experiencing suicidal thoughts or behaviors, the more people will get help.

SENATOR HAMMOND:
How does this bill differ, or compliment, what Senator Spearman has presented with the First Aid bill?

SENATOR HARRIS:
I believe these bills work in conjunction, supplementing each other. The Mental Health First Aid Program to train community members on how to identify and assist a person with a mental health crisis is one piece. This bill is to expand on programs currently offered in the Office of Suicide Prevention at the DHHS where family members of those at risk can go for training and ensure these programs are free for everyone.

SENATOR SPEARMAN:
Everything we are doing this Session reaches out to cast a broad net when we look at the statistics for the completion of suicide. One of the groups we rarely talk about are family members, particularly children, of veterans whose suicide ideation is sometimes a direct result of a parent's deployment, illness or death. This is not duplicative, but complimentary.

KIMBERLY MULL:
I am in support of S.B. 483. Today is the 60-day mark of my graduation from a residential treatment center for Post-Traumatic Stress Disorder (PTSD) and other disorders. Sixteen months ago, I was raped in my home in south Reno. Like 13 percent of rape victims, I became another statistic. I used an unloaded gun I kept in a safety case to run my rapist out of my home. Now I sleep with it loaded in my nightstand. During a very dark time, I found myself spending hours loading and unloading that same gun. I would post pictures of it in my hand on social media with no comment; no one noticed.

Coming up on the one year mark of the anniversary of my rape, I began to make plans for the care of my dog and looking up the dates for my father's next doctor's appointment. I knew I needed help. Without the support of my employer and losing income, in December I checked myself into treatment.

Families of victims of crime, especially those of sexual assault, need to know the signs of severe depression, PTSD and suicidal ideation. This bill will save lives.

ANDY LEPEILBET (Military Order of the Purple Heart):
I represent the Military Order of the Purple Heart which is combat wounded veterans. We support S.B. 483. We would like you to think about its importance from the point of view of the veteran. In WWII, our veterans knew when they went to war they were not coming back until it was over. In Vietnam, we knew we would be there one to three tours. Our young veterans today now go from one to eight or nine tours. We have never had our Guard deployed so often. We have a lot of young people at risk and it is our job to help them.

MICHAEL ROACH (American Legion; United Veterans Legislative Counsel):
The American Legion and the United Veterans Legislative Counsel support S.B. 483. Every year prior to Session, the Nevada Department of Veterans Services, along with United Veterans Legislative Counsel, hold symposiums in Reno and Las Vegas. During these symposiums, one of the main topics is veteran suicide.

MS. HALL:
Nevada Rural Hospital Partners (NRHP) supports S.B. 483. Through a Health Resources and Services Administration behavioral health grant, which NRHP was awarded, we looked at many behavioral health issues. Suicide rose to the top of the issues that were of concern in rural Nevada. We were recently awarded a grant to implement a community paramedicine integrated health program. Nevada Rural Hospital Partners will be using the program providers to preform suicide assessments assisting family members in their homes.

SENATOR SPEARMAN:
I would like to put on the record that we have one of our National Guard units in Nevada that in the last 15 months have had more than 10 suicides. The most recent of those suicides was two months ago, a young woman who was not yet 30 years old with a family.

SENATOR HARRIS:
At times I may ask you to make tough choices; this is not one of those times.

SENATOR RATTI:
I will entertain a motion on S.B. 483.

SENATOR WOODHOUSE MOVED TO DO PASS S.B. 483.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will close the hearing on S.B. 483 and open the hearing on S.B. 424.

**SENATE BILL 424**: Revises provisions governing services for persons with a mental illness. (BDR 39-964)

SENATOR JAMES OHRENSCHALL (Senatorial District No. 21):
I am here to present S.B. 424 for your consideration.

Existing law requires the Division of Public and Behavioral Health (DPBH) of the DHHS to adopt regulations that specify the circumstances under which a consumer of mental health services is eligible to receive those services from the DPBH. Senate Bill 424 simply requires those regulations to prescribe a system to categorize consumers by the scope of the services they need, and establish procedures by which a consumer of those mental health services, or a provider, may appeal a decision of the DPBH concerning eligibility or authorization for services.

I spoke with many providers who brought this situation to my attention. We need to obtain more services for patients than are being provided or authorized today. This bill will establish a process to appeal decisions if either the patient or provider feels what is being authorized is not adequate.

JOE TINIO (Adult Residential Care Providers of Nevada, ECHO):
I am the Chairman and CEO of Adult Residential Care Providers of Nevada, also known as ECHO, an emergency care help organization representing the majority of residential care homes in Nevada. One-third of our staff are providers of mental health services. We have come here to show our support for S.B. 424 and will read from my written testimony (Exhibit I).

RON SUMBANG (Adult Residential Care Providers of Nevada, ECHO):
I am the Vice President of the Adult Residential Care Providers of Nevada, ECHO. We would like to show our support for S.B. 424 in reference to the categorization and appeal process. These two go hand-in-hand due to many of our providers have entered into contracts for a specific period of time, and in the process have experienced a change midway through a contract. They were not being paid the amount that was agreed on in the contract, yet the services provided remained the same. This is one of the reasons the services provided were misconstrued.

When an inspector finds a person requires a certain level of care and that level of care is not provided, it is not the provider's fault as their hours have been cut. The appeal process would provide a venue for providers to bring their concerns around a particular decision. For example, this could be the reduction in hours or to justify they are attempting to provide the level of care required with the reduction in hours.

MS. JEANS:
Washoe Legal Services and Legal Aid Center of Southern Nevada support S.B. 424. Many of our clients are reliant on the mental health services provided by Northern and Southern Nevada Adult Mental Health Services. They are providers of last resort, and the services provided are often essential to keep our clients housed, out of jail and have their most basic needs met.

Nearly 70 years ago, the United States Supreme Court determined due process must be afforded by an administrative agency to the extent its actions may condemn an individual to suffer grievous loss.

An individual who has been denied mental health services by a provider of last resort will most certainly suffer grievous loss in its most fundamental form. The lack of an appeal process for these essential services constitutes a deficiency that has been overlooked for far too long. Our current laws require

administrative processes for other benefits including unemployment compensation, Medicaid, Welfare, food stamps and county assistance.

TINA ANGAT:
I am a provider in a Community-Based Living Arrangement home in southern Nevada and support S.B. 424.

STEVE SPENTZAKIS (Minds Matter):
I am representing Minds Matter, Las Vegas. This bill will be a great asset for our clients, allowing us to provide additional support. It is important to have a good appeal process such as what Medicaid has. I support S.B. 424.

THELMA BALINGIT:
I am a provider for Joran, LLC, and support S.B. 424. I appreciate the opportunity for the appeal process. We have contracts from the State that are going to be changed midway and we will be able to appeal those changes with the passage of this bill. If they cut our hours, the services we provide will also be cut.

LIZ ANGAT:
I am a provider for Klaus Enterprises, LLC, and support S.B. 424.

SENATOR OHRENSCHALL:
In private insurance, if a physician wants us to have a procedure and the insurance denies the procedure, we have an appeal process. I believe it is common sense to allow the appeal process for our mental health patients. In many cases, they may not be able to file an appeal on their own and may need the assistance of the providers handling their care.

CHAIR RATTI:
I will entertain a motion on S.B. 424.

SENATOR HARDY MOVED TO DO PASS S.B. 424.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will close the hearing on S.B. 424.

CHAIR RATTI:
I will entertain a motion on S.B. 425.

SENATOR SPEARMAN MOVED TO DO PASS S.B. 425.

SENATOR HAMMOND SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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VICE CHAIR SPEARMAN:
I will open the hearing on S.B. 457.

**SENATE BILL 457**: Revises provisions relating to health care facilities. (BDR 40-1143)

SENATOR JULIA RATTI (Senatorial District No. 13):
I am here to present S.B. 457 for your consideration. There have been some significant incidents in the news regarding unfortunate events that have happened in certain treatment facilities in Las Vegas. The events surrounding those incidents raised some questions about whether or not we were doing enough to ensure we knew what was happening and be able to evaluate the necessary actions to be taken.

This bill enhances reporting requirements for certain facilities and requires certain information concerning the licensing status and quality of facilities that provide drug and alcohol abuse treatment to be posted online by the DPBH and the DHHS.

According to the National Survey on Drug Use and Health, 3 percent of Nevadans 12 years of age and older reported having an illicit drug use disorder in 2016. The same year, just over 5 percent of Nevadans 12 years of age and older reported having an alcohol use disorder. While the portion of the population reporting an alcohol use disorder has decreased in recent years, the portion reporting a drug use disorder has increased.

Substance use disorders are preventable and treatable, and while there are benefits to treatment, recent research shows that many people do not receive the treatment they need. According to the federal Substance Abuse and Mental Health Services Administration, in 2014, 1 percent of the total adult population Nationwide, or 7.5 percent of adults who reported having a substance use disorder in the past year, received treatment. We know there is not enough treatment available and not enough of our community members who need treatment are receiving it.

In Nevada, recent news articles have exposed numerous deaths at drug and alcohol treatment facilities in the State. These facilities are not monitored by the State, nor are they required to report to any authority events such as patient deaths. In fact, the only way such events at a privately funded, nonprofit medical facility may come to the attention of State regulators is if a complaint is filed. As a State, we also need to ensure people getting into the business of providing these treatment services are doing what is necessary to ensure the providers are qualified, appropriated and well-regulated.

The deaths at such facilities should be reported and this information should be available to the public. Nevadans would also benefit from the availability of a broader set of indicators to better understand the quality of non-medical licensed facilities. When people seek treatment in Nevada for a drug or alcohol use disorder, they should be able to make informed decisions about their options.

The bottom line is that our regulatory processes should result in families having the information they need to make choices about where to receive support and services. Senate Bill 457 moves Nevada in the right direction. We currently have a sentinel events reporting system for medical facilities. This bill takes that existing system and expands it to a broader group of facilities.

We would like to go beyond only reporting deaths, and get to a point where we are also reporting an assessment of the licensing standards and quality for these facilities. Through legislation, the intent is to direct the DHHS to fulfill this through the regulatory process, compiling a website where evaluations of these types of facilities are prescriptive to *Nevada Revised Statutes.* The intent is also to report sentinel events providing DHHS, through the regulatory process, direction to create more information than just sentinel events happening at these licensed facilities.

MS. WOODARD:
We have had an opportunity to speak extensively about the implications of this new legislation. Currently, there are reporting requirements for facilities that are licensed and called medical facilities. This expands the reporting requirements to include health facilities, expanding the scope to include our substance abuse treatment facilities.

Because those facilities are licensed, it is important we maintain a high level of quality of the care occurring within those facilities. It will also allow us to begin developing, through the regulatory process, a way to bring to measure and report on the quality of care provided within those facilities.

As a treatment provider in the past, working with families to find high-quality facilities matching their needs can be incredibly difficult. Having a repository of information that families and individuals seeking treatment could access for important information related to a facility, reported deaths or sentinel events and the quality provided at the facility, will go a long way in helping individuals and families find the care they need.

We welcome the opportunity to continue to work toward developing those regulations.

SENATOR HARDY:
Section 18, subsection 1, paragraph (d) states "unlicensed" programs of treatment for the abuse of alcohol and drugs. How do you find out where these facilities are located and how they are operating?

MS. WOODARD:
We certify all levels of care for our substance abuse treatment facilities and programs. We have a certification that exists for all out-patient treatment providers. The licensure and certification covers those that are licensed. Rarely do we have providers operating as substance abuse treatment providers that are not also certified. We do have requirements for those certified providers to be able to provide information to us. We have the latitude, under the Board of Health, to amend our Division criteria to add additional requirements related to reporting, which we would be able to do under this legislation.

SENATOR HARDY:
Would the program cover 12 step programs done by a church? Will Alcoholics Anonymous, the Triangle Club or other programs qualify?

MS. WOODARD:
They do not constitute certified programs. Those types of programs fall outside of the programs we typically certify.

VICE CHAIR SPEARMAN:
I believe we dealt with this in the Interim. Individuals obtain a license and have an ABC shop; but you have no idea what they are actually doing. Perhaps they are purporting to be a licensed facility, but the patients sent there do not know they are not a licensed facility. How do we get a handle on that?

MS. WOODARD:
What we have included in our certification is a very rigorous review of the quality of the care being provided. We do chart reviews, we look at policies and procedures and look at the availability of staffing and training they have received. Our State certification sets what the standard is to ensure our providers meet that minimum level of certification standard.

VICE CHAIR SPEARMAN:
That would be for those who are seeking to be certified. How do we ensure people are not circumventing the system and putting up a sign to say they are in business, even though they are unlicensed?

MS. WOODARD:
One additional qualifier to that is if a provider wants to bill Medicaid, or receive additional public funds, they are required by statute to be certified. We recognize that may produce some type of gap where individuals or programs are not billing Medicaid, nor are they trying to receive any public funding. In that case, we currently do not have jurisdiction to do much about the way they are operating.

SENATOR RATTI:
The instances bringing this to my attention made me choose to act and ask the DHHS if there was something we can do with regard to the multiple deaths happening at an entity that was certified and licensed. We still do not have much in the way of the kind of information we are collecting or sharing. The

first step would be to get to the point of having the sentinel reporting; knowing from those facilities the trends that may be inappropriate or would raise a red flag, or help us as policymakers or regulators to choose to act on this issue.

The second step would be to create a website for family members to use to find lists of licensed, regulated facilities. This would help in terms of the public education campaign. If people do end up going to a facility for treatment that is not a licensed or certified facility, we can give people the information about the list on the website. We are also hoping to get more robust information on the website about the track record of a particular facility. Right now, there is nothing on licensed and certified, or unlicensed and uncertified facilities.

HEIDI GUSTAFSON (Foundation for Recovery):
I am in support of S.B. 457 and will read from my written testimony (Exhibit J). If treatment companies have this particular designation through the State, they would more likely promote that information on their websites.

There are honest providers in Nevada who support this bill. We actually keep some providers out of our State because they do not want to play in these murky waters as we are not well-licensed and regulated. The bill would make it more difficult for the bad actors wanting to provide services when they see a sentinel event reporting system being implemented.

HELEN FOLEY (Nevada Assisted Living Association):
I represent the Nevada Assisted Living Association and we do not oppose in any way the substance, nor the intention of the bill. One issue we have is when it applies to senior living. In senior complexes there are many aging people receiving hospice care. Everyone is unfortunately on their way out of this life. Assisted living facilities are not medical facilities. We are not healthcare facilities, but this would make us one although we have no doctors or nurses in the facilities. We have deaths occurring quite often.

In a situation where someone dies, there would need to be an investigation, which would be problematic for us. We would not mind if there were suspicious situations surrounding the death, but in senior facilities, people eventually die. I would like Ms. Bishop Parise to further explain the dilemma we are in and offer some potential solutions.

JEANNE BISHOP PARISE (Park Place Assisted Living):
I am currently the Administrator at Park Place Assisted Living. I was originally licensed with license number 156 as a skilled nursing facility administrator. Recently, I took the board exam for community and home-based hospice and home health. I am one of two health services executives qualified in the State.

Within the residential facilities for groups, we have self-reported many of the events on the list the skilled nursing facilities and hospitals are reporting within sentinel events. We have to report suspected abuse or neglect and attempted suicide or elopement, which might meet the qualifiers to report to Elder Protective Services. We are also surveyed by the Nevada Bureau of Health Care Quality and Compliance. They will review our incident reports to manage them with appropriate follow-up.

Once again, we are not medical facilities with registered nurses or doctors on staff; we have certified med-techs. The majority of the population we serve are seniors 70 to 80 years of age. Many of them, when no longer able to anticipate wellness from a rehab standpoint and have chronic illness trending to passing, they will be placed on hospice.

In a given year, the majority of patients are anticipated deaths, and this is how we qualify them. We anticipate they are going to pass, but cannot ascertain whether they are natural or unnatural deaths as we are not professionals. On average, each year I have only had two die who were not on hospice. The majority of those we had recommended to families, along with conversations with physicians, to place them on hospice as they transitioned. They opted not to, as is their right.

Skilled nursing facilities and hospitals have medical records and attending physicians. When someone dies, the physician signs off on the death certificate. The death certificate lists whether it was natural causes or not. We do not close the loop in the record. It is very difficult for us to even have sharing of information from medical facilities.

The bill speaks to administrative sanctions for both medical and non-medical services. It is the same rate; one size fits all which is not appropriate given the fact there is Medicare, Medicaid and larger dollars involved. This is sometimes ten times the daily revenue a small group home or residential facility for groups or assisted living would receive.

We also do not have the administrative staff or resources in our business model or price point to consumers to have a burdensome reporting requirement. This needs to be balanced against public safety and reporting to uncover the bad operator scenarios impacting human lives with repeated adverse events.

We do not have a problem with the portions of the bill that refer to treatment facilities for alcohol and drug abuse where they have repeated adverse events resulting in death. Nor do we have problems with any of the unlicensed Community-Based Living Arrangements.

A simple form could be developed to report unanticipated deaths. There could be an age threshold applied to when a death occurred in someone over 70 years of age and was not reportable.

SENATOR RATTI:
I would suggest a huddle with the Bureau of Health Care Quality and Compliance in the DHHS to take another look at the bill. There is some language exempting an investigation in the event of natural causes. There may be some other ways to address the concerns raised today.

VICE CHAIR SPEARMAN:
I will close the hearing on S.B. 457.

CHAIR RATTI:
Seeing no further business, this hearing is adjourned at 5:50 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 |
| S.B. 266 | C | 1 | Megan Comlossy | Work Session Document |
| S.B. 315 | D | 3 | Megan Comlossy | Work Session Document |
| S.B. 362 | E | 4 | Megan Comlossy | Work Session Document |
| S.B. 370 | F | 2 | Megan Comlossy | Work Session Document |
| S.B. 425 | G | 12 | Stephanie Woodard / Suzanne Bierman / Department of Health and Human Services | Presentation on Supportive Housing and Tenancy Supports |
| S.B. 425 | H | 2 | Greta Seidman / Nevada Hand | Testimony of Support |
| S.B. 424 | I | 1 | Joe Tinio / Adult Residential Care Providers of Nevada, ECHO | Testimony of Support |
| S.B. 457 | J | 4 | Heidi Gustafson | Testimony of Support |