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

Eighty-First Session
March 15, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:32 p.m. on Monday, March 15, 2021, Online. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Lesley E. Cohen, Assembly District No. 29

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Mary Liveratti, Member, Nevada Commission on Aging
Niki Rubarth, Northern Nevada Regional Director, Alzheimer's Association
Amy Moore Peterson, Private Citizen, Boulder City, Nevada
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Barry Gold, Director of Government Relations, AARP Nevada
Marlene Lockard, representing Retired Public Employees of Nevada; and Service Employees International Union #1107
Gillian Block, representing Nevada Coalition of Legal Services Providers
Margot Chappel, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
Brett Salmon, President, Nevada Health Care Association and Nevada Center for Assisted Living
Jim Wadhams, representing Nevada Hospital Association
Connie McMullen, representing Personal Care Association of Nevada

Chair Nguyen:
[Roll was taken. The Chair reminded Committee members, witnesses, and members of the audience of Committee rules, protocol, and procedures for virtual meetings.] We have two bills today, and I will open the hearing on Assembly Bill 216.

Assembly Bill 216: Requires Medicaid to cover certain services for persons with cognitive impairments. (BDR 38-385)

Assemblywoman Michelle Gorelow, Assembly District No. 35:
I am joined by officials from the Aging and Disability Services Division and a member of the Nevada Commission on Aging who will provide technical information on the bill and discuss a friendly amendment offered by the Division.

Assembly Bill 216 was recommended to the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs during the 2019-2020 Interim. The bill mandates that the State Plan for Medicaid include coverage for cognitive assessments and care planning services provided to persons with symptoms of cognitive impairment. Alzheimer's disease is the single most expensive disease in the United States, outpacing the cost of cancer and heart disease. Analysis by the Alzheimer's Association calculated the direct costs posed to caregivers totaled $305 billion in 2020 alone. They also estimated that Medicare and Medicaid covered 67 percent of the total cost.

There are a host of early intervention and detection strategies that can stave off the astronomical expenses associated with late-stage dementia in Alzheimer's. In fact, the Milken Institute released a report showing that early diagnosis in the mild cognitive

impairment stage could create cost savings of as much as $7.9 trillion in U.S. health and long-term care expenditures by enabling better planning, management, and care.

The Centers for Medicare and Medicaid Services (CMS) covers cognitive evaluation and care planning for Medicare recipients. In 2018, CMS added current procedural terminology (CPT) code 99483 to pay physicians an average of $242 to perform early intervention treatment. Unfortunately, Medicaid does not offer the same coverage. Assembly Bill 216 seeks to provide these lifesaving services to Medicaid recipients. By funding assessments and care planning, we can get ahead of cognitive decline to ensure those suffering and their caregivers can manage the devastating effects of cognitive impairment.

As introduced, A.B. 216 would require the State Plan for Medicaid to cover the nonfederal share for cognitive assessment and care planning services for persons with cognitive impairment symptoms. For families whose members have Alzheimer's, this bill will ensure support services are in place. This type of advanced care planning can prevent acute hospitalizations which can be traumatic for individuals and their families as well as generate unnecessary expenses to the health care system. I will now turn this over to the Administrator of the Aging and Disability Services Division to discuss the need further and present their amendment.

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
We are offering a couple of small amendments to make minor changes [Exhibit C]. In section 1, subsection 1, we are replacing the words "who exhibits" with "experiencing the." The change to this language would not preclude anyone who was self-reporting from receiving this service.

In section 1, subsection 2, changes in this section are meant to align the definition of "cognitive impairment" with medical terminology. We would be removing paragraph (d), "Judgment as it relates to safety awareness." Also in section 1, subsection 2, we would be adding the word "or" between the areas of deficiency to clarify that someone could have any one or all of the deficiencies.

Mary Liveratti, Member, Nevada Commission on Aging:
It is vitally important that people have access to early detection and care planning. Dementia is not just a disease for older people and seniors. It is normally associated with those over age 65, but the Alzheimer's Association estimates that 5 percent of those with dementia have the younger-onset form and that currently there are approximately 200,000 people across the United States who have the younger-onset form.

According to data from the Nevada Division of Health Care Financing and Policy, known as Nevada Medicaid, between fiscal years 2016 and 2020, 4,374 individuals under 65 had a diagnosis of dementia or Alzheimer's disease who were already in the Medicaid program. They estimate approximately 730 people per year who are on Medicaid will be diagnosed. How prevalent is cognitive decline among Nevadans under 65? According to a 2015 survey

conducted by the Nevada Department of Health and Human Services, 16 percent or one in six Nevadans aged 45 to 64 reported worsening confusion or memory loss. We call that "subjective cognitive decline" or SCD. It is a condition associated with later development of dementia, but nearly half of these individuals have not talked with a health care professional about their concerns. Not all who experience or report SCD go on to develop dementia or need a comprehensive service, but a review of pertinent research conducted by the graduate students at the Sanford Center for Aging at the University of Nevada, Reno School of Medicine, found that between 5 and 8 percent of those who report SCD go on to develop mild cognitive decline or dementia.

It is so important that we have that early and accurate diagnosis for younger-onset dementia because we know it affects their work, their finances, and their families. An early, accurate diagnosis is crucial to rule out other potentially treatable conditions and to get the most appropriate treatment early in the disease process.

My own personal experience involves my father who, one night, believed there were intruders in his home. He called the police, the police showed up, but then he did not believe they were the police. We had a trusted neighbor come over and convince my father that it really was the police. As it turned out, there was no intruder in the house; however, I called a friend with the Alzheimer's Association. My friend told me that dementia does not come on suddenly and that it is a gradual process in most cases for Alzheimer's disease, although some dementias may progress more quickly. She suggested I take my dad to the doctor. We got my dad to the doctor, the doctor ran some tests, and we found out that my dad had a urinary tract infection that was causing his confusion. As soon as he was put on medicine and was hydrated again, the confusion went away.

It is so important that we know that because sometimes confusion appears to be dementia but it may not be. Early and accurate diagnosis can also give the patient and the family more time to make important decisions about financial and legal issues. It allows individuals time to work with their employer on work accommodations, disability coverage, or early retirement options. In addition, it also allows individuals to apply for disability insurance and supplemental security income benefits from the Social Security Administration. Of vital importance, it allows individuals across the country to access critical potential trials. We know that research is the only thing that will help us find a cure for this terrible disease.

This bill would enable physicians to use CPT code 99483, which is an important tool in the diagnosis of Alzheimer's disease and other dementias. With this code, clinicians have the time to do thorough evaluations of the patient's cognition and also to provide a comprehensive set of care planning services for people with cognitive decline and their caregivers. This billing code was added to Medicare and Tricare programs in 2018. There are 16 other state Medicaid programs currently using this code.

This could provide future cost savings and prevent high costs in Medicaid and our other health care services. The Social Security Administration has added younger-onset Alzheimer's to the list of conditions under the Compassionate Allowances list, which means

those with this disease get expedited access to Social Security Disability Insurance (SSDI) but also to Supplemental Security Income (SSI). This can lead to significant cost savings for Nevada Medicaid. After a two-year waiting period, individuals on SSI can become eligible for Medicare, and this shifts medical costs from Nevada Medicaid to the fully federally funded Medicare program. We believe that will lead to savings in Nevada in future biennia.

Chair Nguyen:
Is there anyone else presenting?

Assemblywoman Gorelow:
I believe we have someone from the Alzheimer's Association.

Niki Rubarth, Northern Nevada Regional Director, Alzheimer's Association:
On behalf of the 49,000 Nevadans over the age of 65 who are already living with Alzheimer's disease, we thank you for your consideration of A.B. 216. The vast majority of Nevadans impacted today are women, and a disproportionate number are people of color. I would like to share some findings from the current Alzheimer's Association's Alzheimer's Disease Facts and Figures report and outline the importance of diagnosing younger-onset Alzheimer's disease as well as the value of care planning and the ways this legislation will help bring about cost savings.

We know there is a modest financial cost associated with this request; however, according to the Genworth Cost of Care Survey of 2019, the average cost for a one-year stay in a memory care setting in Nevada is estimated at $51,000. The cost for nursing home placement over the same period of time is estimated at $127,000. If detailed care planning can take place at the appropriate time, we know we can help individuals remain in their homes, avoid unnecessary trips to emergency rooms, reduce hospital stays, and delay institutional placement, thereby avoiding additional costs to the already heavily burdened health care and Medicaid systems. Nevadans with Alzheimer's made 83,300 visits in 2018, and the hospital readmission rate for people with dementia was 25.8 percent. One out of four end up right back in the hospital.

Prior to discussing care planning, I would like to address the need to diagnose Alzheimer's and other dementias in individuals under the age of 65. As Mary said, nationwide, about 200,000 people know they are living with younger-onset disease. Some are in their 40s and 50s. They have families, careers, or are even caregivers themselves. Since physicians do not even look for Alzheimer's disease in younger people, getting an accurate diagnosis can be a long and frustrating process. Ruling out other conditions is important, as is connecting individuals to clinical trials and possible treatment that might help ease symptoms, improve quality of life, and save on other health care costs.

The specific medical billing code indicated in A.B. 216 gives health care professionals sufficient time to address care requirements during the patient visit and put plans in place—plans that answer the unique needs of patients with younger-onset disease. Those plans can include making connections to services such as those offered by the Alzheimer's

Association—workshops and education classes, support groups, early-stage engagement programs, and access to respite care. If care planning can happen early on, we can anticipate a decrease in costs further along in the disease process. In 2020, Nevada Medicaid spent $203 million on care for people with Alzheimer's, and that number is predicted to grow by 36.5 percent by 2025. We cannot afford to wait until 2025 to look for ways to bring those costs down. This bill starts now.

We sometimes hear from people who are living with Alzheimer's or other dementia that they are much more than their diagnoses. We are urged to look beyond the labels to see the vital, vibrant human beings they still are. If we can empower people with younger-onset disease to make decisions about their own future care needs, including their legal and financial plans, early on in the process, then we can also help preserve their autonomy and relieve a great deal of stress all around.

We do not yet know what causes younger-onset Alzheimer's disease or how we stop, slow, or prevent its progression. The Alzheimer's Association will continue to invest in research to find answers to these questions. What we do know is that individuals at any age deserve an accurate diagnosis at the earliest opportunity and that developing detailed care plans can help preserve a quality of life that makes the future look much brighter. Cost savings are only the tip of the iceberg when we think about the many ways this important bill can help our fellow Nevadans. Thank you so much for your time and attention to this important issue. We appreciate your support for the passage of A.B. 216.

Chair Nguyen:
Assemblywoman Gorelow, do you have any other presenters?

Assemblywoman Gorelow:
We have one more who is going to relate her personal story.

Amy Moore Peterson, Private Citizen, Boulder City, Nevada:
I want to introduce you to my husband, Drew. When he celebrated his forty-seventh birthday, he was living the dream. He was a 737 pilot for a major airline. With a degree in engineering, he owned, restored, and maintained a collection of vintage airplanes. He was an accomplished woodworker, avid reader; in short, he was brilliant. One month after his forty-seventh birthday, Drew would surrender his pilot's license knowing he could no longer fly due to the cognitive decline he was experiencing. I continued teaching for another three years, but I never knew what I would come home to. He could be Dr. Jekyll or Mr. Hyde. The mood swings were increasing and depression was setting in. He was very good at compensating and hiding his condition. I knew that Alzheimer's ran in his family, but I never imagined it would present itself in such a young, healthy man.

I knew something was terribly wrong when the man who had flown 737s for a living could not figure out how many linear feet of irrigation pipe he needed. After numerous doctors; MRIs; scans; tests for heavy metals, STDs [sexually transmitted diseases], and vitamin

deficiencies, a DNA blood test confirmed that there was a genetic mutation on chromosome 14. Another procedure confirmed elevated levels of the tau protein in his spinal fluid. It was official; he had Alzheimer's disease. They referred to it as ApoD-4 [Apolipoprotein D] which is a rarer form of Alzheimer's that presents itself in younger-age-onset and also in familial cases. He was only 50 years old. Drew's mother was one of eight children, five of whom developed dementia in their lifetimes. Drew's sister died last spring at the age of 69 due to complications of Alzheimer's, and his 68-year-old sister is currently in the middle stages of this disease.

After the diagnosis of Alzheimer's there was a flurry of getting the family trust in order, getting powers of attorney in place, and making financial considerations for a man who could no longer work even at the most menial job. I was unable to return to the classroom because now I was a full-time caregiver. Drew was forced to take medical retirement 18 years before his planned retirement at 65. He was 47 when he retired. A friend suggested SSI, and it took a neurologist's diagnosis in writing and numerous psychological tests, but SSI was approved, and he became eligible for Medicare. That was about a four-year process. Drew eventually developed blood clots, both pulmonary and DVT [deep vein thrombosis]. He was becoming a wanderer and a fall risk. As the caregiver, I was living with one eye open at all times. I cracked two molar teeth and was experiencing atrial fibrillation, so the last 18 months of Drew's life were spent in a very nice, clean, safe group home. They attended to his every need, they were wonderful, but they did not accept Medicare. Social Security Insurance covered about 60 percent of Drew's monthly care and the rest was out of pocket.

It was a Sunday morning when I held Drew's hand as he took his last breath. That was two weeks after his fifty-eighth birthday. My husband of 30 years was gone, and I was a widow at age 55. Everything happens for a reason and I have been fortunate to volunteer for the Alzheimer's Association for the past five years doing educational presentations and facilitating caregiver support groups. My story is not unique. The caregivers I work with repeatedly share similar stories. I urge you to consider this bill before you, A.B. 216. It will make such a difference to the families who are affected by younger-age-onset Alzheimer's disease or any dementia. It will make such a difference to have a timely diagnosis and be able to form a care plan. Thank you for your time and the opportunity to share my story and to share Drew's story.

Chair Nguyen:
Thank you, Ms. Peterson, for sharing your story. Are there any questions?

Assemblywoman Peters:
Thank you for stressing the importance of providing services for people who either suffer from dementia or who are caregivers. How many other states have adopted similar coverage under Medicaid and what existing coverage under Medicaid is there? You mentioned some existing coverage for people who are further along in the illness.

Assemblywoman Gorelow:
I am going to ask the representative from the Aging and Disability Services Division if she knows how many other states have this. If not, we can get you that information.

Dena Schmidt:
About 16 other states' Medicaid programs allow the assessment that is allowable under Medicare.

Chair Nguyen:
Are you able to answer the follow-up question about what is currently covered in this area in Nevada?

Dena Schmidt:
Representatives from Medicaid are on the call with us to answer those specific questions because I am not familiar with current services that are covered. I know we do not currently cover this one.

DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
As far as I know, this CPT code is fairly unique. There are medical assessment codes that would fall under the evaluation and management (E and M) of an office visit, but this CPT code, as I understand it, encapsulates not only the assessment but also the care planning. It is fairly unique, so there would not be anything comparable other than just the assessment codes under the E and M visit for a medical provider.

Assemblywoman Peters:
Having had a family member with dementia related to Parkinson's disease, I can understand how important it is to be able to identify these things early on and get the care and help for the family as well as for the patient. The more we can do earlier, the cost savings are really significant.

Assemblywoman Thomas:
I am very appreciative for this bill because before my mom passed, she was diagnosed with dementia. I believe a stroke she had brought it on. She could not remember subjects; she could not remember names. When the onset of dementia occurred, I started asking questions. She was one of ten children and seven of her siblings had this terrible disease of memory loss. Do we know if this is something that develops in families?

Assemblywoman Gorelow:
Yes, we know that it does run in families; however, I will call my friends at the Alzheimer's Association and they will be able to give you some additional information about the cause of Alzheimer's.

Niki Rubarth:
Yes, there is a significant proportion of people with Alzheimer's disease who have a hereditary genetic predisposition to develop the disease. They are ApoD-4, which you have heard mentioned here today. It is one of those genes that might predispose people to develop the disease; however, much of the research now is around identifying risk factors that might be modifiable that might reduce the risk of developing dementia. All of those that we know—a healthy heart leading to a healthy brain, such as good cardiovascular health, a healthy diet, good sleep, and plenty of exercise—those are all factors that might be modifiable and might reduce someone's risk of developing the disease.

Assemblywoman Titus:
Assemblywoman Gorelow, thank you for bringing this bill forward. You are doing a great job for the health of Nevadans, and I appreciate your sponsoring this bill. In section 1, I understand the amendment and the changes; however, I have a question about the definition of "short-term" or "long-term" memory loss and also about "orientation as to person, place and time." I have done thousands of mental health assessments of folks, especially in the emergency room. Some folks are impaired; they may be impaired because they have alcohol on board or perhaps a drug on board. Perhaps there is post-concussion syndrome because they hit their head and need to be evaluated for that. I will ask them some questions, and they do not pass. So, is there a time limit on this? Because that impairment can resolve; maybe it can resolve in a month, a day, or in 48 hours. To participate in sports, they have to be tested again after a concussion. Somebody who sobers up may know exactly who they are. They may not initially know where they are [unintelligible] but maybe not the time or place where they are. I need some clarification because I do not see it here. I do not know if it is defined in statute. I understand where you are trying to get to, but there are other cases where a patient would fall under that. Is there some clarification?

Assemblywoman Gorelow:
You are right. There are a lot of other conditions that can also show some memory lapse. I would need to talk to our legal counsel and get clarification on that. Maybe we need to include that in an amendment.

Chair Nguyen:
Unfortunately, we do not have our legal counsel available as she is working to draft our remaining bill draft requests; however, I would encourage you to reach out to legal. I am sure our policy analyst is also taking notes.

Assemblywoman Titus:
Thank you for that, because I think it needs to be clarified to make sure we are reaching out to the folks who we need to be reaching out to. I am very supportive of this. As everyone knows, I am a fiscal conservative and I like the fact that early diagnosis and early intervention will limit and perhaps delay time of admission. Once they are in the hospital, as was quoted earlier, the cost to care for these folks doubles, not to mention quality of life.

Do you know the number of folks on Medicaid who are currently in extended facilities with the diagnosis of mental or cognitive impairment? Certainly, I have taken care of folks when I was director of a long-term care facility; they were in that facility because they qualified for Medicaid and they had significant mental impairment. That may not have been the cognitive impairment definition, because that is why we are changing the CPT code, but they had other mental impairment such as Alzheimer's.

DuAne Young:
I do not currently have that information. Data provided to us stated that approximately 8 percent of Nevadans are roughly in this cognitive decline; however, we looked at an age range of 55- to 64-year-olds. They will be paid for solely by Medicare after age 65, as you are aware. We looked at those adults who were actively seeking doctor's visits and having primary care visits, and then took a percentage of those who might use this test. We can look at the numbers of those who are in our facilities. If you would like, we can look at what that would do in terms of the relation of the fiscal note for those individuals if they were caught earlier or the length of time they have spent in our facilities.

Assemblywoman Titus:
Thank you for that. I know this is a policy committee, and I really like the policy, but I feel we need to clarify who we would be covering. Of course, when it gets to the money committee, we will need those numbers, so that would be very helpful.

Again, thank you, Assemblywoman Gorelow, for bringing this bill forward. I want to also acknowledge all those who have reached out to me with their personal stories and the ones who testified today.

Chair Nguyen:
Are there further questions? [There were none.] Seeing none, we will take testimony in support of Assembly Bill 216. [The Chair reminded callers of the protocol and procedures for virtual meetings.]

Barry Gold, Director of Government Relations, AARP Nevada:
Public policy at AARP says that we support interventions aimed at preventing or reducing cognitive decline. You heard from the other speakers about the cost, the numbers, the people, the planning, the services, all those items in the assessments, and that is all great. What I want to talk about is the humanity of this—the human impact. Many years ago, I was a facilitator for one of the first groups for adult children of Alzheimer's disease in the state of Arizona. A lot of the time they would talk about "good times" or "good days." I am mentioning this because I want to expand on what Mrs. Peterson said. We all know someone who has had Alzheimer's. We all have known people who have had other diseases that took them too early, and the question is—not only for the person involved, but for the family members and the caregiver—What would you give to have one more good day, one more good time with your family member? Think about that. With this bill, let us talk about what it does. It would help prevent or reduce cognitive decline. What if you could get three months more of good days? What if you could get six months or a year or two years more

good days or good times with your loved one? What is that worth and what would you do for that? On behalf of our 345,000 members across the state, AARP strongly supports this bill which will help people get intervention, preventing or reducing cognitive decline, to give not only the person but their family members more good days.

Marlene Lockard, representing Retired Public Employees of Nevada:
We support A.B. 216 with testimony given by the bill's sponsor and the other presenters. We think this is a very important piece of legislation and urge your favorable consideration.

Gillian Block, representing Nevada Coalition of Legal Services Providers:
Our attorneys provide the right to counsel for all proposed protected persons in guardianship cases. We see how A.B. 216 would be helpful in the context of guardianship. It is possible to avoid guardianship, and the assessment and care planning play a role in that. Cognitive assessments are often required to assess whether a client no longer needs a guardian, but often doctors will not perform these assessments because Medicaid does not pay for them.

I will share a quick example from an attorney at the Legal Aid Center of Southern Nevada. This attorney had a client who had been under guardianship since 2008. Eventually, this client wanted to challenge that guardianship. Using his own funds, he obtained a new physician's certificate from the same primary care doctor who had originally diagnosed him, indicating there was now no longer a need for the guardianship. Despite that physician's certificate being enough evidence to place the client in guardianship in the first place, it was not enough to have that guardianship terminated, and the court required a new cognitive evaluation. This client was required to pay for a new evaluation out of his already-dwindling funds. Typically, these assessments range from $2,000 to $4,800. Assembly Bill 216 would help guardianship clients like this one who are required to use their already-limited funds to obtain cognitive evaluations when it comes to terminating a guardianship.

Chair Nguyen:
Are there any more callers in support? [There were none.] Do we have any callers in opposition to A.B. 216? [There were none.] Do we have any callers in neutral?

DuAne Young:
This is adding one CPT code—assessment and care planning. It would be added to physicians, advanced practice registered nurses, and physician assistants. Anytime we add a CPT code or service, there is a fiscal note. As Assemblywoman Titus pointed out, there are some long-term savings from catching this early, so we will go back and take that into consideration. This fiscal note is around $900,000 over the biennium, but we are happy to continue working with the sponsor to get you that information.

Chair Nguyen:
Is there anyone else to testify in neutral? [There was no one.] I will turn this back over to Assemblywoman Gorelow.

Assemblywoman Gorelow:
I want to thank everyone who presented today and shared their stories. We all have family and friends who have had dementia or Alzheimer's. As a member of the interim Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs, I am glad to see this measure is being heard. It is critical that persons with cognitive impairment symptoms and their families access health services as soon as possible. Assembly Bill 216 delivers much-needed support to Medicaid recipients with a lifechanging disease. For the last four years I have walked the Alzheimer's Walk, and it will be in October again this year for those who would like to join me or start their own team. I urge everyone to support A.B. 216.

Chair Nguyen:
Thank you. I will close the hearing on A.B. 216 and open the hearing on Assembly Bill 217.

Assembly Bill 217: Requires training for unlicensed caregivers at certain facilities. (BDR 40-454)

Assemblywoman Lesley E. Cohen, Assembly District No. 29:
I am here today to present A.B. 217 for your consideration. This bill is sponsored by the Legislative Committee on Health Care which I chaired during the 2019-2020 Interim. It is the result of a study required by Assembly Bill 131 of the 2019 Session. The bill required the committee to examine issues related to training for nonmedical caregivers who provide care at certain facilities, compare training standards, and determine whether certain unlicensed employees and contractors should be required to complete a minimum amount of training.

Our studies specifically addressed training for unlicensed staff who provide care to clients and patients in nonmedical facilities such as assisted living facilities and community-based living arrangements as well as unlicensed individuals who work in medical facilities. These individuals provide a range of services from helping with medication administration to assisting with activities of daily living such as helping with bathing, lifting people, helping people eat, and beyond. The key is that they are unlicensed, so we are not talking about nurses or certified nursing assistants, dieticians, registered physical therapists, or other people who are licensed.

The A.B. 131 of the 2019 Session study built off a 2017-2018 Interim study by the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs which considered many of the same issues. It found that some of the biggest issues could be resolved with training related to sterilization procedures, sanitation, infection control, and appropriate care and treatment. The A.B. 131 of the 2019 Session study was also influenced by Nevada's experience during the COVID-19 pandemic. According to the Department of Health and Human Services (DHHS), the top three causes of COVID-19 outbreaks in skilled nursing facilities in Nevada were: (1) inappropriate use of personal protective equipment; (2) breaches in isolation of infections of COVID-19; and (3) hand hygiene and hand washing. Both the 2017-2018 study and the COVID-19 pandemic emphasized the need for additional

and reinforced training on standard infection prevention and control and the proper use of personal protective equipment, among other issues.

Based on this and other supporting information, the committee's final recommendation was developed with input from officials from the Division of Public and Behavioral Health (DPBH) which is responsible for regulating these facilities. We ultimately decided that the best way to ensure unlicensed caregivers receive appropriate training is to have the State Board of Health adopt regulations prescribing these requirements. This will allow training requirements to be more flexible and nimble than if they were established in legislation. It will also allow the State Board of Health to revise requirements as new issues emerge.

Assembly Bill 217 requires the State Board of Health to adopt regulations prescribing mandatory training for unlicensed caregivers who provide care at certain medical facilities, facilities for the dependent, and facilities licensed under *Nevada Revised Statutes* (NRS) 449.030. This essentially includes facilities, homes, agencies, and providers licensed under NRS Chapter 449. It does not include care provided in individuals' homes or in other places that are not licensed by DPBH. The regulations must designate the type of facilities to which training requirements apply and establish the required topics of training which must include at a minimum control of infectious diseases.

The State Board of Health must also review the required topics of training at least annually and revise them as necessary to address new issues that affect the health and safety of individuals at the designated facilities.

Section 1, subsection 2, requires DPBH to post a list of free, nationally recognized organizations that provide evidence-based training for caregivers that may be used to satisfy the training requirements developed by the State Board of Health.

Section 1, subsection 3, requires the person in charge of a facility to which the training regulations apply to ensure that each unlicensed caregiver at the facility completes the required training and documents the completion in the person's personnel file, ensure the best practices taught in the training are implemented at the facility, develop a plan for the control of infectious diseases at the facility and update it annually, and provide a written copy of the plan to every resident, employee, independent contractor, or other person who regularly provides services at the facility.

Sections 2 through 18 of the bill make conforming changes, and section 19 provides that, while the bill is effective upon passage and approval for the purposes of adopting regulations and performing other administrative tasks, the requirements with which the facilities must comply are not effective until January 1, 2022.

With us is Margot Chappel, the Deputy Administrator of Regulatory and Planning Services in DPBH. Before we take questions, I would like Ms. Chappel to provide her testimony to the Committee.

Margot Chappel, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services:
The goal of A.B. 217 is to prescribe mandatory trainings through regulations for unlicensed caregivers in designated medical facilities, facilities for the dependent, and facilities licensed pursuant to NRS 449.030 that are available for free or at minimal cost from a nationally recognized organization that provides evidence-based training. While reviewing statements of deficiency during the pandemic, we saw ancillary staff such as kitchen staff and those cleaning who did not appear to understand the importance of wearing a mask or keeping contaminated cleaning cloths separated from clean ones. Although there are required trainings in statutes and regulations for unlicensed caregivers depending on the types of services they are providing, the COVID-19 pandemic revealed a lack of knowledge in infection control and prevention by unlicensed caregivers. Therefore, infection control and prevention training would be the focus in the development of the initial regulations. That is what the bill is trying to accomplish.

The topics will be reviewed annually and revised as necessary to address new issues that impact the health and safety at designated facilities. Requiring evidence-based training will help ensure that the information provided in the trainings will be effective. For example, evidence-based infection control and prevention measures have been shown to prevent and control the spread of the disease. The Centers for Disease Control and Prevention (CDC) has developed some really good ones during the pandemic. In addition, the bill proposes to carry this out in an efficient and cost-effective manner by utilizing trainings that are free of charge or have very minimal cost for nationally recognized organizations.

One of the concerns expressed by the industry when requiring trainings is the associated cost. So, we will work to alleviate that concern, and we believe the way the bill is written does that. In addition, utilizing trainings from nationally recognized organizations that provide evidence-based practices such as the CDC allows individuals to access training online, making it much more easily accessible.

Chair Nguyen:
Are there any additional presenters?

Assemblywoman Cohen:
No, we are ready for questions.

Assemblywoman Titus:
Thank you for the bill. This is something that came to light with our pandemic. I am glad you are making sure it will be available at no additional cost. I need clarification about the penalties and fines for not doing this. Under section 3, subsection 4, those penalties are already in existence, so this is not a new penalty or fee. These are already penalties for not following through on workplace safety. I want that clarification on the record.

Margot Chappel:
Yes, I confirm you are accurate in your assessment.

Assemblywoman Titus:
That is my only question, and thank you for bringing this bill forward. I also sat on that committee, and that was a notable void we had. I like the wording that it is open enough so as things change in the infectious disease/health care world, we can change with them and it does not always require new statutes, so thank you for that.

Assemblywoman Summers-Armstrong:
I do not work in health care, but where I do work, there is required Occupational Safety and Health Administration (OSHA) training that talks about cleanliness, disease control, how to deal with separating clean and dirty articles—for instance, when someone is cleaning a bathroom or public facility. How is this different from OSHA training and why is it different?

Margot Chappel:
They would take the same training if it was from the same source. However, OSHA does not necessarily go into our facilities. We regulate them 100 percent; however, if we have a specific issue related to something OSHA manages or oversees, we send them a complaint. As the regulating agency, we are responsible for all of that in those health care facilities.

Assemblywoman Summers-Armstrong:
You mentioned free or very inexpensive training is available. My concern is whether the cost of any of this training would be on the employees or contractors. I include contractors because some facilities may employ small independent contractors or even individuals. How do you control that? My second question is why is this not expanded to include those who go into people's homes as home health care workers, and my question about cost being the responsibility of the employee would also be the same. How do you control and ensure that these employees who generally are not making that much money do not have to absorb the cost?

Margot Chappel:
There are separate regulations that govern training requirements for personal care agency staff and home health care staff. We have cited a couple of personal care agencies for not providing the training at no cost to their staff. That is already addressed in regulation. When we develop regulations, we can add something like that.

Assemblywoman Summers-Armstrong:
The first part of my question regarded those who might be subcontractors at these care facilities. Is there any way to make sure they are not having to absorb that cost?

Margot Chappel:
We can add that into the regulations when we start drafting them.

Chair Nguyen:
It is my understanding reading this that the facilities that would be subject to this are licensed by the state division.

Margot Chappel:
That is accurate.

Chair Nguyen:
Does anyone else have any questions?

Assemblywoman Benitez-Thompson:
I want to clarify that last piece. When I look at the bill, NRS 442.029 through 442.2428 are the facilities we are talking about. There is a distinction between the facilities licensed by the state. I saw supportive living arrangements and hospices listed there as well as the independent center hospitals, homes for individual residential care, and halfway houses. Am I correct when I look at that list of defined medical facilities as the ones being included?

Margot Chappel:
Yes, to my knowledge, correct.

Chair Nguyen:
Assemblywoman Benitez-Thompson, I can have our legal counsel follow up to confirm those are the facilities if you need me to.

Assemblywoman Benitez-Thompson:
I just want to make sure. Sometimes, when we talk about defined medical facilities, they can be different from what we might be thinking about. I think there are only two carve-outs in the medical facilities. For instance, we might not necessarily think of halfway houses or transitional living as being licensed medical facilities. I want to make sure the statute covers all of those and that was the intent.

Chair Nguyen:
Are there any other questions? [There were none.] We will now take callers from our public line in support, opposition, and neutral on A.B. 217. [The Chair reminded witnesses and members of the audience of Committee rules, protocol, and procedures for virtual meetings.] We will now begin testimony in support of A.B. 217.

Barry Gold, Director of Government Relations, AARP Nevada:
I am familiar with this bill and its history. I can remember sitting in Assemblywoman Cohen's office in 2017 talking about this. There was a lengthy discussion among the stakeholders about which facility, which staff, what specific training, who was going to track it, and who was actually going to do the training. Some of the early discussions mentioned that all this training was going to be done by a registered nurse. That is problematic because we do not have enough nurses to take care of people in facilities let alone do all this training. There have been several studies talking about the who, what, where, when, how, and why. Looking at this bill, it allows the Department to look at which facilities we are talking about. We are not talking about the skilled staff in nursing homes or in hospitals. We are talking about these other places where there is staff who do provide some of level of care but about whom we are unsure what, if any, training they are receiving. That is really important.

In 2017 I stated that Nevada is very good in some of these types of facilities as we fingerprint people, we do background checks on people, and we do tuberculosis tests on people. However, sometimes we do not do much more than that. We need to make sure that these people, if your mom or your dad or your grandmother were to go into one of these facilities, we would be comfortable knowing that the people who were going to help take care of them had some basic level of training on some basic care qualities. This bill is fabulous in terms of allowing those decisions, and there was a lot of talk with stakeholders about the best way to do this, to allow that to be done through regulations that would pinpoint who needs to get the training and what the specific topics are. For those reasons, AARP, on behalf of our 345,000 members across Nevada, supports this bill and urges the Committee to pass it.

Chair Nguyen:
May we go to our next caller in support. [There were none.] May we go to callers in opposition to A.B. 217.

Brett Salmon, President, Nevada Health Care Association and Nevada Center for Assisted Living:
We appreciate the opportunity to share our concerns with A.B. 217. Some have been addressed already, but I wanted to get them on the record and hope to have the opportunity to talk about them offline.

We are very supportive of improving the quality of care in assisted living and my nursing facility membership. We have been fighting COVID-19 as everyone else has in the last year. We have had lots of tough times but have also had lots of successes with infection control. We have one of the lowest COVID-19 death rates in the country in our long-term care facilities. My members have done a really good job with regard to infection control, and we appreciate all their efforts.

As to A.B. 217, we would like to have more clarity as to who those unlicensed employees are and how that would apply with the term "provide care." It reads, "unlicensed caregivers who provide care," but maybe that should be sussed out as to what "provide care" means.

The next point that we were hoping for clarification on is the definition of the "designated facility." "Designated facilities" is very broad to us, and we would like some clarity as to the facilities that are included. If it is all of them, that is good to know. The way it is written now, the "designated facilities" language is confusing to us.

Regarding the training aspect of the bill, obviously cost is a factor. If there is free training, that is wonderful, and we hope that will be the case with this legislation. However, when you train employees, there is always a cost involved because of the time factor, so we would like to know more about the length of the training being hoped for in this legislation. Is the annual training just related to general cleanliness and sanitation—such as restaurant-style training—or is it a CDC training for unlicensed caregivers in a nonmedical facility? That causes us concern as well as in the standard of care. We would like to understand more about the intentions of this.

Chair Nguyen:
Mr. Salmon, you are at two minutes, so would you please wrap it up. I would encourage you to reach out to the bill sponsor as well as to other Committee members to follow up with some of your concerns. Hopefully, we can address those.

Brett Salmon:
Great. Thank you for your time.

Chair Nguyen:
Let us go to the next caller in opposition. [There were none.] Do we have any callers in neutral?

Jim Wadhams, representing Nevada Hospital Association:
We followed the work of the interim committee in this regard and believe we understand the intent of this legislation. We are neutral to it. As the Committee may know, hospitals are already covered under a similar law which is found in NRS 449A.300 through 449A.330, which was adopted in 2015, dealing with caregivers. We would be happy to work with any of the other stakeholders as this bill progresses and would appreciate being kept on any list for that opportunity.

Chair Nguyen:
Are there any other callers in neutral?

Marlene Lockard, representing Service Employees International Union #1107:
The Service Employees International Union (SEIU) #1107 represents 13,000 personal care aids (PCAs) who care for elderly and disabled Nevadans. We are in support of this bill, but under the rules we are offering an amendment, so we are testifying in neutral.

We have become aware of an industry-wide problem where personal care agencies are requiring PCAs to pay for their own annual training. This practice is atypical in the home care industry nationally and not supported by Nevada statutes and regulations. Personal care agency licensing regulations, specifically *Nevada Administrative Code* (NAC) 449.3975 and NAC 449.3977, describe the eight hours of annual training that PCAs are required to receive. *Nevada Administrative Code* 449.3973, section 2, paragraph (a) states that the administrator of an agency is responsible for "employing qualified personnel and arranging for their training." Furthermore, *Nevada Revised Statutes* 449.093, sections 5 and 7 specify that employees of personal care agencies "must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency, or . . . and annually thereafter," and that the agency "is responsible for the cost related to the training required by this section."

We recently conducted a survey of PCAs and found that almost 70 percent of PCAs reported that they have to pay for their own training. An equal portion of PCAs reported difficulty affording to pay for the training.

Chair Nguyen:
Ms. Lockard, you are at two minutes now. Can I ask you to wrap this up? I know you have an amendment and it is posted on the Nevada Electronic Legislative Information System [Exhibit D].

Marlene Lockard:
This is an industry that receives a median wage of $11.07 an hour at a time when the Boyd Center is estimating we are going to need an additional 5,300 personal care aides. So, I urge your support of SEIU's amendment.

Chair Nguyen:
Ms. Lockard, we were taking testimony in neutral, so based on our Committee rules and the testimony you presented, you are supporting an amendment not currently on the table, so I am going to recategorize your testimony as opposition testimony. I encourage you to reach out to the bill's sponsor as we move forward through processing this piece of legislation.

Are there any other callers in neutral?

Connie McMullen, representing Personal Care Association of Nevada:
[Connie McMullen submitted a letter of explanation, Exhibit E]. The Personal Care Association of Nevada (PCAN) is not opposed to caregivers receiving more training, especially in the areas of infection control. Currently, state law requires caregivers have training before they can even set foot in one's home. This area does involve infection control and many other areas of importance. Having said that, this is an area where the scope of training and skills taught should not be a hardship to do so. Last session, a much-needed cultural competency training was put into regulation; this year health facilities are trying to meet that mandate, but the only course being offered that meets the criteria is nine hours and $100 a person.

In the bill, the hours of such training were never addressed. We have similar concerns with the language of this bill. The PCAN is not opposed to more training, but the scope of the information must be reasonable in application in these difficult times. On behalf of the 30 companies I represent, I do not have any information as to what Ms. Lockard was talking about, but I would be happy to address it.

Chair Nguyen:
To clarify, was your testimony in neutral of the bill or are you in opposition of the bill as it currently stands?

Connie McMullen:
I am neutral. I need more clarification as to the way the bill was written. I do not think it is specific enough.

Chair Nguyen:
I encourage you to reach out to the bill's sponsor regarding any questions. It appears you have concerns with the language as it is currently presented, so I will probably recategorize your testimony as opposition under our Committee rules. Is there anyone else testifying in neutral on A.B. 217? [There was no one.] I do not see anyone else in neutral, so I will turn this over to Assemblywoman Cohen.

Assemblywoman Cohen:
Does Deputy Administrator Chappel have any final comments?

Margot Chappel:
A lot of the issues that were brought up related to this bill can be addressed during the regulatory process and generally are. For example, I did get clarification on my end that we are considering in section 1(a) making it applicable to all facilities designated in the regulations including medical dependent care and others without statutory definitions pursuant to NRS 499.0303, which is every facility we license. However, the regulations will designate the types of facilities to which the training requirements apply and the other details that were brought up during testimony.

Assemblywoman Cohen:
We have addressed these same issues each session. We have talked about cost, we have talked about who is included, and when we started—because I was not thinking about infectious diseases so much—we talked about how people's lives are affected when they live in these facilities. If you are a senior and you have someone who is untrained taking you in and out of the bath, you can be injured. Obviously, that is still part of the issue, that is still part of the bill, but in the meantime, we had the pandemic. We have seen that infectious disease is a big issue for all of us and in all aspects of our lives, especially in trying to protect Nevada's most vulnerable citizens.

Again, we have been working on this for several sessions and we hear these same concerns that we are going to be able to address now in the regulations. It will have more flexibility than what is in statute. Again, I will remind you that we are talking about individuals who are responsible for caring for some of Nevada's most vulnerable citizens and they often receive little to no training. Cost can be addressed, as can everything else, in regulations, but I think we have to pull the trigger. We have to get this moving and get these issues addressed and not keep punting them.

I am open to discussing this with anyone who is interested; however, I will remind the Committee that this is an interim committee bill, so if there are amendments, it is not my place to accept or reject them. However, I will talk to anyone who wants to discuss it and leave it to this Committee to decide if you would like to accept any of the amendments.

[Exhibit F was submitted but not discussed and will become part of the record.]

Chair Nguyen:
With that, I will close the hearing and testimony on A.B. 217. Our policy analyst has sent out a link regarding interim issues that were worked on, and this bill came out of that committee's work. Please review that if you have further questions about the intent and what kind of work went into the drafting of this bill.

Now, we will move to public comment. I will remind everyone to speak clearly, spell your name, and limit your comments to two minutes. Public comment can always be submitted in writing within 48 hours of the hearing. Is there anyone on the line wishing to speak in public comment? [There was no one.]

Are there any comments from Committee members before we adjourn? [There were none.] Our next meeting is on Wednesday, March 17. We have three bills, one of which is from work done in the 2019 Session, and our policy analyst will send you a link to that. We also have a comprehensive work session, so if you have any questions, reach out to those bills' sponsors or to Committee staff and it will be a much smoother process. I plan on hearing two bills on Friday afternoon, so please pay attention to the forthcoming agendas. We are adjourned [at 3:01 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Rochelle T. Nguyen, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a proposed amendment to Assembly Bill 216 presented and submitted by Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services.

Exhibit D is a proposed amendment to Assembly Bill 217, dated March 11, 2021, submitted by Marlene Lockard, representing Service Employees International Union #1107, regarding Assembly Bill 217.

Exhibit E is written testimony dated March 15, 2021, submitted by Connie McMullen, representing Personal Care Association of Nevada, regarding Assembly Bill 217.

Exhibit F is a proposed amendment to Assembly Bill 217, submitted by Bill Welch, President/CEO, Nevada Hospital Association.