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

Eighty-Second Session
May 12, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 11:01 a.m. on Friday, May 12, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sarah Peters, Chair
Assemblyman David Orentlicher, Vice Chair
Assemblywoman Cecelia González
Assemblywoman Michelle Gorelow
Assemblyman Ken Gray
Assemblyman Gregory T. Hafen II
Assemblyman Brian Hibbetts
Assemblyman Gregory Koenig
Assemblywoman Sabra Newby
Assemblyman Duy Nguyen
Assemblywoman Angie Taylor
Assemblywoman Clara Thomas

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Eric Robbins, Committee Counsel
David Nauss, Committee Counsel
Shuruk Ismail, Committee Manager
Lori McCleary, Committee Secretary
Gina Hall, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Jeffrey S. Duncan, Agency Manager, Aging and Disability Services Division, Department of Health and Human Services
Adrienne Navarro, Social Services Chief, Aging and Disability Services Division, Department of Health and Human Services
Annette Magnus, Executive Director, Battle Born Progress
Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Mason Van Houweling, Chief Executive Officer, University Medical Center of Southern Nevada
Blayne Osborn, President, Nevada Rural Hospital Partners
Susan M. Pitz, General Counsel, University Medical Center of Southern Nevada

Chair Peters:
[Roll was called. Committee rules and protocol were explained.]

We have a work session, which we will start with since we have everyone here today. We have two bills on the work session. We will start with Senate Bill 42 (1st Reprint).

Senate Bill 42 (1st Reprint): Revises provisions relating to the funding of medical assistance to indigent persons. (BDR 38-398)

Patrick Ashton, Committee Policy Analyst:
Senate Bill 42 (1st Reprint) was heard on April 24, 2023. The bill authorizes the use of county funds for medical assistance to indigent persons by the board of county commissioners of certain counties to provide an enhanced reimbursement rate or make supplemental payment to any public hospital in the county for hospital care provided to Medicaid recipients, if authorized under any other supplemental payment program by the federal Centers for Medicare and Medicaid Services [Exhibit C].

There were no amendments.

Chair Peters:
Are there any questions from the Committee? [There were none.] I will accept a motion to do pass Senate Bill 42 (1st Reprint).

ASSEMBLYMAN NGUYEN MADE A MOTION TO DO PASS SENATE BILL 42 (1ST REPRINT).

ASSEMBLYWOMAN GONZÁLEZ SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Taylor. The last bill on work session is Senate Bill 44 (1st Reprint).

Senate Bill 44 (1st Reprint): Revises provisions related to dental and oral health care. (BDR 38-221)

Patrick Ashton, Committee Policy Analyst:
Senate Bill 44 (1st Reprint) was heard on April 24, 2023. The bill transfers the State Program for Oral Health, the Advisory Committee on the State Program for Oral Health, and the duty to appoint the State Dental Health Officer and the State Public Health Dental Hygienist to the Department of Health and Human Services from various divisions within the Department. Additionally, the bill revises certain educational and licensing requirements for the State Dental Health Officer and the State Public Health Dental Hygienist and provides that persons holding these positions are no longer required to devote all their time to the business of their office [Exhibit D].

There were no amendments.

Chair Peters:
Are there any questions from the Committee? [There were none.] I will accept a motion to do pass Senate Bill 44 (1st Reprint).

ASSEMBLYMAN NGUYEN MADE A MOTION TO DO PASS SENATE BILL 44 (1ST REPRINT).

ASSEMBLYWOMAN TAYLOR SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblyman Gray:
I will be a no with reservation.

Chair Peters:
Is there any other discussion? [There was none.]

THE MOTION PASSED. (ASSEMBLYMAN GRAY VOTED NO.)

I will assign the floor statement to Assemblywoman González.

I will close the work session. We have three bill hearings on the agenda, and we will start with Senate Bill 4.

Senate Bill 4: Revises provisions governing certain programs to pay for prescription drugs, pharmaceutical services and other benefits. (BDR 40-220)

Jeffrey S. Duncan, Agency Manager, Aging and Disability Services Division, Department of Health and Human Services:
I am copresenting today with Adrienne Navarro, and we are happy to be here. It has been a long time coming for us to have this opportunity to get this far, so I hope we do our bill well today.

The intent of Senate Bill 4 is to provide the Department of Health and Human Services the ability to adapt to the ever-changing pharmaceutical landscape, which in turn will be the prescription assistance program being more effective in addressing the pharmaceutical needs of a broader population of Nevadans.

The federal government has made many changes to Medicare Part D over the past several years which have positively impacted Medicare beneficiaries. With such changes occurring on the federal level, we as a state need to pivot, which is why we are here today proposing these changes to the current senior and disability prescription program. Furthermore, S.B. 4 will allow for such changes by providing the ability for the program to support the most vulnerable Nevadans who are in need of prescription assistance rather than Medicare beneficiaries only.

I will now turn the presentation over to Ms. Navarro, who will walk you through highlights of the bill. In addition, we will be happy to answer any questions.

Adrienne Navarro, Social Services Chief, Aging and Disability Services Division, Department of Health and Human Services:
In introducing S.B. 4 to the Committee, I will first provide you a brief history of the senior and disability prescription assistance programs. The senior prescription program (Senior Rx) was established during the 1999 Legislative Session. The disability prescription program (Disability Rx) was added during the 2005 Legislative Session. This was in conjunction with the implementation of Medicare Part D in 2006. At that time, both the Senior Rx and the Disability Rx programs were designed to assist Medicare beneficiaries with the out-of-pocket costs of their prescription medications while in the Medicare Part D coverage gap, known as the donut hole, as well as assisting with the cost of their monthly Part D insurance premiums.

Since the establishment of Medicare Part D in 2006, multiple federal laws have passed, positively impacting the overall landscape of Medicare Part D. Most notably, the 2010 Affordable Care Act, which led over time to the final closure of the donut hole in 2020; the Bipartisan Budget Act of 2018, which required pharmaceutical companies to offer the same discounts to Medicare beneficiaries as they offer other insurance providers and pharmacies; and the Inflation Reduction Act of 2022, which will cap insulin copays, limit out-of-pocket drug costs, and allow for Medicare to negotiate drug pricing directly with drug manufacturers, to name just a few.

As Medicare Part D has changed over time, similarly it is important for the Department to evaluate changes to the senior and disability prescription program. Utilization data alone demonstrates that change is necessary, with the average number of program members per month decreasing from 6,073 in State fiscal year 2015, to 550 in State fiscal year 2022. For this program to continue benefiting Nevadans, these legislative changes are being proposed.

Senate Bill 4 will give the Department the ability to adapt to federal and state policy changes and more effectively address the pharmaceutical needs of a broader population of Nevadans, while increasing equity and access to prescription medications for those Nevadans most in need.

I will now walk the Committee through each section of the bill and briefly highlight the proposed changes.

Sections 1 and 2 both remove references to repealed statutes. Section 3 removes the requirement that the funding be directly expended by the Department. This will allow more flexibility in program design, allowing the Department to also provide grants and enter into contracts or intergovernmental agreements to pay for or subsidize the cost of prescription drugs. Section 3 also removes the limitation that the funding must be used only to pay for benefits for seniors and persons with disabilities, and allows for this program to assist a broader population to include natural persons who are residents of Nevada and who meet the eligibility criteria established by the Department. Finally, section 3 revises the requirement of the Department to submit a quarterly report concerning expenditures of the program to submitting an annual report. This aligns with other programs funded through the Fund for a Healthy Nevada under *Nevada Revised Statutes* (NRS) 439.630.

Lastly, section 4 of the bill repeals statutes relating to the specific policies and procedures of the program. This, too, aligns with other programs funded through the Fund for a Healthy Nevada under NRS 439.630.

In closing, we would like to thank the Committee for allowing us to present Senate Bill 4, and we are happy to answer any questions you might have.

Chair Peters:
I will start with a couple of questions. You mentioned the Fund for a Healthy Nevada. Is that how the program is funded?

Adrienne Navarro:
Yes, the entire program is funded through the Fund for a Healthy Nevada.

Chair Peters:
My second question relates to the change in the intergovernmental agreements and contracts. Can you talk a little about who may have participated in the program? It looks like a couple of the deleted sections, specifically NRS 439.660 and 439.665, dealt with cooperation between state and local agencies and contracts. Who participated previously, if any, and then what do you foresee future partnerships to look like and with whom?

Adrienne Navarro:
The current program operates with contracts with national Medicare Part D providers. We contract with them directly through the Aging and Disability Services Division (ADSD). What we foresee looking at is expanding beyond Medicare Part D and through the changes in this legislation being able to potentially work with community partners, subawarding funding to community partners to assist with prescription assistance, potentially working with other government agencies and other contracted government entities in other states as well. There are multiple options we could look at as we look at making changes to this program to meet the needs of those in Nevada. The intent of this legislation is to open that statute to be able to do so.

Chair Peters:
I can see that benefiting some of our local programs in a variety of ways, at least in northern Nevada. Are there any questions from members?

Assemblywoman Taylor:
I have an informational question. You mentioned some dramatic decreases. I know we are talking about the federal changes that have had an impact, but 6,073 down to 550 is a dramatic change. Can you talk about that?

Adrienne Navarro:
Those were dramatic changes. The program has dramatically changed over time, and it has been impacted on the federal level with the changes to Medicare Part D, what Medicare Part D provides, and also the introduction of Medicare Advantage Plans. Many Medicare Advantage Plans do not have a monthly premium for the Medicare Part D portion of their entire package. With that, we then do not have a service to provide to those individuals in need because what we are doing is subsidizing the cost of a Medicare Part D premium with this program right now. We are really looking at trying to expand and assist people with the cost of their prescription medications and go back to that. That is where we have seen the

decrease in the number of people utilizing the program because not as many have a Medicare Part D premium anymore. Again, those beneficial changes on the federal level are potentially now allowing us to utilize the Fund for a Healthy Nevada to look at the needs in Nevada on the state level and how we can best utilize those funds.

Assemblywoman Taylor:
My mom lives with me, so believe it or not, I actually followed all of that. The proliferation of Medicare Advantage Programs has made it so we do not need as much. As many people do not need this because fewer people need Part D because prescription drug care is taken care of over here. Thank you for asking how we can now use these funds to help those seniors who need them. We can now help them pay for their prescription drugs and expand it to help some others.

Assemblyman Orentlicher:
I understand the logic, and it is good to expand if we are not needing the money for people who used to get it. I am curious how this plays out with the overall Fund. These are the tobacco settlement dollars [Tobacco Master Settlement Agreement of 1998]. One of the concerns is we do not do enough for public health. I can see this playing out in a few ways. One is the Legislature decides every other year how we are going to allocate, and you are just saying whatever you are allocating for prescription drugs give us more flexibility so we can use the funds effectively. However, this bill does not say anything about whether the money is going to go to prevention or drugs. Is that correct? This is only as the Legislature decides every two years how to allocate the funds. We can use whatever dollars go to prescription drugs more effectively. Is that the way to read this?

Adrienne Navarro:
Yes, that is correct. Whatever money is allocated from the Fund for a Healthy Nevada to this specific program under this specific statute is what we are talking about. It is about looking at how to utilize those allocated funds to best assist those in Nevada with their prescription needs.

Assemblywoman Thomas:
My question has to do with your amendment. I do not understand section 3 on line 30 when you speak of "natural persons." Why do you use "natural"? Are we looking at natural citizens? I would think "persons" would suffice.

Chair Peters:
We have Mr. Robbins willing to weigh in from the Legal Division.

Eric Robbins, Committee Counsel:
In the preliminary chapter of NRS, the term "persons" is defined to include both actual human beings as well as any corporate or nongovernmental entity. In order to distinguish when we are just talking about individual human beings, we use the term "natural person" rather than "person."

Chair Peters:
I have a similar question related to the resident criteria in that same section. Do you have an existing criterion for what qualifies as a resident that you already use, or is that something you would develop in the regulations?

Adrienne Navarro:
Yes, we do have an existing policy. However, we would be looking at revising that as well to open it up as much as we can. The current requirement for being a resident in Nevada is one year. There is potential of looking at that a bit further as well within regulation to expand it.

Chair Peters:
I look forward to seeing what you come up with. We were just talking the other day about the potential for some discretion in the determination of whether someone's intent is to reside in the state of Nevada versus their actual residential criteria, especially when we are offering social services in the beginning of someone's move to the state. It could be helpful and uplifting just generally for their livelihood in our community to have those services available initially. I look forward to seeing what you come up with.

Are there any other questions from members? [There were none.] We will move into support testimony in Carson City and Las Vegas.

Annette Magnus, Executive Director, Battle Born Progress:
I am here today in support of S.B. 4. We hope you will pass this critical measure.

Chair Peters:
Seeing no one else in Carson City or Las Vegas, we will move to the phone lines. Is there anyone waiting on the phone to provide support testimony? [There was no one.] We will move to opposition testimony. Is there anyone in Carson City, Las Vegas, or on the phone who would like to provide opposition testimony? [There was no one.] We will move to neutral testimony. Is there anyone in Carson City, Las Vegas, or on the phone waiting to provide neutral testimony? [There was no one.] Are there any closing remarks? [There were none.]

I will close the hearing on Senate Bill 4. I will open the hearing for Senate Bill 43.

Senate Bill 43: Makes various changes relating to services for aging persons and persons with disabilities. (BDR 38-219)

Jeffrey S. Duncan, Agency Manager, Aging and Disability Services Division, Department of Health and Human Services:
I will be copresenting with my administrator, Dena Schmidt. Senate Bill 43 makes various changes to services for aging persons and persons with disabilities. We have affectionately called this our agency clean-up bill. The intent of the bill is to clean up language in *Nevada Revised Statutes* (NRS) Chapter 427A related to various public bodies, strategic

planning, and the community advocate program. This language will help us clarify various duties of the Aging and Disability Services Division of the Department of Health and Human Services and our public bodies. I will walk you through each section of the bill and the changes we are proposing.

Section 1 of the bill authorizes the Governor to appoint members to the Commission on Aging who are employees or officers of city and county governments. Expanding the language from officers of these governments to include employees of the city and county governments will help to fill vacancies in the Commission and ensure representation of city and county government is included in the work of the Commission.

Section 2 of the bill removes reference to outdated one-time funding and clarifies the duties of the Division in relation to the strategic plan for people with disabilities for more transparency.

Section 3 of the bill expands language related to the duties of the Commission for services for people with disabilities. Specifically, it adds a requirement to coordinate efforts with the Statewide Independent Living Council in line with the state independent living plan. The Statewide Independent Living Council is a federally mandated council made up of a majority of people with disabilities who are responsible for advocating for the needs of people with disabilities in the state specific to independent living. This language will help to ensure collaboration between the two public bodies and reduce duplication of efforts.

In sections 4 and 5 of the bill, it shortens the name of the Office of Community Advocate for Elder Rights. In the 2017 Session, the duties of the Office of Community Advocate for Elder Rights were expanded to include people with disabilities to better reflect the broader population our agency serves. This change removes the term "Elder Rights" from the title to be representative of the previous changes approved in the statute.

Finally, section 6 of the bill broadens the duties of the Nevada Commission for Persons Who Are Deaf and Hard of Hearing related to the strategic plan. Specifically, the revised language gives the Commission the power to develop a state plan for serving people who are deaf, hard of hearing, and speech impaired, rather than a strategic plan specific to services of the Division. This allows the Commission to develop comprehensive recommendations for services for their target population beyond those under the purview of our agency and is in line with their current priorities.

In closing, we would like to thank the Committee for allowing us to present S.B. 43. We would be happy to answer any questions.

Chair Peters:
Are there any questions from the Committee?

Assemblyman Nguyen:
We have done a lot of cleanup this session, and I feel we are going forward and ensuring we are looking at everything needing to be addressed. Some of these things have been in statute for a while and need looking at as we see how our state has moved in terms of population and demographics. If you have been watching this Committee since the start of the session, you are probably going to know what I am about to ask. That is going to be consistent with my line of questioning in making these changes. How are you ensuring you have a diverse pool of members who could create better reports and recommendations for this community? Where are we on adding a qualified member who comes from a household that speaks more than one language? As our state grows in diversity, the aging community will need input from a household with more than one language so we can accommodate these cultural needs as we prepare to support them in the long run. Hopefully, one of you can address that question.

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
For many of these boards and commissions, some are governor-appointed and some are director-appointed. Where we have the ability to recruit and look at members, we are definitely looking at trying to identify folks who may be dual language or for whom English may not be their first language. As far as the materials and the meetings and making that accessible, we have completed the language access plan in our agency and identified four or five areas where we are working toward making sure all the materials we issue, both on our website and in writing, are inclusive of multiple languages. I hope that helps.

Assemblyman Nguyen:
If that was the intent for you to get more diversity in the body that advises the Division, you are saying the director is probably already ahead of the game. Would it be more helpful to add the intent for the governor's council to be more reflective of this need? I know we all have good intentions, but because it is not said in the bill, it sometimes gets forgotten because there are so many things out there. Could we put that in statute for the governor's council to ensure this population is not left behind?

Dena Schmidt:
I think both bodies do a very good job. We have a close relationship with the individual who processes the appointments, and we communicate with them a lot of times about what is missing in our current membership so when they get applicants, they are looking for whatever might be missing on the board. We try to do a good job of communicating with them whenever we have openings of the type of individuals we are looking for and will continue to do that. It is our intent to continue to do that whether it is in statute or not.

Assemblyman Nguyen:
Do you know if the current makeup of the body has any members coming from a bilingual household? If you do not have that information now, you can get that to me. I want to put it on the public record that we are looking at this and we are going to be intentional in ensuring this happens, not just talking about it, but doing it. I know in the Department of Health and

Human Services (DHHS) you are amazing with your work. There is a lot of work to do, and I appreciate all of your efforts. In my past world working with you and others on the DHHS team has always been innovative. I just want to make sure we put this on public record and we intentionally add these individuals into the makeup of these advisory groups.

Chair Peters:
Seeing no other questions from the members, I have one regarding section 1, subsection 2, paragraphs (a) and (b) and the makeup of the committee to include an employee rather than just an officer. Rather than an officer or their designee, we include an officer and/or employee. Can you describe why we picked that language?

Dena Schmidt:
In my role as the administrator, I currently serve as the chair for the Nevada Commission on Aging. We have always had a robust membership, but we have always struggled to get city or county entities' participation. One of the barriers has been the language of "members of the governing body." Oftentimes, those individuals who qualify are not available, but the folks who work in the government bodies would be available and are very interested in joining the Commission. We are hopeful that if we change it to employees, it can be as broad as possible to get the cities' and counties' views on the issues we cover in the Commission on Aging.

Chair Peters:
I wonder about the difference in that and requiring that a member of the governing body designate someone from their office so there is at least some kind of hierarchy in decision making of the person who is included in the committee so the governing body knows they are there rather than being appointed by happenstance by being an employee. I do not know, Mr. Robbins, if there is a legal difference between a designee and an employee that would cause problems. This is the first time I have seen "employee" rather than "a designee." I am just curious if it makes much of a difference.

Eric Robbins, Committee Counsel:
There is not a legal reason that it says one or the other, at least as far as our drafting goes. This was a policy change requested by the agency, so I feel they are better fit to explain that.

Dena Schmidt:
The intent was to make it as broad as possible so if there is a desire to have a designee, we would not be opposed to it. We would like to make sure we have the voices of the city and the county entities involved, and it has been difficult getting people willing and able to participate.

Chair Peters:
My suggestion would be that we look at potentially changing this to an officer or their designee who is an employee. That way we keep it in the group so we are not getting someone outside the agency but someone the officer knows is there. We will work on that amendment and contact you on that piece.

Are there any other questions from the Committee? [There were none.] We will move into testimony on S.B. 43. We will start with support testimony in our physical locations and then move to the phones. Is there anyone in Carson City or Las Vegas who would like to provide support testimony for S.B. 43? [There was no one.] Is there anyone waiting on the phone to provide support testimony? [There was no one.] We will move to opposition testimony. Is there anyone in Carson City, Las Vegas, or on the phone who would like to provide opposition testimony? [There was no one.] We will move to neutral testimony. Is there anyone in Carson City, Las Vegas, or on the phone who would like to provide neutral testimony? [There was no one.] Are there any closing remarks? [There were none.] I will close the hearing on Senate Bill 43.

We will move to our final hearing today on Senate Bill 192 (1st Reprint).

Senate Bill 192 (1st Reprint): Revises provisions relating to county hospitals. (BDR 40-749)

Mason Van Houweling, Chief Executive Officer, University Medical Center of Southern Nevada:

We are here to discuss Senate Bill 192 (1st Reprint). This bill supports the University Medical Center's (UMC) mission to provide the highest level of care in our state and to provide our patients with the highest level of care, while ensuring quality and meeting our goal as trusted stewards of taxpayer dollars. This bill offers three key improvements.

First, it codifies the UMC governing board in *Nevada Revised Statutes* (NRS), which currently refers to the board as an advisory board. In 2013, Clark County Commissioners, with their foresight, recognized the importance of having dedicated community members with a certain skillset and special knowledge that helped turn around UMC since 2014, and to provide oversight and daily management of the hospital operations. The board is actually created via county ordinance. Clark County Commission members appoint the governing board at UMC. University Medical Center's Clark County Commissioners ultimately serve as the board of trustees of the hospital.

The board consists of nine members. We have a governing board, and within the governing board there are four subcommittees: a quality committee, an audit and finance committee, a human resource committee, and a strategic committee. They meet monthly, sometimes more than monthly, all coming together to help support the operations at UMC.

Next, as you are all aware, this Committee understands the complex nature around health care laws and regulations, and it is constantly evolving. The second intent of S.B. 192 (R1) is to address the complex, unique issues public hospitals face around the regulatory environment. University Medical Center would like the ability to have frank and open dialogue with our board members, both our trustees and our governing board leaders. In fact, our licensing boards, the regulatory accreditation standards, the Centers for Medicare and Medicaid Services (CMS), and others require us to ensure our boards are fully involved in making difficult decisions. Within the ability to have these private deliberations under

Nevada law, procedures and statutes often conflict. Further, it can lead to delays in informing the board in a timely manner. We would like to take proactive measures that serve to improve the quality and patient care that I have been discussing.

To be clear, this bill does not allow the governing board or the trustees or any public hospital in the state to take any action or make decisions in closed session. Recognizing the importance of allowing public hospital boards to conduct certain proceedings in closed sessions, other states have also authorized boards of county hospitals to enter into a closed session for very similar reasons that are outlined in S.B. 192 (R1). Nevada law also currently authorizes other public boards and bodies to go into closed session. This bill will allow public hospitals and governing boards in Nevada to fulfill an essential function and practically address federal and state requirements, as well as potential legal and regulatory issues. This bill is not against transparency, does not create any new privilege, expand existing privileges, or allow any action to be taken in a closed session. This is merely to address the ability to deliberate and have discussions with our board members. All matters of voting will occur in open session and in accordance with all existing requirements.

Finally, the last piece of the bill will allow the employment of dentists. This will expand the language to include dentists. Let me give you an example. Probably every day someone ends up in an emergency room who has a dental emergency. Once we have established emergency medicine and stabilized the patient, often our doctors throughout the state will prescribe a pain medication to try to get them through the next day until they can get to their dentist. As we all know, it is difficult to get into dentists, especially on Fridays. I know with my own dentist it is difficult. What we would like to do is proactively take care of the patients who enter our emergency room. Obviously, a dental emergency does not rise to the level of a stroke, cardiac arrest, or a gunshot wound at UMC, but often patients have to wait hours to seek out care or may not have access to a dentist. What we would like to do is allow patients to see a dentist within our organization either that day or get them in the next morning to start taking care of that dental emergency. Again, throughout our state, doctors are just writing prescriptions and getting them through the pain before they can see their dentist. We would like to use our resources to be able to provide some type of care, either on site or via telemedicine if we need to, or via our Quick Care and primary care offices. I also think it is appropriate to try to minimize the cost to the patient.

In closing, UMC has always worked with various stakeholders to address concerns and is always willing to listen to find a suitable path forward for the best patient care. My thanks to the Nevada Press Association, the Nevada Justice Association, and also Nevada rural health partners. Mr. Osborn will also speak a little more about how this bill not only impacts UMC, but all the public hospitals throughout the state.

Blayne Osborn, President, Nevada Rural Hospital Partners:
I would like to thank our friends at UMC with this proposed amendment [Exhibit E] and to further clarify that when we are talking about county hospitals, we also have to remember our county hospital districts that are also in NRS Chapter 450.

Currently, UMC is the only county hospital, but we have seven county hospital districts that have hospitals, including Humboldt County, Lander County, Lincoln County, Mineral County, Pershing County, South Lyon, and White Pine County. Our county hospital districts' governing boards have to meet all the same requirements with the Open Meeting Law, as with UMC. There are some inconsistencies throughout NRS Chapter 450 that we recognize need to be cleaned up and addressed, hopefully in the next legislative session, so we appreciate not creating another one here with this bill. We appreciate it and will stand for any questions.

Chair Peters:
This is an interesting topic area. I have a couple of questions from members. We will start with Assemblyman Nguyen.

Assemblyman Nguyen:
I am familiar with this particular ask because I have been part of many nonprofits over the years. In terms of having this particular ask, it is so things could be discussed in your closed sessions that are of a more sensitive nature. That creates a level of fiduciary responsibility to these board members. That is the whole intent and these closed sessions are purely for discussion. I just want to put that on the record. Any action derived from those discussions will have to be taken in the public setting. Is that correct?

Mason Van Houweling:
Absolutely. A lot of the discussions are very high level in public, and we want to get more granular, and sometimes it is aggregated. Sometimes we are talking about conduct and performance related to physicians. Everything will always be done in open session, but this allows us to have those very frank conversations. As you know, there are a lot of HIPAA [Health Insurance Portability and Accountability Act] rules and regulations, so this will allow the board to be fully informed and have open dialogue. On the record as well, these will always be done in open sessions when there are decisions to be made or final deliberations.

Assemblyman Nguyen:
The five years in the bill right now, was that standard across the board in terms of other practices around the country, or is that a number we came up with in Nevada?

Mason Van Houweling:
I can at least talk to you about our previous bills. As far as going into closed sessions and others, typically everything is recorded and with notes and transcripts. After five years, they will be released, if not sooner. If public decisions were actually made, that would be sooner. It is consistent with what we have seen at UMC but also throughout the state.

Assemblyman Nguyen:
To clarify, it is not based on any other state's best practices. It is purely based on Nevada's best practices.

Mason Van Houweling:
If you do not mind, could I call on a friend behind me to answer that question?

Chair Peters:
Go ahead.

Susan M. Pitz, General Counsel, University Medical Center of Southern Nevada:
Five years was in existing law in NRS Chapter 450. Previously there was the ability to go into closed session for other issues. We have just kept those five years standard. I am not aware what other states have in the way of keeping those records public for a period of time.

Assemblywoman Newby:
I remember when the governing board legislation initially went through. I am glad to see it is working so well. I want to dive in a little more on the closed sessions. I have been party to a number of those, so I would like you to talk more about what actually happens and the steps in terms of recessing then going into the room and having the discussions. For my colleagues' information, could you talk more about the nitty gritty of how that works?

Mason Van Houweling:
I will defer to Ms. Pitz on that question. She makes sure we follow all NRS and the Open Meeting Law, closed sessions, proper notification, and she makes sure everything is up to standard.

Susan Pitz:
It would be properly noticed in the agenda that the board would be going into closed session. There is a motion to go into closed session. There would be no action in the closed session. In the closed session there is a discussion with the board where there are all members of the board as opposed to a briefing or a one-off discussion outside the Open Meeting Law. This allows them to go into closed session to have a discussion with each other. It is only a discussion—no action can be taken. If an action was to be taken that day and not at some subsequent meeting—many times at a subsequent meeting it comes back and it is on an open session—that is where the action is taken. In the closed session, if it was decided it needed to be for some emergency reason decided that day, they would adjourn the closed session, reopen the open session, and take the action there.

Chair Peters:
When you go into closed session and have a discussion, then go back to open session to make a decision, what do you cover about the discussion in closed session potentially resulting in what is now in the public space? Are there best practices or policies in place where you have to talk a little bit about how the decision came to be while the discussion happened behind closed doors?

Susan Pitz:
Are you asking what we have to explain when we come out of closed session?

Chair Peters:
Yes, if the discussion in closed session ends up resulting in a decision that is made in an open session.

Susan Pitz:
Honestly, I have not had that experience. Typically, it is more to inform the board than to have a discussion. There have not been a lot of times where they would immediately go into open session and discuss it there. If they were doing that, obviously they would have to give context around the matter that was being discussed. If it were a provider matter and unfortunately it was an action against a provider, the board would have to explain what the case or issue was about, then they would need to explain the decision. What they would not be explaining, for example, is specific information regarding a provider or a patient. That is not meant to be shared in a public setting because the patient should not have their information talked about in an open meeting.

Chair Peters:
I understand the patient piece. I have had the privilege this session to dive into the Board of Medical Examiners' process with providers. Most of that is kept very tight so we are not exposing our providers to potential issues with their reputations pending those discussions and the internal workings, so I understand those two pieces. I think there are important parts of the process for dealing with those in the health care space. It is interesting we are talking about this for the first time given there are these existing scenarios in place in which we are protective of people's information.

Mason Van Houweling:
As Ms. Pitz said, we have not had to do that. I am not saying it will not happen, but if there were something with imminent patient harm, I think that would be one where the board would have to do something the same day. Ms. Pitz informed you that typically those get agendized on a regular schedule. If it is not a life-or-death situation, it would go through the normal process and, as she mentioned, context would be put around that. We have not had to do that since I have been there, going on ten years. It would only be used where we see imminent danger with direct patient harm, if that gives you any comfort.

Assemblyman Koenig:
I want to touch on the piece about employing dentists. I am coming from the perspective of an optometrist, so we are cousins but not quite the same. I know in Nevada there are strict laws on employing an optometrist. I know at Walmart and Costco there are doctors not employed by those companies who are independent doctors. I am not sure why none of those places have dental practices. I have never figured that out. You can go to Costco and get your eyes checked, but you cannot get your teeth fixed. Are there any provisions as far as employing a dentist? I think you would have a hard time employing an optometrist; it would have to be a contract. Do dentists have the same rules where they cannot be employed and have to have a contract, or there may not be any rules and you can have them as an employee? Clear that up for me.

Mason Van Houweling:
In Nevada there is very clear guidance around the corporate practice of dentistry. That is what we are trying to do and ensure we respect that rule here in Nevada. We are looking for an exception to be able to hire a dentist and be able to provide that service in an emergency room setting to get patients to the right care sooner, either that day or the next day. We are getting guidance and clearance to be able to do that in Nevada.

Nevada has very clear corporate practice of dentistry rules, so this would allow us to do that. I have talked with the Committee on Dental Hygiene and Dental Therapy and with the State Dental Health Officer. They all think it is a great idea and are supportive.

Assemblyman Koenig:
As long as they are supportive, I would have liked to have had someone here saying they are okay with being employed. This could be a big shift where dentists could be employed. Hospitals yes, but Costco still no. It would be interesting to see what the dental board said, but as long as you have talked to them and have worked things out with them.

Mason Van Houweling:
Obviously, UMC is trying to fill a gap in the community like we always have. I do not know if a lot of the hospitals in the communities are going to hire dentists and put them in emergency rooms or colocate with emergency rooms. We are trying to give great patient care to the patients who show up at our doors so they do not have to wait for days on end suffering.

Chair Peters:
I know I have said this before, but I did not know how important oral health was until I was pregnant. The impact oral health has on the rest of your overall well-being, even your mental health, can be huge.

I do have another question related to this before we move on to other Committee questions. I do not know very much about the inner workings of dental reimbursement through Medicaid. However, I do know there are some limitations and I have had conversations with FQHCs [Federally Qualified Health Centers] who have struggled with providing adult dental care in a facility where they are providing care to Medicaid patients. Did you go through the process of making sure it is compliant with all the funding streams that come in through your facility? I want to make sure there are no inadvertent crossed wires we may have to come back and fix.

Mason Van Houweling:
For years I have been talking to the dental community, especially our State Dental Health Officer. We have had conversations in the past and have worked together on providing online care or telemedicine through some of the state-managed Medicaid programs. The problem is, we have hit this corporate practice of dentistry to be able to pursue some of those insurers. If we had gone to them and filled out applications, they would have kicked it back citing corporate practice of medicine. That is why we are here. They seemed supportive in

providing some of that care. We would panel the dentists we hire to be on those plans, but until we can get past the corporate practice of dentistry and get that exception—we cannot get them impaneled without taking this step first—I do not see any problems with getting reimbursed moving forward. Right now, unfortunately, the system is paying a much higher level for emergency room visits. As you know, the emergency room is the most expensive level of care. What we want to do is shift that over and provide a better option for all payers.

Chair Peters:
Thank you for that answer. I might follow up with you on that piece because I am curious as to how it all works. We have three more questions from the Committee.

Assemblywoman Taylor:
There are so many things I like about this bill because it is about patient care. Specifically, I like the addition of a dentist. It makes sense. If something happens on a Saturday night, you are not going to get in. You probably will not even get in on Monday, to be honest. You said you spoke with the Nevada Press Association in terms of transparency. That is always a question. I know in Nevada we have some of the most restrictive open meeting laws in the country. I used to be on the school board, so I know this. There is a balance between the public and the press, so thank you for speaking with them and at least getting them to the place of neutral. I have a question about the closed sessions. I certainly understand the need for it, and it is in the amendment [Exhibit E]. Regarding section 1, subsection 3, paragraph (d), subparagraph (1) of the amendment, typically when you go into an open session—and I am surprised you did not have that in here before—you can look at the character, conduct, and competence. Subparagraph (1) states, "The compliance of the county hospital with all laws . . . ." I think that is something the public would be interested in. And talking about that, if there is some lack of compliance as it comes down to the regulations or rulemaking around Medicare or Medicaid, is that not something we want? Help me understand why that should be closed session.

Mason Van Houweling:
I will start and have our general counsel answer also. Any CMS [Centers for Medicare and Medicaid Services] reports or findings, settlement events, penalties, or sanctions against any hospital are always public. We would not try to take that and move it into some type of protected status or attorney/client privilege. Sometimes we will have findings we need to talk about in closed sessions around patient care or something a public hospital missed, including UMC. That is what we are talking about. If it is a patient complaint, the patient has the right to report to a lot of agencies—and we have seen them all—state, local, CMS, joint commission, et cetera. There are a lot of regulations. Patients have venues to complain or file grievances through any venue. Should we have to take one of those into the closed session during the investigation period, they are either substantiated or not substantiated. Once it is substantiated, it is usually released. A lot of that is private with the investigator until all the information is received. I do not know if Ms. Pitz has something additional.

Assemblywoman Taylor:
I think that was sufficient. Feel free to jump in, but I would quit while you are ahead.

Assemblyman Orentlicher:
I want to follow up first on Assemblywoman Taylor's question on the amendment, section 1, subsection 3, paragraph (d), subparagraphs (1) and (2). I appreciate your coming up with examples of why closed session would be appropriate, but when you look at paragraphs (a), (b), and even (c), they are written very narrowly. Paragraph (d) looks like it could be anything. Anything could fit under all laws, regulations, and rulemaking, or any conditions of participation. It is hard to imagine what does not fit there. While I can see there are certain subsets of those, you have not written it in terms of the kinds of situations. It seems like it opens it up for anything you want to take into closed session even if it does not fit into the reasons we have closed sessions.

Susan Pitz:
I agree, and as you understand very well, health care is very complex. We have health care on the federal level, health care on the state level, conditions of participation to participate in Medicare. One thing I was going to add to Mr. Van Houweling's testimony was this is not just about lack of compliance but actually compliance. Our patient safety quality committee gives reports on an aggregate level a lot of times. It might be the board has questions they want to follow up on, but we do not necessarily want to get into the information that might be more patient-specific. We would want to go into closed session. Over time, we have tried to narrow it and address all of these questions to make it clear we are trying to meet our requirements from the joint commission and from CMS to have these fully informed boards on all of the aspects of the hospital and all the compliance we need to do to make sure we can participate in CMS programs and our licensure through the Department of Health and Human Services. I think that is what you are getting at as to why it is broad. It is really health care compliance. We do not always know specifically what might be an issue we want to have a fully informed board for, but the joint commission requires that we are able to show we have informed them of all aspects of our health care compliance.

Assemblyman Orentlicher:
Regarding paragraph (c), I understand allegations about competence and character and you want to protect the reputation, but how is the public protected if there are legitimate complaints? Sometimes they get covered up. I do not know of any examples at UMC, and hopefully we never will, but we hear regularly in other health care settings and hospitals where people have an ongoing bad record and nothing is done. Where is the protection when if in a closed session it is not substantiated? How is the public protected?

Susan Pitz:
One thing I would like to add about paragraph (c) is there is the ability to go into closed session for these matters already under NRS Chapter 241 under the Open Meeting Law. The issue and why we would like that clear in NRS Chapter 450 is so there are not conflicts. There are certain notice requirements that might differ. Unfortunately, if we have to take an action, if medical staff of UMC has to take an action against a provider, they have rights. They have to get due process. We obviously make sure and take care they would receive all their due process and receive a fair hearing. If there is a final adjudication for a bad actor, there is also federal law that requires those instances to be reported to the National

Practitioner Data Bank. Those instances are reported there so the doctors cannot go from state to state. That is what that legislation did back in 1986. There are mechanisms on the federal level to make sure those bad providers cannot go from state to state and things are not swept under the rug.

For us specifically, if they were to go through that due process—and here we are specifically talking about appeal—that would go up to the governing board level, which has the delegation to hear appeals of these matters. They are not going to get a new hearing, and under NRS Chapter 241, the language, as it was written, almost appeared to give them different rights, notice requirements, and a new hearing. We are trying to follow their due process, but if there was an action out of that appeal—say the provider's privileges are going to be revoked—that is when we would come out of closed session and make that final action to revoke those privileges.

Assemblyman Orentlicher:
I follow what happens when you find; I am concerned about when you decide not to find. You said there are previous proceedings. Would that cover that? I am worried about the provider who is bringing in millions of dollars and no one wants to touch that person and no findings are made and there is nothing to report to anyone because you do not make the findings you should make.

Susan Pitz:
I am talking about the fair hearing with medical staff. That does not involve the public board, so that is why I am not specifically addressing that. That would be the action of the peer review proceeding where they decide whether or not to take action. It is the appeal of that decision when it is heard by a public body.

Mason Van Houweling:
I understand your question. I have had the opportunity to work in all different parts of hospitals—for profit, not for profit, public, and military—the process is much the same. There is a whole system of bylaws, rules, and regulations. Ms. Pitz talked about due process; it is almost like a court. Fortunately, we do not have to sit on a lot of those, but there are times. I assure you that process is sound and the medical community really does regulate itself. They do not like to have bad marks or bad doctors working with them, but there is a process. There are times when we may not have all the information or the fair hearing does not level to suspension or a report to the Data Bank, or all the way up to the Nevada board. Again, that process happens at UMC and every hospital he represents and every hospital throughout the nation, often what you see on the TV courtroom dramas with hospitals. Again, to get to your question, if that does happen, and if it does not warrant a suspension or a report to the Data Bank, that matter is a closed matter, or they go on some type of monitoring process, or they have preceptor oversight, those types of things. Not everyone gets to see that day to day, but I assure you it does happen. If it does come out of the governing board, that is a reportable action, and we have had to take that in the past at UMC.

Chair Peters:
I think it is important to acknowledge how many layers there are that are intended to protect the public from bad actors in the community. The integrity of our medical community is very important to that trust relationship and privilege relationship our doctors hold. Those include the Board of Medical Examiners who accept complaints; law enforcement can be a part of certain complaints; and then the local hospitals in places where those folks may be contracted or employed. There are several layers in place. It is not one singular decision-making body that is often a part of those issues and the discussion of what privileges those doctors can retain if there is a valid complaint and what the process looks like. I just want to mention it is not just within the hospital setting; there are other areas where doctors are responsible for their actions as well. As I said, I have gotten to explore some of the Board of Medical Examiners process over this session and it is very interesting.

Mason Van Houweling:
We see that with people coming into our state, but we also want to make sure no one is jumping from state to state. It is a national data bank, and I have seen where doctors have tried to get on staff and they have to explain what happened five, ten, twenty years ago. As you mentioned, we hold them to the highest standard. Their peers in the medical community ensure they are delivering the highest quality care.

Chair Peters:
There are some who slip through the cracks, but we are working on it together to make sure we have all the right layers in place.

Assemblywoman Thomas:
I am glad UMC is out in front on this position. I do appreciate Renown; but at UMC, I must say I have had the pleasure of being a patient on more than one occasion. I felt extremely privileged to have the amount of professional services. That even includes the emergency room. Unfortunately, I had to be transported there due to a horrific car accident I had. The service I received there was exceptional in my opinion.

My question goes back to the dental. Would this complete your wraparound services? I know UMC has an excellent burn unit. I know we have obstetrics/gynecological services, mental health services, et cetera. Would this dental part of your business plan support the wraparound service you are looking for?

Mason Van Houweling:
I will certainly convey your comments back to the team in Las Vegas. Thank you for your support. I wish I could say yes, this finally checks off the final piece, but as you know, UMC is home to a lot of firsts and onlys. We just started doing our pancreas transplants, but we need to get into liver transplants. There are a lot of things we provide that others do not. This will allow us an avenue to be able to do that under the corporate practice of dentistry. There is more to come. This is a big step, but I also think it is a relatively small step we can fit in quickly. We are looking at behavioral health issues. There are all kinds of things we get approached about, especially after the pandemic because of what we were able to do

during the vaccinations and testing. We collaborate with Renown quite a bit. We would love to see them grow in burn, transplant, and level 1 traumas. We work very closely with them as well. They are very similar, as you know. I wish I could say this would check off everything and the world's problems would be solved, but there is probably more you will see us on the move for. We are doing online care now so people can do visits at home. A long answer to your question, but we have more moves we will make, but not around this. This will hopefully package it in a way where we can have clarity.

Assemblywoman Thomas:
I do like the component of dental care because we do have the homeless community, and I am sure they have been there complaining about their dental health. They do not have health insurance. COVID-19 has wiped out a lot of families, so we know they are arriving at your doorstep. I think this would be great.

Chair Peters:
Are there any other questions? [There were none.] We will move to support testimony in our physical locations for Senate Bill 192 (1st Reprint). Is there anyone in Carson City or Las Vegas who would like to provide support testimony? [There was no one.] Is there anyone on the phone waiting to provide support testimony? [There was no one.] We will move to opposition testimony. Is there anyone in Carson City, Las Vegas, or on the phone who would like to provide opposition testimony? [There was no one.] We will move to neutral testimony. Is there anyone in Carson City, Las Vegas, or on the phone who would like to provide neutral testimony? [There was no one.] Are there any closing remarks? [There were none.]

I will close the hearing on Senate Bill 192 (1st Reprint). We will move to the last item on our agenda today, which is public comment. Is there anyone in Carson City, Las Vegas, or on the phone wishing to provide public comment? [There was no one.] That concludes our business for the day. We will have a meeting on Monday. I hope you all have a wonderful weekend celebrating the mothers in your life and folks who are the mothers in our lives regardless of their biological attachment to us.

This meeting is adjourned [at 12:19 p.m.].

RESPECTFULLY SUBMITTED:

_____
Lori McCleary
Committee Secretary

APPROVED BY:

_____
Assemblyman David Orentlicher, Vice Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Senate Bill 42 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is the Work Session Document for Senate Bill 44 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is a proposed amendment to Senate Bill 192 (1st Reprint), submitted by Regan Comis, representing University Medical Center of Southern Nevada.