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

Eighty-Second Session
March 13, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:33 p.m. on Monday, March 13, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 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:

Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6
Assemblywoman Venicia Considine, Assembly District No. 18

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Eric Robbins, Committee Counsel
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Theresa Owens-Bigay, Private Citizen, Las Vegas, Nevada
Steven Piskor, Private Citizen, Cleveland, Ohio
Jamie S. Cogburn, President, Nevada Justice Association
Jonathan Norman, representing Nevada Coalition of Legal Service Providers
Marie Coe, State Long-Term Care Ombudsman, Aging and Disability Services Division, Department of Health and Human Services
Catherine Nielsen, Private Citizen, Carson City, Nevada
Dora Martinez, Private Citizen, Reno, Nevada
Brett Salmon, President/CEO, Nevada Health Care Association
Charles Duarte, Nevada Director of Public Policy, Northern California and Northern Nevada Chapter, Alzheimer's Association
Catherine Maupin, Private Citizen, Reno, Nevada
Connie McMullen, representing Personal Care Association of Nevada
Eddie Ableser, representing FreedomCare
Andrew LePeilbet, Chairman, United Veterans Legislative Council
Shirley Gaw, Private Citizen, Las Vegas, Nevada
John Carlo, Private Citizen, Las Vegas, Nevada

Chair Peters:
[Roll was taken. Committee rules and protocol were reviewed.] We have two bill hearings today, and I will take them in order. I will open the bill hearing on Assembly Bill 202, which revises provisions governing electronic communication devices in certain health care facilities.

Assembly Bill 202: Revises provisions governing electronic communication devices in certain health care facilities. (BDR 40-46)

Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6:
With me today is Jamie Cogburn, president of the Nevada Justice Association. We are here to present Assembly Bill 202, which revises provisions regarding electronic communication devices in health care facilities. Existing law establishes certain duties of medical facilities, including a facility for skilled nursing, and specific rights of patients in such facilities. This legislation is narrowly tailored to allow patients in skilled nursing facilities or their guardian to request installation at their own expense of an electronic communication device of their choice. A friendly amendment has been submitted by the Legal Aid Center of Southern

Nevada [Exhibit C]. That amendment requires a guardian to seek court approval in order to install this device.

The Centers for Disease Control and Prevention reports that as of 2016, there are 1.7 million beds in licensed nursing homes in the United States. Many people who reside in nursing homes need assistance with one or more activities of daily life such as eating or preparing meals, bathing and dressing, going to the toilet, managing medications, moving around in the residence, or getting to other locations. COVID-19 had a severe effect on nursing homes. The Centers for Medicare and Medicaid Services reports that as of December 2022, there were 1.37 million confirmed COVID-19 cases among residents of nursing homes and more than 1.43 million confirmed COVID-19 cases in staff of those nursing homes. Since the pandemic began in the spring of 2020, nearly 161,000 residents of nursing homes have died of COVID-19, and 2,839 staff members of these facilities have died of COVID-19. I share these statistics with you because they are the foundation of why this bill is necessary.

Living in a long-term facility can be isolating for its residents, especially if those residents do not have family who live locally or if those family members work, are supporting their own families, and can only visit intermittently. Allowing a communication device in a patient's room allows the patient, if they are able, to call and see their family members to break up the isolation, monotony, and oftentimes the loneliness of being in a long-term care facility. For those residents who are not physically able to communicate, it allows their family member or guardian to initiate communication with them or just see how they are doing. Today, you will hear from my constituent, Theresa Owens-Bigay, whose brother Henry was a resident in a long-term care facility in Las Vegas. He passed away during the COVID-19 pandemic. Also, on Zoom today is Steven Piskor, an advocate in Ohio, whose mother was a resident in a long-term care facility. He has been an activist for this type of legislation for many years. I believe that their experiences will help you understand the necessity for this legislation. With your permission, I would like to turn the presentation over to Ms. Owens-Bigay at this time.

Theresa Owens-Bigay, Private Citizen, Las Vegas, Nevada:
I sit here before you today to share my brother's story and experience in a nursing home and why I passionately believe in getting this bill passed. As my brother entered his 50s, his health started to decline. He was diagnosed with multiple sclerosis (MS) and diabetes. In 2018, my brother suffered several strokes. He was in and out of hospitals. He did not want to be placed in a nursing home because he feared what would happen to him. Eventually, he could no longer walk, and he had to be placed in a nursing home. His worst fear had now become his reality. Two weeks into his stay, I started to notice the red flags. I would go on my lunch at 10:45 and feed him. He will have soiled his diapers 20 minutes after lunch, and I would call for a nurse to change him. She told me she would have a certified nursing assistant change him. I would return to work at 11:45, but when I would get off work at 3 p.m., I would return to see that he was in the same soiled diaper. You may ask yourself, How do you know it was the same soiled diaper? Because I took a marker and I put a check mark on the tab of his diaper. When I got there, that check mark was still there; that is how I know. This happened on several occasions.

I received a call from the nursing home informing me that my brother had an infection and needed to go to the hospital and asking which hospital I wanted him to go to. They would not say what the infection was. I got to the hospital to be told by the doctor that my brother was severely dehydrated, had a severe urinary tract infection, sepsis, and MRSA. The MRSA and sepsis were caused by the staph infection that was in his feces which entered the open bed sore that was about the size of a half dollar located right above his buttocks. Remember, he would soak in feces for hours before he would be changed. The dehydration caused the urinary tract infection.

He was hospitalized multiple times with the exact same conditions. The dehydration explains why, when I gave him water, he would drink it as though he was dying of thirst. That is when I noticed the pitcher of water was being placed out of his reach. When I asked the nurse why his water was being placed out of his reach when he needed to stay hydrated to avoid these reoccurring urinary tract infections, her response was, "Because he would spill it, get his sheets wet, and I would have to change him." A person with MS will eventually begin to have difficulty holding simple items such as a glass of water and eating utensils. I came to wonder whether anyone was giving him fluid other than me; therefore, my brother being nonverbal and nonmobile would have to wait for a staff member to come in his room and hope and pray that they would give him a drink of water, which I did not think happened much because if it did, he would not have been hospitalized for severe dehydration and urinary tract infections. Now take into consideration that we live in the desert, and they did not always have the air conditioner on. But that is another issue for another time.

Then there is the matter of the bedsores. A person with bedsores should be rotated from side to side every two hours. I requested a wedge pillow for him. This would help keep the pressure off that bedsore. I know that wound had to be very painful. Many times, I would arrive at his room and the pillow would be gone. I requested an alternating pressure air mattress to alleviate his pain, and that too would be gone. I requested compression socks to help with the circulation in his legs. They gave him IPC stockings—intermittent pneumatic compression devices. That was a good thing because it prevented blood clots in the deep veins in his legs. He had that for about a month and a half, and then they were gone, and because of not having circulation in his legs and being a diabetic, he had to have his big toe amputated, and his pinky toe just rotted off.

On March 17, 2020, then-Governor Sisolak shut down the nursing homes. I could no longer see my brother. I was sick to my stomach. I believe it was in June when I got the call that my brother had contracted COVID-19. I had the nursing home transport him to the hospital because I did not trust their care. I called the hospital to speak with my brother's nurse and was told by another nurse that she was unavailable to speak with me because she was taking pictures of my brother's body. She told me the reason for the pictures was because they needed to document the condition of his body upon his arrival so they would not be held accountable. I wanted those pictures, and I wanted them badly, but I was told I could not have them until he was discharged, and it became part of his official medical record. I got those pictures, and I had a meltdown. I took those pictures to the news. People needed to know what was happening in this nursing home. You can watch this story on YouTube. Type in "nursing home nightmare." You will see the bedsores and the rotted pinky toe.

After he overcame COVID-19, I placed him in another nursing home. They had availability for patients who were on Medicaid. I was unable to see him in person because of the lockdown. I would call the nursing home and ask the nurse to put the phone to his ear so he could hear my voice. He needed to know why I stopped coming. He needed to know that Nevada was on lockdown. He needed to know that I loved him very much and was doing everything possible to see him. He needed to know that there was this deadly virus, but that I would do everything possible to see him as soon as I could. On Thursday, February 4, I was able to visit my brother through the hospital room window. I remember looking at him. This once strong, vibrant man I used to remember was now reduced to skin and bone. I know my brother endured a lot and his soul must have been tired. I had to utter the words that I never wanted to say to him: "Okay, Hank. It is okay. Go home. Be with Mama. Be at rest. Be at peace. It is okay." Two days later, on February 6, he did just that. He went home. He was 61 years old.

I joined two nursing home support groups in which people shared their family members' experiences in nursing homes. To my astonishment, I learned that the patients in these homes are not only suffering neglect like my brother did, but they are suffering from verbal, mental, and physical abuse, rape, and sodomy. I would like you to take into consideration the story of the 14-year-old Arizona girl who was in a vegetative state for over 10 years and in December 2018 gave birth to a baby boy. The mistreatment of individuals is happening all across this country, and Nevada is no exception. You must realize you have been given the power and authority by the people of this great state of Nevada to make and change laws. I pray to the Most High for two things: I pray that you have the conviction in your heart to push this bill through, but above all, I pray that you will have the courage to overcome the opposition that will follow this bill, and trust me, there will be a lot of it. What I need you to ask yourself is, whose privacy are you really protecting?

I am going to conclude with this: I am grateful at this moment to be sitting here to share my brother's story with you. This bill will not bring my brother Henry back, but what it will do is help protect and maybe even save the lives of vulnerable individuals who, for whatever reason, their family had to place in nursing homes.

Chair Peters:
Thank you, Ms. Owens-Bigay, for sharing your story. I believe we have your written testimony, and it will be included in our exhibits. [Written testimony was not received.] I believe we have other folks who would like to testify as part of your presentation.

Assemblywoman Summers-Armstrong:
The other person who is on the line is Steven Piskor. He is an advocate from Ohio, and he has been working on this type of legislation in his state and assisting others as well.

Chair Peters:
I apologize for not making a statement at the beginning of this testimony about the potential trigger factors of this bill. I do not know if we have the ability to put a trigger warning on our recordings, but I will try to make sure we mention it for folks. You may begin when you are ready.

Steven Piskor, Private Citizen, Cleveland, Ohio:
I have been advocating for cameras in nursing homes for 12 years. I did get a law passed in Ohio for cameras in nursing homes that was named after my mother who was brutally abused in a nursing home in 2011. I put a hidden camera in her room and caught eight aids abusing her. One thing you are going to hear during these testimonies from your constituents are the same things I am saying and Ms. Owens-Bigay is saying. You are going to hear many stories of nightmares, but I want to get into more about the law, because too many people do not understand this law, and they do not know it.

Right off the bat, I am going to ask all of you to vote down that amendment [Exhibit C]. I doubt very seriously that your state attorney general is going to tie up the courts with something like getting permission to install a camera when you have a law. That does not make any sense. Please vote that down. You do not need it. This law is in 14 states, and no one has it. I want to tell you Nevada has the same language that Ohio and the other 13 states have on the privacy law, and the privacy issue has been settled in 14 states. This is not a new law. This law is 20 years old. Texas was the first state to enact this law in 2003. Since then, it is now in 14 states, and we are working on several more. So it could be that a lot more states are going to get involved in this law.

This law, the privacy law, is for the resident only. It does not pertain to anybody else. No one has the expectancy of privacy going into that room. No aide has it. Nobody else has it, no visitor has it, nobody who walks into that room, no caregivers. Nobody expects privacy in that room, so when they walk into that room and there is a camera in there, if they are going to do anything or say anything that is private or that they want to keep private, they should do it someplace else. As far as the camera itself, the cameras are all the same. All 14 states are using the same cameras. They are all very similar. I am sure everybody is familiar with the Ring doorbell cameras; they are very similar to those. They are simple cameras; they can be installed with no tools. They do work off Wi-Fi, and we are telling people to get their own Wi-Fi and not to use the nursing home's Wi-Fi. People are using hotspots and they are working well. This law is working very well in all 14 states. I get calls from all over the country telling me that the law is working. I just got an email from somebody from Ohio who said they see an improvement in care for their loved one because they have a camera in the room. I find it odd every time a hidden camera was put in a room, it caught abuse.

In Ohio and in all the states, we did not want this camera to be hidden. We want everybody to know cameras are there; we want to put up a big sign. We should not be responsible for putting a sign in a facility. The facility should be putting a sign in the room, but not outside the door. Outside the door is not our problem. That is the facility's problem. That is why the clause says "may." So, I want to put a sign up. Please put the sign up. We encourage you to put a big sign up telling everybody there is a camera in the room because when you walk into that room, you have no right to privacy. A few years ago, the Georgia Supreme Court ruled on a nursing home case where the aide was caught on hidden video. The aide brought the case all the way to the Georgia Supreme Court and said that her privacy rights were violated. The Georgia Supreme Court ruled that she had no right to privacy in the resident's room and the videos could be used in a court of law. Everybody knows that a supreme court ruling in a state sets a precedent for all 50 states. In order to get that ruling, you have to take it to the U.S. Supreme Court.

I say the camera law is working in Ohio. It is going to be one year old in ten days on March 23, and it takes time for this to work. You are not going to have hundreds of people running out to put a camera in rooms. It did not happen anywhere; it did not happen in Ohio. It just takes time. It could take a year or two years. It takes time for everybody to get involved in putting cameras in and seeing that nobody else can view these videos. We made it so we did not give any rights to the nursing home. The nursing homes should not have any rights in this. The idea of this is to give residents and families peace of mind knowing they can view the cameras at any time without any problems from the nursing home. If you give the nursing home any rights at all, they will set the cameras off, they will set the Wi-Fi off, they will tamper with the cameras. Anybody who touches those cameras is liable, regardless of whether they work there. Nobody walks into your house and tampers with anything. That room is a resident's home, so nobody should be doing that in a room. You will be held liable for it, so you can put anything you want on the sign.

Chair Peters:
We have several questions from Committee members. If you have any additional remarks, we would be happy to review those in writing. Assemblywoman Summers-Armstrong, do you have any additional testimony on the bill before we get into questions?

Assemblywoman Summers-Armstrong:
I think we can go to questions. Mr. Cogburn is here to help with any technical legal questions I am not able to answer.

Chair Peters:
We also have our legal staff in the room, knowing this issue is a hot topic.

Assemblywoman Thomas:
I have one question, a concern about the Health Insurance Portability and Accountability Act (HIPAA). How does that affect this?

Jamie S. Cogburn, President, Nevada Justice Association:
This is a patient's rights, meaning they are the only one who can waive anything. If there is a privacy concern or a HIPAA concern, it is the patients who decide whether to put cameras in their rooms. By doing that, they are waiving their rights on HIPAA. You have to remember they are waiving their rights as to anybody who can view that camera. But for anybody to view the camera or to use an electronic device, they have to receive written consent from the patient. For example, if my grandmother is in a home and wants to be able to communicate with me, or for me to be able to log in and see things, she would have to give me written consent that would stay on file with the nursing home, and we are the only two people who could view anything or communicate through the device.

Assemblywoman Thomas:
Thank you for that explanation. What if the patient is incapacitated?

Assemblywoman Summers-Armstrong:
We received a request from Legal Aid Center of Southern Nevada. If you go to section 8, subsection 1, you will see it requires the guardians of individuals who cannot speak for themselves to apply to the court for authority and for consent, so this is not just anyone speaking on their behalf. Additionally, the guardian would be the only person, outside of a court order, who would have the right to view the content on the camera.

Assemblywoman Taylor:
The intention of this is to make sure there is a camera in the room, in particular for those dementia patients who are in care. Some of the information we read, and a presenter as well, spoke about the workers, the employees. Do the employees have a right to privacy in that environment? Is this an infringement upon their privacy?

Jamie Cogburn:
To answer the question bluntly, no, they do not have a right to privacy as an employee there. In fact, in every nursing home I have ever seen, there are other cameras throughout the hallways and in other places throughout the facility. The privacy concerns are really the patient's privacy concerns, and we have to go back to this being a patient's right. They have the right to have the camera or electronic communication device. It is not necessarily always a camera. It could be an Alexa device that you can FaceTime with a loved one or something to that effect. Also, it leaves it up to the patient and what they want. You have to remember this is their home; that room is their home, and this is about what they want. No one else has the right to privacy whether they are in the hallway or in the patient's room.

Assemblywoman Taylor:
In the event the patient is unable to make this decision, there is a guardian and someone with a medical power of attorney. If you have a medical power of attorney, do you have to go to

court for consent, or does that medical power of attorney stand in lieu of going to get consent to do that, presuming you are a family member?

Jamie Cogburn:
If you have a medical power of attorney, that would be enough under the statute. However, when you are talking about a guardianship, meaning the person has been deemed to need a guardian, there had to be two doctors who signed off and said the person is either mentally incapacitated or physically incapacitated, and a guardian needs to be appointed. If that is the case, then the prospective guardian would have to go back to court to get approval for the guardianship. That protects the guardian acting on behalf of the patient.

Assemblyman Nguyen:
There was reference to a roommate. If the roommate is not able to make that decision and the family of the roommate refuses, how does that situation work? There may be an agreement on the one patient but not on another patient's family. As the situation gets more complex, where is the recourse in this scenario?

Jamie Cogburn:
It goes back to the patient's right. If you have two patients in the same room, which would be common, and if one patient does not want it and one patient is okay with it, they would switch rooms so you would get two patients who are okay with it. You are not going to override one patient's rights for another patient. If there are no accommodations that can be made, at that point the camera or electronic device cannot be placed because you cannot violate another patient's rights, especially the right to privacy, without an agreement.

Assemblyman Nguyen:
There was mention about sound versus pictures—just the visual part. Are there any thoughts about a roommate having a visual monitor, but maybe sound is not an option? Is there flexibility in this bill in terms of making sure there is compromise? Audio is not an option on the table, but what video would cover is the need to make sure there is some sort of transparency.

Jamie Cogburn:
That has been thought out some and discussed when drafting the bill and with the stakeholders. When COVID-19 happened, you could not go to the nursing homes, and we had a client who had Alexa at his residence. There were allegations of abuse and other things similar to what Ms. Owens-Bigay testified to. There were hours and hours of this gentleman screaming out in pain, asking for help. We think it is important that there is sound. In this case, there was only sound, not video. It comes down to the patient. If they want only sound, they will have that choice. If they only want video, they will have that choice. When you go back to the roommate situation you were talking about, you would need a waiver from anybody who is in that room if it is a room with more than one patient.

Assemblyman Nguyen:
Adding language diversity in terms of patient care: in terms of language access, sometimes we are in rooms with folks from different cultures, different backgrounds, or things like that. I am trying to get a clear picture of who would be in possession of these videos outside of the families. Who would have access to them outside the facilities, knowing all these languages may be heard in these situations?

Jamie Cogburn:
At the end of the day, the only person who has access to this is the patient and the authorized family member or, alternatively, someone pursuant to a court order—so a criminal investigation, the police, something like that, or investigation by the Department of Health and Human Services. They would have the ability to get it, but other than that, no one. This is not something that is going to be streamed on YouTube or anything like that. This is meant to protect the patient and increase communication between the patient and the family.

Assemblyman Nguyen:
What about retention of records? Is there a time we are setting for these records to be kept?

Jamie Cogburn:
There is no set time; it is up to the patient. It really depends on the equipment they buy. If you are doing video, it takes more storage. It depends on how you are going to do it. Some loop every 30 days, every 60 days, every 90 days, some are a year. At the end of the day, the video is for people to check in. If they believe something has happened, they can review the video. I do not think anybody is going to be sitting around on a Friday night watching old video unless there is something they are really concerned with.

Assemblyman Gray:
Does a roommate get to say whether the other roommate can use a telephone, which is open audio, or an Alexa device, FaceTime, an iPad, or anything like that? I am not finding the correlation there because it is already in place. Second, why would you need a court order from a judge if a judge has already issued a court order saying the guardian is appointed to make these decisions? It seems like it would complicate it in the courts—taking it back to the court for a decision you have already been granted permission to make.

Assemblywoman Summers-Armstrong:
A patient can make a phone call, they can use FaceTime, they can use Google Meet, whatever they choose, if they have the capability to do so. Right now, there is no prohibition on that.

Jamie Cogburn:
I want to clarify one thing concerning telephones. The reason you would need a waiver is only when there is a recording device. If there is a camera recording or something where there could be an invasion of privacy, that is when you need the consent of the roommate. As far as the guardian is concerned, this was a friendly amendment [Exhibit C] from Legal Aid Center of Southern Nevada. They were concerned about whether guardians could act

within the scope. It depends on what the court order says. It depends on how much authority they have pursuant to the original court order. If they are allowed to, if the original court order includes that they can add or place an electronic device, a recording device, in the room, then I do not think they have to go back for approval—an additional court order. It depends on what the court order is upfront.

Chair Peters:
There is someone from legal aid in the room who might be able to answer the intent on that question. Again, the question is the intent of the amendment and what we are getting at with a variety of devices.

Jonathan Norman, representing Nevada Coalition of Legal Service Providers:
At Northern Nevada Legal Aid and at the Legal Aid Center of Southern Nevada, we have about 20 attorneys who represent people in guardianship full-time. We have a Protected Person's Bill of Rights. Just because someone is under guardianship does not mean they give up all their rights. An example is that a protected person has a right to visit people they want. If the guardian thinks that somebody could be harmful to the person, they need to go back to court and make a case to the judge. It is similar here. Our protected persons do not give up all their rights, including rights to privacy. I would envision cases where our attorney talks to the protected person and the protected person says, Yeah, I want my son or my daughter to have this ability. I would imagine we would do a stipulation in order to have the camera there, but in instances where the protected person has the ability to verbalize what they want, we want to have a court order for that to happen. We want to have that discussion in front of a judge.

Assemblywoman González:
Under section 10, subsection 1 of A.B. 202, it says, "If a facility for skilled nursing approves a request to install . . . ." Is this mandating, or is this enabling language so if the facility wanted to elect this, they would be allowed to?

Assemblywoman Summers-Armstrong:
My understanding is this would be a right of the person, and the only way the facility could deny it is with some kind of extraneous reasoning. They would have to have a significant reason why a person could not have the camera.

Assemblywoman González:
After we implement this, they would be allowed to regardless of what facility they are in unless there is some circumstance which they would define.

Chair Peters:
Our Committee counsel is here, and he can talk about the way the bill is written and respond to the question. Is that all right?

Assemblywoman Summers-Armstrong:
Yes.

Eric Robbins, Committee Counsel:
Section 10, subsection 1, but if you go to section 9, subsection 4, it says that "A facility for skilled nursing shall approve a request by a patient or the representative of a patient . . . if the request meets the requirements of this section." If the request has all the things in it that the statute requires and there is consent on the part of the roommate, if that is applicable, the skilled nursing facility would have a duty to approve the request. It is not optional.

Assemblywoman González:
In section 10, subsection 1, paragraph (a), it says that they choose the electronic device. Are we saying the family has to choose the device? Is there a burden on the family in terms of money with the device?

Jamie Cogburn:
Yes. Under this bill, the burden is on the patient or the patient's family to pay for the device. There are a variety of different devices, so it really depends. Mr. Piskor was talking about a Ring device. I have a newborn, and right now, I could see my newborn in her crib if she were in her crib. There are all kinds of different devices out there. It is upon the patient or the patient's family coordinating with the patient to ensure what kind of device to buy.

Assemblywoman González:
I got a little confused between the video and the audio. If a device allows for both, is there a stipulation in this bill that only one can be used? For example, a Ring captures both audio and video. If a roommate consents to audio but maybe not video, what would this bill mean in terms of that?

Jamie Cogburn:
I do not have the answer for you, and I can get back with you on that one. If a patient wanted video only, then they would have video. It goes back to the patient's right. They get to decide what they want. They might just want an audio device on which they can connect with somebody at their home; they may want a full-fledged video device that is recording so they can talk; or they may want both devices. Ultimately, it is up to the patient.

Assemblywoman González:
If we are moving patients throughout the facility, this device would follow the patient, right?

Jamie Cogburn:
The patient may move throughout the facility during the day to go eat or do different activities or things like that. It would not follow them there, but it would be where they consider their home—where they sleep and where they spend a large part of their time.

Assemblywoman Thomas:
I have a question concerning section 13, subsection 2. It reads:

> An employee of a facility of skilled nursing shall not refuse to enter the living quarters of a patient which contains an electronic communication device installed pursuant to section 9 of this act or fail to perform any of the duties of the employee on the grounds that such a device is in use.

What happens to that employee if they refuse? Can the patient sue the nursing home, or can the patient sue the employee for not going in where they feel their privacy is being violated?

Jaime Cogburn:
The employee has no right to privacy under Nevada law. For example, if I have cameras in my office, I can log in and see what people are doing. In these nursing homes, there already are cameras in the hallways. What we are talking about here is within the room. Concerning a patient's right to sue: No, but if they were being denied treatment by the nursing home because employees would not go into the room and treat them, that could lead to other issues for the nursing home, as it would be refusing treatment; but they would not realistically have a private cause of action against that nurse or certified nursing assistant (CNA). I cannot imagine a situation where a nurse or CNA refuses to treat a patient because there is a camera, as that comes with their job.

Chair Peters:
Our Committee counsel would like to weigh in here.

Eric Robbins:
Section 1 authorizes the Division of Public and Behavioral Health (DPBH) to take disciplinary action against the license of a facility that fails to comply with sections 3 to 14 of this act, which includes section 13. The way I read it, the facility would have an obligation to make the employee provide treatment more or less in accordance with his or her job duties regardless of the camera. If the facility failed to do that, then the facility would be subject to disciplinary action from DPBH.

Assemblywoman Taylor:
We received a letter from a Mr. Salmon, and I would like to ask a couple of questions regarding item 3 [page 1, Exhibit D]. It talks about third parties that have to consent to recording. My question for legal is, with notification on the door—and that is one of the things they mentioned here—is that enough? If I am an employee or a visitor and I am walking into the room and it says that there are surveillance cameras, or whatever word we want to use, is it enough to say, Okay, I know I am being recorded. Is that consent, or is some other consent required for it to be legal?

Eric Robbins:
The relevant statute here as far as surveillance or a camera in the room without this bill is *Nevada Revised Statutes* (NRS) Chapter 200, section 650, which provides that the consent of

one person who is a party to a communication which is being listened to, monitored, or recorded is necessary to make that recording, listening to, or monitoring legal. In this case, the patient and any applicable roommate would have consented. The plain language of the statute—NRS 200.650—does not conflict with A.B. 202. If there were some conflicts, the courts use maxims called "canons of statutory construction" to resolve ambiguities in statutes, and one of those canons of statutory construction is that statutes should be construed harmoniously when there is some ambiguity or some notion of a conflict. In this case, the harmonious construction would be to give full effect to A.B. 202 and read the provisions of A.B. 202 to apply to their full extent and to not be interfered with by NRS 200.650. Another relevant canon of statutory construction is that a specific statute like A.B. 202, which would apply specifically to the context of installing a camera in a room at a nursing home, prevails over a general statute like NRS 200.650. The provisions of A.B. 202 would prevail over and would be given full effect. It is my legal opinion that any assertion that NRS 200.650 would narrow or obliterate the scope of A.B. 202 is manifestly groundless.

Assemblywoman Taylor:
What you said is that consent is not required of the third person who is there visiting. Is that the bottom line?

Eric Robbins:
Yes. As has been discussed, those employees of the nursing home do not have any right to privacy there. Nursing homes are a very heavily regulated type of entity under Chapter 449 of NRS. The Division of Public and Behavioral Health can go in and inspect whenever they want, so there is not a right to privacy there.

Assemblywoman Taylor:
Is that the same for visitors?

Eric Robbins:
Yes. As we have discussed before, the right to privacy really is in the patient, and when someone walks into someone else's space, they do not retain their right to privacy as to that other person's right to his or her own space.

Assemblywoman Taylor:
One of the recommendations in Mr. Salmon's memo to us is whether there can be a provision for when a camera is being used illegally [page 2, Exhibit D]. Can the facility have it removed? What would be the steps to have it removed if it is being used inappropriately or illegally? I would like your opinion on that. Should that be included? It sounds like something we certainly want to cover.

Chair Peters:
I had a similar question to this related to the statute of limitations in situations in which there is a case that could be criminal or civil in nature and how the authorization of this bill would affect the statute of limitations. If the device is being used for something inappropriate or illegal, how does this affect those cases?

Jamie Cogburn:
Under the authorization, it is allowed to be used under section 10. Section 9 lays out some of the uses. It can only be used and only be viewed by certain people, so hopefully, we should not run into that issue. Of course, if somebody were doing something illegal or clearly inappropriate, I have no doubt that it could be removed because it is not being used for the purpose that was specifically laid out by the request from the patient.

To Chair Peters' question regarding the statute of limitations, most statutes of limitations are based upon when the event happened. If it is a two-year statute of limitations or four-year statute of limitations, then it would be based upon that. The same is with regard to criminal acts. I do not practice criminal law, but depending on what kind of crime it is, they have different statutes of limitation on when a charge could be brought by the district attorney or by the Office of the Attorney General.

Assemblywoman Summers-Armstrong:
We have Marie Coe here. I would like her to step forward if she has a moment to talk to us about what the process for misbehavior is in one of these very highly regulated facilities.

Marie Coe, State Long-Term Care Ombudsman, Aging and Disability Services Division, Department of Health and Human Services:
The process with any complaint at a facility depends on the type of complaint. Adult Protective Services could investigate abuse complaints. If found to be true and valid, the Division of Public and Behavioral Health could receive a referral in addition to a law enforcement referral. My office also investigates resident's rights issues, so this could be a resident's rights violation. We have a process where we would speak with the facility as well as any pertinent person, the resident's family representatives, and anybody else involved to complete our investigation. If the issue is not resolved at that level, we would also send a referral to the licensing agency to take action and apply the law.

Assemblywoman Summers-Armstrong:
The intent is that the facility does not get to preemptively decide about whether or not they want to remove. They need to follow an established pattern of investigation. They have all the phone numbers for the people who are their assistants and making sure that things are done well and go through the process. That is the proper way for them to do it, not to just decide on their own that they are going to remove. I think the regulations along with the law are sufficient.

Assemblywoman Taylor:
One of the issues brought up was that the bill limits it to guardians. Is that your intent? Could a parent be able to make these decisions? If a child is in a nursing facility and they would like to place a camera as well, could they make that decision since by law a parent would not fall under that? I know it is targeting dementia patients, but there are others who may be interested.

Jamie Cogburn:
It is not just for guardians. The patient can request it if there is a power of attorney or the parent, or if somebody has been appointed as guardian ad litem, which is usually for a minor. All of those can make that decision. If they were in a long-term care facility such as a nursing home, a parent could make that decision on behalf of the patient. In those circumstances, usually a guardian is appointed. A separate attorney, such as legal aid as we were talking about earlier, even though a parent may be the guardian, they still have separate counsel to protect their rights. They would communicate with their attorney, and it could be either through a stipulation order or it could be through a court order that is mandated by the judge.

Assemblywoman Taylor:
Does this not exclude a parent?

Jamie Cogburn:
It does not exclude parents. It is about what is best for the patient and the patient's choice.

Chair Peters:
Thank you for the questions. We still have Committee members with questions.

Assemblyman Hafen:
Referring to the devices—that there was really no limitation on the device and that the facility had no way of rejecting any device the patient or the patient's family wanted to utilize—national security issues keep popping into my head. I know this is a health committee, but at the federal level, they have banned certain companies—Huawei is probably the biggest company—from being able to sell these devices or utilize these devices in government facilities. I believe there is a Senate bill coming forward to do something very similar, to at least adopt the list the federal government has established. From what I am hearing from you, there is no prohibition. The facility could not say, Hey, this is national security; we cannot allow these devices in our facility. Now we are saying that they have to be allowed to if the patient so chooses. Have you considered that? Would that be a limitation if the federal government and/or the state is banning those devices from being utilized?

Jamie Cogburn:
There are limitations. The device has to be approved. When I said, "any device," I misspoke; I was generalizing too much, so I apologize. The device does have to be approved. I am looking for the exact language from the bill. I can coordinate with you after the fact, but I did misspeak and was generalizing when I said any device. It is limited to electronic devices, video, Ring devices, and "nanny cams."

Assemblyman Hafen:
Thank you, and I appreciate that. I wanted to get my concerns on the record. If they are approved, I would like to follow up offline with you about how those would be approved to

make sure we are not contradicting another bill that is going to come forward on the Senate side or our federal regulations.

Chair Peters:
Thank you for that question. We are also discussing the definition of "electronic communication device" and may need to look at whether that needs to be defined specifically for this situation. Are there any other questions before we move into testimony? [There were none.] We are going to move into support testimony on Assembly Bill 202. Is there anyone who would like to provide support testimony on A.B. 202?

Catherine Nielsen, Private Citizen, Carson City, Nevada:
I am Executive Director of the Nevada Governor's Council on Developmental Disabilities, but today I am providing testimony as a constituent. My husband, who is nearly 33, is in the beginning stages of developing a disease rather similar to frontotemporal dementia. Some of you may be familiar with this terrible disease. It is the one Mr. Bruce Willis was recently diagnosed with. During the stages of diagnosis, we required video documentation to assist the medical team in their assessments. Many patients have seizures and other ailments that go alongside this degenerative brain condition. For many families, this diagnosis means a nursing home placement at some point in their life. This condition can also come with behavioral changes that are outside of the patient's normal behaviors. Placement of cameras can also provide protection to staff just as much as for the patient and family. In conclusion, not only would cameras assist in the diagnosis and medical care, but assist with the safety of patients receiving care and staff providing that care.

Chair Peters:
Thank you for your time and for your testimony. Is there anyone else who would like to speak in support of A.B. 202?

Dora Martinez, Private Citizen, Reno, Nevada:
I represent the Nevada Disability Action Coalition and am in support of this important and vital bill.

Chair Peters:
Are there other people who want to give support testimony on A.B. 202? [There was no one.]

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

We are going to move into opposition testimony on A.B. 202. Is there anybody who would like to provide opposition testimony?

Brett Salmon, President/CEO, Nevada Health Care Association:
I will be very brief. You have my letter and you have asked lots of questions about issues in my letter. I want to emphasize a couple of things. As per the comment in my letter about a caregiver's right to privacy, they may not have a right to privacy. The point I am making in

that letter is they may have a legitimate concern about doing that. Some of the things our attorneys looked at included that they may have a religious belief about being photographed, being filmed, or being recorded. Another item they brought up may not be common, but it is possible that an employee might have concerns about the use and retention of those private recordings and settings because of their personal safety, such as if they have been dealing with domestic violence or have been the victim of some crime and are trying to maintain a low profile. Being recorded could be a legitimate concern if they would rather not be recorded in those settings. That is something we thought was worth putting on the record.

Another item in the bill concerns a wiretap law issue. Our lawyers disagree with your lawyers on this issue, so I am happy to continue to discuss it with Assemblywoman Summers-Armstrong. She has included us from the very beginning and heard our concerns, so I am happy to work with her offline with our attorneys and her counsel to try to resolve those concerns about the wiretap issue.

Chair Peters:
Thank you for your testimony, and I appreciate your continuing to work with Assemblywoman Summers-Armstrong on those concerns. Are there other folks who would like to provide opposition testimony? [There was no one.] We will move to neutral testimony. Is there anyone who would like to provide neutral testimony on Assembly Bill 202? [There was no one.] I would invite the bill sponsor up for closing remarks.

Assemblywoman Summers-Armstrong:
I just wanted to say thank you. I know this is a difficult issue because there are lots of variables we are all concerned about. The one thing we all have in common, if I may make an assumption, is we all realize our lives are fragile. Every one of us in this room at some point may have a loved one who may need care, and one day we may need care. Depending on what that care entails, we may not be able to stay at home. If my mom had to be in a facility and I am 600 miles away, I would like to be able to communicate with her, to be able to have her call me via Alexa if she cannot use her hands. If I am the designated person, I would like to be able to pop in and for her to be able to hear my voice.

I want us to recognize that times are changing. We have a different dynamic in our world. Now, we have the ability to be able to communicate with one another, and we should allow that to be available when our loved ones are confined in these long-term care facilities. Thank you all so much for listening. I appreciate it.

Chair Peters:
We will close the hearing on Assembly Bill 202.

I will open the hearing on Assembly Bill 208.

Assembly Bill 208: Establishes a program to provide structured family caregiving to certain recipients of Medicaid. (BDR 38-297)

Assemblywoman Venicia Considine, Assembly District No. 18:
I appreciate the opportunity to present Assembly Bill 208, which would establish a structured family caregiver for certain Medicaid recipients. Joining me today is Mr. Charles Duarte and Ms. Catherine Maupin. They will be assisting me with this presentation. For background, Assembly Bill 208 came from a recommendation presented to the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs during the interim in March 2022. At its final meeting and work session, the committee voted unanimously to submit this bill before you today.

Let me provide you with some background information. Nevada has the third-fastest rate of growth for dementia and Alzheimer's disease, and the number of Nevadans living with dementia is expected to grow over 30 percent from about 49,000 to about 64,000 by the year 2025. Based on reports from the Alzheimer's Association in 2021, it is estimated that there are 48,000 informal caregivers in Nevada providing care for adults with dementia. These caregivers provide 78 million hours of unpaid care, which is equivalent to an estimated $1.3 billion worth of care. Nearly 70 percent are women, and 46 percent are caring for a parent or parent-in-law. They play a critical role in the care of senior citizens with complex health needs and disabling conditions by assisting with a wide range of household, self-care, and medical tasks necessary for health, function, and community living. Based on reports from the National Academies of Sciences, Engineering, and Medicine, several studies have demonstrated how Medicaid reaps significant benefits from family caregivers' contributions. When older adults' caregivers receive standardized assessment, training, respite, and other supports, caregiver and patient outcomes improve. Older adults' nursing home placements are delayed; and there are decreased expenditures for emergency room visits, fewer hospital readmissions, and decreased Medicaid programs and services utilization.

Family caregivers play an important role in the state's efforts to help Medicaid recipients safely remain in their communities and in their homes. Rebalancing Medicaid to enable recipients to remain living in the residential settings of their choice has been a longstanding national priority. As of August 2022, at least seven states—including Connecticut, Georgia, Indiana, Louisiana, North Carolina, and South Dakota—currently cover structured family care giving services provided to older adults or adults with special needs under their Medicaid programs. These programs facilitate more effective coordination of care and home- and community-based supports that enable greater independence and quality of life for our older adults. In summary, this bill's overarching intent is to provide financial support and training for family caregivers including legally responsible individuals such as a spouse. I will be turning it over to Mr. Duarte to talk more about the bill.

Charles Duarte, Nevada Director of Public Policy, Northern California and Northern Nevada Chapter, Alzheimer's Association:
On behalf of the 50,000 Nevadans currently living with dementia including Alzheimer's disease, their families, and their caregivers, we strongly support this bill. This is a bill that will recognize the importance of family caregivers to the overall health care system, particularly the Nevada Medicaid program, which is estimated to provide, as of 2020, over $200 million of care to individuals with dementia diagnoses, including Alzheimer's disease. This bill, as indicated, will save money in the long run if you think about how much a nursing home bed costs Nevada Medicaid, which pays approximately $256 a day for a nursing home bed. This bill would establish a payment regimen that would approximately be half that amount per day. If you multiply $256 per day times 365 days, you get approximately $93,000. This bill will allow for the same level of care to keep people safely at home, avoiding that nursing home stay, and avoiding unintentional hospitalizations.

One of the key questions concerns what structured family caregiving is. We have had an opportunity over the last year to invite experts from The National Academy for State Health Policy (NASHP) to Nevada to talk about this type of program. As the Assemblywoman indicated, there are nine states providing some form of structured family caregiving right now. By definition according to NASHP, it differentiates itself by the incorporation of structured and ongoing education for the care partner, and coaching, emotional support, and financial support for the care partner who lives with and delivers personal care services to the Medicaid enrollee. The family caregiver provides personal care and support based on the member's needs and the normal rhythm of the member's day. What is happening is, the individual is there 24/7 making sure that person is safe even though they may not be providing personal care the entire time. It allows them to stretch out service over an extended period of time, and because they are living there, it keeps that person safe.

There are a number of other key elements that establish the difference between structured family caregiving and other types of programs, but suffice it to say the key here is making the care partner part of the care team. They will be employed by a personal care agency or similar organization who will be the employer of record delivering training as necessary and as identified through a functional assessment that will be done by the Department of Health and Human Services. That functional assessment will identify the needs of the Medicaid recipient to receive structured family care, but also what the training needs of the individual's care partner might require to take care of that person as best as possible and keep them safely at home.

With that, I would like to go into some of the details of the bill. It is a rather simple bill; however, there have been some proposed amendments [Exhibit F]. I would like to go over the bill first, let Ms. Maupin speak about her experience with caregiving, and then go into the proposed amendment that has been offered by the Department of Health and Human Services.

Chair Peters:
Everyone has had the opportunity to read the bill; however, it would be helpful if you walked us through the sections of the amendment that are friendly and that you would like to move forward with.

Charles Duarte:
You have a memorandum submitted by the Aging and Disability Services Division of the Department of Health and Human Services (DHHS) dated March 9 [Exhibit F]. This is the division's proposal for amendments to the bill. I have had an opportunity to speak with them about my concerns as well as concerns raised by Eric Robbins, your legal counsel. I will briefly touch on each of these, and then talk about the ones we could still support and recommend. The first request from the Department is to replace all references of amending the home- and community-based waiver program and allow the Department to apply for a new waiver altogether [page 1, Exhibit F]. This is based on concerns expressed by the Centers for Medicare and Medicaid Services (CMS) to the Department regarding "new" versus "amended" waiver applications. It was CMS' recommendation to submit a focused, dementia-specific waiver application that would be new, so it would be in addition to the home- and community-based programs already authorized by the U.S. Department of Health and Human Services. I agree with this proposed recommendation. It does simplify things for the Department, and it would allow for a quicker approval of a brand-new program as opposed to amending an existing program. The second item [pages 1 and 2, Exhibit F] is to replace the word "recipient" with "applicant" in A.B. 208 section 1, subsection 2, paragraph (a). Mr. Robbins raised some concerns about this, and I agree with some of his concerns. At this time, we would not be recommending item No. 2 which would replace the term "recipient" with "applicant."

Eric Robbins, Committee Counsel:
For the record, my concern with this part of the amendment was people cannot receive services through Medicaid until they have been approved to participate in Medicaid. Replacing the term "recipient" with "applicant" was not appropriate because that might imply that a person who has not been approved to receive services through Medicaid could still do it. If we were interested in clarifying that an applicant could do this provisionally, then we could reword it to clarify an applicant could designate it provisionally, and it would not take effect until they were receiving services.

Charles Duarte:
Thank you, Mr. Robbins, for that clarification. I do not know if anybody from the Department is here to explain the rationale for that change. I suggest we agree with Mr. Robbins' concerns and not recommend this request for amending the bill.

Assemblywoman Considine:
Since this is not a solid decision, we can continue talking about this portion of it after our hearing today and continue working with Mr. Robbins and DHHS on this part.

Chair Peters:
That is a great idea. I can see the rationale from DHHS in the description and wonder if there is an underlying issue we are not seeing today, so I appreciate that. Do we want to move on to the third request [page 2, Exhibit F]?

Charles Duarte:
The third request is to remove the term "intermediary service organization." An intermediary service organization is an entity that employs caregivers in situations where the care recipients have identified caregivers and want to self-direct their own care. The Department had a concern about the fact that this was a dementia-specific waiver application and those individuals do not have the capacity to self-direct their care safely. I disagree with that conclusion on the part of the Department. An individual in the mild cognitive impairment stage of Alzheimer's disease, or even in the early or middle stage, is often capable of self-direction in care. In addition, the amendment uses language around the term "capacity." No one is suggesting that they need to have their capacity checked, especially if they are already self-directing care, so removing this choice of an intermediary service organization which allows for that person to self-direct care from a caregiver of his or her own choice is inappropriate unless a court has determined that person does not have the capacity to self-direct care. I am not an attorney, so I am not going to give an opinion on that, but I think eliminating this choice for somebody based purely on a diagnosis of dementia and not on their capabilities is inappropriate. That is the third request [page 2, Exhibit F], and I would recommend against that particular provision of the request.

The fourth request relates to section 3, subsection 2, paragraph (b) of A.B. 208, which provides an effective date for the program of January 1, 2024. The time frame associated with requesting a waiver, or even a waiver amendment, from CMS can be extensive, and the Department is recommending an effective date of January 1, 2025, as opposed to January 1, 2024. I agree with that. I agree with the first and fourth requests, and we are going to have further discussions around the second request.

Chair Peters:
Thank you for walking us through that as there is a lot of information here. I appreciate that you are continuing to work with the Department about their concerns and getting their input on the bill.

Charles Duarte:
I would like to introduce Catherine Maupin, a volunteer advocate for the Alzheimer's Association. She is also a support group facilitator and an educator for the Alzheimer's Association. She has lived experience as a care partner, and I would like her to take a few minutes to tell her story.

Catherine Maupin, Private Citizen, Reno, Nevada:
I am here in support of A.B. 208. For 22 years, I was a caregiver for my mother, who had Alzheimer's disease. I am a support group facilitator for adults who have a parent with Alzheimer's or other dementias. For the past 17½ years, I have listened to stories from

members of my support group who have dedicated themselves to the care and support of their parents. They have endured financial, physical, and emotional hardships as they lost their loved ones to this disease. Many who work have had to reduce their hours, transition to part-time employment, or quit working altogether as their parent moved through the stages of this disease. Some of the caregivers in my group have applied for and received food stamps. Some have had to take money from their savings and retirement recounts. As their income goes down, the expenses go up for medical supplies and incontinent supplies, bathroom modifications, wheelchairs, and gas to take their loved ones to appointments. Many of our members also suffer physically, as they take care of their parents, with backaches, strained and pulled muscles and joints, surgeries, and heart issues. Many suffer from depression, guilt, and anxiety and are in counseling, thus incurring additional medical expenses.

Assembly Bill 208 will help not only the people who have Alzheimer's, it will also benefit their caregivers because the person with Alzheimer's or dementia will be able to choose their caregivers, allowing them to be cared for by someone who is both familiar and trained. They will likely remain in their homes longer, reducing the need for more expensive Medicaid services such as long-term care in an institution, and financially this benefits the state. Caregivers would be more secure financially, physically, and emotionally. Specific training and support for caregivers should lead to fewer physical injuries and emotional issues, reducing their out-of-pocket medical expenses. The more capable, confident, and supported caregivers are, the greater the likelihood that they will care for their loved ones longer, which also financially benefits the state. My thanks and heartfelt appreciation for all of your efforts in drafting and bringing this bill forward and especially for allowing me to have this time to speak with you.

Chair Peters:
Thank you for your testimony. Several of us have experience with dementia and appreciate the sacrifice and navigating the waters of caring for your loved ones. We are ready for questions.

Assemblywoman Taylor:
This is really important care. I was in a meeting with a constituent last week who cares for her significantly disabled daughter. Because of that, she is unable to have a job because her daughter needs around-the-clock care, although she is able to go to school. My constituent was asking about opportunities, and this came up and it would be helpful if it were extended. Has there been any thought given to extending this beyond dementia—not limiting this to dementia care, but including those who may be caretaking people in their families with significant disabilities?

Charles Duarte:
Yes, the discussion has occurred. Last week, I had a phone call with Cheryl Dinnell, the executive director of the Nevada Lifespan Respite Care Coalition, about that issue. While this was drafted in a way specific to individuals with dementia who need long-term care services, I think the program could equally apply to other individuals. For example, it could benefit a parent taking care of an adult child who may have significant developmental

disabilities, or other situations where someone may have a physical disability and might benefit from a family caregiver being there 24/7.

We structured this in a way to reduce the fiscal impact; but at the same time, this program can be applied to a variety of different populations served by the State of Nevada. I would be okay if you want to expand it and help others. It was narrowed because I work for the Alzheimer's Association and wanted to make sure the fiscal impact was limited to that population; but yes, it is applicable, and other states are using it across the board.

Assemblyman Hafen:
You mentioned in your presentation this would be a cost savings. Looking at the fiscal note, it looks like it is going to cost about $66 million this biennium and $91 million each biennium after that. You stated these patients would be able to stay at home, but now we are paying the caregivers, so I am not following the cost savings. Could you provide us with more information on how the actual savings to the State of Nevada would occur that would be different from the DHHS fiscal note of $66 million in this biennium?

Charles Duarte:
I have serious concerns about that fiscal note being overinflated and not representing the true cost of care for this population. The population we are talking about is relatively small. We have been in discussions with the state of Missouri's Medicaid program, which has been running for three years and has a total of 108 clients. They have a similarly sized Medicaid program to that of Nevada, and we expect that experience to be replicated here. In addition, according to Missouri Medicaid staff, 80 to 90 percent of patients on their structured family caregiver waiver are already receiving long-term services and supports financed by the Missouri Medicaid program and covered elsewhere in the budget. The estimate of costs is never exact, but I have asked for a meeting with the directors and key administrators to talk about that fiscal note because, again, I have expressed several times since it was published I believe it is overinflated, and I would like to talk to them about it.

The savings occur because somebody is already receiving that service, and the alternative for that person is to be in a Nevada nursing home bed. They could apply right now without this program being available, and they would be at a nursing facility level of care to get into this program. They have to be at a nursing facility level of care, meaning they are eligible for a nursing home bed. That is a $256-per-day alternative to this, and I do not believe those savings were incorporated into the estimates provided by the Department of Health and Human Services. They are envisioning this as a brand-new program when in fact the vast majority of these people are already Medicaid-eligible—going back to that discussion about recipients versus applicants—and are already receiving paid care someplace else in the budget.

Chair Peters:
I want to remind the Committee this is not a money committee, so a lot of this will get fleshed out when it ends up in our fiscal committees. Reflecting on previous years dealing with Medicaid and the cost versus savings allocations, it is quite the math to get there, and

the State of Nevada runs on a biennial budget cycle which oftentimes does not realize cost savings in that initial cycle; we will see it in future cycles. However, in this case, that might not be the case. I also want to reference that we have been on a time crunch here, so if this was not accurate, the best way to deal with it is to work directly with the agencies to ensure we are all on the same page about the intent of the bill and work toward a solution on the cost-saving measures. Let us address the policy pieces and we can address the fiscal pieces in the next committee.

Assemblyman Hafen:
Thank you, Madam Chair, and my comments are based on the testimony provided. I agree a policy of keeping someone with their family is better than putting them in a home, but I am struggling with the concept of cost savings when we are paying one person or another. If there is a cost savings to the State of Nevada, I would love to see that. I agree with you, the fiscal note is probably inflated because to me, it is one hand or the other. I encourage you to reach out to the Department and provide us additional information. I do think it is better for someone to be with family rather than in a facility.

Chair Peters:
The goal of the cost savings is not just the quality of care. We had a conversation before this bill hearing about the state of some of these facilities and the hospitalizations resulting from those facilities. There are potential cost savings from the reduced need for hospitalizations that I do see referenced in the fiscal note. Again, that is going to be dealt with in a separate committee and is not related to the policy. The policy at hand is the value in ensuring that a family member gets compensation for taking care of their loved one rather than sending them to a home that would receive that compensation, especially if that person has the time and the capacity to take care of their loved one.

Assemblyman Nguyen:
This is a great topic to talk about because families of the Asian American and Pacific Islander (AAPI) community deal with this on a regular basis. This is a relevant topic that triggers memories for me. In section 1, subsection 2, paragraph (b) when we use the word "employee," does that mean that they can be fired? Let us say if the agencies do not think they are doing a good job, but they are the relative of the patient being cared for. If they are employees, are they eligible for benefits like health care? Some of the intent is to give the caregiver cost-of-living expenses and things like that, but when we use the word employee, it triggers other employer-employee relationship questions.

Charles Duarte:
The intent is to have these individuals who are selected to be family caregivers be employees of personal care agencies. There are a variety of reasons for doing so, but one of them is to make sure they are complying with all Department of Labor standards and requirements for a fair wage as well as receiving the training necessary to be a family care partner. In this case, the training can be different because you bring up the case of AAPI families and households. Teaching them and making sure they go through a cultural sensitivity training program may not be appropriate if you are taking care of your father whom you have been living with for

the last ten years. So, there may be some things we want to look at in terms of the training required, but there is still an employer-employee relationship. The employee, or the family care partner in this case, has to pass a background check and has to meet all the other requirements that Medicaid establishes for in-home caregivers—the personal care attendants. Yes, it is important that they are identified as being an employee of an agency who can make sure they are getting paid, and any taxes associated are being handled by the employer. With the intermediary services organization, that employer-employee relationship still exists. It is a little different, but it is important the relationship still be established.

Assemblyman Nguyen:
I try to bring real-life situations into some of these bills. What if a family dispute arises where siblings say a brother is not taking care of dad and the sister should be. Is the agency put in the middle? How do they resolve it? If the patient is in an advanced stage of dementia, they may not be able to make those decisions anymore. When it comes to moving from one caregiver to another, which happens a lot, this person might say, I should be able to get the reimbursement because I take care of Dad. You are just on paper, but I am actually doing the work. Is the agency responsible to make that determination? How would those issues get decided?

Charles Duarte:
Those issues are worked out through regulation development that the Department of Health and Human Services would have to implement as part of launching this program. The way it works in other states is that the care recipient, in this case the Medicaid recipient who is receiving care, designates their family caregiver, and there is only one primary care family caregiver identified. They can have a backup, but there is only one identified as a part of the program, and that person is going to serve and agrees to serve as the primary caregiver. If there is a need for respite care, it is important to have an agency that can have somebody go in and provide respite to that family caregiver so they can take time off. Again, the way the program operates is that there is only one designated care partner, and they have to reside with that individual in their residence full-time. If a change is necessary, assuming the care recipient still has the capability to make that call, they will make the choice of a change in care partner. If they do not, then we get into the situation discussed in the prior hearing concerning capacity. I am not an attorney, so I cannot tell you how that would be resolved except for a guardian to be appointed.

Assemblyman Nguyen:
May I ask our Committee counsel to respond to that question?

Chair Peters:
Would you repeat the question, please?

Assemblyman Nguyen:
When it comes to a dispute among family members in terms of capacity and in terms of the patient not being able to tell who is giving good care, who would step in and evaluate the capacity question?

Eric Robbins:
That is something I would have to research and get back to you on.

Assemblyman Nguyen:
Great. I would love to get more on that.

Chair Peters:
That brings up interesting conversations about how we certify folks under Medicaid. There have been a couple of examples in the last few years in which expertise has been used. Education has been used as the certifying factor rather than employment. A person could be a doula with proof of having met a certifying standard, and Medicaid can approve them for reimbursement. There might be some opportunity there as opposed to an employment standard, but it is worth digging into. I think there are a couple of opportunities out there, but the liability piece is important, especially as we are dealing with vulnerable populations. What is the backstop to make sure folks are taken care of? It is easy to think that the family is a backstop and would see neglect or harm, but sometimes they can be the perpetrators.

Assemblywoman Newby:
Assembly Bill 208 requires that the Department apply for the waiver. Is getting the waiver assured? If it is not assured, what is the backup plan? Counties are often a backstop for long-term care when someone does not qualify for Medicaid, or it does not cover the whole cost. Have there been any conversations with the counties to access this program if it is established?

Charles Duarte:
With regard to the first question related to the backstop, that raises the importance of the value of a personal care agency and that person, that family care partner, being a part of that agency. The backstop is that agency, and there are other employed in-home caregivers who can serve to provide respite or other types of backup care in case the family care partner is sick or otherwise unable to perform their duties.

With respect to the question around discussion with the counties, no. This was initially envisioned to be a care savings. It was not until the Department put their fiscal note on this, identifying a significant amount of costs for the counties, that it became apparent to me that this is something we are going to have to talk with them about. Outside of Medicaid, this should be an opportunity to provide and pay for family caregiving. I have had people who are members of the Alzheimer's Association ask me, Why not other people? Why just Medicaid clients? It raises a good question about what standard of care we want to adopt for folks in general as opposed to folks who qualify for Medicaid.

This was presented as a Medicaid program. That is the reason we are discussing it, but it has wider implications and certainly could benefit the counties in terms of how care can be provided using a structured family caregiving approach. Part of the backstop is this structure. That is important to understand because what you are talking about is creating a program through which a care partner is provided care specific to the needs of that Medicaid recipient.

The way other states have operationalized that is to make that care partner part of the care team. There are state caseworkers in contact or dealing with Medicaid clients through their home- and community-based programs. That state caseworker in the structured family context is constantly in contact either electronically, telephonically, through other means, or through home visits with family care partners. It not only assures safety but appropriate training, and it enables the state case manager to help identify if that person needs respite. The agency serves in that capacity as well as the employer. They have responsibility, and they do it well in terms of identifying somebody who might need respite care. The creation of this as a structure is important because the care partner in this case is in touch with the state case manager through a variety of means and can get help that way. I hope that answers your question.

Chair Peters:
Thank you for the response. Mr. Robbins has some additional thoughts on Assemblyman Nguyen's question.

Eric Robbins:
It would work the way it works for any other incapacitated person. People have the right to make decisions under law until they are found to be incapacitated and a court appoints a guardian for them. If there were a family dispute and one family member thought the person was incapacitated, then the family member who thought the person was incapacitated would have to file a petition for guardianship—a general or special guardianship. The court would evaluate whether the person was in fact incapacitated. If the person is incapacitated, the court would determine who would be the best guardian. I think that is how that would work.

Chair Peters:
Thank you, Mr. Robbins. Are there other questions?

Assemblywoman Thomas:
As you were explaining this process, I was thinking about those private agencies that hire certified nursing assistants and they also hire family members to take care of their loved ones. Those private agencies pay for the services of the family member. Is that also paid by the State of Nevada? You want to have Medicaid pay for this instead of the State of Nevada paying for it.

Charles Duarte:
The State of Nevada already pays agencies for that type of care, and the agencies send trained employees into homes of Medicaid recipients right now to provide care. This bill creates a different way of payment, and that is another important aspect. It pays that individual a per diem, a per-day rate, or a stipend. That distinguishes it from other ways Medicaid pays for services, which is on the quarter hour to an in-home caregiver who is an employee of a personal care agency. They bill, and the agency, in turn, bills Medicaid on a quarter-hour basis. This pays on a daily basis, or sometimes weekly, and some states do it monthly, but it is a stipend based on an average amount of services being provided by that person in the Medicaid recipient's home. Medicaid would still be paying the bill to the

agency; in this case, though, the agency would be paying the family care partner a daily stipend.

Assemblywoman Thomas:
Then the agency would be ultimately responsible for regulating the services of that family caregiver because they would have to train that person and make sure that person was following the agency's guidelines.

Charles Duarte:
Yes, that is correct. This bill does not intend to replace that responsibility. It uses the personal care agencies as intended, as the employer of record who has responsibility for the overall training and delivery of safe care to the Medicaid clients. It is a different way of paying for the service, but the responsibilities of the personal care agency are still there. They do a very good job of managing that care and making sure their employees comply with all the requirements of the Medicaid program.

Chair Peters:
Given the time, we are going to move into testimony unless anyone has further questions. [There was none.] We are going to move into support testimony for Assembly Bill 208. I will take support testimony in Carson City and Las Vegas first, and then on the phones.

Connie McMullen, representing Personal Care Association of Nevada:
[Connie McMullen submitted a letter in support, Exhibit G.] We are in favor of Assembly Bill 208. The Personal Care Association of Nevada strongly supports amending the home- and community-based waiver as it was initially put forward. After hearing today's proposed amendment, we are totally in favor of creating an independent dementia-specific waiver to take care of this specific population. Currently in the Aging and Disability Services Division, there are very few services for people with dementia—primarily respite given through a grant. Further down the line, they have the option for long-term care outside their home, but those beds are few and far between. They are limited in each skilled nursing facility, so we are really in favor of this.

We support what Mr. Duarte said about the intermediary service organization (ISO) option being included in this amendment because currently a lot of personal care agencies are also ISOs. Agencies are allowed to carry those clients, those caregivers who are allowed to be placed in people's homes, and the person receiving the care operates as the employer of record. That is a program that has been in effect for over ten years. As I said, there is a cost saving because whenever you pay somebody as the State of Nevada does in a nursing home environment, it is three times the cost of keeping them in the community. About 20 years ago, Nevada made a concentrated effort to keep people in the least restrictive setting. That is part of *Olmstead v. L.C.*, and that is why we try to keep them with their families. Yes, agencies do employ family members and pay them on a regular basis because they cannot maintain their private job and get paid at the same time. This is a very good program, and we highly recommend support of it.

Eddie Ableser, representing FreedomCare:
I am speaking on behalf of FreedomCare, a personal care service organization that serves over 70,000 individuals across seven states doing this type of work. We are thrilled to see Assembly Bill 208 and thank Assemblywoman Considine for bringing it forward. We are hopeful for the support from this Committee. Many of the issues that have been brought up are on point. It will save a tremendous amount of money to the State of Nevada down the road. Having a new waiver program will open up the door for more structured family caregiving in a variety of settings, including that case management point, which is so important for our individuals struggling with dementia. Another aspect to Assemblywoman Thomas's points about the change in payment, is that the daily rate allows more time for that individual to dedicate to their family members. Oftentimes, family members are limited to one, two, or three hours a day to give care to their loved ones. Under a program like this, you will have more time for that family member to care for the loved one. We hope all members of the Committee support this bill's passage and the proposed amendments Mr. Duarte identified. We also support those specific ones as well.

Andrew LePeilbet, Chairman, United Veterans Legislative Council:
We represent 279,000 veterans, which is 8.9 percent of our population. When you count their immediate families, that is 500,000 Nevadans or 16 percent of our population. Why is this veterans group here? Everyone thinks the Department of Veterans Affairs (VA) takes care of all our vets. Well, in the State of Nevada—and I checked this with the Department of Veterans Services—about 23 percent of those 279,000 veterans receive benefits from the VA. That means 214,000 veterans are not receiving this. As you can imagine, many of our vets are elderly and starting to develop dementia. Self-care is coming from their spouses in most cases, so we support A.B. 208 entirely.

Jonathan Norman, representing Nevada Coalition of Legal Service Providers:
We have about 20 attorneys representing people in guardianship, and we view anything that supports the least restrictive option for people including living in the home. Somebody mentioned *Olmstead.* Whether it is in child welfare, people with disabilities, or elders as they age, I like to focus on the most connected environment—where is the person's most connected environment? Certainly that is living with their family at home, so we are in support of this bill.

Shirley Gaw, Private Citizen, Las Vegas, Nevada:
I am a parent, and I am here to support Assembly Bill 208. I want to share our personal testimony. My two children and I are here for Children's Week. We were also here last week with the Nevada Governor's Council on Developmental Disabilities. I have been a licensed physical therapist since 1996. I have two children on the autism spectrum, and I have been their unpaid caregiver for the past 14 years. The State of Nevada only provides respite services amounting to $125 a month. In order for my children to have quality of life, I gave up my Public Employees Retirement System benefits at University Medical Center in

Las Vegas. Even though our family is not making what we are supposed to be making, it is going to have a long-term effect because being their unpaid caregiver and teaching them self-care skills will improve their quality of life. They will know how to brush their teeth, be aware of personal hygiene, and that will have long-term effects on their health.

I am also teaching them real-life skills to integrate them in the community. I have taken them to concerts and we were able to eat out with hardly any behavioral problems. We can even travel now, which is amazing. My daughter is sitting on her own with her personal device, listening and being a spectator to a legislative hearing. It is not perfect, this is a work in progress, but being her unpaid caregiver, I have been able to teach her to type and she types 30 words per minute. That is going to be a work skill down the road. I hope she will be a productive citizen. She can play beginner piano, and more than 50 percent of the time she remembers to brush her teeth before bedtime. I hope this could expand to other populations.

Chair Peters:
Thank you for your testimony and we are happy to have your daughter here today. Speaking of that, if you get the opportunity to bring your child into the Legislature, please swing by our offices. We have snacks in our offices and love to see the next generation of involved people in the building. We have lost our space in Las Vegas; however, I do not believe there was anybody left in that room to provide testimony. We are going to move on to support testimony on Assembly Bill 208.

Catherine Nielsen, Private Citizen, Carson City, Nevada:
As you heard, my family is faced with an impact from dementia. I would like to quickly give you a few pieces of data from the National Council on Aging and the National Center on Elder Abuse. Statistics show that unpaid family members provide most of the care for people with dementia. Informal family members and caregivers make up one-third of all caregivers. Daughters provide the bulk of unpaid care hours for people with dementia at 39 percent, followed by spouses at 25 percent, and other family and friends at 20 percent. Statistics show that many people with dementia rely on family members even when they have paid care.

Recent studies show that those with probable dementia who lived at home and had paid care providers had informal family caregivers provide more than half of the total weekly care hours. It shows that family caregiving does not end when adults with dementia move into residential care settings such as assisted living. The same studies show that 80 percent of adults with dementia living in residential care had at least one family member or unpaid caregiver assisting with self-care or household activities. Lastly, poor mental and physical health may increase the risk of abuse. Those who have Alzheimer's disease or dementia are particularly vulnerable to abuse. The National Council on Aging and the National Center on Elder Abuse report nearly 50 percent of all elders with dementia experience abuse or neglect. As health and memory decline, it is in the best interest of the person with this debilitating condition to receive care from families or people of their choosing rather than care from individuals in nursing home facilities.

Chair Peters:
Thank you for your testimony. Is there anyone on the public line who would like to provide testimony on A.B. 208?

John Carlo, Private Citizen, Las Vegas, Nevada:
I would like to say ditto to the mother who just spoke. I also would like to thank this Committee for hearing such a bill because this has been one of the best governmental meetings I have ever been a part of. This is the kind of legislation that both parties can come together on, and these are matters that really hit home. I want to encourage the Committee to move forward with this. We need more tax dollars coming back to the people of Nevada.

Chair Peters:
Thank you for your testimony. Is there anyone else on the public line who would like to provide support testimony on A.B. 208? [There was no one.]

[Exhibit H in support of Assembly Bill 208 was submitted but not discussed and will become part of the record.]

Is there anyone who would like to provide opposition testimony on Assembly Bill 208? [There was no one.] We will move on to neutral testimony. Is there anyone who would like to provide neutral testimony on Assembly Bill 208? [There was no one.] I would like to invite the bill sponsor to make any closing remarks.

Assemblywoman Considine:
Thank you, Chair Peters and members of the Committee. I want to thank you for your time, your attention, and your questions. I also want to thank Mr. Duarte and Ms. Maupin. A lot of us have taken care of family members when they are ill, when they are in early stages of dementia, or longer. I appreciate this bill which allows a caregiver the ability to get training and get paid so that person does not fall slowly down into poverty because they do not have an income. On top of that is the ability for respite so that they are fresh for their family. The person being cared for has the comfort of family members helping and being able to live in the comfort of home while going through this.

Chair Peters:
Thank you so much. Mr. Duarte, do you have closing remarks as well?

Charles Duarte:
I would like to express my gratitude to the Interim Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs for adopting this as a committee bill and to Assemblywoman Considine for bringing this forward to the Assembly Health and Human Services Committee. We are grateful. We think this is going to help a lot of folks who are already providing family care to the best of their ability avoid the financial pressures that often lead to caregiver burnout we might otherwise see if they continued to be unpaid. Again, thank you for the time and opportunity to present this bill.

Chair Peters:
Thank you so much. We will close the hearing on Assembly Bill 208.

We will move into our last agenda item for the day which is public comment. Is there anyone who would like to provide public comment today? [Public comment was heard.] With that, we will close public comment. Does anyone have any closing remarks before we adjourn? [There were none.] The meeting is adjourned [at 3:54 p.m.].

RESPECTFULLY SUBMITTED:

____
Terry Horgan
Committee Secretary

APPROVED BY:

____
Assemblywoman Sarah Peters, Chair

DATE: ______________________________________

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a proposed amendment to Assembly Bill 202 presented by Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6, and submitted by Legal Aid Center of Southern Nevada.

Exhibit D is a letter dated March 13, 2023, submitted by Brett Salmon, President/CEO, Nevada Health Care Association, regarding Assembly Bill 202.

Exhibit E is a letter dated March 11, 2023, submitted by Susan Fournier in support of Assembly Bill 202.

Exhibit F is a conceptual amendment to Assembly Bill 208, dated March 9, 2023, written by Aging and Disability Services Division and Division of Health Care Financing and Policy, Department of Health and Human Services, and presented by Charles Duarte, Nevada Director of Public Policy, Northern California and Northern Nevada Chapter, Alzheimer's Association.

Exhibit G is a letter dated March 13, 2023, submitted by Connie McMullen, representing Personal Care Association of Nevada, in support of Assembly Bill 208.

Exhibit H is a letter dated March 9, 2023, submitted by Allan Ward, President, Personal Care Association of Nevada, in support of Assembly Bill 208.