MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-ninth Session
May 31, 2017

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 3:39 p.m. on Wednesday, May 31, 2017, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

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

GUEST LEGISLATORS PRESENT:

Assemblyman Nelson Araujo, Assembly District No. 3
Assemblyman Richard Carrillo, Assembly District No. 18
Assemblyman Michael C. Sprinkle, Assembly District No. 30
Assemblyman Steve Yeager, Assembly District No. 9

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Debbie Carmichael, Committee Secretary

OTHERS PRESENT:

Marta Jensen, Acting Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Glenn Shippey, Division of Insurance, Department of Business and Industry
Michael Hackett, Nevada Primary Care Association
George Ross, Hospital Corporation of America, Inc.; Sunrise Healthcare; Healthy Minds

Kelly Crompton, City of Las Vegas
Paul Moradkhan, Las Vegas Metro Chamber of Commerce
Joan Hall, Nevada Rural Hospital Partners
Dagny Stapleton, Deputy Director, Nevada Association of Counties
Elizabeth Goff Gonzalez, District Judge, Department 11, Eighth Judicial District
John Jones, Office of the District Attorney, Clark County
John Piro, Clark County Public Defender's Office
Cody Phinney, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services
Charlene Frost
Edward Ableser, Administrator, Aging and Disability Services Division, Department of Health and Human Services

CHAIR SPEARMAN:
I will open the hearing on Assembly Bill (A.B.) 374.

ASSEMBLY BILL 374 (1st Reprint): Requires the Department of Health and Human Services, if authorized by federal law, to establish a health care plan within Medicaid for purchase by persons who are not otherwise eligible for Medicaid. (BDR 38-881)

ASSEMBLYMAN MICHAEL C. SPRINKLE (Assembly District No. 30):
Assembly Bill 374 establishes a benefit package, much like the one offered to people who are eligible for Medicaid, available and affordable to anyone who is not eligible for the Medicaid program. Some major confusion has arisen since A.B. 374 was first introduced. In particular is the idea that we are trying to duplicate Medicaid, and this is not true. Assembly Bill 374 will expand the benefit package that goes along with those people who are eligible for Medicaid; however, it is not the program we associate with Medicaid. While in the working group for this bill, we came up with another name for this, and it is called the Nevada Care Plan. The Nevada Care Plan is embedded within the Medicaid program for the State and it will offer, if waivers are provided through the federal government, an insurance package that has the same minimum benefits that Medicaid has today. This insurance package will be at a premium, and people will have to pay for it, but it will be available to all people who wish to purchase the insurance package.

When A.B. 374 was first introduced, it generated a lot of thought and some concern, as many people were confused as to what this bill was about. I

realized that I needed to put together a working group. The working group consisted of department heads through the Governor's Office including Medicaid, the Division of Insurance, the Silver State Health Insurance Exchange (SSHIE) and some community providers. The people who would be involved in putting together the Nevada Care Plan and myself were the ones who came up with what you see today. Once A.B. 374 is signed by the Governor, we can put together the framework to move forward within the next 18 months, and put together what it is we will ultimately present to people and how we are going to do that.

Initially, it was thought to use the SSHIE, but currently that is not possible. This cannot be a SSHIE product, but I am led to believe there are some ways it would be possible if we were to get certain waivers out of the Centers for Medicare and Medicaid Services (CMS) and the federal government, but right now it is not possible. Potentially, we can utilize the SSHIE portal so people who are interested in purchasing health insurance can be redirected to the Website of individual insurance providers that may choose to contract with the State for this program. That is one way the SSHIE could be utilized. It was problematic during our working group meetings that we did not know the number of people who are uninsured in the State. The numbers are very difficult to gather to have a firm concept of who was provided insurance during the expansion of Medicaid and what the potential problems are that can come with changes to the Medicaid program. If we move forward with A.B. 374, money is sitting out there that will allow for an actuarial study. This will allow us to get data that will help us with A.B. 374, and also health insurance as a whole in the State. This is an important thing for insurance and health care moving forward.

The establishment of the Nevada Care Plan will be within Medicaid Services, but it will be in close coordination with the Commissioner of Insurance. That is how the actuarial study will occur. The Nevada Care Plan is a health care plan that mirrors the benefits of Medicaid. During the Interim, as we get into it further, we will come up with a premium package so we know how much we are talking about. My intent with A.B. 374 is a package at cost, plus a few percentage points above. While not included in A.B. 374, the thought was to use the one or two percent to start benefiting the true Medicaid program as we do have concerns that the Medicaid funding may dry up in the future.

By obtaining waivers, the plan will use the SSHIE to promote it and direct individuals to insurance providers who have contracted to assist in administering

the plan. If the waivers are granted, they will allow eligible individuals to obtain premium tax credits that are currently offered. This is another part of the waiver program. If we can get the waivers, we can start building in some type of credit program to help offset the premium costs, especially for those who cannot afford it.

There is still much work to be done to make the framework into something that is implementable in the future. I have extended the implementation date to January 1, 2019. That will give the working group and the stakeholders 18 months to come up with something that works for everyone. Ultimately, I am providing the people of Nevada affordable and accessible health care. In this time of confusion and uncertainty about what health care is going to look like in the future, this is an outstanding way for Nevada to lead the Nation, as there is no other state doing this right now.

SENATOR RATTI:
This is all contingent on receiving a federal waiver, and if we do not receive it then what happens?

ASSEMBLYMAN SPRINKLE:
The waiver will open up certain avenues as far as utilization of the SSHIE and some of the tax credits that we have come to know as being part of the insurance provided today. With this framework, regardless of the waivers, we can still move forward in developing a plan that is implemented and provided through the Medicaid department. We would just have to do it differently, and it would be self-promoting. The application process would be imbedded within Medicaid. Assembly Bill 374 will still allow us to contract with individual insurance providers that are willing to offer those benefits.

SENATOR RATTI:
Would we lose the ability to promote it on the SSHIE?

ASSEMBLYMAN SPRINKLE:
We would need the waiver for the Nevada Care Plan to be a part of the SSHIE, but if we cannot get the waivers, there would still be the ability to promote it. As people are looking for new insurance programs, they would be redirected to the Website of the individual insurance plan. It cannot be anything the SSHIE sells or in any way assists with.

SENATOR RATTI:
Are you saying that if everything goes well, the plans would be on the market by January 1, 2019?

ASSEMBLYMAN SPRINKLE:
Yes, because the bill will mandate that. We would have 18 months to put together something that could be offered to the public.

SENATOR RATTI:
When going through the process, and it is discovered it is not a viable product, what happens next?

ASSEMBLYMAN SPRINKLE:
We would be right on the heels of the next Legislative Session and would have to reexamine and dismantle what we have done here. That is a fair question; we do not know what will happen with health care in the future as there is so much uncertainty. If the funding for Medicaid were to go away, the State would have to take a fundamental step backward and reevaluate what health care looks like as a whole. Assembly Bill 374 may or may not fit that, but I believe it would and it may be the answer in the worst case scenario. There are mechanisms in place to undo what would be done with A.B. 374. Assembly Bill 374 puts the framework together and allows the experienced working group to continue to come up with a product that makes sense for the people of Nevada.

SENATOR RATTI:
Medicaid builds the plan, but they use a third party insurer to sell the plan. What if no one wants to take that on?

ASSEMBLYMAN SPRINKLE:
The language in A.B. 374 is open and broad because the working group will continue to work on it. The working group did not have time in the five weeks during Session to come up with everything. The language in the bill says the Director of the Department of Health and Human Services (DHHS) may contract with the insurance providers. There is still a potential for fee-for-service and all the different ways that insurances work. The working group will figure out what makes sense fundamentally for the people of Nevada and then move forward. There has been some interest expressed from insurance providers to participate since A.B. 374 came out.

SENATOR HAMMOND:
Section 2 of A.B. 374 says the Director of the DHHS shall apply for any necessary waivers. Do you have any idea about what kind of waivers would be needed? When you mentioned that this would be the first of its kind in the U.S., did you mean it would be the first time someone would be selling insurance similar to Medicaid?

ASSEMBLYMAN SPRINKLE:
Mr. Shippey from the Division of Insurance will be coming up to testify and can give you details about what the waivers are. This would be first in the Nation because the Nevada Care Plan would be managed through Medicaid, and it is going to mimic the products currently offered at the base level for Medicaid. Nothing like that is being done in the Nation. Minnesota was working on something similar to this, but it did not get to the point that A.B. 374 has. Using Medicaid and the people who are knowledgeable with the system is going to be first in the Nation, along with offering health insurance through third-party insurance companies that contract with us or the potential of offering for fee-for-service. The waivers are more for using SSHIE and getting credits through the federal government to help offset the cost of the premiums.

SENATOR HAMMOND:
Are you anticipating the need for more than one waiver?

ASSEMBLYMAN SPRINKLE:
I believe it is two waivers, but Mr. Shippey from the Division of Insurance can clarify that. There is no certainty right now. What we have heard is that because states are allowed to manage their own health care systems, the granting of a waiver was extremely difficult in the past. There may be more of an opportunity now.

SENATOR HAMMOND:
Assembly Bill 374 is taking out the transportation services component, so it is not exactly like Medicaid. Is that right?

ASSEMBLYMAN SPRINKLE:
Yes, that is correct.

SENATOR HARDY:
How have you avoided a fiscal note on A.B. 374?

ASSEMBLYMAN SPRINKLE:
There is an appropriation on it.

SENATOR HARDY:
The Medicaid people will be in charge of administering the Nevada Care Plan, but SSHIE will be in charge of the giving the plan to the person who qualifies. Is that correct?

ASSEMBLYMAN SPRINKLE:
As of right now, unless a waiver is granted, the SSHIE cannot provide the Nevada Care Plan. The SSHIE would be a potential portal to redirect people to the individual Websites of the insurance companies that would be under contract. The people within Medicaid are the ones that would administer it. There is an appropriation that came out of the Assembly Committee on Ways and Means for a position to manage this.

SENATOR HARDY:
What would Medicaid manage?

ASSEMBLYMAN SPRINKLE:
Aside from the framework, that is part of why we need A.B. 374. During the Interim, we can look at how this will work depending on the contractual agreements and who is willing to participate. Will it be large insurance companies or will it be the smaller ones that do not work in the State? The concept would be the way they manage Medicaid patients now. They would also help steer and make sure these benefits are being provided to the people paying the premiums.

SENATOR HARDY:
The person who signs up and pays for the Nevada Care Plan would have a card and be able to present it to the pharmacy, hospital or the doctor. Is that correct?

ASSEMBLYMAN SPRINKLE:
Those kind of finite details have not been worked out yet, that is part of what the working group would do. Conceptually, I can see something similar to what you are describing. People would be paying for these benefits through a premium just like they would with any other insurance company. That is the fundamental difference between Medicaid and the Nevada Care Plan.

CHAIR SPEARMAN:
Can you tell me more about the appropriation money?

ASSEMBLYMAN SPRINKLE:
Section 5.5 of A.B. 374 lists the dollars. Those dollars have been built in and appropriated.

CHAIR SPEARMAN:
Section 5.5 says $89,000 a year. What would that be used for?

ASSEMBLYMAN SPRINKLE:
That money is to hire a person to establish and administer the Nevada Care Plan. Part of the reason for the dollars right now is that a person needs to be hired, be in place and become a part of the working group to put together the structure as well as manage it.

MARTA JENSEN (Acting Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
The Division of Health Care Financing and Policy (DHCP) is neutral on A.B. 374, but has been actively participating in the work group. With the uncertainty of the Affordable Care Act (ACA), it is important to look at all options and see what kind of flexibility there is available. We have made a lot of progress in the Medicaid program for helping the uninsured, and we would like to continue that process to make sure there is affordable insurance available for the citizens. The DHCP will continue to work with the work group.

We are thinking the position would be a contract position for the next two years. The position would help us build the framework and figure out what it will look like. The base product would mirror the fee-for-service program. It seems to have the best benefits package minus the nonemergency transportation. We thought that was a good starting point for the basic insurance product. It could be any insurance company that wants to participate. We do not have the finite details of how the enrollment or the payment would look like and who is going to be responsible. The contract position would sit within the Medicaid Division. No Medicaid dollars would be used for the position because it is not a Medicaid product. We have built the infrastructure for the Nevada Check Up Program and other like activities, so we thought it would be a good fit.

SENATOR RATTI:
Medicaid has been expanded to include certain populations and to do things that are not mandated in the core Medicaid program. Does A.B. 374 anticipate that everything in Medicaid would be mirrored, or would there be a subset of certain things? Some of the things in Medicaid do not seem relevant to an individual purchasing a plan on the market.

MS. JENSEN:
The intent was to start with the current fee-for-service product. Many of the benefits were already available even before the ACA. We did enhance the package, but not knowing what the expanded population is going to do within the ACA, if there will be a repeal or replace, this may be a good product for that group. That group of people are working, but are considered the working poor because they do not make a lot of money. To purchase health care on the SSHIE is very high even with the premium. I am not sure they can afford it. It is making sure there is coverage available, but it would be the base product as we see it right now. Again, we will know more as we get through the work group to figure out what it can look like at implementation.

CHAIR SPEARMAN:
Do you know how many people are classified as the working poor?

MS. JENSEN:
I believe the expanded population brought in around 200,000 people. It also brought in the aging, blind and disabled people. While we thought it would focus on the expanded group, our entire caseload increased. There is something else out there that is driving this, but we are concerned about the expanded population if it is taken away because their wages are just too low to support purchasing health insurance. The expanded population will start going to the emergency room, and we have made headway over the last few years reducing that.

CHAIR SPEARMAN:
There are several bills making their way through the Legislative Body this Session to increase wages. It is my opinion that much of what we do with Medicaid dollars we do to help the working poor, and if we do not do that, then hospitals and doctors that provide the services do not get paid as much.

SENATOR HARDY:
Is the State Children's Health Program (SCHP) Medicaid money or is it a separate insurance product that would be administered under your Department? Is the Nevada Care Plan going to be like that?

MS. JENSEN:
The SCHP is a different type of federal funding that is administered through the Medicaid Division and is a separate program. The Nevada Care Program would look more like the Medicaid fee-for-service. The SCHP is very similar to the Medicaid program, but just for children. The Nevada Care Plan would be for anybody that qualifies and pays the premium.

SENATOR HARDY:
Would the Nevada Care Plan be separate and distinct based on premiums and not on federal grants or federal monies?

MS. JENSEN:
We did not exclude federal funding altogether because at the national level they were talking about a high-risk pool, and that additional federal funding might be available. At this point in time, though, there is none available, so the Nevada Care Plan will be self-funded.

SENATOR HARDY:
Will the same 51 mandates that exist for all health insurance companies exist for the Nevada Care Plan?

MS. JENSEN:
We are looking at the base fee for a service product that we have currently which meets the criteria. Because we are in the beginning framework, I do not know how it will materialize, but the goal is to make sure people have the same product available later that they have now.

SENATOR HAMMOND:
How many waivers do you anticipate will be required?

GLENN SHIPPEY (Division of Insurance, Department of Business and Industry):
There is the ACA section 1332 federal waiver program which allows certain parts of the ACA to be modified to accommodate state plans and make them

subsidy-eligible and also allow an alternative pathway for purchasing the plan. Those are the two aspects of A.B. 374 that the waiver would explore.

SENATOR HAMMOND:
There is just one waiver where certain parts of the section 1332 waiver program are requested. You can be specific in what you are asking for in the waiver. The federal government allows the states to come up with an alternative pathway and the waiver application tells them what you have in mind. Is that correct?

MR. SHIPPEY:
Yes, that is correct.

The Division of Insurance (DOI) is neutral on A.B. 374. The DOI has been an active member of the working group, along with Medicaid, SSHIE and the Governor's Office. We do have some federal grant funds available that we have been using to analyze the individual market and explore market stabilization options. We see the studies and further work of the work group as an expansion and enhancement of the studies that are underway.

MICHAEL HACKETT (Nevada Primary Care Association; Nevada Public Health Association):
The Nevada Primary Care Association (NPCA) supports A.B. 374. Our community health centers are federally qualified health centers. The NPCA provides primary, dental and behavioral health care services to the uninsured and Medicaid populations. Assembly Bill 374 has been a work in progress and, if the Committee and Legislature choose to pass it, we understand that it will continue to be a work in progress. The NPCA feels A.B. 374 has the potential to provide benefits to the population it serves. To the uninsured population, those benefits have yet to be determined, and are dependent on pricing and availability of the product. The intent to ensure the long-term sustainability and viability to Medicaid is very important to the NPCA's community health centers because it derives a significant portion of its revenue from the services provided to Medicaid patients. Since the expansion of Medicaid, the percentage of the population served is increasingly becoming Medicaid patients too.

The Nevada Public Health Association also supports A.B. 374.

GEORGE ROSS (Hospital Corporation of America, Inc.; Sunrise Healthcare; Healthy Minds):
Hospital Corporation of America, Inc. (HCA) is neutral on A.B. 374. Assembly Bill 374 provides an avenue to get insured for the many people who are subsidized through tax credit insurance and may lose their insurance. The negative for the HCA is the reimbursement levels and what they will be. It is the Legislature's responsibility, to the extent you feel health care is a right, to provide an environment in which the people who provide health care can do that. Hospitals and doctors will have a significant problem providing that health care if we switch people who are currently getting paid commercial rates for Medicaid or a little above Medicaid. There is a tremendous difference in those rates. I have been told this will end up at closer to commercial rates, but we have to be concerned we are not trading patients who pay a good rate for patients whose provider does not pay a good rate. If we get to the point where these rates are even and we can continue to provide insurance and patients can continue to get the care they need, it would be excellent.

ASSEMBLYMAN SPRINKLE:
Assembly Bill 374 is my passion, and it is important. Once this bill is enacted, I have every intention, and I believe everyone who has testified has the same intention, to work actively to come up with a product that benefits all of Nevada. We do not know what the future holds, but what I do believe in is the importance of people being healthy and having the ability to get the kind of care they need so they can have productive and happy lives.

SENATOR HARDY:
I will vote no with the right to change my mind on A.B. 374.

SENATOR HAMMOND:
I will vote no with the right to change my mind on A.B. 374.

SENATOR WOODHOUSE MOVED TO DO PASS A.B. 374.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION CARRIED. (SENATORS HARDY AND HAMMOND VOTED NO).

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CHAIR SPEARMAN:
I open the hearing on A.B. 428.

ASSEMBLY BILL 428 (1st Reprint): Revises provisions governing the acquisition and use of opioid antagonists. (BDR 40-620)

ASSEMBLYMAN SPRINKLE (Assembly District No. 30):
Assembly Bill 428 is a continuation of what we did two years ago in response to the prescription drug epidemic. This epidemic causes concern and diligent work toward a solution.

Two years ago, by prescription, a medication that reverses effects of opioid overdose became more accessible to caregivers of addicts, police officers and other first responders. Assembly Bill 428 makes the opioid antagonist accessible to all by removing the prescription requirement which allows dispensation by a pharmacist. It will not be available over the counter because use of this drug requires education.

In my other job as a firefighter and paramedic, I know the drug's importance. Once this medication is given, 911 must be called immediately because the drug is metabolized faster than opioids. After the drug is given, the person will start breathing again and wake up. It is miraculous because the person goes from looking like he or he is dead to talking to you within seconds. The drug wears off before the opioid wears off. A call to 911 and transport to the hospital is critical because at that point, the person enters the system, which initiates ancillary help to address the causes of addiction.

The opioid antagonist is a life-saving drug. A person must go through a three- to four-minute consultation with the pharmacist to acquire it, as required by statute.

SENATOR HARDY MOVED TO DO PASS A.B. 428.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
I open the hearing on A.B. 366.

ASSEMBLY BILL 366 (1st Reprint): Creates four behavioral health regions in this State and a regional behavioral health policy board for each region. (BDR 39-987)

ASSEMBLYMAN NELSON ARAUJO (Assembly District No. 3):
Assembly Bill 366 creates four behavioral health regions and corresponding policy boards to advise the Division of Public and Behavioral Health (DPBH) and the Commission on Behavioral Health of the DHHS. Assembly Bill 366 has been four years in the making. In late 2013, the Southern Nevada Forum, a coalition of hundreds of stakeholders who joined forces, met to identify and address serious issues facing the southern Nevada community. One of those issues identified was mental and behavioral health. I served as cochair of the Southern Nevada Health and Human Services Committee during last year's Southern Nevada Forum. At the top of our stakeholder list of opportunities for improvement was exploring the possibility of giving local leaders a more active voice in the decisions that are made as they pertain to mental and behavioral health.

While this started a southern Nevada priority conversation, it quickly turned into a statewide effort. I have learned that all regions of the State are facing unique challenges, and I strongly believe that each region is best qualified to address its respective issues. Today, I am proud to present A.B. 366 that encompasses the concerns of so many diverse experts and leaders in the field and takes us a step forward in ensuring that local communities have a voice in the process. By creating four regional mental health boards, the DPBH will be able to lean on local experts for suggestions on policy, funding and implementation issues.

On the Assembly side, we had about 18 amendments, which was a great sign and meant than many people were eager to participate in the process. We did not accept all the amendments; however, what you are seeing today is a product that we can run with. We know this is something new for the State, but it is something that is needed. I have made a commitment to work with all the stakeholders who have invested so much energy in the creation of A.B. 366, even those who did not get their amendments accepted, and to continue looking for opportunities to make the regions and policy boards stronger year after year.

CHAIR SPEARMAN:
One of your colleagues, Assemblywoman Daniele Monroe-Moreno, has a bill that would require those who are getting paid as counselors to be certified. Would the policy board oversee the counselors if that bill were to pass?

ASSEMBLYMAN ARAUJO:
I see the policy boards serving in an Interim advisory capacity and being influential in the sense of presenting a bill draft request before the next Legislative Session. They have the opportunity to provide a report and feedback. If the bill were to pass and impact each region, the likelihood of the policy boards having to look at the impact of Assemblywoman Monroe-Moreno's bill would be included in the report. I do not think the policy boards would have direct oversight over it. The regions were set up to make sure they are still under the supervision of the DHHS. We think it is important for the Department to remain intimately involved. We also think it is important to have the information funneled up instead of just funneled down from the DHHS.

MR. ROSS:
I was privileged in the 2013-2014 Interim to be the nonoffice holder coordinator of the Health Care Subcommittee of the Southern Nevada Forum. Given the salience of mental health, that should be our No. 1 priority. We had 10 meetings over the course of 15 months and had between 40 to 60 people at every meeting from every aspect of the mental health community. Our No. 1 priority besides the short-term recommendation we made to the Governor's Council was to regionalize the ability to prioritize spending and policy for mental health in the State. It is clear Nevada is a diverse state in terms of the problems that occur in the different regions. The best way to address those problems is to have a great deal of regional input, so A.B. 366 closely mirrors what we recommended. I urge your support.

KELLY CROMPTON (City of Las Vegas):
This is a southern Nevada priority. The City of Las Vegas believes that regionalizing will help the city address issues within the downtown Las Vegas area, specifically issues and services that we provide in the Corridor of Hope. The City of Las Vegas supports A.B. 366.

PAUL MORADKHAN (Las Vegas Metro Chamber of Commerce):
The Las Vegas Metro Chamber of Commerce supports A.B. 366.

JOAN HALL (Nevada Rural Hospital Partners):
Through a Health Resources and Services Administration grant that was awarded to the Nevada Rural Hospital Partners (NRHP) to integrate behavioral health into primary care in 13 of our critical access member communities, NRHP became aware of much more need than could have ever been expected. Behavioral health issues impact entire communities. First and foremost, patients and their families, but also emergency medical services, law enforcement, jails, faith-based groups, food pantries, hospitals, outpatient clinics, primary care providers and county social services are affected. This is more than NRHP ever envisioned. The NRHP became acutely aware of the challenges in assisting patients in getting behavioral health care they need in rural Nevada, and recognized the differences in access in the nine counties that NRHP worked with. The NRHP also recognized knowledge deficits of all involved, on the law, on the process and the entire issue. Positively, NRHP has seen huge benefits in using telemedicine to assist these patients through a relationship that was developed with DPBH and the rural clinics. The NRHP has seen many entities working in silos to solve these issues, but they do not come together regionally or statewide. The NRHP is thrilled with A.B. 366 and believes this is a vehicle to bring disparate parties together, looking at solving things collectively in our region and throughout the State. The NRHP urges your passage of A.B. 366.

DAGNY STAPLETON (Deputy Director, Nevada Association of Counties):
The Nevada Association of Counties supports A.B. 366. The Nevada Association of Counties appreciates the sponsor working with us specifically on the makeup on the four regions and the goal of creating a mechanism to consider local input and expertise throughout the State.

SENATOR WOODHOUSE MOVED TO DO PASS A.B. 366.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the hearing on A.B. 440.

ASSEMBLY BILL 440 (1st Reprint): Revises provisions governing involuntary commitment proceedings. (BDR 39-997)

ASSEMBLYMAN STEVE YEAGER (Assembly District No. 9):
A program called involuntary civil commitments was brought forward in a previous session. The involuntary civil commitment process is where a person who is seriously mentally ill, but not incompetent, can be ordered into assisted outpatient treatment in the community to help the person stay on medication and not go in and out of the criminal justice system. As the program exists already, there are certain people who can initiate a petition for this kind of treatment. Assembly Bill 440 seeks to expand those who could knock at the door to see if someone qualifies for the involuntary civil commitment process. A district court judge, district attorney or defense attorney will be allowed to knock at the door to see if a particular client might suitable for this type of treatment. Knocking at the door would encompass what is in statute now. An evaluation would be done, then the Division of Public and Behavioral Health determines if the person is an appropriate candidate. If those things happen, the court could then order the person into assisted outpatient treatment.

When we presented A.B. 440 on the Assembly side, there were concerns brought up. We worked with the interested parties, and we now have this to a place where there is no opposition to it.

In section 4.7, there is a provision that says that a district court judge would be able to designate another judge or a hearing master to hear the involuntary commitment proceedings. That is permissive language so a district judge could designate a particular judge to hear the proceedings. By statute, only family court judges can hear these kind of petitions right now. There is a high volume in Clark County, so we wanted to give the judge flexibility to designate another district court judge to help out with the workload.

ELIZABETH GOFF GONZALEZ (District Judge, Department 11, Eighth Judicial District):
I support A.B. 440. I have provided my written testimony (Exhibit C) to the Committee. Section 4.7 of A.B. 440 allows the chief judge of a district which has a family division to appoint a judge who is sitting in its civil criminal division, to hear the involuntary commitment calendar without the necessity of going to the additional specific family judge training. Currently, the statute requires that if a judge sits on that special assignment for a period longer than

90 days, the judge is required to go to a special family court training. Section 4.7 removes that training requirement. Our goal in the Eighth Judicial District is to have the mental health processes currently under our competency mental health court program, which is a criminal diversion program, and the involuntary commitment program, which includes the assisted outpatient treatment (AOT) program, be handled in a uniform fashion by judges who are knowledgeable about mental health issues that face many members of our community.

JOHN JONES (Office of the District Attorney, Clark County):
The Clark County Office of the District Attorney supports A.B. 440. I want to thank Assemblyman Steve Yeager for working with us; we are in a place that we are comfortable with.

JOHN PIRO (Clark County Public Defender's Office):
The Clark County Public Defender's Office supports A.B. 440. We believe this will solve the repeating looper problems with the criminal justice system where someone is arrested for a crime, they are stabilized, the person is sent out into the world with no aftercare and winds up back with us again. The AOT program will capture, monitor and keep under treatment those people so we do not have the same problem in the future.

SENATOR HARDY:
Can you help me understand section 4.3, subsection 2, paragraph (b), where it says:

> If the offense allegedly committed by the defendant is a category A or B felony or involved the use or threatened use of force or violence, the court may not order the involuntary admission of the defendant for participation in a program pursuant to this paragraph unless the prosecuting attorney stipulates to the assignment.

If someone murders a person can he or she get off?

ASSEMBLYMAN YEAGER:
What you just read was the compromise language. What that section says is if it is category A or B felony, or there is force involved, the person cannot get into the AOT program unless the district attorney agrees. Even then, the person has to be deemed appropriate for the program, which would not happen until he

or she was evaluated by the Division. Technically, the answer is yes, but it would be unlikely that we would put someone who committed murder into an AOT program. Those are not the kind of individuals appropriate for the AOT. I do not anticipate a district attorney would ever agree to that, and even if so, they would have to jump through hoops.

MR. JONES:
You are correct that in theory someone who is charged with murder could be put into an AOT. However, the district attorney would have to stipulate. I want to refer you to section 1, subsection 3, paragraph (b), of A.B. 440 which deals with who would be eligible for the AOT program. It states that the defendant is not eligible for commitment to the custody of the administrator pursuant to *Nevada Revised Statutes* (NRS) 178.461. That is another program we use for those who are found incompetent but not restorable. In other words, we cannot try them but we can place them in a forensic facility if they meet a certain level. There are some people who allegedly committed murder who do not rise to the level of the need for a forensic facility, so this would give us another option.

SENATOR HARDY:
What you are saying makes sense, but I get nervous when I see "except" or "may." For example, let us pretend the district attorney has kids and someone says he is going to kill those kids unless the district attorney does a certain thing. The district attorney says, okay he will do it. I am sure there are many hoops to jump through. This one makes me really nervous.

MR. PIRO:
As a person on the ground floor who deals with this frequently, I could never foresee a district attorney ever stipulating to that. It would be the narrowest of exceptions, and I do not believe I would ever see that in my career.

ASSEMBLYMAN YEAGER:
I want to direct you to section 1, subsection 3, paragraph (c), that states: "The Division makes a clinical determination that placement in a program of community-based or outpatient services is appropriate." In the case of a murderer, it is hard to imagine the Division as a gatekeeper of the program would allow someone with that kind of past into the program.

SENATOR HARDY:
Why put the category A or B felony in A.B. 440?

MR. JONES:
That was important for the Clark County Office of the District Attorney to have in A.B. 440. If it is a serious crime, the Clark County Office of the District Attorney could be a gatekeeper along with the Division. You have the Division being a gatekeeper of who is in the program and, even if they are accepted, our office will be a second-level gatekeeper of who is appropriate for the program. The Clark County Office of the District Attorney is comfortable with the procedures in place with A.B. 440.

SENATOR HARDY:
The way you are reading section 4.3, subsection 2, paragraph (b), is the person has to pass through the Clark County Office of the District Attorney as well as the Division, and the person is not going to get by the Clark County Office of the District Attorney even if they get by the Division. The way I was reading that section was the person could get by Clark County Office of the District Attorney.

MR. JONES:
Yes, I read it as the former statement.

CHAIR SPEARMAN:
When I appeared before an Assembly Committee this morning, one of the things I talked about was when a person is released from prison, that person is not just put on the street, there are some safety nets in place. I hope as we move forward with A.B. 440 the people involved will stay engaged so we have the benefit of your knowledge in this area.

CODY PHINNEY (Administrator, Division of Public and Behavioral Health, Department of Health and Human Services):
The DPBH is neutral on A.B. 440. We appreciate Assemblyman Yeager bringing forward this issue and allowing the Division work through the process that allows for changes to the knocking-on-the-door program. This does not allow us to expand the size of the program, but it is exciting work on making sure people do not keep cycling through the system.

CHAIR SPEARMAN:
Who pays for this?

MS. PHINNEY:
The services for AOT provided by the State are mental health services, some of which are reimbursable by Medicaid if they are medically necessary. The Division does have forensic psychologists and psychiatrists that are able to provide professional assessment of risk for people coming into those programs.

CHAIR SPEARMAN:
I received three letters of opposition from members of the Second Judicial District Court, District Judge Cynthia Lu (Exhibit D), District Judge Patrick Flanagan (Exhibit E) and District Judge Frances Doherty (Exhibit F).

SENATOR HARDY:
In speaking with our counsel, he reads section 4.3, subsection 2, paragraph (b), the same way as the proponents do, and I am comfortable with it now.

SENATOR HARDY MOVED TO DO PASS A.B. 440.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

CHAIR SPEARMAN:
I open the hearing on A.B. 224.

ASSEMBLY BILL 224 (2nd Reprint): Revises provisions relating to persons with disabilities. (BDR 39-780)

CHARLENE FROST:
I am a mom of two sons who have disabilities. I brought the concept of A.B. 224 to Assemblyman Richard Carrillo after hearing stories from families throughout the Las Vegas Valley and Reno communities about being unable to access services at the regional centers. Assembly Bill 224 seeks to ensure persons with intellectual and developmental disabilities, who have long-term support service needs, will have access to regional center services in a community-based setting and their family can be assured that their loved ones are prepared to live and work in the communities they live in with as much or as little support as they need. Without support, families run the risk of caregiver

burnout. The disabled are often excluded and isolated from their communities, friends and neighbors. They have lower quality of life and poor health outcomes, which often leads to frequent and costly trips to the emergency room, potential homelessness or hospitalization.

With A.B. 224, we felt it was important to use recognized language to more fully capture the population that is served by the regional centers. There were stakeholders who were uncomfortable with the language as they believed it was overly broad. Unfortunately, the Aging and Disability Services Division (ADSD) had to submit a fiscal note that was prohibitive in nature. Our intent was to not limit but to ensure those who needed long-term support and services had access. After many discussions with the ADSD and others, we redefined developmental disability as it relates to regional centers. This language specifically included cerebral palsy, epilepsy, autism and other neurological conditions. In the current term of related conditions, autism is notably absent although the ADSD has been serving this population for over ten years. We had hoped to include visual and hearing impairments; however, this was considered an expansion of the current population and a fiscal note was submitted of about $1 million. It became clear to us that it was a barrier that would prevent the forward momentum of A.B. 224.

CHAIR SPEARMAN:
This is a program for people who are differently abled. Is that right?

MS. FROST:
Yes, that is correct.

CHAIR SPEARMAN:
And you wanted to include hearing impaired and the deaf, but that would expand the program. Is that correct?

MS. FROST:
It is my understanding the ADSD does limited services for the hearing impaired and deaf under a waiver, but they do not necessarily provide services for the blind and the visually impaired.

We removed the language in order to keep A.B. 224 moving forward because we felt it was important. I have asked Assemblyman Carrillo to continue to work with me during the Interim to find a way to bring that population under the

regional centers as well. They are underserved as well, and we want to make sure they get as many services as needed. Throughout A.B. 224, you will see the deletion of the terms and related conditions which are substituted with the term "developmental disability," defined in section 17. Section 17 also defines intellectual and developmental disability centers as an organized program for providing appropriate services and treatment to persons with intellectual and developmental disabilities.

The language in section 45 was inserted to match some language of the federal Workforce Innovations and Opportunity Act (WIOA). The WIOA provides for students who are transitioning from school to adulthood to have the opportunity to be trained for competitive integrative employment. Assembly Bill 224 does not do away with subminimum wage or sheltered workshops. However, it does mandate certain requirements for someone under the age of 25 not to be placed in a subminimum wage working environment. It also ensures individuals with disabilities have access to transition counseling, vocational rehabilitation services and career counseling. That provision was implemented on July 22, 2016. To ensure the provision does not negatively impact any individual currently working in a sheltered workshop, A.B. 224 was amended by Assemblyman Carrillo last night on the Floor of the Assembly. The amendment adds section 15.5, which mimics the language in WIOA. The amendment also specifies in section 45 that except as otherwise provided in section 15.5, a provider of jobs in day-training services shall not enter into contracts with any person or governmental entity to provide for employment to a person under 25 years of age where the person will be paid less than the State minimum wage. There are other provisions of WIOA that are included in A.B. 224 for those over the age of 25, such as career counseling at least once a year. Vocational rehabilitation under the Department of Employment, Training and Rehabilitation (DETR) is already implementing the federal statute, and this section is only meant to codify WIOA into Nevada statute as well as ensuring the NRS is aligned with and not contrary to federal law.

I have provided a letter from the U.S. Department of Labor (Exhibit G) to the Committee that was sent to all 14 certificate holders. The letter clearly lays out the steps to be taken before a young adult can enter a subminimum employment situation. I have also provided a WIOA fact sheet (Exhibit H) from the U.S. Department of Labor and Nevada's Strategic Plan on Integrated Employment to the Committee from the Nevada Governor's Council on Developmental Disabilities (Exhibit I) to the Committee.

Assembly Bill 224 updates language to accurately reflect the population that is being served. It makes sure people are served based on need and centers are not picking and choosing who is going to get help, and determinations are not based on I.Q. or the name of a condition.

SENATOR HARDY:
Does Assembly Bill 224 affect Opportunity Village, Easterseals or any of the other nonprofits, or is it just looking at what the State is doing?

MS. FROST:
It had the potential to affect Opportunity Village. The amendment brought forward last night on the Assembly Floor makes sure there is no impact to people who are currently being served by any Fair Labor Standards Act 14C provider who is working under subminimum wages since July 22 or before.

SENATOR HARDY:
Will Opportunity Village or other 14C providers be able to accept additional people like what they are caring for now?

MS. FROST:
Yes, they will. The WIOA is clear, and it does not change the population that any of the 14C providers are serving or will continue to serve, and they will accept more of that population.

CHAIR SPEARMAN:
I am stuck and I am struck by the fact that there are people who have disabilities, but including them expands the service. I have been working with the deaf and hard of hearing community this Session, and that was one of the things they said to me. They are off to the side. The deaf and hard of hearing community is trying to have a commission that will pay attention to them. Today, you are saying that addressing the deaf and hard of hearing community would be expanding programs.

EDWARD ABLESER (Administrator, Aging and Disability Services Division, Department of Health and Human Services):
Regarding the population of blind and visually impaired, the State has a waiver service and health services for those that might be experiencing those specific disabilities and needs.

CHAIR SPEARMAN:
What does that mean?

MR. ABLESER:
The ADSD provides mobility issues services, health services and in-home, community-based adaptation assistance. Regarding someone who is codified as blind or visually impaired, in a developmental disability definition, which is prior to the age of 19, the disability becomes evident and is pervasive and meets substantial limitation criteria as designated in statute as it is federally classified, we do not provide services. We do not have those adaptation services as a State for that population.

CHAIR SPEARMAN:
Why not?

MR. ABLESER:
It has never been the charge of the State for developmental disabilities and individuals with intellectual disabilities to be included with the blind and visual impairment within that population.

CHAIR SPEARMAN:
Who serves them?

MR. ABLESER:
There is a physical disability waiver that they can access to obtain very specific services if it is beyond their fee-for-service or managed care service providers.

CHAIR SPEARMAN:
My concern is there are Nevadans who are differently abled and we do not have a coordinated program or service in place. At least it does not sound like it. Is there a coordinated program, as a part of a comprehensive plan, to address someone who may be visually impaired, blind, deaf, hard of hearing or speech impaired, that is not developmental, but they still have these characteristics that make them differently abled?

MR. ABLESER:
That is a yes and no answer. There are different types of services that the blind and visually impaired can benefit from, for example, educational and adaptive training services. The DETR does have services and they have been designated

to provide services for the blind and visually impaired, specifically for workforce placement and looking at WIOA. They do that to some extent, but not to the fullest extent of our developmental disability population that might be designated prior to a certain age and reach heightened levels of standards as codified by the federal government. We provide services for the whole array in different pots like the physical disability pot. Within that waiver service, there are certain eligibility criteria that we provide services for individuals who are blind or have visual impairment.

When A.B. 224 came forward, we were looking at an expansion of services for that population underneath the developmental disability and individuals with intellectual disability waiver. Within that population, the cost is approximately $1 million to add helpful services for blind or visually impaired. In-home, community-placement workforce training is now implemented through the ADSD. The idea is to move this population forward with jobs and day training, rehabilitation, education on braille and other adaptive environments in the home. We do not have the fullness of resources available on that specific population.

CHAIR SPEARMAN:
Is that because of money?

MR. ABLESER:
Yes, it is.

CHAIR SPEARMAN:
A citizen of Nevada that is either born differently abled or at some point in his or her life becomes differently abled cannot participate in the fullness and good quality of life because we do not have money. This is not against you, sir, but on some planet that makes sense, but not the planet I am on, if we have additional money to do something else and we are not putting it toward our citizens, I think it is shame on us. They are Nevadans. They are people. I do not understand that. How much would it cost?

SENATOR RATTI:
There is a fiscal note of $4.8 million on A.B. 224.

CHAIR SPEARMAN:
The $4.8 million addresses only this program. It does not address the fact we do not have comprehensive wrap-around services for all of our citizens who are differently abled either by genetics or life circumstance.

MR. ABLESER:
The original fiscal note was extremely large because of differences in language that allowed us to interpret all services, but we rectified that. We have worked with the sponsor and stakeholders to propose providing service for blind and visually impaired through our developmental and disability services. The assumptive cost was roughly $1 million dollars each year to provide those services for the population that was identified. We have services for our aged population who become blind due to aging. There are adaptive services and dollars available for that population. We are talking about a very specific population. Most of them were born this way, and we have the one population where we do not have the fullness of benefits to provide services. It is our ability as staff to do the training, teaching, adaptation and case management.

CHAIR SPEARMAN:
Do we have a school for the blind or the deaf or hard of hearing?

Mr. Ableser:
No, we do not.

CHAIR SPEARMAN:
We do not have schools that help people who are born blind or deaf or hard of hearing. We do not have schools for them, but we are talking about expanding schools for students who are not differently abled. I just do not get it.

MS. FROST:
The $4.8 million fiscal note was based on the original definition Mr. Ableser referenced. That is what you are saying when you talk about a coordinated program as part of a comprehensive plan. That definition includes anyone who becomes disabled prior to the age of 22 and also includes the blind, hearing impaired and the deaf. We had to take the original fiscal note back to the drawing board to redefine it, unfortunately.

CHAIR SPEARMAN:
I am not attacking the fiscal note. There is something inside of me that says this is just wrong. We have people here in Nevada, some of whom are students, and what do their parents do? You do not have to answer these questions. How do the students learn? How do children who are deaf learn? Someone told me they sent their children out of state. How do people who are blind learn? The bottom line is we do not have a coordinated program for a particular population and they are just as worthy of a good quality of life as everyone in this room. The only reason they are not getting it is because they are differently abled and they live in Nevada. That is wrong.

ASSEMBLYMAN RICHARD CARRILLO (Assembly District No. 18):
I came from New Mexico where they have had a school for the deaf since 1887. Every time I go to Santa Fe, I always pass the school. In Nevada, we do not have one.

CHAIR SPEARMAN:
We talk about school choice, but people who are differently abled have no choice. Something is wrong with that.

SENATOR RATTI MOVED TO DO PASS A.B. 224.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
There being no further business before the Committee, I close the hearing at 5:19 p.m.

RESPECTFULLY SUBMITTED:

Debbie Carmichael,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	10		Attendance Roster
A.B. 440	C	2	District Judge Gonzalez / Department 11, Eighth Judicial District	Written Testimony
A.B. 440	D	3	District Judge Lu / Department 5, Second Judicial District	Letter
A.B. 440	E	2	District Judge Flanagan / Department 7, Second Judicial District	Letter
A.B. 440	F	4	District Judge Doherty / Department 12, Second Judicial District	Letter
A.B. 224	G	4	U.S. Department of Labor	Example of Letter sent to Certificate Holders
A.B. 224	H	2	U.S. Department of Labor	Workforce Innovation and Opportunity Act Fact Sheet No. 39H
A.B. 224	I	14	Nevada Governor's Council on Developmental Disabilities	Nevada's Strategic Plan on Integrated Employment