NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

(*Nevada Revised Statutes* [NRS] 218E.320)

MINUTES

August 18, 2022

The eighth and final meeting of the Joint Interim Standing Committee on Health and Human Services for the 2021–2022 Interim was held on Thursday, August 18, 2022, at 9 a.m. in Room 4401, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 4100, Legislative Building, 401 South Carson Street, Carson City, Nevada.

The agenda, minutes, meeting materials, and audio or video recording of the meeting are available on the Joint Interim Standing Committee's meeting page. The audio or video recording may also be found at https://www.leg.state.nv.us/Video/. Copies of the audio or video record can be obtained through the Publications Office of the Legislative Counsel Bureau (LCB) (publications@lcb.state.nv.us or 775/684-6835).

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Sarah Peters, Chair
Senator Fabian Doñate, Vice Chair
Senator Dallas Harris
Assemblywoman Michelle Gorelow

COMMITTEE MEMBER PRESENT IN CARSON CITY:

Assemblywoman Robin L. Titus, M.D.

COMMITTEE MEMBERS ATTENDING REMOTELY:

Senator Joseph (Joe) P. Hardy, M.D.
Assemblyman David Orentlicher, M.D.

COMMITTEE MEMBER ABSENT:

Assemblyman Gregory T. Hafen II (Excused)

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Patrick B. Ashton, Principal Policy Analyst, Research Division
Julianne King, Assistant Manager of Research Policy Assistants, Research Division
Crystal Rowe, Research Policy Assistant, Research Division
Eric Robbins, Principal Deputy Legislative Counsel, Legal Division
John Kucera, Program Analyst, Fiscal Analysis Division

Items taken out of sequence during the meeting have been placed in agenda order.
[Indicate a summary of comments.]

AGENDA ITEM I—CALL TO ORDER

Chair Peters:

Welcome to the eighth and final meeting of the Joint Interim Standing Committee on Health and Human Services. Please mark Assemblyman Hafen absent excused from today's meeting.

I am in Las Vegas to kick off this last meeting with my colleagues. I wish we could all be together, but knowing certain circumstances, we are still entertaining this three-modal model.

[Chair Peters reviewed meeting protocol and information related to providing public comment.]

AGENDA ITEM II—PUBLIC COMMENT

Chair Peters:

We are going to move into Agenda Item II, public comment. Since we will be having a work session today, I encourage individuals to address any item on the work session during the first public comment period. This does not preclude me from requesting clarification if the committee has questions regarding specific items in the "Work Session Document" (WSD) (Agenda Item VII). Therefore, to ensure that you have an opportunity to present your views, you may want to address items in the work session during this first public comment period.

We will start with public comment for those in the physical locations. We will start in Las Vegas, then we will go to Carson City, and then to our virtual folks who may be calling in.

Bradley Mayer, Partner, Argentum Partners, on behalf of the Southern Nevada Health District:

Thank you, Chair Peters. I wanted to specifically call out our support for Item L-2 in the WSD. These noncategorical dollars are critical to improving Nevada's population health. The threats in public health are changing all the time and having the ability to address chronic disease, health disparities, and emerging threats through this proposal is critical. We urge your support and thank you for considering it.

Chair Peters:

Thank you for your comments. Is there anyone else in Las Vegas who would like to provide public comment? Seeing none. We will go to Carson City. Please turn on your microphone, state your name for the record, and proceed when you are ready.

Jay Parmer, American Strategies, Inc., on behalf of the Association for Accessible Medicines:

Good morning, Madam Chair, and members of the Committee. The Association for Accessible Medicines is the national trade association for the generic and biosimilar pharmaceutical industry. I would like to refer you to a fact sheet I submitted and highlight a

few points on the fact sheet for your consideration as you go into your work session today (Agenda Item II A).

I want to point out that the generic and biosimilar drugs provide one of the top value propositions in health care, and here are some statistics to support this statement. In 2020, health care spending in the United States reached $4.1 trillion, yet generic drug spending accounts for only 3 percent of this massive number. Looking specifically at Nevada, in 2020, generic and biosimilar drugs saved the state Medicaid program $485 million and saved the Medicare program $711 million. When combined with commercial and private payers, the overall savings from generic and biosimilar drug utilization to the State of Nevada totaled $2.6 billion.

When talking about prescription drug spending nationally, new data for 2021 shows generic drugs now represent 92 percent of all prescriptions filled but account for only 16 percent of all prescription drug spending. The data shows even more savings compared to 2020 when these numbers were 90 percent of all prescriptions and 18 percent of all spending. This means that even as more generic drugs are being dispensed, the share of the overall cost continues to drop.

As we all know, patient costs are the most important issue we are all concerned with today. On average, the patient co-pay for a generic drug is $6.61, while the average co-pay for a brand drug is $55.82. According to a recent AARP study, they reported the cost of the 390 most commonly used generic drugs by seniors has fallen by 9.3 percent.

It is important to note that generic and biosimilar drugs have entirely different economics than brand drugs. Generic drugs are a commodity market and as a result, profit margins are smaller, and distribution is largely handled through three major wholesalers. Generic manufacturers do not set the price patients pay for a prescription drug. Once a generic drug manufacturer sells to a wholesaler, the manufacturer is effectively removed from the pricing discussion.

In summary, as you craft legislation for the next legislative session, please keep these critical facts in mind. By supporting policy that encourages increased generic drug utilization, you can help lower the cost of health care and improve access to care for all Nevadans. Thank you.

Joanna Jacob, Government Affairs Manager, Clark County:

Good morning, Chair Peters, and members of the Health Care Committee. I am happy to be here in Carson City testifying today on Item D-1 in your work session. It is an item that Clark County submitted for consideration, and I would like to thank you for including it in today's work session.

The intent of this request is to provide a path forward for child welfare agencies to bill federal Title IV-E of the Social Security Act of 1935 (H.R.7260 of the 74th Congress) dollars for a model of care that is emerging from the Family First Prevention Services Act of 2017 (H.R.253 of the 115th Congress) that is called a qualified residential treatment program (QRTP). Some of the guidance coming down from the federal Children's Bureau, Office of the Administration for Children and Families, U.S. Department of Health and Human Services, showed us that there may need to be some updates to the NRS to align with that guidance to provide that path.

With respect to our intent and plans forward, we are working with the Division of Child and Family Services (DCFS) and the Division of Welfare and Supportive Services (DWSS), both

of the Department of Health and Human Services (DHHS), because there are quite a few moving parts with respect to how we are going to license this part with Clark County, Washoe County, and any stakeholders who are designated on this bill. We intend to bring you a consensus product to move us forward to provide this path.

It is tremendously important for Clark County because the federal guidance states that we will no longer be able to bill Title IV-E dollars for this group home model of care beyond 14 days, unless we have certain exceptions. One of which is this QRTP, which the federal guidance also tells us needs to be licensed by the state as a childcare institution, and our definition in Nevada does not match the federal guidance and that is the intent of the bill draft request (BDR).

We will work with our child welfare agency and state colleagues on this bill and want to thank you for including it today for action and ask for your support. Thank you.

Chair Peters:

Thank you, we appreciate your commitment to continuing the work on this issue. Is there anyone else in Carson City who would like to come up for public comment? Seeing none, I will ask Broadcast and Production Services (BPS) to check the public comment line for folks calling in for public comment.

Jimmy Lau, Vice President, Ferrari Reeder Public Affairs, on behalf of Dignity Health, Saint Rose Dominican:

Good morning, Chair Peters, Vice Chair Doñate, and members of the Committee. On behalf of Saint Rose's nonprofit acute care hospital system in Nevada, we want to thank the Committee for its diligent work this interim and offer comments in support of two items in the Committee's WSD.

First, we would like to offer our support for Item L, specifically the creation of a public health infrastructure and improvement account. This item will provide ongoing support for Nevada's public health infrastructure, complementing the work of community stakeholders across our state. Saint Rose is proud to be a part of Nevada's public health infrastructure, offering many free and low-cost programs through its foundation and wellness centers to address social determinants of health for Nevada's most vulnerable and disadvantaged residents.

Second, we would like to offer our support for Item K related to community health workers (CHWs). Saint Rose has supported legislation in previous sessions related to CHWs, recognizing the substantial value they provide the communities they serve. Expanding access to CHWs will provide an immense benefit to Nevada's residents. We are hopeful this revision to the existing statutory authorization for CHWs will allow Saint Rose to bolster its work in providing high-quality and accessible services for Nevada. We look forward to working with the Legislature on these measures in 2023. Thank you for your time and consideration.

Megan Comlossy, M.P.A., Associate Director, Center for Public Health Excellence, Larson Institute, School of Public Health, University of Nevada, Reno (UNR):

Good morning, Chair Peters, and members of the Committee. First, I want to thank Senator Doñate for all the time and work he and staff put into the Senate Bill 209 (2021) study. Through it he received a significant amount of feedback, the results of which are reflected in the work session today.

For many, the Coronavirus Disease of 2019 (COVID-19) pandemic provided the first concrete example of what the public health sector does and underscored the importance of a robust public health system. It also highlighted the consequences of chronic underfunding workforce shortages and an outdated infrastructure, which limited the state's capacity to respond to public health challenges before the pandemic and exacerbated them during the crisis.

The proposal before you in Item L of the WSD, regarding public health modernization, represents a significant step toward improving the ability of public health practitioners to prevent and respond to health crises in the state. Its ongoing flexible funding will be a perfect complement to the historic investment and public health infrastructure that the Interim Finance Committee (NRS 218E.400) approved yesterday.

As you consider these proposals today, I think it is important to remember that there are hardworking public health professionals who are currently stretched thin and doing the best they can with the funding, staff, and capacity they have. This noncategorical funding will enable them to address whatever the public health issue is of the day and respond to the needs of the residents in the communities you serve. Thank you for your time.

Dora Martinez, Nevada Disability Prevention Coalition:

Good morning, Chair Peters, and the rest of the Committee. I echo the prior speakers and we do support Items L and K. Thank you for your valuable time.

Jay Kolbet-Clausell, M.S.W., Program Manager, Nevada Community Health Worker Association:

Thank you, Chair Peters, and members of the Committee for having us today. I will be available to answer questions when Item K comes up, but on behalf of the Community Health Worker Association, please consider a one-word addition to the recommendation. Community health worker is a very broad title and there are CHWs who do not have certification and have staff funding sources that do not require it. Employers have been supporting their staff to pursue the requirements, and we believe that this should be left to market forces to reward CHWs and employers who pursue training and certification.

The federally qualified health centers (FQHCs) and managed care organizations (MCOs) are strong advocates for CHW education and certification. We have seen many of their staff come through our classes even before it was a requirement. Medicaid reimbursement will require CHW certification, and that requirement is appropriate.

With all that in mind, the one-word addition is to add the word *certified* so that the recommendation reads, "Require any person holding himself or herself out as a *certified* CHW in this state be certified as a CHW by the Nevada Certification Board." Thank you for your time.

Chair Peters:

Thank you for those comments; I made notes on that suggestion. Are there other callers for public comment?

Kevin Dick, District Health Officer, Washoe County Health District:

Good morning, Chair Peters. I want to comment on the public health modernization in Item L. We saw the consequences of underfunding our public health infrastructure during COVID-19. We saw the underfunding of public health and impacts during COVID-19. We had

health inequities that were magnified, and disadvantaged populations were severely affected. The lack of resources to work with the disadvantaged communities on inequities and health priorities prior to the pandemic left us ill-equipped to work with these communities to provide the support and access to services. [Inaudible, poor connection.]

Chair Peters:

Thank you for the public comment. We had a hard time hearing you. Hopefully, you will submit those comments in writing to our staff so we can include them in the public record.

Andrea Gregg, Chief Executive Officer, High Sierra Area Health Education Center:

Good morning, Chair Peters. Thank you for the opportunity to comment on the proposed public health infrastructure and improvement fund in the WSD.

I am a proud alumnus of the School of Public Health, UNR, and have spent the last 15 years leading an organization that serves as a critical convener between academic, employer, and community-based partners to focus on the development, diversity, and distribution of our state health care and public health workforce. We know now more than ever that a sound and sustainable public health infrastructure is an urgent matter for our state. The state's experience over the last two years has demonstrated the need to invest in the public health workforce, as well as build for a future while ensuring that health outcomes improve over the longer term.

Finally, the proposed funding and associated investment provides a real opportunity to diversify funding for public health programs in Nevada, which we know would alleviate some of the reliance on federal financing and could lead to the dismantling of programs after that funding has been exhausted if sustainability has not been attained. Often, the very restrictions that come with federal funding can lead many of our most vulnerable communities without access to adequate services. Therefore, providing the opportunity for noncategorical and flexible funding will ensure fundamental public health services are in place and can certainly respond to current and emergent public health needs, as well as improve the health of all communities in Nevada.

On behalf of our organization, I echo some of my colleagues on the line and would like to submit our support for the CHWs. As we know, investments there will also improve our health care impact and outcomes overall. Thank you.

Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District:

Good morning, Chair Peters, and Interim Health Committee. Kevin Dick, the district health officer for Washoe County Health District, was on the phone, but you were having trouble hearing him. I will read into the record what he would have liked to have said.

We are here in support of the public health infrastructure and improvement fund. The public health improvement fund, that we have been working on for several sessions now, is desperately needed after so many years of underfunding our public health agencies.

We saw the dire consequences of this during the COVID-19 pandemic. Health inequities were magnified, and disadvantaged populations were the most severely affected. The lack of resources to work with these communities historically on inequities and health priorities identified in our public health needs assessments, left us ill-equipped to work with these communities to provide the support and access to services they so desperately needed. As you know, we are always at risk of a new public health crisis or emergency. Right now, we

are facing Monkeypox and again are hindered by the lack of adequate and flexible public health funding. I wanted to give you a couple of examples.

We have a federal grant funding to administer COVID-19 vaccines to respond to that emergency, but we are not allowed to use those funds to administer Monkeypox vaccines, or even to assist callers to our call center seeking the Monkeypox vaccine.

We have federal funding to visit medical offices and work with physicians and nurses in our community to help them and their staff to understand how to properly store and administer vaccines for children. This is called "academic detailing." Those nurses, while they are in those physician's offices, are not allowed to provide information and education on how to identify or properly test for Monkeypox because the categorical funding they receive can only be used for education about childhood vaccines.

The current funding system we operate in is ineffective and unsuitable for meeting our public health responsibilities. It is like going to a doctor who could take your temperature but not weigh you, check your pulse and oxygen levels, or have you stick out your tongue and look down your throat, but not look at your ears. We need to fix the categorical funding issues and the chronic underfunding of public health. Thank you.

Marlene Lockard, The Lockard Group, on behalf of Service Employees International Union (SEIU) Local 1107:

Thank you, Madam Chair, and Members of the Committee. I represent SEIU Local 1107, the largest union of health care and public workers in Nevada. Thank you for this opportunity to report on the progress of SB 340 (2021). I am pleased to report that the Board is operating as intended for the first time in the state's history. This legislation has brought together representatives of home care providers, recipients, and employees to discuss and find solutions for the myriad of issues that have contributed to the low wages, poor working conditions, and chronic shortage of home care workers in Nevada.

About a year ago, the Guinn Center issued an assessment of the personal care workforce in Nevada by reporting that a dire crisis was on the horizon, creating a dangerous home care worker shortage, which will hurt Nevada seniors, people with disabilities, and home care workers alike to compound an already simmering public policy time bomb.

The *Elders Count* indicates Nevada has been and will continue to experience an aging tsunami. Nevada's population has increased by more than 11.42 percent, while the 65 and older population increased by 40 percent. Nevada's growth rate for age 85 and older is double the national rate.

There are approximately 13,000 personal care aides who assist elderly and physically disabled Nevadans with daily living tasks such as bathing, eating, toileting, and mobility in their client's home. This workforce is disproportionately women of color, who are currently paid an average only of $11 an hour, with few to no benefits. Close to half of the workforce relies on some form of public assistance because of the low wages and inconsistent hours.

Home care workers play a critical role in keeping seniors and adults with disabilities out of expensive and less desirable care settings. For example, Nevada saves an average of $70,000 a year for every senior who has served through the Home and Community-Based Services Waiver for the Frail Elderly program instead of a nursing facility. Despite the important role that home care workers play—which has been made more evident during the COVID-19 pandemic—the home care industry suffers from over 50 percent turnover rate due to the lack of compensation and respect afforded to these women.

Lastly, most of the home care in Nevada and nationally is delivered through Medicaid. Most individuals needing care cannot afford to pay out of pocket. As such, the state—through its role of setting reimbursement rates and other Medicaid policy—is responsible for setting employment and working conditions for the home care industry at large.

I would like to commend you and the 2021 Legislature for having the foresight to enact legislation to immediately address these critical issues. I am speaking to Item M in the WSD and asking for your support of the recommendations that have been adopted today by the Board. Cody L. Phinney, M.P.H., Deputy Administrator, Division of Health Care Financing and Policy (DHCFP), DHHS, has been tasked to chair the Home Care Employment Standards Board, and I know she will be available to answer any other questions during that item. Thank you, I appreciate your time.

Chair Peters:

Thank you, Ms. Lockard, we appreciate you calling to give us a brief update on the status of that Board, and we look forward to hearing more about those recommendations in the coming session as well.

Chair Peters:

We will go ahead and close out that first public comment period. Thank you to all who provided public comment, we appreciate you being here today with us.

AGENDA ITEM III—APPROVAL OF THE MINUTES FOR THE MEETING ON MAY 19, 2022

Chair Peters:

We will move on to Agenda Item III, approval of the minutes for the meeting on May 19, 2022. Are there any questions regarding these minutes? Seeing none. I will entertain a motion to approve the minutes of the Committee meeting on May 19, 2022.

> VICE CHAIR DOÑATE MOVED TO APPROVE THE MINUTES OF THE MAY 19, 2022, MEETING.
>
> SENATOR HARRIS SECONDED THE MOTION.
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> THE MOTION PASSED UNANIMOUSLY.

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AGENDA ITEM IV—CONSIDERATION OF REGULATIONS PROPOSED OR ADOPTED BY CERTAIN LICENSING BOARDS PURSUANT TO NRS 439B.225

Chair Peters:

We will move on to Agenda Item IV, consideration of regulations proposed or adopted by certain licensing boards, pursuant to NRS 439B.225. I am going to ask staff to go through these for us as listed in the agenda. I want to remind the Committee though that this is informational only, staff has informed you about the status of the regulatory process for the regulations we are now considering. If you have a greater interest in participating in the development of these regulations, the process can be found on the LCB's website, or you can reach out to our staff for additional assistance. Committee review is an important

process for follow-up on bills that we have passed in the last couple of sessions, but we will not be taking any action on these items today. I want to note, this Committee neither approves nor denies any of the regulations before you today. Instead, each board adopts its own regulations followed by approval through the Legislative Commission. The Committee's consideration of these regulations is only from an advisory perspective. If you need further detail, you can reach out to LCB staff or those regulatory boards. I am going to ask Mr. Robbins to go through the list of regulations for consideration today.

A. LCB FILE R010-22 OF THE STATE BOARD OF HEALTH

(Agenda Item IV A)

B. LCB FILE R026-22 OF THE STATE BOARD OF ORIENTAL MEDICINE

(Agenda Item IV B)

C. LCB FILE R057-22 OF THE BOARD OF EXAMINERS FOR MARRIAGE AND FAMILY THERAPISTS AND CLINICAL PROFESSIONAL COUNSELORS

(Agenda Item IV C)

D. LCB FILE R085-22 OF THE STATE BOARD OF PHARMACY

(Agenda Item IV D)

E. LCB FILE R086-22 OF THE STATE BOARD OF PHARMACY

(Agenda Item IV E)

F. LCB FILE R094-22 OF THE STATE BOARD OF HEALTH

(Agenda Item IV F)

Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB:

There are six regulations the Committee is considering today. We have representatives from each agency available if members have questions on the regulations.

Chair Peters:

Thank you, Mr. Robbins. Are there questions on these regulations? Dr. Titus, please go ahead.

Assemblywoman Titus:

Thank you, Madam Chair, I appreciate the opportunity to ask the question. This is in regard to R010-22 of the State Board of Health. On the cancer reporting, I was wondering how the penalty fees were set if someone does not report.

Aundrea Ogushi, Program Manager, Nevada Central Cancer Registry, Division of Public and Behavioral Health (DPBH), DHHS:

The fees were just a clarification to what is already currently in regulation. In working with our stakeholders, including the Nevada Hospital Association and Nevada Rural Health Partners, we realized there was confusion as to what those fees were because in the

regulation, we also have an abstract fee that was placed there prior to looking to amend these regulations.

Assemblywoman Titus:

Thank you. There is a fee for not reporting, but then there is a fee when you report, per facility, so I just needed clarification.

Chair Peters:

Are there any other questions for the State Board of Health?

Assemblywoman Titus:

I have a question on R094-22 relating to music therapy. Is there an issue with this? Has it been abused? Why are we again regulating music therapy? Is it because they are billing for their services, and it requires some regulation and certification? We have so many licenses that we require in our state, it is more of a hindrance to care than helpful care. Can you explain briefly why this was recommended? Where is the problem we are trying to solve?

Leticia Metherell, R.N., C.P.M., Health Program Manager, Bureau of Health Care Quality and Compliance, DPBH, DHHS:

The licensing of music therapists is a statutory requirement per NRS 640D.010, which states, "The practice of music therapy is hereby declared to be a learned allied health profession . . . " and it is needed to protect the public from the practice of music therapy. We license them because it is in statute; we have no choice.

Section 1 of the regulation is a requirement per NRS 622.087 and Assembly Bill 330 (2021), which applied to occupational licensing boards. Since a music therapist is an occupational license, it also applies. The others were existing regulations that were developed because of the statutory requirement to license music therapists. This cleaned up the language to make it more efficient and effective since it is something we already must do.

Chair Peters:

Thank you, Dr. Titus, for the questions. I had an opportunity to visit with the Note-Able Music Therapy Services in Reno. If you are in that area and would like to get a perspective on what music therapists do and how they impact our community, I encourage you to reach out to them and see about a visit.

Are there any other questions on the regulations presented today? I am going to go ahead and close out the agenda item and move on to our first presentation today.

AGENDA ITEM V—PRESENTATIONS REGARDING PRIORITIES AND RECOMMENDATIONS OF THE REGIONAL BEHAVIORAL HEALTH POLICY BOARDS (NRS 433.429) DURING THE 2021–2022 LEGISLATIVE INTERIM

Chair Peters:

Agenda Item V is a presentation regarding the priorities and recommendations of the Regional Behavioral Health Policy Boards (RBHPBs) during the 2021–2022 Legislative Interim. We have five boards to present on their BDR ideas today. Please introduce yourself and proceed when you are ready.

Valerie Cauhape Haskin, M.A., M.P.H., Rural Regional Behavioral Health Coordinator, The Family Support Center, Rural RBHPB:

Chair Peters, and member of the Committee, thank you for this opportunity to speak to you today. I am going to open our series of presentations with a brief description and overview of the RBHPBs to provide some context for the following presentations from each of the coordinators (Agenda Item V).

The RBHPBs were established during the 2017 Legislative Session by AB 366, and in 2019, AB 76 further divided the state into five behavioral health regions. This was done to ensure that regional boundaries were based on common access to services and needs. Each RBHPB consists of 7 to 13 volunteer members and represents a broad group of stakeholders from local communities, including law enforcement, human or social services, behavioral health providers, the criminal justice system, system consumers or family members, insurers, emergency services, and others. Appointments to the Boards are made by various bodies, including the governor, Senate majority leader, speaker of the Assembly, administrator of the DPBH, and other board members.

Due to time constraints, I am not going into great detail regarding the duties of the Boards. However, their duties include advising DHHS and all its subdivisions, as well as the Commission on Behavioral Health, regarding the needs, assets, and progress related to behavioral health in each region. The Boards provide state agencies with local insight to help them prioritize funding in a way that may have the greatest positive impact. The Boards also provide additional insight as to any obsolete, redundant, or otherwise problematic legislation or public policy that creates barriers or other challenges to improving the behavioral health system.

Through this work and other efforts, the Boards aim to promote improvements in the delivery of services both on the part of DHHS subdivisions and private providers. As stated in NRS 433.4295, the Boards must also maintain a repository for behavioral health data, and this is currently done through the Boards' website: nvbh.org.

Finally, the Boards work to improve communication and collaboration among state and local agencies. For a comprehensive list of these duties please see the handout provided, which also includes the full language of NRS 433.4295 (Agenda Item V-1).

After the creation of the RBHPBs, the DPBH created regional behavioral health coordinator positions, held by my counterparts and me. We act as the unofficial staff for each of our respective boards and complete not only the administrative duties for the Board itself, but more importantly, we work as liaisons between the state and local agencies within our respective regions to build capacity and improve various areas of the behavioral health system. This work may include:

- Addressing challenges to community members trying to access behavioral health treatment;
- Assisting with projects that provide education and training for organizations and community members;
- Looking at state and local level data and reporting processes and seeing how we can assist in improving them;

- Assisting with the coordination and communication regarding the available services that are provided by the state and other local agencies within the region to minimize duplication and to fill gaps as best we are able; and

- Communicating local needs and behavioral health status up to state agencies, as well as communicating state plans back down to the local level.

I would like to take a couple of moments to introduce each region and their respective coordinators and chairs. The Washoe RBHPB's region includes Washoe County only. Their chair is Julia Ratti, and their coordinator is Dorothy Edwards.

The Northern RBHPB's service area includes Carson City, Storey, Churchill, Lyon, and Douglas Counties and is chaired by Taylor Allison. Cherylyn Rahr-Wood recently joined our ranks as the coordinator for the Northern Board, replacing Jessica Abrass.

Next, I would like to introduce the Rural RBHPB, which represents Pershing, Lander, Humboldt, Eureka, Elko, and White Pine Counties. The Board is chaired by Fergus Laughridge, and I have the honor of serving as the Rural Board's coordinator.

The Clark RBHPB represents the southern tip of Nye County and all of Clark County. It is chaired by Char Frost and its coordinator is Michelle Bennett.

Finally, we have the Southern RBHPB which serves Mineral, Esmeralda, Lincoln, and Northern Nye Counties. Kim Donohue is their coordinator, and their chair is currently pending. Their first meeting is scheduled for next week, so there are many exciting things to come and to expect for the Southern Board.

In conclusion of this brief overview, much more details regarding the Boards, their priorities, and their respective BDR topic areas will be given within the presentations to follow. Additionally, more details about the Boards, their roles, and activities, can be found in the handouts provided to support this and the region-specific presentations. Thank you.

Chair Peters:

Thank you for the brief presentation. I serve on the Washoe RBHPB, and I love the work that we do and the group of folks who are brought together through these boards. I think we have a couple of folks on the Committee who serve on these boards. Thank you for being here today. I will let you proceed with the next part of your presentation.

A. CLARK REGIONAL BEHAVIORAL HEALTH POLICY BOARD

Michelle Bennett, M.A., M.S., Clark Regional Behavioral Health Coordinator, Clark County Social Service, Clark RBHPB:

Good morning, Chair Peters, Vice Chair Doñate, and Committee members. Thank you for the opportunity to present today on the Clark RBHPB (Agenda Item V A-1) (Agenda Item V A-2).

The Clark Board is currently filled with all positions and a strong representation of professionals in this region. In addition to their day jobs, Board members volunteer their time and participate in various coalitions, committees, and boards across the entire state and bring that expertise to tackle the complicated issues in behavioral health. I am pleased

that the Board members possess a high-level of cooperation and teamwork. There is also a strong community interest in any vacancy that is available.

Following a time of global turmoil, the Board recognizes that organizations are doing their best to serve the community while evaluating every aspect of their business operations to stay afloat. This has resulted in an acceleration of existing challenges, and this Board will reevaluate priorities during the September Board meeting. For the exception of the last priority—to identify wraparound services for individuals experiencing homelessness and mental health crisis—all other priorities predate COVID-19 challenges. The goal is to build better resilience for consumers and service providers with the commitment to creating sustainable value. The Board acknowledges increased service provider scrutiny, and stakeholder consideration is prepared to adjust the list of priorities to serve the community better.

Some of the regional challenges Clark faces echo many of the state's challenges. Clark is currently the second largest county to experience a high percentage of severe depression and frequent suicide ideation and that is among all other large counties in the United States. Workforce shortages, which you will hear throughout the presentations of the other coordinators, is a common theme. This affects access to care, treatment, and proper diagnosis. The Clark County Detention Center is the largest mental health provider by patient and volume. They average about 21,000 inmate populations with a behavioral health need.

However, there are some positive things being done. I want to highlight the Las Vegas Metropolitan Police Department. They are probably the first to bring somebody into the system and are doing their best to reduce arrests and get people into the proper treatment. Some of their attempts are the creation and facilitation of Hot Teams, which provide outreach to individuals who are experiencing homelessness and connecting them to resources. A lot of times this is the first point of contact somebody in our community will have entering the system.

The crisis intervention teams (CITs) are doing some great stuff. They are working with Clark County Social Service social workers who go out with police officers and respond to crisis calls. This reduces arrests and incarcerations and helps those suffering from mental illness get into the services they need.

Finally, I wanted to highlight the Law Enforcement Intervention for Mental Health and Addiction (LIMA) program. This is a diversion program through the Office of Community Engagement which is a collaboration between the Eighth Judicial District Court and Las Vegas Metropolitan Police Department. It is a 9- to 12-month prebooking program geared towards helping people with low-level drug offenses. Participants must have a chemical dependency but are willing to engage in treatment. Throughout their participation in the LIMA program, they are connected with resources, skill levels, sometimes even a reevaluation of their job skills. This program currently has 300 referrals. They have 60 graduates to date, and the recidivism rate for their graduates is only 3 percent. They are doing good work.

One of the main challenges that all these programs are reporting back is the lack of affordable housing and mental health facilities to treat this population. Left with no other options, many times these individuals either disappear from contact or they repeat offenses.

The RBHPBs have achieved remarkable success, but along with numerous community partners, they need help, which leads me to the Clark RBHPB's bill draft request concept for

the upcoming session. In July, the Board voted to approve the development of a supportive service transformational fund, of which a key component is supportive housing. Since many of these individuals are trying to get into treatment or unable to sustain themselves, they often need a third party to help them sustain whatever goal or mental service they need. Supportive housing is a concept that engages rental assistance and supportive wraparound services that can help with case management and care coordination to get somebody in a place where they can function at the most successful rate. Rental assistance is not enough for this population.

Since supportive housing is a primary concept, the development of the fund will provide affordable housing on a short-term and permanent basis to individuals in treatment and recovery from substance addiction to persons with moderate to severe mental illness, including chronically homeless and individuals with intellectual and developmental disabilities. To encourage a cohesive service system across service sectors and maximize available resources, it is important to align services across the range of providers, which include intellectual and developmental disabilities, the justice system, aging, homeless response, behavioral health, child welfare, and youth. All these linkages to affordable housing are alternatives to facility-based care and will maximize dollars because individuals are tapping into one source and not having to go across multiple sources to get their housing completed. Thank you for letting me present.

Chair Peters:

Thank you, Ms. Bennett. What was the name of that fund?

Ms. Bennett:

The transformation fund. I do get a lot of questions on that, and we are developing the language.

Chair Peters:

We look forward to hearing more about how you build that out and what it will start to look like before session starts. Are there any questions from the Committee for Clark RBHPB? Ms. Bennett, if you want to stick around in case questions come up based on the other board presentations, that would be great.

B. NORTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD

Chair Peters:

Our next presenter is the Northern RBHPB. Please introduce yourself and proceed when you are ready.

Cherylyn Rahr-Wood, M.S.W., Northern Regional Behavioral Health Coordinator, Nevada Rural Hospital Partners, Northern RBHPB:

Good morning, Chair Peters, and members of the Committee. Thank you for the opportunity to provide my presentation regarding the priorities and recommendations of the Northern RBHPB (Agenda Item V B-1) (Agenda Item V B-2) (Agenda Item V B-3). I am in my ninth week in this position, so I apologize if I miss anything that should be reported to the Committee. I can supply any further necessary information if needed.

As Ms. Haskin said, the Northern RBHPB consists of Carson City and Churchill, Douglas, Lyon, and Storey Counties. The current population is estimated to be reaching 200,000. The total area is approximately 8,049 miles of rural and frontier. In actuality, the area is 11,976.95 square miles. When looking at the ethnic makeup of the northern region, 74.1 percent of the residents in the region are White, not of Hispanic origin; 16.6 percent are Hispanic; 3.2 percent of the population are Native American; 2.4 percent are Asian; and 1.9 percent of the population are Black or African American. Looking at the age differential, 5 percent of the population is under 5 years of age; 22 percent is between the ages of 5 and 24 years; 23 percent between the ages of 25 and 44 years; 28 percent between 45 and 65 years of age; and then 23 percent are 65 and older. Approximately 19,400 veterans reside in this region as of 2020.

I would also like to offer you some other prevalent data points important to the overall behavioral health of the northern region. Lyon County experienced the highest increase in methamphetamine-related deaths from 2.0 per 100,000 in 2011 to 2.2 per 100,000 in 2020. In 2020, the northern region suffered 64 losses to suicide. Persons living in poverty by percentage in 2019 were 10.6 percent, and the percentage of northern region residents who reported ten or more days of poor mental health significantly increased from 16.4 in 2018 to 26.9 in 2019. Anxiety has been the leading mental health-related diagnosis since 2020 in emergency department encounters. Anxiety-related encounters increased significantly from 2019 to 2021 in both counts and rates. Depression is the leading diagnosis for inpatient admissions in the northern region and emergency departments visits for marijuana, opioids, and heroin increased from 2018 to 2019. These are just some of the statistics this Board must work with as of right now.

In accordance with NRS 433.429, I would like to introduce you to the Northern RBHPB:

- Chair Taylor Allison, Public Health Coordinator, Nevada Association of Counties—representative from a community-based organization providing behavioral health services;
- Vice Chair Ali Banister, Ph.D., Chief of Juvenile Services, Juvenile Probation Division, Juvenile Detention and Probation Department, First Judicial District—representative of the criminal justice system;

- Assemblywoman Robin L. Titus, M.D., Assembly District 38;

- Amy Hynes-Sutherland, Ph.D., Development Officer, Carson Tahoe Health Foundation—representative of hospitals, residential long-term care facilities, or acute inpatient behavioral health facilities;

- Nicki Aaker, R.N., Director, Carson City Health and Human Services—a county health officer or their representative or similar public health position from city, county, or tribe;

- Eric Schoen, Executive Director, Community Chest—member who represents interest of administrators or counselors at facilities for the treatment of alcohol or drug abuse;

- Kenneth T. Furlong, Sheriff, Carson City Sheriff's Office—representative of law enforcement with knowledge and experience with persons needing behavioral health services;

- Sandy Wartgow, Division Chief, Emergency Medical Services, Carson City Fire Department—member who represents providers of emergency medical services (EMS);

- Lana K. Robards, Executive Director, New Frontier Treatment Center—representative of residential treatment facility, transitional housing, or other housing programs serving persons with mental illness or who abuse alcohol or drugs;

- Amy Kegel, Psy.D., Clinical Psychologist, Nevada Behavioral Health Systems—licensed Nevada clinical psychiatrist;

- Shayla Holmes, Director/Public Guardian, Lyon County Human Services—person with extensive experience in behavioral health delivering including without limitation, social services directors; and

- Laura Yanez, Executive Director, NAMI Western Nevada—our peer or family advocate.

Looking at some of the Board's areas of discussion and support, our behavioral health workforce across the northern region is lacking. I believe the consensus on this topic is that it is a hot one statewide. You are going to hear that a lot today, probably from each coordinator. Other areas of discussion and support include regional board infrastructure, the security, and sustainability of it; the insufficiency of coordinated behavioral health responses to those in crisis; and training crisis planning must continue to be developed and providers trained. Crisis response 988 is being built up upon to help close these gaps. While we are a few years away from more optimal services, these deficits to the crisis response model need to be addressed now. Access to care for all ages and levels of treatments will continue to be a problem if the workforce issues are not resolved as well as transportation issues within my region. The lack of behavioral health supportive housing for the serious mental illness (SMI) and substance use disorder (SUD) populations is a statewide issue, and the Board will continue to reach across county lines to work on this as we move forward. Transportation in accessing medical care and mental health crisis transportation is a gap and a huge barrier throughout our great state. It is another hot topic you are going to hear talked about quite a bit. Finally, consistent community awareness or knowledge of state and local programs across the entire region.

There is always hope, so I would like to focus on some positive assets of the northern region. As the newbie, I have been in awe at how these counties truly come together. The resiliency from the northern region is unwavering, and I would be remiss if I did not highlight some of the successful projects and programs that reign in the northern region.

We have our Mobile Outreach Safety Teams (MOST) in Carson City and Douglas and Lyon Counties. They are growing bigger, better, and stronger as 988 and the crisis response model gets built up. We have regional multidisciplinary Forensic Assessment Services Triage Teams (FASTT). They work with incarcerated individuals being released by offering alternative ways for treatment, services, and resources. The Crisis Intervention Training (CIT) program occurs in most of our northern counties with our community partners and law enforcement. I am blessed to be able to train within some of those CIT trainings and there is a great response from our law enforcement. We have Multidisciplinary Teams (MDTs) for individuals with SMI cases who struggle with regular traditional services. These teams are vital when it comes to our most severe SMI population. By working together, they provide that extra special assistance for treatment or need that sometimes warrants a bigger team to figure out. Finally, the northern region’s local behavioral task force teams. Every one of

the northern region counties have a behavioral health task force. I had the honor of sitting in on a couple of the county's meetings so far. They are vital in bringing a nice array of partners from the surrounding communities and counties together at the same table, using their voices to talk about current issues in the surrounding areas, and giving updates on the old and new resources and programs. They are very informative and active. Thank you for the pleasure of allowing me to give you an idea of the assets that I have learned from this region as I am settling in.

Lastly, here is a bit on the Board's recent history, as well as the focus of their BDRs concerning the legislative priorities impacting behavioral health. The Board has been and will continue to provide support, testimonies, intraregional legislative support, education, and advocacy. Advocacy, as always, is ongoing.

During the 2021 Legislative Session, the Board's BDR was rewriting language of Chapter 433 ("General Provisions") of NRS to change, not only the term *legal hold* to *mental health crisis hold*, but also focusing on other language giving persons who are at risk a sense of dignity and a voice. I can speak to the new BDR that the Northern RBHPB's will be writing on the regional behavioral health authority. The Board is in the works of writing the language for the BDR so I cannot elaborate too much, but there is a little bit of the "why" in the one page I provided, and I noted the other BDRs. I want to thank you the time today and hearing what is happening with behavioral health in northern region.

Chair Peters:

Thank you for the presentation. We look forward to seeing how you flesh out that BDR language and it may be worth coordinating based on some of our WSD recommendations today. Are there any questions on the Northern RBHPB? Please go ahead, Dr. Hardy.

Senator Hardy:

In the world of medicine, we find anxiety very common, and what is happening now is the insurance companies are in the process of trying to say that we are not allowed to bill for the treatment of anxiety. I think one of the challenges that we are going to see is more people trying to be less anxious without the help of their insurance and therefore looking for other sources to treat anxiety. I do not know if that is playing a role in what people are seeing in northern Nevada. It is obviously concerning if we see their greatest diagnosis of anxiety and on some circles, we are not allowed to get paid for it. Has that been something that we have seen up there?

Ms. Rahr-Wood:

Senator Hardy, I cannot speak to that answer right now. I have not looked into that with only nine weeks on the job, but I can do some research and get back to you, if necessary.

Chair Peters:

Thank you for bringing that to our attention. It is disturbing to hear, considering for many of us, particularly of my generation, anxiety is one of the only things that takes us into our doctor's offices. There is probably some work to be done around that.

Are there any other questions for the Northern RBHPB? I am not seeing any. Thank you. Again, if you do not mind sticking around for a little while in case questions arise from the other presentations.

C. RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

Chair Peters:

Next on my list is Ms. Haskin with the Rural RBHPB, please introduce yourself and proceed when you are ready.

Ms. Haskin:

Hello again, Madam Chair, and members of the Committee. It is now my turn to give you a brief overview of the Rural Board's priorities and BDR topic area. For the sake of time, I am not going to go into detail on the demographics of our region, but the information can be found on the handout that was provided (Agenda Item V C-1) (Agenda Item V C-2) (Agenda Item V C-3).

For 2022, the Rural RBHPB decided to organize its priorities into tiers, the logic being that the Tier 1 priorities are those that may have the highest positive impact to the behavioral health system and will also affect Tier 2 and Tier 3 priorities.

Tier 1 priorities include: (1) workforce development; (2) improved, safe, and effective transportation options both to and from crisis and noncrisis behavioral health services; (3) improved access to age-appropriate care across the service spectrum that would specifically target the youth and elderly; and (4) improved reimbursement for services, both from public and private insurance providers.

Tier 2 priorities are those that are important but are seen as heavily affected by changes in Tier 1 priorities. The Rural Board's Tier 2 priorities include: (1) improved care transitions and communication among providers across the statewide behavioral health system; (2) improved safeguards to ensure that the care provided to our communities is of high quality; and (3) improved access to mid-level care, which seems to be a statewide problem.

Tier 3 priorities include: (1) improving access to care for active-duty service members, veterans, and their families; (2) expanding the availability of culturally appropriate and respectful services and programs; (3) leveraging tele-behavioral health care for services as appropriate; and (4) reducing stigma. For more detail regarding these priorities, please see the handout provided.

At its June meeting, the Rural RBHPB voted to adopt the building of a robust pipeline to bolster Nevada's behavioral health provider pool as its BDR topic for the 2023 Legislative Session. These concepts are currently subject to change upon Board approval at its meeting next week. The ideas presented here have been developed through conversations with stakeholders across the behavioral health system and are advised by the work of Sara Hunt, Ph.D., Director, Mental and Behavioral Health Coalition, The Lincy Institute, University of Nevada, Las Vegas (UNLV), who has committed a great deal of time to researching these pipeline models. This Nevada pipeline would be based upon successful models from Nebraska and Illinois, and it is my understanding that other states are also looking into adopting similar models. Like these other states, the Nevada pipeline model would likely include the launch of a behavioral health workforce pipeline center (BHWPC), which would collaborate with and help to expand upon existing successful programs—so there is no desire to duplicate efforts—but would introduce new programs and connections across the educational system and occupational licensing works, going from K through 12 education through professional practice. The types of providers currently intended to be targeted in this model include clinical social workers; marriage and family therapists; clinical

professional counselors; psychologists; psychiatrists; and all drug, alcohol, and gambling counselor types. For the sake of conversation, we are currently defining "underserved" as rural; frontier; Black, Indigenous, and People of Color (BIPOC); LGTBQ+; and other minority communities.

The first component of the behavioral health workforce pipeline is K through 12 education. Here, the Board and its stakeholders would love to see expansions of career and technical education programs across the state to be consistent and robust, regardless of location, and of course to include opportunities for students to learn about behavioral health professions. Additionally, the BHWPC would collaborate with current successful programs, such as the area health education centers (AHECs), which provide support and guidance to high school and college students who want to pursue health careers. Here, the BHWPC would support the AHECs across the state in expanding their efforts to include behavioral health professions. The efforts of the pipeline at the K through 12 level should also be focused on supporting minority youth and those who are otherwise disadvantaged in pursuing careers in behavioral health. Lastly, it is intended that efforts of the BHWPC are interwoven with, or support, existing social and emotional learning and suicide prevention programs in our school districts.

The next segment of the pipeline would focus on both the institutions within the Nevada System of Higher Education (NSHE) and the colleges and universities that may serve Nevadans but sit outside the NSHE system, such as online college programs. Here, the BHWPC would help ensure that undergraduate students are fully prepared for the rigors of graduate school and would help those students navigate the coursework and testing requirements to successfully apply for their chosen programs. Much of this work is already being done by the AHECs, but the intention here is to help support and expand these efforts further into behavioral health.

One of the BHWPC 's objectives would be to work with higher education institutions to ensure that easily accessible opportunities for students to access internships are readily available, both during graduate school and for postgraduate clinical experience. This would include the expansion of approved supervision sites, increase the number of approved supervisors through training and active recruitment, and would streamline approval processes for these internship opportunities between the schools and the licensing boards. Additionally, there would be a focus on creating these opportunities for students specifically to gain experience working with underserved communities and special populations across Nevada. Next, the BHWPC's pipeline efforts would focus on assisting the occupational licensing boards, as needed, with further streamlining their processes and keeping their communications with applicants clear and consistent. This may include ensuring that licensing boards, who are not already doing so, are focusing their efforts to improve efficiency relating to application processes for both applicants from Nevada and those from out of state seeking licensure by endorsement, reciprocity, or preferably, interstate compact.

Finally, while professional practice is at the tail end of this pipeline, most of the efforts listed here will be interwoven throughout the course of earlier components. This would include working with Nevada Health Service Corps, Nevada State Office of Rural Health, Office of Statewide Initiatives, UNR School of Medicine, and related federal or state programs to help place providers in underserved communities, while also assisting new providers with student loan forgiveness or repayment programs. Additionally, the pipeline's programs would include programming to help new providers understand the "business" side of professional practice. Finally, it is intended that the providers who have benefited from the pipeline's

programs would be recruited and trained as supervisors or preceptors for other students to complete their internships or clinical hours, thus coming full circle.

Again, the concepts presented to you in this presentation today have not yet been voted upon for inclusion by the Rural Board, and they are still subject to change. However, we are open to any suggestions or ideas that could strengthen this concept or program. Thank you.

Chair Peters:

Thank you for the presentation. Can I clarify, you kept saying center, are you looking at creating a pipeline support center and partnering with other agencies, is that the intention?

Ms. Haskin:

The models from Nebraska and Illinois both focus on having a center that is housed within one or more—I think it is two or three for both of them—institutions of higher education within the respective systems. With that, it pulls together the different programs at the different locations within the higher education system—it would be NSHE in Nevada—so they must work collaboratively and ensure that communication. One of the big pieces is looking at internships so we can make sure that people who are graduating have internships to move on to, which is a major issue the Board has seen and that I have seen as the regional coordinator with people having a difficult time finding placement. The time within graduate school to postgraduate and licensing would be the major focus. Again, we would not want to duplicate any efforts but need to pull these different agencies and organizations together.

Chair Peters:

Thank you for the clarification. Are there any other questions from the Committee?
Dr. Titus, please.

Assemblywoman Titus:

Thank you for your presentation. I was a product of my county paying my way through school. I went back after medical school and had medical students and residents rotate with me from the first day I opened my doors and continued for about 38 years. You mentioned duplication of efforts. How much time have you invested in meeting with the UNLV School of Medicine's existing residency program in Winnemucca or looking at putting something in Elko? Have you brought them to the table when discussing this bill?

Ms. Haskin:

We have not spoken with the School of Medicine simply because the professions that are focused on here are outside of the scope of the Board of Medical Examiners, except for psychiatrists, which is a new professional focus for the Rural RBHPB. We have previously focused on clinical social workers, marriage and family therapists, clinical professional counselors, and drug and alcohol counselors. We have had Gerald Ackerman, M.S., Director, Office of Rural Health, who also oversees the Nevada Health Service Corps program, on our calls and in our strategy meetings. It has been incredibly helpful.

On the behavioral health side, it seems as though there is less knowledge among students about the opportunities to access these programs that can help them. One of the issues, that I believe I heard from Mr. Ackerman, is they are not given any funds for marketing. Having a BHWPC would help fill in the gaps between the professionals within each particular

program, because people get busy and focused on their work. This would help to coordinate the education and ensuring the knowledge of the availability of these services and programs.

Assemblywoman Titus:

Thank you. The fact that you have Mr. Ackerman involved gives me comfort because he knows his job and has done a tremendous job for the rurals and understands all of the layers of the health care folks need.

Have you talked to the superintendent of the school districts out there for the pipeline of students to get interested?

Ms. Haskin:

I have been working my way through my email list this last week to get emails out. I have also reached out to NSHE.

Assemblywoman Titus:

Perfect. We have to grow our own to get these kids to come back to these rural areas. I like the concept of the pipeline and the umbrella of health care workers, and the fact that Mr. Ackerman is involved gives me confidence that you are going to have some good direction on how to do this. It always sounds great, but then when it comes to fruition or trying to implement it and not repeat stuff and look for money . . . . Using the Nevada Health Service Corps as part of the program would be good if we can get that funding. Thank you for what you are doing.

Chair Peters:

It looks like you have a couple of folks in the Senate this time around who are invested in this bill. I am looking forward to those conversations and hearing how this pans out for you.

Any other questions? Seeing none. Thank you. Would you mind sticking around for a little bit in case we have more questions?

D. SOUTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD

Chair Peters:

We will move on to our next presentation, the Southern RBHPB. Ms. Donohue, please introduce yourself and proceed when you are ready.

Kim Donohue, Southern Regional Behavioral Health Coordinator, Nevada Rural Hospital Partners, Southern RBHPB:

Good morning, Madam Chair, and members of the Committee. Thank you for the opportunity to provide these updates on the priorities and recommendations of the Southern RBHPB (Agenda Item V D-1).

It is important to note that the Southern RBHPB is not at the same level of the other policy boards. The Southern RBHPB was developed with the 2019 legislation and this position had been vacant for over three years before resuming this role. The Board had not been able to successfully form a full board and hold a quorum in the past.

On January 3, 2022, I accepted the role as the Southern Regional Behavioral Health Coordinator. I cover Mineral, Esmeralda, northern Nye from the 38th parallel—which is from Tonopah up to the Duck Water Reservation, and Lincoln Counties. It covers approximately 26,000 square miles of Nevada. The population is estimated to be between 13,888 and 16,000. I have pulled this 2020 data from the United States Census Bureau of the U.S. Department of Commerce and Nevada's Department of Taxation. Nye County is divided between two coordinators, me and the Clark regional behavioral health coordinator. With having that county divided, it makes the populations and square miles I serve difficult to narrow down precisely. The ethnicity breakdown has also been provided to best understand the community's makeup that encompasses the southern region.

On July 28, 2022, the Southern RBHPB held its first scheduled policy board meeting. We had 30 people attend online and 50 attended in person. However, due to a technical difficulty, the deputy attorney general respectfully requested the meeting be ended for us to comply with the Open Meeting Law. We then rescheduled the meeting.

I have seven board members appointed and would like to announce that Franklin Katschke, Public Defender, Lincoln County, has been assigned to the Board. Other members include:

- Kerry D. Lee, Sheriff, Lincoln County Sheriff's Office;
- Kevin Osten-Gardner, Psy.D., Associate Vice President of Academic Affairs and Executive Director, Adler Community Health Services, Adler University—practicing in Las Vegas and British Columbia;
- Assemblyman Gregory T. Hafen II, Assembly District 36;
- Melissa Rowe, Administrator/Chief Executive Officer (CEO), Grover C. Dils Medical Center—hospital representative;
- Stacy Smith, Chief Executive Officer, NyE Communities Coalition—drug and alcohol facility administrator representative; and
- Scott Lewis, Fire Chief, Pahrump Valley Fire and Rescue—EMS representative.

These seven board members bring a wealth of knowledge and experience, many holding over 25 years of experience in their current position.

During the August 22, 2022, board meeting, the seven board members will be voting in the six open-appointed positions with eight candidates applying for those six positions. I will have one position that remains open; we are looking for candidates to fill the private or public insurer representative position. This coordinator has requested through Medicaid to help identify a representative who covers the southern region. By pulling data, I have identified that United Healthcare Services, Inc. is one of the largest insurance providers in the southern region. The rescheduled August meeting will be held as a hybrid meeting through Zoom. Microsoft Teams is not well-supported and makes it extremely difficult and provides a lot of barriers for the board members in the southern region, so we use Zoom. The UNR extension office graciously serves as the location for those who would like to attend the board meeting in person.

The regularly scheduled recurring board meetings have been scheduled for the fourth Thursday of every month from 9 a.m. to adjournment. Our first board meeting will be held on August 22, 2022, followed by our second board meeting on Thursday,

August 25, 2022. During the second meeting, we will vote on a BDR, or the Board will decide to take the next two years to prepare for the next session. Since the Board has not been formally able to hold a meeting until next week, I will allow the Board to make that decision.

As the Southern Regional Behavioral Health Coordinator, I will be presenting the board members with the findings gathered over the last eight months in conducting needs assessments and strength, weakness, opportunity, and threat analysis within the communities I serve. This information was gathered by holding meetings with the sheriffs, undersheriffs, coalitions, and hospital CEO administrators from Mt. Grant General Hospital in Mineral County and Grover C. Dils Medical Center in Lincoln County. I also have met with my EMS, fire services, emergency directors, county managers, the statewide coordinators, school superintendents, principals, school counselors, human service directors, community stakeholders, tribal partners, and many other statewide agency partners across the state. These findings will help educate and contribute to the board members' areas of focus when determining the Board's priorities and possible BDR selection.

Some of the gaps identified have been consolidated into the Board introduction and overview document provided for the LCB and those interested to understand the important findings I have gathered (Agenda Item V D-2). The gaps include transportation access to affordable, reliable, and reimbursable nonemergency transportation to medical and behavioral health services that is accessible to the community by phone or online and appropriate to meet their real-life schedules. Access to appropriate emergency behavioral health services—that is safe for the patient and the transporter—reduces trauma, stigma, and shame; and reduces the impact on the very limited emergency services such as our sheriffs, EMS, and medical flight staff.

Another area that I will be highly discussing with the Board is the idea of increasing specialty courts across the southern region for individuals who might be experiencing severe mental illness, substance use or opioid use disorder, or co-occurring symptoms to reduce recidivism and increasing access to supportive programs and services to provide more successful and sustainable outcomes. I will also discuss increasing supportive housing services with wraparound services to include place management for individuals with SMI or also co-occurring substance use or opioid use disorders.

Behavioral health workforce is another gap identified. You have heard this is a common thread across the state, to increase behavioral health providers and workforce available to treat patients living in the rural and frontier regions across Nevada. I would like to note that I feel most of the southern region is very frontier. Also, we need to identify the process to improve licensure reciprocity for mental and behavioral health providers and increase youth access and visibility to well-defined career paths in mental and behavioral health in the public health fields.

Another area of gap became very apparent within my first few days on the job. Due to the almost three-year vacancy of this coordinator position, the community lacks the knowledge of and/or access to federal, state, and local grassroot programs and services available to our youth and elder populations who may be experiencing SMI, SUD, opioid use disorder, or co-occurring disorders, and the coordination of communication of emergency services, processes, and procedures in responding to a mental or behavioral health crisis across the southern region.

Another gap identified is: (1) the awareness, connection, and support of programs addressing youth behavioral health in schools and at home; (2) the awareness, connection,

and support for programs addressing elder behavioral health; (3) the awareness, connection, and support for new and existing programs that may support wraparound services for individuals and their family members who might be experiencing mental behavioral health challenges; and (4) increasing access to programs and services for individuals with substance use and opioid use disorders.

Another area identified as a gap—and I worked very hard in my previous position with the state, as I do in this current position—is building our tribal partnerships across the state and working with our tribal partners to identify areas of concern on tribal land. In the southern region we have the Walker River Paiute Tribe in Mineral County, the Duckwater Shoshone Tribe in northern Nye County, and the Yomba Shoshone Tribe also in northern Nye County. We need to improve access to our federal, state, and local programs and services to improve the overall health and well-being of Nevada's indigenous population.

I think we always focus on what is broken and some of the negativity, but being a positive person, I would like to draw on some of the assets and strengths across the southern region. Resiliency is number one. My frontier communities have demonstrated incredible resiliency. The NyE Communities Coalition has some drivers who have been supporting our FASTT, which encompasses, as previously mentioned, our CIT and MOST, by expanding them and trying to make them more statewide instead of regional, with standardized language, processes, and procedures.

Regarding multidisciplinary teams, with my location in the southern region, I am positioned to utilize many of our state agencies and programs both with our northern teams and our southern teams. I am supported by the southern regional MDT and also the northern MDT.

I am lucky to have several coalitions in the southern region where I have found a lot of the strength and boots on the ground. I have been able to have incredible visibility and identification of the strengths, weaknesses, and opportunities across the southern region.

Lastly, the development of the behavioral health task force, also previously mentioned, has been a priority to help bring community stakeholders to one table, to discuss and tackle the county's mental and behavioral health concerns, challenges, strengths, and priorities. I formed the Mineral County Behavioral Health Task Force and we held our first meeting. Meetings are on the first Tuesday of every month from 11:30 p.m. to 1:30 p.m. It has had incredible participation and collaboration with Shannon Ernst, Director, Social Services, Churchill County. It has provided a great avenue. I have plans to expand and develop more behavioral health task forces across my region.

I would like to thank the Chair and the members of the Committee for the opportunity to provide these updates. If you have any questions, please feel free to contact me. Thank you.

Chair Peters:

Thank you, Ms. Donohue. You have brought in a wealth of information for only being there eight months. Congratulations on pulling together your Board, and we are looking forward to seeing how you flesh things out next month and if you come up with a bill. Are there any questions from the Committee on the Southern RBHPB? I do not see any.

E. WASHOE REGIONAL BEHAVIORAL HEALTH POLICY BOARD

Chair Peters:

We will move on to the Washoe RBHPB, which is the board I serve on. Ms. Edwards is in Carson City to present on the Board. I am looking forward to everyone hearing what we are trying to do with that Board. Please introduce yourself and proceed when you are ready.

Dorothy Edwards, Washoe Regional Behavioral Health Coordinator, Washoe RBHPB:

Good morning, Madam Chair, members of the Committee, staff, and guests. I submitted a summary that provides more explanation of what I will touch on this morning (Agenda Item V E-1) (Agenda Item V E-2).

The responsibilities, as you heard, along with the criteria for board composition, are outlined in Chapter 433 of NRS, and we have a strong composition of subject matter experts. The Board is currently chaired by former Senator Julia Ratti in her current role as the Director of Programs and Projects for the Washoe County Health District. The Vice Chair is Steve Shell, who serves as the Vice President of Behavioral Health at Renown Health. Then, we are honored to have the fabulous Assemblywoman Sarah Peters as our legislator.

Each biennium, the Board works on establishing priorities and opportunities for support within the behavioral health community. Through review and analysis of behavioral health data, collaboration and outreach with our state and county behavioral health partners, locals, and a review of existing behavioral health legislation, Board members select subjects or areas that might require policy development, revision, or enhancement in the field of behavioral health. You can find a more detailed break out of the data and policy development in the annual report and the behavioral health profile that we coordinators do each year.

Developing a crisis response system has been Washoe's largest area of attention for the last several years. We know that people are experiencing challenges to mental and behavioral health daily. Additionally, COVID-19 has impacted not only the economic and physical well-being of communities, but the mental health of individuals and families across the country. A robust crisis response system ensures that every person in crisis receives the right help, at the right time, in the right place. Far too often, individuals experiencing a behavioral health crisis are transported to jail—in part due to the likelihood they will receive treatment referral more readily there than other methods—or sent to an emergency room, which is also inappropriate and creates an ethical and fiscal issue.

During this past biennium, the Washoe County Health District contracted with social entrepreneurs to support the implementation of a behavioral health crisis response system in Washoe county region—which includes Reno, Sparks, and Washoe County. This regional planning project is designing a continuum of services to stabilize and engage anyone experiencing a behavioral health emergency and link them with appropriate interventions to address the crisis. This has been an amazing collaboration because we are now experiencing collaboration and leadership at the table from city and county law enforcement, emergency responders, and other behavioral health professionals, which you do not often see. We have subject matter experts and technical advisory committees all following the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, guideline for behavioral health crisis.

A crisis response system has three prongs or legs. The first is someone to talk to and that is represented by our crisis support services call center, a call line, which is enhanced now by our 988 call center ability. Second is someone to respond. This will be a mobile response team composed of a peer and a mental health clinician and does not take the place of the higher level MOST team, which is comprised of law enforcement and a higher-level clinician when law enforcement is necessary. Most of the time we are finding that that would not be the case. Third is some place to go and that is the crisis stabilization center. This is what we are currently working to roll out at Washoe County. I could not give you a date. We spent last year on our implementation plan and now that we have perhaps identified a vendor and a location, we are hoping this next year to roll out an opening. I will keep you informed.

Another subject that we considered a priority over the last couple of years was the equitable focus on SUD. We were able to address that in our BDR from the last legislative session with SB 69 (2021). The bill addressed several areas around substance misuse.

After discussions and looking at research, the Board has identified its priorities for this year. We identified where the Board could lift and/or support policy development in compliance with the criteria outlined in Chapter 433 of NRS.

Behavioral health response before, during, and after a crisis is a priority. If we learned anything from the public health crisis, it was that we need a more robust plan and trained staff who can cope with the sometimes-overwhelming behavioral health consequences of an emergent event. You will see here the strategy for success. I was able to rewrite a draft of an emergency behavioral health plan as an annex to Washoe County's emergency plan. We are hoping to get with the state and our regional partners to do a tabletop exercise soon. We also host the ambassadors, a group of paraprofessionals who have agreed to offer their help and support. From a daily list provided by the Health District, they have reached out to individuals who have tested positive for COVID-19. I did not bring the data, but I can provide it. We have had thousands of contacts and it has been phenomenal how these ambassadors have been able to help these individuals get resources. Sometimes they do not need anything, but sometimes they need someone to talk to. I was contacted last week to see if we could provide some resources to the small handful of individuals who have tested positive with monkeypox, and we have been able to provide some assistance there as well.

Diversity and inclusion—the behavioral health needs of minority communities have been historically and disproportionately underrepresented. The Washoe Board seeks to identify and promote the effective retention strategies for prevention, treatment, and recovery support providers and providers who are or who will serve members of all minority communities.

The mental and behavioral health needs of children—while our crisis response implementation plan is for adults 18 years and older, the Washoe Board realizes the need for similar services for our youth and that children cannot be treated for behavioral health crisis in the same way as adults. We are supporting our partners who are working on advancements and participate. I participate in as many of those groups as I can, bringing forward the continued concepts and plans for children's behavioral health needs to our county leadership.

Housing and behavioral health—our crisis response center is not going to cure homelessness, but we know that chronically homeless individuals suffer from mental illness and SUDs often, so adequate housing is seen as a critical foundation to providing successful treatment.

Lastly, I want to talk about our legislative priorities over the last biennium. I mentioned the 2021 BDR, which was SB 69 and passed. Last week the Board voted on our concept. We have been all about the crisis response in our county and around our Board, so you might be surprised to hear that our BDR is focusing on a component of workforce development. It was a unanimous vote by our Board. The reality is we can have a beautiful crisis center—a nice building with all the bells and whistles. We can have policies in place and a robust plan, but if we do not have staff to address the behavioral health crisis before, during, and after, it is all for not. A waste of money and time. We realized that we must also forge ahead with pushing workforce development. We are still fleshing out the concept, but we are anxious to work with our RBHPB and any other supporters of legislation that has to do with workforce development. Our current concept will focus on increasing and retaining our behavioral health workforce through more graduate medical education slots such as psychiatry or advanced practice registered nurses (APRN), and we are looking at advancement in the other licensure areas as well. We are looking into the need for more support for the organizations and individuals who supervise residents and interns—Ms. Haskin gave us a great overview of that need. As I said, we are just now exploring. We have meetings scheduled next week. We are working with hospitals, UNR, and some of our other partners to fully flesh out the concept so we can support it to LCB by our deadline.

So that gives you an overview of what Washoe County is busy doing. I invite you to attend the meetings and reach out to me if you have any further questions. Thank you.

Chair Peters:

Thank you, Ms. Edwards; we appreciate your time here today. Are there any questions from the Committee for Ms. Edwards or any of the other presenters from the regions? I am not seeing any here.

Thank you all for sticking around. We look forward to seeing these BDRs get fleshed out and working together on them in this next legislative session. I am going to close out this agenda item.

AGENDA ITEM VI—OVERVIEW OF THE PATIENT PROTECTION COMMISSION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND ITS WORK DURING THE 2021–2022 LEGISLATIVE INTERIM

Chair Peters:

Agenda Item VI is an overview of the Patient Protection Commission (PPC), DHHS, and its work during the 2021–2022 Legislative Interim. The PPC met recently to discuss and vote on their proposed BDRs. I am looking forward to hearing what came from that meeting. Ms. Southard, please introduce yourself when you are ready and proceed.

Malinda Southard, D.C., C.P.M., Executive Director, PPC, DHHS:

Thank you, Madam Chair, and members of the Committee. Today, I will be giving you an overview of the PPC, as well as the priority focus of the PPC over the past year, the health care cost growth benchmark, and then finally, a brief overview of the three BDRs the Commission will put forward to the LCB. (Agenda Item VI).

We will start with an introduction of the PPC. First, a little background. The PPC was initially created by SB 544 in 2019. This bill was sponsored by the governor, approved by the Nevada State Legislature, and was codified to Chapter 439 ("Administration of Public

Health") of NRS. In 2021, there were a few modifications to the PPC that were approved with the passage of AB 348. These included:

- Changing the Commission's membership;
- Adding responsibilities and topics for review assigned to the PPC;
- Moving the PPC from the Office of the Governor to DHHS;
- Requiring the PPC to adopt bylaws; and
- Designating the PPC as the sole state agency responsible for managing Nevada's participation in the Peterson-Milbank Program for Sustainable Health Care Costs. We will talk more about that piece later.

The current makeup of the PPC is as follows. We have a wide variety of organizations, patient advocates, and viewpoints. We have one current vacancy on the PPC awaiting appointment from the governor. Mark Decerbo, PharmD, Associate Professor of Pharmacy Practice, Roseman University of Health Sciences, was just appointed to the PPC yesterday and will fill the PPC designated membership role for a pharmacist at a pharmacy, not affiliated with any chain of pharmacies, or a person, who has expertise and experience in advocating on behalf of patients. The one remaining vacancy is the designated voting member for a representative of the general public. We also have four ex officio nonvoting members of the Commission serving in an advisory capacity to the Commission.

The PPC's mission, vision, and values are summed up nicely in this quote from the governor, "The PPC is designated to provide a forum for all stakeholders to come to the table and work together on the critical task of improving health care access and affordability in Nevada." The recurring goal that the PPC wholeheartedly agrees on is doing what is truly best for the patient. I see this reflected in their work and recommendations in the short time I have been with the PPC, since April of this year.

As codified in NRS, the PPC is charged with systematically reviewing issues related to the health care needs of residents of Nevada and the quality, accessibility, and affordability of health care, including prescription drugs. Most notably for the primary focus of the PPC during the interim, this review includes examining the cost of health care and the primary factors impacting those costs.

Now, we will focus on some of the key activities of the PPC over the 2021–2022 Interim. A few highlights of the activities include the development and adoption of the bylaws, as was required by the passage of AB 348 (2021), as well as approval of a conflict-of-interest form for all voting members to complete.

On December 29, 2021, Executive Order 2021-29 was signed regarding the Nevada health care cost growth benchmark. This Executive Order was in conjunction with Nevada's acceptance into the Peterson-Milbank Program for Sustainable Health Care Costs, back on March 1, 2021. The PPC did not meet from June through September due to membership constraints; therefore, after the Executive Order was signed in December, the reconstituted PPC revisited this topic.

Nevada was selected as one of only five other states to participate in this program from Peterson-Milbank, and therefore, authorized to receive critical technical assistance from the Milbank Memorial Fund and Bailit Health as the PPC worked to advance the health care affordability discussion in Nevada to set and implement a health care cost growth benchmark through the authority provided in this Executive Order.

The PPC also created a stakeholder advisory subcommittee, initially developed in 2021 to advise the PPC on all matters relating to the Peterson-Milbank Program for Sustainable Health Care Costs. Since its inception, the subcommittee had 21 members, all appointed by the PPC and has truly served its purpose over the past 12 months in reviewing strategies associated with the health care cost growth benchmark.

Yesterday, the PPC voted to continue to engage stakeholders by way of an email distribution model to solicit feedback on all matters related to the Peterson-Milbank Program for Sustainable Health Care Costs and the health care cost growth benchmark, while additionally deciding to pause on formal meetings of the subcommittee until a later date. This stakeholder email distribution will be all-encompassing, in that it will include the 21-member stakeholder advisory subcommittee as was originally approved in 2021, with the addition of the newly suggested members as noted during both the July and August Commission meetings. The stakeholders will continually be asked to give input either verbally or in writing during the PPC public meetings to ensure active continued communication and engagement between stakeholders and the Commission.

The work associated with the Peterson-Milbank Program for Sustainable Health Care Costs has been the primary focus of the PPC over the interim. The technical assistance awarded to Nevada and associated with this program will currently expire after December 31, 2022, however, the work will continue. The cost growth benchmark is one of the first steps in helping to make health care more affordable and transparent in Nevada. To support the statewide effort with the Peterson-Milbank program, Governor Steve Sisolak requested assistance from the PPC to provide recommendations specifically to: (1) develop a statewide health care cost growth benchmark; (2) calculate and analyze statewide health care cost growth; and (3) to analyze the drivers of health care cost growth. Per this request, the PPC has been hard at work with Peterson-Milbank and Bailit Health to provide these three recommendations to the governor.

What is the *health care cost growth benchmark*? The official definition is that it is "an annual rate of growth benchmark for health care costs in a given state." I also provided some national statistics. Between 2015 and 2019, the average per capita health care cost growth was 4.1 percent. For those same years, the per capita gross domestic profit (GDP), or measure of a state's business growth, was only 3.5 percent, and the average hourly wage growth was only 2.6 percent. Between 2015 and 2019, health care expenditures grew faster than businesses were growing and faster than wages were growing. Some key points to keep in mind about a health care cost growth benchmark are setting a public benchmark for a health care spending growth alone will not slow the rate of growth. A cost growth benchmark serves as an anchor, establishing an expectation that can serve as the basis for transparency at the state, insurer, and provider levels. The cost growth benchmark is a support strategy to help ensure costs do not rise faster than the economy, state revenues, or wages. To be effective it must be complemented by supporting strategies, and a cost growth benchmark is not a price control.

I would like to share with you the visual model associated with explaining what a cost growth benchmark is and the alignment with the focus and activities of the PPC over the interim. First, we start with measuring. We must first measure performance relative to the anchor or the benchmark. Next, we analyze. We see that our performance either falls above or below the benchmark for a given year. Now, let us do a deeper dive into that data to find out why. What specific factors relative to health care costs are driving those costs higher or lower in a given category. After the analysis phase is complete, we then report on the findings. Here is what we found out as to what specific factors are driving up health care costs in the state. It is also important to note that the findings will be shared with the health care and insurer industry prior to being publicly released so the industry can additionally

validate the findings for accuracy and be well-poised for public release of the report. After reporting out on the analysis, we would then have conversations within health care industry experts in Nevada to identify those opportunities and potential strategies to help slow health care cost growth in the state in a collaborative and effective way. Lastly, we work together with our partners to implement those cost growth strategies.

A few points to highlight around Executive Order 2021-29 are that this executive order established the health care cost growth benchmark for years 2022 through 2026 and set a benchmark of 3.19 percent cost growth for year 2022 when compared to prior years spend. The intent is to help curb those climbing health care costs.

Since this work has been the primary focus of the PPC over the interim, I would like to further highlight some recent PPC activities regarding the benchmark. The PPC previously requested an analysis of both state Medicaid and Nevada's Public Employees' Benefits Program (PEBP) health care spending data, and PEBP was being used as a proxy for the commercial market for the years 2016 through 2020. This data was presented at the monthly PPC meeting on April 20, 2022, which is archived on the PPC website. The cost growth benchmark program will assess health care cost growth for all Nevada residents with commercial—both insured and self-insured—Medicaid and Medicare coverage, or who receive health care through the Veterans Health Administration, U.S. Department of Veterans Affairs, and the state correctional system. Health care cost growth at the state level is measured using total health care expenditures, which include claims spending, nonclaim space spending, consumer cost sharing, and insurer administrative costs. It is really meant to be that all-inclusive look at health care expenditures.

Finally, I would like to present to you a brief overview of the PPC's final three BDR concepts for the 2023 Legislative Session. First, a brief background—NRS 218D.213 authorizes the PPC to request the drafting of not more than three legislative measures which relate to matters within the scope of the Commission. Since March, the PPC has been having a more focused discussion on potential BDR topics for the 2023 Session. A total of 16 topics were initially brought forward for consideration, which truly is an impressive number for such a young commission. With one topic being withdrawn, a total of 15 topics have been up for consideration for a few months now. After much deliberation and discussion, the PPC has reached a consensus on its final three BDRs in support of the charge of the PPC. While I will be providing you a brief overview of these topics today, I look forward to a much greater in-depth analysis and detailed description to present to you on these topics officially during the 2023 Session. Today, I will only be providing a very brief statement of each BDR.

The first PPC BDR is to codify the Nevada health care cost growth benchmark program as set forth in Executive Order 2021-29 and include a requirement to measure and report on primary care spending.

The second PPC BDR is to mandate that all providers of health care and custodians of health care records implement an interoperable electronic health care record system, expand immunity for provider compliance with providing and receiving electronic medical records, and revise NRS 439.584 with relation to health information exchange and other areas identified.

The third and final PPC BDR is to address the rising costs created by health care market consolidation by prohibiting hospitals and possibly some other facilities, such as freestanding emergency rooms, from hiring physicians and revise these exemptions now in law to ensure that only public hospitals and academic institutions are exempted.

I also want to present for your consideration two topics that were not chosen for final BDRs from the PPC but have the full support and recommendation from the PPC as equally valuable topics. One being to request a study, to be completed by an experienced vendor, to determine different strategies and design decisions for a health insurance program for infants, children, and young adults up to age 26, who are ineligible for full Medicaid coverage under federal law due to their current residency or immigration status; to outline coverage options that are primarily state-funded; and to conduct a return-on-investment study of at least two options selected by the PPC to inform future proposals and budget requests as they relate to addressing the growth of health care costs related to the health status of this population. The PPC must procure a vendor to complete that analysis at no greater than $200,000. With this item, I would like to note that the PPC voted yesterday to add this topic as a budgetary consideration for DHHS's PPC budget proposal for the next biennium as an alternative approach to a BDR. However, the PPC would also like to put this item forward in a letter to the Legislature noting full recommendation and support of the PPC for this topic being put forward during the 2023 Session.

The other topic being recommended by the PPC for consideration is to create a prescription drug affordability board and to expand on NRS 439B.630 to set allowable rates for certain high-cost drugs identified by the board. Additionally, of note for this item, the PPC also voted yesterday to include this topic in a letter to the Legislature noting the full recommendation and support of the PPC for this topic being put forward during the 2023 Session. I will be drafting the document and posting for consideration, approval, and signature of the PPC anticipated during the September meeting.

That is all for my presentation today and I thank the Committee for inviting me here for this informational item. I would welcome any questions at this time.

Chair Peters:

Thank you for the presentation. I am excited about these options you have come up with and looking forward to hearing more about how they flesh out. Are there any questions from the Committee on these BDR recommendations from the PPC? Please go ahead.

Assemblywoman Titus:

You have perked my interest in your potential three BDRs. I want to hear more about them because of the potential positive, but also significant negative impact they may bring forward—especially the concept of the electronic medical records and communications. As a primary care provider, we were mandated to go to electronic medical records, but we were not mandated that they communicate with each other, and everybody started their own medical records. It really has been a problem. Unfortunately, the cost of that to the providers has been tremendous. I am concerned that although it may be well-intended, it may have a significant negative impact. As that particular BDR moves forward, I would love to have more information as you and your Commission meet. I appreciate what you are trying to do, but again, sometimes the pathway paved by good intentions, and I have concerns. I would appreciate some follow-up on that BDR as it moves forward.

I am also somewhat concerned about your other BDR drafts and would love to be involved as you meet in September to sort some of this out. Are those the three potential BDRs you are going with or will you be considering others?

Ms. Southard:

The three BDRs I presented today will be the three BDRs the Commission has decided to put forward to the Legislature.

Assemblywoman Titus:

You are going to send those BDRs, but obviously the language has not been developed at this point in time and is just conceptual. I would like to be able to support them, so if it is possible, it would help me if I know what is in them before they are submitted as final drafts to the Legislature; that way, I am not testifying against them when I am in the Senate. I appreciate your reaching out.

Ms. Southard:

I am absolutely willing to work and communicate with you as we move forward.

Chair Peters:

It is an important point to make that these BDR recommendations are conceptual at this point, and they are getting fleshed out through the research and development process up until they are introduced in session. Then we still have the entire session with stakeholders working together prior to and beyond the initial hearings and voting on these bills in both houses. The process is not complete, and it is just the beginning of a vast process getting these BDRs into law.

Thank you for your presentation. I do not see any additional comments. We look forward to seeing these fleshed out and receiving some of those letters you mentioned. I will close out the last of our presentations.

AGENDA ITEM VII—WORK SESSION—DISCUSSION AND POSSIBLE ACTION ON RECOMMENDATIONS RELATING TO:

Chair Peters:

I will open Agenda Item VII, which is our work session. Everyone has the WSD (Agenda Item VII) in front of you, and we have had some suggestions on language changes that we will discuss as we proceed.

Senator Hardy:

Madam Chair, as I understand it, the WSD is dealing with BDRs and then regulations, is that right? Or are they just BDRs?

Chair Peters:

All of these are BDR work session recommendations and we have a couple of letters, but those are separate from the BDR recommendations.

Senator Hardy:

Do we need to be fussy about the verbiage of the BDR recommendations since we know they are going to be debated, discussed, and dissected during the session? Are we going to spend a lot of time on that or are we going to send them on?

Chair Peters:

In most cases, I would say the same thing. I have asked staff for their input on the importance of some of these language changes that have been suggested. The Joint Interim Standing Committee on Judiciary adopted a measure that was included in one of our BDRs, so we will remove that piece before we adopt our BDR recommendation. There is a language change that creates a significant change with *certified* versus leaving out *certified* in Recommendation K for CHWs. If we do not include *certified* in this BDR draft language, we may be looking at some significant fiscal notes. We will change that. Then, we happen to have one extra BDR, so I was going to ask to split one of these out. We have a couple of things to go over, not any big modifications to language, but just some things to clean these up before we hand them over to the drafting process.

Members, the WSD is posted on the Committee's meeting page, and there are hard copies on the tables in the committee rooms. It contains a list of proposed recommendations related to child welfare, the COVID-19 health crisis interim study, and multiple other matters in the purview of our Committee.

I want to thank everybody who has brought recommendations to the Committee in your presentations and has worked with us on the substantial issues in our state, including the significant discussion around behavioral health and the needs for both our adult and children's communities.

I am going to ask Mr. Ashton to walk us through the document. We will go one by one through each of these, and I will ask for motions as we go. Mr. Ashton, please proceed.

Patrick B. Ashton, Principal Policy Analyst, Research Division, LCB:

As nonpartisan staff I can neither advocate nor oppose any measures that you will consider today.

The Chair and LCB staff of the Joint Interim Standing Committee on Health and Human Services (HHS) prepared this WSD to assist the Committee in determining which legislative measures it may request for the 2023 Legislative Session (Agenda Item VII). Committee staff compiled and organized the proposals so that Committee members may review them and decide whether they want to accept, reject, modify, or take no action on the recommendations. The document groups the proposals by topic, and they are not preferentially ordered.

The HHS Committee may request up to 15 BDRs that relate to matters within the scope of the Committee. The Committee may choose to recommend any of the following actions: (1) draft legislation to amend NRS; (2) draft a resolution; (3) draft a letter; or (4) include a policy statement of support in the Committee's final report. It should also be noted that any potential recommendations listed may or may not have a fiscal impact. Any potential fiscal impacts have not been determined by staff at this time.

Madam Chair, may I proceed with Recommendation A?

Chair Peters:

Please go ahead.

A. COMMERCIALLY SEXUALLY EXPLOITED CHILDREN

Mr. Ashton:

We will begin with Recommendation A regarding commercially sexually exploited children (CSEC), which you can find on page 2 of the WSD. This recommendation was proposed by Brigid Duffy, Chief Deputy District Attorney, Director, Juvenile Division, Clark County Office of the District Attorney, during the April 21, 2022, HHS meeting. The recommendation is to request a BDR to:

1. Require training for teachers, administrators, and individuals working in the child welfare and juvenile justice systems to identify and assist children who are commercially sexually exploited or are at risk of being commercially sexually exploited;

2. Require all child welfare and juvenile justice agencies to use evidence-based screening methods for children in their care;

3. Revise Chapter 432C ("Protection of Children from Sexual Exploitation") of NRS to allow the formation of multidisciplinary review teams for CSEC. An agency of a local governmental entity may appoint and organize one or more multidisciplinary teams to review the cases of children who are victims or survivors of sex trafficking and exploitation (for Item 3, see also suggested language in Attachment A-3 of the WSD);

4. Establish a statewide executive committee within the DCFS to evaluate the cases of children who are commercially sexually exploited; and

5. Enhance and streamline stronger safe harbor statutes for CSEC by adding crimes of trespass, minor in a gaming establishment, obstructing an officer, and possession of false identification. Stakeholders indicated these misdemeanor offenses are more likely to bring victims of commercial sexual exploitation to the attention of law enforcement.

Chair Peters and Committee members, I want to note that last Friday the Joint Interim Standing Committee on Judiciary voted to draft legislation that is similar in its request to Item 2 of this CSEC recommendation, which is the requirement to use CSEC screening methods. If you want to move forward with this BDR recommendation, you may want to exclude Item 2 since it will be drafted and introduced as a separate BDR for the upcoming 2023 Legislative Session. Thereby, you would avoid a duplication of efforts.

Chair Peters:

Thank you, Mr. Ashton. I want to reiterate that this is not the forum for debate on these bills. These are not bills, these are BDR ideas so if you have questions to the ideas, we have experts in the room. Are there any questions from the Committee?

SENATOR HARDY MOVED TO APPROVE RECOMMENDATIONS A (1), (3), (4), AND (5).

VICE CHAIR DOÑATE SECONDED THE MOTION.

Chair Peters:

Is there any discussion on the motion?

Assemblywoman Titus:

I am going to support it to get it out of this work session, with the caveat that the ultimate final BDR I may not be able to support until I see it.

Chair Peters:

Thank you, I appreciate that as always. This is not a commitment to a vote during session. I appreciate your discretion and appreciate you helping us move this forward.

THE MOTION PASSED UNANIMOUSLY.

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B. HOMELESS YOUTH AND YOUNG ADULTS UNDER 25 YEARS OF AGE WHO ARE EXPERIENCING HOMELESSNESS

Mr. Ashton:

Next is Recommendation B on homeless youth and young adults under 25 years of age who are experiencing homelessness, which you can find on pages 2 and 3 of the WSD. This recommendation was developed by Chair Peters in consultation with Committee staff in response to testimony provided by Trevor Macaluso, Chief Executive Officer, Eddy House, at the April 21, 2022, HHS meeting. The recommendation is to request a BDR to:

1. Ease requirements for homeless youth and young adults under 25 years of age who are experiencing homelessness to obtain essential documents as follows:

    a. Revise Chapter 440 ("Vital Statistics") of NRS to provide a minimum of 30 days during the application process for a certified copy of a birth certificate to show proof of all necessary documents required for birth certificates of homeless persons, including, without limitation, a homeless child or young adult under 25 years of age who is experiencing homelessness;

    b. Remove the requirement to show proof of a Social Security number of a homeless youth or young adult under 25 years of age who is experiencing homelessness when applying for a state identification card;

    c. Authorize school identification cards as an alternative method to show proof of identity when applying for a state identification card with certain conditions;

    d. Waive any costs associated with receiving a state identification card for a homeless youth or young adult under 25 years of age who is experiencing homelessness; and

    e. Authorize DWSS to assist with the issuance of a state identification card. The Division shall collaborate with the Department of Motor Vehicles to facilitate this additional outreach service.

Now moving on to Item 2 of this BDR recommendation.

2. Require a county, with a population of 100,000 or more residents, to develop a strategic plan to address homelessness by the respective governing bodies of the

county and the cities within the county. The strategic plan shall contain the subitems A through E as outlined on page 3 of the WSD.

Each such county shall develop a strategic plan on homelessness and present it to the Joint Interim Standing Committee on HHS next legislative interim.

Chair Peters:

Are there any questions from the Committee regarding this recommendation?

Senator Hardy:

I move to approve this as a BDR and as much as it is a committee BDR, recognize that we are not held to what is actually going to be in the verbiage nor are we held to that we are actually going to support it during the next legislative session. Obviously, my motion will include it to be a BDR which will be discussed, debated, and dissected during the session.

Chair Peters:

Thank you. Is there any other discussion? Seeing none.

SENATOR HARDY MOVED TO APPROVE RECOMMENDATIONS B-1 and B-2.

VICE CHAIR DOÑATE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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C. BEHAVIORAL HEALTH CARE

Mr. Ashton:

We are moving to Recommendation C, behavioral health care, on pages 4 and 5 of the WSD. This recommendation was developed by Chair Peters in consultation with Committee and DHHS staff in response to various testimony at the March 24, 2022, HHS meeting.

There are two items under this recommendation for a BDR. The first item relates to regulatory clinical oversight of behavioral health care, specifically:

1. Require DCFS and DPBH to each formulate and operate a comprehensive state plan for behavioral health clinical standards of care for children and adults;

2. Require each Division to coordinate the efforts to carry out its state plan and coordinate all state and federal financial support for behavioral health services in Nevada;

3. Require a behavioral health care provider to consult and advise with either Division in the planning of projects and all applications for grants from within this state, which are concerned with programs for behavioral health treatment. Either Division shall review the applications and advise the applicants concerning the applications;

4. Require each Division to certify or deny the certification of behavioral health care programs based on the standards established by either DCFS, if relating to programs

treating children, or the State Board of Health if relating to programs for adults. Any behavioral health care providers, facilities, or programs that are not certified shall be ineligible to receive state and federal money for programs for behavioral health treatment; and

5. Require DCFS and the State Board of Health to adopt regulations that prescribe the clinical care standards for behavioral health treatment providers for children and adults, respectively.

The second item under this BDR recommendation relates to cost savings reinvestment in children's behavioral health system of care. The BDR would:

6. Define the children's behavioral health system of care as outlined in subitems A and B of Item 6 on page 4 of the WSD;

7. Require the Commission on Behavioral Health, DPBH, DHHS, to track the spending of federal funding in the children's behavioral health system of care to account for costs avoided across the child-serving systems within DHHS;

8. Require DHHS to establish an evidence-based methodology to quantify averted expenses;

9. Establish authority within the Commission on Behavioral Health to provide oversight for the use of the funding for the purposes of reinvesting those funds in the children's behavioral health system of care in accordance with best practices; and

10. Require the Commission on Behavioral Health to prepare and submit a report for the governor, the director of DHHS, and the director of the LCB by August 1 of every even-numbered year preceding the next regular legislative session. This report shall include:

    a. The projected amount of costs avoided by the state for the next biennium; and

    b. Recommendations to the Senate Committee on Finance and the Assembly Committee on Ways and Means for the reinvestment of those cost savings.

Chair Peters; Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, DPBH, DHHS; and Cindy Pitlock, D.N.P., A.P.R.N., C.N.M., Administrator, DCFS, DHHS, are available for questions.

Chair Peters:

Are there any questions from the Committee? Seeing none, I would entertain a motion to approve Recommendation C. Is there any discussion on the motion? Seeing none.

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATIONS C-1 THROUGH C-10.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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Chair Peters:

Thank you. This is a big lift, but I am very excited for the future of Nevada's behavioral health systems.

D. QUALIFIED RESIDENTIAL TREATMENT PROGRAMS

Chair Peters:

Mr. Ashton, please proceed with BDR Recommendation D.

Mr. Ashton:

Thank you, Madam Chair. Now we are moving to Recommendation D, QRTPs on page 5 of the WSD. This recommendation was proposed by Joanna Jacob, Government Affairs Manager, Clark County. This recommendation also relates to testimony provided by Domonique Rice, Ph.D., M.S., B.S., Deputy Administrator of Quality and Oversight, DCFS, DHHS, on the Family First Prevention Services Act of 2017 (H.R. 253 of the 115th Congress) at the April 21, 2022, HHS meeting. The recommendation is to request a BDR to:

1. Revise the definition of "childcare institution" in NRS 432A.0245 to include QRTPs pursuant to the Family First Prevention Services Act. The QRTPs should be able to provide services for up to 25 children, different from a childcare institution, which provides services to 16 or more children.

We have Ms. Jacob present, as well as several representatives from DHHS, to answer questions.

Chair Peters:

Are there any questions from the Committee? Seeing none, I would entertain a motion to approve the recommendation. Any questions on the motion?

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION D-1.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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E. FETAL ALCOHOL SPECTRUM DISORDERS

Mr. Ashton:

Recommendation E is on fetal alcohol spectrum disorders (FASD), which you can find on pages 5 and 6 of the WSD. This recommendation was proposed by the Grant a Gift Autism Foundation, Children's Advocacy Alliance, and the Nevada Chapter of the American Academy of Pediatrics during the solicitation of recommendations period.

The recommendation is to request a BDR to:

1. Add “fetal alcohol spectrum disorder” to the definition of “developmental disability” set forth in NRS 435.007; and

2. Revise NRS 442.003 to read “fetal alcohol spectrum disorder” instead of "fetal alcohol syndrome" and make corresponding changes throughout NRS.

Committee members, we have several representatives present from the entities that made this recommendation, as well as DHHS subject matter experts. The WSD also contains a brief intent of this recommendation.

Chair Peters:

Thank you, Mr. Ashton. Are there any questions from the Committee? Seeing none, I would entertain a motion to approve the recommendation. Are there any questions on the motion?

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION E-1 and E-2.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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F. SCHOOL-BASED HEALTH CENTERS

Chair Peters:

We will move on to BDR Recommendation F.

Mr. Ashton:

Recommendation F is on school-based health centers (SBHC) on pages 6 and 7 of the WSD. This recommendation was developed by Chair Peters in consultation with Committee and DHHS staff.

The recommendation is to request a BDR to:

1. Require Nevada Medicaid and Nevada’s Department of Education (NDE) to collaborate on a study to:

    a. Review standards of care and evaluate opportunities to reduce the complexity of certification through DPBH;

    b. Evaluate the need for an on-site laboratory;

    c. Review the requirement for school board approval if the SBHC is near a school and not on school grounds;

    d. Review Medicaid reimbursement rates;

    e. Consider opportunities to incentivize SBHCs; and

    f. Submit the study’s findings and recommendations to the Joint Interim Standing Committee on Health and Human Services by December 31, 2023.

2. Require DHHS to develop a resource office to help providers with the certification, Medicaid enrollment, and billing for school health services and certified SBHCs or other alternatives, such as a satellite clinic for those currently able to bill Medicaid through physician provider types; and

3. Ensure SBHCs are enrolled in Medicaid managed care provider networks by requiring Medicaid managed care organizations to contract with all SBHCs by designating the school-based health clinics as essential community providers for the Medicaid managed care program.

Chair Peters and Committee members, we have several subject matter experts from DHHS present in case you have any questions.

Chair Peters:

Thank you, Mr. Ashton. Are there any questions from the Committee on Recommendation F?

Assemblywoman Titus:

I do have some questions on this one.

Chair Peters:

Please go ahead.

Assemblywoman Titus:

I take it SBHCs already exist, correct?

Chair Peters:

That is correct.

Assemblywoman Titus:

Then, clarify the issue about the requirement for school boards having to authorize these if they are not on school grounds. Is that already existing? Has there been an issue there?

Chair Peters:

The point of this study is to review the requirement for a school board to approve. How much of an issue that is today is not clear, but it is important to assess it as a potential barrier to access off-campus SBHCs, which essentially would be community health centers.

Assemblywoman Titus:

Thank you for the clarification. Do we know if there are any regulations from the 17 county school boards that limit them off campus?

Chair Peters:

Do we have someone on the line who could speak to the existing regulations?

Senator Hardy:

While you are waiting Madam Chair, can I say something?

Chair Peters:

Please go ahead.

Senator Hardy:

Obviously, the SBHC must have all sorts of things to be able to qualify for Medicaid reimbursement, as well as the provider. The study, as I see it, is putting together what it would take to have either an on-site or off-site providership and provider to qualify for Medicaid reimbursement, which is problematic. I am sure somebody has done it somewhere, but it is something that would be a new creature, as I understand it. It could have a lot of hoops to jump through, and I think this study is trying to figure out what those hoops are so they could do it. I do not think that all school boards are going to be able to adjust to it, but I think that is why we study it.

Chair Peters:

Thank you. We have Ms. Ives with DPBH willing to jump in on this one. Please proceed.

Vickie S. Ives, M.A., Deputy Bureau Chief, Bureau of Child, Family, and Community Wellness, DPBH, DHHS:

There is nothing in the certification process with DPBH that speaks specifically to any regulations related to the school districts. I do know that NDE has folks on as well who might want to speak to that piece, but there is nothing intrinsic to the certification process on DPBH's side that creates a barrier, nor have we been identified of that specific barrier.

Chair Peters:

I want to be clear on the point of a study, Dr. Titus. We have this ability to pull together SBHCs. It exists. We do not have very many, and it seems like low-hanging fruit for access to children and their families on creating relationships with primary care providers and other providers. We have private partners such as communities and schools—and I think Family First Services in Las Vegas does this as well—where they act as care managers and coordinators for kids in schools. We are already trying to piece parts of this together. This BDR is trying to pull everyone into the same room to talk about how it works on the ground, what works for everybody and what does not, and how we can make sure that we are getting kids the care we can where they are because school is mandated in schools.

Assemblywoman Titus:

I do appreciate the concept, but do we need a law or bill to address this or is it something we can do outside that scope, perhaps through the DHCFP? It sounds like this is forcing folks to communicate with each other and sometimes that is what our job is, making this thing happen. I am supportive of the concept.

The next question I had was on Item 3, which was ensuring they are enrolled in Medicaid managed care provider networks. Certainly, out in the rurals, many areas or hospitals are fee-for-service, and mandating that they are enrolled in Medicaid will be an interesting concept, especially in the managed care provider networks. I will be interested to see how

this progresses and how that communication happens and some of the information we get for it. Certainly, I can support the conceptual bill draft.

Chair Peters:

You are asking a lot of the questions that will have to be fleshed out before session. I look forward to continuing to talk about the different needs of the communities.

I will entertain a motion to approve the recommendation. Is there any discussion on the motion before we vote? Seeing none.

> VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATIONS F-1 THROUGH F-3.
>
> SENATOR HARDY SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

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G. LICENSING OF PHARMACEUTICAL SALES REPRESENTATIVES

Chair Peters:

We will move on to BDR Recommendation G.

Mr. Ashton:

Recommendation G regarding the licensing of pharmaceutical sales representatives is on page 7 of the WSD. This recommendation was developed by Chair Peters in consultation with Committee staff in response to testimony provided by DHHS staff of the Pharmaceutical Drug Pricing Transparency Program at the July 21, 2022, HHS meeting. The recommendation is to request a BDR to:

1. Require DHHS to license and regulate pharmaceutical sales representatives who are operating within the state. Any fees collected from the licensure of pharmaceutical sales representation: (1) shall be accounted for separately in the State General Fund; (2) shall be used only to cover the costs of licensing and regulating pharmaceutical sales representatives and for the purposes of improving transparency concerning the costs of prescription drugs; and (3) do not revert to the State General Fund at the end of any fiscal year.

This BDR would be essentially a redraft from Reprint 1 of SB 201 (2021), which did not pass during the 2021 Legislative Session.

Chair Peters:

Are there any questions on this recommendation? Seeing none. I will entertain a motion. Is there any discussion on the motion? Seeing none.

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION G-1.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYWOMAN TITUS VOTED NO.)

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H. LICENSING AND REGULATION OF PHARMACY BENEFIT MANAGERS

Chair Peters:

We will move on to BDR Recommendation H.

Mr. Ashton:

Recommendation H in the WSD is on page 7 and relates to the licensing and regulation of pharmacy benefit managers (PBMs). This recommendation was developed by Chair Peters in consultation with Committee staff in response to testimony provided by DHHS staff of the Pharmaceutical Drug Pricing Transparency Program at the July 21, 2022, HHS meeting. The recommendation is to request a BDR to:

1. Require a PBM operating within the state to obtain a license from DHHS;
2. Prohibit a PBM from using spread pricing and specify that a PBM shall agree to only enter into contracts with third-party payers that are fully transparent to the contractual parties, including, but not limited to, the disclosure of all rebates, discounts, product pricing incentives, and fees collected by a PBM. The PBM's only source of income shall be from disclosed administration fees for services. All manufacturer discounts, product pricing incentives, and fees collected by a PBM must be reimbursed to the third-party payer and rebates must be passed down to patients;

3. Require a PBM to allow a client full audit rights, including, but not limited to, pharmacy claims, rebates, and similar information needed to assure compliance;

4. Establish a fiduciary responsibility for a PBM to a third-party payer. The benefit of the payer is the primary and sole interest of the fiduciary, and any conflict with that role must be disclosed and avoided; and

5. Prohibit PBMs, Medicaid managed care plans, Medicare Part D plans—including Medicare Advantage Part D plans and private health insurers, to the extent authorized under federal law—from reimbursing less for prescription drugs because they were purchased under the federal 340B Drug Pricing Program, which is also called "discriminatory contracting" (see Attachment H-5 in the WSD).

Committee members, this BDR would be a redraft of SB 392 (2021), which did not pass during the 2021 Legislative Session. The exception is Item 5 of this recommendation, and you can find background information, as already mentioned, in Attachment H-5 of the WSD. We have again Beth Slamowitz, PharmD, Senior Policy Advisor on Pharmacy, DHHS, as the subject matter expert, as well as representatives from the Nevada Primary Care Association to respond to any questions you may have.

Chair Peters:

Are there any questions from Committee members on this recommendation? Dr. Titus, please go ahead.

Assemblywoman Titus:

Thank you for bringing this forward, I think it is something we do need to address. There are several states that have passed these laws and other states where the laws were presented but did not pass. Do we have any idea what we are being encouraged to model? California's did not pass. Arizona passed a program that may or may not work in Nevada. There are some other states out there; are we going to mirror any other states?

Chair Peters:

I am going to ask Mr. Robbins to talk about how the bill was initially drafted since this is pulling in a bill from last session.

Mr. Robbins:

Basically, under current law, PBMs are licensed or certified. I do not remember off the top of my head what the credential is, but they must go through some sort of registration process with the Division of Insurance (DOI), Department of Business and Industry. Senate Bill 392 (2021) proposed to take that out, while still leaving all the provisions that currently apply to PBMs as administrators and basically reenacting them into a different chapter of NRS and having them be licensed by DHHS rather than DOI.

Then, it added some of these additional provisions about prohibiting spread pricing, requiring a PBM to allow a client full audit rights, and establishing a fiduciary responsibility. Currently, a PBM has a duty of good faith and fair dealing; the BDR would change that verbiage a little bit. There is not a model from other states. It is just trying to keep what we have in existing law regarding their licensure as insurance administrators and shifting that process over to DHHS rather than DOI.

Chair Peters:

Are there any other questions from the Committee on this recommendation? Seeing none, I would entertain a motion.

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATIONS H-1 THROUGH H-5.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Chair Peters:

Any discussion on the motion before we vote?

Senator Hardy:

I am going to take the privilege of voting no on something as this may be my last chance.

Assemblywoman Titus:

I am going to support this until we see how it is drafted. Again, we will have to continue the discussion further down the line, but I will support this today.

THE MOTION PASSED. (SENATOR HARDY VOTED NO.)

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I. MEDICAID COVERAGE FOR INTEGRATED CARE MODELS THAT COMBINE GENERAL MEDICAL WITH BEHAVIORAL HEALTH CARE SERVICES

Chair Peters:

We will go ahead and move on to BDR Recommendation I.

Mr. Ashton:

Recommendation I relates to Medicaid coverage for integrated care models that combine general medical with behavioral health care services, which you can find on page 8 of the WSD.

The recommendation was developed by Chair Peters in consultation with Committee staff in response to testimony provided by various stakeholders at the February 17 and May 19, 2022, HHS meetings. This recommendation was also recommended by Belz & Case Government Affairs representing Shatterproof and on behalf of the Nevada Collaborative Care Model Coalition. The recommendation is to request the drafting of a legislative measure to:

1. Amend the state plan for Medicaid by adding a coverage requirement for mental/behavioral health and substance use services that are delivered through evidence-based, integrated behavioral health care models, such as the collaborative care model.

Members, we have DHHS representatives and subject matter experts from the entities who submitted this recommendation present to respond to any questions you may have.

Chair Peters:

Are there any questions from the Committee on this recommendation? Seeing none, I would entertain a motion.

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION I-1.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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J. MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDER

Chair Peters:

We are going to move to BDR Recommendation J.

Mr. Ashton:

Recommendation J is on medication-assisted treatment for SUD, and you can find this recommendation on pages 8 and 9 of the WSD. It was developed by Chair Peters in consultation with Committee staff in response to testimony provided by various stakeholders at the February 17, 2022, HHS meeting. The recommendation is to request a BDR to:

1. Require any health care provider who is authorized to make a diagnosis of opioid use disorder to provide information and counseling on evidence-based treatment options, including controlled substances used for medication-assisted treatment of opioid use disorders approved by the U.S. Food and Drug Administration (FDA), to a patient the provider has diagnosed with an opioid use disorder;

2. Require the health care provider to prescribe an FDA-approved medication for the treatment of an opioid use disorder at the patient's request as long as such a medication has no contraindications for the patient. If the health care provider cannot prescribe such medication, he or she must refer the patient for treatment to a provider that is authorized to prescribe such medication;

3. Require all behavioral health care providers in the state to prioritize SUD treatment funded by federal or state money according to the priority populations of the federal Substance Abuse Prevention and Treatment Block Grant, administered by SAMHSA; and

4. Require all jails and state prisons to offer medication-assisted treatment for inmates diagnosed with opioid use disorder in the same manner and to the same extent as other forms of health care, and prohibit jails and prisons from discriminating against medication-assisted treatment in favor of other forms of treatment or abstinence without treatment. If a person is incarcerated in a jail or transferred from a jail to a prison and has already received medication-assisted treatment, the jail or prison must facilitate the continuation of this treatment. The jail or prison must also take reasonable measures to facilitate continuation of medication-assisted treatment upon release.

Members, we have Dr. Woodard from DHHS present to respond to any questions you may have.

Chair Peters:

It was brought to my attention yesterday that some of this language in Item 2 did not get directly to the point and purpose. Assemblyman Orentlicher has been working to address that language. Would you like to present your suggested revision, Assemblyman Orentlicher?

Assemblyman Orentlicher:

Yes, thank you. Rather than saying "a physician has to provide upon the request of the patient," I think it would work better to say, "for patients for whom medication-assisted treatment is indicated, the providers should offer the treatment or refer the patient to another provider who can offer the care." We want to make sure that patients have better access and appropriate access but mandating a prescriber to offer treatment would be problematic in some ways.

Chair Peters:

Thank you. That does get to the intent of this BDR recommendation as we worked on it. Are there any questions on the BDR recommendation as presented? Assemblywoman Titus.

Assemblywoman Titus:

Thank you for that clarification on Item 2 because I had real concerns that we "must" do something. I feel this state has been actively and aggressively going at opioid addiction for a number of years now. At least since 2015, in my first session, there have been rules and rightfully so. Our opioid addiction and overdoses are incredibly high and frequently not addressed, but I think we have done a good job recognizing the provider component of that and regulating providers, prescription plans, et cetera.

To add more regulations when we have seen and had testimony in this very Committee, and despite all of that we, as providers, have done a better job. We are not prescribing the medication as we have in the past. The state was successfully involved in a lawsuit to the drug companies to prevent the drug company's implications and the provider's implications. We have all stepped up, yet we are still seeing a dramatic increase of opioid deaths.

We all know where the drugs are coming from illegally, that is the real problem, and we are not addressing that in any of these BDRs. I am frustrated that this is the opioid BDR that we are coming up with. I cannot support yet more regulations on health care providers when what we have done has been excellent and it still has not affected the outcomes that I can see. I certainly appreciate the Dr. Orentlicher's addition and clarification about mandates and I am just very concerned. I know the intent. I know we still see huge numbers, but I am not sure this is a solution.

Chair Peters:

Thank you. Senator Hardy.

Senator Hardy:

I am going to echo what the other doctors are saying and add to it. When we require medication-assisted treatment that includes methadone, methadone may be more problematic in some jails or prisons than it is in others.

Sometimes we have a therapeutic discharge when we are dealing with somebody who is using or abusing, and when we start to say you have to do something, it overrides the medical judgment. It is a dangerous position for us to be in, and certainly for the physician who may find himself or herself in the very difficult position to have a defense. I would be opposed to this as it is written.

Chair Peters:

Thank you, both, for your concerns. I am going to ask if Dr. Woodard can talk about the intent of this bill. It is not intended to direct folks who are already providing this kind of opioid treatment service to do more, but it is more intended to address the community's understanding of the access to treatment. Dr. Woodard, please go ahead and explain a little more about the intent.

Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, DPBH, DHHS:

Chair, you are correct. I would like to go back to Assemblyman Orentlicher's comments. The intent here is very similar to some of the language that was added in AB 474 (2017) and the Controlled Substance Abuse Prevention Act. The goal would be to preserve the patient and prescriber relationship. In my opinion, there should never be the mandate in law to mandate the practice of medicine. The goal here is to ensure we have the education for individuals who have been diagnosed with an opioid use disorder on the availability and the effectiveness and efficacy of medications for opioid use disorder.

I agree with Assemblywoman Titus's comment, especially around the work that prescribers have done to this point. They have carried a lot of weight when it comes to rectifying some of the overprescribing that we were seeing of prescription opioids in the past. What we are trying to do here is address the other side of the issue. Unfortunately, we do have very low rates of medication-assisted treatment being offered to patients. Very rarely are they even aware that they have options for medications available to them. The goal is to ensure that individuals who are receiving that diagnosis are being offered what we would consider the standard of care for the treatment of opioid use disorder.

Chair Peters:

Are there any other questions from the Committee? Yes, please go ahead.

Senator Hardy:

Dr. Woodard, can you address the issue of methadone in all facilities where a person is confined when we talk about offering medication-assisted treatment? Are we administering methadone in all facilities or are we capable of doing all that? Do we have not just waivers, but licenses for everyone and enough physicians who are able to do that? Do we have some safety factor in doing that in the prisons and jails?

Dr. Woodard:

Currently, we do have some jails that are offering methadone to individuals who are already on methadone as a maintenance drug. We also have some jails that may not be offering that same connectivity to treatment, even if the individual has previously been maintained on that medication. What we are attempting with the language here is to ensure that there is preservation of access to medication for an individual, especially if they have already been established on that medication. Certainly, forcible withdrawal for individuals who are in an incarcerated setting leaves them at an increased risk for experiencing overdose upon discharge, especially if they must be restarted on medications they previously had been on. The connectivity to care upon discharge is critical for ensuring that people are reducing risk for the potential for overdose upon reentry back into the community.

Senator Hardy:

Are all the prisons able, capable, and adequately manned to be able to do that? Do we have the workforce that can do that? Do we have the safety factor throughout our 17 counties that can do that?

Dr. Woodard:

We would have to reach out to each of the jails and the Department of Corrections in each of their affiliated prisons to determine if they had the capacity. We have demonstrated capacity in some of the jails across the state so that would be around looking to see if they had the capacity potentially with community partners to be able to provide methadone.

I think part of the issue here is the language that describes making sure they can provide a treatment for opioid use disorder in the same manner and to the same extent as other forms of health care. I will ask, perhaps we need some additional clarification on that language, that we would not be providing an undue burden by a mandate that would fall potentially outside of what we would consider the same manner and the same extent of other forms of health care.

Chair Peters:

Thank you. Mr. Robbins has a comment.

Mr. Robbins:

I wanted to clarify for the purposes of the initial drafting of the bill with the proviso that this could change before the bill is introduced and certainly after the bill is introduced through the amendment process. Regarding J-1 and J-2, the way I read "any provider who is authorized to make a diagnosis of opioid use disorder," would mean that it would apply to first of all the prescribers—physician, physician assistants, and APRNs—and then the mental health providers—psychologist, marriage and family therapists, clinical professional counselors, social workers, and alcohol and drug counselors. The prescribers, obviously, would prescribe if it is appropriate, and the mental health providers would refer to a prescriber to prescribe if it is appropriate. I want to make sure that was okay for the purposes of initial drafting or if there is another approach the Committee would like us to take.

Chair Peters:

I appreciate the comment and the opportunity for the Committee to make the initial decision on who to include in the bill. To me, this list sounds like a great starting point, and I appreciate that it can be refined through the drafting process and during the legislative session through amendments.

Are there any other comments or questions on the BDR recommendation as presented? Please go ahead.

Senator Hardy:

I will be voting no as a red flag. I have probably talked about substance abuse disorder more than anybody else around town. I believe in treating. I think this has dangerous implications that we are putting ourselves in impossible positions to do something that we are not able to do. I think it needs to be more encouraging and mandating on a lot of

different levels. I will be voting no. I think we need to take a step, and this has to be more fully vetted than it has been.

Assemblywoman Titus:

Madam Chair?

Chair Peters:

Please, go ahead.

Assemblywoman Titus:

I echo Dr. Hardy's statement.

Chair Peters:

We are still in the question portion of our voting procedures. I would and take a motion with the suggested revision on Item 2 presented by Assemblyman Orentlicher.

> VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATIONS J-1, J-3, AND J-4 AS STATED IN THE WORK SESSION DOCUMENT AND THE SUGGESTED REVISION BY ASSEMBLYMAN ORENTLICHER TO J-2 TO CHANGE "A PHYSICIAN HAS TO PROVIDE UPON THE REQUEST OF THE PATIENT" TO "FOR PATIENTS FOR WHOM MEDICATION-ASSISTED TREATMENT IS INDICATED, THE PROVIDERS SHOULD OFFER THE TREATMENT OR REFER THE PATIENT TO ANOTHER PROVIDER WHO CAN OFFER THE TREATMENT."
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Chair Peters:

Any discussion on the motion? I have a question from Mr. Ashton.

Mr. Ashton:

To clarify Item 2, the changes you are requesting is that a health care provider should offer information about FDA-approved medication-assisted treatment, but not be required to prescribe it when requested by a patient. Is this the intent?

Chair Peters:

The intent I have is for patients whom medication-assisted treatment is indicated, the providers should offer the treatment or refer the patient to another provider who can offer the treatment.

Mr. Ashton:

Thank you.

Chair Peters:

I have a motion and a second, and we have clarified the intent and language.

THE MOTION PASSED. (SENATOR HARDY AND ASSEMBLYWOMAN TITUS VOTED NO.)

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K. COMMUNITY HEALTH WORKERS

Chair Peters:

We will go ahead and move on to BDR Recommendation K.

Mr. Ashton:

Recommendation K is in regard to CHWs on page 9 of the WSD. This recommendation is from Jay Kolbet-Clausell, M.S.W., Program Manager, Nevada Community Health Worker Association, and was provided during the July 21, 2022, HHS meeting. The recommendation is to request a BDR to:

1. Revise NRS 422.2722 by authorizing DHCFP to promulgate policies regarding who may supervise CHWs who provide services to Medicaid patients in addition to a physician, physician assistant, or APRN. The intent is to ensure that DHCFP has the authority to expand the field of settings where CHWs may practice under supervision and be reimbursed by Medicaid, such as, for example, behavioral health care settings that have a licensed clinical social worker as the supervising entity; and

2. Require that any person holding himself or herself out as a CHW in this state be certified as a CHW by the Nevada Certification Board.

Committee members, Jay Kolbet-Clausell is present to answer any questions you may have. During public comment provided earlier today, it was mentioned that the word *certified* should be added to Item 2 before CHW so it would read "require that any person holding himself or herself out as a *certified* CHW in this state be certified as a CHW by the Nevada Certification Board."

Chair Peters:

Are there any questions on the recommendation with the requested revision to include "certified" before CHW on Item 2?

Assemblywoman Titus:

I have some concerns. I support CHWs and I support most of this BDR except for having them work under a licensed clinical social worker in a health care setting. I have some concerns about that so I cannot support this draft as presented.

Chair Peters:

Any other questions? Please, Senator Hardy.

Senator Hardy:

I am intrigued. I think we need the concept and certification of the CHWs. Do we have a nationwide certification process where the CHW passes a test, does so many hours, and

receives a certificate that says he or she is a certified CHW that is viewed as such in other states? Is there a consistency for what they do?

To Dr. Titus's point, when we talk about a CHW, we think they are going to be taking blood pressures, making sure a person takes their medicine, or helping them with their rehabilitation, and now they are going to be under social workers. Is there a sub certification of CHWs under social workers that are more prone to discussions versus the CHW for medicine that says this is the medicine you are supposed to be taking, this is your nutritional need, this is what you must do to avoid getting sick, and you have to make sure that your blood pressure has taken. I think the flexibility is what we are talking about and may be one of those questions that has to be worked out. Do we have subsets of CHWs? It would be unusual for a CHW who is under social workers to pretend they are a CHW who should be supervised under a doctor or a nurse practitioner.

Chair Peters:

Thank you for the questions, and we have Jay Kolbet-Clausell available for questions. Would you mind talking about how the current certification process was developed, what we are asking for here, whether there is a common certification process through the country, and the scope of the workforce is for CHWs.

Jay Kolbet-Clausell, M.S.W., Program Manager, Nevada Community Health Worker Association:

Chair Peters and Committee members, there is not a national certification for CHWs. There is a national association, but the growth of the certification has been market-driven and led by the states, so each state has developed their own certification process. The State of Nevada collaborated with the State of Washington and the State of Massachusetts primarily when developing their certification system through DPBH and that was launched in November 2018, I believe. The Nevada Certification Board reviews those applications for the DPBH-approved curriculum that covers 13 competencies over an eight-week period.

The next part of the question is on the scope of work. I would like to start by saying there is no such thing as a "medical" CHW—that is out of the scope of a CHW. A medical service should be provided by somebody who has the training and/or licensing required for that. If a CHW has the training to take blood pressure, then they could do that. When assisting with medications, they can read the bottle to the client, help with translation, and help give those reminders so the client can understand the way they are supposed to be taking their medication. Going to that broader level, a CHW should not be replacing the work of a social worker. They help with a lot of those details, like making calls to try to find housing, encouraging the client, or spending extra time with a client to help them achieve their case plan, but they do not write the case plan. One of the specific things I like to tell social workers is a CHW should not be asking things like the miracle question, because that is crossing over into therapy. Asking the client, "If you could have the world you wanted, what would your perfect life look like?" is not the CHW's role. A CHW is there to help the client understand the options that are in front of them, from a culturally competent standpoint. Our CHWs come from the communities they are representing, but they are not bringing in medical training or behavioral health training. They are just helping spend that extra time with the client and extend the reach of those licensed and approved supervisors.

Senator Hardy:

How do you become certified in doing something that does not do health or social work? Is there an amorphous certification process that does not do social work and does not do health, but it is a CHW?

Jay Kolbet-Clausell:

We do have an extended program. The College of Southern Nevada takes 13 weeks to go through the curriculum. They also add in some Health Insurance Portability and Accountability Act of 1996 (HIPAA) training and mental health first aid. Truckee Meadows Community College also has an approved training through DPBH. I do not remember the exact number of weeks, but it covers all the same competencies. Our curriculum spends eight weeks with the client, and we teach them the roles and boundaries. A lot of CHWs are already out there. They are already doing a lot of work, but maybe they are not referring as much as they should be, and they need to have stronger connections with those licensed providers in both behavioral health and in physical health.

Senator Hardy:

Do you see the CHW as being an asset to a physician's office or a nurse practitioner's office? Are they working under somebody's direction or are they autonomous or could they be autonomous?

Jay Kolbet-Clausell:

They should not be operating autonomously. In some of our rural areas, there are no other services, and they end up in difficult positions where they try to do the best for the client. It is something that we would like to remove and mitigate by encouraging them to form one of these contracts with a licensed provider or go under the social services that we have in the state.

Senator Hardy:

Madam Chair, I am going to be supportive of this, recognizing that we have a huge need, but I think we need to put some boundaries on this during the legislative session that make it inviting for people to become a CHW. We also need to think about how they are getting paid and what the results are. Do we have any way to be sure the scope of practice is safe? Are you ready for a motion?

Chair Peters:

Thank you. I have one more clarification from staff on the first point about the authority for Medicaid to set supervisory roles.

Mr. Ashton:

This alludes to Dr. Titus's comment about licensed clinical social workers who may supervise CHWs. This is something the Committee may decide to strike from the language in the WSD. The intent is to give Nevada Medicaid the flexibility to decide, within their own policy authority, who can be an appropriate supervising entity in any setting—medical setting or behavioral health care setting. This is the flexibility and intent of it as I understood it from conversations with Nevada Medicaid. Again, the Committee can decide to take out licensed clinical social worker from the recommendation. It was merely in the WSD as an example. I

also want to state this relates to CHW Medicaid reimbursement because the issue is—as alluded to in earlier presentations—that as of right now, it is limited to physicians, physician assistants, and APRNs who can be a supervising entity for CHWs. This recommendation would expand it and give more flexibility to Medicaid.

Chair Peters:

Thank you for the clarification.

Senator Hardy:

Madam Chair? One of my concerns is that Medicaid probably would require us to apply for a waiver for Medicaid to cover a CHW separate and distinct from somebody who already can be covered by Medicaid for what they do. I am I correct in that?

Chair Peters:

I am going to divert to Medicaid and see if Ms. Bierman can help us out here.

Suzanne Bierman, J.D., M.P.H., Administrator, DHCFP, DHHS:

Good afternoon, Chair Peters, and Committee. We added CHWs by a state plan amendment, so my initial sense is that we would handle this by an amendment to the state plan. I am certainly happy to follow up with our federal partners at the Centers for Medicare and Medicaid Services (CMS) and verify that. We can take that as a follow-up and report back to the Committee, but my initial thinking is that it would likely be via state plan amendment.

Senator Hardy:

When you say a state plan amendment, are you saying that it would be an amendment to put them as an individual, standalone person who gets eligibility to bill Medicaid or be under somebody who does?

Ms. Bierman:

We would be amending the types of providers that we would be reimbursing for the services. The new provider type was added by a state plan amendment, so I think any expansion would also be handled via state plan amendment.

Senator Hardy:

Are you saying a standalone person as a CHW or not standalone but be eligible to get paid for services under somebody who already can get Medicaid reimbursed?

Ms. Bierman:

I think it would be an expansion of how we define the provider type, which is outlined in our state plan amendment. It would really be changing those requirements, which would require federal approval from CMS, to further expand the types of providers that would be allowable for reimbursement as CHWs.

Senator Hardy:

What are their services that the people in the federal government would say is a Medicaid service they need to do, because I am not sure what the nebulous description is that you

are going to put in your application. Again, I think we need to move forward with it, but I think it has to have some fence around it.

Chair Peters:

I appreciate your comments, and I think you are getting at some of the work to be done between now and session and even during session on fleshing out the language to be included in the legislation.

Are there any other questions? Seeing none. I will entertain a motion. Is there any discussion on the motion? Seeing none.

> VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION K-1 AS STATED IN THE WORK SESSION DOCUMENT AND ADD THE WORD *CERTIFIED* TO RECOMMENDATION K-2 SO THAT IT WOULD READ AS, "REQUIRE THAT ANY PERSON HOLDING HIMSELF OR HERSELF OUT AS A *CERTIFIED* COMMUNITY HEALTH WORKER IN THIS STATE BE CERTIFIED AS A COMMUNITY HEALTH WORKER BY THE NEVADA CERTIFICATION BOARD."
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN TITUS VOTED NO.)

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L. PUBLIC HEALTH ADMINISTRATION, EMERGENCY PREPAREDNESS, AND TELEHEALTH REIMBURSEMENT PARITY BASED ON THE FINDINGS OF THE CORONAVIRUS DISEASE OF 2019 (COVID-19) HEALTH CRISIS INTERIM STUDY PURSUANT TO SENATE BILL 209 (2021)

Chair Peters:

That brings us to BDR Recommendation L.

Mr. Ashton:

Members, the following three recommendations were developed by Vice Chair Doñate in consultation with Committee staff in response to several roundtable discussions and stakeholder input during the COVID-19 Health Crisis Interim Study pursuant to SB 209 (2021). After each recommendation, I will hand it back to the Chair and the Committee for further discussion and potential action. I will start with the recommendation on public health modernization, which you can find on page 10 of the WSD. The recommendation is to request a BDR to:

1. Authorize the establishment of health districts among nonadjacent counties in Nevada. Specifically, remove the word "adjacent" in subsection 1 of NRS 439.370 and make other conforming changes as needed; and

2. Establish an account for public health infrastructure and improvement in the State General Fund that is administered by DPBH. The Fund shall appropriate general funds of $15 million each fiscal year (FY), for FY 2023–2024 and 2024–2025. Additionally, the following provisions should apply as outlined in subitems A through F on page 10 of the WSD.

Chair Peters and Committee members, we have Julia Peek, M.H.A., C.P.M., Deputy Administrator, Community Health Services, DPBH, DHHS, and Ms. Comlossy, present to respond to any questions you may have.

Chair Peters:

Are there any questions from the Committee? Seeing none, I would entertain a motion. Any discussion on the motion? Seeing none.

> VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATIONS L-1 AND L-2 REGARDING PUBLIC HEALTH MODERNIZATION.
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

****

Chair Peters:

We are going to move on to the next recommendation under this item.

Mr. Ashton:

We will continue with the recommendation on public health emergency preparedness under Recommendation L of the WSD, which you can find on page 11. This recommendation is to request a BDR to improve the public health emergency preparedness by:

1. Providing in Chapter 414 ("Emergency Management") of NRS that the use of the Emergency Assistance Account is not dependent on the determination of an emergency by the governor; and

2. Requiring the Department of Employment, Training, and Rehabilitation to conduct a study during the next legislative interim to explore alternative unemployment benefits, such as *Kurzarbeit*, and to evaluate essential versus nonessential businesses and workers in different types of crises. There are more items under this study requirement, all of which are outlined in the WSD on page 11.

Committee members, we have David W. Fogerson, C.E.M., Chief, Division of Emergency Management/Homeland Security, Office of Homeland Security, Office of the Military, and Allison Genco, Public Health Resource Officer, Office of the Governor, present to answer questions.

Chair Peters:

Are there any questions from Committee members on this item? Seeing none, I would entertain a motion. Is there any discussion on the motion? Seeing none.

> VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION L-1 REGARDING PUBLIC HEALTH EMERGENCY PREPAREDNESS.
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

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Chair Peters:

Please proceed with the next recommendation.

Mr. Ashton:

Next, we have a BDR recommendation related to telehealth reimbursement parity. The WSD contains a summary on SB 5, which passed during the 2021 Session, on pages 11 and 12. Among other provisions, SB 5 prohibited various third-party payers from:

- Refusing to pay for services provided through telehealth because of the technology used; and

- Categorizing telehealth services differently than services provided in person for purposes related to coverage or reimbursement.

In addition, SB 5 required third-party payers to cover telehealth services in the same amount as services provided in person or by other means—except for services provided through audio-only interaction. These reimbursement parity requirements for telehealth services were temporary, facilitating access to telehealth only for the duration of the COVID-19 public health emergency. The recommendation is to request a BDR to:

1. Repeal the sunset requirements for all reimbursement parity requirements for telehealth services pursuant to SB 5, and thereby making all reimbursement parity requirements permanent.

Chair Peters:

Are there any questions on this recommendation? Assemblywoman Titus.

Assemblywoman Titus:

I certainly appreciate telehealth, especially in rural areas. If anything, COVID-19 brought out that the access to health care can be tough. I am concerned about the parity of reimbursement now with those who might have brick-and-mortar buildings in the state. I will not be able to support this at this time because I am anxious about how it is going to turn out as it finalizes and again, making certain other requirements for telehealth.

Vice Chair Doñate:

I want to share one sentiment; I think the field of telemedicine or telehealth and the umbrella is still very new. There is research coming out determining the efficacy of one mode versus the other. My understanding is that CMS is collecting feedback from providers nationwide to see if audio services can relate to an in-person visit and what the nuances are for coverage. We will learn a lot of that as we continue moving forward throughout the COVID-19 pandemic as it turns to an endemic and of course with other public health crisis that come about. My hope is that when this bill comes out during session, we can have those conversations and debates as to what requirements come forward during a public health emergency similar to COVID-19, or if we want to make them permanent to entice digital health companies to come to the state or what that looks like. I think that is the intent of this proposal.

Chair Peters:

I want to take a moment to discuss that during the past legislative session when we decided to put sunset provisions on reimbursement parity requirements in committee, we made a commitment to come back around to assess the requirements for parity with telemedicine. I feel like this is a good starting point, but again, the bill goes through a process and we are just at the beginning of that process.

Any other comments or questions from the Committee? Seeing none, I would entertain a motion. Any discussion on the motion? Seeing none.

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION L-1 REGARDING TELEHEALTH REIMBURSEMENT PARITY.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYWOMAN TITUS VOTED NO.)

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M. RECOMMENDATIONS FROM THE HOME CARE EMPLOYMENT STANDARDS BOARD, WHICH INVESTIGATES AND MAKES RECOMMENDATIONS REGARDING THE IMPROVEMENT OF WORKING CONDITIONS IN THE CRITICAL HOME CARE INDUSTRY

Chair Peters:

We are going to move on to Recommendation M.

Mr. Ashton:

These are now recommendations to draft letters. Recommendation M was developed by Chair Peters in response to a recommendation provided by Marlene Lockard, Principal, The Lockard Group, representing Service Employees International Union Local 1107, during the solicitation of recommendations period.

The recommendation is to draft letters to the Senate and Assembly Committees on Health and Human Services and the director of DHHS expressing the Committee's support for the recommendations identified by the Home Care Employment Standards Board created by SB 340 (2021).

Committee members, we have Cody L. Phinney, M.P.H., Deputy Administrator, DBPH, DHHS, and Chair of the Home Care Employment Standards Board, present to respond to any questions you may have.

Chair Peters:

These are letters from the Committee that suggest our support as described in the recommendation.

Are there any questions on this item? Seeing none, I would accept a motion. Any discussion on the motion? Seeing none.

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION M.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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N. ADULT DENTAL COVERAGE AT FEDERALLY QUALIFIED HEALTH CENTERS; MEDICAID POSTPARTUM COVERAGE

Chair Peters:

Please proceed with Recommendation N.

Mr. Ashton:

Recommendation N is on page 12 of the WSD. It was developed by Chair Peters in consultation with Committee staff in response to multiple testimonies provided at the May 19, 2022, HHS meeting.

The recommendation is to draft letters to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the director of DHHS expressing the Committee's support for budget items considered for special considerations regarding: (1) providing adult dental coverage at federally qualified health centers; and (2) extending Medicaid postpartum coverage to 12 months.

Committee members, we have several stakeholders and subject matter experts present to answer any questions the Committee may have.

Chair Peters:

Are there any questions from the Committee? Seeing none, I would entertain a motion. Is there any discussion on the motion? Seeing none.

VICE CHAIR DOÑATE MOVED TO APPROVE RECOMMENDATION N.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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Chair Peters:

That brings us to the end of our work session agenda item. We are going to close this item. Thank you for your input and questions. I always appreciate the discussion and look forward to future discussions as we move through the legislative session.

Assemblywoman Titus:

Madam Chair, before we go to public comment.

Chair Peters:

Yes, please go ahead.

Assemblywoman Titus:

I just want to acknowledge the Committee's efforts and hard work and all the hearings and folks who have contributed to improve the health of all Nevadans throughout our state. This is our last meeting for this Committee and the time that has been spent has been impressive. I think we have some good things moving forward, and I look forward to further conversations. Thank you to all the Committee members, staff, and especially Madam Chair for taking on these tasks.

Chair Peters:

Thank you. Go ahead, Senator Hardy.

Senator Hardy:

I appreciate what you have done and our staff. Mr. Robbins and Mr. Ashton have been personally helpful to me in my position. I appreciate the opportunity to have served on this Committee and these long years. I look forward to continuing good relationships with all of you, but I will give you the ball and let you continue to carry it. Thank you very much.

Chair Peters:

Thank you for sharing the sentiments; I was going to wait until after public comment to share. Similarly, I have very much appreciated working in service with all of you over this interim. I have appreciated all the effort put in by the entities who have come before us and those who have shared their opinions, expertise, and life stories on these important issues.

I also want to take a moment to extend our appreciation to you, Senator Hardy. It has been a pleasure serving with you in this capacity. We have not served on a committee together before, and this being your last committee, it feels like I missed out not having served with you previously. We want to wish you the best of luck in your next chapter—you will be missed, Senator Hardy. Thank you for your service and the concern for your community and your willingness to always come to the table and have discussions on these really important issues. We are looking forward to seeing how things go in the next chapter of your life.

I also want to extend an enormous thank you to our staff, who are not quite done yet. I think their work is just getting started. We could not have done this Committee without you. You keep us reined in, you coordinate with our stakeholders and agencies, and you make sure that I have notes drafted in ways that are helpful in getting us through meetings. You are invaluable. Thank you for your help and the work that you do.

AGENDA ITEM VIII—PUBLIC COMMENT

Chair Peters:

I am going to move to public comment. This is our last public comment of the interim. We have physical locations and online. I am going to ask folks to limit your comments to three minutes.

Is there anybody in Las Vegas who would like to come up for public comment at this time? I am not seeing anyone in Las Vegas approaching for public comment.

Is there anybody in Carson City who would like to approach for public comment? I do not see anybody coming up.

Is there anybody on the public comment line for public comment today?

BPS:

Chair, the public line is open and working, but there are no callers at this time.

Chair Peters:

Thank you again. This is our final meeting, and we will be working on these BDRs. Senator Doñate.

Vice Chair Doñate:

Chair Peters, before we conclude, I want to express my gratitude to you for bringing me alongside the decision-making process and to the unsung heroes of some of the bills today, which were the biggest task, the COVID-19 bills. Our committee staff guided us throughout that process. I know that we did not get a lot of it into those bills, but hopefully we are just getting started on some of those processes.

Senator Hardy, I think a lot of us share the same sentiment. You have been very gracious to work with, sir, and it was such an honor to have the ability to work with you in the Senate. I am truly going to miss you. In this respect, the folks of Boulder City are lucky to have your service. Thank you for serving and for your expertise. I look forward to hopefully still pulling you into this committee meeting at some point in the future for your expertise.

Chair Peters:

I was remiss on acknowledging your effort on the COVID-19 study and bringing amazing stakeholder groups together and talking about these dynamic issues and for serving with me and helping to make these hard decisions. It truly is a group effort, and we had an amazing one. I am so proud of the work we have done in this Committee.

The following public comment was submitted for the record:

- Lela Arney, Reno Resident (Agenda Item VIII A);
- Health Services Coalition (Agenda Item VIII B);
- Tom McCoy, J.D., Executive Director, State Government Affairs, Nevada Chronic Care Collaborative (Agenda Item VIII C);

- Ken Kunke, PharmD, Executive Secretary, Nevada Pharmacy Alliance (Agenda Item VIII D); and
- Lauren Rowley, Senior Vice President, State Affairs, PCMA (Agenda Item VIII E).

AGENDA ITEM IX—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 12:55 p.m.

Respectfully submitted,

_____

Crystal Rowe
Research Policy Assistant

_____

Patrick B. Ashton
Principal Policy Analyst

APPROVED BY:

_____

Assemblywoman Sarah Peters, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II A	Jay Parmer, American Strategies, Inc., on behalf of the Association for Accessible Medicines	Written Remarks
Agenda Item IV A	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB)	LCB File R010-22 of the State Board of Health
Agenda Item IV B	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R026-22 of the State Board of Oriental Medicine
Agenda Item IV C	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R057-22 of the Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors
Agenda Item IV D	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R085-22 of the State Board of Pharmacy
Agenda Item IV E	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R086-22 of the State Board of Pharmacy
Agenda Item IV F	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R094-22 of the State Board of Health
Agenda Item V	Valerie Cauhape Haskin, M.A., M.P.H., Rural Regional Behavioral Health Coordinator, The Family Support Center, Rural Regional Behavioral Health Policy Board (RBHPB)	PowerPoint Presentation
Agenda Item V-1	Valerie Cauhape Haskin, M.A., M.P.H., Rural Regional Behavioral Health Coordinator, The Family Support Center, Rural RBHPB	Handout

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item V A-1	Michelle Bennett, M.A., M.S., Clark Regional Behavioral Health Coordinator, Clark County Social Service, Clark RBHPB	PowerPoint Presentation
Agenda Item V A-2	Michelle Bennett, M.A., M.S., Clark Regional Behavioral Health Coordinator, Clark County Social Service, Clark RBHPB	Handout
Agenda Item V B-1	Cherylyn Rahr-Wood, M.S.W., Northern Regional Behavioral Health Coordinator, Nevada Rural Hospital Partners, Northern RBHPB	PowerPoint Presentation
Agenda Item V B-2	Cherylyn Rahr-Wood, M.S.W., Northern Regional Behavioral Health Coordinator, Nevada Rural Hospital Partners, Northern RBHPB	Handout
Agenda Item V B-3	Cherylyn Rahr-Wood, M.S.W., Northern Regional Behavioral Health Coordinator, Nevada Rural Hospital Partners, Northern RBHPB	*2020 Northern Behavioral Health Profile Report*
Agenda Item V C-1	Valerie Cauhape Haskin, M.A., M.P.H., Rural Regional Behavioral Health Coordinator, The Family Support Center, Rural RBHPB	PowerPoint Presentation
Agenda Item V C-2	Valerie Cauhape Haskin, M.A., M.P.H., Rural Regional Behavioral Health Coordinator, The Family Support Center, Rural RBHPB	Handout

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item V C-3	Valerie Cauhape Haskin, M.A., M.P.H., Rural Regional Behavioral Health Coordinator, The Family Support Center, Rural RBHPB	Letter
Agenda Item V D-1	Kim Donohue, Southern Regional Behavioral Health Coordinator, Nevada Rural Hospital Partners, Southern RBHPB	PowerPoint Presentation
Agenda Item V D-2	Kim Donohue, Southern Regional Behavioral Health Coordinator, Nevada Rural Hospital Partners, Southern RBHPB	Handout
Agenda Item V E-1	Dorothy Edwards, Washoe Regional Behavioral Health Coordinator, Washoe RBHPB	PowerPoint Presentation
Agenda Item V E-2	Dorothy Edwards, Washoe Regional Behavioral Health Coordinator, Washoe RBHPB	Handout
Agenda Item VI	Malinda Southard, D.C., C.P.M., Executive Director, Patient Protection Commission, DHHS	PowerPoint Presentation
Agenda Item VII	Patrick B. Ashton, Principal Policy Analyst, Research Division, LCB	Work Session Document
Agenda Item VIII A	Lela Arney, Reno Resident	Written Remarks
Agenda Item VIII B	Health Services Coalition	Written Remarks
Agenda Item VIII C	Tom McCoy, J.D., Executive Director, State Government Affairs, Nevada Chronic Care Collaborative	Written Remarks
Agenda Item VIII D	Ken Kunke, PharmD, Executive Secretary, Nevada Pharmacy Alliance	Written Remarks

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item VIII E	Lauren Rowley, Senior Vice President, State Affairs, PCMA	Written Remarks

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