# NEVADA LEGISLATURE
# JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

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

## MINUTES

**February 16, 2024**

The first meeting of the Joint Interim Standing Committee on Health and Human Services for the 2023–2024 Interim was held on Friday, February 16, 2024, 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 3138, 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 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:

Senator Fabian Doñate, Chair
Assemblyman David Orentlicher, Vice Chair
Senator Rochelle T. Nguyen
Assemblywoman Tracy Brown-May
Assemblyman Brian Hibbetts

## COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Robin L. Titus
Assemblyman Ken Gray
Assemblyman Duy Nguyen

## LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Patrick B. Ashton, Principal Policy Analyst, Research Division
Davis H. Florence, Senior Policy Analyst, Research Division
Sarah Baker, Research Policy Assistant, Research Division
Julianne King, Assistant Manager of Research Policy Assistants, Research Division

Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division
Aaron McDonald, Principal Deputy Legislative Counsel, Legal Division
Jeff Koelemay, Deputy Legislative Counsel, Legal Division
Kimbra Ellsworth, Senior 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 Doñate:***

Welcome to the first meeting on the Joint Interim Standing Committee on Health and Human Services (JISC HHS) for the 2023–2024 Interim. We have a lot of agenda items today, and it is great to see everyone and be back since the Legislative session closed.

[Chair Doñate went over housekeeping measures and public comment protocols.]

I would like the opportunity to have the Committee members and our staff introduce themselves, so everyone knows who is present. For Committee Members, if you can go over the district you represent, your background or interest in HHS, and then, because it is the morning, to make it a little bit fun, your favorite breakfast item.

***Vice Chair Orentlicher:***

I represent Assembly District 20 on the southeast side of Las Vegas. If you are standing on Maryland Parkway with the University of Nevada, Las Vegas (UNLV) at your back, you are facing my District. I am in my second term. I also teach at UNLV, so it is convenient to be right next door. I teach health law and constitutional law, and my background is in medicine and law, so fortunately, this Committee converges nicely with my academic interests. I always try to start the day with some grapefruit.

***Senator Nguyen:***

I represent Senate District 3, which is one of the most weirdly shaped districts, but I encompass most of the medical district down at Charleston and Rancho in that area, but I also incorporate a lot of the other medical areas around Mountain View Hospital. I follow Rancho all the way up to Ann Road as a part of my Senate District and extend almost into Summerlin off Charleston and Sahara all the way up to Cimarron. I have a pretty expansive District. My favorite breakfast item is probably chilaquiles.

***Senator Titus:***

I represent Senate District 17, which is all of Douglas County, Lyon County, Churchill County, Esmeralda County, Mineral County, and Nye County, but only Tonopah in Nye County. I am a family practice doctor. This is my fifth session. I have been on this interim Committee multiple times, and I have always sat on an HHS Committee during session. I am still a practicing physician, a long-term care medical director, and I am the County Health Officer in Lyon County. I am passionate about health care as many of you know. My favorite breakfast is not very healthy, but I am still passionate about it; it is marionberry pie.

***Assemblywoman Brown-May:***

I represent Assembly District 42, which is half of China Town, Korea Town, and all of Spring Valley, and goes as far south as the 215. I have the IKEA, which is very interesting. I am honored to be here as part of this Committee. I have often testified in front of the HHS Interim Committee but have never served, so I am thrilled to be here. My day job is as a

disability advocate, so I have spent the last 20 years supporting people who have high medical needs. I presented to this Committee in the regular session on multiple occasions, which is probably how I got here. I would have to say my favorite breakfast item is also not very healthy: it is cold pizza.

***Assemblyman Gray:***

Thank you, Assemblywoman Brown-May, for stealing my favorite breakfast food. I represent Assembly District 39, the Central Lyon Corridor as well as all of Douglas County. My background is 26 years in the Air Force, and I served as everything from a flight medic and a ground combat medic to an emergency room (ER) nurse and a health care administrator. This is my first term, and I am loving it.

***Assemblyman Hibbetts:***

I am the representative for Assembly District 13, which is in the northwest part of Las Vegas in the Centennial Hills and Sky Canyon area, Durango and 95, if you are familiar with the area. I served on the HHS Committee during Session. This is my freshman session, and I am still learning everything that is going on. My District has absolutely zero hospitals in it, which I would like to change. There is a standalone ER but no actual hospitals, and although I can throw a rock and hit one from my District, it is not actually in it. My favorite breakfast food is bacon and eggs.

***Chair Doñate:***

I am honored to serve as the Chair for this Joint Interim Standing Committee. This is my second interim. I served in two legislative sessions—I was elected in 2022—and I have a professional background in public health. Day-to-day, I am a health care administrator, so I am very passionate about this subject interest, and I am honored to be here.

I want to take a quick moment to showcase the work that we will be talking about during this interim. My philosophy is pretty simple. I try to make sure that every presentation and everything that we talk about is solution-oriented. I do not want us to talk about the problems and why they persist. I think we should spend most of our time talking about how we can fix them rather than being repetitive.

I also want to make sure that the success of this Committee is not measured by the number of presentations or discussions we have. I want to make sure that every bill that gets passed out of this Committee is bipartisan, and that those bills can come to fruition when we go into Session in 2025. We have an obligation to protect and serve the people of this State based on their health and their well-being.

We will be discussing a lot of items. The main four priority areas that we have decided for this interim are access to health care, behavioral health, public health, and workforce and infrastructure. As you may know, there are a lot of subjects that we can tackle in this Committee, but we only have a short amount of time, and those are the pressing needs. We will have discussions later today on what that means for our State, but that is essentially what I hope to accomplish during this moment and through my service here as Chair. For my breakfast item, I am always a big fan of maple glazed donuts. That is the key to my heart. Next, I would like to have the Committee staff introduce themselves.

***Ms. Ellsworth:***

I will be going into my fourth Legislative Session in 2025. For the last two, I have carried some of the HHS accounts, and I stand ready to answer any budget-related questions or do any follow up as needed for the Committee. For my favorite breakfast item, I would have to say egg in a basket.

***Mr. Robbins:***

I have been with LCB since 2012. I have been with this Committee since the 2013–2014 Interim. My favorite breakfast item would be a nice big breakfast burrito smothered in spicy pork green chili.

***Mr. McDonald:***

This is my first year here. I spent the last 12 years of my legal career at the Legal Aid Center of Southern Nevada. I was the lead attorney of the Housing Justice Program there. My favorite breakfast item would also be a breakfast burrito. There must be something with the Legal Division and breakfast burritos, but I enjoy that as well.

***Mr. Koelemay:***

I came to the Bureau a little over three and a half years ago out of civil practice in Reno. During the last session, I was involved with helping staff a committee in a different subject area, but I have worked closely with my colleague, Mr. Robbins, on things in this area. I look forward to being useful to this Committee during this interim. I am surprised that no one has said what I think is the most obvious breakfast item, which is coffee. That is always my favorite, and it is important.

***Mr. Ashton:***

I think this is my fourth interim and during both the interim and session, I staff health-related committees. I am a licensed social worker and have a master's degree in political science. My favorite breakfast item is coffee for sure, and also gallo pinto with fried eggs sunny side up. I am happy to be your Committee Analyst this interim.

***Mr. Florence:***

I have been with the LCB for a little over a year now, and it is my first time serving on the interim Committee. Mr. Koelemay stole my answer, but my favorite breakfast item is also coffee.

***Chair Doñate:***

Additionally, we receive assistance from our Committee Secretary, Sarah Baker, as well as staff from Broadcast and Production Services (BPS) and General Services, so I want to thank all of them for all the work they do.

Let us move on to our first agenda item, public comment.

***Senator Titus:***

Before we take any public testimony, perhaps we could introduce our Member who has just arrived.

***Chair Doñate:***

Assemblyman Nguyen, can you provide a brief background, your interest in HHS, and your favorite breakfast item before we move on?

***Assemblyman Nguyen:***

Apologies for my tardiness. I am not used to the commute—it has been a minute. It is nice to be back here, and it is great to see everyone. I have the honor to represent Assembly District 8 in southwest Las Vegas. It is the most diverse district in the State with 40 percent of Asian American Native Hawaiian Pacific Islanders, so I am very proud to share that statistic over and over.

My background has been about direct service and working with our immigrant and underserved communities, and I have been doing that for over 20 years. One of the things that I experienced as a parent, when my firstborn arrived about 11 years ago and had so many issues in the first couple of weeks of his life, I had to learn the hard way how to be not only a parent but a caregiver as well as ensuring that the kid was going to stay alive. I thought I was educated, but boy was I wrong, and I learned a lot in terms of navigating the health care system. It ignited a passion of mine to be more involved in the health care space and in ensuring that it does not matter who you are, your background, and whether or not you know, you can come together and make sure that everyone thrives and does well.

For my favorite breakfast, I would say coffee because that is something that I need to have every morning. I am not a morning person. I think that is public knowledge.

## AGENDA ITEM II—PUBLIC COMMENT

***Chair Doñate:***

Let us begin with public comment. We will start in Las Vegas and then move on to those in Carson City.

***Lea Case, Nevada Psychiatric Association:***

I am here today representing the Nevada Psychiatric Association regarding LCB File R059-23 (Agenda Item IV-R). We have had the opportunity to speak with the Board of Pharmacy on this regulation. It was up for discussion at the Legislative Commission on January 10, 2024, but that meeting was canceled due to weather. The letter I have submitted was also emailed to all of you is dated January 10, 2024, for the Legislative Commission, but the recommendations remain the same (Agenda Item II A).

I wanted to focus my public comment this morning on a group of physicians in this State who have the specialized training in addiction medicine and addiction psychiatry, and the way this regulation reads, it highlights a discrepancy in the way we treat these various prescribers. In Nevada, we have Advance Practice Registered Nurses (APRN), physicians' assistants, and physicians who have traditionally been the prescribers of

medications, the diagnosticians. They are the folks who you go to see, and you say, "This is how I am feeling," they give you the diagnosis, and then you go and get your medications. The Legislature in turn has said, "This is what we require of you as a prescriber to be able to work with the public to keep the public safe."

Assembly Bill 156 (2023) passed last session, and in Section 12.3, it states that the Board of Pharmacy must come up with these protocols. That is a deviation from past practice in the Legislature, where you as a legislative body, have specifically designated what these guidelines and protocols need to be for other prescribers. We are seeing this deviation in prescriber types and the requirements for each, and it is sending a message through the psychiatric community that you are not the prescribers or diagnosticians we want in Nevada. You are treated differently in Nevada though they have this expertise, they have this training, and we know they are competent. They have been doing this for years or for decades, and now we have a discrepancy in how we are going to treat this particular patient population of folks with addictions, folks who are struggling with opioid use disorders. There are recommendations in the letter that we have submitted. It is a joint letter from the Nevada State Medical Association.

***Chair Doñate:***

Ms. Case, can you please wrap up your comments?

***Ms. Case:***

Absolutely. Please refer it back with guidance to increase the protocols.

***Zach Roscoe, Nevada Pharmacy Alliance:***

I am here on behalf of the Nevada Pharmacy Alliance. I am a licensed pharmacist in Nevada, and I am here to support the regulation LCB File 059-23 from Assembly Bill 156.

I wanted to give a brief example of the safety, efficacy, and expanded access that might be seen with the implementation of these regulations. While I live here in Nevada, I do work remotely in Idaho for Idaho State University as the Director for the Center for the Advancement of Pharmacy Practice and Research. In July 2023, restrictions on pharmacists in the State of Idaho were lifted to allow pharmacists to independently prescribe controlled substances, including medications for opioid use disorder.

I want to give a firsthand account of a community pharmacy, I am familiar with in rural Idaho, that recognized the need of their patient population where there was limited access to licensed and trained physicians and other health care providers. The pharmacist started offering medications for opioid use disorder treatment within their community pharmacy and has taken up a panel of about 60 to 80 patients they see on a regular basis.

Beyond tracking safety and efficacy of this treatment, they also assessed the patients' other health care needs and found that while these patients were previously engaging in opioid use treatment at other providers and could not continue with them for various reasons, they were never encouraged to engage in primary care or other health care services. The pharmacy team screened the patients for other needs and through partnerships with community providers was able to connect about 70 percent of the patients with primary care for the first time. I wanted to give an example of what this could look like with similar regulations in place.

***Krystal Riccio, Associate Professor of Pharmacy Practice, College of Pharmacy, Roseman University of Health Sciences:***

I am a licensed pharmacist here in Nevada and I practice at Behavioral Health, which is an addiction treatment center here in Nevada. I applaud the session last year for passing A.B. 156. I feel it meets a critical need. We have one person dying every eight minutes from a fentanyl overdose or poisoning in this country. It was an "all hands on deck" bill and I believe that it is going to meet the needs of our community.

You mentioned public access, behavioral health, and access to health care, being your priorities of this Committee. I believe that this bill and this regulation do answer that. I feel this is going to be an "all hands on deck" priority for our State and our country, and I feel the session answered that, and I feel regulation 059-23 is in response to this crisis.

***Penni Echols, Act4Kids Nevada:***

I am here today with Act4Kids Nevada as a parent of children with special medical needs (Agenda Item II B). I would like to comment on Agenda Item X, a discussion of topics related to HHS for future consideration and meeting topics. I ask that you consider a robust discussion on access to pediatric subspecialty care in Nevada and work to identify ways to improve access to comprehensive care.

For our family, the burden of travel out of state for medical care has been heavy. In August 2022, one of my daughters suffered a concussion at soccer practice and was set to resume activity when she was concussed again in October. However, this time, the seizures and pain that resulted from that second concussion required emergency room care, and she spent three days with constant non-epileptic seizures and pain that did not respond to medication. We waited 72 hours for a psychiatrist to visit her in the Pediatric Intensive Care Unit (PICU) to help us prescribe a plan of action. My husband advocated for an ICU-to-ICU transfer, and she was sent to the Neurotrauma Unit at Primary Children's Hospital in Salt Lake City.

Once my daughter had access to providers who understood her condition, she was able to come home and heal with a new understanding of the interplay between mind and body. During school breaks, we travel for specialized physical and occupational therapy and for treatment of chronic migraines resulting from her post-concussion syndrome diagnosis. Our insurance covers the cost of office visits but not our travel costs, and no one can reimburse me or my husband for the cost of separation from family, bedtime hugs missed, family meals spent in different states, my daughter's exhaustion from traveling during a migraine episode, missed hours of school, foregone recreational activities, and the ghosts of trauma that haunt us every time we have to share her medical history with a new provider because hospitals and primary care physicians and specialists do not have access to each other's records.

I ask the Committee to consider changes that we need in Nevada to access that comprehensive pediatric care. I ask you to work towards solutions including a freestanding nonprofit children's hospital and an improved provider pipeline for my family and thousands more who need care that is close to home. Thank you again for your attention to this topic and the opportunity to share my story. I appreciate your dedication to the idea that Home Means Nevada, and I encourage us all to consider how we can improve our home to take care of our sickest children.

***Patrick Kelly, Chief Executive Officer (CEO), Nevada Hospital Association:***

I would like to begin with a thank you. In the last Legislative Session, you appropriated $20 million for nursing programs in the State. It was much-needed money to support, improve, and expand our nursing programs. We hope that you will consider a larger appropriation in the next budget if you determine that the money was well spent.

Workforce continues to be a huge challenge for health care providers, and nursing remains at the top of the list. Hospitals alone have more than 2,000 open Registered Nurse (RN) positions. Other health care providers such as nursing homes, public health departments, and others have significant openings too.

The nursing shortage creates a bottleneck in Nevada's health care delivery system. Hospitals are unable to discharge patients who are medically cleared for discharge because other providers are limited in the number of patients that they can admit to their facilities because of staffing shortages. On average, hospitals are currently holding hundreds of patients a day who are medically cleared for discharge.

This is concerning for three reasons. First, the equivalent of one large hospital is taken out of the State's health care delivery system. If a major catastrophic event occurred, hospitals would be in short supply of hospital beds. Second, we do not have rooms for patients who need to be admitted. I am sure you have heard stories of patients waiting for a bed to become available. Third, housing patients in the hospital is not good for the patients. Hospitals are built, designed, and staffed for short-term stays. Patients need to be moved quickly to an appropriate level of care so they can receive necessary services like physical therapy, occupational therapy, and speech therapy. Patients also need to be in an environment that promotes socialization and activities that stimulate their brains; without these, atrophy can set in.

Behavioral health is another area of concern. Many law enforcement agencies and first responders transport patients with mental health problems to the Emergency Department (ED), but they are not a good environment for people experiencing a mental crisis. They are noisy and extremely busy. It is not a calming environment. Moreover, disruptive behavioral health patients can impact the care provided to other patients in the ED.

Our behavioral health system needs to improve. Nevadans who experience a mental health crisis should be taken to an environment that is conducive for de-escalation like a crisis stabilization center or a behavioral health hospital. We are committed to working with you during the interim to tackle these difficult issues, and we appreciate all your hard work. I like fruit loops for breakfast.

***Kinnsi Sigler, Act4Kids Nevada:***

I have been a proud Las Vegas resident for 27 years. I went to school here, met my husband, and we had our four amazing children here. It is in this great State that we started our small business and planned to live out our American Dream. For us, home truly does mean Nevada (Agenda Item II C).

Unfortunately, due to gaps in its children's health care infrastructure, we may not call it home for much longer. It is out of my love for this great State and the amazing families that call it home that I plead with you to agendize conversations for solutions to these gaps,

including a freestanding children's hospital and comprehensive health care system. Families including mine need more access to specialty health care for our children.

As a mom, I could spend the remainder of the meeting describing the gaps that my children have personally experienced, the challenges in accessing health care and specialists, how our amazing providers are under-resourced and overworked, but in the interest of time, I will share one of our most recent experiences.

Over the summer, my 12-year-old underwent brain surgery that resulted in life-threatening complications, additional surgeries, and many more unexpected weeks spent in the hospital. During this time, she did not want me to leave her side and I did not want to leave hers, but I had to in order to get referrals from multiple pediatricians and specialists for treatment for my other children. The process was grueling and overcomplicated with the need for referrals from multiple offices.

If all had gone according to plan, I would have driven a total of 33 miles between the three providers located across the Las Vegas Valley, but the odds we are not in my favor. Referrals were lost in the pipeline between one provider to the next, resulting in back-and-forth drives, miscommunication, and ultimately a missed appointment with our subspecialist due to the delay in paperwork. The next available appointment is over four months away, meaning my family's care will be greatly delayed.

Imagine if all these providers were under one roof in a freestanding children's hospital. How would my odds have changed that day? Nevada is known for playing the odds, but it is not thrilling when it comes to our kids. It should never be the luck of the draw whether you get an appointment or the help you need. Let us not gamble with our children's health. It is time for a freestanding hospital in Nevada to improve access to comprehensive specialty health care for our children.

***Chelsea Bishop, Act4Kids Nevada:***

I am here to speak on Agenda Item X. I am a registered nurse, a Henderson native, and a mom of medically involved children. I am here to ask you to agendize for future interim meetings the conversation about solutions to increase access to specialized pediatric care in Nevada, such as through a comprehensive children's hospital (Agenda Item II D).

In 2015, I worked as a pediatric nurse on a local hospital floor before our oldest child was diagnosed with stage four cancer. We traveled on and off for over six years of her treatment to Los Angeles, San Francisco, Salt Lake City, and Houston before she unfortunately passed away in 2021. When we were in other cities for health care, we noticed the incredibly large difference between comprehensive children's hospitals and the type of health care framework we have here in Nevada.

Between the four of my children, we have seen well over a dozen different subspecialists throughout the Las Vegas Valley for their medical needs. We have had surgeries and multiple inpatient stays, so we are very familiar with the system here. Subspecialists are sprinkled all over the Valley in different networks. This type of setup delays care for our children and is certainly not best practice. In addition, there are many gaps in subspecialists that are forcing children out of state for health care.

I look forward to a future where this does not need to happen, and our pediatric care is comprehensive in Nevada. Accessing health care has been a large burden on so many

families in our State. We have had wonderful providers here in Nevada, ones we truly feel are caring and competent, but they are under-resourced and need a better framework to work within.

I am part of a grassroots group called Act4Kids Nevada, and we are advocating for a freestanding children's hospital and a statewide health system for Nevada families. We are here to support any measures that will take strides towards this bright future for Nevada's kids. We would like to work on solutions together. Thank you for considering how we can help improve access to specialty health care for our children in Nevada and for hearing my story today.

***Leann McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics (AAP):***

The pediatricians of the Nevada AAP are committed to working with many of the parents you have heard from this morning and helping to meet their needs to access subspecialty care more easily, but we also have two other agenda priorities that the members have voted as the most important to them; we ask that you prioritize them this interim. The first is addressing the public health crisis of gun violence in our community, and the second is ensuring that children have access to high quality, age appropriate, and affordable health insurance (Agenda Item II E).

The Nevada AAP currently has 287 members, most of whom are board certified pediatricians; both primary and specialty care. Members also include pediatric nurse practitioners, physicians' assistants, pediatric residents, and medical students, all of whom live and work in Nevada and have dedicated their professional lives to the health of all children. My role as the Executive Director of the Nevada AAP is to connect physician leaders at our Chapter to you, our legislators, to ensure that you are aware of the most recent evidence-based pediatric care thinking available as you make critical governing decisions for our State. I am at your service.

***Jason Greninger, Coalition for Patient Rights:***

I am a certified surgical technologist, and a resident since 1989. The Coalition for Patient Rights provides a voice for the people, aiming to improve the health care of the nation by highlighting systems failures, lobbying, and advocating for regulatory change, treatment education, environmentally friendly policies, and safeguarding new technologies.

We would like to address with you—and potentially with BDRs—the need for Nevada's Medical Marijuana Program (MMP) changes, which are well past due as patients have not had any bills that have truly supported their needs since 2017. The industry has left patients with no voice or rights protecting them, but the patients still need care.

We will be championing and seeking their support and voices supporting one A DUI-D reform bill for patient exemptions and considerations and two MMP program protections and updates such as plan limit increases, removal of halo for all patients, full tax exemptions, removal of presentation fees, removal of MMP application barriers, and an easier, faster application processes. These are just a few of the main needs. We seek truth and we are determined to find that truth. We find that our patients' rights are best protected by transparency and open dialogue.

***Ken Kunke, Nevada Pharmacy Alliance:***

I am a practicing pharmacist here in the State of Nevada, and I represent the Nevada Pharmacy Alliance. We want to thank the Nevada Psychiatric Association for bringing their concerns to you. I feel that the concerns have been alleviated by the two letters that were submitted by Roseman University and the Nevada Pharmacy Alliance.

Pharmacists go through extensive training, and to get a Drug Enforcement Administration license, they will have to do eight hours of training based on medications for opiate use disorders. Also, I want to point out that pharmacists prescribing medications is not new for Nevada. We are already allowed to do that for prevention of HIV—training, the referral process, all health care providers do that—so if there is something that we cannot handle or someone who could do a better job, obviously, all health care providers provide referrals.

Finally, I want to point out that if they feel that the statutes or regulations are hindering their practice, we encourage them to look at getting those regulations or statutes changed and not hindering this service or this access to care for patients in Nevada for opiate use disorders.

***Chair Doñate:***

Is there anyone else here in Las Vegas wishing to provide public comment? Anyone in Carson City? Anyone virtually?

***BPS:***

The public line is open and working; however, there are no callers at this time.

***Chair Doñate:***

That concludes public comment. We also have a public comment period at the end of the meeting, so if folks did not have the opportunity to speak, you can always come back.

## AGENDA ITEM III—REVIEW OF THE INTERIM WORK PROGRAM

***Chair Doñate:***

We are going to move on to the review of the Interim Work Program.

***Mr. Ashton:***

I will start with the responsibilities and duties of the JISC HHS (Agenda Item III). After that, I will hand it over to my colleague Davis Florence, who will provide you information about required interim studies, audits, publications, reports, and other relevant information.

Before I begin, I want to mention that an electronic copy of the Interim Work Program has been uploaded on the Committee's website. You should also have a hard copy in your meeting binder. On page one of the document, you will find a list of the members and alternates appointed to the HHS Committee followed by a section on the Committee's authority and responsibilities. I will focus on the latter part.

The Committee considers a wide range of HHS topics, including child welfare; health care and health insurance; behavioral health; public health, safety, and welfare; and food, drugs,

and cosmetics, among many other issues. This JISC is the successor of the Legislative Committee on Health Care. Its primary responsibilities and duties were transferred to this new HHS Committee during the 2021 Session, including reviewing and evaluating the effectiveness of programs to prevent illnesses, analyzing the overall system of medical care in Nevada, and coordinating service provisions to avoid duplication of efforts. The Committee may also review issues related to health insurance, hospitals, medical malpractice, and health-related regulations, which we will have later today as an agenda item. Additionally, the jurisdiction and membership of the Standing Senate and Assembly Committees on Health and Human Services from the 2023 Session are reflected in JISC HHS.

The Committee may request a total of 15 bill draft requests (BDRs); 10 are within the scope of the Committee and 5 are limited to issues that address child welfare matters. The Committee must conclude its work on or before September 1, 2024. I will hand it over to my colleague who will continue the presentation from Carson City.

***Mr. Florence:***

The two Committee-mandated interim studies are found on page two. First, we have Senate Concurrent Resolution 5 (2023), which requires the Committee to review existing cardiovascular screening programs in Nevada and explore how State agencies may collaborate with federal agencies, programs, and private organizations to evaluate and possibly expand those programs.

The second study comes from Assembly Bill 155 (2023), which requires the Committee to study the cost-effectiveness of biomarker testing. This study will be done in coordination with the Department of Health and Human Services (DHHS), and the bill included an allocation of $325,000 to the Division of Health Care Financing and Policy (DHCFP) to contract with a qualified provider to conduct that study of cost-effectiveness.

In addition to the two mandated issues above, the Committee will focus its time on four primary topic areas, which Chair Doñate mentioned earlier. These include access to health care, behavioral health, health care infrastructure and workforce, and public health.

On page three, you will find relevant audits, publications, and reports relating to the work of the Committee. In addition to the Work Program, this information can be found on the Legislature's website, or you can reach out to staff, and we can assist you with finding these resources.

On page four, you will find a list of the scheduled meetings for the Committee. I would like to note that a tentative joint meeting with the Joint Interim Standing Committee on Growth and Infrastructure has been scheduled for July 17, 2024, pending approval from the Legislative Commission.

Lastly, you will find all the staff assigned to the Committee at the end of the Work Program. This concludes our presentation, and we stand open to any questions.

***Chair Doñate:***

Are there any questions from the Committee Members at this time? Seeing none, we will proceed to Agenda Item IV, consideration of regulations proposed or adopted by a certain licensing board pursuant to NRS 439B.225.

## AGENDA ITEM IV—CONSIDERATION OF REGULATIONS PROPOSED OR ADOPTED BY CERTAIN LICENSING BOARDS PURSUANT TO *NEVADA REVISED STATUTES* 439B.225

***Chair Doñate:***

For this presentation, we have Mr. Robbins, who will go over a few of the regulations. Some of them have already been approved, while others are up for approval. It is the role and responsibility of this Committee to have them come back and for us to provide feedback if there is still an opportunity to do so. There are a lot of regulations on the agenda because we have not met in quite a while, so we will go through them and then take questions from Committee Members if you have pressing questions or comments on any of specific regulations. (Agenda Item IV A) (Agenda Item IV B) (Agenda Item IV C) (Agenda Item IV D) (Agenda Item IV E) (Agenda Item IV F) (Agenda Item IV G) (Agenda Item IV H) (Agenda Item IV I) (Agenda Item IV J) (Agenda Item IV K) (Agenda Item IV L) (Agenda Item IV M) (Agenda Item IV N) (Agenda Item IV O) (Agenda Item IV P) (Agenda Item IV Q) (Agenda Item IV R) (Agenda Item IV S) (Agenda Item IV T) (Agenda Item IV U) (Agenda Item IV V) (Agenda Item IV W) (Agenda Item IV X) (Agenda Item IV Y) (Agenda Item IV Z)

***Mr. Robbins:***

Chair Doñate asked me to provide an introduction to this topic for the purposes of the Committee going forward. The Committee is required by NRS 439B.225 to review each regulation that certain licensing boards that license health professionals or health care facilities propose or adopt that relate to the standards for the issuance or renewal of licenses, permits, or certificates of registration issued to a person or facility regulated by the board, giving consideration to any oral or written comment made or submitted to it by members of the public or by persons or facilities affected by the regulation, the effect of the regulation on the cost of health care in this State, the effect of the regulation on the number of licensed permitted or registered persons and facilities available to provide services in this State, and any other related factors the Committee deems appropriate.

Some of the regulations have been adopted and approved by the Legislative Commission and are effective. This is an entirely separate process from the approval process by the Legislative Commission. The Committee does not take any formal action on these regulations but can provide feedback and suggest ways to improve regulations that are still in the proposed stage or recommend changes to *Nevada Administrative Code* (NAC) sections for the regulations that have already been adopted or even include something related to any of these regulations and its BDRs at the end of the interim.

Normally there are representatives from each agency here to answer questions about the regulations, but because the regulations are so numerous, I am not going to call them out individually. If any member of the Committee has questions about a particular regulation, they can let the Chair know; then the Chair can hand it over to that member and the representative of the relevant agency can come up and hopefully answer the question.

***Chair Doñate:***

Again, because we have quite an extensive list of regulations that have either been approved or are up for consideration, if there is any Member right now who would like to

highlight one that you have a question on, we can circle all the ones that we have. That way, we do not waste time on the ones we do not have any questions on.

For instance, I will go first. The one I will pull aside for discussion is LCB File R069-23 of the Board of Medical Examiners (Agenda Item IV G), so they will answer any questions we may have. Are there any others that Committee Members would like to pull aside? Even if it is not a question, but more of a comment, that is fine.

***Vice Chair Orentlicher:***

I want to comment on LCB File R059-23 of the State Board of Pharmacy (Agenda Item IV R).

***Chair Doñate:***

Are there any others? Seeing none, let us proceed to LCB File R069-23 from the Board of Medical Examiners. If there are any representatives here, you can come forward.

Considering that this regulation is up for consideration, my concerns are more comments, and I had LCB research part of what my comments will be. It is interesting that my understanding of this regulation—and of course, it could be corrected based on what is being proposed—was it is coming to fruition based on the activity of the Legislative Session and is setting up the proposal for anesthesiology assistants to be able to operate in this State.

Part of my question was that oftentimes, when we are creating new regulations for new licenses or practitioners to operate in the State, sometimes we take portions of law or administrative code that can be replicated from one thing to another. That does not mean it is always right, and that is my line of questioning today.

The first thing I wanted to push back and inquire on is in Section 3 of the regulation, specifically Section 3, subsection A, which requires that a person who wants to be licensed as an anesthesiologist assistant must be able to communicate adequately orally and in writing in the English language. My first question is, does this appear in administrative code for other licenses that are under the Board of Medical Examiners? And if so, what is the rationale for that?

***Sarah Bradley, Deputy Executive Director, Board of Medical Examiners:***

I believe that comes from a regulation for practitioners of respiratory care, and I think your point is correct, at least initially when we are looking through our existing regulations to see what we might need for this new license type. I believe that is where that came from, and I believe the examination for certification is only provided in English, so they would need to be able to pass that exam obviously and be certified to be licensed pursuant to AB 270 (2023).

***Chair Doñate:***

That is what I expected the answer to be. I think as part of the recommendations that you should take back to the Board and do some more work on—I was thinking about this the other day: English proficiency does not dictate the competency of being able to do your job. If we had the best surgeon in the world coming to Nevada to do neurosurgery, it does not matter if they are able to speak English if they are able to perform the action, so I think

that is something that we should obviously entertain. If the exam is only being given in English, but we have practitioners who want to move into the State who have years of experience, I think that we should expand those opportunities. That is the only thing I wanted to push back on.

I know that in other provisions of the regulation—and again, I think it is more standard practice, I believe there is a disclosure that requires providers to disclose the prescriptions they are prescribed and whether it would impact their work—we have heard from physicians and other professionals that the application process, right now through the Board of Medical Examiners, can stigmatize those who suffer from mental health conditions. They may not welcome disclosing those medical conditions—if they ever received any sort of counseling, et cetera—I think we should be mindful of these conversations as we approve more regulations. I, for one, believe that we should simplify, not add more. That is part of the review process that we will probably have in coordination and hopefully we can bring you back in the March meeting. That is the only thing I wanted to mention.

Again, I think you need to go back and make sure that all the regulations you have under the Board of Medical Examiners are revised and we take out the English proficiency. I do not think it dictates anything, but that is my personal opinion. Are there any other comments on this proposal?

Seeing none, we will move on. The next regulation we pulled out was LCB File R059-23 of the State Board of Pharmacy (Agenda Item IV R).

***Vice Chair Orentlicher:***

I would like to commend the State Board of Pharmacy for its work on this proposed regulation. As we have heard from public comment, this addresses a serious problem in our State with opioid use and overdoses, while at the same time, we have good treatments that are not reaching people who can benefit. Only 20 to 25 percent of people who have opioid use problems get the treatment that will help them.

This bill, Assembly Bill 156, that we passed last year, is designed to implement best practices for substance abuse disorder, and I commend Executive Director Dave Wuest and the Board of Pharmacy for acting in a timely and careful manner to draft a regulation that will effectively implement the bill and assure patient safety. They have made necessary adjustments as comments have come in and also properly rejected some meritless requests that asked them to duplicate existing regulations or even asked them to nullify the bill. Thank you to the Board of Pharmacy for acting correctly, efficiently, and in a timely manner.

This bill and the regulation allow us to take full advantage of our existing health professionals and their skills. We have a serious shortage of health professionals in this State, and one problem is that we do not take full advantage of the resources and skills we already have. This bill does that with pharmacists to address a critical problem.

***Chair Doñate:***

Are there any other comments on this agenda item? Are there any other regulations that we want to pull before we move on to the next agenda item? Seeing none, let us close this agenda item.

## AGENDA ITEM V—PRESENTATION ON NEVADA'S HEALTH RANKINGS AND PRIORITY ISSUES TO CONSIDER FOR THE COMMITTEE

***Chair Doñate:***

We will now move on to the presentation on Nevada's health rankings and priority issues to consider for the Committee.

***Megan Comlossy, Director of Public Affairs and Policy, School of Public Health, University of Nevada, Reno:***

I want to thank you for the invitation to present to you this morning on the State's priorities for improving health care and reducing health disparities (Agenda Item V). Over the past couple years, the State's Division of Public and Behavioral Health (DPBH) has funded the School of Public Health to lead several projects that look at health needs throughout the State to identify strengths and challenges and then outline a number of priorities to focus on over the next few years. We will talk about both of those projects.

The first is the 2022 State Health Needs Assessment, a report that describes the current health needs of Nevadans. It included a significant amount of data compilation from state and federal sources as well as input and feedback from residents. More than 2,000 Nevadans participated either in a community survey or focus groups to provide information on their health and factors that influence it: physical activity, nutrition, access to healthy foods, and barriers to accessing health care generally. All that data is compiled in the report, and the report paints a picture of what health needs, challenges, and barriers are throughout the State.

We do not have enough time to review all the data in the report today, but I included a link in the slides. We will make sure you have the link after the presentation. What I want to talk about in alignment with the Chair's goal of talking about solutions is how we are translating all this data into action.

The second project that the School of Public Health has worked on, over the last more than a year, is the State Health Improvement Plan (SHIP). This is the first of this type of plan that we have ever done in Nevada, and the SHIP builds on the 2022 Health Needs Assessment. It considered additional information from other sources and was developed in collaboration with close to 100 stakeholders who represented a variety of sectors and organizations.

The plan provides a road map for DPBH and community organizations to work together to improve the health of Nevadans. It provides guidance to state and local agencies, community organizations, and other stakeholders to take steps to improve health. It can serve as a tool to create and refine priorities; prioritize resource allocation; and develop and implement projects, programs, and policies; and it also provides a foundation from which we can take collective action.

Essentially, anyone looking to make a difference in the health of Nevadans can look at the SHIP, review the priorities, goals, and objectives it outlines, and then come away with an idea of the best direction to go in. The idea in making this a State plan rather than a plan for DPBH or DHHS is that we can accomplish more and make more progress together if we are all moving in the same or a similar direction, so it is truly a statewide plan.

To outline the process used to create the SHIP, there was a ton of community involvement. We had a Steering Committee that developed a list of possible priorities. We used a community survey to narrow those priorities. We had subcommittees for each priority chosen, which delved more deeply into the priority and identified sub-areas of focus within those priorities, and we consulted with subject matter experts to inform the goals and objectives that were ultimately included in the plan.

The SHIP has four priorities, and the intention of the plan is to help guide collective action to move the needle on each. These are largely similar to what this Committee is going to be working on over the interim, and a lot of them are also reflective of the public comment that you heard this morning on access to care, mental health, and substance use. These are all super broad issues, but the SHIP narrows the focus of each by identifying three or four key areas of focus within each priority and then creating a goal and several objectives for each of those issues.

I am going to walk through the priorities and focus areas within each, and if you are interested in the specific goals and objectives that are included in the SHIP, they are included at the end of the slide deck and in the actual plan. It is not posted to DPBH's website yet, but it will be soon, and we will provide you the link to it as soon as it is available. When you look at it, you will see that it provides context and additional information about each of these issues, including recent efforts to address the issues, what is planned for the near future, and the goals and objectives.

The first priority area is social determinants of health, which are the conditions in which we live, work, play, age, worship, et cetera. We know that those conditions are more impactful on health and more determinative of our health outcomes than things like genetic factors or access to care, so they are important to consider.

The SHIP Subcommittee could have chosen a whole host of different social determinants of health but ended up landing on the four on the screen. Food security relates to helping ensure people have reliable access to affordable, sufficient, and nutritious food. Health literacy is essentially the degree to which people are able to find, understand, and use information as they make health-related decisions. It is also how health care organizations provide information to people and how difficult or simple they make their systems. Air quality and climate change largely came about due to a number of comments and concerns with smoke from wildfires as well as other air quality issues.

Housing was also a large topic of discussion and something that we saw in the State Health Assessment. The SHIP Subcommittee zeroed in on supportive housing as a specific type of housing that is needed. It combines affordable housing with intensive coordinated services to help people maintain their housing, so if there is an individual with mental illness, they may have supportive services to review the terms of their lease or ensure they are paying their rent on time. If there is an individual with chronic illness or chronic conditions, they may get help managing their diet or ensuring they make it to medical appointments, so they do not end up in a hospital or nursing facility.

Regarding access to care, you have heard multiple times this morning that this is a huge issue in Nevada, both in rural and urban parts of the State, and a lot of the challenges people face in this area trace back to the severe shortage of health care providers that we experience in Nevada. We have probably all experienced issues with either getting a timely appointment or finding the right specialist or person in Nevada who can address our needs.

Health care workforce is a huge issue and makes up two of the subcategories in this priority. The other one is access to oral health care, which is a significant issue, especially among certain groups and in rural Nevada. Oral health care influences overall health in a variety of ways. Oral diseases cause pain and disability, but they are also linked to things like diabetes, stroke, and heart disease. In Nevada, tooth decay is especially problematic among young children, and we know that sort of tooth decay influences young people's health and development, so these are critical things to address in Nevada, especially in underserved areas.

I would like to say that we have seen a lot of momentum in these areas, especially related to workforce. In the Legislature, you passed several bills last session that aimed at improving the health and behavioral health care of workforces, which is huge, so we are taking great strides in the right direction, but there is still a lot to do.

Mental health and substance use are two of the top issues identified in the State Health Needs Assessment, and I think we all see and feel this between the opioid epidemic and the drug overdose death rates. Suicide is also still a huge concern. Last year, the United States Surgeon General produced an advisory related to what he called the "epidemic of isolation and loneliness" and its impact on mental health, and that is not to mention all the behavioral health issues or impacts of the Coronavirus Disease of 2019 (COVID-19) Pandemic. This is a huge need.

We know there is a ton happening in Nevada related to mental health and substance use. It was challenging through the process to narrow the focus of this priority, but our SHIP Subcommittee decided to focus behavioral health issues to those that have a statewide impact or the potential to be expanded statewide, involve major systems change, require State resources, and are being addressed through collaboration of various partners.

The first area that meets those criteria is children's behavioral health, in light of the 2022 U.S. Department of Justice (DOJ) report and investigation that found that Nevada over-institutionalizes children with behavioral health needs, and the need to instead provide more community-based services.

Second is the crisis response system. This relates to 988, which you are all familiar with from funding it over the last couple of sessions. It is the suicide and behavioral health crisis lifeline that people can call or chat with to get assistance, but it is an entire system. It does not stop with the 988 call line. Nationwide and in Nevada, we are working on developing a system that aims to ensure that individuals and families in crisis have someone to talk to, someone to respond, and somewhere to go in addition to 988, including mobile crisis response and crisis stabilization centers.

The third item is improving and increasing substance use prevention, harm reduction treatment, and recovery services, that whole spectrum, and finally, we had to include this as an objective because throughout the SHIP process, we heard over and over from behavioral health experts that having a robust behavioral health system relies on sustained and comprehensive funding, and it needs to be more funding than we have had in the past. We cannot and will not improve the system without significant and ongoing investment and it cannot be taken from funding that is currently available and going to services and putting it somewhere else. We need to expand the pie of funding, whether that is looking at new sources or leveraging existing sources in new ways to increase funding.

I also want to note the SHIP builds on a ton of work that is happening across the State in these areas at all levels, from the smallest community-based organizations all the way up to State departments. The SHIP's goal was to highlight and elevate the work that is happening and build on it rather than duplicate it. There is a ton going on here, and we could have focused on a million issues, but these are those that were included in the plan.

The final priority is public health infrastructure. You all know from this past session and other experiences that public health serves a critical role in keeping people healthy, but that work, and those systems are often invisible. You do not necessarily see the public health work that is happening. You all know that public health is different than individual health, the health care you seek in the doctor's office or at the hospital, because it focuses on keeping entire communities healthy and safe, doing things like preventing and controlling infectious disease and making sure water is clean and the food we get at restaurants does not make us sick—that sort of thing. We know that the COVID-19 Pandemic brought more focus on public health than ever before and exposed a number of issues in the public health system that we did not realize were there, but which need to be addressed so the public health system can better respond to public health crises in the future. That is where these specific subcategories came from.

We have made progress in a lot of them. A huge thanks to you all for passing Senate Bill 118 (2023) last session, which provided the first flexible funding ever to local public health authorities to address the issues they need to in their communities. That is such a huge step forward and a good start, but sustainable funding is what we are going to need if we are to address all those systemic issues that are the result of decades of chronic underfunding in the public health system.

With other issues like public health workforce, we see high vacancy rates in some public health agencies. We also know that we want a highly qualified public health workforce if we want them to keep our communities healthy. This is also a field that is heavily reliant on collecting and compiling data and easily communicating to partners to stop the spread of disease and that sort of thing. There is a significant need for modernization and steps are currently being taken, but we need to take additional steps.

The final piece is identifying opportunities to engage with communities and ensure public health systems meet their needs. An example of this is the recent creation of the Central Nevada Health District, which is the first rural regional health district in the State. It was created by four counties that came together and said, "We think we can deliver public health services better to our people. We understand our needs better, we can do this, and we want to do it," and ensuring that all communities have that opportunity.

In terms of next steps, we are working on developing an action plan for each objective that is included in the SHIP and compiling into a comprehensive plan. We are working to implement them. We are going to track implementation and report progress through DPBH's forthcoming performance management system, so we are building in accountability, and then we will review and revise the SHIP action plans annually through 2028.

What is important to you is what the SHIP means to you, why you should care, or how you can use it. Essentially, the SHIP can be a tool to you as policymakers. You can consider the priorities outlined in the SHIP as you think about issues to consider either during the interim or the legislative session. It seems like there is already a lot of alignment with what the Chair is planning to consider and the SHIP. You can review and identify specific goals and objectives that have policy options or policy solutions and then consider policy options to

meet those needs for potential BDRs. You can also encourage community organizations, agencies, and stakeholders in your districts to become familiar with the SHIP and align their work to it as well, because if we are all working in the same or a similar direction, we are going to accomplish more in all these priority areas than we would individually.

That is all I have. I would be happy to answer any questions and there are also representatives of DPBH here to help answer questions.

***Chair Doñate:***

The way that we will handle these presentations—if you notice many of them start with the context of problems and then there are solutions, and now we are in the question-and-answer period. Also, this is more of a conversation. We can ask our presenters as we are going through each of these presentations and throughout this interim about their perspectives, and how we can tackle these challenges.

The reason why I wanted this presentation to go first is because this is the ground that we currently sit on. We know there are plenty of issues that we can go into related to health care, but we cannot solve all of them in one or two years. These are the areas that we should be aligned towards.

Coincidentally, when we were working on the work plan, I did not plan for the priorities to be the same as this presentation, but I think it is timely because a lot of this is aligned in addressing pressing needs. We can ask any individual questions we may have on what was presented, we can offer feedback, and we can ask for their personal recommendations. At this time, let us allow Committee Members to ask any questions if they have any.

***Assemblywoman Brown-May:***

My question is related to the timeliness of the projected action plan. Do you have an estimated delivery date? How quickly are you working on the action plan?

***Ms. Comlossy:***

We are currently working on it; I would say it is half done and we will probably have the actual action plan completed in the next month or two. Essentially, the action plan is going to include an action plan for each objective that is created either by someone within DPBH or a partner organization. It is not going to reflect all the work that is being done to implement or align with the SHIP, but it will provide examples of the type of work that is being done to implement the plan. We are happy to share that with you as soon as it is completed.

***Senator Titus:***

Thank you for putting a very difficult subject in a pretty straightforward narrative, making sure we understand the difference between what is best for public health versus individuals and making sure that we still respect individual rights and liberties to health care. That is always a challenge, and you did a great oversight on that.

One question I have—and we will deep dive into this later and throughout this whole interim—earlier we heard public testimony regarding pediatric care in Nevada and how it is disjointed with no one place to go. A standalone pediatric hospital, although it is a great idea, it absolutely costs an incredible amount of money and takes a lot of work and time.

Having said all of that, you mentioned children's mental and behavioral health, and I am wondering where we are in the process. I know the State has had issues and we are undergoing litigation because of the placement and institutionalization of some of our children. My question is, how many kids does the State take care of out of state and were located out of state? It is all relevant to looking at something we can do within our State. Could you give me a quick update on that, please?

***Julia Peek, Deputy Administrator, Community Health Services, DPBH, DHHS:***

Unless Megan's pulling it up right now on our dashboards, I will have to get back to you. I want to get with our sister Divisions on this. What I will note though, is the SHIP and the work being done here is not the only effort occurring in the interim. Nevada's Department of Education (NDE) developed a working group, which is all our sister agencies at DHHS, community partners at our universities, and we are going through trying to figure out what we can do in the area of children's health with their families as wraparound services. Behavioral health, of course, rose to the top of that, and physical health later, but we have more in physical health than we do in behavioral health. We are putting forward great ideas and recommendations of how we could do differently and also looking at grant funds that could potentially help us across all of the agencies.

There is good work being done that I want to highlight, but we can get you data unless Megan wants to speak to that right now.

***Ms. Comlossy:***

I would note that DHHS has a data dashboard that identifies children and youth out-of-state placements; we can provide this link to you. They have data on how many are out-of-state at the end of the month, admissions, discharges, total placements, and those placements that last more than 15 days. There is a ton of information, and they update it at least monthly.

***Senator Titus:***

Great. I am sure all of us would like that. Perhaps you could share that link with all of us. I think it is good information to have as we move forward and get priorities with what this possible Committee can do and recommend on a statewide basis.

***Chair Doñate:***

Any other questions in Carson City? Anyone here in Las Vegas?

I have a quick question, and it is probably more of your personal feedback working in public health. I want to ask about the public health infrastructure; there is workforce, data, information technology (IT) modernization, and of course governance. I know in the last Legislative Session, we worked on SB 118 that would establish the continual funds that could help public health entities coordinate together in response to new outbreaks, et cetera. That proposal was structured under our per capita rate, which we needed to achieve the gaps in our funding for public health. You alluded to the fact that we also need to figure out a sustainable funding mechanism for it.

My real question is, we want to make sure that we empower the new Health District that has been stood up in the rural areas, but there are still counties that have not joined that District. What do you see in terms of the future of public health so that counties that

have not participated in that Health District also are uplifted, and we can drive and empower local jurisdictions to also have a stake in terms of delivering and improving public health? Do you have any recommendations? Should the future of the per capita rate change? Should it modulate? Do we provide a base? Do we provide them more funds based on performance? What do you foresee as a progression for this legislation?

***Ms. Comlossy:***

Currently, our partners at the Nevada Association of Counties (NACO) are conducting assessments in all counties in Nevada looking at how foundational public health services are provided, and providing that information to local officials to have the information they need to determine whether they would like to establish a local Health District similar to the Central Nevada Health District or on their own, whether regional or single county or single entity. They are working on that assessment and doing it in conjunction with the Nevada Economic Assessment Program at the University of Nevada, Reno (UNR); they are economic people who look at all the data and numbers, so they are pulling that information together as we speak, and I think they have met with six additional counties to provide that information. They are currently planning on meeting with the rest of the counties to pull that information together. That piece is moving forward, I am going to refer to Julia Peek on the funding piece and where we go from there.

***Ms. Peek:***

I want to acknowledge the work of NACO. A silver lining in the COVID-19 pandemic is the partnership we now have with NACO in public health; they have a public health liaison that works with us. In addition to what she is doing with the foundations of public health, she is also working on SB 118 funds, and some of the feedback we have heard from the smaller rural counties is that it should be a funding formula with a level of infrastructure based then a per capita on top. This is not atypical. We have done funding formulas in the past, so we are looking forward to talking with NACO, getting that feedback, and figuring out what that might look like if it is different.

As you know, SB 118 is not ongoing funding. It was a one-time appropriation. It starts July 1 and goes that year and then they could spend the following year as well, so we are looking at foundations of public health in that regard and what the individual county sees as the need. The bill was designed for them to dictate what that looks like, and then we provide the support to make that happen.

I will note that there are several counties working with NACO to remove the assessments in NRS Chapter 439. That is a first step, and you saw that with the Central Nevada Health District. They are expressing they would no longer like to pay DPBH to do that assessment on their behalf. It includes infectious disease response, nursing, and environmental health services. That will come forward to the Governor and if he supports it, a recommendation will move on to the Interim Finance Committee (IFC). That would be the first process of standing up local public health services. There are a few counties—we are not ready to present which counties yet—but NACO is doing a great job helping them walk down that path.

***Chair Doñate:***

As you are going through this process, if you have any recommendations in terms of implementation or reconsiderations, I think we need to make sure that we prioritize that.

Are there any other comments or questions? Seeing none, we will close this agenda item and move on to the next one.

## AGENDA ITEM VI—OVERVIEW OF OBJECTIVES AND PRIORITIES AT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE STATE OF THE POST-CORONAVIRUS DISEASE OF 2019 HEALTH CARE LANDSCAPE, AND ALLOCATION STATUS OF FUNDING FROM THE FEDERAL AMERICAN RESCUE PLAN ACT OF 2021

***Chair Doñate:***

Our next presentation is the overview of objectives and priorities at DHHS.

***Richard Whitley, Director, DHHS:***

I was asked today to present on specific focus areas (Agenda Item VI), but before that, I think it would be good for me to lay a little bit of the foundation of our agency. Sometimes to a fault, we try to be all things that are needed, and you will hear when I talk about the post-COVID-19 environment with workforce and those things, the challenges, but I think it is important that I lay out a little bit of our infrastructure.

You can see our organizational chart. We are organized in divisions, but our role, regardless of division, falls into functional areas, is to deliver, fund, and regulate direct services. Medicaid is the largest payer of health care, and you will hear from them after my presentation. We do this with a workforce of about 7,300 employees, and our budget is a little over $8 billion annually with funding sources being the State General Fund, federal funds, fees, and settlement funds. The largest use of funds is with Medicaid as the payer of health care.

Our agency priority areas. As you heard previously, access to care is one of our priorities, but I think it is important to acknowledge where we came from. In 2012, prior to the Affordable Care Act and the expansion of Medicaid, Nevada's uninsured rate was 72 percent. I think it is important because most of the policy making as it relates to health care has been incremental and did not happen overnight. As we manage expectations going forward, it is important to look at that.

On access, you have the people and then you have the system of care for the people. We are currently at about 90 percent of people insured in our State, so who is that 10 percent? Are they choosing not to be insured? Are there barriers? Are there disparities in terms of populations? That is an area we are looking at to see if there are people out there who we could do outreach to make it easier to get enrolled and to have health care coverage.

The other component of access is the actual health care system, and I think the Governor and the Legislature passed—both in budget and in legislation—unprecedented rate increases and services for the health care network. As we see that shake out in terms of the more robustness of the health care, I think that will definitely improve access. As mentioned earlier when it comes to access, we have some clear deficits; you heard about pediatrics, but in the space of primary care, we are trying to prevent perhaps inappropriate use of hospitalization.

There was a question related to the U.S. Department of Justice (DOJ) substantiated complaint for children's behavioral health, and the specifics of the complaint are a public

document that anyone can look at is over-utilizing or relying on institutional levels of care when home- and community-based services likely could have prevented that hospitalization. We have been working for the last year with the DOJ on an agreement and although what caused us to have to do this, not good. I think the process of actually looking at—you have data in one place, and you have advocates in one place, and bringing everything together in a way to put together a package of services that could prevent hospitalization or institutionalization of children for behavioral health needs has been a highlight in my career of being able to detail that.

Many states have had these findings. What is different for Nevada is that the Governor's bill, SB 435 (2023) that the Legislature passed, allowed us to take 15 percent of the voluntary provider tax for hospitals and utilize up to 15 percent of that to invest in children's behavioral health to address this deficit that was identified by DOJ. We are finishing that project with DOJ, finalizing the agreement, and we will be going to IFC with a package that will detail the services for children for home- and community-based services. It is not just adding new services, it is also looking where we needed to increase rates, because we have service providers who were not providing the services because the rates are too low. We are happy to provide an update to this body as well. For those of you who sit on IFC, we will be presenting before you the logic on the new services and rate increases going forward. That is the most specific I can get because we have not yet finalized or signed off on the agreement with DOJ, but we have been having weekly meetings with them, the Medicaid team, and clinicians from the Division of Child and Family Services (DCFS), so I wanted to revisit that question that came up in the last presentation.

That all goes to access, and I do think that none of these issues or solutions are simple, but I think the primary care piece is clearly an area for other populations—seniors, adults—that we are focused on how we can move the dial as it relates to health care and preventing the inappropriate use of the emergency room or hospitals so they are getting that care at the community level.

A big part of that access is workforce again, a complex issue, and it is not just doctors and nurses, it is all the allied health care clinicians that allow doctors and nurses and others to provide services to their highest scope of practice. As you will hear at the end of my presentation on an update on the U.S. American Rescue Plan Act (ARPA) of 2021 funding, we have demonstrated great benefits from investing at different places along the pipeline for workforce, and that focus, whether it is the licensing board—because it is not all about making new providers, it is also inviting providers out of state to more easily enter our State with their licensing boards. It is not always easy, and if you have a husband and wife, which we have had, and they are in different disciplines and their boards work at different paces, that presents a big challenge.

The complexity of the health care workforce, even who is attracted to that clinical workforce—for example, social workers. There was another Committee this week on people with disabilities, seniors, and Veterans, and social work came up as a discussion point where there are vacancies. We know that people are attracted to that discipline who sometimes have had life experiences that have allowed them to utilize social services. The investment in scholarships is important in the pipeline, not so much loan repayment at the back end, but in the front end. Where we invest along the way with workforce is critical, and so is knowing what that workforce looks like and what would move the lever for those populations.

I heard the guidance in the beginning about coming with solutions, and I think there is an opportunity for a deeper dive on workforce, not just declaring the problem and not just focusing on a on a handful of providers. We are looking at positive things that we have learned out of the COVID-19 Pandemic, that skilled nursing facilities and hospitals have been able to do by leveraging out of necessity, the scope of practice. With nursing, there is a national shortage, a State shortage, and it was a shortage before the Pandemic. If looking at why that is with our universities and the production and education pipeline for nurses as well as how nurses enter our State and how we sustain them; those are all very complex and do need the detail. As an Agency, we are looking at not thinking single solutions are going to solve the problem but asking how we are incrementally moving towards that, and if it is based on data. Workforce is a key to access.

Finally, we have health care quality and outcomes. Hopefully, you have all noticed what a transformation has occurred in our Nevada Medicaid program with all new leadership. That is in no way to take away from the past leadership—again, incremental. It was the past leadership that allowed the current leadership to move swiftly in making changes. One of the things we are seeing that we will continue you to utilize when it comes to quality is incentive payments. It does motivate health plans to serve. You heard from Ms. Comlossy about determinants of health; they have flexibility in their provider payment to provide services that we cannot as a program for fee for service directly reimbursed. They have a wider margin, and as they look at populations to cover and what those needs are, they offer those wraparound supports that help keep people and families healthy.

Those are our areas, and I think they overlay nicely with what the Committee has laid out as priority areas. The one leveler with health insurance or health plans is that we all get every year to pick a plan. If you know what your needs are and what that plan does a good job at, and I think there is something in that space; we are looking at it. From the previous presentation you heard about data, but data is not information unless it is framed for the user. Lots of reports are compiled, but if it is not framed so it is useful for decision making, whether that is a person or a nonprofit or a for-profit, it is not useful. One of our priority areas for our Department is to do a better job in health literacy and making information more useful to the consumer.

Turning to the post-COVID-19 health care landscape, I looked at it from different perspectives, from the consumer, the provider, and the infrastructure. From the consumer, we saw a lot of pent-up need, either not accessing screenings and things because of the Pandemic, so there have been shortage areas in most of our State prior to COVID-19. That has been exacerbated by the Pandemic. A positive side that we have seen is the use and familiarity with telehealth where perhaps providers are not available in a community, the utilization of telehealth instruments, and feeling comfortable with getting an outcome from that has been a benefit.

With providers, those of you that have been around a long time—most of our State, the federal government's Health Resources Service Administration, they do the national assessment of every state by zip code of workforce shortage areas. To reiterate, but not to linger in a problem, but our whole State is a workforce shortage area for primary care and behavioral health; that did not happen because of the Pandemic. We were in a workforce shortage area prior to the Pandemic, so it heightens our need to be supportive of making improvements in this area and prioritizing where we can move the dial.

The final area is the infrastructure and ARPA investments. I was given 15 minutes to do an overview, and I am not going to do justice. The IFC is not a forum where these ARPA

projects get fleshed out. I will tell you that as an organization, we cluster them differently. We have a monthly meeting by Division looking at the status, so we break them into category areas: behavioral health, childcare, infrastructure like capital improvement projects, public health, social services, and workforce.

To make them meaningful, they need to be discussed in that way. When I think back on when we made requests to IFC for these projects, they were coming fast and furious. Some were approved on consent, so they were not heard, and the report out—because it is a finance committee, they are reported out financially with a driver being, how much is left?

I would say that of our projects at DHHS, 45 of our projects are finished, and we are de-obligating approximately $10 million. Those projects were completed but they were completed under what we had requested. In total, more than $574 million was budgeted to the Department for a total of 148 projects. We can provide them as a spreadsheet, and I think they become relevant as topics are discussed, like what we are doing.

If you sit on IFC, you know that we approached each one with a sustainability plan, and were lead-ins to what we intended to have covered by Medicaid or an investment in workforce that, at the very least, we got the outcome of that workforce we invested in. I do believe, as I said previously, there are initiatives there that are worth us looking at sustaining.

On the workforce, I am looking at opioid settlement funds and targeting the clinical positions that way to continue them. There are probably solutions with braiding funding for as it relates to workforce, but I do think they are worthy of having the discussion of what we saw as outcomes.

One of the best efforts that was implemented by the Nevada Rural Hospital Partners was the nurse apprenticeship program. Joan Hall, who has since retired, stood that program up along with Lisa Sherych, who was the Administrator of DPBH, and the Nursing Board changed their regulations to allow for that program. It was slow to start, but boy, once it took off, it has been an asset. The outcomes are that many of those nurses do stay where they have been able to apprentice and supports them in their education. That is one example as we start to look at this with ARPA funding. It needs to be put in context.

Population focus and geography are other ways of framing these projects. I am happy to provide you a spreadsheet of where our spending is and what the status is, and we are happy to provide it in the way that we utilize it, which is clustering in these areas that are shown in the graph, because it makes it relevant to how we are addressing the problem.

All the administrators have made an effort to not have a cliff that we drop off with services. If to stand something up is an intention, if it is working and people are seeing a benefit, we want to continue it. That is our focus as an Agency. Our timeline and our opportunities are that we will do an agency request to the Governor, and we must compete with other State agencies, but that is our process, so we are doing our due diligence in these areas to have the best outcome possible. I am happy to answer any questions.

***Chair Doñate:***

This is an opportunity for Committee Members to ask any questions that Director Whitley or his team presented on regarding ARPA funding or DHHS. If there are other things that we

have not talked about, you have the opportunity right now to ask. Are there any questions at this moment?

***Assemblywoman Brown-May:***

It is less of a question and more of a statement. First, I want to thank you for all of your hard work from yourself and your team throughout the Pandemic to bring us here today. I want to get on the record that I would very much like to see the spreadsheet of the existing projects so that we know what has been completed and where we are, especially as you work to de-obligate those funds knowing that we do have priorities that we can still address.

***Chair Doñate:***

Quickly, do you know the percentage of ARPA funds that have to be reallocated? Do you have that number on the top of your head? I know there are projects that have, and you are going through that process with IFC. I do not know if you have a number off the top of your head.

***Debbie Reynolds, Deputy Director, Fiscal Services, DHHS:***

According to our spreadsheet, 45 percent of the projects are 100 percent complete, and this represents 30 percent of the projects that are funded overall. I am sorry—were you asking about the de-obligation?

***Chair Doñate:***

Yes, that is correct. From my understanding, there is a deadline the federal government has set for the State of when we must expend those funds, otherwise they must go back to the federal government. Because of the whiplash of COVID-19, IFC allocated funds to certain projects, but they will not be completed in the time frame that the federal government has subsided for us, so now we must reallocate to other projects. Do you happen to have what that percentage is? I am assuming it is a small amount, but I wanted to ask.

***Director Whitley:***

To be declarative, I can tell you with certainty that we are de-obligating $10 million from the projects completed. We are currently working with the Governor's Finance Office (GFO). This is a hard exercise, but we must make projections, which we have gone through with GFO. They are giving us an opportunity to finalize that we are correct, but we must look at projections.

Some projects are easier to do. I would say childcare is an area where capital improvements with expanding or building construction to expand capacity and a workforce piece—because there are workforce shortages there—those have different timelines and different processes. They are being managed by projects for construction, because if they cannot spend it and they had a great idea to expand, but they cannot get construction to do the building. We are internally—and we have not arrived there yet. Chair Doñate; I am not skirting the question. I am saying with certainty, $10 million of completed projects are available to de-obligate. We are working through with GFO to land on a number where we would modify our contracts with providers looking at what they are spending—not just cold cocking them, but talking to them and making sure that everyone is informed and that we are moving at the same pace.

It is going to come down to that, and I have a responsibility for those resources to spend them appropriately and, if they cannot be spent, return them so that they could be utilized for other purposes. I am not skirting your question, but I cannot give you dollar amount. We are working on that now with deadlines to GFO and it has been clear that IFC wants that from us—not just our Department, but all the departments. We are doing the work, and we will have it; and will be happy to share that with you as well as the requested spreadsheet with the status of each project, as requested, so that you could be informed on where we are at.

***Chair Doñate:***

That would be greatly appreciated. My rationale for that question is, if there are certain time frames because of the clawback provisions that we have to send the money back, but there are still good initiatives that could impact access to care, behavioral health, as we mentioned, we still need to at least relook at making sure those projects get funded. That was more my line of questioning, but I think a lot of it can be discussed if you can provide that feedback. Let us go to questions in Carson City.

***Senator Titus:***

I want to point out what you brought up, that we do not hear enough of because I have brought up multiple times falling off a fiscal cliff and worry about the monies that we brought in from the federal government, that we are giving to these agencies, and then what happens when it runs out?

You brought up an important point today, which I do not think gets appreciated enough. There is also the concern about the services cliff. Not only do we look at it from a fiscal aspect, but you in your Department—and I appreciate this—you are looking at what services are going to fall off that cliff, so thank you for making it more reality, more human, and less about dollar signs. When we can no longer fund these projects, the services are cut. I really appreciate the distinct difference there, thank you for putting that in mind.

Sitting on both the Finance Committees and this Committee, it is sometimes hard not to see both sides, and I always look at that. I know our GFO and IFC have been pushing to make sure that we do not send any money back to the federal government, and that we make sure that we keep these funds in Nevada. My question to you is, when you are talking about reallocating this $10 million and there are two distinct different times—one when we must have them allocated, and one when we must have them spent—are you looking at reallocating them within your Department, or would these funds be back to be obligated for whatever "shovel-ready project" is so we do not lose these funds?

***Director Whitley:***

I should have said that. I was not hiding it or disguising it, but I had too many things in my head. We have put forward requests of other needs that have emerged. One that is top of mind is that Vitality Center in Elko has a treatment facility here in Carson, and the Carson Health and Human Services is not renewing their lease in what was an old rehab hospital. They are using it for DHHS and those are about 30 treatment beds serving not only the rural counties, but folks getting out of jail and prison who perhaps could be sustained in recovery that would go offline. That is an example of a project that we have put forward as a request trying to fit within efforts that we are already doing.

Some of those projects that we have put forward are on the side but other priorities—or maybe we got it wrong; there are a few projects that simply could not be executed. It was a great idea perhaps at the time. I think it was probably not most appropriate for the DCFS to do scholarships for registered nurse (RN) to APRNs; it has been a wonderful program, but if I could do a do-over, it would not reside with them. It just so happened that the Administrator was a APRN and came forward with an idea and it is executed wonderfully.

There are things that we had that maybe were a good idea. Certainly, I think in our spreadsheet, we capture that in terms of, some studies that we did not need to linger in the problem longer and thought we do not have—all these require management. I did not go over the challenges we have with workforce, and although we are seeing an improvement with the raises that were given, I think we still are at a deficit in all areas including managing contracts. I am probably tough on staff that if we obligate to a nonprofit, we need to pay them in a timely manner and all those things. There are projects that simply cannot be completed that will be captured in the spreadsheet. We would be happy to provide it and then answer any more detailed questions.

***Senator Titus:***

Along that same line, you mentioned that you have completed 45 projects, correct? Of the other projects though, that $10 million estimated funds coming back, are those projects that are completed and those were the funds that then were not used. I understand that. When you send us that spreadsheet, I would appreciate seeing the other 70 percent of projects that are not completed. We need to know where we are fiscally on those projects too, and how much money might be coming back. That also seems to me to be a huge effort when we are looking at this timeline of making sure these funds are allocated and then spent. Obviously when they are allocated, we would hope that you would have an idea that the money could be spent. That is the key thing. We could allocate money all day long to make sure we meet the deadline, but that one thing about having them spent in a timely manner, I think is important. When you send that spreadsheet, those other ideas and potential monies, would be important to know.

***Director Whitley:***

I know that was not necessarily a question, but I would say we are doing that. I welcome the opportunity to show our work and the work of the divisions, because that is being done and it is being captured. If the delays are that the childcare provider is challenged with getting a contractor for construction, that is captured, so we are happy to provide that. It does not mean there is not a need, but it may mean that we cannot meet the timeline to complete that project. We do capture that by project, and we did a briefing to the Governor's Deputy Chief of Staff last week, project by project, and I feel proud of the work we are doing—never a forum to present it in. I am happy to share our spreadsheet and then answer questions.

***Senator Titus:***

It sounds like you have heard from the GFO and from IFC from the fiscal point, and this Committee, of course, is now looking at the key components that you said, that services fiscal cliff.

***Assemblyman Nguyen:***

It is hard to say you have a 15-minute presentation because how can you be asked to share content of a 1,000-page book by reading the first page? It is difficult, right? It is hard to sum up HHS in 15 minutes. I do not think that is possible. Again, as one of the newer members of the Committee, I am encouraged to hear the workforce piece because it is truly the challenge that we have. Like you said, you had that issue before COVID-19, and after COVID-19, it became bigger, and it changes our thinking and the way that we learn how to see things. It completely changed our game.

Looking at ARPA funding, since we are on this conversation: you said earlier that sometimes between IFC and this policy Committee, there is a lack of understanding in terms of, sometimes we need to make room to get into the nitty gritty details so we can understand not only as lawmakers, but also as everyday people, where HHS is in terms of a lot of these priorities.

I am curious, because you mentioned a lot of workforce things in terms of your priorities and presentation when it comes to access to care, health literacy, and the education pipeline. That is awesome and amazing, but I am curious that the priority on the funding part, even though workforce is a highlight and a priority, it is only 11 percent of the expected expenditure. I figure that is small in terms of allocating resources. Obviously, infrastructure is a huge concept and takes a lot of work; that is why I see 33 percent—and I agree with that—but I am quite curious that if workforce is such a priority, using this one-time funding and setting up this expansion of access, that 11 percent seems a little low in my eyes. Could you address that?

***Director Whitley:***

I would first address it by saying that this is just DHHS. It would be interesting to pull workforce out across all the State agencies that have initiatives going with ARPA funding. I think we are a spoke in a bigger hub, so I would not say this is all. I am trying to choose my words carefully here. We put forward work programs to spend ARPA funding because there were not any other—like the example I gave with nurse to APRN, it seemed worthy because Medicaid had in their budget pay parity. The Legislature passed years ago independent practice. There is a workforce that could help us with primary care. The University of Nevada Reno and the University of Nevada, Las Vegas (UNLV) have their fingers on the pulse of what our State needs are; UNR with a specialty in psychiatry, UNLV with a specialty in pediatrics. Rarely does that happen where the education system, the need, and funding is available. We applied for that from DCFS simply because no one else put forward an initiative on nurse to APRN.

There is more work that is needed here, and I think where those investments are, for workforce as well becomes so important, whether it is the apprenticeship piece and its being able to pay. Uniquely with nurses with the apprenticeship, they can work to the scope of practice they have had training for. The Nursing Board was fairly flexible with helping us to stand that up.

Not all boards are the same. Social work is a good example of one that this chart does not capture—it is ARPA spending, but concurrently, we got a federal grant to give stipends to supervisors of social work interns, so there is more story to be told here. This captures ARPA funding that was allocated by the State for these efforts, but they also need to be put in context because there are categorical funds also being invested in this.

I would say social work is the best example. Social work interns are reimbursable by Medicaid. Employers need to know that so they perhaps could utilize social workers, but you need a supervising social worker. Well, why would someone take on the burden of having students? We have a federal grant that pays an incentive for supervisors to do that. There is a nice pipeline there that you do not have to go too far to connect the dots I believe worthy of probably illustrating something that other clinical disciplines with licensing boards could look at. What better way to promote a discipline that we have a shortage of in the State than to incentivize the workforce at a community level and with providers. It is an incomplete picture both from ARPA and also with the context of other braided funding that goes to support workforce.

***Assemblyman Nguyen:***

I understand there are constraints in terms of this information being available in a manner that can truly give you the full picture. I get that, and I want to make sure that opportunities that we have as a State in terms of having the ability using these dollars. It is not a do over or anything, but it is a way to innovate and modernize the things that we do. I want to make sure that if we are going to prioritize these new ways of doing things or find a much more efficient way of addressing—I think you mentioned earlier in your comment about a couple that is experiencing a licensing issue where the timeline might not be the same because of either data or the way we flow information may not be up to date—looking at the big picture of ensuring that we like these dollars correctly and be able to innovate because this is a good opportunity for us to bring the State forward in terms of the work we have done so well in the past and now we have the funding to do more that we want to do, but we could not do before because of the of the dollars.

I understand the complexity of all these agencies and inter-agencies working, but hopefully, whether it is offline or accessible through a different access point, I as a lawmaker could see these innovations, examples, and these projects you are doing in a way to address these concerns and priorities that you have in a much more detailed manner. I understand today is an overview and have limitations, but I look forward to learning more about these innovations that your team is doing in the State; that is my request.

***Chair Doñate:***

Are there any further comments or questions?

***Assemblyman Gray:***

I am going to go a bit sideways here, but I want to get this out while it is still fresh in my mind. As we are addressing shortages, especially in the social work arena. I think one thing we need to look at—there was a BDR last session that addressed the social work compacts. Two states have passed it, our next-door neighbor Utah—just passed it, and there are some 20 others looking at it right now. If we are to enter a compact like that, that would address some of the need in, say, West Wendover. I hope we could use one of our BDRs to bring this back and take a look at that. I will not say it is new, or fresh, or innovative, but I think it is new, and fresh, and innovative, at least for us, and something that we should use to plug those holes. I wanted to get that out there.

***Chair Doñate:***

If you can send us the mock language, I am sure we can slate it for the agenda when we talk about behavioral health days.

***Director Whitley:***

I will gladly do that for you, sir.

***Chair Doñate:***

Is there any other feedback or anything else? Seeing none, we will go ahead and close this agenda item.

## AGENDA ITEM VII—UPDATES FROM THE NEVADA MEDICAID PROGRAM REGARDING IMPLEMENTATION OF LEGISLATIVE MEASURES RELATED TO MEDICAID PASSED DURING THE 82ND LEGISLATIVE SESSION, PRIVATE HOSPITAL PROVIDER ASSESSMENT, STATEWIDE MANAGED CARE PROGRAM, VALUE-BASED PAYMENT EFFORTS, ALL-PAYOR CLAIMS DATABASE, AND THE UNWINDING PROCESS FROM THE CORONAVIRUS OF 2019 PUBLIC HEALTH EMERGENCY

***Chair Doñate:***

We will move on to our next presentation, updates from Nevada Medicaid.

***Malinda Southard, DC, CPM, Deputy Administrator, DHCFP, DHHS:***

Before we dive into more specific updates, I would like to give a quick overview of Nevada Medicaid, then a recap of the legislative activity from last session impacting the Division as well as updates on our major projects listed. Finally, Deputy Administrator Cantrelle will be providing an update on the public health emergency unwind with respect to eligibility redeterminations for Nevada Medicaid (Agenda Item VII).

As Committee Members may recall, like all states, Nevada Medicaid is overseen by the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services. Every state must have a single state agency responsible for the functions of their Medicaid program, which for us is our DHHS.

The functions of the single state agency for Medicaid in Nevada have been delegated by the Director to two Divisions within Nevada DHHS. These are the Division of Welfare and Supportive Services (DWSS), which oversees the State's eligibility and enrollment systems and outreach programs for Medicaid along with the State's appeals process for recipients regarding eligibility determinations, and DHCFP, which oversees the coverage side of the program. This includes the budget and financing provider, enrollment and payment program, integrity activities, appeals and hearings for providers and recipients on coverage, audits, and the development of benefits and rates. At DHCFP, we also oversee the benefit delivery systems, which include both the managed care program and the fee for service program.

From a Medicaid recipient’s standpoint, DWSS is the point of contact for enrollment acting as that front door to the program and ensuring all those enrolled are eligible once the recipient is enrolled; DHCFP, or its contracted managed care plan, becomes the recipient's main point of contact for coverage and access to Medicaid benefits. Providers also work with DHCFP, or the contracted managed care plan, for billing and payment when serving Medicaid recipients. Since July, DHCFP has been working hard to implement 52 bills that were passed and signed into law last year that directly impact Nevada Medicaid. Two of

these bills require the Division to update regulations under the Director's regulatory authority, while 39 require system updates in our Medicaid Management Information System—that is our payment and claim system—and over 22 State plan amendments and policy updates are required as a result of this new legislation. This is all in addition to over 20 other major projects Nevada Medicaid has underway.

Many of the bills passed last session require the Division to seek and receive federal approval before fully implementing program changes. Thus far, we have received federal approval of many of these requested changes. I want to note there are a few updates, I am going to provide regarding the dates. First, we have the applied behavioral analysis (ABA) rate increase. Next, we have the dental rate increase, and I do have a correction here that this approval is retro effective to January 1, 2024, not July 1, 2023. Another quick clarification here: a retro effective date approval means that providers who already billed for dates of service from the retro effective date through the date the change was approved will not need to resubmit those claims, as they will be reprocessed automatically to reflect the new rate paid to the provider.

We also have a rate increase for both residential and assisted living providers. You will note that assisted living is separated on this list, but the rate increase here includes both provider groups and is retro effective to January 1, 2024. The rate increase for residential group providers has been implemented and the rate increase for assisted living providers is set to implement on February 20. With rate increase for home health and private duty nursing providers, I would note another correction; that system updates have since been implemented, and this approval is retro effective to January 1, 2024, not July 1, 2023.

Additionally, we received approval for our personal care attendant (PCA) rate increases and are providing another update here today, that these system updates have since been implemented. We also have gender dysphoria coverage for adults, physician rate increases effective January 1, and APRN and certified nurse midwife rate parity increases effective January 1.

I am happy to report that last week, we received federal approval of the bill expanding the types of providers able to supervise community health workers. After approval, the next step is to ensure the Division's MMIS system (or our payment claims system) is updated to reflect program changes in payment or coverage. This may take a few additional days or weeks depending on the size of the change.

On the other hand, we have a handful of bill implementation requests that are pending federal approval and review. These include requests for postpartum care coverage expansion to 12 months, skilled nursing facility rate increases—and on that, we are requesting a retro effective date of January 1, 2024—as well as a unique reimbursement rate for specialty clinics for cancer and rare diseases, rate increases for providers of service to people with intellectual disabilities, the personal needs allowance bill, and the dental coverage expansion bill. Committee Members should have also received a handout of the public stakeholder presentation the Division held last month, which includes more detailed information and updates on the over 50 bills the Division is actively working on.

In addition to State plan coverage updates, the Division has several waivers it is required to seek and implement under State law. The first one is the State's Section 1115 Waiver of the U.S. Social Security Act to permit Nevada Medicaid to draw down federal funds to help cover the cost of substance use treatment for adults in residential settings, also known as institutions for mental disease. The State received federal approval for this Waiver on

May 24, 2023, but was not able to fully implement the payments until it received federal approval of the implementation plan, which we did receive on August 1, 2023. The Division is currently awaiting federal approval of an updated payment methodology that will improve payments to these residential providers under this Waiver.

Additionally, the Division is working to implement legislation from the 2021 Session, which includes seeking additional federal authority to cover the cost of treatment in residential settings for adults with serious mental illness. The Division hopes to submit this Waiver amendment later this year for federal approval with an effective date of January 1, 2025, pending CMS's review timeline.

The third item on this list is from another 2021 bill that required the Division to seek federal authority to cover dental services for a segment of the adult population with diabetes when treated in a federally qualified health center. The Waiver is still under review with CMS, and the Division is involved in answering various questions from CMS regarding this waiver at the current time.

Lastly, the Division is in the very early stages of planning for a new 1115 Waiver submission. This Waiver is the result of AB 389, which requires the Division to seek new federal authority to allow the State to draw down federal matching funds to cover services for individuals who are incarcerated up to 90 days prerelease. The Division recently secured a list of vendors to support its waiver activities and is working to identify which vendor is going to best support these efforts. We plan to establish an advisory committee across multiple stakeholders and agencies impacted by this Waiver, including DWSS, Department of Corrections, counties, jails, our managed care organizations, and several others with an emphasis on gathering engagement and feedback from those with lived experience as this is truly a community conversation requiring that cross-system collaboration.

Before we move on, I did want to note that CMS has reported up to a five-year waitlist for certain 1115 Waivers. Administrator Weeks is exploring ways to reduce this timeline, one of which includes asking the National Association for Medicaid Directors to work with CMS on strategies to simplify or streamline the Waiver process at the federal level.

In January of this year, the Division implemented the new private hospital provider tax and payment programs. This slide provides an overview of the various activities since lawmakers last convened during Session. As you can see the Division conducted the required survey of hospitals and received the necessary votes to move forward with implementation. This included seeking federal approval of three new Medicaid payment programs to supplement payments made to private hospitals in the State of Nevada. In mid-December, CMS approved all three payment programs. This includes approval to pay new supplemental payments to private hospitals retroactive back to July 1, 2023, with respect to claims paid through the State's fee for service program.

For the first two quarters of this calendar year, the Division is applying a ramp-up period to avoid cash flow issues for hospitals with four assessments and four payment cycles.
To date, the Division has issued two tax invoices and completed a full payment cycle to complete fee for service payments made to private hospitals. The second payment cycle is scheduled to be sent to hospitals on February 23. Starting July 1, 2024, the Division will end this ramp up period, and we will issue invoices and payments once per quarter.

The total new Medicaid supplemental payments made to hospitals are reflected in this chart with approximately $552.6 million to be paid in Fiscal Year (FY) 2024 and a projected

approximately $927 million in FY 2025. As a reminder, these new payments are made up of two revenue streams. One of which is the new tax revenue paid by all private hospitals, and the other is the new federal Medicaid fund the State is now able to draw down to match the tax dollars. The provider tax revenue makes up a little over one-third of the total new supplemental payments made to private hospitals.

Along with the implementation of the provider tax, our team has been working hard to prepare for the rollout of statewide managed care in 2026. To gather feedback, the Division visited all rural hospitals this past fall and released a request for information to gather information from stakeholders on the upcoming procurement. Some common themes raised by stakeholders for consideration included the need for greater use of telehealth in provider networks, improved access to reliable non-emergency medical transportation, new strategies to address significant gaps in the State's health care workforce, and solutions to the State's behavioral health crisis especially in rural areas of the State.

To support the development of the request for proposals (RFP) the Division contracted with Manatt Health Strategies earlier this month. We are currently aiming for a release date for the RFP sometime in October of this year to ensure enough time for the contracting process and any necessary system updates. The next public workshop on the statewide expansion of managed care will be held on February 22, 2024, at 3 p.m.

The expansion of managed care will impact about 75,000 rural Nevadans. We have recently updated the numbers, so when we look at today's population, managed care serves about 72 percent of the population. This expansion is anticipated to increase the portion of the population served by managed care by about 10 percent or less. This is because the Medicaid expansion does not include all individuals enrolled in Medicaid. Instead, the managed care expansion only applies to adults without children up to age 64, children who are not in the welfare system, and parents or guardians up to age 64. Other populations across Nevada will remain in Medicaid fee for service, which includes those listed here on the slide. I also want to note that tribal populations will remain a voluntary managed care population, meaning once enrolled in a Managed Care Organization (MCO), they can request dis-enrollment to fee for service at any time.

Another important effort we have been working on with managed care plans is increasing the use of value-based payment design in the State's Medicaid program. By using more value-based payment models with providers and plans, the Division aims to gain better value for the taxpayer dollar. This effort includes tying payments to value and quality rather than only volume like fee for service and rewarding providers and plans for improving outcomes and increasing efficiency in the system, which includes lower costs.

Right now, the Division is focusing on several initiatives that aim to advance the use of value-based payment design. The first is a new hospital and health plan collaborative on using value-based payments to improve quality and outcomes. This initiative will begin later this year. The second is a new bonus payment program in the managed care program that rewards plans for increasing spending on primary care services and for conducting certain public health campaigns to improve prenatal and postpartum care. The last effort will begin later this year when the Division begins developing its new procurement proposal and budget concepts for next session. This includes developing certain State models for value-based design that will work across all plans in the State's Medicaid Managed Care program with consistent metrics and requirements.

Last but of course not least, is the State's new All-Payer Claims Database (APCD). The Division recently collaborated with OnPoint Health Data to develop the State's new APCD program over the next 12 months. The Division also received federal approval in December of last year for enhanced federal Medicaid funds to help support this effort at a 90-10 match. Regulations related to APCD are currently in the process of being finalized, and the Division anticipates hosting a public workshop in the coming months prior to submission of regulations to LCB. More information about APCD and this process is available on the APCD website. With that, I will turn it over to Deputy Kelly Cantrelle to discuss the Medicaid unwind process.

***Kelly Cantrelle, Deputy Administrator, Division of Welfare and Supportive Services, DHHS:***

I am going to talk to you briefly this morning about the unwind. In the middle of last year, the Medicaid unwind from the public health emergency started, and what that means is that for the first time in three years, individuals who are no longer eligible for the program, or who failed to turn in their renewal packet, could be and were terminated from Medicaid eligibility.

Three months after we started the unwind, we received policy clarification from the federal government letting us know the way we were doing renewals was no longer an appropriate way of doing them, so we moved into reinstating about 114,000 individuals and put them back on Medicaid until we could meet the requirements of the new policy clarification.

Three months after that, in January of this year, Nevada was able to restart eligibility determinations, and once again, individuals that do not turn in the renewal packet or who truly are not eligible for Medicaid are terminated and lose their Medicaid coverage. The unwind in the State of Nevada is expected to end in September 2024, so we are right in the thick of it.

What does that look like? In the beginning of the unwind, fewer than 30 percent of individuals were able to be renewed using our automated renewal process, which you will hear called ex parte. The ex parte process uses electronic data sources and can renew individuals without any intervention from a worker or need for the customer to return a renewal packet, but due to system enhancements and flexibilities that we have been allowed through waivers since renewals have resumed, that number went from 30 percent of individuals being ex parte to 69 percent of all individuals being ex parte. Again, that is without the need of any worker intervention or mailing out a packet to our customers.

That 69 percent are ex parte and an additional 18 percent are turning in those packets that we send through the mail. They are continuing eligibility based on their own efforts, so what that means to us today is that 88 percent of all Medicaid renewals due are turned in and are renewed and are found to be eligible. This is huge.

I want you to know that prior to COVID in 2019, 31 percent of all Medicaid individuals were terminated for failure to provide that redetermination packet. This is historic. This is a historic high. We have a historic number of people retaining Medicaid eligibility and continuity of care, and we fully believe that it is due in part if not entirely to the collaborative and outreach efforts between the Welfare Division and Nevada Medicaid, Nevada Health Link providers, community partners. Together we are now only terminating 12 percent of all Nevadans off Medicaid. Those are my brief comments, and Ms. Southard and I are here to answer any questions that you might have.

***Chair Doñate:***

I have a few questions, but I know everyone probably does, so I will let other folks go first. I do have one quick comment. I asked Medicaid to include this in their presentation items. There are specific things that I wanted to make sure that we are aware of—same thing with some of the bills that we passed, so we can understand their workload in the interim—there was one that obviously was left off. I would ask that we refrain from asking questions related to the public option because we will be coming back to that towards the end of the interim in a different meeting. This item for the presentation in question should be solely focused on the items that they have presented. If we can please keep our comments to that.

***Vice Chair Orentlicher:***

I want to pick up where you left off. Congratulations on the 88 percent. That is great. I wish all my students would be at least at that level. I am interested in another statistic: historically, there have been problems with people who are eligible for Medicaid, but do not enroll because they are not aware of it, or it is complicated. Whatever. Do you have a number on that—where we are? Have we been able to close that gap on making sure people sign up in the first place as opposed to renewing?

***Ms. Cantrelle:***

I do not have those statistics available with me. I believe we have that on our dashboard, and we could get that information back to you, but I will say the Division of Welfare has an unprecedented, targeted outreach partnership group, a team of individuals who work out in the community. They do not work in a traditional welfare office. We are in 196 outreach sites, including criminal justice, medical, social services sites like dental schools and jails, and we go out into the community to meet people where they are, to break that stigma of someone having to come to the welfare office. There is extensive outreach to get people on our programs.

We also do events where we will go to—for one of the events I can think of offhand, we went to a Latin grocery store, set up tables, dressed everyone down in blue jeans and t-shirts, and we talked to them about, "Hey, are you interested in any programs? Do you need food stamps or medical?" It was a very informal 'meeting people where they are' setting, so I think we try to do a good job of reaching out to individuals where they are to try and close that gap.

***Assemblywoman Brown-May:***

That is a lot of great, detailed information. Congratulations on the progress being made. My question is relative to the PCA rates. That is what I get most often in my inbox. I have moms of adult children who have significant needs and the personal care services that allow them to go to work—there has been a delay in the implementation and the rate increases you reported, though, that have now been implemented. Can you talk a little bit about that? When did that take effect? Why did we not go back to July 1, as opposed to that January 1, 2024, implementation date?

***Ms. Southard:***

I know that our team has been working hard to get that implemented, and as I mentioned, if we have the retro effectiveness back to the January 1 date. However, I cannot speak to

why we chose January 1 over July. I defer to any of my colleagues in Carson City who may have that information.

***Chair Doñate:***

I am not sure there is anyone in Carson City who can answer that question, but if not, we can have Medicaid come back and provide us a response to that.

***Senator Titus:***

Thank you for the presentation and especially the update on the unwind. I get a lot of questions regarding that, and it has been in the news a lot. I appreciate the fact that you as an Agency and we as a State were not trying to kick people off Medicaid. There was a process, and you had that setback because the federal government said, "You need to do it this way," and moving forward updates on that.

My question revolves around the application—good job on getting 88 percent of those returned. I am very impressed with that. I have been at this in the past and the accessibility of getting those applications returned, and a lot of folks who are on Medicaid may not have a home, may not be able to get to the post office, or may not be able to return those; I am wondering if you are continuing that collaboration at different sites, say, the Food Bank where folks come in and I know there you can apply for Supplemental Nutrition Assistance Program and different things. Are you continuing to be at those locations? I think I heard you say you do set up and you went through a different Hispanic location of some sort—I am not sure that you were there, present. Are you also continuing that here in the North and making sure that you get out there in the community to make sure all those are eligible indeed are getting signed up for it?

***Ms. Cantrelle:***

Yes, we are definitely in the North. We are in the rurals. If we cannot service the site with someone in that actual location, we do service especially the rural sites virtually. I rattled off a couple—criminal justice, medical, social services—but we also attend health clinics and health fairs. We do tribal health fairs. We are in behavioral health clinics, in libraries, and we go to back-to-school nights. If you can think of it, we have probably been to an event or were in an area where people are. We get requests for these all the time. In fact, my waitlist right now for community partners is 86. There are 86 more sites that want our people there and due to staffing and what it takes to get this stuff done; it is hard. We are even in safe nests—we are in domestic violence—we go as many places as we possibly can and cover as much ground as we can, and yes, we are looking to grow that program. It is something that is on our mind every day, and I feel like the more we could grow, the more we could reach people.

***Senator Titus:***

In the news recently, we have seen concerns about people who are dually eligible for Medicaid and Medicare. What kind of set up do you have for that? It is becoming more of an issue of folks who qualify for both and somehow, they get lost in that.

***Ms. Cantrelle:***

We also service individuals that are Medicare and Medicaid eligible. There are programs where they get Medicare for their medical appointments, and we will pay for the Medicare

premium, help with copays, and stuff like that for Medicare individuals. That is done on a tiered basis, so the higher the income they have, the fewer things are covered, but we do work with both Medicare and Medicaid patients. It is something we have done for quite some time. I hope that answers your question.

***Senator Titus:***

Broadly, it does. The proof will be in the pudding, though, on how easy it is for folks to do that. One final question: you mentioned people applying—the dashboard. How easy is it? Where do we go for that website? What I am looking for—and the question would be on your dashboard, and I know this is a moving target—the number of folks who are on Medicaid now versus the number who were on pre-COVID-19. Do you have those types of numbers on your dashboard? If so, what is a quick easy access that we can go to find that?

***Ms. Cantrelle:***

Yes, we do have those exact numbers on there. The dashboard is accessible through the Office of Analytics, but you can get there through the Director's Office website and then it is accessible through that. We can make that link available to you after this if you would like, for that to be a little bit easier. I will tell you we were right around 950,000 Medicaid recipients at the height of the Pandemic, and right now, we are at about 884,000.

***Senator Titus:***

What were you before the Pandemic?

***Ms. Cantrelle:***

We were at 650,000 and those numbers are averages.

***Senator Titus:***

If you would please make that available, because having to go through one website to go to another website, to go to another website, to get to the dashboard—it would be nice if I could go to the dashboard.

***Ms. Cantrelle:***

We will get that link over to you.

***Chair Doñate:***

Are there any other questions? I will ask mine. First, I want to talk about the assessment and payment schedule. I think it was impactful that the providers for the hospital assessment came together for this good initiative. Do you by any chance have a breakdown of how much each hospital will get in terms of new revenue for the next projected two years? Is that something that you guys have already?

***Ms. Southard:***

I am going to defer to Lynette Aaron in Carson City.

***Lynnette Aaron, DHCFP:***

Yes, we do have that information, and we can provide that offline.

***Chair Doñate:***

I think it would be helpful for Committee Members to understand how much new revenue is going to be projected and, of course, through the federal matches that we have coming in.

The next question I have is on the value-based payment design program. I know there is a bonus program tied to participants and managed care. I talked to a lot of physicians that do not want to deal with MCOs. They do not want to deal with Healthcare Effectiveness Data and Information Set measures, et cetera, but it is probably because of how complicated it is, and they trace straight to fee for service. Are there options or are you thinking of incentives to help providers who are maybe independent, but do not have the capacity; they are interested in helping follow quality metrics, but they do not participate in other programs? Is that something you have considered to help those small physicians who need a little bit of support to help their patients receive better access to care?

***Ms. Southard:***

Yes, absolutely. The Division is happy to work with all providers to determine how we can mitigate those gaps and help break down the barriers to access to care for folks. We want to engage with them in a conversation and work with them.

***Chair Doñate:***

The last conversation is with the public health emergency unwinding. Walk me through the outreach processes. You mentioned that you have situated yourself in making sure that you are in a community that you are presentable and accessible, not intimidating, et cetera, but I think oftentimes, there is planning and then there is the implementation of it. Working in the health care space, we see that outreach can be incredibly difficult. Especially if people are transient and they listed an address, but their address is not exactly where they live. We, as government officials, will send out government notices saying, "Hey, you need to fill out this form," but they might not even receive it in the first place. We have found it incredibly difficult to reach out to folks who are perhaps experiencing homelessness and so forth, and it is incredibly complex to reach those populations for health care delivery. What other processes outside of going to grocery stores, do you have in place? Do you have a door-to-door knocking program? Are you going out to those communities? Are you calling them several times before you unwind them? Walk me through that process if you can.

***Ms. Cantrelle:***

For our outreach, I will say the homeless population is indeed hard to reach. I want to say—and this is a guess off the top of my head—I believe we have nine people who sit at the courtyard to help service that homeless population. When our people are out in the community, they have what we call an "office in a box," so they have everything they need to hand over a food stamp card—if someone applies for food stamps, they can hand them that card so they can access benefits and not have to go to an office to get that part of it done. It is very robust, organized, and efficient in that regard.

In conjunction with DHCFP, when a renewal is due, multiple people notify the individuals to let them know, not only Division of Welfare, but DHCFP texts everyone, so when the

renewal is coming due, they send a text message. The pharmacists have been made aware of lists of people and doctor's offices, and they are saying, "Make sure you watch your mail," or "Do you know that your renewal is done," because that is stuff they can see.

***Ms. Southard:***

We also have tear-offs that we have distributed to several providers saying, "If you have lost your coverage, here is a quick "how to" to gain that access back." As Deputy Cantrelle noted, yes, we have our Medicaid app where we text recipients and listservs, and send several notifications to try to get the word out the best we can. We are doing our best to reach everybody.

***Chair Doñate:***

I think about data and metrics, and obviously we have our dashboards, but I think what we see nationally—and Nevada is not the only one—is oftentimes, when we have these departments and organizations, by nature of organizing things, there are departments that collect data that do not work in conjunction; are there opportunities that you see in partnering with, say, NDE? If parents are filling out forms for free and reduced lunch, that could be a trigger to making sure that we are connecting the dots and working together across departments. Is that a conversation that has existed? Is there work being done, or do you need an infrastructure to bring that together? It is more of a question of how connected are our data points that we have across our government system; that is probably the better way of phrasing it.

***Ms. Southard:***

Yes, we have an excellent collaboration with NDE. We also work with them closely in our school health services program, as several school districts can request Medicaid reimbursement for authorized services provided in the schools. We are very connected with them in that way, and we have talked about how we can communicate better to parents through their fliers and things they send home with the children. We are collaborating with them and looking forward to collaborating with several other State agencies, especially as we work on these other projects. It is related to AB 389 (2023) and the Section 1115 Waiver and connecting with the other State agencies in that way. We are open to the conversation.

***Chair Doñate:***

One more clarification: for the folks who, as part of the unwinding who are now going to be disenrolled because they did not submit their paperwork, et cetera, has there been any post follow up on that? I am assuming a lot of them are, "I got a job. I already have health insurance. I do not need Medicaid anymore." Obviously, some pass away, some of them move away, and so forth. Are there any metrics that our State has gathered post-unwinding to try to make sure that it was not a mistake, essentially. Explain to me what those efforts have been from the Division.

***Ms. Southard:***

I will defer to Sandie Ruybalid in Carson City.

***Sandie Ruybalid, Deputy Administrator, DHCFP:***

I would add that part of our outreach also involved the MCO doing direct outreach because they are very motivated to keep their members. They do not want to start over, so that was a key factor. We are not currently gathering or surveying members about why they are falling off the rolls. Some states are doing that. We do not have the resources at this time to perform that type of outreach. I would add—and maybe Kelly could explain the reapplication process—if you do fall off, you have a period of time, that Kelly can explain, to get back on to the program.

***Ms. Cantrelle:***

Historically, about 35 percent of individuals who fall off reapply, and if anyone reapplies within 90 days of being terminated, they can be made eligible back to the date they originally lost coverage so there is no gap in care at all. Like I said, our applications are available everywhere. They are online. We have people out in the community. People can fax. Chair Doñate, you asked earlier about getting applications to us. They can do it over the phone. We take applications over the phone, through fax, and online. There is a myriad of ways they can get them to us, but about 35 percent of people who fall off do end up coming around, and like Ms. Ruybalid said, we do not track the metrics yet of individuals who fall off, and we do not ever see them. We know a portion of them, though, we refer directly to Nevada Health Link—the Silver State Exchange. If they are over income, they go there to see if they can pick a plan that starts as low as $30 a month. We know that is happening.

***Chair Doñate:***

The reason why I am asking these questions—I think it is more my personal perspective—I want to dive deeper into what was alluded to, which is that we can have resources in place to help with that post-analysis. We do not have them yet, so I want to make sure that I empower you to determine what resources you need to get to that point. I do not think trusting the MCOs—and I need to mind my words carefully—I do not think it is enough to say that we are going to let the MCOs do this, because by the very nature of how the market works, if someone is a high-utilizer and they are high-risk, is there a return on investment to keep them on? I do not know. I think it is important that we make sure that we are keeping folks updated, that we are not letting people fall through the trenches, and that we have an obligation to protect the people, and whatever resources we need to make sure that is being done adequately, I want to make sure that we as a Committee empower you to do so in partnership with the MCOs. I want to make sure that they also have the resources as well. I wanted to make sure that I had that clear.

***Senator Titus:***

I asked the question earlier about the number of people who we are enrolled pre- and post-COVID-19 and currently, but I also meant to ask—and it has been a question that I have raised in the past—when we expanded who could receive Medicaid and services, I alluded that it was very much like giving everybody a free bus pass, but not any new buses; just because you have insurance does not mean you have care. One of the conversations here is this access to care, because we do not have enough providers.

There is a question here: one of the numbers that I would like to know—and if you cannot get it to us now, perhaps when you give us all this additional information we have asked for, you could include it—what would the enrollment of providers be during that period of time?

What is the current enrollment of providers? Have you increased the number of providers who will see Medicaid patients?

In my practice, I would see whoever walks through my door, but then getting them to the next level, the next specialist or whatever the treatment, that was always the barrier that I faced, not necessarily getting into their primary provider, but it is their subsequent treatments. I would be interested to know if Medicaid has expanded the possibility of providing and who they are. I know it is up a lot to the MCOs, who they have contracted with, but it makes a difference being able to go see somebody, not just to have that insurance. If you do not have that now, I would like to see it in the future.

***Ms. Southard:***

We would be happy to get that information for you. I apologize that I do not have it with me today, but we will follow up.

***Vice Chair Orentlicher:***

I have a question about that terrific increase in funding through the hospital provider assessment, and the answer may depend—you may not know all because of the managed care role—but what I am curious about is, with the increase that you will now be able to implement for reimbursement, do we know now how reimbursement will compare to other important benchmarks like what Medicare pays, what their actual costs are, or what private insurance pays? Do you have a sense of how our reimbursement will compare to those other benchmarks?

***Ms. Southard:***

I defer to Lynnette Aaron in Carson City, if she has the answer.

***Ms.  Aaron:***

I am sorry. Can you restate the question?

***Vice Chair Orentlicher:***

Sure. With the increased funding from the hospital provider assessment, reimbursement rates will increase for hospitals. How will their new reimbursement rates compare to other benchmarks for their reimbursement, whether actual costs they incur for care, what Medicare will pay them for the same service, or what private insurance will pay for the same service? Do you have that information—which I know can be complicated with managed care plans as intermediaries—but do you have a sense of that?

***Ms. Aaron:***

I think we will have to take that question offline to make sure we can capture all of the questions you have regarding that and go into detail into the specifics that you are asking for.

***Chair Doñate:***

Are there any other questions? Seeing none, we will close this presentation.

## AGENDA ITEM VIII—PRESENTATION ON HOSPITAL-BASED RURAL HEALTH CARE IN NEVADA, NEEDS, CHALLENGES, AND POLICY CONSIDERATIONS TO IMPROVE ACCESS TO RURAL HEALTH HOSPITAL SERVICES

***Chair Doñate:***

Let us go to Agenda Item VIII, a presentation on hospital-based rural health care in Nevada and the needs, challenges, and policy considerations to improve access to rural health care services.

***Blayne Osborn, President, Nevada Rural Hospital Partners:***

I appreciate the opportunity to be here and help you all kick off your interim work. First, I want to talk a little bit about the makeup of our hospitals. None of you are new. I think you all know us well, so I will go over that briefly. Then I want to talk about the priorities that we got passed last Legislative Session and where we are in implementing those items. From there, I want to touch on our challenges and needs as we start looking for ways that we hope the Committee will be able to support us next session (Agenda Item VIII).

Nevada Rural Hospital Partners is a consortium of the 13 critical access hospitals (CAHs) in the State—that is every rural hospital in the State except for Elko, which is larger and not a critical access hospital. Affiliated with our 13 critical access hospitals are 18 rural health clinics. Of our CAHs, five of them are corporate-owned. Seven are county hospital districts, meaning they are governmental entities governed under NRS Chapter 450, and they receive limited tax support. Of the 13 CAHs, seven operate a distinct part long-term care unit. Those are often the only long-term care beds available in those communities.

Earlier today, there was a certificate of need hearing by DPBH for support of a project that Barton Health is doing. For those that are not aware, Barton Health is intending to move their hospital from their current location in South Lake Tahoe on the California side across the border into Nevada. That project is underway, and they had their certificate of need hearing today. We will see what the results of that are, but they expect to be able to open a hospital there at Stateline as soon as 2029.

Additionally, there are communities in the State of Central Lyon, West Wendover, and Tonopah that are all interested in opening hospitals. We passed a bill last Legislative Session on rural emergency hospitals, AB 277 (2023), and we think that is a good model that is perhaps a solution for some of those communities if we can get congressional changes. We talked about it during the Legislative Session: currently, to become a rural emergency hospital, you must be a critical hospital and convert to that, so you must be an existing facility. It is not open for new facilities to start, but we are hopeful that a congressional fix can be made to that, and that might be a good model for some of those communities.

Additionally, I want to provide everybody with the average payer source in the emergency departments across our rural hospitals. Currently, the average payer mix is 30 percent Medicare, 30 percent Medicaid, 12 percent commercial insurance, 10 percent self-pay or others, and 18 percent other types—Indian Health Service, Veterans Affairs, worker's compensation, those types of insurance products. Financially, all our critical access hospitals are recovering very well from COVID-19. We hear a lot across the country about the rural

hospital closure crisis. I am happy to say that none of our critical access hospitals in the State of Nevada are on the verge of closure.

Later in the year, I hope to be able to report back on the status of SB 241 (2023) passed last Legislative Session, which should make the financial position of those county hospital district hospitals even stronger. If any of you are interested in more statistics on any of our rural counties or rural hospitals, I would refer you to the Nevada Rural and Frontier Health Data Book published by the Office of Statewide Initiatives at UNR, School of Medicine.

Last session was wonderful for our critical access hospitals, and I want to thank you all for your support of our initiatives. Some of the big items for us—I mentioned SB 241, Senator Titus brought that bill for us, and we appreciate that. The bill allowed cost-based outpatient reimbursement for our critical access hospitals and cost-based swing bed reimbursement for those CAHs, that have swing beds. Currently—and Ms. Southard went over this in her presentation earlier—DHCFP has drafted a State plan amendment. There is a public workshop coming on that at the end of March, we expect that to be submitted and approved by CMS probably by the beginning of June, and then that reimbursement will be made retro back to January 1, 2024.

Additionally, in conjunction with that, we talked about the provider fee program. We appreciate the changes that we are made in SB 435 (2023), and as you heard, those first assessments and distributions have been made. I want to be clear, though, that is for the private hospitals in the State. Those are six critical access hospitals participating in the provider fee program, those county hospital districts, and those public hospitals are not included in the provider fee.

I mentioned AB 277 for rural emergency hospitals. Currently, the Board of Health is tasked with doing regulations on that. We are hopeful that those will be passed in an upcoming Board of Health meeting.

Another initiative that we spent time on last Legislative Session was certified registered nurse anesthetists. Senate Bill 366 (2023) was passed and has been implemented by those boards, which has ensured there is no disruption to anesthesia services in our critical access hospitals.

Lastly, I want to mention AB 45 (2023), the Treasurer's Loan Repayment Program. The Treasurer's Office has developed regulations on that, and I believe they are close to finalizing and approving those regulations, and that ensures that the Nevada Health Service Corps is now fully funded.

I wanted to address the needs, and by far the biggest need we have is workforce. You heard Mr. Kelly's comments in public comment. The way I look at it, last session was a good start in addressing workforce. We had the loan repayment bill, AB 45. In addition to that, we had AB 37 (2023), which created behavioral health workforce development centers. We had SB 289 (2023), which ensured protections against violence for health care employees and volunteers, and SB 350 (2023), which implemented much-needed updates regarding GME and residency programs. We had SB 375 (2023), which Mr. Kelly mentioned, regarding the allocation for those nursing programs. SB 117 made various changes for community health workers. Assembly Bill 401 (2023) revised the nursing school faculty ratios, and AB 443 (2023) opened the Millennium Scholarship to include more Nursing Programs in that. I think all of those are a wonderful start.

Chair Doñate, you started off your comments today by specifically requesting that we bring forward solutions and I took that to heart. I wish I could say that we had a silver bullet to fix our workforce issues in the State of Nevada, but the reality is that there is not one. We have all heard that saying, "death by 1,000 papercuts," and I think we need life by 1,000 Band-Aids when it comes to workforce in the State. We just listed off about seven or eight bills. I think that is a good start, and I encourage the Committee to build upon that in this next session.

As for some of the bills that did not pass last session that could help, and that were in strong support of, earlier, Assemblyman Gray mentioned the social work licensure compact. Arguably the more needed one—although the social work compact is very needed—is that nurse licensure compact from AB 108 (2023). I know that is a hot topic. It has been discussed in a lot of sessions, but we would sure love to see that brought back and be able to be implemented into law this session.

Additionally, SB 369 (2023)—Senator Titus had that bill last session, which I thought brought about some very innovative ways to fund residency programs in the State, and I would love to see more solutions around that. Lastly, AB 460 (2023) was a bill regarding nursing pools in the State. There are very interesting technological solutions brought by companies like Nursa and others; they operate very similar to Lyft and Uber, and these applications where now these companies sign up licensed nurses in the State, and they can partner with hospitals and list available shifts. Nurses can go on that app, and they can look at what shifts are available to them, sign up, and go over to XYZ hospital and work a shift on Wednesday and on Friday pick up a different shift at ABC Hospital. Some of those technological solutions are in existence, but I think some of the regulations currently in existence, and the law around those nursing pools need to be adjusted to bring about those solutions for the State.

That brings me to my first conceptual policy proposal. Director Whitley stole my thunder on it, which is great because we talked a lot about the nursing apprenticeship program. In my mind, the nursing apprenticeship program in the State has been a phenomenal success, and I would love to see ways it could be continued. Since March 2022, more than 670 nursing students have been nurse apprentices in the State, and that is over 44 different nonprofit critical access hospitals and skilled nursing facilities in the State. Additionally, the program has supported the direct hiring of more than 165 nurses upon their graduation from Nevada nursing programs. The program supports salary reimbursement for the nurse apprentices time working in facilities, a salary stipend for the required supervising nurse, a travel reimbursement for nurse apprentices willing to work in a facility more than 50 miles away, which obviously helps and encourages those nursing students to be out in rural Nevada, and lastly, a retention bonus for the fulltime employment of the nurse apprentice.

As Director Whitley stated, it was off to a bit of a slow start, but now it is catching fire. I think word of mouth is very important. These facilities are talking a lot about the successes of this program, so it would be a real shame as the ARPA dollars expire, for this program to expire as well. My first request would be for the Committee to help us work on that and see what budgetary support we could get for this program moving into the next biennium.

Another area I wanted to highlight is conceptual policy proposal too. Currently, Nevada Medicaid does not cover surgical implants separately from the service with the exception of cochlear implants and long-acting reversible contraceptives. One Nevada critical access hospital is losing an average of $10,000 per surgical case, many of which are orthopedic

surgeries. I have more data, and I can submit all of this to the Committee as we look at this. We look forward to working with Medicaid throughout this interim, but we would love to see budgetary authority for Nevada Medicaid to cover the cost of these devices separately from the cost of the service.

Lastly, I wanted to highlight for the Committee that a lot of the infrastructure in the State of Nevada is aging when it comes to our critical access hospitals. We have three of our critical access hospitals—Senator Titus, I know you are very familiar with one of them—that was originally built in the 1960s and the 1970s; these buildings have a lot of challenges, as many of you know, with asbestos, with size, and with many of them being grandfathered into older codes. They have difficulties, high costs, and compliance with standard items—like the Americans with Disabilities Act (ADA). They have even more challenges when it comes to being innovative or advancing technology with fiber optics. Currently, there are not many resources available to support any of those types of large-scale infrastructure projects beyond limited U.S. Department of Agriculture (USDA) loan funding.

This is an idea I am kicking around: in Florida, I believe in their last Legislative Session, they passed a new capital improvement fund for rural hospitals. I do not have a proposal for you on what that might look like for the State of Nevada, but I think it is an interesting concept that is worthy of exploring. These are some of the things that we have talked about, and I look forward to being here with you throughout the interim and working together on finding innovative solutions. I stand ready for questions.

***Chair Doñate:***

Blayne, with the fund that you mentioned at the end, that Florida passed, do you happen to know any more specifics on it; how much money was allocated to it? Is it just for infrastructure improvements? Is it for other rural health facilities, or is it just critical access hospitals? Can you explain as much as you can? I know that you alluded to it.

***Mr. Osborn:***

No, Senator, I do not have a lot of details on it, but I will be happy to pull all of that and provide to the Committee.

***Chair Doñate:***

Committee Members, are there any questions at this time?

***Senator Titus:***

We heard earlier today—and I know you were in the audience to hear this—regarding Medicaid going to MCOs for the rural hospitals, too. It is one thing that we have, in my time, pushed back from because we were a fee for service; basically cost to help keep those rural hospitals open. They said in their testimony, they have reached out to the rural hospitals, and I am wondering where you are as a group with that decision by the State and the possible negative impacts or positive impacts. Either way.

***Mr. Osborn:***

I want to start off by saying first, that I sincerely appreciate the partnership the rural hospitals have with Nevada Medicaid. That relationship and that partnership is stronger than I have ever seen it. They mentioned the road trip they conducted with rural hospitals in the

fall—I was a part of that and went to every one of those stops with Nevada Medicaid; we had representatives from every division within DHHS as part of that trip. It was a phenomenal experience for those folks, for the hospitals to get access to the deputy administrators and administrators for each those divisions, but also for those administrators to get out into our rural communities to see the hospitals and see what those communities look like. I appreciate Director Whitley's support for that.

We have always had a reserved attitude or unenthusiastic approach to the expansion of managed care in the State. I feel very good now that with the language changes we have included in SB 241 and other pieces of legislation, Nevada Medicaid has what they need to implement what they call state-directed payments. Our understanding of state-directed payments is, in essence, the rates we have established for our critical access hospitals and rural health clinics are going to be the floors for where the managed care contracts will start with the rural hospitals. That has always been our big concern; critical access hospitals get paid cost for a reason, to keep those hospitals in those communities, so as long as those managed care plans are paying those rural hospitals correctly, we feel comfortable in supporting the expansion.

***Senator Titus:***

They have agreed to do certain things when you made that tour—and thank you for participating in that—it sounds like you are going to make the best of things; it looks like it is going to happen. Are there quick checks and balances—these things move so slow, and I worry that if it is not sustainable, how quickly you, as a group, will be able to come back to us and let us know, "Wow, we are losing money," more than they are losing money, so we do not lose these hospitals with this change. It may be a success, but if it is not, are these contracts written for a year with a reevaluation every three months? How quickly will we be able to decide if it has not been a good decision?

***Mr. Osborn:***

These are all things we are thinking about, but right now, Nevada Medicaid has not released the RFP for those MCOs to even apply for that next four-year cycle of managed care. I expect that RFP will be released probably sometime in the fall of this year or early next year, and with that, we are hoping that a lot of those things will be stipulated in the RFP and in the responses from those MCOs that end up applying. I feel comfortable that we are going to be a part of that process and we are going to be monitoring that closely, and we will be able to report back to this Committee and to the full Legislature how that implementation is going.

***Senator Titus:***

Thank you for the answer. Four-year cycles are a big concern.

***Chair Doñate:***

Are there any further questions from Committee Members at this time? Seeing none, we will close this agenda item.

For Committee Members to note, as you may have noticed, now that we are diving deeper into the access to health care conversation, these two presentations are going to connect us into the March meeting where we will spend the full day talking about access to health care. I have requested the groups that come before us to present policy proposals, so at the end

of the access to health care day, we can deliberate in more detail and try to discuss what they could look like if they were formed into a BDR.

## AGENDA ITEM IX—OVERVIEW OF RURAL TRIBAL HEALTH CARE IN NEVADA: CHALLENGES, EQUITY ISSUES, AND POLICY CONSIDERATIONS

***Chair Doñate:***

Let us move on to our last presentation for today, an overview of rural tribal health care in Nevada, challenges, equity issues, and policy considerations.

***Angie Wilson, Health Director, Tribal Health Center, Reno-Sparks Indian Colony:***

I am an enrolled member of the Pit River Tribe of Northern California and a Klamath and Modoc descendant of the Takelma tribes of Southern Oregon. I serve as the Health Director for the Reno-Sparks Indian Colony. In addition to my directorship, I also serve on the National CMS Tribal Technical Advisory Group for the Phoenix Area Indian Health Services on behalf of the Arizona, Utah, and Nevada tribes. It is an honor to be here today.

I would like to start the presentation by describing the special Federal Trust responsibility and the legal obligations for Indian health care to educate people about the Tribal Health Care Delivery System (Agenda Item IX A-1) (Agenda Item IX A-2) (Agenda Item IX A-3) (Agenda Item IX A-4) (Agenda Item IX A-5) (Agenda Item IX A-6) (Agenda Item IX A-7) (Agenda Item IX A-8). There are treaties between the United States and our tribal nations that provide the original legal foundation of the federal government's obligation to provide health care for American Indians and Alaska Natives, and this is known as the trust responsibility. You will hear me refer to that often in this presentation. Congress has defined this relationship in repeated case law, statutes, and executive orders as a unique political relationship, the only one of it is kind.

The modern authorization for the provision of health care services to American Indians and Alaska Natives is known as the Indian Health Care Improvement Act, and the primary authorization to pay for federal services for general welfare remains to this day to be the Snyder Act.

To show you what our Indian Health Care Delivery System looks like, it is covered by three initials, I/T/U: I for the Indian Health Service (IHS), T for tribal health, and U for Urban Indian programs. The IHS is an operating division of the U.S. Department of Health and Human Services. It provides culturally appropriate care to our American Indians and Alaska Natives across the nation. Again, we usually refer to it as ITU—Indian Health, Tribal, or Urban.

The Indian Self-Determination and Education Assistance Act of 1975 provided tribes the option of managing our own tribal health care delivery systems in contracting or compacting with the IHS. In our State, we have two facilities that are directly operated by the IHS. We have one Urban Indian program called Nevada Urban Indians, and 12 tribal health programs throughout the State from Battle Mountain all the way to Yerington, which a lot of you represent; these tribes are in your areas.

I want to cover what we are up against in Indian country, but before I start to go through these disparities, I want to say that it is important to note key historical factors that greatly impact the health outcomes of our American Indian people. The history of this nation is

outlined in the development of federal Indian policy, all of which have played a key role in the impact to our people, and that is everything from coexistence to moving into the Indian removal and reservations era of the 1800s, to the allotment and forced assimilation era in the late 1800s to 1932, to the Indian Reorganization Act that lasted through 1945, to the termination era that lasted through 1960, and then where we are here today, which is known as self-determination.

One of the things I want to talk about so you can understand the impact of these outcomes is that during the Indian removal and the forced assimilation era, the removal from Indigenous lands had a great impact on our Indian people. The forced assimilation into boarding school era resulted in the loss of language, culture and traditional practices, traditional family units, as well as the loss of gathering Indigenous foods and hunting, traditional medicine and ceremony; we call that today historical trauma.

One thing I want to mention is that I am not talking about hundreds and hundreds of years ago. This happened in my grandpa's era, my mom's era, and my auntie's and uncle's era. In relationship to that, I want to premise this before I cover the disparities, because all of this impacts where we are today, including the outcome of diabetes, alcoholism, suicide, and other risk factors in our communities.

I am not going to go through all of them, but I will cover some of these disparities. I left the information for you, and I especially appreciate those of you with a health care background and clinicians because you will understand why this is so important to us. When I go through the disparities, these are coming from the Office of Minority Health on a national level, and they are compared to non-Hispanic whites.

Our American Indians and Alaska Natives have almost twice the infant mortality rate. Our infants are 2.7 times more likely to die from accidental deaths and 50 percent more likely to die from complications related to low birth weight. Our American Indian mothers are almost three times more likely to receive late or no prenatal care at all. Our American Indian adolescents are 30 percent more likely, and our adults are 50 percent more likely, to be obese. Our adults are three times more likely to be diagnosed with diabetes and 2.3 times more likely to die from diabetes. We are twice as likely to be diagnosed with end stage renal disease. There are comparisons to heart disease and cancer.

In 2019, chronic liver disease was the fourth leading cause of death for all American Indians and Alaska Natives, and the second leading cause of death for our American Indian men aged 35 to 44. In 2018, our American Indian people were 1.6 times more likely to be diagnosed with chronic liver disease. American Indian women are 2.2 times as likely to be diagnosed with chronic liver disease and 4.8 times more likely to die from chronic liver disease. The overall death rate for Indians is almost four times higher than that of the non-Hispanic white population.

In 2019, suicide was the second leading cause of death for our American Indians and Alaska Natives between the ages of 10 to 34. That same year, adolescent American Indian females aged 15 to 19 had a death rate that was five times higher than non-Hispanic whites; and in 2018, our males aged 15 to 24 had a death rate that was twice that of non-Hispanic whites. According to the Centers for Disease Control and Prevention, in 2021, we had 1,358 American Indians die due to an opiate overdose; the highest rate of any racial or ethnic group across the nation. I know we have talked about some of that here today in the presentations that you have heard earlier. The next statistic is overwhelming:

violent deaths, unintentional injuries, homicide, and suicide account for 75 percent of mortality in the second decade of our American Indian and Alaska Native lives.

One thing I want you to understand—and I apologize; sometimes going through these are tough—there is a misperception that American Indians and Alaska Natives get completely free health care, and the tribes get all this federal funding, and I can tell you there is nothing further from the truth. There is a Federal Trust responsibility of the U.S. Government to provide health care to American Indians, yet we have the highest health disparities of any other ethnic population.

This is what funding looks like in our world: the IHS funding per capita spending is 50 percent of the next nearest federal health program expenditure: the 2021 Medicare spending per enrollee, the Veterans per enrollee, Medicare, the national health expenditure per capita, and then where we fall in IHS.

I want to talk about the Federal Medical Administrative Percentage (FMAP) as it contributes to the opportunity to strengthen the government-to-government relationships between our State and our tribes. In 1976, the Indian Health Care Improvement Act amended the Social Security Act to permit reimbursement by Medicare and Medicaid for services provided to American Indians through the IHS or tribal health facilities, and these protections were further augmented in Section 5006 of the American Recovery and Reinvestment Act of 2009. When Congress authorized 100 percent FMAP, it did so because "the federal government has trust obligations to provide services to Indians, it has not been a state responsibility."

I want to show you what that looks like for our State. The first example is an American Indian and Alaska Native Medicaid beneficiary that comes to our clinic. Our clinics can bill at the all-inclusive rate, which is a rate that is established in the Federal Register every year, and for 2024, that rate is $719. We, the tribes, get to bill up to five Medicaid encounters per day if it is medically indicated, and the State gets 100 percent FMAP return; meaning that at the end of the day, there is zero cost to the State budget.

When we refer a patient out to a specialty care provider and for additional services—and I think I heard you talk about that today; we can see them in our clinics but getting them out to specialty is difficult—but when we do send an American Indian out to specialty care who has Medicaid and they see that Medicaid provider, the State does not get 100 percent FMAP on that. There is a cost of care for that service, and on average, it is 68 percent FMAP.

However, in 2016, CMS released the State Health Official Notice allowing expanded 100 percent FMAP to states for any referrals to or through IHS or tribal health clinics. I want to show you what that would look like. We have two ways we are able to do this. The expansion of FMAP to the State is controlled by the tribes. The State cannot mandate the tribes to do it. They cannot mandate it from Medicaid providers. It must be at the discretion of the tribe.

The tribes can do a straight written care coordination agreement, and that is the next example, where we would send somebody out to the Medicaid provider. The Medicaid provider sees our patient and bills their rate, and we have the written care coordination agreement with them. They can then bill the State and the State can now get 100 percent reimbursement on that cost of care, but in that example, there is no benefit to the outside provider because they are not getting paid anymore. There is no additional access to care.

It is going to be difficult for our Indian people to get into specialty care. The only winner in this situation is the State getting 100 percent FMAP.

The other option is tribes can negotiate a written care coordination agreement where I can go out to a Medicaid provider, offer a written care coordination agreement, and I can negotiate to pay that Medicaid provider a rate higher than what Medicaid can pay. For example, here I used the rate that would be the Medicaid rate plus 40 percent, so that outside provider would now get paid from the tribal clinics at $147. That provider is happy that they are getting more money, and it creates better access for Indian people to be able to get into specialty care, but what happens is that once they send those notes to us, we then get to turn around and build the State our all-inclusive rate, the $719, and the State gets 100 percent of those costs back to it is State budget. This is a win-win for the outside provider, for the State budget, and for clinics to be able to offset the disparities in our federal funding to better meet the needs of our American Indian and Alaska Native patients so they can have hopefully better outcomes than some of the things we have reviewed prior to this.

Before I give suggestions, I wanted to discuss a couple of items before I go into potential things to think about as you go into Session. First is to recognize that our tribes and tribal programs have the knowledge, expertise, and authority to design and deliver services in ways that are best suited for our tribal communities. We do that by building on cultural strengths and traditions in the way that we provide care.

Second is to understand that effective efforts for health equity in Indian country must approach health equity through the lens of tribal sovereignty, the government-to-government relationships like we are having here today, and also the Federal Trust responsibility, and it must conceptualize the work around and understanding of American Indians and Alaska Natives as a group with a unique political status, not as a racial minority.

With that being said, I am going to share a couple of things for you to consider. One of those is Tribal Medicaid determination. I think we heard from the Medicaid Department from the DWSS on getting people signed up for Medicaid and keeping them signed up. I could tell you right now that every single tribal clinic in this State works very hard to get our patients signed up for Medicaid and keep them on Medicaid. It is the only access we have to bring in revenue into our clinics, and the only access we have to deter the cost for American Indians, but we do the heavy lift, because American Indians will come to the clinic whether they have insurance or not to be seen. We must do a lot there.

What we are asking is, there must be a pathway to allow tribal benefit coordinators access to go through the Medicaid Academy, which we have already accomplished, but giving our tribes the ability to do on-site Medicaid determinations. You heard earlier from DWSS that they do outreach, but what is really happening in our tribal communities is that there is not enough outreach workers, so what we are hearing is, "We do not have anybody to send to you." That is huge for us in a State with 17 counties, 3 which are rural and 11 frontier counties in which most of these tribal clinics reside. We can be the assistance for Indian people. It is a big issue for us in Indian country, and it certainly impacts the State budget.

Also, I have already requested through DHCFP to consider a State plan amendment to expand Tribal Medicaid reimbursement for pharmaceuticals. One additional thing I would like to point out to this Committee if I could ask for anything, if I showed you how tribes control expanding FMAP to the State, to look at reinvesting some of the 100 percent FMAP

savings back into our tribal communities—because that is gathered based on American Indian and Alaska Native Medicaid beneficiaries—if we can work together in our tribes to extend FMAP to the State to and through our clinics, you have seen the disparities that we are up against in regard to federal funding and what our outcomes can be. We can have great collaboration between our State and our tribes to be a win-win for all of us. In the supplemental documentation that I provided to you, I give an example of how the State of Oregon passed a house bill to do that and reinvest savings of 100 percent FMAP into the Oregon tribes.

The other is tribal Medicaid administrative activities, looking at ways to partner with tribes to develop a pathway for tribes to be able to claim reimbursement of our Medicaid administrative activities. The State gets payment from CMS to not only to run the Medicaid program but to also operate it, but the tribes are doing a lot of the heavy work. I provided examples from other states, California and Alaska, where their tribes are doing outreach and education, helping people sign up for Medicaid, and doing program planning for Medicaid beneficiaries in which those tribes are able to claim for those costs back to their State. We are looking for a pathway for that, and to generally look at any State funding that comes through, maybe developing pathways to strengthen the government-to-government relationship instead of having tribes compete with outside agencies for any funding that comes through. Last, is to look at culturally-based practices and accept those practices into our system, that is work we can do on our end.

One last issue I will leave you with that I believe can be a great bill for you to consider is to expand the Silver State Health Insurance Exchange Board of Directors to add a permanent tribal representative seat to this Board. I want you to understand that the Affordable Care Act has been enacted now for over a decade and every single provision for American Indians and Alaska Natives are included in this law—tribal sponsorship, zero to limited cost sharing provisions, open continuous enrollment, aggregate billing for tribes that makes it easier for us to be able to purchase insurance for uninsured and us not having to contract with the Qualified Health Plan to be able to get paid—none of it has been implemented for a decade. I will say this: we have had to do the heavy lift to educate the State, the Silver State Health Board Exchange, the Nevada Health Link leadership, and the Department of Insurance every single step of the way.

I do not want to lose sight of the hard work of Russell Cook with Nevada Health Link since his leadership has taken this on and championed this through for us. We have a good working relationship with Nevada Health Link, but it should not take a decade; if we had a permanent tribal representative on that seat, we would not have run into these issues because we know our health care delivery systems. This is important to us; all of these years, we could have been purchasing insurance for our Indian people and closing the loop, but we have had no pathway to get there. That would be the ask that we have.

I know we are short on time, so I want to leave you with some other larger ideas that maybe we can return to and continue to have dialogue on ways to strengthen our tribal public health capacity and infrastructure. I want to especially thank Chair Doñate for asking for this presentation on tribal health care and thank you to the Committee for opening up the dialogue. I think it is important. I think this is a historic moment, and I am very proud to be here. I am sorry for being emotional.

***Chair Doñate:***

No, do not worry about it. Is this your first time presenting to the Legislature?

***Ms. Wilson:***

Here, yes, but not my first time presenting. Last week, I gave testimony in Washington, D.C. to the Senate Committee on Indian Affairs for a bipartisan bill sponsored by Catherine Cortez Masto and Mark Wayne Mullin from Oklahoma. I get emotional as a Tribal Health Director—I have been in tribal health administration for 30 years, and when you stop and take a look at the outcomes of Indian people, you cannot help but to feel it right here.

***Chair Doñate:***

Before we go into questions—and I know many of us are probably eager to dive into your policy considerations—this is a phenomenal presentation. I have had groups ask us for presentations, et cetera, but you laid it out perfectly in a good example of explaining the context, explaining the relationships with how the State can help your organization, how we can address the issues, and then you gave us a lot of pages of documents, which is a good thing, because now we can have robust conversations with you.

I want to allow my Committee Members to ask any questions if they have. Any here in Southern Nevada? Are there any questions in Carson City?

***Senator Titus:***

Thank you for putting your energy, time, and dedication to your whole career, the folks around you, and the people you represent. Obviously, it is emotional; you own it. It is important. I also live that. I have many tribal members and currently have a number of them in long-term care taking care of some of the things, and when I am taking care of people younger than me in long term care, it makes my heart break. I appreciate your passion for that.

I have a couple of questions. Are there 47 distinct tribes? How many distinct tribes have been recognized in Nevada?

***Ms. Wilson:***

There are 28.

***Senator Titus:***

Now the question is, with that 28, do they each need to negotiate? Would each tribe have to do their own negotiation when it comes to the Medicaid and FMAP? Like you are representing Reno-Sparks. Is that correct? You would do yours, but can that be replicated? Does each tribe need to do their own? And if so, do they even have the capacity to do that?

***Ms. Wilson:***

Yes. The Nevada tribal health directors work closely together, and the Reno-Sparks Indian Colony's tribal health clinic is the very first clinic to transition into this model. We went through a State plan amendment to have a new designation, known as a Tribal Medicaid FQHC status, which would allow us to extend the FMAP to the State. We have worked closely with DHCFP to get all the fee schedules for every single provider. We have worked with our tribal leadership to develop mechanisms for what our rates could

be. We are working closely with other Nevada tribes so that when we go out to negotiate, we can use the same mechanisms. Reno-Sparks is the first to go through the process.

A lot of times, our tribes work together to see who goes through that process first and what is working, because the one thing we do not want to do is say that Reno-Sparks can offer this rate, and then another tribe will say they are going to offer a different rate, and then have that same provider hold out. The nice thing about doing this is that in option two, where we can go out and negotiate rates with outside providers, the great thing is that when we are billing our encounter rate, the $719; we can assume those costs. We want to do it as consistently as we can, but at the end of the day, the tribes are sovereign and do have the right to negotiate whatever rates they choose, although I think all of us in our tribal health capacities feel the need to be as consistent as we can.

***Senator Titus:***

I was concerned about the price setting or rate setting because you are all 28 sovereign nations, and if you collaborate to a certain degree, where does that get into trouble with federal regulations and laws, et cetera? At least you are communicating with each other about the application process, because not all 28 tribes would have the resources to do that. You can share that, but that rate setting may have issues there.

***Ms. Wilson:***

I think the tribes are afforded full capacity, so through CMS and through the new designation, we can determine any capacity. A tribe could also determine not to negotiate a rate and still expand 100 percent FMAP to the State on option one. However, it would only be at that provider's rate. Again, it does not open the door for access to care, and we talked a little bit about that in some of the other presentations today. It is difficult when you are a primary care provider to try to get somebody into neurology or dermatology, let alone into women's health care. That is part of the challenge that we have, so what we are hoping to do is have capacity to be able to overcome those challenges that end up being a win for that provider, the State, and our tribes.

***Senator Titus:***

One other note: the concern, it is tremendous, for the loss of young lives in the tribal nation, and the figures that you gave on the percent of deaths in that group and the number one cause of death is dramatic. Recently, more information has come out about the loss of women, especially young women, disappearing, death, et cetera. As a body, when you went to Washington, how do you see us helping? Money may or may not be out there, but how can we as a State help you address that? Is there other conversations, or can you come up with suggestions? Mental health is an issue everywhere. Drug addiction is an issue everywhere, but those statistics for the group that you represent are incredibly dramatic, and it must be more than access to health care.

***Ms. Wilson:***

We hosted U.S. DHHS Secretary Xavier Becerra at my clinic a couple of weeks ago and had the exact same conversations about needs in our tribal communities and what we are up against. I think every single one of us sitting in this room who happens to be American Indian have all had somebody missing or murdered in our families. I know I have. When I talk about chronic liver disease, my sixth extended family member has just succumbed to

cirrhosis, and all of them were under 34 years old with the most recent being 28. It is challenging.

One of the things, if I could say anything, is having these conversations—this is the first time that I am aware of that the tribes have been able to present to the JISC on issues, and I think the number one thing is to open up these conversations. Sometimes, when we do not understand each other—we have our own health care delivery system, and I know it can be confusing—but if we can see how we can partner, which are win-win opportunities for us, we can see how we might be able to get our hands around these issues.

I think the number one thing is what we are doing right here today. I have been listening intently to the presentations and the dialogue in this entire meeting from the time I got here to now, and when I hear pharmacists talking about access, especially for the opioid issue and looking at how that affects our rural communities, it is huge. The fact that you are doing the work that you are doing to see how we might be able to get our hands around this in this State, I cannot tell you the significant impact to our tribal communities of you already doing that work at looking what we can do.

I would say there are other issues that we can address—I can sit here and go on all day long about mobile clinics and access to care and how we help the workforce issues that we have in this State, which are severe for our tribal clinics—by opening this dialogue, inviting us to come back, doing work sessions, whatever we can do to better understand where you may be able to help us and what we can ask for, and looking at things that help to decrease the barriers for tribes. When I look at it, I can see that we all are on the same team. We do not know how, and if we are able to sit down and look at how we can address these barriers and be innovative in this State to close the gaps is huge. I would encourage us to continue the dialogue here, and I am 100 percent willing to come any time and meet with any of you on opportunities to innovate in this State to support our First Nations people.

***Chair Doñate:***

Are there any questions in Carson City?

***Assemblyman Gray:***

A couple of quick questions. One, you talked about reinvesting the money back into the community. What would you see that looking like? Back into the clinic? Programs? Outreach? That is the first question. Second, with the opioids, do you have easy access to Narcan? Is it readily available in the community?

***Ms. Wilson:***

Yes, we do have access to Narcan. I think it has been a big issue for us as well as making sure that we have immediate access to harm reduction tools like fentanyl strips and those types of things. We are looking at putting in kiosks where people can have immediate access to Narcan or fentanyl test strips and those types of things, whether the clinic is open or not, and putting those kiosks all throughout the tribal community so people would have immediate access. We are looking at that.

I would also say that when we look at reinvestment of the savings of 100 percent FMAP, there are a million ways that we can use that. If you saw the disparities we have in our health care funding to meet the need and what our disparities actually look like, there are a

million different ways that we can use the reinvestment of those funds: additional health care providers and more access. We just purchased a mobile dental and medical clinic and being able to staff those; I think there are many innovative ways to reinvest.

I know that for the Oregon tribes, for part of that savings, they will divvy that up with the tribes based on their patient populations and allow the tribes to design programs that best meet the needs in their tribal communities for the patients they are seeing and what they can do. I think it should always go back into health care. These are dollars that are derived from Medicare and Medicaid expenditures, so they should go back into the health care delivery system, but I would encourage a continued open dialogue on ways we might be able to do that.

***Chair Doñate:***

Anyone else in Northern Nevada?

***Assemblyman Nguyen:***

I appreciate your level of expertise. It is hard to not get emotional in your presentation. I am absorbing everything you are saying. As an immigrant to this country and learning how everything works, I still have a hard time truly representing the community I grew up with, as well as the millions of immigrants in this country in terms of the cultural competency piece. I think that turned on a couple of light bulbs in terms of the culturally-based practices.

In terms of the tribal relationship, when you work with tribes across the country, making sure that you are all in sync in these culturally-based practices model, I am wondering—and maybe I am asking this question as a learning opportunity for the communities I represent, the immigrant communities that are always underserved and then also from a culturally competency level, we are still fighting to this day in terms of having folks understand that complexity that we grew up with, or we came from another part of the world. How does that work in terms of the culturally-based practices that would be obvious and solidified in terms of the tribes internally, right? What if you have young people or folks who go to school outside of the tribes? Or you have folks who maybe do not live in a tribal area but in a suburban area outside of the tribes. How would you ensure that these culturally-based practices are being communicated to the non-tribal communities?

***Ms. Wilson:***

For our Indian folks who move away, let us say, and they go to more urban Indian settings, that is why the Urban Indian health care part of the ITU system is so important so we can stay connected to tribal health care needs. When it comes to the non-Indian population, sometimes when we talk about health equity, if we look at health equity across the board, what is that? Healing from our past. Well, how can anybody tell us how to heal from our past if they do not understand who we are, what our traditions are, what our values are.

Alcohol and drug treatment is a great example. The Substance Abuse Prevention and Treatment Agency will want to make sure that we are following evidence-based practices, but in American Indian communities, one of the beautiful things that I love about our culture is that there are specific practices and cultural ways that we follow that require you to be sober, that require you—if you go into the sweat lodge, you cannot be using. They

help you on that path to wellness in a culturally appropriate way that goes hand-in-hand with evidence-based practices for alcohol and drug treatment programs.

When we work with other entities like treatment programs, it is always important that we have that connection. We do that right now with our folks who are incarcerated in jail; we have our clinicians reach out to the jail to offer support services, and I think any opportunity that we can continue to do that is meaningful, especially in our communities. Like I said to you, some of the history of our nation was not all that long ago. When I look at my grandpa, he was in the 1930s, and all of this was happening during that time. It is a lot. It is a fresh wound that we are still dealing with today, so we must look at ways—and I would encourage us to be open to doing that no matter what ethnicity—to be able to respect that of who we are and our healing pathway moving forward.

***Assemblyman Nguyen:***

Thank you for that lesson, and I encourage you to continue working with not just this Committee but the multicultural communities in Nevada and across the country to share your best practices on how we can collectively help all of our communities truly be seen. Like you said, for the immigrant community as well, like the Vietnamese community, this is the first time they have a voice from the immigrant community from Asia. We are still changing those narrative and we want to be able to learn from you as well how we can work together. I would seek out your guidance offline to see how we can effectively—not just in the interim but in the years to come—lift us all up. Thank you again for all your work and I applaud your commitment to the state of health for all Nevadans.

***Chair Doñate:***

I have a couple of questions, some that are contextual to your presentation and some that are not. Let us talk about the policy recommendations you presented. Part of me wants to put them all in one BDR and see how far they go, but I want to make sure that we do our due diligence, so that we actually make progress.

Let us talk first about administration. One of the documents that you submitted was from the California State Tribal Medi-Cal Administrative Activities (CTMAA) Program, which is created to address several concerns relative to our native American tribes. Later in the document, there is discussion about the California Rural Indian Health Board founded in the 1960s to help tribal governments in California to serve as central coordinating points for planning and development. I think that is what you have alluded to.

In your position, and with your experience, and the coordination you do with other folks or other tribes in other states, do you feel that there is a gap in authority or coordinating entities in our State in terms of infrastructure that you would like to see fit? An example is the CTMAA program in California, and I do not know if Oregon has a different authority. Is there perhaps programming that you wish the State had that we do not yet have. That would be the first question.

***Ms. Wilson:***

Yes, I think that one of the challenges we have is understanding what is eligible for tribes to be able to look at it within the law. The California Rural Indian Health Board is a consortium of tribes that acts as the health board for several rural tribes. California has 110 federally

recognized tribes, and the California Rural Indian Health Board serves a portion of those tribes in technical assistance and support.

The State of California developed a pathway for tribes to claim reimbursement for Medicaid administrative activities, and they did that by opening a local governmental agency option. The California Rural Indian Health Board stepped up to the plate and said they would do it, so all tribes would submit their claim to the California Rural Indian Health Board, the Rural Indian Health Board would make sure those claims were consistent and appropriate, and then they would send it off to the State of California for reimbursement. The State would then reimburse the Rural Indian Health Board, and the Rural Indian Health Board would then reimburse the tribe. They were the medium in between the State and the tribes, but it provided a pathway for tribes to be able to claim for necessary reimbursement for those services.

Here in our State, we do not have a mechanism for that, so identifying options that tribes should be able to apply for or get reimbursement for, we are doing the work that the State gets paid to do on their end for Medicaid administrative activities. How could we tap into that as tribes? The first part of that is having the dialogue that it is possible, and the second part may be, how do we find the pathway to get there? That might take collaborative effort, it may take reinvestment of 100 percent FMAP savings to develop what that looks like or the agency that could step up to the plate to do those reimbursements, or additional staffing at the State to support that effort. We have to be somewhat innovative. We do not have an agency like the California Rural Indian Health Board here in this State.

***Chair Doñate:***

Is there interest in pursuing that? Do you think that could help with your notes earlier about recaptured funds and making sure they are being reinvested in the coordination? Is there an interest in pursuing that policy option?

***Ms. Wilson:***

I think that is a huge issue for us because, like I said, we could be a benefit to the State. We heard earlier from Medicaid's DWSS about the outreach, but I can tell you, in tribal communities, we do not get State workers out there right now because they do not have the staff for it. With a lot of our tribal clinics in very rural areas, it makes it even harder. My clinic is here in Reno, and they cannot get somebody out here on a regular routine because they do not have the staffing. Imagine if I were in Walker River or Ely, which makes it even that much more difficult. This is where I think the tribes could be a benefit and a partner with the State in closing the gap, especially given the State gets 100 percent FMAP for American Indians and Alaska Natives seen in our clinics.

***Chair Doñate:***

I completely agree, and I appreciate your comments. I think that if we do it right, that sets us up in a similar position to the Oregon proposal that you submitted. There are several initiatives that our State could be replicating in terms of family wellness projects and developing childcare centers to explore the health disparities that you presented earlier, but we do not have the mechanism to that. I am glad that is something that we should consider.

I want to talk about COVID-19. I think there is always a discussion of where we went wrong, which is OK. Nothing ever goes as planned, especially when the unplanned happens, but I want your perspective on how you feel the coordination occurred between our tribal communities and health care during the COVID-19 Pandemic? What do you think should be prioritized in terms of reforming the system? We talked about the oversight that we could potentially explore, but what do you think we should explore with regards to how we have emergency preparedness and response and the coordination of care?

***Ms. Wilson:***

I want to back up and give a perspective here. I think the beautiful thing about our tribes is that at the end of the day, our commitment is to Indian people and for us, it does not matter who is in charge. We need to have the dialogue. When Medicaid expanded, Governor Sandoval was in office, and we worked closely with him to look at the potential of opening Medicaid here. When COVID-19 hit, Governor Sisolak was in the seat of the governorship, and at that point, we are all hit—everybody, the whole world.

I feel like we have a good partnership with the State of Nevada in a lot of ways—Governor Sisolak really did bring the tribes together to talk about the current needs right now and how we can we help. Tribes were forthcoming in that. The IHS on the federal level was involved, but we were taxed then when it came to anything related epidemiology or assistance. We partnered with Northern Nevada Public Health and tried to work with them to collaborate, vaccines, testing, you name it, and trying to get our hands around it.

I can tell you that the Reno-Sparks Indian Colony lost a significant amount of tribe members who succumbed to COVID-19, which was devastating for the tribe, but we were not the only tribe to experience that. All the Nevada tribes were affected because of that. It is a direct impact of the high prevalence of chronic disease and risk factors in our in Indian communities, and when they had to deal with COVID-19 across this nation, American Indians and Alaska Natives had the highest rates of hospitalization than any other ethnic population across the entire nation. I think that speaks to the prevalence of chronic disease and risk factors in American Indian communities and the lack of resources to get our hands around health care services in our tribal communities because of the lack of fiscal resources.

One of the things I would say is, there were a lot of lessons learned all the way across the board. I do not think it was easy for any of us, but I think we can come together and say, what were the disparities and how do we start building on them? How do we start partnering for better outcomes for data? What about tribal data when it comes to the mechanisms?

Earlier, we heard our partners give a presentation on SHIP. I have been working with Northern Nevada's team that did their community needs assessment, and we do not have good data outcomes for American Indians and Alaska Natives. When we look at epidemiology or surveillance, especially when it comes to things like a pandemic, we need a better partnership where the tribes meet the State halfway, and we look at ways that we can develop opportunities to strengthen what that looks like here.

But I will say this, it is not just the Pandemic. When I look at the environmental impact, Reno-Sparks has been hit with Air Quality Index issues when we have had past fires. Pyramid Lake was impacted when it comes to flooding, and the destruction of roads out there where people could not get access in or out. The Washoe Tribe in the Carson Colony

has been prevalent to mudslides and fires right up to their tribal reservations and in their tribal communities.

Across the board, there is always improvement that could be needed building capacity to support our tribes at the local level regarding community education, and first responders training in addition to the impact of public health initiatives across the board. There is always dialogue, and I think we should always sit down and figure out how we can get through that, but there are a lot of opportunities for improvement and vast opportunities for sharing things that have worked well for us.

***Chair Doñate:***

Are there any final questions or comments before we close this agenda item? Seeing none, Ms. Wilson, we greatly appreciated your time. I am sure we will be reaching out and this might not be the last time that you hear from us during this interim. I greatly appreciate your time and your presentation.

***Ms. Wilson:***

I want to say one thing before I go: thank you so much to the Committee. This is history in the making. You should be very proud, and I know we are in Indian Country, to even have this dialogue. Genuinely.

***Chair Doñate:***

We will close this agenda item and move on to the next item.

## AGENDA ITEM X—DISCUSSION OF TOPICS RELATED TO HEALTH AND HUMAN SERVICES TO BE CONSIDERED AT FUTURE COMMITTEE MEETINGS

***Chair Doñate:***

We will move on to our last and final agenda item before public comment, which is a discussion of topics related to the HHS Committee to be considered for future Committee meetings.

This is an open dialogue, if there are any further comments or issues that folks would like to have in discussions for the following Interim Committees to explore. I know Assemblyman Gray mentioned the compact of social workers, so we will have that discussion when we get to Behavioral Health Day, but this is the moment if anyone else has any other comments or requests.

***Assemblyman Hibbetts:***

I would like to see if we could get information on the growing mental health crisis in our State, specifically the State-run mental health hospital in Lake's Crossing, because there is a massive backlog moving criminal defendants that have been deemed incompetent or are awaiting competency tests. Once a Judge orders them to the hospital, they have approximately 30 days, I believe, and the State hospital is taking 90 to 180 days to get them there, so our State is suing itself to try to solve this problem. I hope that somehow, we might be able to come up with something that would assist that hospital in expanding their capability so that we do not have this backlog again, but I would like to hear more from them if we might be able to do that.

***Chair Doñate:***

We will make sure to list that down. Behavioral health will be given a considerable amount of time during this Committee. We are probably going to do it closer to May and June, and it will be split in half. We will have one day dedicated to children's behavioral health and a separate day for adult mental health, because it is a lot. We will make sure to note that. Are there any other discretion items down here in Las Vegas? Is there anyone in Northern Nevada?

***Assemblyman Gray:***

Since we are going to be talking about the social worker compact, I would also like to talk about the nursing compact again. That is something we should be exploring.

***Chair Doñate:***

Is there anyone else before we close out this agenda item?

***Senator Titus:***

An overview of a discussion that you and I had, is that I appreciate you putting together the organization of this Committee and the fact that you are focusing on things that we can accomplish. This is a big world we are looking at with lots of needs, but one of the things that I brought up to you and we had a conversation that I believe this Committee gets ten BDRs, and many times—and I have served on this Committee many times—we put all the time and effort into the BDRs, but we only get one or two passed. I know there is no guarantee that we will get more passed this next time around, but I like the concept that we are focusing on things that we may be able to achieve. We may not be able to solve all the problems, but we should try to solve the ones we can, so breaking it down, on the presentations we had today and moving forward, I appreciate the approach.

***Chair Doñate:***

I could not agree more. I think you will see it more when we get to the March meeting that after the end of each day, now that we have broken them down into the different subject items, at the end of these Committee meetings, we will have the ability to deliberate and discuss policy options. We already have several of them through this Committee meeting, we will get to the point where we can start identifying what these BDRs will come in. As I mentioned earlier, our goal is to make sure all of them get passed bipartisan and fully supported so they can make their way all the way to the end in 2025. That is something I am committed to. If there is nothing else, we will move on to public comment.

## AGENDA ITEM XI—PUBLIC COMMENT

***Chair Doñate:***

We will now open the public comment period. Is there anyone who would like to give public comment at this time?

***Ken Kunke, State Executive, Nevada Pharmacy Alliance:***

We are working on two other policies that I would like to bring up and offer our support to you; if it is something that you are interested in. The first one is prescription benefit managers (PBMs). Ever since AB 440 (2023) died last session, I have been reading things

daily about how these entities work, and why we are not passing laws here in Nevada about these prescription benefit managers, and what I found is that they control all the data. They can come to you, insurance companies, and patients and say, "Hey, we are saving the health care system money," but if they are truly doing that, why are not they releasing their data? Why is that data not available?

What I have seen is that there are 16 policies tracked nationally and some states have passed all 16 of those policies, but unfortunately, Nevada has not passed any of those. I have been reading those policies, and I have a list of people who deal with PBM reform on a regular basis. West Virginia and Florida just passed comprehensive reform, and it is in California's Session right now. Indiana has a bill in their session right now that would make that data available to insurance companies and the State, so it might be something we want to look at here in Nevada.

The second issue is not dealing with PBMs. Right now, a lot of the payment that pharmacists get are for dispensing product. We have the scope to do things, but we are not able to bill for our clinical services for a lot of things; for example, if a pharmacist was to get hired at a primary care clinic, if the doctor met with that patient for 15 or 20 minutes or whatever the normal meeting time was, and they discovered that patient was on a lot of medicines and they might be having a lot of side effects or they are not controlled well, the patient would transfer to another office and meet with the pharmacist. Right now, that pharmacist cannot bill for that service, so there is no sustainable way for that pharmacist to work inside that clinic.

Senate Bill 201 (2023) was brought up last session, but I think we started the education on that way too late. We would like to bring that back again this session and find a way for patients to see a pharmacist inside a clinic. You keep talking about access to health care, and we feel this would benefit our State. In the last two years, seven states have passed this type of reform. If you have any questions for me, please reach out.

***Chair Doñate:***

Is there anyone else in Southern Nevada offering public comment? Anyone in Northern Nevada? Broadcast and Production Services, anyone virtually?

***BPS:***

The public line is open and working and there are no callers at this time.

The following written public comment was submitted:

Rebeka Acosta, Executive Director, A&J Patient Advocacy (Agenda Item XI A)

Larry Fannin, BS Pharm, PharmD, Dean, Roseman University of Health Sciences, College of Pharmacy (Agenda Item XI B)

Tahnee Forolini, PharmD, BCPS, Act4Kids Nevada (Agenda Item XI C)

James Leonard, Reno, Nevada (Agenda Item XI D)

Amy Hale, PharmD, BCPS, RN, President, Nevada Pharmacy Alliance (Agenda Item XI E)

***Chair Doñate:***

Our next meeting is on March 11, 2024. We have opened the link for people to submit policy recommendations. It is available on the Nevada Legislature's website through the JISC HHS Committee’s webpage, folks can start the process of submitting items early. We are doing it earlier than we did last interim so folks can be interacted with us. Hopefully, we can provide good policy recommendations towards the end. That concludes our work for today.

## AGENDA ITEM XII—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 1:52 p.m.

Respectfully submitted,

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Sarah Baker
Research Policy Assistant

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Patrick B. Ashton
Principal Policy Analyst

_____

Davis H. Florence
Senior Policy Analyst

APPROVED BY:

_____

Senator Fabian Doñate, Chair

Date: _____

# MEETING MATERIALS

| AGENDA ITEM | PRESENTER/ENTITY | DESCRIPTION |
|---|---|---|
| Agenda Item II A | Lea Case, Nevada Psychiatric Association | Written Public Comment |
| Agenda Item II B | Penni Echols, Act4Kids Nevada | Written Public Comment |
| Agenda Item II C | Kinnsi Sigler, Act4Kids Nevada | Written Public Comment |
| Agenda Item II D | Chelsea Bishop, Act4Kids Nevada | Written Public Comment |
| Agenda Item II E | Leann McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics (AAP) | Written Public Comment |
| Agenda Item III | Patrick B. Ashton, Principal Policy Analyst, Research Division, Legislative Counsel Bureau (LCB)<br>Davis H. Florence, Senior Policy Analyst, Research Division, LCB | Interim Work Program |
| Agenda Item IV A | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R067-23 |
| Agenda Item IV B | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R075-19 |
| Agenda Item IV C | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R069-17 |
| Agenda Item IV D | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R086-23 |
| Agenda Item IV E | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R103-23 |
| Agenda Item IV F | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R002-23 |
| Agenda Item IV G | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R069-23 |

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| Agenda Item IV H | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R177-22 |
| Agenda Item IV I | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R189-22 |
| Agenda Item IV J | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R051-23 |
| Agenda Item IV K | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R114-23 |
| Agenda Item IV L | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R115-23 |
| Agenda Item IV M | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R169-22 |
| Agenda Item IV N | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R140-17 |
| Agenda Item IV O | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R090-18 |
| Agenda Item IV P | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R145-23 |
| Agenda Item IV Q | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R035-23 |
| Agenda Item IV R | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R059-23 |
| Agenda Item IV S | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R100-23 |
| Agenda Item IV T | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R164-20 |
| Agenda Item IV U | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R178-22 |

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| Agenda Item IV V | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R179-22 |
| Agenda Item IV W | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R180-22 |
| Agenda Item IV X | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R181-22 |
| Agenda Item IV Y | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R196-22 |
| Agenda Item IV Z | Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB | LCB File R197-22 |
| Agenda Item V | Megan Comlossy, Director of Public Affairs and Policy, School of Public Health, University of Nevada, Reno | PowerPoint Presentation |
| Agenda Item VI | Richard Whitley, Director, Department of Health and Human Services (DHHS) | PowerPoint Presentation |
| Agenda Item VII | Malinda Southard, DC, CPM, Deputy Administrator, Division of Health Care, Financing and Policy, DHHS<br>Kelly Cantrelle, Deputy Administrator, Division of Welfare and Supportive Services, DHHS | PowerPoint Presentation |
| Agenda Item VIII | Blayne Osborn, President, Nevada Rural Hospital Partners | Policy Proposals |
| Agenda Item IX A-1 | Angie Wilson, Director, Reno Sparks Tribal Health Center, Reno-Sparks Indian Colony | PowerPoint Presentation |
| Agenda Item IX A-2 | Angie Wilson, Director, Reno Sparks Tribal Health Center, Reno-Sparks Indian Colony | American Recovery and Reinvestment Act of 2009 Section 5006 Protections for Indians Under Medicaid and CHIP |
| Agenda Item IX A-3 | Angie Wilson, Director, Reno Sparks Tribal Health Center, Reno-Sparks Indian Colony | California Tribal Medi-Cal Administrative Activities User's Manual |

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| Agenda Item IX A-4 | Angie Wilson, Director, Reno Sparks Tribal Health Center, Reno-Sparks Indian Colony | Oregon Health Authority LC 496 |
| Agenda Item IX A-5 | Angie Wilson, Director, Reno Sparks Tribal Health Center, Reno-Sparks Indian Colony | Oregon State Plan Amendment 17-0007 |
| Agenda Item IX A-6 | Angie Wilson, Director, Reno Sparks Tribal Health Center, Reno-Sparks Indian Colony | Oregon Tribal Evidence Based and Cultural Best Practices |
| Agenda Item IX A-7 | Angie Wilson, Director, Reno Sparks Tribal Health Center, Reno-Sparks Indian Colony | Centers for Medicare and Medicaid Services, Department of Health and Human Services, Federal Funding for Services to Medicaid-Eligible American Indians and Alaska Natives |
| Agenda Item IX A-8 | Angie Wilson, Director, Reno Sparks Tribal Health Center, Reno-Sparks Indian Colony | State of Alaska, Department of Health and Social Services, Tribal Medicaid Outreach and Linkage Plan, Tribal Medicaid Administrative Claiming |
| Agenda Item XI A | Rebeka Acosta, A+J Patient Advocacy | Written Public Comment |
| Agenda Item XI B | Larry Fannin, BS Pharm, PharmD, Dean, Roseman University of Health Sciences, College of Pharmacy | Written Public Comment |
| Agenda Item XI C | Tahnee Forolini, PharmD, BCPS, Act4Kids Nevada | Written Public Comment |
| Agenda Item XI D | James Leonard, Reno, Nevada | Written Public Comment |
| Agenda Item XI E | Amy Hale, PharmD, BCPS, RN, President, Nevada Pharmacy Alliance | Written Public Comment |