NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

(*Nevada Revised Statutes* [NRS] 218.E320)

MINUTES

March 11, 2024

The second meeting of the Joint Interim Standing Committee on Health and Human Services for the 2023–2024 Interim was held on Monday, March 11, 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
Senator Rochelle T. Nguyen
Assemblywoman Tracy Brown-May
Assemblyman Brian Hibbetts
Assemblyman Duy Nguyen

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Robin L. Titus
Assemblyman Ken Gray

COMMITTEE MEMBER ATTENDING REMOTELY:

Assemblyman David Orentlicher, Vice Chair

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Davis H. Florence, Senior Policy Analyst, Research Division

Destini Cooper, Senior Policy Analyst, Research Division
Sarah Baker, Research Policy Assistant, 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—OPENING REMARKS

Chair Doñate:

Welcome everyone to our second meeting. It is an honor to be here with all of you today. I apologize for scheduling a meeting on spring break—I know that many of us have kids—but hopefully today will be a good and eventful meeting. As you may have noticed on our agenda, we have a lot of good presentations today. During our first meeting, we mentioned that the Committee would have several discussions on different priority areas we are focusing on, and today's theme is access to care. Many of the conversations we will have today deal with access to care, so for those giving public comment, these are points that you might look to emphasize. Hopefully by the end of the day we can start to have policy discussions on what we can do to improve access to care in the State.

[Chair Doñate reviewed meeting protocols and information related to providing public comment.]

We will now open public comment. We will start here in Southern Nevada and then move on to Carson City.

AGENDA ITEM II—PUBLIC COMMENT

Jamelle Nance, Early Childhood Policy Director, Children's Advocacy Alliance:

I wanted to say how grateful I was to see child care and housing on the agenda for the presentation with the National Conference of State Legislators (NCSL) and offer a few highlights and things to consider. We have seen significant investments over the years due to the Coronavirus Disease of 2019 (COVID-19), but we are currently serving about 10 percent of infants and toddlers in the State, and we attribute this to our continued child care desert impacted by low wages and reimbursement rates that do not reflect the true cost of care. Our United States American Rescue Plan Act of 2021 (ARPA) funds did provide some much-needed relief. However, there is a looming fiscal cliff happening at the end of September that will place many child care providers back where they started if the necessary support is not secured.

I want to further acknowledge the promising new updates to Nevada's Child Care and Development Fund. However, we know that without the proper infrastructure, we will not be able to see the full benefits the updates offer. For example, one of the updates includes expanding child care choices for families that meet their needs. However, we continue to face significant hurdles with expanding home-based child care due to homeowner's associations and zoning regulations.

The systemic issue we face cannot be remedied with funding alone. It is important for Nevada to have a governance structure that supports a comprehensive early childhood system to ensure that we meet the needs of the whole child. We must continue to challenge these systemic barriers, including affordable, stable housing. According to our partners at Schoolhouse Connections, there were an estimated 6,825 children experiencing homelessness between the ages of zero to three. We want to emphasize that children need stable housing to best support their physical, social, and emotional development to ensure they enter school ready to learn. Thank you for your continued support, and we ensure that we will continue to keep early childhood top of mind in the State.

Dan Musgrove, United States Anesthesia Partners (USAP):

I am speaking on agenda item VII. regarding consolidation. I wanted to make sure that you had an opportunity to think about a few things as you listen to that presentation, because there are several remarks about USAP in the PowerPoint provided by the Culinary Health Fund. I wanted to make sure you had some thoughts in your head as you hear their presentation, because I am not sure what they will be saying.

Nevada is unique, and USAP is one of the few anesthesia groups where the bulk of their business is Medicaid. They treat 60 percent of the Medicaid patients in the State of Nevada. Let me put that in perspective, because you know—and I think those of you who have been on these Committees before and even on Ways and Means and Finance understand—that when it comes to government programs, reimbursement rates are very lean. In fact, anesthesia has not had an increase since 1991; they had a dramatic decrease in 2010 of 43 percent of their Medicaid and Medicare rates. We got notification today that Medicare is going to be reducing rates again.

When you think about consolidation, you want to think about the services we must provide in a lean market. Today, every day this week, and every day after that, 18 of our physicians are on call because of a shortage of anesthesiologists. Why? Because Nevada is not an attractive market when it comes to reimbursement rates. Factor in the fact that we doubled our malpractice insurance: again, why would people want to come to Nevada?

At USAP, we work harder than anybody to try to bring people to Las Vegas and to service those who need anesthesia services. We provide the only residency program in the State of Nevada through USAP. We work with Certified Registered Nurse Anesthetists (CRNAs) to make sure they get training, so we can provide the coverage that is sorely needed in this Valley. There are a couple discussions of lawsuits in Texas and in Colorado. I can tell you the Texas case has not been resolved. The Colorado issue was settled with the agreement of both parties, but again, no claims by either party have gone to court.

Chair Doñate:

Mister Musgrove, could you complete your comment, please?

Mr. Musgrove:

Absolutely. I wanted to have you think about those things as you listen about consolidation. It is very important to provide infrastructure for these doctors because they need to be serving patients, not worrying about the back end of the house, and the worst thing we have is chasing payments. We would welcome the opportunity to talk about USAP with you individually or during a subsequent hearing.

Chair Doñate:

Is there anyone else in Southern Nevada? Let us move to Carson City. Is there anyone in Carson City?

Tom Clark, The Children's Cabinet, United Way of Northern Nevada and the Sierra:

I am here to speak on agenda item XI. Like your previous speaker, I am excited to see that child care is an issue you will be discussing during this interim. The Children's Cabinet is a leader in this arena, and we look forward to this presentation today and respectfully request that The Children's Cabinet and our other stakeholders have an opportunity on a future

agenda to discuss how these impacts are happening in child care and early childhood learning here in the State.

Cindy Green, Emergency Medical Services (EMS) Chief, Reno Fire Department:

I am here on behalf of Dave Cochran, the Reno Fire Chief, and also the President of the Nevada Fire Chief's Association. I am specifically speaking to agenda item XI. You will see their presentation this afternoon. (Agenda Item II A)

The need for increased investment in the State EMS program is vital and important to the Reno Fire Department. Over 60 percent of the calls we run and receive are for medical treatment, and each of our 300 first responders carry an EMS license to practice medical care. Each year, the Reno Fire Department must renew a permit to provide EMS services in Washoe County. We recertify approximately 150 EMS personnel. We request inspections of our fleet of EMS vehicles and report data related to the medical calls we run.

The EMS program is currently understaffed and under-resourced. They have been unable to fill positions that are open and available, and they are now sitting at a 50 percent vacancy rate. Currently, three program representatives serve the entire State, excluding Clark County, and are responsible for the oversight of licensure for 6,000 to 7,000 providers. These vacancies have led to long wait times in our service requests and a delay in our ability to provide emergency medical services to our communities. If something does not change, there is a very real possibility of a catastrophic outcome that would compromise the safety and livelihood of our Nevadans.

Looking forward; one solution would be to change the EMS program to a Bureau of Emergency Medical Services. We understand this would allow for a reclassification of the existing eight positions, which we believe would increase the State's ability to recruit and retain these essential workers. I look forward to seeing what the Committee can accomplish in the interim and the next legislative session.

Dale Carrison, D.O., F.A.C.E.P, Chairman, Nevada EMS Advisory Committee:

I am the former head of Nevada's Homeland Security Commission for seven years and three governments. I have been involved in EMS services in the State of Nevada for the last 30 years. I am speaking to agenda item XI, and I could speak to agenda item V. I initiated the first emergency medicine residency in the State of Nevada.

We are here today because of multiple issues concerning the support for the Division that Ms. Sullivan oversees. I think people forget what importance of calling 911; when you call 911, who is going to show up? You will have an Emergency Medical Technician (EMT), an advanced EMT, or a paramedic, and without that support, we do not have that. You may be familiar with the recent article showing that Nevada is an ambulance desert. I find that highly concerning for the State that I have adopted. I was at University Medical Center (UMC) of Southern Nevada for almost 30 years, and I am currently in Currant, Nevada. I am also the Associate Medical Director for East Fork Fire in Douglas County.

These issues that will be presented to you today regarding EMS are incredibly important to our State. *Nevada Revised Statutes* eliminates Clark County from this consideration, so now, in Northern Nevada and everywhere outside of Clark County, we are trying to have the resources necessary to provide EMS in these other parts of the State. It is an ambulance desert, and the support of this body and the State is incredibly important so we can get rid of the title of "ambulance desert," which I find highly offensive for the State of Nevada.

We need paramedic education. There are three. The Reno Emergency Medical Services Authority (REMSA) is currently having a paramedic class. Unfortunately, Western Nevada College canceled their paramedic class, and I do not know why the Board of Regents allowed that, but we need more paramedics. I am in contact with the paramedic education programs in Las Vegas. Right now, they have a class of 60 paramedics, which we desperately need in rural Nevada and the other cities outside of Clark County. I would appreciate your support for representing my Committee members, all the fire departments and other individuals involved in EMS education, and providing ambulance services in rural Nevada.

Benjamín Challinor, Director of Public Policy (Nevada), Alzheimer's Association:

We thank you for the opportunity to speak in support of the American Cancer Society's proposal on expanding biomarker coverage. The Alzheimer's Association is the largest voluntary health organization in Alzheimer's and dementia care, support, and research in addition to the largest Alzheimer's advocacy organization in the world, which is why we are here in support.

There are currently over 49,000 Nevadans aged 65 or older living with Alzheimer's disease or dementia, but as many as half of them are not formally diagnosed. Early and accurate diagnosis of Alzheimer's can improve access to care and supportive services, enhance quality of life, and reduce the financial impact of the disease. With the historic approval of treatments that slow the progression of the disease, early detection and diagnosis of Alzheimer's is even more critical to ensure individuals receive the most benefit at the earliest point possible in the disease progression.

Currently, diagnosis of Alzheimer's disease relies largely on documenting cognitive decline, at which point Alzheimer's has already caused severe brain damage. Experts believe that biomarkers offer one of the most promising paths to improve dementia detection, diagnosis, and treatment. By expanding biomarker coverage, we not only save lives, but we can also make sure that we save the State money.

Julie Ellsworth-Baker, Ph.D., Dean, Life Sciences, Allied Health and Public Safety Division, Truckee Meadows Community College (TMCC):

I was here for agenda item X, but being over the Paramedic Program at Truckee Meadows Community College, I wanted to say a couple of words regarding the need for the changes that will be presented in agenda item XI. In the Paramedic Program, we have difficulty finding internship placements because there is such a lack of trained personnel; they are doing double and triple overtimes, so the need to train new paramedics is hampered in and of itself by not being able to have internship training to pipeline the number of students that we need in that workforce to serve our community.

Chair Doñate:

Is there anyone else in Carson City who would like to give public comment. Broadcast and Production Services (BPS), is there anyone virtually?

Kent Ervin, Nevada Faculty Alliance:

I represent the Nevada Faculty Alliance, the independent statewide association of professional employees at Nevada's public colleges and universities. In agenda item IX, the University of Nevada, Las Vegas (UNLV) and University of Nevada, Reno (UNR) Medical Schools are providing information. We appreciate that the two medical schools are working

together. Nevada is served best when the rivalry between the two comprehensive universities is kept to athletics. (Agenda Item II B)

Item IX B provides statistics on Graduate Medical Education (GME). Attracting medical students to residencies in Nevada is the first step in recruiting them to stay and practice as physicians, but the quality of the educational experience is also important in making residents want to stay in Nevada. How are the two medical schools working to meet national accreditation standards for resident training? More importantly, what are they doing to enhance the educational experience?

Using more community-based medical partners and residencies means that greater oversight is needed. Ideally, these programs can develop residencies into longer-term professional relationships in Nevada, or else residents can be seen by private partners as cheap labor to maximize profits. How are the medical schools monitoring residencies in the field to ensure proper clinical supervision, high-quality education, and humane working conditions? How is State funding being dedicated towards those goals?

Item X considers nursing education. The cost-of-living adjustments approved by the last Legislature were a historic step in improving State employee salaries across the board, but nursing faculty salaries especially have been far short of being competitive. How are the colleges and universities addressing nursing faculty salaries to increase the nursing pipeline and access to care in Nevada?

Adam Zarrin, Director, State Government Affairs, Leukemia and Lymphoma Society (LLS):

Our mission is to cure blood cancers and improve the quality of life for patients and their families. Last week, LLS published a new report entitled *Health Care Consolidation is Raising Prices and Jeopardizing Cancer Care: Policy Recommendations*. I submitted that report for the record (Agenda Item II C).

As you discuss agenda item VII, in short, a few large hospital systems are increasingly purchasing local health care systems, hospitals, and doctors' offices. Those big health systems are gaining more control of their markets, leaving insurers and employers with less leverage to negotiate lower costs. These increased costs are passed on to consumers through higher premiums, out of pocket costs, and even lower wages. This means patients are less able to afford the care they need and are more likely to delay or even forego treatment. These are well-researched and documented facts about our health care system.

The research also shows that consolidation—particularly hostile mergers—is especially harmful to Black, Hispanic, Indigenous, low-income, and LGBTQ+ communities as well as other people of color and women. Mergers among health care providers often lead to fewer services offered, leaving people in marginalized and disenfranchised communities with fewer options for where to receive certain types of care.

What can policy makers do? Our report outlines recommendations for policy makers that strengthen antitrust enforcement, reform pricing and reimbursement rules, prohibit anti-competitive contracting terms, and improve transparency standards. We appreciate the opportunity to share this information with the Committee and look forward to future conversations to address health care affordability.

Chris McHan, Ambulance Director, EMS Chief, Elko County Ambulance Service:

The Elko County Ambulance Service largely covers portions of Elko County and collaborates with those within our County to provide services throughout the rest of the County. I wish to speak to agenda item XI. I am excited to see this item is on the agenda today to discuss the state of our EMS Office here in Nevada.

One thing I have noticed as I have interacted with many other agency leaders throughout the nation is that our EMS Office is pared down compared to many other states. To give you an example, our EMS Office is charged with helping regulate things like trauma centers; in other states, that is commonly the sole job or even a program or an office of their own that runs something like that. Our EMS Office has several assignments that they carry within their Office in addition to the regulation of ambulance services.

I am excited to see that we are talking about this and helping give them more support. I know from personal experience several, years ago, I looked at becoming an employee of the State and working in the EMS Office, but it would have been a significant pay cut for me. I was making about double what the position was advertised for. That seems like a challenge for our EMS Office to be able to recruit and retain staff when those who are equivalently qualified in agencies are paid significantly more to work in the EMS industry.

I would like to see an opportunity for our EMS Office to receive more funding and support to meet their objectives and authorities and be able to regulate where they need to. Since they struggle with recruitment, as has been mentioned in previous testimony, they have a large gap, which slows down the credentialing of ambulance agencies and personnel. This is something we need to address within our State to make sure we have continued EMS services here in Nevada.

BPS:

Chair, you have no more callers at this time.

Chair Doñate:

We will close public comment and move on to the approval of minutes for the meeting on February 16, 2024.

AGENDA ITEM III—APPPROVAL OF MINUTES FOR THE MEETING ON FEBRUARY 16, 2024

Chair Doñate:

For clarification, the February minutes are not ready for approval, so we will skip this item. I wanted to make sure that was for the public's input.

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

Chair Doñate:

We will move on to consideration of regulations proposed or adopted by certain licensing boards pursuant to NRS 439B. For this agenda item, I will let Mr. Robbins review the

different regulations and then afterwards, similar to our last meeting, I will open it up to Committee Members if they want to pull any particular regulation to discuss.

Mr. Robbins:

We have five regulations for the consideration of the Committee today: LCB File R072-22 of the Board of Dental Examiners (Agenda Item IV A); R125-23 of the Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors (Agenda Item IV B); R068-23 of the Board of Medical Examiners (Agenda Item IV C); R095-23 of the Board of Psychological Examiners (Agenda Item IV D); and R108-23 of the Speech Language Pathology, Audiology and Hearing Aid Dispensing Board (Agenda Item IV E).

Chair Doñate:

Committee Members, is there any regulation in particular that you would like to pull out? I do not know if we have anyone here in Southern Nevada. Is there anyone in Northern Nevada?

I do not think we have any questions, so we should be good. For clarification, if you see something and you want to bring it back to our attention, we can always communicate offline to the different boards.

AGENDA ITEM V—PRESENTATION ON GRADUATE MEDICAL EDUCATION FUNDING, IMPLEMENTATION UPDATE ON SENATE BILL 350 (2023) (CREATION OF THE GRADUATE MEDICAL EDUCATION GRANT PROGRAM), AND POLICY CONSIDERATIONS

Chair Doñate:

Next, we will continue on with agenda item V, a presentation on graduate medical education funding, implementation update on SB 350, and policy considerations.

Brian L. Mitchell, Director, Governor's Office of Science, Innovation, and Technology (OSIT):

I am pleased to be here today to provide an overview of the GME grant program that OSIT administers (Agenda Item V). Today I was requested to talk about how GME funding is allocated and give an update on SB 350 implementation and any policy considerations for the Committee, after which I will be happy to take any questions.

I bring greetings from the Governor and the Governor's Office, and the desire to communicate to the Legislature the Governor's strong commitment and support for the GME grant program to the State. The Governor recently outlined several different policy priorities to State agencies, and those of us at OSIT were pleased to see that GME was included in the policy matrix as a specific policy the Governor wants State agencies to focus on. This is a priority for the Governor, something that he believes is very important, and he is looking forward to working and collaborating with you all on the GME program.

Briefly, I think it might be helpful for clarification to talk about what GME is and the current state of GME in Nevada. Following the completion of medical education—for example, either at UNLV or UNR Schools of Medicine—doctors must complete a residency program to practice medicine. Without GME, physicians cannot become board certified or obtain a

license. The length of GME programs depends on the specialty and may last as few as two years or as many as five years.

Residencies are where physicians become specialists, such as in pediatrics, family medicine, psychiatry, internal medicine, et cetera. For more complex medicine, residents may pursue a fellowship or a subspecialty, such as cardiology or neurology. Fellowships can last an additional one to three years beyond the residency, and some subspecialties require multiple fellowships.

I appreciate the public comments that talk about the various deserts we have in Nevada, and physicians in many specialties and subspecialties throughout Nevada and in different regions of the State certainly qualify. Nevada consistently ranks as one of the most underserved States in most areas of health care delivery, both in urban and rural settings, due in large part to a shortage of physicians. Additionally, many graduates of Nevada's medical schools must leave the State if they want to seek a GME specialty since Nevada lacks many specialties and subspecialties. Nevada produces more undergraduate medical students than it has residencies or fellowships available.

According to the Nevada Workforce Research Center at the UNR School of Medicine, recently about 40 percent of physicians graduating from GME programs in Nevada plan to remain in Nevada to begin their clinical practice or pursue further training. In contrast, 33 percent plan to leave the State to begin clinical practice elsewhere, and 26 percent plan to continue training outside of the State in programs that do not exist in Nevada; about 60 percent plan to leave the State in total. Over the last decade or so, retention rates of graduating physicians who plan to begin clinical practice have varied from a high of about 48 percent down to a low of about 25 percent. Overall, the numbers speak to the need that we have in the State to do more to retain physicians who graduate here and attract ones from elsewhere.

I would like to talk about the current GME grant program, and how that helps increase both the raw numbers of physicians remaining in Nevada as well as those coming from outside of Nevada by increasing the numbers of residencies and fellowships. The current program also provides the opportunity to retain more physicians in Nevada who plan to continue their training, given that many of them leave for training programs that have not historically existed here.

When I speak about collaboration on GME, the Governor's Office, and the Legislature have a long history in this State of collaboration. The GME program was first funded in 2015, which was also the year that OSIT was created, so the GME program was assigned to OSIT upon its creation. I have worked at OSIT since 2015, so GME is a program I am very passionate about, and I consider it very important to me personally. Since we awarded the first grants in 2016, we have made 28 awards, which have a combined capacity or number of slots between them of about 160 fellowships and residencies; we have awarded about $28.5 million.

I want to talk about the process of awarding funding for these programs. The first step involves a lot of preparation and consultation with data and particularly looking at health profession shortage areas when it comes specifically to physician practice. When we first started the GME grant program, we focused exclusively on family medicine and mental health. Those were the two eligible specialties for the first several rounds of funding. Since then, we have expanded the eligible specialty and subspecialty set to include any specialty or subspecialty where a region in Nevada ranks below the national average for that specialty or subspecialty. There are places in Nevada, for example, where for a certain specialty, we

are above the national average in the North and below the national average in the South, so programs in the South would be able to apply for funding for that specialty or subspecialty.

I want to take a moment to thank Dr. John Packham at the Office of Statewide Initiatives at the UNR School of Medicine. He is an amazing resource for all sorts of data when it comes to physician practice in the State.

The eligible entities that can apply for funding are any entity accredited by the Accreditation Council for Graduate Medical Education (ACGME), which is the accrediting body for GME programs across the country. We allow for either new programs—a new subspecialty or subspecialty that wants to get started—or a program that has a waiting list for the specialty or subspecialty to expand the number of slots they have available, for example, maybe to go from four slots to eight slots. The program allows for any expenses related to the startup of a new grant program, and I will go through some of those in a minute. Typically, these programs take about four to five years total to ramp up. It is quite an extended length of time.

For the programs themselves, typically, in the request for proposals, we will ask for a budget narrative—a plan—a project narrative that consists of a needs assessment using data to show the need exists and that it is a particularly acute need for the residency or fellowship program, a feasibility assessment that discusses the institution's ability to carry out the program, and a work plan that details how the applicant will go about achieving accreditation and carrying out the proposed project. We also ask for a sustainability plan detailing how the program or the sponsoring institution—whether it is a medical school or a hospital—will be able to sustain the program over time, and an accounting of what the ongoing costs of the program are, and finally, how the program will collect data and evaluate their success, including contributing data to Dr. Packham at UNR. The final thing they must show us is a certification of accreditation.

Regarding the evaluation process, OSIT assembles an evaluation team of individuals with expertise in GME who do not have a financial interest in any of the proposals. We have a scoring rubric wherein the proposals are evaluated and then funding decisions are made.

I mentioned that over the years we have funded 28 different programs, and I wanted to provide a snapshot of some of the specialties and subspecialties where Nevada is below the national average and the number of physicians per capita. These are the different programs we have funded: psychiatry and behavioral health, primary care, obstetrics and gynecology (OBGYN), internal medicine, geriatrics, family and community medicine, physical medicine, rehabilitation, surgery, pediatric emergency medicine, pulmonary and critical care, critical care surgery, forensic psychiatry, radiology, preventative medicine, pediatrics, hematology, and medical oncology and rheumatology.

We funded grants in the north and in the south. Medical schools in the State have been successful applicants along with individual hospitals. We have also funded grants where there are rural tracks or components of the training, so a physician or a resident may start out in an urban setting and then spend a few years of the fellowship or residency practicing in a rural area before wrapping things up back at the home base.

Moving on to SB 350 implementation, it has certainly not gone as quickly as we had hoped or expected. When SB 350 first came into being, separately from its passage, the Governor proposed, and the Legislature funded the hiring of a new staff person who would be wholly dedicated to the funding of the GME program. As the GME grant program has grown over time, the need to monitor and continue to follow up with previous grantees as well as have

a new grant program and administer that became too much, so we needed to hire a new staff person for this grant program to continue to be successful.

We identified a six-month plan where we would onboard the new person and begin to implement SB 350, but in the 14 years I have been a State employee or worked in various capacities for the State, I have never had a tougher time hiring a person. It has been quite a difficult process, and this is something that we are still working on.

I want to give you an idea of the type of person we are advertising for. The candidate needs to have the ability to do program strategic direction, budgeting and projections, and stakeholder engagement—particularly director-level engagement with key stakeholders at medical associations, medical schools, hospitals, chief executive officers (CEOs), the Nevada Hospital Association, the Department of Health and Human Services (DHHS), and so on.

This individual needs to be able to do program implementation, including the oversight and management of the competitive GME request for applications process; organizing a review Committee; writing the grant agreements; executing awards; doing all the grant management and follow-up to ensure that the costs expended are eligible for reimbursement; monitoring and oversight, including the post-award fiscal and programmatic compliance reviews; and finally, administrative and regulatory work related to overseeing the process, Open Meeting Law and other meetings, including agendas and minutes that need to be taken care of. We are still having conversations internally with Human Resources and hope to be able to resolve that soon. We are now in the middle of a recruitment and hope to be able to start interviewing candidates very soon.

Once this person is brought on board, we have a six-month plan that will allow for the person to get up to speed on what GME is. It includes a significant amount of stakeholder engagement to previous awardees as well as eligible entities that can apply for grants, and then we would be able to begin putting together a five-year strategic plan for GME and present that to the Committee as has been identified in SB 350.

The Committee also asked for policy considerations, and the one that I would like to bring forward today may be a better fit for the budget committees, but given your role in improving health care access, I want to mention it briefly here today. A new GME grant program, as the folks in the room who have been recipients of funding know, typically takes two to four years and sometimes even longer to create and successfully launch.

The creation of a new GME residency or fellowship requires adherence to externally mandated timelines that do not always easily align with the State Fiscal Year (FY) or biennium. For example, accreditation bodies only meet a few times a year, and accreditation is needed to move forward with some aspects of the program that we funded or some aspects of creating a new residency program. For example, if there is a delay in hiring a program director, that could cause a program to miss an accreditation window and cause a delay of six months. Sometimes when a program seeks accreditation, they need to revise the program to receive accreditation, and that can cause delays as well. If a program receives an accreditation in the springtime, the program will not onboard residents for a full 15 months because resident recruitment begins in early fall and residents start the following July.

These things take time to build, and if we have awarded funding in one FY, we need to be able to map out and project those costs of creating the program. We had conversations during the last Legislature around being able to balance forward unspent funding from the GME grant program that had been obligated to a particular grantee to allow for that

program to be able to meet its accreditation timelines and grow over time. Something happened where I guess it did not make it into the final legislative language, so that is something we will be bringing back up again during this upcoming legislative session—the ability to balance forward dollar amounts that we have obligated to certain grantees beyond the biennium. That will allow us to have a dedicated amount of money, which will allow for more surety for the grantees that if they embark on a program, their funding will be there in subsequent years to fully build out their program, even if there is an unforeseen delay. I am happy to take any questions the Committee may have.

Chair Doñate:

Let us proceed with questions from Committee Members at this time. Do we have anyone in Southern Nevada?

Senator Nguyen:

I have questions and they might be better for one of our next presenters. If you are presenting from the medical schools, you might be in a better place to answer this. I know we have not had many changes to federal GME funding since I think the mid-1990s. Considering that, I know there have been proposals or talk about supplanting State funds into these GME programs. Do you know how many GME residency programs or spots there currently are in our State?

Mr. Mitchell:

I do not know the total number of residency spots that are created, but you are right that the medical schools will be better at answering this question than I am, and that U.S. Congress has not increased the amount of federal funding for GME for many years. In fact, the formula was first introduced back when East Coast states had a significantly higher proportion of the population than they do now, so it is a bit of a sore spot for us in the West who are still growing, that we are stuck with a much smaller amount of funding than perhaps we need.

Senator Nguyen:

Again, this question is probably better answered by the next presenters, but I will put it out there if there is information they can find out. I am curious what percentage of the residency programs are housed in private hospitals. Even if we have an influx or more money that went to these programs, you still need those facilities to create programs. I am curious how you would do so to fill in those deficiencies rather than create more existing residency spots. We are deficient across the board, so I have some concerns about that.

My other question is, currently this program is housed within OSIT, but I know in other states, it is housed within their DHHS. Do you see any benefit to it remaining where it is now as opposed to moving into a more health care related space?

Mr. Mitchell:

At OSIT, we serve as both the State Science, Technology, Engineering and Mathematics (STEM) Office and the State Broadband Office, and GME education was viewed as a part of the Governor's broader STEM education and workforce development initiative; so the funding was sent to OSIT. I think we have been successful over the years in managing and working collaboratively with folks at DHHS; they sit on our review committees and provide information and expertise on the selection of which specialties and subspecialties are eligible

in the design of the request for applications process. As a smaller agency, I think we can turn on a dime and be a little bit nimbler than some of the larger agencies, so that works to our advantage. I also am not aware that anyone necessarily in DHHS has spare capacity, so regarding moving it to another agency, I do not know that they would be able to take on a program like this without appropriate staffing resources.

Chair Doñate:

Are there any other questions in Southern Nevada?

Assemblywoman Brown-May:

If you do not mind, I am going to follow up on that questioning. Not to suggest that OSIT is not doing a good job of managing the program, but in your testimony, you noted that your Division has been slow to ramp up GME, and in many of the conversations we are having here, particularly in Southern Nevada, those slots are essential. We have the funding for them, and I am curious to know: is it helpful to grow your partnership with DHHS to move a bit more quickly to deploy those programs? Do you have any recommendations for how we can help you execute more quickly?

Mr. Mitchell:

Perhaps the most important thing for us would be to be able to balance forward funding from year to year. To provide more context in that regard, I have interviewed several of the GME Directors at different medical schools and hospitals and come up with the number of steps required to create a GME program.

Programs must recruit and hire a program director—which is a big and important step—then hire a program coordinator, and those two folks are primarily responsible for overseeing and managing the program at the institution and developing the application for accreditation.

They must also recruit and hire faculty who will build the program and the application, and once they do that, they develop and submit an accreditation application to ACGME; that Committee will meet and then there is an accreditation decision, and again, sometimes these take six months to a year to develop the program and get on the agenda.

Finally, the program will address any deficiencies in their application and then resident recruitment will begin. Regardless of when that program is approved by their accrediting body, resident recruitment begins in the fall and residents start July 1, so when you look at how long these timelines are, it can be very difficult and inefficient for us at OSIT to have to deal with individual FYs.

For example, if we have budgeted a certain amount of funding for a particular program over a FY, if there is a delay in hiring a program director, which can push out some of the timelines beyond that FY, and then we end up reverting funds back to the General Fund because the program simply had delays in ramping up their program.

That means we must pull money from a future FY to meet our grant or funding obligation to that particular program, so if we are able to dedicate a pot of money and have that balance forward over years beyond the FY to that program, that will be more efficient for us in terms of making sure every dollar counts that has been appropriated to the GME program.

Assemblywoman Brown-May:

I appreciate that very detailed walkthrough and hear what you are saying relative to the balance forward. I have one further question though; if I am developing that program within the medical school and we are investing in hiring a director and hiring a program manager and developing that, is there a promise from OSIT that you are going to fund the development of that program from this grant fund, or is that cash that I am outlying first to invest in the hopes that OSIT is going to walk alongside me later?

Mr. Mitchell:

I am glad you asked because it allows me to clarify the process. When an institution—either a hospital or a medical school—applies for funding, what they are presenting to OSIT is an idea; they say there is a need, for example, for pediatric emergency medicine, which is one of the applications we received a few years ago. Other than the cost of putting together a grant application, the applicant has not expended any funds.

In their budget, the applicant would say, "We need X amount of dollars to hire a program director, X amount of dollars for faculty. We might need some money to build out or renovate a space within the hospital or medical school and to buy the necessary equipment. We will need time to develop curriculum, so on and so forth." Those expenses are all planned and proposed to OSIT.

When we award the funding, we award a total amount of money that includes everything that program would need from the start to begin to recruit and hire that program director all the way through the resident or fellowship salaries for the first cohort of residents. We will take them all the way through the development, cover all the expenses related to applying for the accreditation application, and then the expenses to ramp up and start the program through that first cohort, however long that takes. Again, this is a multi-year endeavor, but the applicant would not be out any money if they are not funded or are not successful in their application.

Assemblywoman Brown-May:

I have one other request: would it be possible for you to share with us the rubric for the programs that you are currently assessing? How are you making those decisions based on your applicants? If you do not mind, the rubric would be very important. Also, how many other programs are you operating out of OSIT besides the GME program?

Mr. Mitchell:

The rubric is available publicly on our website, and I will make sure your staff gets a copy of it. Whenever we solicit funds, we post the entire Request for Proposal on the website and included in that, is the rubric used so everybody knows up front how different programs will be assessed. Beyond GME, as I mentioned earlier, OSIT has two sides to the house. We are the State STEM Office and the State Broadband Office.

The State STEM Office has several different programs related to teacher professional development. We operate the Governor's designated STEM school program; we provide a STEM leadership academy for schools; they learn what they need to do to meet the requirements for designation. We also have several other different grant programs related to providing more STEM equipment like robotics equipment for K–12 schools.

On the Broadband side, our mission is to ensure that all Nevadans, regardless of where they live, have access to an affordable and reliable high-speed Internet connection. We are in the process of allocating funding to make sure that that happens for everyone.

Chair Doñate:

I will come back to a broadband question. We are not done yet. Is there anyone else in Southern Nevada? Seeing none, let us go to Northern Nevada.

Senator Titus:

This is obviously a passion of mine, and I have several questions for you. Number one, on SB 350, as a cosponsor of that bill, part of that bill was to allow for the balanced funding to be brought forward and continue forward. Is that not your interpretation of that bill, sir? I am curious. Balance funding is currently in SB 350 that did pass.

Mr. Mitchell:

In talking with LCB Fiscal Staff as well as the staff at the Governor's Finance Office (GFO), it was our interpretation that the funds are allowed to balance forward within the FY, so all of the funding for the biennium, rather than being divided between the two FY, is appropriated at the beginning of the FY, but any leftover funding at the end of that biennium is reverted. The conversation we would like to have is about allowing funds that are appropriated and then obligated during that biennium to balance forward beyond the biennium so there is a dedicated source of money over time, and if it takes a program four, five, or six years to finish, we have that funding available for them; we are not essentially robbing from a future biennium to pay for a grantee that we award now.

Senator Titus:

I think the intent certainly was to allow that to go forward recognizing that it can take more than five years sometimes to start these programs, so thank you for that. We will have to look at LCB and readdress that if that is not clear to the staff, because it certainly was, I am sure, Senator Pazina's intent.

You mentioned that you wanted it to stay in your Department because your Department is very nimble and you can make choices and decisions, so I am curious about how your Department—you said you have been there for quite a number of years now, and in 2017, UNR started a rural residency program in Elko. And under your watch, in January 2023, that program closed because the Northeastern Nevada Regional Hospital was not going to support it anymore. I wonder, where were you in that? Was there funding available to step in and maybe save that program, recognizing that it takes years to develop these programs?

Mr. Mitchell:

The rural residency program at UNR in Elko was one of the residencies that I was most excited about when we received the application and funded it. Having been to Elko many times, I know there is a great need for more doctors in rural areas, and as I have traveled the State in my capacity as the Broadband Director, there is a huge hunger for health care that we are hoping that telehealth and telemedicine can help address there.

When the School of Medicine gave me a call and let me know they were discontinuing the program, I was extremely disappointed that happened. We were informed by the School of

Medicine that it was a decision by the hospital, and the School of Medicine was also very disappointed about having to close the program. I had several phone calls with the School of Medicine trying to figure out alternatives to save the program, and ultimately, they said they were going to try to figure out other ways to have some of their other programs, that did not currently have rural tracks, go out and have a rural experience and provide rural care.

The purpose of the GME funds, as approved by the Legislature, was for startup expenses for new or expanded programs. It would not have been appropriate for OSIT to allocate additional money to the hospital in Elko to continue the program. Moving forward, we would hope to be able to reengage with the hospital at a future date, and maybe, if their expenses or finances have improved, I know the School of Medicine would be willing to restart that rural program. We know how important it would be to have it.

Senator Titus:

There was no opportunity for you to say, "Hey, we could supplement some of that income that you needed from the funds?" Is the language so limited in the GME funding that you did not feel you could intervene?

Mr. Mitchell:

Ultimately, given the huge need that we have for new specialties and programs and more doctors, we have always told the Legislature that is how we would use the funds. If we began to become a line item in the budget, those funds would forever have to be allocated to that program, and we would never be able to create new programs because eventually, the hospital would say that without these funds, they will cancel the program; so we would have to continue. If there is a need for certain programs to have recurring revenue to sustain them, I think that is a separate conversation those program sponsors should have with the Legislature and these GME funds ought to be reserved for the expansion of new programs in the State.

Senator Titus:

I have a couple of other questions. Regarding SB 350, is the Council (Advisory Council on Graduate Medical Education) fully committed? Have all the members been appointed?

Mr. Mitchell:

I do not have the answer to that. I know that some members have been appointed. I do not know if all members have been appointed, but I am happy to follow up with the Boards and Commissions staff at the Governor's Office and provide a response to you.

Senator Titus:

I ask that because as you have explained to us, it has taken a long time for you to hire somebody, but I am concerned that the moment that person is hired, they need to be engaged, so we want to make sure that Council is up and running. The next question regarding that: as you said, there is a six-month plan. Who wrote that plan? Is that something you created? Where can we find that six-month plan?

Mr. Mitchell:

I put together an internal document to explain to the Governor's Office how, once a dedicated GME Director is hired, they would then go about implementing SB 350 and the GME grant program. We are working extremely diligently. It has been a lot of work, and we are hopeful that we are close, but at the same time, there are a lot of policies and procedures at the State level that govern how you go about hiring people that we must follow.

Senator Titus:

One final question: you talked about balance forwarding of the funds. How much of those funds do you currently have that you have not allocated and spent that you would want to balance forward?

Mr. Mitchell:

We will not know until the end of the biennium the amount of funding we would balance forward because every quarter, all the GME programs will submit to us their quarterly fiscal and programmatic reports and reimbursement requests. Each quarter, we understand how much money they are spending; how their programs are progressing; and we also talk to them about this during site visits and so on. The person who would be hired—and believe me, there is nobody in the State who wants this person to be hired more and faster than I do—would work with the Administrative Services Division and the GFO at the State towards the end of the biennium to balance forward remaining funds with no change in purpose.

Senator Titus:

I understand that you may not know what the future biennium is going to ask to carry forward, but what about our last biennium? Do you know how much was left?

Mr. Mitchell:

Given that we did not have this authority, we did not go through the exercise of calculating a balance forward, but we can certainly look at past years and see if we can come up with an estimate. Ultimately, it depends on the individual programs, and how quickly they can stand up their programs. Some of the programs are more complex and may have different accreditation timelines, so depending on the next group of programs, year to year, how much money may be left obligated but unspent may depend. Given that it takes four to six years to build out these programs, it is in the millions of dollars every biennium.

Senator Titus:

I know there are programs waiting to get started. Carson Tahoe Hospital is looking at doing a program, and I would hope that things become more efficient as SB 350 moves forward.

Chair Doñate:

Assemblyman Gray, do you have any questions?

Assemblyman Gray:

Yes, Chair, I do. By the numbers, it said you have 160 fellowships and residencies. Are those positions created, or are those people who have already gone through?

Mr. Mitchell:

That would be the annual training capacity, so the number of slots or the number of people each year who are participating in a State-funded GME. Some of them may be in a one-year fellowship, others in a four-year residency, but that is the total number of people, and the number of slots that have been created. In other words, there are 160 people total who are moving through the pipeline.

Assemblyman Gray:

Got it. I know it is not a number-for-number comparison, but that is about $178,000 per position to create those positions. I am wondering about the return on investment for taxpayers. Are we tracking how many of those residents and folks are staying in Nevada? The crux is, how many of these people are we going to be able to retain, or have we retained so far?

Mr. Mitchell:

It is well known in GME circles that individuals or doctors are more likely to stay in practice where they do their residency or their fellowship—so their GME training—rather than where they do their medical school. There is a huge difference, so if the State trains somebody at a medical school and then they go out of State to go do their residency program, we run a large risk of losing that person unless they have a very strong tie to come back. It does not happen, so when it comes to a return on investment, I think having more residency programs and attracting doctors that way to come to the State is a large return on investment that we would otherwise lose. If we were to substantially increase the number of medical students in the State without a residency home for them, we would essentially be exporting a lot of doctors to other states. This is a very important part of what we need to do to grow our physician workforce.

Assemblyman Gray:

I understand there is a high propensity for them to stay, but out of the students who have been, say, put through under your tenure, how many have stayed in Nevada as a percentage compared to how many went through? That is what I am looking for. Are we tracking that and reporting it?

Mr. Mitchell:

On an individual student level, no, we are not tracking it, but as a State as a whole, those numbers are tracked and monitored by Dr. Packham at the UNR School of Medicine. I would be happy to ask him for updated numbers and communicate those to the Committee.

Assemblyman Gray:

That would be fantastic if we could get that, especially by specialty. If we are turning out a whole bunch of general practitioners but we need neurosurgeons, is the money going in the right spot? I want to make sure we are getting what we need in the State and are able to retain it.

Mr. Mitchell:

That is why we do our homework beforehand and look at the specific areas and locations in the State that need greater numbers of doctors. We will only award money to locations for specialties where the number of doctors per capita is below the national average for that specialty or subspecialty.

Senator Nguyen:

To clarify for the legislative record, during this interim Committee, I do not think a lot of people in the public recognize that OSIT not only manages GME but also K–12 STEM education and broadband; three arguably different areas of expertise. I asked initially about whether having GME within this Agency was the most appropriate thing. Are there things that we can do legislatively to empower and give more expertise in this area—like expanding an Advisory Council? Can you think of anything that would make this more efficient and professionalizing within this unique skill set? Does that make sense? How can we help you?

Mr. Mitchell:

At OSIT, we have a very long history of excellent stewardship of GME funds and of creating residency programs. We have awarded and created over 160 slots over the years, so at this point, the most important thing for us given that we have reached a tipping point where having another staff person—and this makes sense—as programs grow, you need to grow administratively with them. Once we have hired this staff person, both to manage the workload as well as the additional responsibilities that we are given to OSIT and SB 350, I think we will be off to the races.

I cannot think of anything right now that the Legislature could do, but we are certainly open to continued conversation between now and the start of the legislative session if either party thinks of anything.

Senator Nguyen:

My other question has to do with this carry over or balance forward money that you have been alluding to causing problems. Obviously, SB 350 is from this last legislative session and in reviewing it, I will concur with what Senator Titus had mentioned earlier. It is not a very large bill, and in Section 2, Subsection 5, it explicitly says that the legislative intent is that this money carry or balance forward.

I put in requests with Fiscal Staff to find out if that is limited to grant funding and gifts that they make sure they do not revert at the end of the biennium to the General Fund and how that works, but if it has not been implemented, how do you know this is a problem already? Is this a conversation you are having in establishing these programs, or are we too early in this process to know?

I know you are still actively working on a strategic plan. Is it your anticipation that you will need these "carry over" funds outside of the normal budgetary process? I am curious about where that is as agencies are already starting to formulate their budgets going into the next legislative session. I am curious where that information is coming from.

Mr. Mitchell:

I want to be clear up front that we have had a GME grant program in the State for many years, so SB 350 did not necessarily create anything new other than the Advisory Council, and if it had not passed, OSIT would have continued to award funds. The funding was separate from what was appropriated; it was in the Governor's budget, so even in the absence of SB 350, it was always our plan to continue the GME program and move things forward. There are a couple of tweaks, namely having this Council, but other than that, we are still moving forward.

When it comes to this issue of not being able to balance forward across biennia, this has been something that we have been dealing with since the beginning of the program and our first awards in 2016. It is not a theoretical thing. It is something we have always dealt with, and in conversations with your Fiscal Staff, it was their belief that all funds that were left over from the end of a biennium—so to be perfectly clear, there is authority to balance forward unspent funds from FY one to FY two, but not to balance funds left over in FY two into the next biennium to continue to be able to use those with the same program. In conversations with your staff, they told us that was their view, and we have we have complied with that.

Mr. Robbins:

I have been looking at the budget bill that appropriated money for this program, Senate Bill 511. Section 2 of that bill appropriates money to OSIT, and Section 40 of that bill says that of the money appropriated, $8.53 million will be appropriated to support grants to establish new GME programs and is available for FY 2023–2024 as well as FY 2024–2025, both fiscal years, but then that money would revert at the end of the biennium. This is the language of the bill so people can look it up and see what you are talking about.

Chair Doñate:

I am going to ask a separate question since I have you, and it is not a curveball. I want to continue talking about health care access, but I remembered that you are also facilitating broadband access Statewide. I am going to ask you a question not related to SB 350 because I have you here. I will reserve most of my comments until the end of the question.

In terms of broadband access, I know when we talk about expanding access to health care through telemedicine, a lot of that in rural areas is vitally important because some facilities might not have the capacity, and the numbers might not make sense to open a full facility in some parts of the State because of the magnitude of how big we are. Broadband can help us achieve a lot of the goals we have for access to care. What are some of the initiatives we can do to support you in terms of broadband access? Have there been any discussions of what we can do to empower physicians or medical professionals to ensure they have the capacity to do telemedicine in parts of rural Nevada?

Mr. Mitchell:

That is not a curveball at all; it is a fastball right down the middle. When it comes to broadband, there are so many different applications that can benefit society generally, and access to health care is certainly at the top of the list. As a first step anywhere in the State, whether it is rural Nevada or even here in Las Vegas where folks have medical needs, but they do not have reliable transportation to get to a doctor's office. It is important that we figure out how telehealth and telemedicine can play a role in increasing access to care.

I think as a first step, we need to make sure that people have access to broadband in their homes, which means having an affordable connection, a reliable Internet-connected device, and the digital literacy or skills needed to feel comfortable using that device.

As I have traveled throughout the State, particularly in rural areas, a lot of folks say they are simply not comfortable conducting medical visits via telehealth or virtually, so there is some amount of education and instruction that we will need to do as a State to make folks feel more comfortable with that, particularly in areas where they do not have ready access to health care.

On the other side of the equation, the medical professionals and the health care community will need to figure out a lot of different things related to telehealth parity. I know there are folks in the room who are a lot more knowledgeable about things like reimbursement rates for telehealth visits or making sure that doctors are properly trained in how to conduct health care visits or having the right equipment, both at the rural health care sites and that can link back to a specialist in a place like Renown Regional Medical Center or UMC, so there are several different pieces there.

I know there are a lot of folks who are trying to solve for things on the health care practitioner side to set ourselves up well, and I see OSIT's role in that as giving people the infrastructure in their houses or health clinics in rural locations so they can connect, and then helping folks feel more comfortable or digitally literate so they are more willing to participate in telehealth.

Chair Doñate:

I appreciate those comments and sentiments because I think you are right. We can do more to help empower individuals, especially those who live in the rural areas, to make sure they have access to care. I mentioned earlier that broadband is the connectivity that can help us reach those communities. There was a telehealth bill last session related to parity and continuing the extensions we had during COVID-19. I know there is obviously room to grow and make sure that we are reaching our milestones so every home in Nevada is equipped and connected to the Internet should they need it.

To close this conversation regarding SB 350 and GME education, I wanted to bring this request for presentation because I think that in general what we have seen with GME—and we have our deans ready to present right after this—is that it is complex and not an easy issue to solve by throwing dollars at it. I think the dollars can get us one step closer, but we are fighting against a system that has predated a lot of the infrastructure that we have in this State itself. A lot of it is predetermined federally, so I think it is important for the public to understand there are things that are out of our control. Of course, we need to make sure that we do our own investments, and make sure we are following and setting up an infrastructure of our own. That is why I pulled this presentation together.

From my personal perspective, when it comes to GME education, there are several issues that come into play. Oftentimes, I think there is a rhetoric that residents are treated as free labor, and after speaking with some of the residents and students I know, that certainly is not the case. Many of us would love a system where the residents can stay in this State once they complete their program. If I remember correctly, about 39 percent of students who complete their residency program end up staying in this State. Obviously, a large portion of them are leaving after residency completion, so I think that is why we have conversations about child care, education, and housing reimbursements; it is not just one piece of the puzzle.

Part of my goal—and I would hope that through this presentation the Committee Members have some level of understanding of where we need to go—is that we need a strategic plan. It is not enough to say we are going to open this grant program and facilitate applications for GME, and then see how those programs are coming to fruition. We need a strategic plan to say, "These are the initiatives where we are following; the most in gaps of care and this is how we are going to accomplish it within the next five to ten years," so by the time we get to 2030, we already know what residencies that we need to invest in.

Ultimately, if you ask a health care provider, if I work in primary care, I am going to tell you the most important one is the residency program in primary care. If you work for a cancer research center, the most important programs for them are cancer research fellowships. All this needs to come together, and I think over time, what I have understood from this presentation is that you do not have adequate support systems you need.

Perhaps we need to focus and revamp the Office's mission, and look at creating either a bureau or some type of administrative level position that has the support staff you need, not just the Director that you were allocated. We need an actual strategy of health care workforce, and how the students that are going through the K-12 system and learning about STEM can become health care practitioners. That is what I think is missing in our State infrastructure. I would hope that when we discuss GME, which will go all throughout today, when we talk about access to care, I would hope that is something we can accomplish in 2025.

I know the Governor has mentioned that this is his priority and part of his strategic plan, and you alluded to that in the beginning. I think it is up to all of us to ensure that we are delivering on that, so there is room to grow. I know you have things you must follow up on with us, but know that we can be partners and help ensure the programs and the money, that were allocated, are coming to fruition to expand access to care.

Mr. Mitchell:

Consider my Office a partner with you as well in ensuring that we have the physician workforce we need in the State.

Chair Doñate:

We will now close this agenda item.

AGENDA ITEM VI—PRESENTATION ON GENERAL POLICY TRENDS RELATING TO CHILD CARE AND HOUSING, AND AN OVERVIEW OF POLICIES TO ADDRESS HEALTH CARE WORKFORCE AND PHYSICIAN LICENSURE

[This agenda item was taken out of order.]

Chair Doñate:

For background, typically because of the nature of how we do presentations, I wanted the NCSL to come because they have a lot of resources for legislators to understand what is happening nationwide. Through this process, we can ask them what the current policy trends are, and then take that into consideration as we move into the latter half of the day.

Kelsie George, Policy Specialist, NCSL:

My portfolio includes health workforce topics as well as EMS, and I am joined by my colleague Kelly Hughes, Associate Director of Health Care. I was invited today to share state legislative trends that NCSL has identified in health and human services (Agenda Item VI).

I want to start with a reminder that, as legislators and legislative staff present today, you are members of NCSL. We exist to serve your legislative needs, including legislative tracking in a variety of databases, numerous policy publications available publicly on our website, policy research to answer any of your questions, and presentations like the one I am providing now. While NCSL is a partisan organization and our leadership alternates between Republican and Democrat every year, NCSL staff like Kelly and I are nonpartisan, and we do not advocate for or against any state policies.

I want to start with a quick road map of what I will cover today. We will start with HHS policy trends; I will dive into health workforce trends; and then we will focus even deeper on physician licensure strategies we are seeing across states. I will close with a couple of additional resources, and I am happy to take any questions afterwards. I want to note that for the sake of time, I will have to breeze through many of these topics, but I am always happy to provide more detailed information after today's meeting. The resources highlighted in teal boxes on each slide are also a great place to start for more information.

I want to begin with HHS trends. Our NCSL staff have identified many of the trends that I will share today from our legislative databases and questions we received from NCSL members like yourselves, and I anticipate many of these will be familiar to all of you. The word "cloud" on this slide summarizes questions that NCSL staff answered from legislators and legislative staff between 2020 and 2023. Given that time frame, it is no surprise that you see COVID-19 was a big priority among states, but I want to touch on a few other notable areas you will see pictured here as well.

Medicaid accounts for anywhere between 13 and 41 percent of state budgets including federal funds, so it is a significant priority for states. Our Executive Committee, which is made up of legislators and staff, identified behavioral health as a top issue for states in 2024, and given the severity of U.S. maternal mortality rates, many states are also prioritizing maternal health this year.

Last but certainly not least, health workforce remains a top priority across many states amid shortages, high turnover rates, and bottlenecks in the educational training and licensure processes. More on this in a moment. For more on these topics, you can read our *Forecast Special Report*.

Let us turn to the human services side. Child care remains a priority for states. Legislators are considering how to incentivize employer-supported childcare through tax credits and deductions, cost-sharing programs, and grants, and many are also trying to expand eligibility for child care subsidies and improve compensation and public benefits for child care providers.

States are also addressing housing through legislation. This includes strategies like regulating investor purchases of residential properties, taxing or registering short-term rental properties, expanding eviction protections for tenants—especially older adults—and incentivizing housing production and creating homeownership opportunities. The NCSL staff also track legislation at the intersection of housing and health outcomes, and we continue to

see states pursue strategies to support behavioral health and assist older adults in aging in place. You can read more in our *Forecast Special Report*.

With this overview as our foundation, I want to take a deeper look at health workforce trends. We heard a lot of information on the challenges both in Nevada and across the country in the last two presentations, I do not want to spend a lot of time here, but two of the main health workforce challenges we hear regardless of the profession or occupation, are shortages—meaning not enough workers—and turnover of workers leaving the profession.

Many workforce shortages are exacerbated by recruitment and retention challenges. These may be financial, educational, or workplace challenges. One profession I want to focus on is behavioral health. The map shows provider-to-population ratios for behavioral health specialists. Darker colors indicate more providers per 100,000 residents and lighter colors indicate fewer providers and likely shortages. Nevada is in a pale yellow color and many Nevada counties have zero behavioral health specialists based on this tracker from George Washington University.

Another challenge we are seeing involves turnover rates. Retention, or ensuring that existing workers stay and grow in their professions, is critical to addressing workforce shortages. The graph on the left shows estimated turnover rates. All settings across long-term care, ambulatory care, hospitals, and others experienced increased turnover rates from the pre-pandemic period of 2019 to post-pandemic in 2020. One profession I want to highlight here is long-term care, and while other settings have returned to their pre-pandemic rates, turnover continues to increase in this area. We maintain resources on these health workforce topics and more, which can be found through the link on the slide.

With that bleak landscape out of the way, let us turn to something a bit more hopeful. What are states doing to address these challenges? When we talk about health workforce, I like to start with a simple question: what data, research, and expertise can we use to understand the health workforce? We see states moving beyond counting the number of licensed professionals to understanding who is providing what services to whom and where.

Several examples are highlighted on this slide. States like Colorado and Florida are gathering data in long-term care; Georgia and Illinois have established data collection for behavioral health professions; and Indiana and Utah established systems across all health professions to collect information during the licensure process.

Nevada has many similar systems in place, including the State's Health Workforce Research Center and the Home Care Workforce Employment Standards Board. Data collection and analysis, as I am sure all of you are very aware, are critical to the policy making process and may provide a baseline to compare policy interventions against.

I want to first look at recruitment. The largest trend we see here among states is creating career pathways, which create a pipeline of qualified individuals who are ready to fill in-demand health care jobs. For example, Colorado established a pathway program in 2015 and established new pathways that specifically focused on behavioral health between 2019 and 2020.

As I mentioned, Indiana required health workers to report certain data during their licensure renewal process beginning in 2018, and their largest community college, Ivy Tech Community College, established a certified nursing assistant bridge program for direct care workers based on the information gathered. Nebraska established a program to incentivize

local high school graduates to pursue health care careers in rural areas within the State. Nevada has several pipeline programs across the State as well, and you can read more about career pathways at the K–12, community college, and postsecondary level in the report linked on this slide.

To address turnover, many states are turning to financial incentives, which may include things like loan forgiveness and repayment programs or tax credits and deductions. Many of these programs were originally established to address physician shortages, and today these are being expanded to address other health care workers—like behavioral health professionals or direct care workers. Most of these programs have a practice requirement, so to be eligible, health workers must commit to practice within the State for a certain number of years, and the dollar amounts and requirements for each incentive vary greatly.

Finally, I want to share a couple of emerging topics that NCSL is closely tracking within health workforce. The first is EMS, which has historically sat between transportation, public safety, and health care; we have seen an increase in EMS legislation across all these areas. National Conference of State Legislators maintains an EMS legislation database, which is linked on this slide, and the most common themes from enacted legislation include declaring EMS as an essential service that governments must provide; allowing reimbursement for community paramedicine or care that is provided by EMS clinicians within the community; adjusting licensure age requirements to allow high school students to complete training and certification as EMTs; and creating financial incentives like retirement or health benefits, tax incentives, and loan repayment or forgiveness. I know we are discussing this topic later today that Nevada shares many EMS challenges we are seeing across the country.

Another emerging topic I want to touch on is artificial intelligence (AI). This is a growing topic and several states have proposed legislation specific to AI's use in health care. I want to note this is a very new area, so we are not seeing many enacted bills, but we are keeping a close eye on legislative actions. More than 115 bills have been proposed on AI topics generally so far this year, and in 2023, we saw at least 11 states consider legislation on the use of AI in health care settings.

Some common themes in proposed legislation relating to health include monitoring or preventing discrimination in the use of AI, setting provider monitoring and review requirements, and ensuring transparency for patients when AI is being used. Artificial Intelligence has the potential to alleviate some workforce challenges like burnout. The average nurse spends about a quarter of their time on administrative activities, and this is one area where AI may build capacity. Research suggests that more than a third of administrative tasks could be automated by AI to decrease human error.

Finally, I want to look at state actions on physician licensure. The American Association of Medical Colleges has predicted significant physician shortages within the next decade, and Nevada continues to see low physician-to-population ratios in primary care and general surgeons as well as specialties in pediatrics and psychiatry.

Some common challenges we have identified within physician licensure, at NCSL, include processing times and portability. I will begin first with processing times. The American Medical Association suggests that physicians allow at least two months between applying for and receiving official licensure in most states. However, wait times make may take as long as six to nine months in some states.

I want to note that state-specific data on turnaround times is often not publicly available or may not be tracked due to limited staff capacity. I understand the Board of Medical Examiners will share Nevada-specific data later today. The table on the right is the closest I could come to finding an example of nationwide data and this comes from the Inter-State Medical Licensure Compact of which Nevada is participating member. The data on this table notes that even as applications increased from 2018 to 2020, the number of days from application to licensure was issued or maintained.

Across states, some commonly cited challenges for licensing processing times include paper-based applications, increased licensure applications due to the COVID-19 pandemic, background check and fingerprinting delays, and staff capacity. I will share examples of how states have addressed these challenges.

Several states have recently moved from paper to online applications, including Nevada several years ago, and California, for example, identified its paper-based procedures as a barrier. They expedited the online application development process during the pandemic as they saw increased applicant volume. California piloted their direct online certification submission system with several medical schools, which removed physical barriers to licensure like getting access to notaries, school seals, and other things. They also established an online verification system for continuing education, which expedited licensure renewal processes.

Wisconsin identified that many of the delays they were experiencing were due to missing paperwork throughout the process. They developed an online platform that allowed applicants and employers to monitor the progress of their applications throughout the process. After implementing this, turnaround for applications decreased from 90 to 30 days, and discussions are still ongoing within the State about how to address remaining backlogs. The Governor has proposed the Agency keep revenue from licensing fees to hire additional staffing to create more capacity, and the Legislature is currently undergoing an audit of the Agency.

Requirements for state and federal background checks vary. While background checks can serve an important role in ensuring patient safety and quality of care, they may also create barriers to licensure. Background checks are required in most states and territories for medical professionals as shown on the map, but a handful of states do not require background checks, while at least three do not require fingerprinting or federal background checks.

Nebraska is an interesting example I want to note here: recent legislation required the State to submit fingerprints to the Federal Bureau of Investigation for medical licenses, causing delays in at least 100 applications from being approved in certain professions. To address this, the Governor signed a temporary executive order that allowed State Patrol to conduct federal background checks instead, and this cleared that initial backlog. The Legislature enacted a bill in 2023 that allowed State Patrol to process these background checks permanently.

Beyond processing times, portability is also an important consideration for states. This refers to the ability of health workers to practice across state lines. Policy strategies under portability may include temporary or emergency licenses, which we mostly saw during the pandemic; reciprocity or endorsement, which we mostly see through interstate licensure compacts; and the state's ability to waive certain requirements for licensure.

At NCSL, we maintain a database of recent occupational licensure legislation, which is linked here. We saw many states implement temporary or emergency licenses, like Alabama and Maryland, during the public health emergency, and these were often done through temporary rules or executive orders. Since the majority of these have expired, I am not going to spend a lot of time unpacking them here.

Next, I will move to reciprocity, and as I mentioned, the most common action we see from states is joining interstate licensure compacts. The Interstate Medical Licensure Compact (IMLC) facilitates interstate practice for physicians. Nevada is a member, and you will see several other health-related compacts on this slide as well.

It is important to note here that each compact has different requirements, governance structures, and restrictions. The Council for State Governments maintains a National Center for Interstate Compacts, which is a great source of information, and a summary of NCSL's recent session at one of our meetings on interstate compacts is linked here. States may also establish reciprocity agreements with neighboring or similar states. One recent example I want to highlight here is the Department of Motor Vehicles (DMV) reciprocity pathway for physicians that allows them to practice across Washington, D.C., Maryland, and Virginia.

Telehealth emerged earlier in our conversations, and I want to note that while Nevada and many other states require full licensure within the state to provide services via telehealth, some states have created limited licenses to create an expedited process and increase access to care provided virtually. One example is Idaho, which does not require a license for virtual care when a physician meets certain requirements, including consulting with an Idaho licensed provider. Another example is Arizona, which does not require a license for telehealth services if the physician registers with the State annually and meets other requirements.

Lastly, states have the option to waive certain requirements for licensure, and during the COVID-19 pandemic, we saw this for a variety of health care workers. Post-pandemic, however, we mainly see this relating to international medical graduates. Most states have unique requirements for international medical graduates including Educational Commission for Foreign Medical Graduates (ECFMG) certification, residency requirements, and language competencies.

Policies for international medical graduates often emerge at the federal level, unsurprisingly, but states have several policy levers here too. Some states, like Colorado and Minnesota, have established support programs to help international medical graduates address barriers and complete licensure requirements. Other states like Idaho and Tennessee established temporary restriction or licensure for international medical graduates who meet certain requirements.

We have talked a lot about GME so far today, and another bottleneck in physician licensure for both international and domestic applicants is GME. Historically, GME has been funded through Medicare, but states also have leverage here through Medicaid and state appropriations. Florida and New Mexico have leveraged GME funding through Medicaid to expand residencies for specialties and non-traditional residency sites like federally qualified health centers. New Mexico's approach has been informed by their GME expansion five-year strategic plan, which was developed by the Human Services Department in 2019.

On these Medicaid examples, I also want to note that states may leverage a variety of authorities under Medicaid for GME funding, and this may include hospital base rates or supplemental payments to teaching entities. We heard more information on Nevada's GME

grant program from OSIT a moment ago, but I also want to highlight that Iowa has appropriated State funding to start new programs, a cost that typically is not covered under Medicare reimbursement for GME.

Of note to our conversations today, many states have also created coordinated statewide GME initiatives. This includes Oregon, which has a residency collaborative alliance for family medicine; and Colorado, which maintains a family medicine residencies network. These exist to provide ongoing technical assistance to program directors and new programs within the state.

Many NCSL resources are linked here and throughout my presentation for future reference, and my contact information is also available on this slide. Please reach out if any questions emerge after today's meeting. With that, I am happy to answer any questions.

Assemblywoman Brown-May:

I appreciate NCSL, and the nonpartisan information you provide. It is always great. With Medicaid funding, you said Florida appropriated $97.3 million. We know what Nevada is doing. I am curious to know: are there additional federal match dollars available that we have not considered to date that could help us fund GME or other positions that we are not tapping into?

Ms. George:

Medicaid at rural emergency hospitals, which is a new facility designation, is one new example that has come up within the last year or so, but I am happy to follow up and send more information.

Chair Doñate:

Are there any other questions? I do not see any. I know we are all digesting the information. We asked about GME funding, the licensure portability measures, and you talked about Arizona and Idaho. When we had NCSL present during the last interim, we talked about telehealth parity and some of the initiatives and trends that certain states are doing. Can you discuss those initiatives more? Are we seeing more recently that we are more flexible to help ensure access to care? Can you discuss these two initiatives more concretely?

Ms. George:

During the pandemic, we saw nearly every state and territory alter their telehealth regulations in some way, either through executive orders or legislation, and we continue to see states make some of those changes permanent or adjust back to pre-pandemic rates. So far this session, we have seen at least 1,000 bills introduced on telehealth alone, and some of the biggest trends are cross-state licensing like licensure compacts that I mentioned and allowing online prescribing and patient-provider relationship establishment requirements. We also see a lot of activity with telehealth on reimbursement policies, expanding access to broadband like the conversation we had this morning, and pilot programs and regulatory and licensing issues like the examples I gave from Idaho and Arizona of either temporary licenses or waiving certain licensure requirements for physicians licensed in other states to provide telehealth to patients who may be located within the state.

Chair Doñate:

Are there any more questions before we close out this agenda item? We greatly appreciate the resources you have provided. I know there are a lot of different policy initiatives, and we are excited to start talking about them later in today's final agenda item. We will now close this agenda item.

AGENDA ITEM VII—PRESENTATION ON THE IMPACTS OF HEALTH CARE CONSOLIDATION

[This agenda item was taken out of order.]

Jesus Vidueira, President, Culinary Health Fund:

The Culinary Health Fund is a nonprofit labor management trust fund providing care for 130,000 lives in Las Vegas. As a payer, we pay approximately $600 million per year in benefits. We are also part of the Health Services Coalition, a 25-member coalition negotiating hospital contracts, and we represent over 250,000 lives in the Las Vegas region (Agenda Item VII A).

Part of our vision is to provide quality health care and build out medical centers. We currently have two: our first on Nellis Air Force Base, opened back in 2017, and our second opened in May 2023. Our hope is to have four of these medical centers up and running by 2026.

We try to provide as many services as we can to our members and their dependents. It is a way to manage our quality and cost of benefits in our centers. We provide primary care, pediatric care, dental care, eye care, and mental health counseling. We have pharmacies that are free from any co-payment, physical therapy and acupuncture, laboratory, and wellness classes; all of this is provided with zero or very little copayment.

Nevada has made important transparency steps to begin to address health care consolidation, but more must be done. In 2021, Senators Lange and Doñate sponsored Senate Bill 329 to address the anti-competitive contracting practices, which also required hospitals and physician groups notify DHHS within 60 days of a merger or acquisition. The State is also responsible for documenting these transactions and reporting them. In that same session, the Legislature also passed AB 278 sponsored by Assemblywoman Duran requiring physicians to list their employer on initial licensing and renewals.

Compliance to us is not yet clear. The research literature shows that nationally, private equity acquisitions in health care are accelerating and are associated with higher costs, workforce cuts, and mixed to harmful impacts on quality. A study published last week in the journal *Health Affairs* found that private equity acquisitions and physician practices grew sevenfold from 2012 to 2021. The same study showed that private equity share of physician practices in ten specialties was 10 to 30 percent of the Reno and Las Vegas Metro areas in 2021.

Private equity clearly has a significant piece of the State's health care market, and we expect it to continue to grow, but there is not a good understanding of its footprint or impact on the community. As participants in the health care market purchasing services for our participants, we have seen major consolidation in the ownership of physician practices, the expansion of freestanding Emergency Departments (EDs), and hospitals hiring doctors. This has led to reduced competition; canceled contracts; higher price demands or costs;

delayed care; and physicians locked into non-compete agreements, forcing them to leave the community if they want to work independently or in another practice.

This slide has a lot and is not a complete list of private equity movement in Nevada, but it does highlight some of the areas. As you can see, private equity is involved in air and ground ambulance, ambulatory surgery centers; hospitals; long-term acute care; behavioral health physician groups—including anesthesia, dermatology, radiology—physician staffing companies; and urgent cares.

Personally, I can share with all of you an experience that happened recently with private equity interference. We had a capitated contract with a local radiology provider, probably the largest in the city. They got acquired by Radiology Partners, which is a private equity group, and immediately things changed for us. Part of the capitated agreement involved access to care, but also quality metrics that needed to be reported out.

Quickly thereafter, we realized they were not meeting quality, and we could not get access for our members. It seemed that every time a member called for an appointment, they were treated as third class citizens, and that was not the case before. We continued to report it out to Desert Radiology, and we found that they did not want to meet any quality metrics, and they wanted a fee-for-service deal.

We terminated our capitated deal and removed services from our health centers because they were the provider. We ended up paying 115 percent of Medicare allowable only to come back to renegotiations a few months later. They wanted 225 percent Medicare allowable with 5 percent increases in years two and three. They insisted on a three-year contract. Obviously, we did not go for that deal. We opened our network and provided access to our members, because it was becoming a continuity of care issue and in reality our patients were getting upset.

Clearly private equity has a hold in Nevada. Another study in 2019, proved that 40 to 50 percent of services in anesthesia and emergency medicine are private equity-owned or owned by publicly traded companies. Because of the negative impact private equity has had on driving up health care costs, cutting workforces, and harming quality; regulators and policymakers are acting at the federal and state levels.

The Federal Trade Commission (FTC) filed a lawsuit last September against USAP claiming the company had a scheme to roll up anesthesia practices in Texas to reduce competition and drive up prices and their profits. Last week, the FTC, the U.S. Department of Justice, and U.S. DHHS announced a federal probe into private equity impact on health care patients and affordability. Last December, U.S. Senators Chuck Grassley (R-Iowa) and Sheldon Whitehouse (D-Rhode Island) announced a bipartisan investigation into private equity impact on hospitals.

Regarding state regulators, in February, the Colorado Attorney General (AG) resolved an investigation into USAP's anticompetitive business practice. They did not admit any wrongdoing, but will end contracts with five hospitals and completely end their non-compete agreement within the next 18 months.

Mason Van Houweling, CEO, UMC:

I represent UMC, the State's largest public and academic teaching hospital in the State of Nevada. Across the nation and in Nevada, we continue to see the negative impact of private equity firms in our health care system. At UMC, we have experienced these challenges

firsthand, with key long-term partners being acquired by private equity firms and subsequently demanding new contracts, exorbitant fees, and reduced services. Unfortunately, our experience has been that when private equity wins, Nevada patients lose.

Nevada is not immune to this crisis, and the trend is alarming. I can give you lots of examples, and my friend Jesus has mentioned USAP and Radiology Partners, but I want to talk to you about radiology. There are a lot of examples currently happening, but also more that will be happening in the future.

As mentioned, our longstanding, most trusted local radiology partner was acquired by Radiology Partners, a national company backed by private equity and venture capital firms. In 2023, UMC received notice from Desert Radiology that the company planned to terminate its agreement with our health care system. This is how UMC's 58-year partnership with Desert Radiology came to a sudden and unfortunate end. Apparently, serving the community's most critically ill and injured patients is not profitable enough by the firm's backing companies like Desert Radiology. In fact, I was looked in the eyes by this company and told our 10 percent margins are not enough—we had to be at 20 percent.

Nevada's prohibition on the corporate practice of medicine is at the heart of today's conversation and concern over private equity along with the need to address non-compete and restricted covenant clauses. State restrictions throughout our country on the corporate practice of medicine are meant to protect patient and physician relationships, so decisions are made in the best interests of patients—not solely on corporate margins.

At it is core, this is what AB 11 (2023) was all about, and you all did great work on that. Ultimately, it was vetoed by our Governor, but two years later, the market is starting to feel the effects of what medicine run by faceless corporations can mean to patients as well as health care providers looking to deliver that access to patient care; as Chair Doñate mentioned at the opening of this Committee on looking at access to care. Parties can disagree on when and where corporate practice of medicine restrictions should apply, and those same parties can work towards determining what exceptions to Nevada corporate practice of medicine should exist. However, all parties in this industry should be worried about how health care will be run by private equity. It will further diminish access to care in our State.

As many of you know, my advocacy on this matter has not been fully supported by some of my own colleagues, but I ask, where will patients go in the future? Since we are in spring training in baseball, I will use a bit of a baseball analogy: the Culinary Health Fund and organizations like UMC are first in the batter's box, but as the season progresses, hospitals, insurance companies, Medicaid Accountable Care Organizations, and physician offices throughout our State will soon be impacted, squeezed, and held hostage.

As we look back, we may see a missed opportunity to lead and strengthen the protection of our patients' affordability and quality. As private equity firms continue their endless pursuit of profits at the expense of our patients, at UMC and the team back at 1800 West Charleston, we fully remain committed to building a healthy future for our community and our industry by expanding access to life-changing care for Nevadans.

Chair Doñate:

I believe there is another presentation from Families USA before we go to questions.

Jen Taylor, Senior Director of Government Relations, Families USA:

In case you are not familiar with our organization, Families USA has been a leading national nonpartisan voice for health care consumers where we work to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all. Key to that work is addressing our nation's health care affordability and quality crisis, which is fueled by our health care system's lack of transparency and healthy competition. That is what we are going to focus on here today (Agenda Item VII B).

My colleagues are going to talk you through most of the details, and you already had a good up-close look at the challenges in Nevada, but before I hand things over to them, I wanted to paint a picture of what we are dealing with in terms of our health care cost and quality crisis.

The cost of American health care is a profound economic problem and an urgent public health issue. Almost half of all Americans have reported having to forego medical care due to cost. Almost a third have indicated that the high cost of medical care is interfering with their ability to secure basic needs like food and housing. Over 40 percent of American adults—100 million people—face medical debt, and high and rising health care costs are a critical problem for national and state governments. I think you know this all too well: it affects the economic vitality of middle class and working families; crippling the ability of workers to earn a living wage.

National health expenditures, which include both public and private spending on health care, have grown from $27 billion in 1960 to nearly $4.5 trillion in 2022. Relative to the size of the economy, that means our health expenditures grew from 5 percent of Gross Domestic Product (GDP) in 1960 to 17 percent in 2022, and it is projected to get much worse, growing to a total of $7.2 trillion or 20 percent of GDP by 2031. That means one-fifth of our economy will be spent on health care.

This far outpaces what similarly situated countries are spending on health care. On a per capita basis, the United States spent just over $12,500 in 2022, which is $4,000 more per person than any other high-income nation and the largest proportion of this spending is on hospital care, which accounts for one-third of health spending at a whopping $1.4 trillion a year. Since 2015, hospital prices have increased by as much as 31 percent, growing four times faster than workers' paychecks, and high hospital prices result in about $240 billion in waste every year.

As the largest category of spending, that means hospital prices are the biggest driver of increasing costs impacting people in a variety of direct and indirect ways; they are built into premiums, resulting in lost wages. We are seeing high, rising, and variable prices across a wide range of health care goods and services, including prescription drugs and diagnostic tools. These prices are also irrational, with no relationship to quality of care.

Some of the statistics here paint a bit of this picture: the average pricing of magnetic resonance imaging in the United States just under $1,500, which is three times higher than Switzerland and seven times higher than Australia. That price can vary widely within a single hospital system, and we are seeing privately-insured consumers and employers paying an average of 2.5 times what Medicare would pay for the same inpatient and outpatient services.

We know Medicare is not always the "be all end all" source of what is rational or fair for payment, but it is the best proxy we have given their ability to negotiate for pricing and set reasonable prices, so it is a great proxy to show us that people with private insurance are suffering because of these variable prices.

For all that spending, the quality is not better—not in more volume of care, and certainly not better quality of care. We are seeing things like 72,000 hospital-acquired infections and high rates of preventable deaths. Despite spending two or three times more on health care than in other countries, the United States has some of the worst health outcomes, including the lowest life expectancy and highest infant mortality rates. This all goes back to the product of broken financial incentives within a system that rewards building local monopolies and incentivizing price gauging instead of rewarding success and promoting the health and well-being of the community.

I want to emphasize that when we talk about poor health outcomes, these are not shared proportionately across populations. In fact, poor health outcomes are even worse for people of color, who experience higher rates of illness and death across a range of health conditions compared with their white counterparts. That means they are taking the brunt of exorbitant and unjustifiable prices, largely due to these trends in consolidation that have eliminated competition and allowed monopolistic pricing to flourish. I am going to hand it over to my colleague Jane, who will talk us through what we see nationally in consolidation, and then we will jump into a state picture.

Jane Sheehan, Deputy Senior Director of Government Relations, Families USA:

As Jen illustrated, our health system is in crisis, and consolidation is playing a dominant role in getting us to where we are. We are talking about consolidation in the health care space. We see it in many ways, and this is probably a simplistic view, but I will talk through it to make sure we are all on the same page.

First, we have horizontal integration, which involves the acquisition of another company in the same business line. We often see this with large hospital systems coming in and buying up smaller hospitals and with insurers merging. We even see this on a smaller scale with independent physician practices merging, and it is also happening in the pharmaceutical space.

Then we have vertical integration, which is when a company is taking control of another entity in a different sector. In health care, that often looks like a large health care system or hospital buying up smaller physician offices, and sometimes it involves providers and insurers merging within a market. We also see this with mergers between pharmacy benefit managers and insurers. Drug manufacturers, wholesale distributors, and retail pharmacy outlets also get in the game, too; think CVS buying up Aetna or Amazon buying pharmaceutical startups. We see it in many ways, but this is a good overview of what we are talking about here.

In terms of trends, consolidation is on the rise, it has broadly taken place without meaningful regulatory oversight or interventions, and it is becoming more acute. You can see statistics here, and I will not read through all of them, but we can show there are few truly competitive health markets left in our country.

Hospital mergers are happening more frequently both within and across health care markets, and in both cases, this is leading to higher prices. According to the American Hospital Association, between 1998 and 2017, there were about 1,500 mergers, and

40 percent of those happened between 2010 and 2015; that illustrates it is on the rise and becoming a lot more common.

When it comes to insurers, the insurance market is not as highly concentrated as providers, but there is still a lot of evidence of markets with little competition between insurers. When we talk about the four biggest insurance companies, they control over 80 percent of the market nationwide.

With vertical integration, we see a huge increase in the number of hospital-acquired physician practices. Between 2012 and 2018, this number has doubled, and today over half of physicians are now employed in hospital-owned practices. When we think about physicians now being more frequently employed by hospital-owned practices, that trend was accelerated by COVID-19, which obviously exacerbated a lot of the financial vulnerabilities of smaller and independent practices. Primary care was hit particularly hard by that, and many primary care physicians now work in hospital settings.

What does this mean for affordability? Nowhere is the negative impact of consolidation more evident than the rising cost of hospital stays and services. This is becoming the negative that consolidation is increasing dramatically. Over the last decade, hospital spending has gone up and up and these costs have increased despite having lower hospital utilization, because prices are going up. Increased consolidation is eliminating competition, allowing medical monopolies and large health care corporations to form.

There are statistics that show what we know can happen when there is a large amount of both horizontal and vertical mergers. Long story short, prices and costs for consumers are going up, and with less competition in markets, these health systems can charge whatever they want and there is a lack of competition and oversight.

Our colleagues, who gave presentations previously, did a great job of illustrating what the role of private equity looks like in the State. I will briefly give a national perspective here. Private equity is becoming a bigger player in all of this, and vertical and horizontal health care consolidation have been occurring for a while now, long before this more recent growth of private equity involvement. As the trend grows, with staffing firms employing anesthesiologists, emergency department physicians, and owning hospitals outright, we are seeing further impacts on consumers and patients. Around 9 percent of non-public hospitals are now owned by private equity, and that is an even larger number when we talk about for-profit hospitals.

Overall, consolidation is playing a harmful role in the health care system, worsening quality, affordability, and access because the business model of private equity is fundamentally at odds with delivering high-quality, patient-centered care. We are looking at a business model that applies a short-term and profit-driven lens, and when applied to health care, the consequences can be dire for patients.

We will now return to the State level. I will turn it over to my colleague Aaron to talk about what these trends look like, and how consumers and patients are being impacted in the State. Then we will talk solutions and wrap up.

Aaron Plotke, Senior Policy Analyst, Families USA:

With that national context in mind, let us take a closer look at affordability and accessibility of health care in Nevada. As you all know, Nevadans continue to struggle with accessing the medical care they need. Over half of all Nevadans report delaying or foregoing the care they need due to the high cost, and the vast majority worry about affording health care in the future.

At the same time, on important measures of health care quality, Nevadans do not receive or have access to the high-quality care and treatments they deserve. For instance, too many folks are not receiving appropriate screenings and tests or treatment for their health conditions such as mental illnesses.

Why is this? Well, what we see driving this health care affordability and access crisis in Nevada and across the country is a fundamental misalignment between the business interests of the health care sector and the health and financial security of Nevadans and people across the country. Specifically, it is high and irrational health care prices.

Chair Doñate:

I am sorry to interject. We already had discussions on Nevada, so I wonder if we can skip a few slides straight to the policy solutions and talk about that. I apologize for going all over the place, but I want to make sure that we are using our time in the best way we can.

Mr. Plotke:

Before jumping in, we want to recognize that you all have taken such important steps in your role as legislators to promote affordable, high-quality health care in the State with the work you have done on improving transparency with your All-Payer Claims Database, strengthening State oversight of health care market transactions, reining in anticompetitive practices, et cetera. We want to recognize the important work you have done in the past.

At the same time, based on what I am sure you all see on the ground and what we see based on the data, there is also more work to be done. To that end, we want to highlight a few key policy opportunities for your consideration. There are a menu of options that you as State legislators can consider, but we want to raise four main areas for you to consider moving forward.

The first is to further improve health care transparency. We urge you to consider codifying the federal hospital price transparency regulations to have even more complete data on health care prices across the State to understand where low- and high-value care is being delivered and hold health care providers accountable.

The second area we would urge you to consider is to regulate high prices at the provider level, banning unfair hospital facility fees that are increasingly being billed to patients, even when they are seeking care in a doctor's office or clinic. This has grown worse as more large hospital systems have been buying up small, local doctor's offices unbeknownst to their patients.

The third policy area is to strengthen competition and prevent further consolidation, and to that end, we are urging you to consider strengthening the authority the State Attorney General (AG) and/or DHHS has in overseeing health care mergers and acquisitions by giving them explicit authority to not only review or be notified of a given health care transaction or

merger, but also to approve or legally challenge that merger. We encourage you to give one or both of those agencies the authority to make conditional approval, for instance, if a health care transaction or merger is being proposed, to make sure that provider is not closing that rural health clinic a year after that merger or acquisition goes through.

The last policy area that we would urge you to consider is building on the important work you have done in putting in place a cost growth benchmark program in 2021, and strengthening the enforcement mechanisms associated with that, so that in addition to using the "name and shame" approach and calling out the drivers of unsustainable spending in the State, you also add authority so the Patient Protection Commission, for example, can put in place a performance improvement plan for those providers or sources of unsustainable spending. In addition, you may also consider the authorization of financial penalties for those providers, insurers, or whoever is driving unsustainable spending to ensure they are complying.

The policies we are recommending you consider today represent common sense, popular reforms that are increasingly being adopted by states across the country, which is all to say that you are in good company here. You have broad adoption of these reforms across the country and, importantly, the support from your residents to build on the important work you have already done and to keep going to ensure that Nevadans have access to the health care they deserve.

Ms. Sheehan:

We wanted to illustrate there is a growing understanding that the status quo is not sustainable. There is momentum on the state level across the country, including in Nevada, but also on the federal level, and we hope to see the federal momentum continue along with robust leadership at the state level. We all know the feds can be slower to act, so when states are out there showing leadership and progress, Congress and the federal administration can be more incentivized and inspired to act.

We want to close with some polling. We drill down on the state statistics showing there is public appetite for action. In what can often feel like a particularly partisan political time, hopefully we have highlighted today along with our partners that these issues are critical to act on, and the fact that this meeting is happening today, and you are dedicating time to these issues shows leadership is critical. We have one last slide highlighting resources, and we are happy to share these links in follow-up. We are happy to take any questions you may have.

Chair Doñate:

Before we move on to questions, I wanted to reiterate why we are having this conversation. In general, we have seen a consolidation in health care over the last few years. As the presentation mentioned, there are examples of both horizontal and vertical integration. There are sectors of health care we can easily identify that the insurance company owns the physician or provider that you go to, and they also control the pharmacy, and all sorts of factors and other companies are involved in the system. I view this as a bipartisan issue because when we have out-of-state entities coming in and ruining the contracts or agreements that we have in our system, which is already fragile, and that can become a national security issue.

To that same point, there is also concern that as companies start integrating with one another—the example in vertical integration, what happens in the instance where

cybersecurity now enters the conversation and a company that is at risk leads to other companies now being at risk. We recently saw a news article on Nevada physicians falling into this, so I think there is at least a discussion of what transparency can look like, and how this impacts the day-to-day patient, because most patients do not recognize that the person they are receiving the bill from is controlled by some other entity.

When that is in the hands of Wall Street, the sole interest is in making a profit, not in terms of what is at stake within our own borders as a State, that itself can become problematic. I want to make sure that we all know what is happening, and why this is relevant now more than ever. It is not just Nevada looking into it; other states are as well, and it is also a federal bipartisan priority to look at the role of private equity. I want to open it up for any questions Committee Members may have.

Senator Nguyen:

I know policy solutions were included as a part of the presentation, and Members at this table here—at least in Las Vegas—have been working hard to begin the process of enacting some of that. Are there states that have a gold standard in this transparency, or have ideal all-payer claims databases that are up and running so they have been able to utilize information collected from these policy recommendations? Would we be on the forefront of that in our State?

Mr. Plotke:

States such as Massachusetts, Oregon, and others have been able to stand up these all-payer claims databases to inform their cost growth target benchmarking work and ability to target where providers are playing a leading role in driving unsustainable spending in their states. Both of those states are in conversations to raise the enforcement mechanisms around those driving unsustainable spending. Of course, there are many others who have stood up all-payer claims databases and are using them as part of oversight of their markets. We are also happy to follow up with more examples, but those are a few.

Senator Nguyen:

Have you found between those two states that they have commonality? I think someone said 80 percent of the health care industry is controlled nationally by four or five different insurance companies, so I imagine there would not be too much of a difference between Massachusetts and Oregon. Is there a difference, or have they been able to look at that information in those two states? Can we already start working on legislation based on some of the data that has come out of these other states, or would we suspect that the information we are going to acquire would be completely unique to Nevada?

Maya Holmes, Health Policy Director, Culinary Health Fund:

I do not think there is a state with a gold standard yet, but many states are doing a lot that we can look at individually as standards and then build upon based on their experiences. Connecticut has done a lot on its scale, as have other states like California and Massachusetts. Oregon and Washington have also done some stuff.

A foundational thing that all the states have realized is that we must have good data, especially on ownership and transactions, if we are going to start addressing this. The public and policymakers cannot study, regulate, or do anything if you do not understand what is happening in the market.

The slide our President showed earlier is a snapshot of what we see either through direct experience in the market or that we have picked up from reports, newspaper articles, and the academic researchers who are studying these ownership transactions; it is difficult to get. States are pressing that their AGs and their HHS departments that we need to have that understanding and then build upon that. It is a critical first step.

Senator Nguyen:

In current statute, does our AG have authority to go after these monopolistic practices? Do they need that authority, or are they choosing not to do it at this point? I do not know if you know that answer.

Ms. Holmes:

I am not an expert on what the AG's rights are. My understanding is that in general, AGs do have the authority to address anticompetitive practices and broken markets because the ideal is that you have competition in a market. I think the AGs in previous sessions have done work to improve their tools. It is critical that we look at what tools the AG has and whether they can be enhanced.

Other states are looking at their tools to ensure the AG can do that, because one of the problems we see with consolidation is the federal threshold for reporting is very high. It is $111 million or something for a transaction to be reportable, but there are a lot of smaller transactions occurring that are not reportable. They are under the radar, but suddenly, you realize this company has 30 or 40 percent of the market because they have rolled up all these smaller practices. That is what they saw in Texas and Colorado.

Mr. Van Houweling:

I served recently on the Patient Protection Commission for four years and now a new Commission is set forth, but that Commission was working on the price transparency and looking at the studies in Massachusetts or Washington. Clearly, those are much more mature programs, but we were doing a lot of the good work utilizing their methodology and trying to figure out the formula to look at our State as a study. I am not sure if that Commission is going to continue that work.

The core of Assembly Bill 11—and again, I compliment both committees' work on that—is looking at these smaller transactions. We have had multiple AGs' opinions on that, and it was something we were trying to clarify. I hate to look backward a couple of years, but we were looking at those in the Patient Protection Commission, which was a very diverse group of payers, patients, pharmaceutical hospitals, and others. Hopefully they will continue that work, and I am sure they would love to get in front of you at some point.

Chair Doñate:

I certainly agree. I know there are a few questions in Northern Nevada, so I will go after this. Oftentimes, from my personal perspective, it is easy to see hospital consolidation because that is usually where the attention focuses, but while we are focusing on that, there are other sectors of health care—ophthalmology, dentistry—that are easily going through consolidation, but we are not paying attention to it.

What people often forget is, under the premise that Nevada is already ill equipped to handle resources—we had a presentation today that we do not have all the residency programs or specialists that we need—if we only have, say, three specialists for allergy care or ear, nose, and throat; a company could very easily come here and control a large portion of the market. There is nothing stopping them.

There are obviously cases where consolidation could make sense, especially if they are in critical areas and are about to go bankrupt, but a transparency effort should also exist so the public can have an understanding of what could potentially happen with their practitioner, especially if it gets a acquired from a private equity company and decides, "You know what, I am not going to accept your insurance anymore," or "We are not going to accept Medicaid patients anymore." That could have a lot of detrimental outcomes in terms of receiving the care you critically need.

Senator Titus:

I have a couple questions for the Culinary Health Fund folks. Can you describe what you folks are? Do Culinary Union members have to be members, or do their fees go into your Culinary Health Fund?

Mr. Vidueira:

All the Culinary Union workers get health insurance through the Culinary Health Fund, so we pay for benefits. We manage our own network, and we are building out our own medical centers as well because there is a lack of practitioners in the area. We partnered with Keck Medicine from the University of Southern California to provide primary care for our members, but they have the option to go to any physician in the network if they want to.

Senator Titus:

You are technically an insurance agent, then.

Mr. Vidueira:

No, we are a Taft Hartley Fund; we are self-insured, and we pay for members' health care benefits.

Senator Titus:

Are they mandated with their fees as union members, or can they shop around for other insurances? What I am getting at is, are you yourself a monopoly?

Mr. Vidueira:

No, we are not. I would not say we are a monopoly at all.

Senator Titus:

Do they have options to go to other insurances? Can they still be a member of the Union and go contract with another insurance company?

Mr. Vidueira:

They can, but it does not cost them anything, let us say, and it is a pretty rich package. It is an open PPO package. They can; there is always the option, but rarely have I seen it happen.

Senator Titus:

Out of curiosity, you are a fund. Do you make a profit, and if so, do you lower the dues of your members? Does it go back to your members?

Mr. Vidueira:

We always look at the benefits and see what we can improve, but we are a nonprofit organization. We are not looking at an Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA) of any sorts. We are reinvesting into the fund and back into their benefits.

Senator Titus:

So they never get reimbursed or lower costs—

Chair Doñate:

Senator Titus, this is not a Culinary Health presentation directed at them. The intent was to talk about consolidation, so I want to make sure that your questions are in line. I will let you continue.

Senator Titus:

I appreciate that because one of the things I saw as a doctor who was in private practice, who could not afford to stay in private practice anymore because of the rules and cost, is that I had to go work for a hospital corporation. Many times, when we change our practice and are not in private practice because we cannot exist any longer in our current structure and regulations, when I hear folks present who are against us consolidating to stay alive, I always wonder what the background is. I needed baseline on, are you indeed calling the kettle black, perhaps? It sounds like you are not, but I would love to see more information about the corporate structure of what you run.

Chair Doñate:

Are there any other questions? Seeing none, we will close this agenda item. I appreciate the conversation, and if we have any further questions, we will take them offline.

AGENDA ITEM VIII—OVERVIEW OF THE MEDICAL LICENSING PROCESS AND PROVISIONAL LICENSURE, POTENTIAL BARRIERS TO LICENSING, AND FUTURE CONSIDERATIONS

[This agenda item was taken out of order.]

Sarah A. Bradley, J.D., MBA, Deputy Executive Director, Nevada State Board of Medical Examiners (NSBME):

I am going to start the presentation and Dr. Spirtos has a couple comments to make when I am done. Also, in Carson City, we have our Chief of Licensing, Kori Linn, here to help with questions if I cannot field them. Mr. Clark, our lobbyist, is also here. (Agenda Item VIII)

The Board issues five license types on a big level; medical doctor is the license that I think gets a lot of attention, but also physician assistants (PAs). Regarding medical doctors, we have an active, unrestricted license. I am not going to go through the whole list, but I want to highlight for you that we have a special purpose license for telemedicine, so anyone with that license agrees that is how they are going to practice medicine in Nevada. Otherwise, they would have an unrestricted. That does not mean doctors with unrestricted licenses cannot do telemedicine, but special purpose is only that kind. We also license physician assistants, practitioners of respiratory care, perfusionists, and our new category is anesthesiologist assistants. I am excited to say that we now have three active anesthesiologist assistants, and we think we will get more this summer as people graduate and hospitals give out offers.

For an overview of the licensure process, the first step where we know the application is there is when an applicant submits their online application form and pays the application fee. I highlighted that because sometimes people will start things in our online portal ahead of time, but until they click submit and pay the fee, we do not know they are there. Sometimes I think people think they have started, and they are still entering information.

Once that is done, the applicant's file is opened, initial reports are run, and the file is given to a license specialist. They are assigned by last name, and it is on our website. They look up their last name and they can find out who they should be speaking to, and that person will work with them throughout the process.

The license specialist then reviews the applicant's file for eligibility. If they are not eligible the way they have initially submitted, the license specialist will communicate with them regarding other licensure options like endorsement or other things that might work better for them than the more traditional route. If an applicant is eligible for licensure via their initial submission, the license specialist opens the applicant's application.

The applicant then receives by email an acknowledgement packet that essentially says, "Thank you for your application. I am your license specialist." It also includes information on fingerprints, which we are now doing electronically, which is a new and exciting thing for us, and we will talk about that more in a minute. The license specialist stays in contact with the applicant to obtain all necessary documents and verifications. As you can imagine, it is important to verify schooling and postgraduate training. Things like that are important.

Once an application is complete, it is submitted for final review, a double check to make sure everything is there. Once that is approved, then the person is told their application has been approved and is asked to log in and pay the registration fee, and once that is paid, the license is issued.

The Interstate Medical Licensure Compact is very important to Nevada. We are getting approximately 50 percent of our new medical doctor licensees through the Compact, so we wanted to talk about that. This is an expedited pathway to licensure for physicians in multiple states, and Nevada was one of the first states to join the Compact. I think we were the ninth state.

Licensure in Nevada takes one to three business days on average through the Compact. Not every person is always eligible to come here; they must have a State of Principal Licensure (SPL) sponsor them—so another state that is a member. The ones that are in navy blue have SPLs and they are full members of the Compact, 32 states right now and growing. Some other states in blue and lavender are in the process of getting going with the Compact to allow more options, and then the gray states are not in the process yet.

The total licenses we issued last year in 2023 were 2,072 and of that, 1,688 were medical doctors unrestricted, and 839 of those were through the Compact. That is a little less than 50 percent. I think it was 49 percent when I did the math. For special event licenses, we had six, and we had five special purpose telemedicine licenses. It is not required; you can do telemedicine as an unrestricted, but special purpose can only do telemedicine. Special event licenses are for special shows and things where there is a demonstration or a limited duration of practice in Nevada.

For PAs, 175 licenses were issued, and 8 of those were simultaneous with the Board of Osteopathic Medicine. The Legislature might remember that back in 2021, we started doing simultaneous licensure with that Board, which reduces the application fee for PAs. For practitioners of respiratory care, we issued 166 licenses, and for perfusionists, we had 24 unrestricted last year and 7 temporary licenses, so they are waiting for their exam and certification. There was one denial last year, and that was a practitioner of respiratory care; not a physician.

The average licensing times in 2023 for medical doctors—including through the Compact, so this is our total average—is 86 days from the date they push the "submit" button and pay their fee to the day the license is issued. Last year, the fastest licensing time was not a Compact person—because as I said, that is 1 to 3 business days, so it can be fast—was 22 days. For PAs, it was 116 days on average; for practitioners of respiratory care, it was 146 days; and for perfusionists, it was 127 days. Last year was a renewal year, so more than 14,000 license renewals were also done by staff, including almost 11,000 renewals for medical doctors. That was all done in less than three months. Sometimes we are busy during that period and working as fast as we can.

We wanted to talk about residents. I know that has been one of the conversations today. With few exceptions, all residents' licenses expire each year on June 30, so this is a yearly thing. Right now, we have 534 practicing in Nevada based on the new licenses we issued last year and the renewals. Nine institutions in Nevada offer approximately 64 accredited programs. We say approximately because sometimes it can vary, and I think you heard about that today: a new program will open or one will close, so things will change. According to the American Association of Medical Colleges, 52.3 percent of medical doctors will stay in Nevada if they complete here, and we thought it was interesting that according to an article by the journal *American Family Physician*, 56 percent of doctors practice within 100 miles of their residency.

So far, in the first two months of 2024, we have 441 new licensees. We have 339 unrestricted medical doctors, 152 through the compact, 1 special event, 1 special purpose, 72 PAs, 20 who are simultaneous with the Board of Osteopathic Medicine, 424 practitioners of respiratory care, 1 temporary perfusionist, and 3 new anesthesiologist assistants. So far this year, there have been no denials.

Here is a snapshot. These numbers change throughout the day, but at the time we compiled this, there were 48 approved applications waiting for registration fees. Maybe by the end of the day, half of those folks have paid, but we grabbed it right then. Five applications were complete waiting for final review and approval, and we have 462 open applications waiting for the applicants to submit their materials.

So far in 2024, our average licensing time has been 49 days including the Compact. The fastest licensing time not through the compact was 15 days, for a PA was 66 days, for a practitioner of respiratory care was 82 days, and for a perfusionist was 29 days. We have been working hard to make changes to make these times faster.

We opened an online application portal on January 1, 2021, and before that, all our applications were processed through paper. We think this is a good thing to be doing electronically, so that has been a change we needed to implement, work on, and refine, but we are excited that we have that. We also have a new Chief of Licensing as of February 2023. She is doing a great job, and it has been helpful to have somebody who is new to the position look at things and ask, "Why are we doing this? What can we do better? How can we do it more quickly and efficiently?" We have been working on that.

Effective February 13, 2024, applicants can submit their fingerprints via live scan, meaning electronically, which is a big change and not one that we were able to implement by ourselves. We had to work with the Department of Public Safety, and again, it is only for people in Nevada. If they are an applicant out of the State, they can come to Nevada and get a live scan, but they are not allowed to do a live scan in another state. That is not our rule, but it is still very exciting that we can do live scans.

In June 2023, we started implementing changes after reviewing our processes and with our new Chief, as well as talking to the Federation of State Medical Boards, an association of all the state boards in the country. We had their staff come out and audit our processes and look at what we are doing and make comments.

All initial correspondence and fingerprint instructions are being sent via email. We used to send those by regular mail. We now accept a notarized copy of an identity document rather than the applicant sending the original, and as you can imagine, there were some delays, but it was an important document for us to track. This way, they are sending us a notarized copy. Only one addendum is requested at the end of the process, after all verifications are received, and that is an additional explanation from the applicant regarding various questions. In the past, they may have done an addendum for each one, but now, we do one at the end of everything.

We use the Federation of State Medical Board's Physician Data Center to do a report for medical doctors and PAs that helps us verify their license information in other states, and we do not need a direct source from the other state boards because the Federation already has that. That is how they have entered it in their system, so it saves us and the applicants a lot of time as well if they are licensed in more than one state. We no longer require direct source verification of clinical rotations for Island or Caribbean schools. These certifications are now going to be verified electronically by the license specialist instead of having the

applicant send those to us. We also no longer require proof of observership or research positions.

Many unnecessary and redundant questions in the application addendum were removed. We removed things we felt were outdated and unnecessary to simplify the process. Applicants only need to provide a summary of their activities for five years preceding the application date or since graduation from medical school or other postsecondary school related to their licensure. If their graduation was less than five years ago, we used to ask for all their activities since graduation, and for some folks, that was a long time. Now we are going back five years for everyone or fewer if they are a newer graduate.

Malpractice documentation must only be provided for cases within the last ten years, so that shortens the information gathering for our applicants. Arrest documents are no longer required of applicants unless they are appearing before the Board in connection with their application, so if they are going to appear at a Board meeting and the questions are related to a criminal history, that is when they must provide those otherwise. Just because they say yes, for example, to having a conviction in college for driving under the influence, we are not requiring documentation for that. Multiple changes have been made to staff processes that allow the license specialist to work more quickly and efficiently.

Regarding staffing changes in the Licensing Division, since January 2023, we have added 3.5 full-time equivalent license specialist positions, and these are folks who deal with our applicants and talk with them all day. Their job is to work with our applicants, so we have more staffing there to work with applicants. Two licensed specialists are dedicated to the Compact applications. Those are a bit more streamlined and simpler, which is why we only have two, but it is still an increase. We have more licensed specialists who work with traditional applications, and additional licensed specialists are trained in the final review and resident licensure processes because as I mentioned, we do that every year, and that is about 500 either issuing or renewing, so that takes time. We have more people who can help with that than we had in the past.

We have regulations and processes that are going to help streamline the application process for all license types. I have given you those numbers; the changes we are making are things about residents. For example, we used to ask about the resident's address going back to graduation from high school and then forward, but now all we need is a permanent mailing address for our applicants for the Board and a public address that will go on our website. We only need two current addresses. We have also reduced staff turnover in the Licensing Division by implementing the staff raises and bonus structure that the Legislature adopted last session, and we were excited to do that to help with retention.

Regarding coming changes to licensing efficiency, this year, we will be getting an updated licensing software. This is not something that we are totally able to control ourselves. We have been told for a while they are going to upgrade us, and right now, our anticipated date is September 2024.

We are excited about these changes because they will update the process for both license specialists and applicants, who will be able to communicate securely with staff through the system; rather than sending emails or calling; they will be able to send a secure direct message as well as upload documents directly into the system.

They will also provide other enhancements to the applicant and licensee portals. While they are applying, they have this portal to get their application together, and then afterward, they can log in, for example, to change their address. Licensees still use this portal later to

provide information to the Board, change their address, and upload continuing medical education (CME) certificates, so that will be more robust with the new upgrade. We are hoping to have that done by Labor Day. That is the target time frame depending on our vendor, but that is what they have told us as of today.

We are adding a new staff member to focus on information technology (IT) improvements because we want to increase that ability, so that person will be full time helping with IT issues and improvements. We are working on application instruction videos on the Board website to aid applicants, so we will have our staff talking about what they need to do—click this button, do this—it will be instructional. We do not have those live yet, but we are working on getting those live.

We also want to work with the Office of the Chief Information Officer to revamp the Board's website. In some ways, the design of the Board website is not totally up to us since we work with the State IT and there are certain templates available, but we want to do our best to revamp it and make it as easy as possible for applicants, the public, and licensees to find information. We are working on continuing to empower our Board staff to suggest and implement changes that will allow us to improve efficiency and licensing. We are proud of our staff, and they are doing this every day. Sometimes I think the best ideas we can get for how to make things better and faster are from the people doing it, so we are doing that.

Here are some perceived Board-related delays to working in Nevada. One thing we wanted you to keep in mind is that other entities like hospitals often will not begin their credentialing process until someone is licensed, so someone may move to Nevada, but they may not be able to work for a longer period than it takes them to get their license because of that credentialing process. That is not something we have control over, but sometimes people maybe blame the Board or are upset about the delay. Our process often comes first and then the credentialing process is second.

Nearly 75 percent of the time to issue a license is related to applicants obtaining the proper documentation. This is something that came out in the legislative audit. We cannot control that, we need time to process it, and we are trying to do it as quickly as we can, but waiting for responses and information slows it down. In a recent example, an applicant took four months to provide additional information regarding an undisclosed arrest, and that is going to delay that application. Things like that happen. It is not uncommon to message them and not hear back. We try to follow up and our staff does that regularly. They flag them for continued follow up, but we are not in control of that process.

The other thing is that we do not know the application is there until they have hit "submit" and paid the fee. We have talked with folks in the past who have said their application has been pending since "X" day. No, you may have started entering information like your name into the portal, but you did not submit it for several months. That happens and I do not know why. I know it is a process to gather things, and maybe a savvy applicant would start to put things in the portal before submitting, but we have heard it attributed to us when we know exactly when they submitted and paid for their application.

We were asked to talk about potential bill draft requests (BDRs) that we might want to see. The first one is that we would like to do a clean-up. We are still gathering statutes that we think might need some clean up. I keep a list of those to make sure that we are being updated regarding changes. I know there is one statute that did not get anesthesiologist assistants added to it, and I want to make sure they get added to that and make a few other changes like that.

We wanted to talk to you about the CME requirements for doctors and PAs because it is confusing and can be burdensome, and perhaps it is something that this Committee and the Legislature in general may want to address. All medical doctors and PAs must do 40 hours of CME every two years, but a lot of those hours are spoken for by different legislative enactments, and some are even a bit confusing because they are duplicative.

Extra credit is given for CMEs in geriatrics and gerontology, effective management of medications, and diagnosis of rare diseases, including pediatric cancer. There is a statute that says the Board should encourage people to take those courses. There is a regulation in place already on geriatrics and gerontology and the diagnosis of rare diseases. We have one that we are going to be bringing forth regarding the effective management of medications because we do not have a regulation yet giving double credit for that. Eight hours is required in the first two years of licensure in the areas on that slide: four hours in acts of terrorism and bioweapons; two hours in evidence-based suicide prevention and awareness; and two hours in screening, brief intervention, and referral to treatment. Everyone must do these at the start of their time in Nevada, so once they get licensed, their first renewal must include those eight, and then every two years afterward, they do ethics, pain management, or addiction care.

This is where it gets confusing: if they are registered to dispense controlled substances with the Board of Pharmacy, then they must do misuse or abuse of controlled substances, prescribing opioids, or addiction. My understanding is that most but not all our physicians are licensed to dispense, and that is not something we give them the authority for, so they would have to know they are licensed to dispense, so they must do this one.

They must also do two hours of cultural competency and diversity, equity, and inclusion. This is only for psychiatrist, MDs, and PAs working under supervision of a psychiatrist. Again, we have screening, brief intervention, and referral to treatment. This is only required for those who did not get it in the first step—the first two years—so everyone else must do it once by this coming renewal in 2025.

Every four years or every other renewal, everybody must do a suicide detection, intervention, and prevention class, and there is a new requirement as of the 2025 renewal for two hours on stigma, discrimination, and unrecognized bias toward persons who have acquired or are at a high risk of acquiring human immunodeficiency virus (HIV). This will be a lot of our licensees because this is for everyone in an emergency medicine and primary care setting. I would say close to half are going to have to do this.

As you can imagine, it is hard for licensees sometimes to know what they need to do and when. We try our best to communicate that to them, but it is also harder for our staff to figure out when we do renewals. We do not audit every single one or we would never be done, but we do audit a percentage, so we must figure out, "Okay, for this person, it is their first renewal, so they have to do these," and then, "Oh, they work for a psychiatrist. They must do that," so it can be challenging. I do not know if there is a way to make that simpler, because we would request that from this Committee. I have no further information. I will now turn it over to Dr. Spirtos.

Nick M. Spirtos, M.D., F.A.C.O.G., Board President, NSBME:

I would like to add a couple of points to what Sarah has mentioned. First, I would like to point out to everyone what an incredible job Mr. Cousineau, Sarah, and the entire staff have done working towards the goal of shortening the time of licensing and modernizing the system.

I am going to first address the issue of CMEs. Not only is it confusing on the licensing part, but it is detrimental in terms of getting a license. We are one of the few states that have such detailed requirements for our licensees, and one of two that require training or CME in acts of terrorism and use of weapons and biological weapons of mass destruction. For suicide prevention, we are one of seven states that have such specific requirements.

I would ask not only that we clean up these bills and simplify the rules, but also leave it more to the discretion of the specialty boards. We also have requirements within each specialty board of CMEs that we need to have within our specialties so legislators in Nevada periodically decide what is good for the medical practitioner. We need to look in the other direction and simplify those codes in NRS and allow physicians to direct more of their CME.

In terms of physicians and how we incentivize or make this a State that is more likely to encourage physicians to come here to practice, we have heard multiple discussions today about the cost and impact of our medical malpractice changes, and there would be consideration given that there are 600 physicians working as clinical faculty members. Maybe consideration should be given to those physicians also being considered under the reduced level of the Pain and Suffering Act so the cap would be reduced or those who are acting in a clinical capacity would be treated similarly to full-time faculty members.

For example, at the Women's Cancer Center, we teach residents and medical students daily, so full-time in essence, but we are not subject to reduction of our cap as well. That might make it a little more enticing for people to contribute and be part of the clinical faculty at the various institutions.

The other discussion I think we should have, at some point, is regarding restrictive covenants. Physicians who are practicing in the State who may want to leave and go to another employer cannot always do so because there is a restrictive covenant in place. You have a situation where physicians are currently practicing or present, and their families are here, but if they have, for lack of a better term, a disagreement with their employer or feel they have a better opportunity across the street, they are not able to pursue that because of a restrictive covenant and therefore must look for out of state employment. That is another reason why we might lose physicians.

Those are the most important things, but those changes could make Nevada a place where physicians are more likely to either stay or come to practice. We are open for questions or comments.

Chair Doñate:

When working with the Committee staff, I had requested a few bullet points and numbers. All of us will probably have questions, and we are very eager to dive into the issues.

I want to start my round of questions to set the parameters for the discussion, and then I will let the Committee Members go. I wanted this presentation because oftentimes, licensure can become a barrier to the ability to practice in this State. The presentation from NCSL noted there are states considering physician licensure as a priority. We saw the legislation in Idaho and other states trying to make expansions and reform how licensure is done, and there is also consideration of the timeline it takes for us to recruit physicians from other states to start practicing, whether they are faculty at universities or elsewhere. Folks in our community request this needs to be done faster. We already have a problem with physicians not being here, so we need to make sure we equip you with the right resources to get this done now.

Let us start with a baseline question. Say I am an applicant. I completed medical school. I completed my residency program. I am done with my training and finally ready to be a doctor. I submit my application to the Board of Medical Examiners. After that, under my interpretation, I do not have any work history or malpractice claims because I have not fully practiced yet. The application is submitted, and I believe I have submitted everything correctly. What percentage of applicants do you usually follow up with once the application is submitted? Will, say 90 percent of the applicants require another look at their application? What does that process look like as they are going through the pipeline?

Ms. Bradley:

Kory Linn is available to give us an answer to this question. I understand what you are saying, and she can clarify more, that people with malpractice history and other kinds of incidents that they must disclose, and we must verify tend to be more of a delay-causing situation, but I will have her clarify further.

Kory Linn, Chief of Licensing, NSBME:

What Sarah said is correct, that it is malpractice and things like that. Residents can be sued for malpractice. It is not common, but sometimes, if they are in their residency, they can be included in a lawsuit, so that does come up. Additionally, many applicants make errors on their applications, so they will get their medical school information dates incorrect, and we will not know that until we get their verification and transcripts. Things like that will come up, and generally, new graduates are quick to license. We often do those in less than a month, and as the audit stated, most of that time is simply waiting for verification that they have completed their medical school and postgraduate training.

If they had any discipline or probation in their postgraduate training that must be addressed, arrest history can often come into play as well as anything else they did not disclose. For example, if their fingerprint results come back before they are licensed and it turns out they were arrested and never told us about it, that is an issue that we must address. Almost every application has an addendum that needs to be done. They can be quick, and most of them are. If they read the directions we send. We try to be very specific and careful about how we word our correspondence with them to make it clear what needs to be corrected, and if they send that back, it is a quick process.

Chair Doñate:

To clarify: in general, we can expect that every application submitted will need follow-up. Is that a fair assessment?

Ms. Linn:

That is correct. Once they hit the submit button, we get back to them almost 100 percent of the time within the week to tell them exactly what the next steps are, how to fingerprint, and everything like that. There will always be some sort of follow-up because they need to get fingerprints done, so we give them instructions on that. There are application forms they need to sign, they need to do a waiver for the Department of Public Safety to get the fingerprints completed, and then we will notify them of the verifications they need to request of their medical schools and postgraduate training. Furthermore, for seasoned doctors or those who have had malpractice, we will guide them on the steps for that as well. We follow up with 100 percent of them almost always within the week, especially given our new process of getting in touch with them electronically rather than mailing their acknowledgement packet.

Chair Doñate:

I am asking these questions on purpose to help Committee members in their flow of ideas. Why is that not being requested at the time of application? If you are going to follow up with them, why not request that as part of the submission being considered when we have the applicant's attention?

Ms. Linn:

We give that information on our website, and it is part of the application directions, so before they even get to a screen where they can input information, there are directions on the kinds of verifications that will be needed and where they can obtain those. There are links to things like the examinations, whether it is the U.S. Medical Licensing Examination or ECFMG, and links for them on those instructions at the very beginning before they ever start putting information in. We do give them a heads-up on that in the application itself and on our website.

Chair Doñate:

One further question: when was the last time the licensing fee was increased?

Ms. Bradley:

Right now, the cap is set at $800 for the two-year period; that is the maximum that can be charged. It had gone down for a short period, and recently, the Board voted to increase it back to the $800 within the last year. That cap has been set in statute for quite some time. The statute was updated more recently, but I would have to take a minute to find it.

Chair Doñate:

We will review that as we are doing our questions. One last question from me: in the presentation, it was mentioned that a lot of the applications are done in the same period. Is there a requirement that it must be done by a certain day? Is that in NRS? You understand the reason why I am asking that. I do not know if that leads to the time frame of why the workload is always at the same time of each year. Is that date usually identified in NRS?

Ms. Bradley:

Yes, the June 30 renewal date for physicians and, I believe, PAs is in NRS. The other license types are in the regulations, and I think we did it to match that. For the resident renewal, NRS says that the resident license is good for one year. Because of the way the programs operate, they start in July. That is the time frame for them when people are graduating.

Dr. Spirtos:

I wanted to add that when we looked at the fee schedule, I believe that fee has been set. It has been in place for more than 20 years. I do not have the exact dates, but when we looked at it briefly at one of our meetings, that is what we had identified.

Ms. Bradley:

I was looking at 2003, and it was $600; so it was after that.

Chair Doñate:

In the interest of time, if it is easier to follow up—I want to make sure that Committee Members can contribute—we can circle back on this question and make sure the figure is right. I was asking because we have noticed the rise of inflation, so it might be time to reexamine the fee structure, especially when it comes to providing you the right infrastructure and support. It is important for us to have this presentation, at least for now.

Assemblyman Nguyen:

You provided a lot of information, and what caught my attention right away is that timeline between the compact licensing time versus the noncompact licensing time. It was a very big gap between them. I know your staff increase was very recent, Ms. Bradley, in terms of having 3.5 full-time employees added in January 2023, but my question is, what happens between the compact versus noncompact in terms of the length of time for getting it done? There is three times the amount, so what if that person comes in through the renewal period? When you must deal with the rest of the world being renewed, does that timeline even exaggerate to a longer wait time?

Ms. Bradley:

That is why we said one to three business days on average because there are factors that can extend that Compact licensee being issued. However, under normal circumstances, it is within a matter of a couple of business days.

The difference is, when someone comes through the Compact, they must have a SPL from one of those member states that has already vetted everything we need, so if somebody who is licensed in Texas, which I will use because they are a newer example, wants to come to Nevada, Texas has already vetted everything for somebody to designate Texas as an SPL, so all the verifications are done. We get a letter from Texas that says, "Please license Dr. Jones," and that is our process. We receive and process that as quickly as we can, so it speeds up. We do not need verifications from graduate school or things like that.

We still do require state-specific requirements like identity documents, but according to the rules of the Compact, one to three business days is what we must do. That is the rule, so we make sure we do it. Sometimes we are waiting on state-specific documents from them, but they still get their license.

Assemblyman Nguyen:

For the 45 days you listed on the presentation; you said that is an average?

Ms. Bradley:

The 45 days—that was the 2024 number. For the licensing times in 2023, I have 86 days average for medical doctors, and that includes everyone, Compact and noncompact. You can see the improvements we have made are decreasing the time, because it is now 49 days, so it has gone down from 86 to 49 because we are requesting fewer documents. The legislative audit showed 75 percent of it was gathering information. If they must gather less, then they are getting licensed quicker, so it was 49 days as of the end of February. We do not give you the average for the Compact because we know it is one to three business days.

Assemblyman Nguyen:

I wanted to make sure I was clear on that one. Is the 49 days you are referring to for the entire renewal period from June 30, or is that a year-round average?

Ms. Bradley:

That is the average time for a physician in January and February of this year, so for anyone who was licensed starting January 1 to February 29, the average time from when they hit "submit" to when they got their license was 49 days. That is two months, but we are excited about that number because we are working hard to bring it down. Last year our total was 86, so it has gone down quite a bit, and I am hopeful that it will continue to go down as we keep processing applications.

Assemblyman Nguyen:

What is the gold standard?

Ms. Bradley:

I would say as fast as possible, which I think is what you would all say. It is going to take time for us to process, but if you look here, the fastest licensing time not through the compact was 15 days, meaning that person hit "submit," their license specialist reached out to them and said, "Here is your packet, please get your fingerprints, et cetera," and that person responded quickly and got their license within 15 days. Maybe that is our gold standard; that is the fastest we have done it in the last two months, and a lot of that was probably that person having their transcripts. Applicants can get things ready ahead of time, so if they have everything gathered, they might be diligent and careful in gathering these documents and they upload it and hit "submit," they could be licensed in 15 days.

Assemblyman Hibbetts:

What is the cost of the license application?

Ms. Bradley:

I am going to ask Ms. Linn to take that question for me.

Ms. Linn:

At the beginning of the process, they pay an application fee, and a physician unlimited license is $600 plus the background check fee. Once their application is completed and approved, they have a registration fee, their licensure fee, of $800.

Ms. Bradley:

The background fee is $75, so it is $675 to start the process, and once they are approved, they pay $800 for the next two years of practice.

Assemblyman Hibbetts:

Is the application fee applied to the licensing fee, or is it $600 for the application, $75 for the background, and $800?

Ms. Bradley:

Yes. The total they would pay if they were at the start of the biennium would be $1,475, and that gets them their application process and two years of practice. They would not have to pay again until two years later. The reason I say start of the biennium is that we prorate the registration fee depending on where they are because we want to try to be fair. We do not take the full $800 if they are applying later. For example, it is March 2024, and our next renewal is in 2025, so we are still in the first part, but once we pass into July this year, then we will start charging less for the registration fee.

Assemblyman Hibbetts:

For the application fee, is that set within statute, or is that an arbitrary fee made up by the Board?

Ms. Bradley:

All the fees are in NRS Chapter 632.168, and I believe the Legislature sets a maximum both for the application and the registration fee as well.

Assemblyman Hibbetts:

So it could be less?

Ms. Bradley:

I think the maximum for the application fee is $800, if I remember correctly and hopefully Mr. Robbins can correct me if I am wrong. I believe it is $800 maximum for the application and $800 maximum for the registration. We charge $600 and $800.

Assemblywoman Brown-May:

My question is related to applications that are waiting for payment. Your presentation noted that there are 48 in your snapshot. I am confused. Let us start there: initially, you said that we did not know they were there until they made payment and hit "send," but in your presentation, you also said there are 48 applications waiting for payment. How does that happen? How do we know they are there? Do we follow up with them?

Ms. Bradley:

I apologize. I think there is a little confusion there. They must pay the application fee at the start and that is when we know their application is pending. The 48 who are approved and awaiting payment are people we have told their applications are approved and asked them to pay their registration fee so their licenses can be issued. We have them pay at the start the application fee, we work on their application, and then at the end we say, "Please pay your registration fee," so they can get their license number. They get emails when it is done, and I know staff follows up. They have checklists. Ms. Linn can correct me, but I believe they follow up at least every week, but I am not certain on that.

Assemblywoman Brown-May:

Thank you for that clarification; that was helpful. I want to make sure that I am clear: for the folks coming to us through the Compact, they are the same fees for licensure as if you are going to start a Nevada license. Is that correct?

Ms. Bradley:

I believe they are the same fees.

Senator Nguyen:

Is all the licensing on a rolling basis based on your admission? Are they all at the same exact time?

Ms. Bradley:

I am sorry if I am misunderstanding, but your question is, how are we getting applications in? I would say applications for new licenses come in on a rolling basis.

Senator Nguyen:

After you are on a rolling basis, you had said something about prorating it based on that. Once you are in there, is the renewal all at the same time?

Ms. Bradley:

All licensees must submit their renewal by June 30 of the odd year, so the next renewal for us is June 30, 2025. All 14,000 licensees will renew by that date. We prorate the fee because they are coming in on a rolling basis, so it would not be fair to charge someone for the full two years if they are not going to use their license for the full two years.

Senator Nguyen:

Is it in statute that they are all on the same renewal schedule, or is that just a part of your process?

Ms. Bradley:

Chapter 630 of NRS lays out the requirements for the renewal for physicians and I believe PAs on June 30. I just did the regulations for anesthesiologist assistants, and we added the June 30 date there since that is when everyone else renews, and for the other two profession types, I do not recall off the top of my head exactly when they are. Some of them were created in regulations more than in statute if that makes sense, but I know the physician license is in NRS.

Senator Nguyen:

How many doctors, PAs, and others are you responsible for renewing licenses for? How many individuals are there?

Ms. Bradley:

There are just over 14,000 of all types, and they all come in on June 30 of the odd year.

Senator Nguyen:

Would it be helpful to have it on a rolling basis? It seems like you are doing all your work in that same time period.

Ms. Bradley:

It is hard to say. We would have to change a lot of processes, so it might be a bumpy start if we were to do it. We bring in a couple of seasonal people to help, so we have staff to try to help with that. Right now, our process is written that way, so there would be changes and that might cause some hiccups for us, but I understand what you are saying. I could have Ms. Linn speak to this if she wants to add anything.

Senator Nguyen:

It seems like it is concentrated work to the point where you are having to hire outside people to come in because all 14,000 are there, and then you are backdating and prorating new licenses because they are probably coming out of their programs in the fall?

Ms. Bradley:

Online renewals make some of the renewal process easier. I am not saying that it does not require human review, but I know that at least some of it is processed through the ordinary course and the biggest staff time is people having a hard time logging into their portal. Sometimes people forget their password, so we get a lot of calls and there is a lot of communication, but we are not processing a lot of paper like we used to. It would be a big change to do it. I am not saying that it would not be wise, but it is hard to say how that would impact us. Our licensing vendor would also have to be on board with that.

It is perhaps easier because everyone does it at the same time, so there is no confusion about when you are due, whereas if everyone had a varying date, if somebody called and asked, "When does my license expire?" the answer would not be the same. I do not know how it would work. I know other boards do exactly what you are saying, and a lot of boards do the one-year time frame.

Chair Doñate:

For the record, I am strongly advocating for us to do it on your birthday the same way that my driver's license renews. It is a good thing for us to remember. I do not think many of us will forget our birthdays, so maybe that is where we can start. Let us go to Northern Nevada.

Senator Titus:

Having served on the Medical Board many moons ago, you have come leaps and bounds. I was first licensed in the State of Nevada on July 1, 1982. That is how long I have been a doctor: 42 years. Having gone through this process every other year, the fact that you have improved this process is dramatic as far as I am concerned, so thank you.

I have several questions and clarifications for all those who have not gone through this license process, which I have done many times. We do not all push the button on June 30 and apply for a license. They give us ample warning our licenses are due, and we do it online, so it comes through a process. Not everything falls on that day. It is when your license expires, so it truly is not pushing the button and 14,000 applications go in at one time and shut the system down. They are giving us ample warning.

My question revolves around the data you gave us regarding this licensure. You pointed out that the average license is 49 days to licensure, and you are no longer requiring direct source verification for clinical rotations for Island and Caribbean schools. That was one of

the issues: we had a lot of American students go offshore who could not get into medical schools here and were trying to find some of that data. I am happy to see that you have loosened some of that.

My question revolves around other foreign medical schools. What is the time to license somebody who has gone to Oxford or somewhere in England or India? Some of these other countries that come to America have had great training and that was always a delay for us to get their license. What is that average time?

Ms. Bradley:

I will turn this over to Ms. Linn.

Ms. Linn:

It depends. Since we do accept direct source verifications via email, that has helped a lot, so if it is coming from a ".edu" address or whatever the foreign equivalent is directly from the school, we can accept it by email. The increase in use of Federation Credential Verification Service (FCVS) packets, which is under the Federation of State Medical Boards, is very helpful for foreign medical grads to have that FCVS packet ready when they apply. Often, we can license them as fast as an American graduate if they have that.

Sometimes it does take longer, especially if the graduation was from a school in a country that maybe is not willing to be forthcoming with the United States. That can be difficult. We work with the applicant to try to do what we can to get them licensed regardless, but there can be delays if we cannot get that verification because we need to know that they graduated, and they legitimately went to school. It is important that we obtain that direct source documentation so we can assure the public that we are vetting these physicians and that they are qualified regardless of where they went to school, whether that is in the United States or abroad. We do everything we can, but we encourage graduates to obtain an FCVS packet, especially when they are in a foreign school, because then it is ready to go, it has already been direct source verified, we have the packet in front of us, it flies through, and we do not have to worry about those delays that can occur.

Senator Titus:

You mentioned that there is an application fee of $600 and every other year a fee of $800. Does the applicant get that money back if they do not qualify?

Ms. Linn:

It is in the law that the application fee and the background check fee are nonrefundable. We refund the background check fee if they have not submitted fingerprints and completed the background check. The application fee is nonrefundable, but it can be reviewed by the Board if it is an extenuating circumstance, so those refunds do sometimes occur.

Senator Titus:

With all due respect, Chair, I think the $800 is plenty for me to spend every other year on our application or licensing fee, and I am curious where we are compared to other states. Have you looked at what other states charge for their medical licenses? Are we high? Are we low? We do not want doctors not coming here because we charge too much.

Ms. Bradley:

I did research on that back in 2020, for one of the interim committees, but I have not updated that research since then. I would be glad to share what I have, but I think it probably should be updated. Those are the last comparison numbers we put together for that.

Senator Titus:

Where were we when you did that comparison?

Ms. Bradley:

We are higher than some states and lower than others. We are higher than states with umbrella boards and different structures regarding licensing. As far as boards like ours, we may have been $100 more or $100 less. I do not recall us being totally on our own.

I have heard that in recent years, the State of California and the State of Washington have raised their fees, perhaps in response to budget concerns, so my understanding is the picture might look different than it did back in 2020. For the record, I started with the Board in November 2019, so I believe it was just prior to the COVID-19 pandemic that I did that research. I am not sure how it would shake out today.

Senator Titus:

Is your Board fee-based, is that how you operate? I know this is a policy Committee, but we have been talking about costs. Is your Board 100 percent fee-based, or do you also have some State budget added?

Ms. Bradley:

We are funded by licensing fees, so the application fee and the biennium renewal fee for all our licenses. We also sometimes get cost reimbursement for the time we spend on disciplinary cases, but any fine monies that we collect, we send to the General Fund, so those other forms provide our budget.

Senator Titus:

Thank you for bringing up the onerous mandates that have been put on physicians about mandatory CME every session. When I vehemently protested many of these CME requirements and pointed out exactly what you pointed out today, that we already must get 20 CMEs per year, that by these additional mandates, we cannot even do the ones that we really need to do, which is all about diabetes and cardiovascular disease, et cetera. And for me, as a Long-Term Care Medical Director of stuff I must do for my aging population, I want to know: why were you not at the table when all these CMEs were being passed? I want to know because I do not think you were in the audience when I was protesting. Thank you for pointing that out, and I would love to work with you folks on trying to clean up our CME regulations.

Chair Doñate:

You do not have to answer that question. I interacted with many physicians during that process when those bills came forward, but I appreciate those questions.

Assemblyman Gray:

I am going to dovetail into what Senator Titus had mentioned about CMEs going into potential BDRs. There are two hours on stigma, discrimination, and unrecognized bias towards persons who have acquired, or are at risk of acquiring, HIV. Why are we singling out one disease? When I worked in the ER and other places in EMS, I was more afraid of getting Hepatitis C in a lot of cases. I think we have all learned, especially today, to treat every patient with the same universal precautions, if they are a regular patient of yours and you are working in family practice or something, but I do not think additional education serves a purpose. Unless there is an answer for that—I do not know—it seems like "feel good" legislation.

Chair Doñate:

I can answer that question quickly. Assemblyman, a lot of the provisions they mentioned are guided through laws that are implemented and have been signed by the Governor and passed by the Legislature. I think what you are seeing is a culmination of multi-year initiatives, and now there is a consideration of, does this make sense for all specialties or entities? Maybe they do, but maybe they do not. I think that is the review process we are going through right now.

Assemblyman Gray:

My point is that any caregiver can have a bias towards any patient with any given disease. I have a couple more questions. The average licensing times including IMLC is 49 days. What is it without the IMLC? If you are telling us that it is one to three days for the IMLC, how is that impacting that timeline? It seems like it could artificially lower it quite a bit.

Ms. Bradley:

I am hoping Ms. Linn has that number. Otherwise, I believe I have it in my email and could look that up.

Ms. Linn:

Sarah, I do not have that with me, but if you have it in your email, that would be helpful.

Ms. Bradley:

If you give me one second, I can find that. I do not know if you have other questions. I will find it.

Assemblyman Gray:

I have one other question, which is interesting to me as well. We accept a notarized copy of an identity document rather than an applicant mailing original documents. What is a notarized copy of an identity document? Is that something you provide that they must sign in front of a notary? A notary cannot notarize a birth certificate. They cannot notarize anything that they did not see signed, and an individual does not sign their birth certificate. I wonder what you are after there. Is it supposed to be a certified copy?

Ms. Linn:

We mirrored how the Federation of State Medical Boards does it, so the document itself is not notarized. The applicant presents the original document to the notary, the notary attests that they saw it on a certificate of identification, and then that notarized certificate of identification along with a photocopy of the document they viewed are sent to the Board.

Assemblyman Gray:

Maybe that should be cleared up in here: it is a notarized attestation. That made no sense to me at all.

If you could give me the average without the IMLC, I would appreciate it. My gut feeling is it is quite a bit higher than 49 days.

Dr. Spirtos:

The Assemblyman is correct. That number will be prolonged if the IMLC number is so short, but we should also be emphasizing here the changes that have been made. As Senator Titus pointed out, the Board has made several changes in the last 12 to 18 months—and certainly over the last 6 months—to streamline the procedure, whether it is using IT or other methods like reducing the number of requirements or the number of years that we are going back to.

The real test of this will be six months or a year from now how well the Board has performed in terms of reducing that number of days. That is the real question here, because I do not think it is a fair measure after we have made all these changes to look at it over the last 60 days or 90 days. Whatever those numbers are, they are certainly improved, and I would think those numbers would be even shorter after these changes have been implemented.

I would also like to comment on foreign medical schools. I understand there are about 150 to 155 medical schools in the United States, and there are over 700 medical schools in India, for example. Trying to make sure that you are getting accurate information from 700 schools scattered throughout India has proven over time to be quite difficult.

Ms. Bradley:

To answer the previous question, I apologize that I do not have it for 2024, but if you want to compare it for 2023, we had 86 days as the average including IMLC and 168 days not including IMLC, and the fastest non-IMLC was 22 days. It looks like the number goes down by about half if we add in the IMLC. For 2024, I do not believe we have calculated that yet, but what we have right now is the 49 average days. We will have updated numbers, and we are glad to give them to you as you request.

Chair Doñate:

I believe we have reached the end of this presentation. I do not have any further comments or questions. I want to say that we are open, at least from the Committee side, to reviewing and supporting your infrastructure. There is a common theme of making sure that as we get doctors and fill these gaps, our State has the resources to make sure that these processes are fast and efficient. I want to thank you for not only answering our questions, but also providing us the data we needed to also understand the process and how can we help you. Do you have any other closing comments?

Ms. Bradley:

In closing, on the last slide, you have our website and our email, so please contact us if you have questions; we would be glad to answer them. It sounds like Mr. Clark has something.

Tom Clark, Owner, Tom Clark Solutions:

I do not. They have covered it quite well. I am always available if you have questions or comments on any of the issues that you have heard today or have questions going forward. Assemblyman Nguyen carried our administrative clean-up bill last session as a freshman. He did a phenomenal job and we made nice changes there, one of which was that we increased the fines implemented by the Board, but instead of those resources going to the General Fund, they now go to the State Treasurer, and those resources are used to help students pay down debt, folks who want to practice in the rural parts of the State, and that kind of thing.

Ms. Linn:

May I make a comment? I have another licensing number that could be helpful. The average license time since the new procedures were implemented—168 days, I believe Sarah said—included the time period before these new procedures were implemented. Since the new procedures were implemented, we had 95 days, which included some of the more difficult files like undisclosed malpractice or files that had to stay open for Board appearances. We did not filter those out, and it was still down to 95 days from that 168 without including the Compact numbers.

Vice Chair Orentlicher:

Do you mind if I ask a question?

Chair Doñate:

Just one question because we do have other presenters that might have to leave. Please make it quick.

Vice Chair Orentlicher:

Thank you for speeding things up and making all these changes. It is great and impressive how low the rejection rate is. You ended up denying a license to only one out of about 2,000 people last year. I wonder, given the fact that it seems like people who are applying are qualified and a lot of this information is available electronically, whether you can do a quick screen with whatever databases are out there or whatever they submit, and if there is not a red flag or they are not from one of the 700 medical schools where you cannot get good information from an overseas country, you could grant a provisional license, and then they would have to confirm everything to make it a regular license. Is that something that could speed up the process?

Ms. Bradley:

I have a preliminary comment, and then I will turn it over to Ms. Linn. Regarding applications that are denied, there is a larger number of people who withdraw their applications during the process. Denials are reportable, and they are a different thing, but several people apply and realize that they do not meet the qualifications or there are other issues, and they withdraw their application rather than be denied because they do not want

that reported to the National Practitioner Data Bank as well as other entities. I do not know if Ms. Linn has anything to add to that.

Ms. Linn:

Sarah is correct on that: if someone looks like they are they are going to be ineligible, sometimes we can tell right away, and we talk to them at the beginning of the process and give them options. If there is not an option, they can withdraw their application, and if something comes up later in the process, they can choose to appear before the Board and try their chances with them, or withdraw rather than take the chance of that denial.

Ms. Bradley:

As far as the provisional license goes, I am not sure, and we can talk about it more. We do not hold licenses up for things except for what is not submitted, so if there was a list of items that the Legislature believed we do not need to verify before that, but at this moment, it is not something we do, or have a process for, or have thought about in detail.

Once the application is complete and everything has been gathered, the license is issued within the next business day after payment. Once they pay that registration fee, they get their license. Any delay is either from them not sending or us not receiving documents that we need. We do not hold up licensure for fingerprints. There are times when people submit their fingerprints toward the end of the process and we do not wait for those results, so we have done everything we can to speed it up and await direction from you on other things you would like to see.

Chair Doñate:

We will close out this agenda item. Thank you all for participating, and of course, we ask Committee Members if they have any further questions to take them offline so we can continue with our process.

AGENDA ITEM IX—PRESENTATION FROM NEVADA'S SCHOOLS OF MEDICINE AND FUTURE CONSIDERATIONS

[This agenda item was taken out of order.]

Paul J. Hauptman, M.D., Dean, University of Nevada, Reno (UNR) School of Medicine and Chief Academic Officer for Renown Health:

We will begin with some numbers and then drill down further. In terms of the two public medical schools in the State, we educate approximately 550 students. The average annual number of graduates is 122 and growing and we have multiple GME programs as well (Agenda Item IX A) (Agenda Item IX B).

Marc J. Kahn, M.D. Dean of the Kirk Kerkorian School of Medicine Vice President for Health Affairs, University of Nevada, Las Vegas (UNLV):

Collectively, we have 471 residents and fellows between the two public medical schools. I estimate that we have about 90 percent of the graduate medical education (GME) positions in the State between us, but we can work on getting you exact numbers. Annually, we collectively graduate about 148 residents and fellows.

Allow me this opportunity to thank Senator Pazina and the cosponsors of SB 350 for working to expand funding for GME in the State. I would like to again thank the Committee for offering Dr. Hauptman and I the opportunity to address questions.

Dean Hauptman:

We also have a physician assistant (PA) studies program at UNR School of Medicine. There are 48 students, and it is a 26-month program. The average annual number of graduates is 23; that also helps to improve the health care workforce.

Dean Kahn:

There are benefits to public medical education, and over the past year and a half or so since he has been here, Dr. Hauptman and I have been working closely to expand medical education in this State to address access to care and critical needs for health care in our State. We are working together to expand GME.

We would argue that as the deans of the State medical schools, we know what is necessary to create and build GME programs. Collectively, both of us have about 60 years in that arena—to date us a bit—and we are also in a position to understand the needs of the State. For GME, it is not only a matter of locating a program in the appropriate place. It is also having the faculty to develop curricula and train the next generation of physicians.

Dean Hauptman:

During the previous presentation, you have heard several data points about retention. I want to go over in broad brushstrokes the retention numbers. These come from Dr. John Packham at UNR Medical School. It is what I call the 40:60:80 rule, so 40 percent of our medical students will ultimately practice in the State, and 60 percent of our graduating residents will ultimately practice in the State, but if you combine attendance at a public medical school in the State plus a residency in the State, the retention rate goes to 80 percent. It is hard to do much better than that.

I should also point out that not only do we have a PA studies program, but at UNLV, there is a School of Dental Medicine; and a Speech Pathology and Audiology program at UNR Medical School. We are looking to grow those graduate programs as well.

Dean Kahn:

I think I speak for my colleague Dr. Hauptman, when I say the public medical schools funded in large part through taxpayer dollars are here to improve access to care by training the next generation of medical personnel.

Dean Hauptman:

We talk a lot about physician supply, especially in rural settings, and we believe there is an opportunity to grow rural tracks and residencies plus expanded loan repayment programs, which at this point attract approximately 50 physicians as they pay back their loans and serve in rural communities. That program is also run out of UNR Medical School.

Dean Kahn:

As a relative newcomer to the State that I call home and have grown to love, what impresses me is the fragmentation of health care. At UNLV and now at UNR, we are trying to further the concept of academic health. There are about 130 designated, recognized academic health centers in the United States. Dr. Hauptman and I would like to create academic health in the north and south under one umbrella, with him leading the charge in the north and us leading it in the south.

When I look at UNLV, we have five health science schools: (1) a school of medicine; (2) dental medicine; (3) nursing; (4) public health; and (5) integrated medicine. Then we have behavioral health distributed across three or four colleges. We have been working together for the past three years or so. We have developed a strategic plan and are in the process of updating it for bringing this coordinated care to our community where patients can come and almost in a "one-stop shop" get the care they need.

Let me give you an example. I am an oncologist by training, and what typically happens here is a woman discovers a breast lump, so she finds her way to her primary care provider. She is subsequently sent for a biopsy. She is then sent to a surgeon, then to a medical oncologist, and finally, maybe to a radiation oncologist and a mental health professional. This needs to occur all in one place at the same time, and that is one of the things that academic health can bring to this community.

At UNLV, we are working very closely with our partners at UMC and UNR; they are working very closely with their partners at Renown. Several weeks ago, the CEO of UMC, Mr. Van Houweling, and I went up to UNR to meet with Dr. Hauptman and the CEO at Renown to see what we can better coordinate together and learn from each other.

Dean Hauptman:

Before we move on to other issues, I would like to point out that in terms of GME, we take as our model the State of Texas, which sets aside $200 million in each biennium for new programs and to sustain existing programs. Given that we are about one-tenth the size of that State, we believe that a $20 million figure per biennium is reasonable, and we would like to propose that the two public medical schools be awarded, as part of their regular State budget, $5 million a year to grow GME. We are committed at UNR Medical School, and I believe Dr. Kahn is likewise at UNLV, to grow five new programs by 2030, and to do that, we need the financial backing of the State. In addition, philanthropy and the hospitals will contribute.

We talked about GME and academic health. Dr. Khan and I are working together on a project that we believe would be of great interest to the State to stand up in Nevada a Center for Patient Safety and Simulation. One of the major advantages of such a Center would be to take medical simulation to the rural hospitals, which is a real gap. The cost of mannequins is tremendous. They often cost over $100,000 each, and then you need individuals steeped in the education of simulation in medical settings. We have those skill sets, and we would like to stand up this Center for that purpose. There are several additional programs, and I would like Dr. Khan to touch base on those.

Dean Kahn:

At both UNR and UNLV, we want to make sure that we ensure student success. Both of our schools have been successful with graduating physicians, having physicians who match, and having physicians who pass their standardized tests, but there is a need for support, learning specialists, career advisors, et cetera. We think that is critical for getting the workforce that we need.

Dean Hauptman:

In addition, as I mentioned, we are looking to expand several of our graduate programs, specifically master's degree programming in speech pathology, which clearly needs to grow. It is an unmet need in the State. We would also like to stand up a new program in medical laboratory science. If you reach out mostly to the rural hospitals, there is a dire need for individuals to direct a hematology lab, a chemistry lab, a pathology lab, and a microbiology lab. That requires special education, and we believe we can stand up such a program. In addition, we are looking to begin a clinical trials administration program that would be a master's degree.

Dean Kahn:

At UNLV, we are very thankful that in the last biennium, through the Governor and the works of the Legislature, we received monies to increase our class size. That was intended to be recurring, because we cannot hire faculty for two years. We are not going to get permission to increase our class size, so we have a huge priority to make sure that is a recurring item in our budget. We started out with 60 students per class. We are allowed to increase by 10 percent without specific permission from the accreditors. This past year and this upcoming year, we are going to have 66 students, but we would really like to get to 90. We are in the process of hiring faculty, so we will be able to do that, but those dollars need to be recurring.

Dean Hauptman:

I will also point out that at UNR Medical School, for the first time this year, we are prospectively recruiting students into an M.D./Ph.D. program. We were asked not only to talk about fiscal priorities but also policy priorities. I think you recognize the first one: sustained and reliable funding for GME at the two public medical schools and affiliated partners.

Dean Kahn:

Importantly, we are asking this group and others consider the funding go to the State medical schools. Again, we are in a position to be able to develop curricula. We do not have a problem finding program directors, and I think together we are in a position to see what is best for the State. There are members of the Board of Medical Examiners here, but both of us feel that we need to streamline the licensing process; without getting into details, we both had a rather substantial delay in getting our State licenses despite our training and records to date. Similarly, I think we need to work on speeding up the process to get our in-state providers credentialed with State agencies like Medicaid.

Dean Hauptman:

Finally, with the last budget, we thank our elected official Senator Lange for helping us pass a bill that allowed faculty at the State medical schools to have access to insurance panels. We need to strengthen that bill. We are not getting traction, and we are still being blocked from entering panels. That means we lack the ability to have trained providers to train the next generation of physicians.

Dean Hauptman:

I will conclude by saying, in the photograph in the upper left, you will see four of our medical students who, in the last biennium, traveled to Carson City with us to testify. They are the best diplomats and supporters of medical education in this State, and they feel passionately about the need to grow GME. We are open to any questions you may have.

Chair Doñate:

I am going to start with my questions first. Can you go back to the fiscal priorities? Can we go through the line item of how much each you are looking for each of these programs? That would be helpful for us.

Dean Kahn:

For GME, again, the State of Texas provides, as my colleague said, $200 million for GME in their biennium; we are about one-tenth of the size, so we are asking for $20 million in the biennium.

Dean Hauptman:

I will make a point that program has been incredibly successful. It is not just picking out a number and saying that is what we want to recreate in Nevada. They have made it their goal that the number of new slots in GME exceeds the number of graduating students from all their medical schools, and they have achieved that. There are 1.1 internship slots available for every medical student who is graduating.

Dean Kahn:

We did get a bit of funding last year for academic health, about $2 million between the two schools, probably a $1.5 million for UNR and $500,000 for UNLV. That will get us the same number over the time period.

Dean Hauptman:

Regarding the Nevada Center for Patient Safety and Simulation, we are looking for seed funding on the order of $2.1 million over the biennium. We believe we will potentially qualify for some additional federal funding, and it is a great philanthropic cause, too, from our perspective.

Dean Kahn:

For increased support for student success, we are talking about $500,000.

Dean Hauptman:

For the master's degree program, each one of them has a separate line-item budget, and we would be happy to share that with the Committee.

Dean Kahn:

For increased class size, it was $9.2 million in the biennium that we would like to see recurring.

Chair Doñate:

Now we will go to questions from the Committee Members.

Assemblyman Nguyen:

I wanted to go back to the GME number comparing us to Texas: as much as I want us to compare it to them, and I have had this conversation with you before, rather than say, compared to a similar state, let us look at the program as a whole. We are behind, we all know that, and we can say that every time we talk about anything HHS related, so $20 million is a good percentage if we compare to Texas. How about we compare it to the needs we have? I know it is a bit more dire, so let us say that we are in a perfect world. What does that number look like for us to be up to par, so we can have an idea? If we want to look at things in the long run, how can we look at not just this biennium but also ten years down the road?

Dean Hauptman, I talked to you last, and it takes four years to get a program up and running, so by the time we get these funds, we are going to come back and ask for different resources. I want to get both experts here and give us an idea of what the actual number looks like if we look at Nevada by itself and not compare us to another state.

Dean Hauptman:

Let me try to answer it this way. At this point, we are projecting that we could stand up five programs by 2030: an obstetrics and gynecology (OB-GYN) residency, a rural track in family medicine, a fellowship in addiction medicine, a fellowship in cardiovascular medicine, and a residency in surgery. That will keep us quite busy between now and 2030. We have a green light to move forward, at least administratively, with an OB-GYN residency, and we are projecting a start in 2026. That timeline is short; that is a two-and-a-half-year timeline for us to get a curriculum and initial accreditation and do our recruiting, but we believe that that is feasible. The other programs would be added on from there.

The actual dollar amount depends on which program, and how large they are. As an example, the minimum number of residents in a general surgery program allowable for accreditation purposes is five. That means at full maturity, the program will have 25 residents, so that program will be very expensive compared to a one-year addiction medicine fellowship where you have two fellows a year and it does not grow year over year. Every year you can count on there being one to two fellows. It is hard to come up with a strict figure, but of course, if the Legislature is favorably inclined to more than $20 million over the biennium. We would be very supportive of that.

Dean Kahn:

For UNLV, the programs we are entertaining include anesthesiology, dermatology, ophthalmology, hematology, and medical oncology.

Assemblyman Nguyen:

What I am looking for is us to be more descriptive. You do not have to have to answer now. You can come back, and I know I am meeting with you both later on next month. Give us that perfect picture: for $20 million, you are going to get five more programs by 2030.

Dean Kahn:

We are going to get ten.

Assemblyman Nguyen:

For $40 million you are going to get 20. I do not know if the more programs we have, the less of a discount we get. I do not think it works that way, but if there is a road map for us to see in a perfect world, if we can truly cover all the specialties here in Nevada, what would that price tag be? It has to be broken down by a 10- or 20-year strategy, so if we look at multiple strategies, we can figure out what will be the best and look at it from a much more urgent perspective. If you do not have that number now, it is fine, we can continue to look at this number more, but I want to see how it looks if we have a long-term road map. That would be helpful to see if we can create more resources.

Dean Hauptman:

I would put it this way: if we did a back of the envelope calculation, the OB-GYN program, which is an intermediate-sized program—it is not as small as addiction medicine; it is not as large as general surgery at full maturity—our projection is that it would cost about $2.7 million per year to maintain. That includes resident salaries, program directors, and all the other ancillary requirements for keeping a program fully accredited and thriving. If you multiply that figure by five, that gives you some idea what that would look like for our goal of reaching five by 2030.

I do not think the onus needs to fall entirely on the State. We are pursuing philanthropic dollars and the hospitals themselves benefit by bringing these programs forward. It is a pipeline for them, and you also have individuals who can work up to 80 hours a week if needed to provide direct patient care. This is going to take a village, it is going to take multiple sources of support, and that is what Dr. Khan and I work diligently to obtain.

Chair Doñate:

I have a quick clarification. Have you had any conversations with your colleagues from other states? This can go for Dean Kahn as well. I know that other states have implemented Section 1115 Waivers of the U.S. Social Security Act to look at GME payments and the federal matching funds for GME. Is that a conversation you have had with other colleagues? Is this relevant to this conversation?

Dean Hauptman:

Could you clarify which federal mandate you are referring to?

Chair Doñate:

Some states have utilized Section 1115 Waivers through Medicaid to create different initiatives to help fund GME payments. They have used managed care as an opportunity to help expand the payment delivery for GME slots, et cetera. Have you had that conversation with other states? I am asking this question because other states use other pools of money, perhaps from fees or taxes associated with it. What other mechanisms have you seen implemented in other states to help provide that recurrent funding?

Dean Hauptman:

The timing of the question is impeccable because next week, Dr. Kahn and I will be at a Council of Deans meeting in New Mexico where all the medical school deans from the United States will congregate, and we will certainly have an opportunity to discuss this with them. In Reno, along with our hospital partner, we are looking at Medicaid uplift as an opportunity to help GME going forward.

Dean Kahn:

I think you are hinting at an all-payer system. For the past several decades, GME has fallen on the shoulders of U.S. Centers for Medicare and Medicaid Services (CMS). As was mentioned earlier, those funds were frozen by a balanced budget act that passed in 1996 and went into effect in 1997, and we were a very different State then than we are now. I do not think either Dr. Hauptman or I are very optimistic that we are going to get substantial federal funding to help. I think it must come from the states. It must come from the hospitals. Both of us are looking at philanthropic sources to start GME; and it must be all in if we are going to catch up to where we need to be as a State.

Chair Doñate:

I implore you to work with our Medicaid folks statewide to develop these ideas and initiatives. Several states have looked at this issue, so I think a collaboration could potentially exist as a bill to help mobilize and start this conversation in the near term. I will stop for now. Do we have any other questions in Southern Nevada? Seeing none, let us go to Northern Nevada.

Senator Titus:

This conversation is important throughout our State and especially to me. I have a couple of questions. First, a comment that my bill, that I brought through last year, would have solved this problem with some of this funding had it gone forward. We may need to revisit that.

You are two of the public schools here in the State of Nevada, but we also have private schools. What collaborative efforts are you doing with the private schools that are also trying to set up these residency programs?

Dean Kahn:

There is one private osteopathic school called Touro University Nevada, and the dean and I have lunch at least once a month and probably talk every other week. They do not have residency programs, nor do they have plans to start residency programs, at least through my discussion with Dean Gilliard. The other medical school is not yet accredited—that would be Roseman University of Health Sciences—and again, Dr. Gilliard, Dr. Greer from Roseman,

and I have lunch every couple of months. It is my understanding they do not plan to start residency programs either. The two public medical schools are predominantly in the residency and fellowship business.

Senator Titus:

They are going to be producing Doctor of Osteopathic Medicine and M.D., so they are going to want to have these GME slots. Along that same line of questioning, how involved were either of you in trying to save the residency program we had in Elko that closed in January 2023?

Dean Hauptman:

We were obviously very involved in that decision. That was our program, and I echo the sentiment of Director Mitchell that we are disappointed that the hospital decided to withdraw funding from the program, which left us in an untenable position of continuing the program.

We are in active discussions with two other rural hospitals that are a bit closer to Reno at this juncture to stand up a new program there. One thing we are discussing is potentially combining the rural track with a Master of Public Health degree with a concentration in rural medicine. I think there is optimism there, but I do not see a future at this juncture for standing up the program again in Elko.

Senator Titus:

That is unfortunate. How are you reaching out to the other hospitals in the area? Clearly that was a non-supportive regional hospital. Are you garnishing support in these other regional hospitals so this does not happen again?

Dean Hauptman:

We are in discussions with two hospitals. One is in the lead, if you will, in terms of their level of interest, and we have hired a consultant from the American Academy of Family Physicians to help us do a critical analysis of their readiness to stand up a program for precisely the reasons you are outlining.

Dean Kahn:

We have a rural residency program in the State in Winnemucca. It is small, but it exists, and again, I applaud my colleagues' efforts to try to expand. I think that is something our State needs.

Senator Titus:

I am aware of the application for Carson Tahoe Regional Medical Center; they are interested in starting something. Is that one of the programs you are referring to?

Dean Hauptman:

That is not one of the programs we are referring to; that would be a separate standalone program. It is my understanding that at Carson Tahoe, this is their first step into GME. They do not currently have programs.

Senator Titus:

I want to make sure that throughout the State, there are not any territorial concerns and that you as deans are welcoming other ideas for expanding GME. I bring this up to make sure what happened in Elko does not happen again. If we have other areas, other schools, or other hospitals with some of their own ideas, I hope that communication stays so that, in my mind, we are "all hands on deck" to make sure our State expands these opportunities. That is more of a comment than a question.

Dean Hauptman:

I would say that GME is an increasingly complex exercise partly because of the ever-changing accreditation environment and because of the rapid changes in medical education. We believe that our combined experience and the experience in our institutions make us leading candidates for the growth of GME in the State. That is not to say we would block anybody else from stepping forward, but we would want them to be held to the very high standard we have set for ourselves.

Vice Chair Orentlicher:

I have a couple of data questions. The comparison with Texas is helpful. Thank you for pointing that out. You mentioned that they have 1.1 residency slots for their graduates. Where are we currently?

Dean Kahn:

We have 404 CMS-funded slots for the entire State. When you compare that to California, which has over 9,000, or New York, which has 17,000; the number of spots we have is woefully inadequate. You can add to that some Veterans Affairs (VA) hospital positions. Certainly, our ratio of graduates to GME spots is less than one.

Vice Chair Orentlicher:

It sounds like you are also saying that because we have so few slots, we need to rely on recruiting physicians from outside; if we kept all our medical students, that might not be enough?

Dean Kahn:

We showed you numbers from the two State public schools. The osteopathic school graduates 181 students per year, so now you see how high our numbers are. We have approximately 0.75 residency positions per graduate. Our residents, our graduates, and our students must go out of state, and as we have mentioned, there are specialties that are not even represented in our State like dermatology, urology, and ophthalmology. We have a lot of work to do.

Dean Hauptman:

I would agree with Dr. Khan on that point. It is not just that the residency slots are available, it is also the waterfront of what students are looking to pursue in terms of their medical careers. Some want to go into family medicine, there is no question about it, but the specialties are still in high demand, and frankly it meets the demand of our patients as well. If you want to get a visit with a rheumatologist in this State, it is probably going to be a wait time of six months. That is simply unacceptable.

Chair Doñate:

Let us go back to Southern Nevada. Does anyone have questions?

Assemblywoman Brown-May:

I have a clarifying question. You talked about 404 State GME slots and the numbers of slots that we are currently utilizing; is that specific to the State schools? Does that include Touro University or other private nonprofit schools? How does that affect the number?

Dean Kahn:

Residency positions are sponsored by either a hospital or a medical school, but students from other programs come into those programs. We will find out, Dr. Hautpman and I, on Friday at nine o'clock, where our students are going. Similarly, the students at Touro—again, they do not have their own residency programs per se—will find out where they are going, and many of their students will go to each of our programs, so these are not exclusive at that level. The 404 is the number of CMS-sponsored spots allotted to our State.

Senator Nguyen:

I am going to apologize in advance for my rambling, and hopefully you can follow me. Of those 404 residency spots within our State, how many of those programs are housed within what would be the closest to public institutions?

Dean Kahn:

We can get exact numbers, but Dr. Hauptman and I estimate that about 90 percent of residents are affiliated with one of our two schools. Remember that those are the funded spots, but Mr. Van Houweling is in the audience, and he would jump to say that his hospital has more residents than they are funded for. Unfortunately, that is true for about 70 percent of academic health centers. I will get the numbers close but not exact, but he might be funded for 205 positions, but his hospital has 254 residents. There are residents who are over-capped or unfunded, but to answer your question directly, we estimate somewhere around 85 to 90 percent of the State's residency programs are affiliated with one of the State medical schools.

Senator Nguyen:

We live in a State where we cannot overlook the fact that most of the hospitals operating in this State are private hospitals, and it goes in direct relationship to our previous conversation with OSIT. Do other states have a more coordinated effort to facilitate not only GME but also workforce development specific to this health care space and these intersecting private, public, and federal dollars into coordinating a more efficient use of those limited spaces federally as well as where you are inserting dollars? Would you be open to a more statewide residency program funding model, or is this a territorial thing where everyone wants the money to go directly to them?

Dean Hauptman:

I would answer this in several ways. Quality control is extremely important. We are confident in our curricula. We are confident in the quality of the individuals on our faculty who do the teaching. At UNR Medical School, for example, we collaborate with the Veterans Administration (VA). A lot of our residents spend time at the Sierra Nevada VA Health

System, and we are confident they are getting a top-notch education there as well, but to expand a particular residency slot to multiple locations across the State is problematic, too. The residents themselves are not going to want to get in their car and travel all over the State and move their families for three or six months at a time to do rotations.

It is our position that when you are dealing with tax dollars, the public medical schools should be the primary beneficiaries. The largest purveyor of GME in the country is a for-profit hospital chain, HCA Healthcare, and they are doing that for business reasons more than anything else. We are here to educate the next generation of doctors to take care of Nevadans. That is our primary goal, and that would be the goal of our hospital partners as well.

Senator Nguyen:

Are there things that other states do to have those protections? When private hospitals operate a majority of those programs, they might be inclined to do ones that are more profitable. I do not want a bunch of ortho doctors residency programs or things that are needed as well, but also would not diversify the type of education programming. Are there protections that other states put into place to make sure we do not just get one type of residency program in private hospitals?

Dean Kahn:

In other states that fund GME, and that is not every state, I do not believe they send many dollars to for-profit entities. We are different that way. To get to your point, who is looking out to make sure the State is getting the types of residents it needs? That gets to the question that Mr. Mitchell discussed, and that the committee Dr. Hauptman and I sit on will address, but I think you are right, that absolutely needs to be coordinated Statewide. It would not make sense, for example, for Dr. Hauptman and me to both want a radiation oncology program. There is not that great of a need, and that program should live in one place or another, and right now, he has a Cancer Center. Suffice it to say the State does not have a single radiation oncology training program, and it needs one. I think that would be the role of an oversight committee, and the public entities are in a position to look out for what is best for the State.

Dean Hauptman:

We have the opposite of an embarrassment of riches in the State; depending on which discipline you are looking at, we rank 45th to 49th in terms of doctors per capita. You could almost argue that any training program can be supported and justified on that basis.

Senator Nguyen:

I can follow up offline, but you mentioned people not wanting to travel around. I believe other states have rural GME programs. Is that something that would also be considered?

Dean Hauptman:

Yes. We would like to start a new rural track in family medicine called a "one plus two" program. They will spend one year in Reno and then two years at the rural site and move themselves and their families there. What I am referring to are instances where trainees must travel to different hospitals. In fact, now in OB-GYN programs in states where abortion is illegal, those residents are finding the need to travel to different states to get training.

Senator Nguyen:

You are not necessarily opposed to having a more comprehensive Statewide funding program or formula that would benefit residency training and workforce development and all of the above.

Dean Hauptman:

In any given program, because of accreditation requirements, you need to have a sponsoring institution and be responsible for the education in that sponsoring institution. If you are thinking about an OB-GYN residency, for example, that is statewide, that will not be viable in the eyes of the accreditation body, the ACGME.

Senator Titus:

I am curious. To clarify, fellowships are also part of that discussion on GME. Is that correct? That has not been mentioned.

Dean Kahn:

Yes, fellowships are certainly part of GME, and both my colleague and I have done fellowships. We know about those, and as you know as a physician, sometimes these are all lumped together as residencies even though they are fellowships. In the common vernacular, they are sometimes combined, but yes, we are talking about both. We need expansion of fellowships as well as the primary programs.

Senator Titus:

Somebody mentioned earlier that they could not get in to see a dermatologist, or a rheumatologist, or a neurologist. To be clear, you could start your internal medicine residency, but boy, those are all then subsequent training, and subsequent fellowships, and cardiology, et cetera. I appreciate that, and when you give us the numbers about breakdown, it would be nice to see the anticipated numbers of fellowships you are looking at in addition to residency slots.

Dean Hauptman:

When we mentioned the five programs we are interested in standing up at UNR Medical School, two of them are fellowships. One of the residencies, OB-GYN, could certainly benefit from the development of a maternal fetal medicine fellowship, but you need the residency before you can stand up the fellowship, and that is an area of great need in this State as well. I think they go hand-in-hand, the development of new residencies and fellowship programs.

Chair Doñate:

Two questions have been brought to my attention that I want to make sure I ask you. In talking about other policy initiatives, we have fiscal questions that we will go through, and obviously GME is something we are always in discussion about.

Let us talk about the things that were passed last legislative session. Talk to me about the conversations you have had over medical malpractice, the cap being raised, and how that impacts the academic institutions. Can you give us your personal feedback on how your schools are dealing with it?

Dean Kahn:

I am going to let my colleague answer as well since our systems are a bit different. Our primary teaching hospital is UMC. My colleague's primary teaching hospital is Renown. The change in malpractice has affected our faculty less than practitioners in the State because we are still covered by sovereign immunity, but clearly, as we have seen in other states—and it is almost reproducible—as you raise the cap, costs for malpractice insurance go up and physicians start to leave the state. Although it does not directly affect my faculty, we need to be careful and look at this very closely because we do not want to be in the position we were in several decades ago.

Dean Hauptman:

I think it is a bit early to know what the impact has been on practitioners in the State, since the increase in the cap just occurred at the end of the last biennium or the beginning of the new fiscal year. However, it is something that we will continue to watch closely because it can impact physician behavior. As you may recall, when testimony was given at the time of the biennium, there was a lot of concern about history repeating itself. I do not think that has happened. I think the initial proposals were rather draconian, and a compromise was reached that seemed to satisfy both parties.

Chair Doñate:

Regarding finding folks who can mentor your students not just in terms of faculty, but as the extenders in the community that could be affiliated with your universities, is there an interest in revising CME requirements in the State and including mentorship as part of that? Can you talk to us about that?

Dean Kahn:

I think that is a great idea. Between our two institutions, we probably have 600 or so community faculty and they are critical to the success of our State medical schools. They teach medical students, they are involved with medical students, and we appreciate what they do. When they prepare to make rounds and they are working with medical students, if we could get CME for that experience, I think it would be both important and appropriate.

Dean Hauptman:

It is very important to us and our future that we engage our community faculty and the teaching of students. This is an area we spend a lot of time thinking about. I think there may be several creative solutions, and CME is just one of them. There may be an opportunity to provide them with tax credits or another avenue to encourage ongoing participation in teaching students.

Chair Doñate:

Are there any last-minute questions before we close out this agenda item? I know there are always so many questions. We did not get the chance to talk about student retention, making sure there are enough resources for them to go through your programs, making sure that undergraduates are supported in their efforts to become premedical students, and retaining them as part of the application process. A lot more work needs to be done, but I think it is important for us to have these discussions.

The policy recommendations you had at the end are discussions we will have throughout the day, including licensure. We had GME funding already in the morning. We will go through our process, but I think it goes to show it is historic to have both deans here presenting together. We greatly appreciate your collaboration of bringing ideas that can help steward our State forward. It is at least incredibly optimistic to see both of you here.

AGENDA ITEM X—PRESENTATION FROM NEVADA NURSING PROGRAMS ON IMPACT OF SB 375 (2023) (GRANT FUNDING FOR NURSING PROGRAMS) FUNDING AND FUTURE CONSIDERATIONS

Natalie J. Brown, Ph.D., Assistant Vice Chancellor for Workforce Development and Community Colleges, Nevada System of Higher Education (NSHE):

First, I want to brag a bit about our nursing education programs, and highlight the great work occurring in NSHE. Each program is committed to excellence with high retention rates, on-time graduations, and impressive National Council Licensure Examination pass rates. Through collaborative efforts and ongoing consultation with community agencies, graduates are well prepared to meet the evolving needs of the health care sector in Nevada. We thank you again for passing SB 375 last legislative session to grow capacity in these high-quality nursing education programs to assist in meeting the rising demand for care in Nevada. (Agenda Item X)

As you are aware, SB 375 appropriated $10 million each year of the biennium to expand undergraduate and graduate nursing programs within NSHE. After passage of SB 375, business officers within NSHE came together to determine allocations. The FY 2024 allocations are outlined here for your review. They were determined based on current enrollment levels of nursing education programs with a funding floor of $500,000 to provide an adequate level of funding to each institution. Nursing education deans and departments created proposals on how they would utilize the allocated amount to maximize program expansion. For allocations, we have started with FY 2024 and will soon reconnect with programs and business officers to review allocations for the coming fiscal year, adjusting as needed to maximize outcomes.

The chart before you outlines the FY 2024 authority by institution, total expended year-to-date, amounts obligated, and total remaining for this fiscal year. Actual funds were received by institutions in September, and recruitment of positions needed for expansion began. A few institutions have been able to hire positions, including nursing faculty and support positions, where others still have open recruitments, which in many cases is a required first step to expanding cohorts. Equipment such as high-fidelity mannequins, task trainers, simulation equipment, educational services, marketing, and recruitment materials makes up much of the other realized expenses, with plans to hire open positions and purchase needed equipment and supplies between March through June to close out this fiscal year.

This slide looks at new enrollments in nursing programs at each institution. To give you a high-level overview, FY 2023 is our baseline and approximately about 1,000 nurses were entering the different cohorts across our institutions and projected by FY 2025 were approximately 1,400 to 1,500. For instance, looking at UNR as an example, in FY 2023, they admitted 72 students per cohort with two intakes per year or 144 newly admitted students. Starting in FY 2024, they increased their intake from 72 to 96 per intake period. Some institutions will still have summer intakes during this fiscal year, so these numbers are not quite final, and others are projected to increase the amounts outlined here for FY 2025 if all

goes to plan being able to hire as needed, getting nursing board approval, and any other steps in this process.

As much of the expenses relate to program faculty and staff, we provided this information here by institution. You can see where we have hired and where there are planned or currently open recruitments. There has been difficulty filling open positions owing, in some cases, to lack of competitiveness and salary placements as well as hesitation committing to a position with an end date of June 2025.

The road map to continued success varies by each institution, but overall, the ability to maintain current staffing levels is something you will see across each of these institutions, recruiting and developing new nurse educators and support staff, and each institution has provided a brief outline of their unique plans for how they plan to achieve ongoing successive nursing expansion. You will see differences between types of institutions, different service areas, and general expansion efforts.

Continuing the nurse expansion grant program beyond FY 2025 would provide the biggest support to our nursing programs. Realizing gains from expansion efforts and increased cohorts will not be immediate. The increases are incremental as we gain expanded cohort sizes and enter new students into those cohorts. It takes a few semesters to graduate them and realize those increased graduation numbers. The entire process will take no less than two years.

Securing current funding levels to support expansion efforts is needed to ensure continued success and growth in this sector. Considering a State-funded student loan repayment program with an in-State practice requirement for faculty was one idea to entice qualified applicants into nurse educator positions as well as recruiting and hiring qualified faculty, which remains challenging.

Overall, we are extremely grateful to receive the funding and look forward to the next opportunity to provide updates. With that, I conclude my report and welcome any questions. We also have representatives available from each of our NSHE institutions for any specific questions you may have regarding an individual institution.

Chair Doñate:

Committee Members, are there questions for any of the member institutions? I know that this was a priority from our leaders of the Legislature during the last session, so I wanted to make sure they provided where they are with the current spending and all their initiatives. Are there any questions down here in Southern Nevada? Are there any in Northern Nevada?

Senator Titus:

It looks like you are doing amazing work and the money is going where we intended it to. One of the questions I frequently have is regarding young folks trying to get into the programs. Number one, that pipeline of young folks who want to go into nursing—I started out as a nurse's aide before I got into medical school. I am fully aware of the journey, but having the scholarships and loan repayment is somewhat difficult. One of the things that I was helped with was that my county paid my way through medical school so that I would go back and practice there. Reimbursement is sometimes a barrier to support during the education process. Is much or any of this money going to helping pay not just for the school itself, but for living expenses and those issues that students have during this journey?

Ms. Brown:

The SB 375 funding is not outlined for direct student support. A lot of this is for faculty, staff operations, and supplies.

Senator Titus:

We perhaps need to look at that again and make sure that some of this forward thinking is helping support and reimburse them while they are getting this education because they cannot be working when they are doing that. That would be a good discussion on how we can use this money to secure these.

My final question is, under recruitment and retention of faculty, you gave the list of all those you hired. It looks like you have been successful in hiring, and that would be the key. We frequently authorize funding, but then you cannot fill a position; for example, with the GME funding earlier today, they are still looking for somebody, but it looks like you have been successful in hiring. As a matter of fact, on that page, everybody has been hired and you are only opening a recruitment process—is that what I am seeing here?

Ms. Brown:

What you see here is for the College of Southern Nevada, for instance, they are going to the Interim Finance Committee (IFC) for approval for authority for the funds in April, so these are some of their planned openings utilizing SB 375 funds. For some of the others, I think there has been more success in the support positions. We are still having challenges hiring faculty, and it looks like I have a few of our representatives who I am sure want to speak a bit on that front.

Staci Warnert, Dean, Health Science and Behavior Health, Great Basin College:

We are fully aware that hiring qualified faculty is a challenge anywhere and it is even more challenging in rural areas. We have been successful in hiring one nursing faculty in our Elko location, but our nursing program is in Elko, Ely, Winnemucca, and Pahrump. Pahrump is our area of greatest need and where we can grow, and we are still seeking two nursing faculty in Pahrump. Those members will be essential to our ability to expand our nursing program there.

Dr. Ellsworth-Baker, previously identified:

We have had great difficulty recruiting and retaining faculty. We have a cadre of part time employees, but our core faculty of full timers was 12 prior to COVID-19, and that allowed us to have 40 students accepted per term, so 80 graduates per year if they all went through on time. We lost 10 of those 12 faculty members during COVID-19 through either early retirement or going to better paying jobs in industry, so we had 10 vacancies. Over the last four years, we have been able to fill six of those ten. We have had four ongoing vacancies since COVID-19, and even with this funding, offering another job, another vacancy with two years of funding is not attractive. We have successfully raised our baseline salaries, but that has to be done across the board for all of our faculty. This would not be enough money to raise all of those even temporarily, so recruiting and retaining faculty is an ongoing issue to grow our cohorts.

Senator Titus:

Thank you for that clarification. I know that we have had difficulty in Yerington finding a teacher for our nursing assistant program, so when I looked at this page that NSHE put together on recruitment and retention faculty, and said you hired a nursing director, five nursing faculty, and six at UNLV, I am wondering, is it true that you were able to hire all those folks? I am hearing that there are openings, but you are not able to fill what you could.

Dr. Ellsworth-Baker:

At TMCC, that is correct. We have ongoing postings. We get a few applicants and interview those applicants. Oftentimes we are not offering enough salary for them to take an offered position. We have been able to hire a nursing concierge, which is a support staff person, but we have not been able to hire any additional faculty with these funds.

Senator Titus:

I am sure Committee Members would like to see, when it talks about the recruitment or retention of faculty, you pointed out your success, but I would like to see the void. What is the real picture here? Yes, you hired that person, but you really need 20 people, and that paints a different picture than the sheet that I am looking at. I was impressed, which is why I ask these questions, so it would be nice to know. Do you see barriers that we could help with? Everybody says salary. I get that, and I know we have people who live in our communities who become traveler nurses because they make more money. I realize money is an issue, but are there others? Is there an issue with getting them licensed? Is there a process there? Do you see anything that we could do to assist you?

Imelda Reyes, DNP, MPH, FNP-BC, CPNP-PC, CNE, FAANP, Interim Dean and Associate Dean of Advanced Education, School of Nursing, UNLV:

I love that question because I think there is one issue that would address the pipeline and the barriers. One of those slides you saw showed the enrollment growth. An issue we find here within the State of Nevada is that I was able to hire the faculty I needed, and I would love to grow to 408 students per year, but one of the issues we face, and I know other facilities or schools face as well is that I do not have the clinical capacity. I must rely on clinical partners to place my students.

Currently, I am at 312 students, and it makes it difficult because within the State, we do not necessarily measure or regulate how many schools are in this area. That is a barrier. In terms of the pipeline issue, we have 900 students who enter UNLV wanting to be pre-nursing students. Again, I can meet that need of 312 to 400 per year, but it comes back to the issue of being able to clinically place them throughout their education. We are very economical in terms of the cost of their education, but I do not always have a placement for them, which is a limiting factor.

Senator Titus:

We heard earlier from the deans about the community partners, and we would certainly want to have community partners in our nursing programs, too.

Cameron Duncan, Ph.D., DNP, APRN, FNP-C, PMHNP-BC, CNE, Interim Dean, Associate Professor, Orvis School of Nursing, UNR:

I want to echo what Dean Reyes said. It is not just our nursing students, though, who are having challenges with clinical placement and being able to get into the hospital and complete the required hours of training they need. It is also our graduate students who are nurse practitioners training in many different specialties who are having a hard time with the competition of private schools and those students coming in and trying to get their rotation.

Unfortunately, within the State system, we do not have a way to compensate these preceptors or clinicians who are taking our students and training them in their clinical sites. If we could have some way to compensate them or to support them a bit more, I think it would help with the process of getting these students into these sites. Unfortunately, some of the private schools can compensate them, but as a State agency, we cannot. I am familiar with other states that offer tax credits to nurses or nurse practitioners during training; that is not an opportunity for us here, but if we can find a solution like that, it will support us growing our nurse practitioner programs and filling those primary and specialty care shortages we were talking about earlier.

Senator Titus:

I taught many a medical student, many a family practice resident, and many a nurse practitioner student, and I have never been compensated for it, but I recognize that is a real barrier. Thank you for bringing that up.

Chair Doñate:

Senator Titus, you brought up excellent points. Dean Duncan, do you happen to have an idea of how much funding you would need to help incentivize preceptors, or what the capacity of need is? I know you can speak only through your institution and maybe UNLV and the other institutions can speak on this as well.

Dr. Duncan:

That is a difficult question to answer because it depends on the region where these students are training. At our school, we have students who are training in Reno, in rural areas, and out of state, and those challenges apply in all those locations. For instance, in California, the amount that we might have to pay a preceptor is going to be different than what we might have to pay here in Nevada, and probably the same thing is true in Northern Nevada versus Southern Nevada.

Ms. Reyes:

There are lots of different models, and one of the things I want to highlight is that nursing, unlike GME, is not funded. For instance, in some cases our students are paying themselves for their clinical rotation, so they are in clinic settings and paying for that. On average, if they are paying on their own, students pay $500 to $1,000 per rotation.

I recently came from the State of Georgia, and with the tax credit they had in place there, for every 180 hours that they precepted a student, they got $1,000, and that is a clinical rotation for a semester. It makes it difficult when we do not have that mechanism that we can use here within the State.

If I were to do something like this, compared to GME, it is not quite as expensive, but I have 30 students in family, 30 students in psych mental health, for instance, who are providing that essential service, but I am only able to accept 30 students in each cohort because I do not have a clinical placement for them. From that perspective, it is about $500 to $1,000 per clinical rotation. I am more than happy to get what it would cost to be able to provide these clinical rotations, but that gives you a roundabout figure.

Dr. Duncan:

If I may add, to put this in context, we have about 200 nurse practitioner students at UNR, and they do anywhere between three and five semesters of clinical rotation, so that is at most about $5,000 per student.

Chair Doñate:

In terms of continuing education, I asked this for physicians earlier, but is that also something of interest for nurses, or have you seen other states apply some of the continued education credits like mentorship opportunities to subsidize or be a part of that conversation?

Ms. Reyes:

Yes. Our certification boards offer credit for taking a student, but it generally is not enough of an incentive for them to take the student. Here within Southern Nevada, I have other entities that are paying, so for my family nurse practitioner students, for instance, it is difficult to get them a pediatric rotation because every school other than UNLV is paying.

Chair Doñate:

I think that makes perfect sense. We must move on to our next agenda item and I apologize for not being as robust, but it might be of interest to bring you back a second time and we can follow up with you.

Our health care partners were interested in also seeing this because they are on the receiving end once the nursing students graduate, and I am glad that we have at least made some segments of applying the funding. I know it is often difficult to try to figure out how we make sure we are addressing the needs now that we have a pot of funding.

What I do not see in this presentation—perhaps it is more institutional based, and I would assume you already have these—that I would like to see, is where we are at with the funding received. You have this on your slide, but this is the need that we have not even reached yet. The easy example would be that maybe you have 10 faculty, but realistically, based on the number of students and applications you receive, you need at least 20; you have 10 preceptors, but you need at least 30. We would like to see what those gaps are and what it would take for funding for each of the institutions.

I think you already know those numbers, but you must start thinking through them so we can take into consideration that we gave you this amount of funding last time, and now we set the parameters of where you need to go within the next few years, and if you meet those goals, we will increase the funding for you so that you have a level of accountability that goes through.

I would imagine you are already doing that work, but I think if we have a strategic plan—and maybe that is something that NSHE can help coordinate over the long term and perhaps they already are—that can help us as legislators to realize the monetary value of "Okay, we are giving you funds, and now let us go do something." I would at appreciate receiving those data points before we go into the legislative session, and that could also go into BDR consideration as well.

Senator Titus:

I also want an update on the Nurse Apprentice Program because it is something we did right. During COVID-19 especially, we were able to get nursing students who needed to go out and do rotations reimbursed through the Nurse Apprentice Program. In the future, I would like an update on that and on the funding needed to continue that program because I think it is something we got right.

Chair Doñate:

As a final point, our partners in health care are always more worried about making sure that—and this came up for debate last session in terms of increasing the class size to faculty ratio—I think we need to be mindful of the gaps that we need over time, how we are closing those gaps, and if we are being competitive to other states. If the issue is being competitive towards the private programs, we have an obligation to the public education system to make sure that you have the resources you need. Let us have that discussion and then set metrics of accountability, so if you meet them, you can be rewarded for it. We are at a good place so far, at least from what I see, so I appreciate all the work that you have done.

I do not think there are any further questions, so we will now close out this agenda item. We have two more agenda items to complete, the EMS overview; and then submitted policy recommendations.

AGENDA ITEM XI—OVERVIEW OF EMERGENCY MEDICAL SERVICES WORKFORCE CHALLENGES, LICENSING ISSUES, AND FUTURE CONSIDERATIONS

Chair Doñate:

I know your presentation is robust, Ms. Sullivan, but we might want to skip through and talk about your issues with funding and challenges. Maybe we should start at slide ten. That could be helpful to move straight into the problems if we can.

Cody Phinney, Administrator, Division of Public and Behavioral Health (DPBH), DHHS:

On the Nurse Apprentice Program, if I might digress, we were the pass-through Agency for that, so we are happy to provide information and help our partners at the Board of Nursing. I am going to let Bobbie talk, and then we will be happy to answer your questions. (Agenda Item XI A) (Agenda Item XI B) (Agenda Item XI C)

Bobbie Sullivan, Program Manager, Emergency Medical Services (EMS)Program, DPBH, DHHS:

Thank you for this opportunity to provide you an overview of the EMS program. Beginning with slide ten, regarding our funding challenges, this is our current revenue source and allowable uses for that funding. Our General Fund operating is $1,059,424. We also have an

EMS for Children Grant which aids in purchase and training for pediatric related emergencies. Part of the licensing fees we collect through our applications is used to offset the cost of our tracking system used to track education opportunities of volunteers. Certification fees that we collect are turned back to smaller departments to help support training opportunities. We are in the last year of a Helmsley Charitable Trust private grant of nearly $7 million to purchase automatic external defibrillators for all the law enforcement agencies throughout the State of Nevada. That is $1,722,000 and we are ending that project at the end of October. The final line you see is Treasurer's interest distribution.

Regarding workforce challenges, not unlike anybody else, we currently have four positions filled. We have four that are vacant. One position that was a recent retirement of someone who had 20 years within our office, so we lost that institutional knowledge. With EMS staff, we do not have a data management person, so staff have had to learn how to make changes to our software data system that affects anything that is within Nevada; because this is a national program, anything that reflects our regulations we are able to do internally.

Regarding workforce challenges, staff are required to maintain certification and licensure as other professional medical practitioners including continuing education and verification of skills. Currently, staff have no opportunity for outside employment. It is considered a conflict of interest. In the past two years, candidates who have applied and been selected have declined the job offer due to the wages offered even with accelerated salary. We currently have no opportunity for growth within the office because of competition from outside agencies, and we also have a large burnout.

One of the past licensing issues that was brought forward in the last session was the delay in processing applications. We currently have a database of active providers of over 4,000 providers. We went to an online license management system in 2019, which significantly reduced the turnaround time for our applications. By the time we go through the process of the applicant submitting that application if it is an initial application, that is roughly 15 days. It does increase over what we consider our renewal cycle, but at this point, we went from months to roughly two weeks.

Another concern that was voiced about those applications was the expiration date. Under our regulations, certifications cannot be issued for more than 24 months. Currently, we are in the process of changing expiration dates to coincide with the date of birth of the applicant. We are moving away from March 31, which was creating a large influx of applications between January 1 and March 31; with the support of our Advisory Committee, we moved that to date of birth, not only to help streamline the process so we have less of a glut of applications at one time, but also to help make it easier for providers to remember when to renew their certifications.

One of the other things we were able to accomplish through assistance and guidance from our Deputy Attorney General (AG): we had held applications pending background results. We were informed that we could go straight to issue and if there was an issue with the background results, we would go towards revocation at that point.

Regarding future considerations that we have come across, in the last session, there was a voiced concern about having regional areas. Prior administration had directed staff at that time to step away from regionalization in that direct contact, forcing people to reach out to whoever you could get to answer the telephone. We are going to go back to regionalization to provide that one-on-one contact with an established person so there is less time explaining the issues on your end. Somebody already knows your area.

Ms. Phinney:

I want to point out that the EMS program is regulated statewide by DPBH through Bobbie's Bureau, but in Southern Nevada, the Southern Nevada Health District has that authority within that area. There are the two authorities across the State. When I say statewide, it is everything but Southern Nevada. As some of the discussion has been today, rather than having all the applications for renewals come in at one time, they have moved to spacing it out over the year; and also not waiting for the background checks and issuing the license and then going to revocation if there is a problem.

Ms. Sullivan:

I wanted to expand on the oversight. Ms. Phinney is correct that Southern Nevada Health District addresses the credentialing as a primary agency for the Southern Nevada Health District. This office has some level of oversight over all of the counties. Our office issues the permit numbers that coincide with our data collection system, so we have that oversight. We collect patient care reports on a redacted system into the central repository that we sent to the National Emergency Medical Information System for data collection that is sent to National Highway Transportation Safety Administration (NHTSA) to improve patient outcome in prehospital settings. There is some of that collaborative effort between our office and the Southern Nevada Health District.

Nevada joined the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA) in October of last year. We are fully implemented. There is still delay on the Southern Nevada Health District implementation, but we expect them to be on board at any time. We did notice immediately that this has made a much smoother movement of EMS personnel between the Compact states, and what the Commission and I as a member of that Commission for the Compact are working on currently is to identify the states that do not require background checks, and what that looks like from the time that you enter that other state. Do you have to get state credentialed? Currently under the Compact, you can come in and as long as you are working from a Compact state to an agency, that transition is there, but where is that loophole closed so that you have credentials within Nevada? We are working very closely with the Compact, and they have been extremely helpful in that process.

Back in 2009, the NHTSA did a statewide assessment of EMS, and you will see some of those direct quotations from that report in 2009. Unfortunately, the week that everything closed due to COVID-19, we are supposed to have a reevaluation. We are currently looking for the funding to support another statewide evaluation; so that is on our list.

On slide 18, there is an overview from the National Association of State EMS Officials showing most of the organizations of EMS offices around the State. We have a very active and supportive EMS Advisory Committee, and here are some of the implementations we have made based on guidance from them. We updated the trauma report guidelines that were in our *Nevada Administrative Code* 450B. We removed the requirement that a student must be an advanced EMT to enter a paramedic program of training. We supported updates of the pediatric skills verification that all the providers must submit when they renew their credentials, and as I explained earlier, we changed the expiration date from March 31 to the date of birth.

Based on recommendations from the Board, we recently created two subcommittees that have both met and are very energetic. One is to review the fees that are charged; currently, an initial credentialing for a provider is $54, which includes a certification of $24.30 dollars

and $30 for the ambulance attendant license. They are looking at those fees and other fee opportunities and doing a comparison of similar states. There are states that do not charge their providers, and all the fees for that come directly out of their general fund. The other committee was formed to help create a statewide set of protocols. The last issued statewide set of protocols was in 2003, so the larger organizations are helping to build that foundation of statewide protocols so we can bring agencies more on board with similar practices. With that, I would be happy to take questions.

Chair Doñate:

I apologize for skipping a few slides, and I would encourage Committee Members to meet with them privately if you have not interacted with our State EMS office or DPBH. I think they have robust information on things that they do behind the scenes, and as Ms. Sullivan mentioned, it is interesting because Southern Nevada often operates differently than the rest of the State, but we are here to talk about the gaps and try to perhaps update or streamline what we are seeing statewide.

Assemblywoman Brown-May:

I have a question relative to the NHTSA recommendation. You noted, on slide 17, the recommendation is for an updated assessment. It looks like our last one was done in 2009. Are you currently working with anyone to put that in motion? Is it federally funded with relief dollars we have in this State? Is there any way to get that moving?

Ms. Sullivan:

We are looking at multiple opportunities to fund this evaluation. We are working with our direct partner at NHTSA and hoping to decide that and secure those funds probably by the end of the year.

Assemblywoman Brown-May:

To clarify, do you have an estimated cost for how much that study costs?

Ms. Sullivan:

Roughly $75,000.

Chair Doñate:

As a follow up comment, I had the opportunity to meet with a lot of our EMS folks throughout the State, in Northern Nevada, Southern Nevada, and rural Nevada. There is a discussion that perhaps we need to provide more support for Ms. Sullivan and your team in elevating the positions that we have. I know other states have a model of having a State EMS office under HHS. We had this conversation last time, and we are trying to figure out how we can provide resources so we can process licenses faster and work in different jurisdictions. You mentioned the approach of regionalization, and I think we must find a model that works. It would be interesting to review. I know you submitted the exhibit of things that we should have done in 2009, but we still have not enacted yet, so hopefully we can put that together in a BDR soon.

I will now close this agenda item. We will circle back when it comes to reviewing BDRs, but I would encourage Committee Members to read the report because there are a lot of things

our State needs to do, but we have not had the chance to do yet. I appreciate the folks from DPBH for being here and for all that you do for our State.

We will now move on to Item XII, submitted policy recommendations to be reviewed by the Committee.

AGENDA ITEM XII—SUBMITTED POLICY RECOMMENDATIONS TO BE REVIEWED BY THE JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

Chair Doñate:

Now that we have approached the end of the meeting, the structure that I want to have for each of the meetings throughout the interim is, during the first one we laid out that if you are able to submit the survey, a list of policy considerations and NRS changes you could add on to this agenda item.

So far, we have only received that from one group, so I would like to invite the Biomarker Coalition to proceed. We have a few folks who are ready to present online, so you can give us a broad overview of the policy you are looking to have the Committee sponsor, and then we can move on to questions.

Zach Hardy, State Government Relations Officer, Michael J Fox Foundation for Parkinson's Research:

Thank you for the opportunity to testify before the Committee on policy recommendations related to coverage for biomarker testing. Founded in 2000, the Michael J. Fox Foundation for Parkinson's Research has been singularly dedicated to finding a cure for Parkinson's Disease through an aggressively funded research agenda, and to ensuring the development of improved therapies for those living with Parkinson's today. To date, the Foundation has funded nearly $2 billion in research programs worldwide (Agenda Item XII A) (Agenda Item XII B) (Agenda Item XII C).

Assembly Bill 155, which passed the Legislature last year, requires health insurance policies to include coverage for biomarker testing as it relates to the diagnosis and treatment of cancer. Biomarker testing is a crucial step in accessing precision medicine, including targeted therapies that can lead to improved survivorship and better quality of life for patients.

While most current applications for biomarker testing are in oncology, there is research underway to benefit patients in other areas, including neurological conditions such as Parkinson's Disease. For example, this past April, the Foundation announced that through our ongoing work of our landmark clinical study, the Parkinson's Progression Markers Initiative (PPMI), a new biomarker was identified for Parkinson's Disease. This breakthrough was published in the scientific journal *The Lancet Neurology* and opens a new chapter for research with the promise of a future where every person living with Parkinson's can expect improved care and treatments, and newly diagnosed individuals may never advance to full-blown symptoms.

The Foundation recognizes the importance of biomarker testing, and how it will soon broadly benefit our community. There are estimated to be more than 1 million Americans currently living with Parkinson's Disease with about 90,000 more diagnosed each year

according to the Centers for Disease Control and Prevention. Parkinson's Disease is the second most common and the fastest growing neurological disorder worldwide.

In Nevada, there are an estimated 10,000 people currently living with Parkinson's with direct and indirect costs to care for these individuals estimated to be $484 million annually. We believe these statistics on both prevalence and economic burden to be an undercount.

It is crucial that non-oncology applications be included in the State requirement for insurers to provide coverage for biomarker testing. In the last two years, over a dozen states have taken legislative action that requires insurers to cover biomarker testing while including language that makes this requirement disease agnostic. Biomarker testing has the potential to revolutionize the way people are diagnosed with Parkinson's and how people who are living with the disease are treated.

As the Foundation's own recent biomarker breakthrough demonstrates, advancements can happen at any time, and it is important that patients have access to biomarker testing as an important tool in their health care as soon as new tests become available. On behalf of the Foundation and the community we support, I thank the Committee for the time and the chance to discuss this important topic. I am happy to answer any questions.

Chair Doñate:

To clarify, you do not have any other presenters. Is it only you on behalf of the proposal?

Mr. Hardy:

I think it is just me. We have worked closely with the American Cancer Society as well, and as I stated in my testimony, AB 155, that passed last year, does focus on oncology and cancer patients, while we believe there are many other areas that can benefit from biomarker testing and insurance coverage of biomarker testing.

Chair Doñate:

Committee Members, again, as community members send us policy recommendations, if they meet the requirements that we are asking of them, that would be the time to start reviewing it. We can put up this for consideration in a BDR later, but this would be the time that you can gauge and see if this proposal makes sense, provide feedback, et cetera.

Let me start first with a question: in the bill proposal that was submitted, one of the striking things I saw was that you are removing and striking the language of "medically necessary." Why would you do that? What is the rationale behind that?

Mr. Hardy:

The preferred language when it comes to discussing when biomarker testing should be covered by health insurance companies is "medically appropriate." It may sound incredibly close to "medically necessary," but because of the ever-changing research and development of these biomarker tests, there are different ways that these tests make it to market. Not all of them, for example, go through a U.S. Food and Drug Administration (FDA) approval or clearing process, and there are certain instances where that can be used against a biomarker test.

While it may be beneficial to a patient or a community, it may not be cleared because it does not follow the dynamics of a "medically necessary" definition, whereas "medically

appropriate" is determined by a doctor and can move forward to have a patient have access to a test that could reveal information related to specifics about the disease that they may have, whether it be cancer, Parkinson's, amyotrophic lateral sclerosis (ALS), or other neurological disorders.

That can unlock more knowledge between the patient and the doctor about how they go about their treatment, what specific treatment they may need, and it may allow the patient to not have to go through certain treatments that may not be the best for their specific type of cancer or the specific disease they may have. That is the difference between those two definitions; we have used medically appropriate in other state bills, so that is one reason why there is the difference between those two terms and why we use "medically appropriate" whenever we can in legislation across the country.

Chair Doñate:

How many states have passed this expansion? I know that we did the biomarker bill for cancer and now you are proposing to expand that to other diseases. How many states have passed that? I am assuming based on my own research that it has been only recently, so how many states are we at now?

Mr. Hardy:

We are at over a dozen states now—I believe there are 13 total. Yes, you are correct to note that we have seen a push within the last two years in state legislatures, but there have been over a dozen that have gone ahead with this legislation, and have also included language that makes it disease agnostic so that it is not just for cancer and oncology. I can clarify that and get that to you and your staff.

Chair Doñate:

Regarding the biomarkers that you are looking to cover, are they FDA cleared, or FDA approved?

Mr. Hardy:

With Parkinson's, several have already been developed and are at different stages of approval through the FDA. For instance, the one that I mentioned through my testimony that came through our PPMI, that was discovered last year. There is a process that must happen to make that test commercially and more widely available, so for that test in particular, it still may be another year or two until it is more widely available.

The purpose of having these bills cover areas like Parkinson's now is so when more tests come online, it is not the case that we have to return to a legislature and say, can we move outside of the oncology field and have other neurological conditions or spaces in health care covered by the same rules that now are covered in Nevada for oncology.

Chair Doñate:

I will make a quick comment, and then let other Committee members speak. Here is my interpretation of what biomarkers are—and I wanted to have this dialogue because I think the description of biomarker is magnitude in itself, and there is quite a difference between FDA cleared and FDA approved.

With biomarkers, as I mentioned, there has been an initiative in states all throughout the country, and this is a recent initiative. I expressed my hesitation last time when we had this biomarker bill that there are influences that could occur when you mandate things by law, and there is always the discussion of coverage and payment to ensure that if we do mandate things by law, someone must pick up the bill at some point. I think that is very clear when we talk about in anything with dealing with treatment.

My main concern with any biomarker expansion is that if I was an owner of a biomarker company—and again, biomarker is a vast term that has been changing over time—if I was the owner of a biomarker company and Nevada passed a law that mandated biomarker coverage for a disease as we just did, the first thing that I would do as owner of the company would be to send and hire as many representatives as I could to talk to all the physicians in the State. I would work to ensure that every physician knew that was the priority. There is nothing in law stopping them from receiving gifts, or transactions, or trips and learning about this product, and then I would send a notification to the insurance company saying they have to mandate this by law. If the cost of the biomarker was $500 before, I would obviously increase that, because there is nothing stopping me from doing so.

These are all considerations when we start to mandate things by law, because in certain instances, there could be unintended consequences, and I do not want patients feeling a false sense of hope when the science may not always be there. If there are technologies that are coming into the market, we should do our best to help engage our patients to receive the care they need, but it might not be successful, and we must be careful when we do expansions because there could be unintended consequences like the encounter that I illustrated. Maybe there are other comments from other Committee Members on this policy expansion.

Assemblyman Gray:

Thank you for bringing this back. I like it. I am not a big fan of mandating anything, but you hit the nail on the head when you said that it will help target treatment, and if we are able to better target treatment, we reduce the shotgun approach where you are trying different treatments, putting the patient through hell, going from one course to another course. If you can narrow it down, it would be a whole lot easier and have a better idea of what you are trying to attack, I think it has already been proven in a lot of cases that there are better health outcomes. There may be huge potential here to save a lot of money going forward. This is worth the Committee's time to look more into and consider.

Assemblywoman Brown-May:

I have a clarifying question, but first, a moment of personal privilege if you do not mind. The reason that I am here today as a member of the Assembly is because of my personal mentor, and he is a full-time caregiver for his wife of 45 years who has Parkinson's and has gone through many trial treatments and lots of special insurance considerations. It is important that we have access to good quality medical data. I am curious to know if you can further put on the record the other conditions or diagnoses that would be relevant to this type of biomarker testing. You talked a bit about Parkinson's and ALS, but are there others? What is data turning out as to the efficacy of this treatment and the positive outcomes? Is there anything to support that position?

Mr. Hardy:

I represent the Michael J. Fox Foundation for Parkinson's Research, so from where I sit, I can speak about the Parkinson's community and their experience, particularly with their path to diagnosis. I will note that with Parkinson's and so many other neurological conditions like Multiple Sclerosis or ALS, the journey to get to a final diagnosis can sometimes take years, and there is not necessarily—certainly for Parkinson's—one specific test that leads you to that diagnosis. When we look at biomarkers and the idea of biomarker testing as it pertains to Parkinson's Disease, that is where we see so much potential with, for instance, the biomarker that I spoke about in my testimony.

I am not a researcher, but in discussing biomarker testing all across the country, I have learned a lot about the tool and where can be used. For the tool that I was talking about in my testimony, it is called alpha-synuclein, which is the Parkinson's protein, and through our initial studies, it showed that 93 percent of people with Parkinson's who participated were proven to have an abnormal alpha-synuclein. That means 93 percent of people had that biomarker indicating Parkinson's, whether they had not yet been diagnosed but could be later, or if they did have Parkinson's disease. It accurately identified through that alpha-synuclein abnormality that they did have the disease. That is specific data on that one biomarker test that I was referring to that came from our long-term clinical study.

But yes, there are plenty of neurological disorders in a similar space as Parkinson's. Biomarker testing has been a game changer for the oncology space and has led to a lot of patients and their medical professionals, that they work with, being able to retool what their treatment plan looks like based on the results of biomarker testing. Our goal is to have biomarker tests for Parkinson's Disease continue to evolve through continued research, and with the biomarker I specifically mentioned, there is more work to be done in that space.

There are other neurological conditions that have biomarkers currently available that are also benefiting from those state laws across the country that have expanded beyond oncology and have insurers now required to cover these biomarker tests. When people get that devastating diagnosis and are sitting there with their doctors, they can use biomarker testing to drill down and save time and costs on treatments to say, "This is the correct path that we should go down," in terms of how to tackle your cancer diagnosis, your Parkinson's Disease, or other neurological conditions.

In summary, yes, there are certainly other areas that benefit from biomarkers including Parkinson's, but there are other coalitions and spaces that work alongside this issue of advocating for broad expansion of access to biomarker testing. I would be happy to talk with those groups to get you and your office additional information. I am here to represent the Parkinson's community, but it is certainly fair to say that there are many other disease states that can benefit from biomarker testing today with additional research in the future to expand that even further.

Assemblywoman Brown-May:

One quick follow up: the way this NRS is currently written does not currently apply to Parkinson's; it is specific to cancer. Is that correct?

Mr. Hardy:

That is correct.

Vice Chair Orentlicher:

As you point out, the Parkinson's biomarker is new, so I am curious: as Assemblywoman Brown-May pointed out, and you have discussed other conditions, we have a long track record with Huntington's Disease testing. Do you know anything about the track record of insurers in covering Huntington's Disease testing? To what extent has that been a problem?

Mr. Hardy:

I do not have information on that specifically in front of me, but I am happy to get back to you and your office with more background and history on that. In general, not to speak to the history of a biomarker specifically there, but in terms of this idea of coverage and bringing it into the conversation of how patients can access biomarker testing, this has been a broader conversation over the last several years in legislatures across the country because there has been such a groundswell of seeing what biomarker testing has done in the oncology space and trying to replicate that for other neurological conditions and other disease states across the spectrum.

It is important to follow the data and the science, and make sure these tests are ready to provide reliable results, but as that happens, that coverage requirement is what patients—certainly in the Parkinson's community, but I would assume elsewhere—are looking to have. As I said, when you are faced with these developments and diagnoses as a patient, whatever you can do to help guide that decision of what to do next with your physicians is what is most important. Specific to your question, I can certainly look at that and try to get more information on the history there, but I would say largely, for many different conditions and disease states, this has been a much more recent development of trying to have a broader conversation about what should be covered and try to make it as disease agnostic as possible so the most people can benefit from this kind of testing.

Senator Nguyen:

We are talking about these biomarker testing, and I love the idea that we can target using science and this technology to potentially save lives or target treatment in a more like evidence-based scientific way. On the flip side, I know that we use the term "biomarker testing" generally to include lots of different types of testing. To your knowledge, are there certain diseases where these biomarkers have been more effective? I appreciate the fact that we passed this bill to study this, and I know they are going through the process of looking to see what the actual cost savings might be so we can have those concrete numbers. But do you know if there is the same effectiveness of these tests throughout, or if there are certain diseases where these tests are more accurate at determining treatment?

Mr. Hardy:

I may not be able to speak to the full totality and history of all biomarker tests for different disease states, but from where I sit, in terms of the Parkinson's community and coalitions looking at this issue and patients from across the spectrum of different disease states and how we can benefit from biomarker testing is yes.

Not to give too many specifics, because I do not have that information in front of me, but generally the space of oncology and cancer treatment has benefited by far the most from biomarker testing. Certain autoimmune diseases have benefitted as well in recent years, but again, the expansion in the research that is underway in other areas, including Parkinson's, is what is spurring this moment to ask where this can fit in a patient's health care plan and what their treatment is going to look like.

Thankfully and luckily, that research is underway across the board, and I wish I could speak to a whole host of different areas on this topic, but what I know in terms of the Parkinson's space is there have been certain biomarkers identified in the past. There was a great breakthrough last year with the PPMI and the biomarker identified there that shows the promise of this technology and science. I wish I was a researcher so that I could speak more eloquently to the specific nature of these tests, but they can open the doors in terms of how to shape treatment, save costs related to treatment, and not have to go down the rabbit hole of attempting different ways of tackling diseases people are afflicted with. That is what the conversation is all about.

Again, I am taking all of this from all members in terms of the different questions and certainly happy to follow up with others who are involved and able to speak to certain disease states and drill down on more of those specifics of where biomarker testing has been more successful as of today.

Senator Nguyen:

You said there are 13 states that mandate the biomarker testing. Are they limited to oncology? Are they open-ended, or are they different depending on the state?

Mr. Hardy:

Out of those states, I can say that most of them are disease agnostic, so they go beyond oncology and cancer, but it certainly is a state-by-state basis. Each bill that has been presented may have been written differently or narrower in scope, but most of the bills that have passed go beyond limiting the scope of the coverage to oncology and cancer.

Senator Nguyen:

Do you know if any of those states collect data on the cost savings of providing or mandating that kind of testing, or how much that is saving the state or even those providers in the long term? If they do, if you might be able to help provide that information on the act.

Mr. Hardy:

We can look at that. As I said, for those 13 or so states, most of those bills were either introduced and passed in 2023, or even this year and have passed in the last few months. I do believe that some are tracking the cost savings related to this, so I can certainly follow up with information that may be available from the earlier states that have brought this legislation forward and share with the Committee.

Chair Doñate:

Are there any last-minute questions before we close out this agenda item? I do not see any. I think it is important to have this discussion. You mentioned that other states are looking at it, and I think many of the Committee Members appreciate the opportunity to have these

discussions before we go into the next legislative session because of the nature of looking at patient care and access and making sure that patients receive treatment. We also want to make sure that it is a fair assessment of treatment, so I appreciate your presentation and submission of the policy recommendation. We will close out this agenda item and move on to our last agenda item, which is public comment.

AGENDA ITEM XIII—PUBLIC COMMENT

Chair Doñate:

Is there anyone who would like to provide public comment in Southern Nevada? Seeing none, let us move to Northern Nevada. We will start there, and then we will go to online.

Benjamin Challinor, Nevada Director of Public Policy, Alzheimer's Association:

For Alzheimer's, based on a 2018 analysis, there was a projected cost savings of approximately $63,000 per person, of which $30,000 was Medicare, $20,000 was Medicaid savings, and $13,000 was for other savings in terms of early diagnosis and biomarker testing.

Oftentimes we think of biomarker testing as blood samples, but it also includes Computed Tomography imaging and anything that we can make sure that we are able to identify these specific biomarkers. With Alzheimer's, because the only way we could get that diagnosis right now is through a cognitive assessment, sometimes by the time they are showing cognitive decline, it is already too late to get folks into treatment. If we can get these biomarkers tests approved specifically for Alzheimer's and other types of dementia, we can diagnose folks up to two years sooner, but we want to make sure it is approved for all diseases.

Chair Doñate:

Is there anyone else in Northern Nevada? Seeing none, BPS, let us go virtually.

Dennis Nolan, Clinical Coordinator, EMS Program, TMCC:

I retired last year as the EMS Division Chief for the Reno Fire Department, and prior to that, I spent nearly 30 years in Southern Nevada in EMS and the fire service. I wish to show my support for the need for adequate funding for the Nevada EMS Program and the necessary change of its status from program to a bureau. These changes are needed to support Nevada's ability to provide efficient, effective emergency medical services. (Agenda Item XIII A)

The program was created in NRS in 1973, when there were fewer than 100 EMS providers and now, they deal with tens of thousands of EMS providers and agencies in licensing and certifications. If you review the National Registry of EMT's website that shows state status, most states, including our neighboring states of Idaho, Utah, and Arizona, have EMS Bureaus with division sections and offices populating the majority of the remaining. For decades, the program has been underfunded, understaffed, and under supported. As a result, often the staff—who I found to be hardworking and loyal State employees—struggle to efficiently execute their mission.

The effect on the fire departments, private and volunteer ambulances, EMS providers, and educational institutions like TMCC and Western Nevada College who are responsible for training EMS students is service which interferes with or delays these various organization operations.

One item that could relieve unnecessary and burdensome workload of the State EMS staff and which could be affected simply through a letter of intent from the Legislature or Committee is the requirement for EMT and advanced emergency medical technicians (AEMT) students to have to provide apply for the same provisional licensing that all professional people do to do a one-time training ride along. The State requires this now.

Chair Doñate:

Mr. Nolan, if you can please wrap up your comments.

Mr. Nolan:

I will provide a written summary of my comments. I know some of my colleagues had provided testimony earlier this morning. We need to work to support the EMS Division and update it to the 21st century, and there are suggestions in my letter to do that.

Chair Doñate:

Are there any more callers who wish to provide public comment?

BPS:

You have no more callers wishing to participate at this time.

The following individuals submitted written public comment:

- Rebeka Acosta, A+J Patient Advocacy (Agenda Item XIII B)
- Chelsea Bishop, Act4Kids Nevada (Agenda Item XIII C)
- Stacie Sasso, Health Services Coalition (Agenda Item XIII D)

Chair Doñate:

We will close public comment. Are there any other comments from Committee Members? Seeing none, we will close out this meeting. We will see everyone for our April meeting. That discussion will be solely focused on public health since it will be Public Health Day or Public Health Week. We are excited, and if there are any Residents watching, congratulations on matching this week. We are excited to hopefully keep you in Nevada.

AGENDA ITEM XIV—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 3:54 p.m.

Respectfully submitted,

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Sarah Baker
Research Policy Assistant

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Davis H. Florence
Senior Policy Analyst

APPROVED BY:

_____

Senator Fabian Doñate, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II A	Cindy Green, Emergency Management Services Chief, Reno Fire Department	Written Public Comment
Agenda Item II B	Kent Ervin, Nevada Faculty Alliance	Written Public Comment
Agenda Item II C	Adam Zarrin, Director of State Government Affairs, Leukemia and Lymphoma Society	Written Public Comment
Agenda Item IV A	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB)	LCB File R072-22 of the Board of Dental Examiners
Agenda Item IV B	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R125-23P of the Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors
Agenda Item IV C	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division	LCB File R068-23 of the Board of Medical Examiners
Agenda Item IV D	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R095-23 of the Board of Psychological Examiners
Agenda Item IV E	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R108-23 of the Speech Language Pathology, Audiology and Hearing Aid Dispensing Board
Agenda Item V	Brian L. Mitchell, Director, Governor's Office of Science, Innovation, and Technology	PowerPoint Presentation This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item VI	Kelsie George, Policy Specialist, National Conference of State Legislatures (NCSL) Kelly Hughes, Associate Director, Health Program, NCSL	PowerPoint Presentation
Agenda Item VII A	Jesus Vidueira, President, Culinary Health Fund	PowerPoint Presentation
Agenda Item VII B	Jane Sheehan, Deputy Senior Director of Government Relations, FamiliesUSA Jen Taylor, Senior Director of Federal Relations, FamiliesUSA Aaron Plotke, Senior Policy Analyst, FamiliesUSA	PowerPoint Presentation
Agenda Item VIII	Sarah A. Bradley, J.D., MBA, Deputy Executive Director, Nevada State Board of Medical Examiners (NSBME) Nick M. Spirtos, M.D., F.A.C.O.G., Board President, NSBME Kory Linn, Chief of Licensing, NSBME Tom Clark, Owner, Tom Clark Solutions	PowerPoint Presentation
Agenda Item IX A	Paul J. Hauptman, M.D., Dean, University of Nevada, Reno (UNR) School of Medicine and Chief Academic Officers for Renown Health Marc J. Kahn, M.D. Dean of the Kirk Kerkorian School of Medicine Vice President for Health Affairs, University of Nevada, Las Vegas (UNLV)	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item IX B	Paul J. Hauptman, M.D., Dean, UNR School of Medicine and Chief Academic Officers for Renown Health Marc J. Kahn, M.D. Dean of the Kirk Kerkorian School of Medicine Vice President for Health Affairs, UNLV	Fact Sheet—Academic Health for a Healthy Nevada
Agenda Item X	Natalie J. Brown, Ph.D., Assistant Vice Chancellor for Workforce Development and Community Colleges, Nevada System of Higher Education	PowerPoint Presentation
Agenda Item XI A	Bobbie Sullivan, Program Manager, EMS Program, Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS) Kyle Devine, Deputy Administrator, DPBH, DHHS	PowerPoint Presentation
Agenda Item XI B	Bobbie Sullivan, Program Manager, EMS Program, DPBH, DHHS Kyle Devine, Deputy Administrator, DPBH, DHHS	A Reassessment of Emergency Medical Services Report
Agenda Item XI C	Bobbie Sullivan, Program Manager, EMS Program, DPBH, DHHS Kyle Devine, Deputy Administrator, DPBH, DHHS	Survey Analysis of EMS Office Structure and Functions
Agenda Item XII A	Zach Hardy, State Government Relations Officer, Michael J Fox Foundation for Parkinson's Research	Biomarker Policy Proposal

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item XII B	Zach Hardy, State Government Relations Officer, Michael J Fox Foundation for Parkinson's Research	Biomarker Testing and Cost Savings
Agenda Item XII C	Zach Hardy, State Government Relations Officer, Michael J Fox Foundation for Parkinson's Research	Biomarker Testing: Beyond Oncology
Agenda Item XIII A	Dennis Nolan, Clinical Coordinator, EMS Program, Truckee Meadows Community College	Written Public Comment
Agenda Item XIII B	Rebeka Acosta, A+J Patient Advocacy	Written Public Comment
Agenda Item XIII C	Chelsea Bishop, Act4Kids Nevada	Written Public Comment
Agenda Item XIII D	Stacie Sasso, Health Services Coalition	Written Public Comment