NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

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

MINUTES

January 6, 2026

The first meeting of the Joint Interim Standing Committee on Health and Human Services (JISC HHS) for the 2025–2026 Interim was held on Tuesday, January 6, 2026, at 9 a.m. in Room 165, Nevada Legislature Office Building, 7230 Amigo Street, Las Vegas, Nevada. The meeting was videoconferenced to Room 3137, Legislative Building, 401 South Carson Street, Carson City, Nevada.

The agenda, minutes, meeting materials, and video recording of the meeting are available on the Joint Interim Standing Committee's meeting page. The 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:

Assemblymember Tracy Brown-May, Chair
Senator Fabian Doñate, Vice Chair
Senator Roberta Lange
Assemblymember Rebecca Edgeworth
Assemblymember Brian Hibbetts
Assemblymember Hanadi Nadeem

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Robin L. Titus
Assemblymember Heather Goulding

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Davis H. Florence, Senior Policy Analyst, Research Division
Anthony Ciaramella, Senior Policy Analyst, Research Division
Jen Jacobsen, Research Policy Assistant, Research Division
Serina Hale, Research Policy Assistant, Research Division
Eric Robbins, Senior Principal Deputy Legislative Counsel, Legal Division
David Nauss, Senior Deputy Legislative Counsel, Legal Division
Karl Kahambwe, Deputy Legislative Counsel, Legal 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 AND INTRODUCTIONS OF MEMBERS AND STAFF

[Roll was taken.]

Chair Brown-May:

First, welcome to the first meeting of the interim for this Committee. A couple of housekeeping items as we begin. First, I want to remind everyone to please silence your electronic devices. Mine was just singing to me a minute ago. Committee members will be utilizing laptops and other electronic communication means to make sure that we are following along with presentations. Please do not take that as a sign of disrespect. Our agenda is posted. Agenda items may be taken out of order as we will proceed naturally throughout the course of the day. Additionally, two agenda items may be taken together. Please make sure you silence your electronic devices at this point. Agenda items may be taken out of order or combined. Committee materials can be found on the website. If you want to testify in person, please sign in at the table by the door. If you do not, you can also sign in and you do not have to testify. Make sure you turn your microphone on when you do come up to testify.

We will now continue with our introductions. I would like to take a few minutes to introduce this interim Committee to the members of the public, and to each other, as we have a number of new staff members that have joined us.

We are going to start with Vice Chair, Senator Doñate. Would you tell us a little bit about your background, the district that you serve, and a history of serving on this Committee?

Vice Chair Doñate:

Good morning, everyone. I proudly represent Senate District 10, which is in the central Las Vegas region. I have served on this Committee for several years now—I was appointed in 2021, elected in 2022, and I have served as Chair on the Senate side since 2023. I am so very honoured to get to serve on this Committee.

Senator Lange:

Good morning. I represent Senate District 7 in Las Vegas, and I have served on HHS [Health and Human Services] for many years in the session committee and interim committee. Thank you for having me on.

Senator Titus:

First and foremost, thank you for allowing me to be on this Committee. I look forward to working with all the other members, and throughout the state with people on concern—we have opportunities to solve some big issues here in the state on health care. I am from Senate District 17. I am proud that I am the only physician in the Senate and hoping someday that will change; health care is critical. I represent six rural Nevada Counties. Although I do not see patients on a day-to-day basis—still make house calls. Still have on my phone, if you ever call my personal phone, you will say, if this is an emergency, please dial 911, because people still call me. I am still the Lyon County health officer, so I am still practicing, and I work for Lyon County School District. Health care is key for me; access to

care is really the term I use. We can all agree that everybody needs to have access to health care, it is how we get there and who pays for it, is one of the discussions that we will be talking about here on this Committee. Chair, looking forward to working with everybody.

Assemblymember Goulding:

Good morning. I represent Assembly District 27, which is on the north side of Reno. I served on the HHS Committee, the Assembly HHS Committee during my first session here a year ago. I am delighted to be here during the interim. Thank you very much, Chair.

Assemblymember Nadeem:

I represent Assembly District 34. I am honoured to be in this Committee, and my passion is to make health care more accessible and affordable for my fellow new audience. Thank you.

Assemblymember Edgeworth:

Good morning. Thank you so much for letting me be on this Committee; I am very excited. I was on HHS Committee during my first session that just wrapped up, a year ago—I guess. I represent Assembly District 35, which is down in Southwest Vegas, down in Southern Highlands. I am the only practicing physician in the Assembly, so there are two physicians. I am very excited, and I totally agree that we should have more medical things, because medical concerns are a very high priority for our state. I work as not only a physician, but I also am a professor at a university teaching the next generation, and I work with a lot of underserved populations. I too am very excited about helping get access to quality health care for all Nevadans.

Assemblymember Hibbets:

Assembly Disrict 13, northwest portion of Las Vegas. I served on the HHS Committee in both 2023 and 2025 Sessions, and in the interim committee last interim. Thank you.

Chair Bown-May:

Thank you, and I am honoured to serve as Chair of the JISC HHS. I represent Assembly District 42, and I have spent the last two decades working on the human services side of health and human services in support of our disability population throughout Las Vegas. Like the Senator, I was appointed in 2021, and I am honoured to continue to serve in this role.

As we move forward, we are going to hear now from the many staff members that support this Committee, because while we are elected as members and represent our constituents, we certainly cannot do this alone. It does take a number of very talented staff members to make sure that we are able to proceed. We are going to start with our Legal Division.

Mr. Robbins:

I have staffed this Committee since 2014, and I have staffed Senate HHS since 2015, and I am excited for the Committee.

Mr. Nauss:

I have been working on HHS for the past four years. I have been on the Assembly HHS for the past two sessions, worked on the Senior, Veterans and Adults with Special Needs Interim Committee, last interim, and excited to be helping to staff this Committee this year. I also am Counsel for the Nevada Youth Legislature; excited to be here and to help this Committee as it works to make health care better in the State of Nevada. Thank you.

Mr. Kahambwe:

Good morning. This is my first time staffing this Committee, but I am very happy to be here and looking forward to contributing to this Committee's work. Thank you.

Mr. Florence:

Good morning. I have been with the LCB for about three years, and this is my second time with this Committee, I most recently staffed the Assembly HHS with our Chair. Thank you.

Mr. Ciaramella:

This is my first interim committee and happy to be here, thank you.

Chair Brown-May:

Additionally, I want to call out the assistance that we received from a number of our Committee Secretaries: Serina Hale, Christina Harper; John Kucera from the Fiscal Analysis Division. As well as staff from General Services, our Audio Visual and Hearings team (AVH), thank you so much for all that you do, and for helping us to be successful as we work through the interim.

AGENDA ITEM II—PUBLIC COMMENT

Chair Brown-May:

With that, I would like to move into our public comment period. Public comment is Item II and on our agenda; public comment will be limited to two minutes per speaker, staff will time the two minutes. If you are interested in offering public comment, please come forward up here in Las Vegas as we well as in Carson City.

Sue Burtch, Executive Director, Nevada Chapter of the National Organization for Women (NOW):

Good morning, Chair, and members of the the Joint Committee. Today, I am representing NOW, and a coalition of women of all ages, and backgrounds, and from other organizations, and we want improvements to reproductive health care in this state; something we are calling a "Reproductive Health Care Bill of Rights".

This is our rough draft, yeah, I know. We manage our reproductive health for more than half our lifetimes, our periods, our fertility, and finally those dreaded hot flashes. But, what about all the other issues: endometriosis, risk of heart disease, strokes, et cetera? It is all connected. We know we will be asking for a considerable investment, one that will improve education, research, and training. But, we also know that the dividends will be substantial. Yes, we have made some improvements, and yes, we elected the first female majority

Legislature in the country. So, why do we consistently rank near the bottom for women's health care? We are tired, tired of being told to suck it up, tired of being told our symptoms are all in our heads. We are tired of bandaids on our symptoms. We are half the population. We deserve the investment, and I thank you for your time, and Happy New Year.

Steven Cohen, Member of the Public:

Good morning, Madam Chair, and members of the Committee, I would defer to the written remarks I submitted, which may have just been submitted to staff. Thank you. (Agenda Item II A)

Chair Brown-May:

Thank you, Mr. Cohen.

I do want to go ahead and get on the record, the telephone number to call in, if you are interested in calling in. If you would like to call to provide telephonic testimony, please dial (888) 475-4499, and then when prompted to provide the meeting ID, enter 891 2994 9350 then press the # sign when prompted. With that, we will go ahead and move up to Carson City. You may begin when you are ready.

Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities:

Hi, good morning, Chair Brown-May and members of this Committee. Thank you for allowing us to provide a public comment today. I am speaking briefly to highlight the written testimony that we have submitted for the record regarding emerging disruptions to Applied Behavioral Analysis, or ABA services across Nevada, and to share early observations from an ongoing data collection effort. (Agenda Item II B)

Less than 12 hours ago, we released a short Google form to Nevada families to help document changes to ABA coverage, costs and services, and accesses, beginning on January 1, 2026. In that short time, we have already received 32 responses with additional responses continuing to come in. Even at this early stage, the information being shared is notably consistent. Families are reporting increased out of pocket costs. The introduction of new co-pays and coinsurance, coverage denials, reductions in authorized service hours, and delays or pauses in services. Several families, also report receiving limited or unclear explanations for these changes, and these experiences appear to be occurring now, and are having immediate effects on families. For families who rely on ABA, particularly those children receiving early intervention services, unexpected reduction in services and denials, or new financial barriers—can disrupt progress and create instability during critical development periods.

Our written testimony provides additional context, and why this issue is significant, how it intersects with workforce and system capacity challenges, and what the early data is beginning to show. We have submitted the initial Google form results with written comments and testimony, and we will provide the additional results as they come in. Thank you so much.

Patrick Kelly, Nevada Hospital Association:

Good morning. We believe there are two areas in need of a better understanding to support quick and effective decision making during the next session. First, we urge the Committee to conduct an interim study on access to care focused on identifying root causes and

developing practical solutions. Across our state, urban and rural patients are experiencing longer wait times, difficulty finding providers, and growing barriers to timely care. The study should examine what is driving these challenges, and what policy funding and systemic improvements can strengthen access statewide.

Key components of the study should include:

- A statewide assessment of access challenges including wait times, provider availability, and geographic gaps;
- Identification of root causes including workforce shortages, and capacity constraints in various care settings;
- Evaluation of Nevada's health care workforce pipeline including recruitment, retention, training capacity, and clinical placements;
- Review of state-funded workforce initiatives to determine what is working, what is not, and what is producing measurable results;
- An analysis of health insurance network adequacy and associated challenges; and
- Review of best practices from other states and the development of an action plan to improve timely access to care.

Secondly, we recommend an interim study on the impact of H.R.1 on Nevada's health care system. A comprehensive assessment of the provisions affecting Nevada, along with anticipated costs, operational impacts, and mitigation strategies would be extremely valuable. Nevadans need a clear picture of how these changes will affect both consumers and providers, and what steps can be taken in Nevada to mitigate harm and protect access.

Thank you for your consideration, and I wish you all a very healthy New Year.

Chair Brown-May:

Thank you, is there anyone else here in Carson City or Las Vegas, who would like to offer public testimony? Seeing none, we will move to the telephone lines.

AVH, is there anyone on the telephone who would like to offer public comment at this time?

AVH:

Thank you, Chair. If you would like to provide public comment, please press *9 now to join the queue.

Dora Martinez, Member of the Public:

[Inaudible] Good morning. Good morning, Madam Chair, Vice Chair, and members of the Awesome Committee. Just a reminder that here in Northern Nevada at the Washoe County District Health Department, they are doing free flu shots tomorrow; 1:30 p.m. to 6 p.m. I just want to put it out there in case people did not see that, and it is totally free. You do not need insurance, just go in, no need for appointments. So, please get your flu shot. I want to thank all of you for listening and remember that all of us we can do so much good and for our Nevadans. Thank you Madam Chair, Happy New Year.

AVH:

If you have recently joined and would like to provide public comment, please press *9 now to join the queue. Chair, we have no additional public comment via the phone line.

Chair Brown-May:

Thank you. Okay, this time we will move to agenda item number three, which is a review of the Interim Work Program, and I will turn this over to Mr. Florence.

AGENDA ITEM III—REVIEW OF THE INTERIM COMMITTEE BRIEF

Mr. Florence:

Good morning, and thank you Madam Chair and Committee members. I have the pleasure of serving as Committee's policy analyst. My colleague, Anthony and I are going to briefly go over the Interim Committee Brief. Before I begin, I want to remind all the members that staff here from the Research Division, and other Divisions are here to assist you in any way possible—especially as we are entering the new year, and you begin thinking on your personal bill draft request (BDRs), or the work you want the Committee to be focusing on. We are here to assist you with that, so do not hesitate to reach out.

Moving into the review of the Committee Brief. I would note that each of you should have a copy in front of you, as well as a version that is uploaded to the Committee's website. (Agenda Item III) Going into it, on page 1, is a brief introduction along with the assigned members, alternates, and staff from each of the Research, Fiscal, and Legal Divisions. Moving into page 2, you will find the Committee's authority and responsibilities. You will note that the Committee considers a wide range of health and human services topics. This includes child welfare, health care and health insurance, behavioral health, mental health, public health, and other issues. This includes the jurisdictions of the two standing committees from the Senate and the Assembly, along with a few additional items that were carried over from the Legislative Committee on Health Care. You will note that the Committee is able to request up to 15 BDRs that relate to the topics within its jurisdiction of those 15 BDRs. Five of them are limited to issues relating to child welfare, and the Committee must finish this work by September 1, of this year. You will note later on, the Committee's work session is in August.

The next section covers Committee scheduled meeting dates that we have so far, along with a tentative list of topics that the Chair has identified to be prioritized. To quickly summarize those, you will notice the February meeting is going to be prioritizing maternal fetal and infant health; March will prioritize public health and health care workforce; May will be focusing on mental and behavioral health; and June will be evaluating issues relating to child welfare; and then the final meeting of the Committee is going to be in August to determine the Committee's 15 BDRs. I would just note that the items in those meetings are not exhaustive, and any other pertinent matters that the Committee members or Committee Chair decide to focus on can be included. With that Madam Chair, that concludes my portion, and I would pass it over to Mr. Ciaramella to cover the rest.

Mr. Ciaramella:

Thank you. To continue with our presentation of the Committee Work Program, you will find past Committee action on page 3. At the conclusion of the previous interim, the Committee approved 14 recommendations for BDRs, of those 14, 8 were then passed by the Legislature and signed by the Governor. The table on page 3 provides a brief overview of these bills and

their status. The original forms of these bills can be found on the JISC HHS Bulletin, which is provided at the top of page 4 in the Additional Resources section. The Additional Resources section outlines the various materials available to this Committee, whether mandated, or published by the LCB, to support the work of this Committee concerning health and human service issues in Nevada. Along with committee bulletins, there are legislative audits—the goal of the legislative audits is to provide independent and reliable information to the Legislature about agency operations, functions, and programs.

For this Committee, relevant legislative audits from the previous and current interim include:

- Inspections of governmental and private facilities for children—to determine if the facilities adequately protect the health, safety, and welfare of the children in them;
- Information Security related to the Silver State Health Insurance Exchange;
- Audits of the Division of Health Care Financing and Policy (DHCFP), the Department of Health and Human Services (DHHS), Hospice Care Claims, and Fiscal Agent Contract—to determine if proper oversight control and applicable laws are being adhered to; and
- An audit of the Dual Enrollments and Supplemental Drug Rebates—to determine if DHCFP was adequately monitoring activities related to managed care enrollees and drug rebate payments.

Moving on to page 5, you will find information regarding statutorily required reports. As you know, the Legislature requires various state and local entities to provide reports to the Legislature, and a variety of these reports are transmitted directly to the Committee. These reports can be found through the Research Library's website or staff can assist you in accessing these reports. The table on page 5 lists newly required reports that were passed in bills from the 2025 Legislative Session. Some of these reports include information on planning for long-term care, licenses to practice medicine by qualified graduates of foreign medical schools, and lung cancer screening access and inequities. I would note that there are many other reports that are required to be sent to the Committee. This table demonstrates the new reporting requirements. With that, this concludes our presentation, and we stand open to any questions. Thank you, Chair.

Chair Brown-May:

Thank you, members are there any questions?

Senator Titus:

I want to first thank you staff for putting this together, and also acknowledge Senator Doñate's work and effort of this Committee last interim; impressed that. Frankly, people may not know that in the past this Committee, although we might have 15 bills, very few got passed. It was an opportunity to make a difference in health care and to have 18 of the 14 bills introduced—actually enacted, is a big lift. I want to acknowledge the work the Committee did last interim, thank you.

Chair Brown-May:

Thank you, Senator, I agree wholeheartedly. There was a lot of work that was done collaboratively to make sure that we were well prepared to bring those measures in. Congratulations to our Senator and the rest of the team. On a go forward basis, Senator,

thank you for bringing that up. But, that is exactly how this Committee is intended to function this interim as we well. The lessons that we learned and how thoughtfully we can proceed through the interim, will prepare us to be able to bring measures that have a bit of consensus around them, so that we can pass measures in the next legislative session as well—looking to have the same level of success. We are open to hearing as a Committee, from the community, so that we are able to address the issues and items that are relevant to our constituents, and the residents across our great State of Nevada. So, all of the members of our public and our members on the Committee are encouraged to bring in issues that they would like to see addressed by this Committee—so we have an opportunity to fully vet them, and identify relevant policy that we can bring into the next session. You will note as we go forward, public comment will be offered both at the beginning and at the end of each of our meetings that we have scheduled; policy recommendations and considerations are encouraged from members of the public. That did us well, I think, as a Committee during the last interim, and we were able then to be very successful as noted by Senator Titus—with the work that was done. I will continue to reiterate as we go forward, please bring your ideas to this Committee, so that we have an opportunity to bring policy issues forward. With that, we are going to move into the next item on our agenda, given that there are no other questions from Committee members or comments at this point.

AGENDA ITEM IV—UPDATE FROM THE NEVADA HEALTH AUTHORITY REGARDING IMPLEMENTATION OF SENATE BILL 494 (2025) (CREATION OF THE NEVADA HEALTH AUTHORITY AND RESTRUCTURE OF THE DEPARTMENT OF HUMAN SERVICES) AND OTHER LEGISLATIVE MEASURES PASSED DURING THE 83RD LEGISLATIVE SESSION, ROLLOUT OF THE NEVADA PUBLIC OPTION, AND AN OVERVIEW OF MEDICAID REIMBURSEMENT RATES SCHEDULED FOR REVIEW

Chair Brown-May:

The item agenda that we have brought together today is to, first, familiarize this Committee and our community with the changes that are happening within the Nevada Health Authority (NVHA) and the Division of Human Services (DHS). There are a number of changes within names, and structure, and departments that are moving. I think as we move forward, the first thing we want to do is develop clarity around those two areas. I would like to welcome the NVHA to the table, so that they may begin their presentation—and then members we will break as we go through specific areas, so that you can ask questions. If you do have questions, please note that, but we would like to break this up into bite size pieces, so that we can seek clarity as we go forward. With that, I will officially turn this over to our presenters and welcome them to the table. You may begin whenever you are ready; thank you for being with us.

Stacie Weeks, Director, NVHA:

Good morning, Madam Chair, Committee members in the North and South. We are going to talk a little bit about the overview of NVHA, a lot has happened since last session—pretty quickly. I think we had less than two months to stand up a new department, and then we had a cyberattack, so it was a lot going on the first six months of our department. But, I am happy to say that we have fully transitioned into our new department. I am very pleased with the team that we have been able to build, and are moving forward with all of our day-to-day work, and new projects that we have been given from last session.

I want to walk through a mission that we have kind of outlined, our strategic priorities. We are putting together like a three year target, or business plan for our work. We are also going to be doing a public workshop in a couple of weeks to walk through that—also want to walk through the major projects that our department is working on, and some specific legislative updates and status. If you have specific questions about specific bills, I will do my best, and with our team to try to answer them. But, we have been doing large stakeholder meetings every six months since last session to provide very specific updates on each bill. If you have questions, we do have that available, and I am happy to talk about that. Then walking through kind of what we are focusing on for the coming year, and hopefully getting feedback from all of you on that focus, and if we are missing anything and there are things that you guys would like to see that we are looking at, and then we will open up for questions.

Last session we had Senate Bill 494 (2025) that did what we kind of really call "Agency Reorganization" across the state. It took DHHS and divided up into two agencies, and also brought in other health care agencies into one—NVHA, which we are now under one umbrella. DHS is still the Department of Human Services, and it really focuses on that direct care and the direct public benefits that the state provides to Nevadans. As you can see in that gray box on the left, we still have four divisions at DHS: (1) Children and Family Services—Child Welfare remains with that department; (2) Public and Behavioral Health; (3) Social Services, which was formerly Welfare and Supportive Services; and (4) Aging and Disability Services. Now the stars that are there because some elements of those divisions came over to the new NVHA. For Public and Behavioral Health—what came over is Health Care Quality and Compliance, which a lot of you may know as HCQC, which is our licensing entity for facilities. They do inspections; they do a lot of other things around health care, quality, and safety in the state—that part of that division came over. Also, under the Division of Social Services, as Medicaid is moving into a new single state agency under federal law—that state agency is the entity responsible for Medicaid, so eligible policy came over. We still work with Social Services and the division there to implement and provide eligibility enrollment. But, we own the rules and requirements around that at the NVHA, and work with the Center for Medicare and Medicaid Services (CMS). Aging and Disability Services (ADSD), the pieces that came over are really around our provider audits, and other things that we need to do to have oversight of the home- and community-based waiver services that ADSD administers for Medicaid. At NVHA we have four, I would say new divisions: (1) Nevada Medicaid, Division of Health Care Financing and Policy is now what you may think of as Nevada Medicaid; (2) Consumer Health Services; (3) Public Employee Benefits Program (PEBP); (4) what we are calling "Health Care Purchasing and Compliance."

When you think about the new health authority, and kind of what we will walk through in a little bit about our focus. One of the things I think that is really important to remember about bringing all these health care programs, which you can see at the top: Nevada Medicaid; Battle Born State Plans (BBSP); Nevada Health Link; and PEBP—altogether, you have nearly a million lives. It is almost one in three Nevadans. It is a large footprint that we have an impact on, and I think that is very important when we are working on streamlining health care requirements—making things easier for providers. We are having a larger impact when we are doing that together, so that is really what we are leveraging is this footprint to be able to change health care in the state. With these programs we enroll or contract with one in two providers, possibly all providers, if you want to consider all the products in Health Link. One in two births in Nevadans—we already know Medicaid covers

50 percent, and you add in PEBP and the qualified health plans in exchange—is at least one in two births in the state. When you put all these programs together, we are spending over $13 billion state and federal on health care. We have a pretty large footprint, and I would argue a lot of buying power in the health care system given the money that we are giving out to providers in reimbursement.

This is our new executive leadership team, some of these faces you may already know, some are new. On the right here at the very top, we have what we are we are calling our "Senior Clinical Team". Two of our main leads that are in-house are: Dr. Keiko Duncan, she is our Senior Clinical and Pharmacy Officer; and Dr. Keith Benson, he is our State Dental Officer. We have three new physicians, well two we have already gotten hired through the University of Nevada, Reno (UNR). We are working to get at least one or two more physicians that will be on contract with us through the universities—that we are able to leverage Medicaid federal dollars, and the university puts up the state cost of those positions, so it is a real win for us as well as them. These individuals are helping us on a variety of policy issues. We have one who is a Clinical Informatics Physician, which I did not even know that existed. He has been an amazing part of our team, and is already diving in, and helping us look at data in a way we have not really looked at. Very excited to have the academic partnership that we have been building, and working hopefully soon to get some the University of Nevada, Las Vegas (UNLV) physicians as well.

Over here on the next row is our Director's Office, so when you think of maybe DHHS, there was the Director's Office—this is the Director's Office team. We have Lynnette Aaron, many of you probably have seen her at the table with me at the Interim Finance Committee (IFC) and other budget committees; she is our Deputy Director of Health Care Financing. Before—when DHCFP existed as a full Division—Nevada Medicaid budget was under that Division. We moved that budget up because there is so much of the Department that can be leveraging federal dollars, and she is looking at maximizing that for the state in a way that is supporting Medicaid and is appropriate under federal law. She is also managing the rates, financial analysis, provider payments, and federal funding and reporting to the federal government. We have Allison, she is our Chief of Staff—she is over Human Resources (HR), Communication, she is going to be doing all the legislative outreach, so if you need something, please email Ali. She is going to be overseeing our Office of Analytics and the work around the All Payers Claims Database (APCD), we will talk a little bit later about that project. Sandie Ruybalid is our Deputy Director of Enterprise IT and Innovation, and a lot of her work before was only on Medicaid, now her team is supporting the entire Department and making sure our cybersecurity is strong—she is over a lot more, but I will move on. Malinda is over our Community Engagement and all of our Workforce, she is our Deputy Director. She does our boards and committees that we have at the Department, she is over Workforce Development, all of the new grants, which I know everyone is eager to talk about the Rural Health Transformation Grant. Our Patient Protection Commission is right now with her, but is also still living under Consumer Health Services, so it has been supported by Malinda as we are building up our teams.

Down below are the four divisions. On the left is Todd Rich, he was over our Purchasing Compliance—his last day was last Friday, already missing him. He moved on to the private market and very grateful for all the work that he did while he was with us to help us stand this up; he helped us get through session. Cynthia Leech, some of you may know her, she is here today. She was previously over our Medicaid Inspector General office and has done a lot of work around provider enrollment—making that a better process and automating that. She has been a huge advocate of getting rid of provider fraud, and waste and abuse, and has really led that area into success. She has stepped into the Administrator role as of yesterday, so I will be replacing his picture soon. This Division is over Regulatory and

Compliance; Purchasing and Contracting; Medicaid Inspector General Office; Provider Enrollment; Centralized Credentialing; and our Facility Licensure Inspections and other things that HCQC did before at the Department of Public and Behavioral Health. Jennifer Krupp is our Administrator over the Nevada Health Link, the Patient Protection Commission, and our public option, which is our BBSP. Nevada Medicaid, our Director and Administrator of Medicaid is Ann Jensen. What still remains under Medicaid—Benefits and Delivery System, which is our managed care program and fee-for-service; Federal Policy and Waivers, so all of our benefits are developed and maintained by this Division; Community Supports, all of our waivers; and Long-Term Care. Theresa Carsten, last but not least, is our PEBP Executive Officer. She administers the PEBP program and manages those contracts and the board.

To give folks a sense of who is under each Division, because we have been getting a lot of questions and totally appreciate that—I just want to say, I know our website could be much better. We are in the process of moving to a new platform, and we will be working to make that much easier to navigate, and grateful for the Governor's Office IT team, who has been helping us get that ready and up and going. On the left here, as you can see, Deputy Administrator Kyle Devine is over HCQC, he came over with the transition. I mentioned Cynthia earlier. Her position is now open, as well as a new Administrative Services Officer IV, who will be doing all of our Health Care Purchasing and Contracting at the new Division. We just posted that and working to get that position filled. Jennifer Krupp, I mentioned, Janel Davis is our Executive Director of the Silver State Health Insurance Exchange. She was previously the Operations Deputy, and we are very excited that she has moved into that role. Adam Plain who came over from the Division of Insurance (DOI) is over our 1332 Reinsurance Waiver Programs, as well as our Public Option. He is managing all those contracts and setting up the new Reinsurance Program with DOI. Dylan Malmlov is over our Patient Protection Commission. Under Ann's team, she has got two deputies, Kirsten Coulombe who used to be the Chief over the waivers has now moved into the Deputy Administrator. She is over all of our waiver programs like she was before, as well as the District Offices who do care coordination and help people who are having struggles transitioning to care. As of yesterday, Jimmy Lau joined our team. He came to us from the Health Care Government Relations World here in Nevada. We are excited. He is going to be over Benefits and Delivery Systems—managed care program, all of our benefits. He will be overseeing Medical and Behavioral Health and Dental. Our Agency Manager is Casey Angres, she is over our Federal Policy and all of our waivers. Tonya Stevens, who came over with the Division of Social Services to run Eligibility Policy for Medicaid. I think PEBP looks a little bit the same, Nik Proper is still our Operations Officer. Monica McJoy is new, she is our new CFO [Chief Financial Officer] at PEBP, and Leslie Bittleston is our Quality Control Officer.

All right. We will dive into the Mission and strategic priorities. We tried to come up with a easy slogan, and I will tell you for those of us who work in health care we are very much jargony; so trying to avoid jargon, but you know, you cannot help it. Our vision is a healthy, thriving Nevada where health care is affordable and reliable. I really think that last word reliable is super important. We can make health care coverage affordable all day, we can get, everyone can have insurance, but if they cannot get in to see a doctor when they need it, then what is the point? Right? It has to be reliable. That is really, I think something we are going to really focus in on is what does it mean to have health insurance and make it reliable to access care. Our Mission is to meet that vision. Our Mission is to really work on leveraging our buying power, that footprint I mentioned earlier to get the best deal and value for Nevadans, streamlining our programs where we can leverage each other's resources and align even requirements with our providers. It is simpler and—drive hopefully—drive better quality and innovation in our health care system with that footprint

and all the things that we are trying to do and implementing them consistently across all of these markets. Our values we have outlined are really public service, obviously is really important to all of us and our team. Fiscal discipline is vital to the work that we do. Program integrity as well transparency for the public and really that accountable leadership. We have outlined four goals. I mean, I think it is hard to really narrow it down to four. There is so much that needs to be done in health care. It is one of those systems that feels like there is always work to be done, but we really focused in on four, and I think they align a lot with the statute that was passed—the bill. The first one is obviously health care improvement. On the right here, you can see our scorecard—this is for 2024 and 2025. I know when I usually present this, someone always reminds me that they have been here a long time and they have always been the bottom ten. So, you know, but I would just point out we are not just in the bottom ten—we are at the bottom. That is not okay. We are spending over $13 billion on health care services and we are 51st; we are beating Mississippi for 51st, and I am from Arkansas originally, so I feel like I can pick on Mississippi. But the fact that we are now 51st says something—we are not doing what we need to be doing in the state. That is something we are taking seriously, and trying to look at what can we do to move the dial, and move up out of the bottom ten on these areas. We are focusing in on—chronic disease management and prevention, maternal health, quality of care and safety of care, and mental and behavioral health substance use treatment—trying to ensure that we have access and better outcomes. Number two is Program Viability. We can do all this work and make everybody happy and increase rates all day—but if the program is not sustainable for the budget—we have also failed. Is important that we do this work with an eye on what it costs us, and what are we getting for the very limited revenue dollars that we have in the state. Having economic resiliency for our coverage programs is very important. Third is Health Care Workforce Capacity—goes back to that reliability. We all know we have a health care workforce shortage—we are not alone in the country with that, but I think this is key to making sure that our coverage is reliable for families. Luckily, we have got two new grants on the table: one was passed by this body, SB 5 or the Sharp Act. Thank you guys for that funding, it is about $60 million, which can help go into workforce efforts as well as the Rural Health Transformation Grant. We are grateful to have those opportunities to help with this goal. The last one is Value and Innovation. We are looking at how we use our programs. For those of you that may not know, for most of the programs that we oversee and manage—we have contracts with the providers in some way, as well as the carriers. There are ways that we can align those and incentivize value and innovation. If you do that across markets, has a bigger bang for the buck. Those are things that we are going to be looking at over time, and how we do that across our programs.

Let us dive into Health Improvement first. There is a lot of other stuff—we picked a handful of projects that we are working on, including just standing up Adult Dental—is a big one. But, I wanted to highlight some things that we have been working on that I think many of you are familiar with to give you an update on them. At the end, if there are other things that you want to know we are doing or that was missing, please ask, and we are happy to talk about. Healthier Nevada Schools is an initiative we have been working on—especially Deputy Director Malinda Southard, prior to NVHA's establishment. We have been doing a lot in the space of trying to understand what our schools are billing for, why they are not billing very much, and how do we make it easier? We have a new pilot—thanks to a federal grant we got, I think it was a year and a half ago; it feels like yesterday. But Malinda and her team have been working hard to get a pilot vendor up and going to offer billing services to schools, because that is often what we hear—they do not have the time, the capacity, or even the electronic health record they need to do what they need to do to bill. What if we provided them that vendor that they can connect to? Maybe we can get a better deal on that for them as a whole, as a state, and they can actually start to bill us, especially for behavioral health services. We cover a lot of services in schools, and what we are primarily

seeing and have been seeing for years is just the basic mandatory services that they have to provide for disabilities. Which is great, but we want to see them billing for other things—preventative services, screenings, and the behavioral health care that we know students need—those are the things we are working at. Four local education agencies, which are our school districts—will participate in the pilot and then we will be expanding it to all schools in the '26–'27 School Year—to use the new vendor. We are going to see how this goes—if it goes really—we will probably be bringing it forward next session to look at ways to fund it long term, so we can ensure that schools can continue to bill for these services. We also developed a new user-friendly Medicaid School Health Services Manual—like other states have—that helps schools, because often they go to our billing manual, and it is written for a health care provider. Schools are not always health care providers. They are teachers, and often other people that work there. Maybe they are health care providers, but they do not have time to go through all the details. Trying to make that simpler and easier was a big task, and I think we have done that. We also setup a School Health Access Resource Center and a Steering Committee. That Committee has played a big role in establishing the billing vendor—giving us feedback on a lot of our work around how schools are billing. There is also a Medical Billing Technical Assistance effort that we are doing with the Department of Education, but our Medicaid team has a monthly training and office hours with schools. If anyone wants to hop on and ask our team questions, they can, if they do not—they do not. But it is a way for us to have a door that they can access, because often what we hear is, "I emailed the inbox and never heard back." How do we make sure we have a door open for them? Our team has been doing that monthly. We are also looking at behavioral health and working closely with UNR, the Division of Public and Behavioral Health (DPBH), and Department of Education—on how do we implement best practices in schools around behavioral health, because we know that is a big challenge for our schools.

Statewide Medicaid Managed Care was effective January 1. We are up and going—proud of that. I think we are always holding our breath when we start something new and go statewide. For years—for those of you that may not know—Managed Care delivered and pays for services for years just in Washoe and Clark County. This expanded it to statewide—from the last session—this was passed in 2023. It took two years, as you can see, to get that stood up. We did use competitive procurement, and we had several key goals: making sure that we had adequate service areas, network adequacy, access to care, member and provider experience—especially in our rural areas. We did a rural hospital tour, which was valuable to us and our team—understanding what our rural communities are going through and struggling with was really powerful. When we built this, we wanted to make sure that they had choice in a health plan, but they were not overwhelmed with their options. We narrowed it down to two in the rural counties, because no one needs four or five contracts and all the negotiations that go along with that. We picked our two top performers in rural: CareSource, a new nonprofit health plan in the state, and Silver Summit Healthplan, the other rural health care carrier. We also focused in on Care Quality and Outcomes. Federal law requires us to have a quality strategy that is part of our efforts, but we did a lot more. We are requiring value-based payment design, community reinvestment dollars, and a variety of other initiatives to ensure that there is a focus on building up infrastructure, so we can have quality and better outcomes. The other piece is—Population Health was a big piece of our procurement. That peach box at the bottom are the two rural plans, as you can see, that is the rural service area. These plans are also in our Urban Washoe area as well as Urban Clark. Urban Clark area has an extra plan, in that blue box, which is Health Plan of Nevada. That means Clark County has five, and according to our consultants and our actuaries, it is okay to have five plans given the size of that population. We did not want to go beyond four for Washoe, given the size of the population. (Agenda Item IV)

Children's Behavioral Health Transformation, this is being led by—

Chair Brown-May:

Can we pause as you go through each one of the programs to make sure that we do not have questions. The information that you are providing is really robust, and I want to make sure that we have a clear understanding. Can you go back to the Healthier Nevada Schools? I want a little bit more clarity around where we are relative to that piece. The local education agencies, I believe you stated, are the actual school districts and there are four of them that we are currently considering to launch this pilot. Is that correct?

Director Weeks:

Madam Chair, I am going to defer over to Deputy Director Malinda Southard, so she can answer these questions.

Malinda Southard, Deputy Director, NVHA:

Madam Chair, members of the Committee. Yes, the local education agencies (LEA) include all school districts as well as the State Public Charter School Authority (SPCSA). We are having an application process—that is actually going on right now—for all the LEAs to be able to apply to participate in this pilot. We will be reviewing those applications and letting the four LEAs know, as soon as we can, if they have been provided that opportunity or not.

Chair Brown-May:

Thank you, do you have any anticipated time frame for when that approval process will be completed?

Deputy Director Southard:

Yes, today we are reviewing all the applications that have been received. I believe we received ten or a little bit more than that, which is exciting for this new program. We will be reviewing those today, and I want to say within this month we will be notifying the four LEAs.

Chair Brown-May:

Thank you. As you progress through this pilot program—you will be working on the billing as a state agency, or will each of the school districts that are in the pilot be billing directly?

Deputy Director Southard:

Yes, all of the LEAs will be working with the vendor. The vendor will provide the Electronic Health Record System as well as Medicaid billing components, so the LEAs will be able to bill Medicaid through that vendor.

Chair Brown-May:

Thank you for that clarity. I missed the vendor piece of it, so that makes more sense to me at this point. There is a steering committee that was identified, can you talk a little bit about who is identified to be on the steering committee?

Deputy Director Southard:

Yes—the steering committee—we wanted to have a wide variety of individuals who are associated with schools and school health services. We do have members on that committee from the Nevada Department of Education (NDE) as well as urban school districts and rural school districts. We also have members of the NVHA that are on that committee that help to manage and facilitate the committee. We also have members that are participating from UNR Multitiered System of Support Office, so we do have a wide variety on that steering committee. They have met quarterly to provide input and technical assistance to NVHA on components that we are looking for in a school electronic health record and Medicaid billing vendor support; what types of technical assistance would be most helpful for the schools; and providing that sounding board, so that we could write a well-encumbered request for proposal for that vendor.

Chair Brown-May:

Thank you for that clarification, and then one final question from me, before we go to the rest of the Committee. I am curious to know about parental involvement relative to the delivery of a medical service at the schools. I know that that has come up at times in the past. How do we have a parental authority as to what types of treatment kids are receiving in the schools? Can you talk that through a little bit.

Director Weeks:

Madam Chair, I think that is a better question for NDE to probably answer; we can follow up with them. Usually they have to provide consent; I just do not know all the details. I think the NDE does that part, but we can follow up with you on that. We just pay for the services once they are provided.

Chair Brown-May:

Thank you for that clarity. Members, any other questions relative to Healthier Nevada Schools?

Senator Titus:

Thank you Madam Chair for stopping and going back to the Healthier Nevada Schools. My question is in regards to the pilot programs and identified education. The four different schools that you are going to identify, is that school districts?

Deputy Director Southard:

Yes, LEAs include school districts as well as the SPCSA.

Senator Titus:

Thank you for that clarification. It is a discussion I have had for a long time regarding Medicaid billing. I have spoken to the Superintendent of Education; I have spoken to you—the Medicaid offices. It is a true issue; schools could be gaining a lot more funds if they bill properly. I am concerned about the delay in a pilot program when every single school district has these issues. I was led to believe when I have met over this issue—is NDE was going to look at hiring billers to help all the districts bill Medicaid. Now, I am hearing you are doing a pilot program with only four. I know because I actually serve in a capacity for Lyon County Schools where I do their special education reviews—sign those

charts off—they do not bill for my services and they should. It is current. It is happening now. The money is lacking, and I am actually discouraged to hear that instead of getting something actually done, we are going to do a pilot program. Tell me how this actually accelerates what the issue is today. It has been years where they have not billed. Now, instead of helping them with billers, we are pulling out only four districts to get the billing done—leaving the others behind? What is this process here? I am a little disappointed.

Director Weeks:

When we got the grant, CMS really pushed us to do the pilot first to make sure we test it with schools that we thought were ready. It is only a year of a pilot, and then after that, it will be open to all schools. It is a grant that we are following the federal requirements, but once we get through the first year—we test out any kinks—but to have all the schools, if there is any issues, would be challenging. We wanted to focus in on four—make sure we get all that right, and then expand it out in a year.

Senator Titus:

Thank you for that. The issue is personnel and hiring the people that it takes to do Medicaid billing. There is nothing that prohibits schools from going forward if they had the capacity to bill now, correct?

Director Weeks:

That is definitely correct; we already have schools billing. I think this effort is to help those schools that tell us every day, even when they hire someone, they are still struggling. Today schools should be billing us, and as you said they just do not. We are trying something some states have tried, like Arizona, and others that has been successful. But to get this grant this is sort of the process that we went through—if it was not for the federal grant, we probably would be coming next session to do this. It helped us get started quicker in this process.

Senator Titus:

I like the word start, I like the word quicker, and I like that within a year we may be seeing a difference. This has been going on decades—it is not a new problem. What is new is that we have identified—hey, here is something you should be doing. To your credit, you have said, "Hey, why are not you billing? This is something that you should be picking up on." Thank you for doing that, I just need to see some results.

Director Weeks:

I appreciate that, and we need you to push. Honestly I wish we could move faster, but I promise you we are trying our best. This has been a high priority for us.

Chair Brown-May:

Thank you, and I would like to note—I do believe that was one of the measures that we did work on last session—that we were not able to successfully get through. Know that this Committee has been working in a dedicated effort to to move that direct billing to schools, so that we are drawing down additional federal support. With that, we will go ahead and move to our next question.

Assemblymember Goulding:

Thank you Chair. For a point of clarity, are the services that are provided in schools only available to students who are Medicaid eligible, or are they available to all students?

Deputy Director Southard:

Those services are available to all children regardless if they are enrolled in Medicaid or not.

Chair Brown-May:

Thank you, next question.

Assemblymember Nadeem:

Thank you for the presentation, and thank you for making it clear for everyone. My question is regarding the Statewide Managed Care Rollout. The insurances: Health Plan of Nevada, Molina, Silver Summit, Care Source, and other. How will that go? These insurances are independent identity, so entities, they will be included in the state managed care rollout or the billing? How the patient get those insurances and how the billing take effect?

Director Weeks:

We already have Managed Care today. We do not directly deliver health care services, we pay for them. One of the things that Managed Care plans help us do is build a network—they manage that network, they do all the claims review, they do all the prior authorization. They help us pay for those services in a way that we cannot, as a state, hold the capacity to do that. They do other things too, but that I think at the basic core. The people that are not in Managed Care today, or that will not be in the future, will be anyone who is in a disability bucket—or aged, blind, disabled, and on a waiver. Those folks will be fee-for-service. For example, they have access to the network, but it does not mean we have done the quality and network adequacy, and all the things that Managed Care plans do. They can still get Medicaid, but the provider bills us directly, and we pay the provider and manage that work. The other population right now is a child welfare population that would be fee-for-service; Katie Beckett, which is a buy-in program for disability families who make too much to qualify for Medicaid; and our senior population—I mentioned the aged, blind, disabled. They will be outside of Managed Care, and anyone that is on those home- and community-based waivers. Everyone else—all of our families, adults, parents, adults without children, pregnant women—today in Washoe County and Clark County are on Managed Care plans. They each choose a plan, and that plan provides benefits to them that we cover, and the providers will bill that contract with that health plan—to bill for those services that Medicaid pays for. That is the way it will work in the rural areas, except they will only have to contract with two carriers, or if they want, they can contract with one. Hopefully they have all worked these things out—I think they have; we met the readiness review. But in the rural areas, it will be similar. The only thing different in the rural areas is that there are a lot of what we call "directed payments" to protect providers, like our critical access hospitals, our rural access clinics. Some of those entities under state law have what we call a "directed payment", which means the health plans cannot negotiate a rate below what we would have paid fee-for-service. It is a way to protect them in terms of their cash flow, and going to fee-for-service is not going to result in less money for them. That was the goal to preserve that infrastructure, which we know struggles in the rural community. Hopefully that answers your questions. Happy to dive in more if you need it.

Assemblymember Nadeem:

Yes, thank you so much. I have one more question. My question is regarding Medicaid as I myself am in health care and deal with the patients and the providers. In the last week, we saw there were five patients on Medicaid, but they ineligible and they did not know about that. I want to know how your department is helping them in knowing that they do not qualify for Medicaid anymore, and what they can do to have another insurance.

Director Weeks:

We currently contract in interagency way with the Divsion of Social Services to do enrollment and outreach. Typically when someone is disenrolled, they get a letter and information about how they can find other options. Now, I am not going to say that all the individuals that we send these letters to get them. I mean, that happens; it is a transient population. A lot of things happen where they are not always getting the information. Some of the new modernization efforts that we are trying to do through our exchange for this population, which is a very modern platform—automated in real time—I think will be a really great service to individuals in that situation. Not only will they get a notice—but then they can go through the same entity that they got their Medicaid through, and find a health insurance plan that they can qualify in the private market. We also have navigators under the NVHA. Thanks to the grant that this body approved during special session, we will be helping this population—who have been disenrolled—connect with private health insurance through the Exchange and get subsidies—often they are eligible.

Assemblymember Nadeem:

Thank you so much.

Chair Brown-May:

Thank you. Senator Doñate.

Senator Doñate:

I had a question regarding the slide dealing with the Statewide Managed Care to continue on the questions on that. I was reviewing the report that was published under DHHS, which is the 2025 through 2027 Quality Improvement Program that Medicaid was implementing. One of the two things that I mentioned was a goal targeting star improvement ratings and network adequacy. My first question is with CareSource coming into the market, how are we monitoring network adequacy for them specifically? The second question—to finish up that first, sorry. Both for the new market player and also for them entering into the rules. Then following on to that, what efforts are we going to start implementing to make sure that we are holding Managed Care Organizations (MCOs) accountable for their lower star ratings or their decreasing star ratings?

Director Weeks:

Those are good questions. The first one is around CareSource. Under federal law, there are a couple of required quality efforts that we have to do, and what you refer to as the QIP—the Quality Improvement Program. I will be honest, every state does those, and it is unfortunate, but we do not usually see an uptick in that area. It is often when we put incentives tied to something we see changes, or require value-based arrangements with their providers. What we are trying to do in the new contract is tie what we are calling a "hospital"—we are starting with the hospitals, because we know that they serve a lot of

individuals in the state. We are starting with what we call a "quality collaborative," and that quality collaborative is focused in on improving some of these metrics. When it comes to CareSource specifically, we use an entity called Health Services Advisory Group (HSAG). Federal law requires that we have an Independent External Review Organization that monitors and assesses on a regular basis our network adequacy standards, and does all of our quality, independently of us and the managed care plan. They kind of really are that check. We send those reports that you are referring to and other reports to CMS as well, that reviews that for us. At this point, what we had a few months ago is what we call a "readiness review," which is required when you are standing up a new contract period. You want to make sure all the plans are ready their new networks are working, they meet all the requirements, and there is no gaps for recipients of those benefits, and HSAG and everything has gone well. We would not be sitting here today saying "it has been implemented," if those readiness reviews were not met. Right now, we can say that we have met that. We will use HSAG like we typically do with CMS to monitor progress. We are having monthly calls. There are going to be some efforts where we are going to encourage—especially in our rural areas—that our Managed Care entities go out and do another rural tour. At least halfway through the contract here, because what we have found—it is those relationships that are really important—and face-to-face conversation about the issues that they are experiencing. I do not want to pick any plans and say there is any favorites, because we do not really say that. But I will tell you, I have gotten amazing feedback about CareSource from multiple providers, and their contracting process. Right now, I am feeling pretty good about where we stand on that, but we will be monitoring them carefully. When it comes to the MCOs and the quality metrics, we do have a quality withhold. We probably will need to really look at that opportunity in our contract as a way to penalize, or reward those that are doing better, or worse. I think in the past, we have waived some of those because of COVID-19, or because of other issues. But I will say that we are looking at those quality metrics and definitely want to make sure that they are getting better. I think the quality collaborative is important, but MCOs alone cannot fix this problem. We need our providers to come to the table and be a part of quality. They provide the service. It is not just on the MCOs, which I appreciate; we pay them a lot of money. That is one of the reasons I am very hopeful about this hospital quality collaborative, because I think we do need those larger health care providers at the table to improve quality too.

Chair Brown-May:

Thank you for pausing and allowing questions. Okay, seeing no other questions. We are ready to move on to Children's Behavioral Health.

Director Weeks:

Children's Behavior Health Transformation Project. This was really in response to—I think many of you have heard us talk about this—Ann and myself, as well as former Director Whitley and others. The Department of Justice (DOJ) Settlement Agreement that we entered into over a year ago. The DOJ came in and did an investigation into a complaint that they received that we were institutionalizing children unnecessarily—who have behavioral health conditions. As you guys may remember under the Americans with Disabilities Act, we are not allowed to just institutionalize anyone just because they have a disability. We have to do our best when we are providing public programs to ensure that those public programs cover and offer home- and community-based services. When the DOJ came in and said "We can either go to court"—right, that is usually the threat—or "We can come to a settlement." The settlement agreement outlines a set of services that we have to stand up in Medicaid and cover—trying to build out new provider types that will help these

children, their families, and their parents and guardians support them in the community setting. So they do not have to go into what we call a "Psychiatric Residential Treatment Facility" (PRTF), which I think some of you at IFC recall the PRTF that we were talking about. Also inpatient psych hospital setting—trying to avoid those higher level institutional settings for the home and community services. Often there are some kids that still need that treatment and that is okay. But our goal here is to make sure that only the kids going in there do need it and that they are not there forever. That they are not staying long periods of time, or they are not coming out and cycling back in, or into juvenile justice system—which is often another area where this population can sometimes go. We have been working on a couple of things—I would say it is a three-pronged approach. What benefits are we missing—let us get those added. I think we have submitted a lot of state plan amendments. I hate to—I love to blame CMS actually—but I hate to always use that as an excuse. We are waiting on a lot of things right now from CMS, but also they most recently have been responding. We are excited that, maybe, we are getting closer to some approvals. But a lot of these benefits will hopefully be coming online soon. We do have family and youth peer supports, I think, up and going. But we do want to get planned and emergency respite approved, and start paying those services. We also have rate increases that we have put into place a lot for our PRTFs, so we can actually support their ability to hire quality providers. Rate increases, hopefully, are going in to ensuring that there is quality care. We also did rate increases for individual family therapy as well as psychosocial and rehab services. Some of those are pending and some have been approved. A lot of them will be backdated, but we are still in the process right now of working with CMS on that. The third item is the delivery system, right now, it is a fee-for-service program. Our care coordinators do an amazing job at the district office, but they cannot—and neither can the counties, I think at times—manage the workload of this population. It is a difficult population to find services for, and what we are standing up is what we are calling a "Specialty Managed Care Plan." It will be one plan that is dedicated to this population to ensure that they have services available in-network, and that they are making sure that every family has what we call a "wraparound facilitator" that goes in and supports them. If they are willing to let that person in, there is also some families that do not want you in their business. So we also have to figure out how we help families in their home under the DOJ Settlement Agreement in a way that is respectful, and comfortable to them. We are currently trying to get a federal waiver to finish this process—we did issue the procurement recently, so that is up and going. We cannot speak to the plans yet, but hopefully we will be making those awards sometime this year; it will be effective January 1, 2027, and we are definitely working closely with CMS to get all the authorities we need to get this going.
I mentioned our PRTFs—not just on the Medicaid side. We are looking at, which I mentioned—the licensing and inspection side—just given some of the things that have happened recently and the Moriah Ignite Facilities. We are going to be taking a hard look at what we require. How often are we going out? Do we need more clinical expertise on some of these teams that are going out, and ensuring the kids are getting actual treatment in these facilities—and that they are safe, and they are getting better. Also, the last piece that is really important, I think, is holding them accountable for their actions when they are not taking care of these children. That is something separate from the Medicaid side that Cynthia Leech will be working on with Ann. But this is a big project, and I am going to stop here, Chair, because I am sure there is some questions. I will just open it up here.

Chair Brown-May:

Thank you, I appreciate that. Members, questions? Okay, I do have a couple of questions. There was a period of time where we had a number of youth that had to receive services out-of-state, and we were working diligently to bring them back into appropriate services within the state. Do you have a current count on how many children we are serving that are perhaps still out-of-state?

Ann Jensen, Administrator, Nevada Medicaid:

We can follow up with the exact number as of today. This is something that our team monitors on a monthly basis. I can confirm the total as of January 1 was 330 children in total, and of those, I believe it is about 40 that are out-of-state. But we will confirm what that looks like, including in our most updated numbers as well.

Chair Brown-May:

Thank you, Ms. Jensen, I appreciate that. There seems to be some concern regarding a delay in assessments. Do you have any data around—how long does it take for a child to get assessed appropriately for this type of service?

Administrator Jensen:

Yes, that is actually a data point that we are held to as part of the DOJ Settlement Agreement to analyze on a quarterly basis, and share that with both the DOJ team and our independent reviewer. We will also—we have a new public dashboard that is available with some additional data points. What I will tell you right now though is that we do not have a standardized assessment process in this state, and that is part of what we are held to do in the settlement agreement. What we can measure as of right now—the time between when an assessment is billed and when services are initiated—is something we have been tracking for the past year, and we can confirm with you how that is trended during that time. However, I think there is a significant opportunity, as you are noting, to both decrease that time, and also look at the process to get the assessment before that process even begins. Unfortunately, that is not data we have right now, given the assessment process. I am really thankful for our clinical team that is working to develop that assessment process with the support of DOJ and our independent reviewer. We actually have a Summit on Thursday of this week with providers from across the state joining to talk about the screening tool component of the process, which is really step one, and then step two will be that assessment tool and system development process. Lots of work to come on that, happy to provide additional detail as is helpful.

Chair Brown-May:

Thank you, Ms. Jensen. One additional question for me at this point. Director Weeks, you talked a little bit about the Moriah situation that came up during the IFC in particular. While we as a state do not license them, from what I understand, you all have done oversight, and we are not as a state sending kids into that care setting. Is there a way for us to identify the number of kids that do not come through our state systems that were referred to a behavioral health home such as the Moriah Facility?

Director Weeks:

We do license PRTFs. The issue is they do not just take Medicaid. I can look at claims data, but also claims data does not tell me real time who is there. Our requirements require them to have up to date medical records, so we should be able to. The issue has been whether or not they are complying with the requirements that we have, and I think that might require harsher penalties, and us providing more regular overview and oversight. That is going to require staffing and maybe additional contractors, and making sure that our team feels equipped to assess those records too, so that may be where the clinical expertise needs to come in. We do license them. I think when it comes to tracking children, the issue is we do know there is some cash pay—there is private pay. We know TRICARE sends kids to these—all these insurances send kids to these facilities, but we do not really track that. We do not have that process, and that is probably something I think we are looking at. Do we need something with even the DOI? Should we be reporting to them? So, they can tell the insurers that are in our market that this provider maybe is not a good provider. Because we can pull out of that provider, but whether or not they close their doors. The other issue is providers operating without a license. That is another issue that we are going to have to tackle, and it is going to require probably law enforcement to deal with that. I think that is something we are going to have to bring to this Committee and next session.

Chair Brown-May:

Thank you for that. I know that there has been a significant amount of work that has been done relative to the safety and welfare of children who have high behavioral health support needs. I appreciate the dedicated efforts relative to protecting our children and the families that are supporting those kids as they move through youth into adulthood.

Members, any other questions?

Assemblymember Nadeem:

Thank you so much for answering the questions. I want to go back again to Medicaid, because what I have seen, and what I am experiencing—I am really worried about it; about the Medicaid cuts, and how it is affecting the patients and the people. I want to know that with the new Medicaid benefits and rate increase—it says that it will be supporting the behavioral health and pending federal approval effective no later than January 1, 2027. The new facility Managed Care that is for the children behavioral health, requires additional federal waiver effective January 1, 2027. So, what will happen? The patients and the people who are the community members—who are on Medicaid services, and cannot pay for the private insurances—as the premium are increasing. What they are going to do in between?

Director Weeks:

I am going to take part of the question and then hand it to Ann to talk about what has been already implemented and some of the rate increases that we can or should be able to provide before 2027. I want to say relief is on the way. We have just been kind of holding our breath with I think the federal shutdown—all the things that have been occurring. I want to clarify, there are no Medicaid cuts right now. I have deep concerns about us with that message, because I do not want people to think that they cannot get the care that they need. Anyone who is disenrolled right now is disenrolled because they are ineligible under the same rules that have applied since last year, and the year before, and since the Affordable Care Act. Work requirements and some of the other changes are coming in 2027, so that is when we are going to have those conversations—I think in this Committee too—I know the Chair wants to talk about these changes. But I want to be clear right now,

because I want to be mindful of the narrative that scares a lot of people. I just want to be careful that we are not saying that Medicaid, right now, is cut. I want people to know they can still get their care. I just want to say that—I know there is a lot of confusion about H.R.1, and what it means. There are some funding changes. They will happen to hospitals, but many of them are not directly to our budget. I know that does not—maybe—give you relief, but it is good news to some of us that manage the program, because I am hopeful we do not have to make big cuts. Those are the things I just want to start out clarifying. We are working really hard though to get these services going, and I think it would be great if you want to reach out to Ann and me. We could sit down and kind of talk through what you are seeing on the ground. Because sometimes we only hear these things—they bubble up—I would love to understand too where we can maybe do better at giving your patients resources to help them when they are experiencing a change between Medicaid and the private market. You are right, private market does not cover a lot of these behavioral health services, or does not cover them the in a way that is affordable for a lot of these families. That is a struggle, and unfortunately, there is nothing that we can do with the NVHA around that. But those are challenges. I think that all families that come go off of Medicaid into the private market face—unfortunately. I am going to turn over to Administrator Ann Jensen to talk through some of the rate increases and timeline there. If you do not mind, Ann.

Administrator Jensen:

Happy to provide an update on all of the rate increases and benefits coverage changes, which I will admit predates even my time here in the Medicaid Division. It really began in spring of 2024, thanks to Director Weeks's leadership and the team's work there. They were able to secure funding through an IFC that was held in April of that year. Since that time, our team has been hard at work to get these changes submitted to CMS and approved as quickly as possible. As Stacie has mentioned, we have spent a lot of time with that team, and they have been really appreciative of the of the partnership and collaboration. But with a transformation this significant, it does take time for them to really review these items. We have a total of four significant rate increases that are currently pending with CMS. Those will be effective retrospectively back to January 1, 2025, which I know is over 12 months ago. We actually submitted our request to CMS for those changes in fall of 2025, so over 13 to 14 months ago, and there has been significant back and forth with CMS on all of these items. It is not that there is not work happening, it is just a long process. I know that our providers are eagerly waiting those changes. Please know that we are working hard on our end to be as responsive as possible to CMS's questions, but also to get all our system changes and updates in order. That way as soon as we get that federal green light we will be able to turn things on in our system, and recycle the claims, and be able to pay things at that higher rate. For some of the services like our inpatient psychiatric hospitals and our PRTFs, we have been able to offer letters of agreement in situations in which that increased payment would facilitate access or higher quality care for our patients. Please know that we are working very closely with our providers to ensure their needs are met in the meantime. For the new services, so this is things that we do not currently cover but are happening in our state right now, and so providers would be accessing a new funding stream. We are in the process of what is really a multiyear endeavor to get Medicaid coverage for those. As Stacie mentioned, we are really thrilled to celebrate when family and youth peer support were covered. We received that from CMS back in August of this year and really grateful for our community partners' and Nevada PEBP's strong efforts to make that process happen. I recognize that has been over two decades in the making, so we did take a moment to celebrate before we started the hard work of really implementing it and getting folks enrolled in billing in our system. Which is a significant process, and I can appreciate folks that are providers on this Committee can speak to that. The other new benefits—we are still working through the process with CMS to get coverage for things like respite care,

wraparound care coordination, updates to the way that we pay for mobile crisis—all of these things. We are spending time to do it right, but also moving as quickly as possible. Happy to answer any specific questions on those, but hope that overview is helpful.

Chair Brown-May:

Thank you. Next, we have Senator Titus.

Senator Titus:

Oh, so many questions. I appreciate you trying to take the challenges. We are going all over the place with these questions as you do your presentation. I want to first acknowledge and thank you for the clarity, Director Weeks, and making sure that we keep the narrative accurate that nobody is losing their Medicaid at this time. I think that is critically important. Now, do we have to deal with it in the future? Absolutely. That is why we are having these meetings and this discussion, so thank you for being in front of that. Having said that, I have some questions back to the inspection and the licensing of facilities. It has been in national news. Some facilities run from perhaps folks from out of the country—having medical facilities that there is nothing there. The reporter brought this up. It was not because somebody inspected these places. I am curious about Nevada. I know that it takes personnel, and I know that you do not have enough. But when you license a facility, how often do you inspect it? This Committee had to deal with—in Reno—childcare facilities that needed fire inspections, and they could not get them done. I mean, it is a huge issue on the follow-up, and documenting that you have licensed this building. Do they even have any patients there, or what is the deal? How often do we in this state make sure that the these facilities actually exist?

Director Weeks:

I definitely know what you are talking about from the videos and have seen that. We were just talking about that internally. I know with Cynthia Leech moving into the Administrator role—one thing we are thinking about—are they keeping the right medical records? All the things that they are supposed to be doing, are they doing it? There is a challenge getting out. I will follow up with you—if that is okay, by facility type—how often we are required to go out? My understanding is often we are in, for example, the hospitals, the skilled nursing facilities and sometimes PRTFs on a regular basis, because of complaints we are supposed to go out. I think the challenge—a lot of it is workforce, but will we ever have the workforce we need to be watching every provider? There are a lot of providers. One thing we have been thinking about, or at least I have been noodling on, is the All Payers Claims database. We can maybe track actual claims data, and we can notice when a provider has some anomalies and whether or not they are billing; there is ways to do that. Also can we hire contract staff, for example, more on a interim basis to go out on these facilities. I think what we are going to have to do internally is look at—is there a better way of looking at data, because we cannot be everywhere all the time. People—unfortunately—that do these kinds of crimes are very clever. But are there ways that we can be looking at data—not just Medicaid data, but private data too—from the all payers claims database to see any trends, and some providers who are not billing, for example, or any anomalies? Often that is where we are catching fraud. We just got an amazing new system for Medicaid, and I can tell you it catches any anomalies—like out of the norm all of a sudden we are billing for a lot of prenatal vitamins for seniors—men. There is like things like that we can kind of catch. But

when it comes to like having empty facilities, I think it is going to be the challenge of—do we supplement our current workforce with contractors? But yeah, it is something I think every state is definitely like, "Oh no, are we doing enough?" But it is a challenge to keep up with the fraud.

Senator Titus:

Well, thank you. I know you do a good job at long-term care; as I was the Medical Director of Long-Term Care for decades, we saw you—I think sometimes too often. I want to thank you for that; so I appreciate what you are doing.

Chair Brown-May:

Thank you. Members, any other questions? I am going round back out to the original question regarding timeliness. I am curious to know timeliness to assessments. You mentioned that while we had the original DOJ Settlement Agreement that recognized a standardized assessment to time to assessment. I am curious to know, are we narrowing that? How close are we to to fixing that assessment piece?

Administrator Jensen:

It is a good question. What you will see in the data as we share that initial trend—we just started tracking this in the past six months. I will admit it is a pretty limited view, and it is very specific to kids that are in our focus population. I am excited to work with Ali and our Office of Analytics Team to expand on that to see if we can show some broader trends across our state for kids on the Medicaid Program that are accessing assessments. I cannot speak to trends across the board, but I will say for our focus population, we are seeing some decrease over time over these past six months. I would hate to take that to the bank before we really have a broader sense of what the data looks like though. I will be the first to admit we have a lot of work ahead of us on the assessment front, and we are doing that really methodically and with a lot of input from partners nationally. At the University of Connecticut Innovations Institute, we are receiving technical assistance. I work very closely with my counterparts in other states that have implemented these types of programs. There is a lot of different ways to do it, and I think what is really crucial is that we are both collecting information in a really sensitive manner to these kids and families, and not asking them to retell their stories over and over. But we are also decreasing the administrative burden for providers, so we can share that information as seamlessly as possible. I am really excited for the specialty plan to be part of those conversations starting this spring and summer as well, because they will have a key role to play. But I will say our initial data view is limited. It is initially heading in the right direction. I would hate to really say that we are too far into it, because there is a lot of work ahead of us, and happy to share what that work plan and timeline looks like if you are interested.

Chair Brown-May:

Thank you. Yes, I would appreciate that additional information, and please do share that. Okay, I think we are good and ready to move on to the next subject.

Director Weeks:

We will dive into Justice-Involved Population and Care. This came from a bill from Speaker Yeager to seek what we call the "Reentry Justice-Involved Population Waiver." Before these waivers were approved at the federal level—for decades—Medicaid has really never covered anyone who is considered incarcerated—and that can be in the jail—that can

be someone in juvenile justice. Even though we cover this population immediately when they leave, we are not really able to support sort of that transition. I think the point of these waivers was to allow people getting ready to reenter communities—so 90 days pre-release; these waivers will allow Medicaid, once approved, to cover a variety of health care services included in that bill, including things like medication-assisted treatment, behavioral health care, case management, basic medical care. I will note, just to correct myself for a second, if there is an emergency, and someone in a prison setting or who is incarcerated under the law is in an emergency and sent inpatient, we do cover that. But that is not always what they need, so people need care to prevent the emergency situation often. This is really allowing us to get more upstream and to support individuals who often need to have their behavioral health provider already arranged when they leave, already know that they have their medications ready, or already on the right medications. All of that work can start now 90 days earlier. Our team has been working really hard under Deputy Malinda Southard. She has been doing all the implementation of this waiver. Once it is approved, it will be under our Medicaid team, as sort of like any other benefit that we cover, so Ann Jensen will be overseeing it at that point. But I would say that the challenge has been—we did submit it in December 13, 2024. It has been over a year. We were told lots of things happen and CMS likes to tell us a lot of things, but of course, never in writing. They told us verbally at one point that it would be approved in September of last year, and then we got word that all waivers were on pause at the federal level. Now we are looking at hopefully early this year. This is a really important effort, and I know that our prison system and correctional facilities and people that we work with and colleagues there are really anxious to get this funding. It will help offset cost to counties for a lot of these efforts that they are having to pay for themselves, including the state. We are working with the vendor to really—the one thing I would say is implementation is going to be a lot for these facilities. We did get some funding to help us build out the ability for our systems, prisons, jails, and our juvenile system to bill. That is going to include needing to get electronic health records, so they are kind of like our school systems. It is like taking a system that has not really billed or been part of the health care system, and helping them in a not—because they are nontraditional providers in some ways—getting them enrolled, getting them billing, and all of that. Our team is working hard on that with a variety of vendors, and thanks to a federal planning grant that we were awarded. I am going to stop there for questions in case members have any.

Chair Brown-May:

Thank you for that presentation. It does not appear as though we have questions, so you may proceed.

Director Weeks:

Next, we will talk a little bit about our work at the Marketplace Health Insurance. This is our Nevada Health Link. It is open enrollment season, still in Nevada, and this is where individuals who are not on an employer plan, who do not have affordable coverage under the ACA through their employer, or who are not in Medicaid—can go shopping. A lot of these individuals are eligible for what we call "advanced premium tax credits" to help buy down their health insurance. There has been a lot of discussion at the federal level. I want to clarify, advanced premium tax credits are not going away altogether—it is just that enhanced subsidy that was on top of the regular ACA tax credit is going away. There was an additional increase during COVID-19, but I want to talk a little bit about what we are seeing, and then if there are questions we can go from there. We had our open enrollment start November 1 through December 31, for anyone who would need coverage January 1. We do have January 1 through 15, for coverage that starts in February. At that point, they would have to have a life condition change in circumstance to actually come in, and change

health plans, and enroll in the marketplace. I can say that we have had some challenges regardless of the advanced premium tax credits—the enhanced ones expiring. On average states are seeing really historic rate increases. I mean, we are seeing on average across our individual market about 26 percent higher. That is huge, and I will say we are seeing this similar in Medicaid—not up to 26 percent, but it is double digits. There is something going on after COVID-19 in acuity in the population, and just the cost of health care is really going up, and inflation is very high. Like I mentioned, losing those enhanced subsidies during this time is a challenge for families. But there are some opportunities that we have in our Marketplace. Unlike some states, we set up a new reinsurance program for this year, as well as our BBSP, which is the public option. These programs together brought down the premium reduction. They did a premium reduction in the market of about 7 percent, which was really the target that we were looking for with the public option. The average consumer premium cost was reduced with this new program of about 4.7 across all rating areas. You can see here the premium amounts without—what we call "without waiver"—which means without the public option premium reduction target and the reinsurance program. Then there is with waiver, which means with the new public option and the reinsurance program, and you can see there the rate difference by rating area. All carriers reduced premiums by 4.4 percent due to this reinsurance program. Our public options are roughly currently 8 to 9 percent enrollment. They are anticipated, especially with consumers still shopping—we expect that to continue to go up. It was actually closer to 8 percent when we put this together and now it is at the 9 percent mark, so it has gone up in the last week or two weeks. I cannot remember what day it is. I am going to go through this slide real quick, Madam Chair; because I think it kinda is the whole picture, and then we will open up for questions. On this slide here, and you can see on the box here, because I knew that when I put this on the PowerPoint you probably would not be able to see these numbers. If you look at this box—and this is a snapshot in time where we are, roughly right now, in open enrollment. We are not done as you can see. You can see that orange line, the one above that is where we were last year. As you can see, we are not that far off, surprisingly, given all the rate increases. I want to note, about 50 percent of the market right now is auto enrolled into a plan, which means they have not quite gotten their bill. When they get their first premium bill this month—we are likely to see—there is going to be probably some fluctuation here. Of those that actively enrolled, that means they came in, they shopped, and picked a plan instead of automatically being reenrolled in their product. About 20 percent of those are in the new BBSP. But again, I think we are not going to have a good sense of where all this lands until we get through that this month, and see at the end of February where everything shakes out. We could have people drop off—we could have people—we are encouraging people to shop. If you can please encourage your constituents to not give up if they get a high bill—to go and shop. We do have affordable products. They may not offer all the same benefits. But we really want people to come in and shop, and make sure before they decide that they are just going to disenroll and be uninsured. Our big campaign right now is please come shop and look to see what we have if you feel like your premium increased and your auto-enrolled is too high. We will have more information for the Committee, hopefully, at the end of February—kind of where things land. I am going to open it up for questions, and to see where people are.

Chair Brown-May:

Thank you for that. We will start with Senator Doñate.

Senator Doñate:

First and foremost, I want to say, thank you Director Weeks and to your team on the implementation of the public option. I know that it took you many, many hours and years of implementation. I think—for me at least—it is a success when someone that was uninsured now finally has health insurance access. That to me is a big win, so I want to commend your team. I know it was a very arduous process to work with the federal government for its approval and seeing it implemented. I know it is going to take some time to see the benefits of it, so I want to, first and foremost, say thank you. I know that we have exchanged offline in terms of demographic information, in terms of those who are being enrolled, in terms of their economic situation, their job status and so forth. I look forward to receiving those numbers, and hopefully that can be shared with other Committee members as well. I wanted to ask a specific question regarding some of the concerns that we have seen. At least on the news. I know that there is hesitancy from some of the brokers in terms of enrolling patients into the public option. I want to reiterate that it is their responsibility and their ethical duty to do so, and I want to make sure that that is being implemented correctly, and I know that the Legislature allocated you some dollars to help with this process. I do not know if this is an appropriate question for you to provide an update on how those dollars are being utilized. I know that there is some cross reference with the DOI to make sure that they are following the ethical code, but that is a separate conversation for another entity.

Jennifer Krupp, Administrator, Consumer Health Services Division (CHSD):

Thank you, Senator Doñate for the question. That is a very wonderful one. Thank you to this body for approval of SB 4 in the 36th Special Session of the Nevada Legislature, which appropriated $1.25 million to the BBSP Public Option Program to help support carrier or broker incentives to enroll consumers into BBSP. This was a challenge from our certified on exchange brokers, because they had several concerns about not being compensated in any way for the enrollment for consumers into the BBSP. As well as there were concerns about their professional errors and omissions liability insurance, and because there was the appearance of there not being a business transaction—that they would not have sufficient coverage for that. With the $1.25 million, we are issuing payments to brokers at the end of open enrollment, once we have finalized numbers for any and all enrollments that occur into a BBSP. We are issuing this at a flat fee, and we are considering these a—a grant fund to reimburse these brokers for any of their expenses in time that may have been incurred for signing these consumers up. To qualify for this grant, we have requested that all brokers take an additional certification on the exchange for—and it is about a 15-minute certification that walks through the BBSP, and does clarify some of the misconceptions that were brought to our attention here at the exchange. In the lead up to open enrollment, and at this time, of the 794 certified brokers that we have—we have about 70 brokers that are still outstanding who have not taken the training. We do have active outreach that is occurring on an individual basis to those 70 remaining brokers, and we are very hopeful that they will get that certification completed. At the conclusion of open enrollment, and once we have finalized data. We will run an analysis with our open enrollment reporting to determine which consumers not only enrolled into a BBSP, and which consumers actually effectuated their coverage, which means they paid their monthly premium to make that coverage become effective. We are expecting to get that finalized data in March, and at that point, we will issue payments directly to the individual certified brokers on the exchange. Thank you. Happy to answer additional questions.

Chair Brown-May:

Thank you. We were trying to determine whether or not we had additional questions, so I appreciate the follow up. We do. Okay, next Assemblymember Nadeem.

Assemblymember Nadeem:

Thank you so much Madam Chair. Thank you so much Director Weeks, for the explanation, and for the presentation, and for telling us such new information. My question is regarding the premium increase. One of my friends, she was telling me—even yesterday, I had a talk with her, and she was telling me about her premium increase. Which is from $1,000—she was paying for her insurance, and now it has suddenly jumped to $2,000. She was like—she had to do some cuts, and she had to go from PPO—that is that she can see all the doctors to HMO—that is the limited access to the physicians. The people, and this is—I am talking about the ordinary people. People who cannot afford jumping from $1,000 to $2000, but there is a gap. Is there any specific information or the insurance that they can get to—instead of going without insurance, and then have the health problems. What they can do? Is there, is there any guidance on that, please?

Director Weeks:

Yes, I would encourage them to go to Nevada Health Link's website—put in their information to see—she; they may be eligible for advanced premium tax credits. Yes—it is still, you know, there is still premium increases in a lot of the products. But if she—if they can go in and shop. There may be some hard decisions, unfortunately, that some families have to make. Like they may not get all the providers—and that they had today—or they may have to pay a higher out of pocket. I would encourage them to go to our navigators who offer assistance to individuals who are just trying to understand the coverage options in front of them, and that could be a helpful resource. There is also a broker, if you prefer a broker, but there are a lot of resources to help families make some of those decisions about like how can they pick a cheaper product? And understanding what they are—when they are picking a cheaper product, what the—the pros and cons are of those products. Thank you.

Assemblymember Nadeem:

Thank you so much.

Chair Brown-May:

Thank you. Members, any other questions?

Senator Titus:

Madam Chair?

Chair Brown-May:

Senator Titus.

Senator Titus:

Thank you. How—when does open enrollment close?

Administrator Krupp:

Thank you for the question. Open enrollment officially closes on January 15, 2026. However, any consumers who have completed an application but have not selected a plan as of midnight on January 15, will be given an additional five days to fully enroll into a plan. Any coverage that is selected during that time would begin on February 1.

Senator Titus:

Thank you for that. Follow up question, Madam Chair? I—where is this being advertised that folks know that this public option has started, and that it is going to close on the 15th. Here is an option for you as someone mentioned just now in Las Vegas that, you know, their premiums jumped up $1,000. What is the public service announcements? How is this being rolled out? Because I have yet to—I mean, I am fully engaged in this process as you know. But I am wondering about literally as a citizen, constituent, consumer myself, have not seen anything about what—other than what I am engaged in.

Director Weeks:

I can let Jen speak specifically to some of the marketing. I think a big piece of what we do at the Exchange is market sort of shop, shop, shop; and please come and take a peek because we do have this new option. There have been things like—I think—at some of the hockey game, there was an ad. I will say that that those ads are on TV. But, you know, it is not only just about the Battle State Plan, that is an option alongside other options. There is one rating area where, you know, the second lowest cost silver, which is where you maximize your tax credits. You know, there is one rating area where a health, another carrier beat the BBSP, and came in even lower. I think, you know, we are encouraging in our marketing strategy at the exchange to—for people to shop. Jen, I do not know if you want to talk a little bit about any of the outreach in the rural areas. I know there are Navigator events too.

Administrator Krupp:

Absolutely. Thank you for the question. The Exchange does have a very robust marketing and outreach campaign. In October alone—that is the most recent number that I have actual data for, but we attended, I want to say over 100 outreach events through our Navigator entities and organizations. We also have 11 grants directly to brokers to help promote open enrollment on the Exchange, and help assist consumers with having an actual face-to-face person to sign up for coverage because there tends to be a lot of questions. Within the Exchanges marketing campaigns, we have also talked quite a bit about the option of the BBSP, so that consumers are aware of these plans. However, the Exchange itself cannot promote any, you know, one type of plan over another. Another avenue that we are working very closely with our carrier partners to market and provide some outreach for the BBSP is in with each of our carrier contracts. Each of the BBSP providers are required to submit to us for approval, and execute on outreach and marketing plans, and so we have been working very closely with our three BBSPs, and they have been working very hard to include these plan offerings with their existing marketing and outreach efforts. We also send out weekly newsletters. We have social media posts through https://nevadahealthlink.com. Really, as Director Weeks had mentioned earlier, our biggest message this year is to encourage consumers to come onto the platform and shop. Because in many cases, consumers are going to find lower plans—or lower cost plans that do maximize their financial assistance and subsidies further than the plans that they may have been auto-enrolled into.

Senator Titus:

Thank you for that, and then finally, at least on this subject. So, the broker payment, it is going to be a flat rate once they have—they can show what, so you are going to pay them after they do basic—we are paying them to do the job, which that is a whole another comment. However, the rate that you are paying them, is that a standard rate that the—say private insurance—would pay them? How did you figure out a rate? There has been some concerns about what are we paying these folks to do their jobs.

Administrator Krupp:

Thank you for the question. Through the funding that was awarded through SB 4 from the 36th Special Session, the payment is substantially lower than what a carrier would normally pay a broker. I think on average carriers pay a per-member-per-month that can total to, you know, $200 or $300 a year, but with the one flat fee of $35, I mean, that is going to be significantly lower. We—looking at our rate filings and our counterfactual rate filings from all carriers across the market, we anticipated potentially up to 30,000 consumers who might enroll in BBSP. And so, while allocating and leaving some money aside for any special enrollments that may happen in plan year '26 after the close of open enrollment so that there is funding reserved for those consumers. We basically did flat math, and so $1.25 million divided by 35,000 came out to about $35 per enrollment.

Senator Titus:

Thank you for that. I like flat math, not emotional math, so thank you for that.

Administrator Krupp:

Myself as well.

Senator Titus:

Thank you Madam Chair.

Chair Brown-May:

Thank you, Senator. Okay, seeing no other questions. Feel free to move on.

Director Weeks:

Thank you, Chair. All right, so now we are going to talk a little bit about our focus on our—some project updates where we are working on program viability. I mentioned earlier—trying to really look at cost, and what can we do to control spending and get more value out of our dollar. The first one here was past last session. It was a single PBM—Prescription Benefits Manager. We are working hard to get that up and going. We also have a single prescription drug list that went live January 1, as well. Which also we anticipate will bring in additional rebate revenue that is helpful to the state. Proud to say that that went up and live, and is going well so far, fingers crossed. If you have questions from anyone about their prescriptions or anything that happens, and you have constituent requests, please send them over to us. We are happy to help, if there is any confusion. We all—I am going to talk a little bit about our purchasing strategy, and then our efforts around some of the federal funding maximization that we are looking at right now. We are going to do more of that over the years as well. All right, so Dr. Duncan is leading our single PBM, and she also led our single PDL implementation. Again, this comes from SB 389, and we are

setting this up, and the goal was to really control the cost for our—for Medicaid around prescription drugs. And I—you know, we are not the only state that is really looking and will be doing this. We know Ohio, Louisiana, and a couple other states—I think even Minnesota is standing up something—all states are grappling with the growing, really high cost of prescription drugs. Right now, we are working through all the different authorities that we may need with the federal government, and different models to ensure that we are maximizing our premium tax, still we do not want to impact our premium tax revenues that we get to tax these—the revenue—or the expenditures from prescription drugs today through the managed care plans. We probably will be getting a waiver to ensure that we can protect those revenues, and still tax the expenditures for the state. We are going to be doing an RFP [Request for Proposals] for vendors to help support the implementation, and that is anticipated next year. We have, as permitted in the legislation instead of funding it then, because we were not sure what we would need until we really work through the different models that we can—we will be working with. We now have a sense of some—of the new—of the staff that we will need, and we will probably be coming back again later to IFC for additional money. But we will be using some of our rebate money out of the budget account 3245 to get the staff, and the resources we need to implement this program. I will just say this is not an easy task and will take several years. But our hope is that it will be definitely worth and valuable to the state in terms of controlling, or at least maximizing rebates from prescription drugs.

The next one here is our Health Care Purchasing. This is really going to be working across all of our programs; and where can we be smarter when we are contracting with carriers. Even just some of our basic vendor services. I mean, we have multiple actuaries I mean, should we be streamlining those more? Should we be purchasing those and procuring those in a way where we are get—we are going out with all of them to together, so we get a better deal, you know, for the state. We are looking at even things like that, but then we are looking at broader. What can we do, for example, to really support PEBP? We know that there are still some challenges, right? We know people—state employees, that the premiums are expensive, and we need to ensure that we can pay our bills for that program. Those are hard conversations that need to happen. But what can we do from a purchasing strategy to help them? We are going to be looking at that. We have new vendors that we will be going to BOE [Board of Examiners] next week for which is—I think maybe this week, I cannot remember, one of these weeks is coming up to get these, finally get these vendors on board, and so we can start to model a couple of ideas that we are going to ask them to put together some recommendations—and so we will be modeling that and bringing some of those to the PEBP board. Hopefully some of those to this Committee, and then obviously, if there is legislative and there probably will be changes needed, or funding. We will be bringing that next session, but happy to keep everyone up to date on that. Like I mentioned, it is really leveraging that footprint. Often it is Medicaid, is the big one, it has the most money tied to it. But putting them all together, and making sure that often it is the same carrier we are contracting with, or the same vendor, that we are getting the best deal for all the programs from the same vendor. The other effort that is being led by Deputy Director Lynnette Aaron—oh, sorry, I forgot to stop Madam Chair. I will stop for questions.

Chair Brown-May:

Thanks. If you go ahead do that one next one, and then we will stop for questions.

Director Weeks:

Okay. Thank you, Chair. A lot of this came from last session, thanks to this body. You guys added additional staff, and resources, and vendor support for us. Not only to get our arms around our budget challenges, you know, just in general in terms of staffing, but also to support ways to really maximize federal funds, and ensure that the way we are spending them is appropriate. Lynnette has been working already on some of these efforts and I wish I could explain it. I do not know if she is here today. I think it is her birthday. But I know already she has been able to achieve, I think $100 million in additional money for the state and for providers. So, there is a lot of exciting things there, and happy to bring that to next session, and update folks on some of our efforts. We are in the process right now of getting our fiscal audit team hired, and getting some of those other contracted Medicaid budget experts up and going. I am really excited because I do think there is opportunities not just within NVHA to leverage Medicaid dollars in support of efforts that improve outcomes for the Medicaid population, but also for public health. When you look at, for example, 988, we can definitely be helping on the administrative side, because that service serves a lot of Medicaid recipients as well as other public health activities like screenings, and assessments, and preventative services. So really looking at ways to maximize that, and Allison on our team, Genco Herzik, will be working on that with the DPBH. The other thing we have been doing, I mentioned this earlier—is looking at ways that we can do Medicaid academic partnerships, not just with—to get physician and clinical support for our team, but also to partner, for example, with the University of Public Health. The one specifically right now—or University of the School of Public Health. The one at UNR we have been talking to about a public health strategy or population health management strategy, and hoping we can leverage their expertise, and some of their students and training too. To help us put together a larger population health strategy for all of our health care programs, for the state. All right, I am going to pause there Madam Chair and open up for questions.

Chair Brown-May:

Thank you. Members, questions? Okay. We only, we have one I believe. I am curious to know if you could identify for us—in a report for me, not—please do not talk through necessarily, right this minute. How many waivers do we have, Medicaid waivers, and what is the administrative time it takes to-to do that? I know that it takes a significant amount of time to complete a waiver and to make the request. There are a number that are pending or have been pending, and I know you will get into how many requests we have for the division as a body a little bit later in your presentation. But that is a question that continues to pop up. How many waivers do we have operational within the state?

Director Weeks:

Madam Chair? Yeah, Madam Chair, I know we have more than five, probably eight, now. I have to go back and look, I will get you those numbers. You are correct. It takes a lot of time. Often we need to have one dedicated individual, it is also pulling data, we have to do quarterly reports on some of these waivers to CMS on a regular basis. CMS is always up in our business wanting to know, and especially 1115 wanting to know is it budget neutral, right? All the math and the time that goes into that for, you know, budget neutral to them. It is a lot of work—not only like you said, getting them. But we do—it is not like once you get them, it is done, you know? They—instead of getting like a state plan amendment approved, where a benefit is a solid benefit in our program. Waivers are—we are going to test you and make sure this benefit meets all of our federal requirements, you know, and every year there is an evaluation that we have to do, an evaluation plan, data analytics.

There is so much work that—it is not to say they are—they are bad, they are there—they are a lot of work and time, and a lot of staff time. Thank you for that question.

Chair Brown-May:

Thank you. Okay, go ahead.

Director Weeks:

All right. Thank you, Madam Chair. All right, let us talk a little bit about Workforce Capacity. We have a couple of new opportunities—was exciting—we have the World Health Transformation Project and Grant; the SHARK—or SHARP Grant; the State Health Care Access and Recruitment Program; GME [Graduate Medical Education] Advisory Committee, there are a lot of changes. Last session, I want to talk about what we are doing there and then generally some of the work. I know the Committee had questions about what we call our "Quadrennial Rate Review," but I want to talk a little bit about that program, and kind of what it means, and what it does not mean for this Committee.

Our new workforce grants, like I mentioned are two. The big one is H.R.1 established up to—well, it is about a $1 billion, or sorry, $50 billion across all states, but the CMS advised states to at least apply for $200 million, so that is what we threw our dart at. Some states obviously applied for way more, we are learning that with the awards, but we applied for $200 million per year. It is the—you have to apply each year though for the funding; so each year we will not really know if we are going to get the full, you know, billion at the end of the five years that we were aiming for, because each year could be different. We did get the award—I was very excited. It is $180 million, so it is $20 million under what we asked for, which I think is a win. We have four initiatives that we recommended, and I will say that Malinda and her team worked really hard to engage stakeholders in a very short amount of time. I think we had like, what, nine weeks; if not less. Once we finally got guidance about what this thing was going to be we did a huge statewide survey even with the cyberattack, and we kept trying to get that out, and it felt like the world was working against us a little there, but we did have multiple stakeholder meetings. We also had a subset of stakeholders that were close to the rural hospitals, and the rural providers, the Primary Care Association, and a small advisory committee to our team in putting our application together. I want to say that—thank you to all of those folks that participated because we could not have come up with these on our own. We definitely felt like we got a lot of advice and support, and tried to do our best to make this meaningful to rural Nevada. The first initiative is our Rural Health Outcomes Accelerator. About 15 percent of that award of the $180 million we think will go to this program. I will say we are still trying to figure out if they reduced it down from $200 million, did CMS mean to reduce it out of one bucket, you know? We are still—there is some open questions there that we will be having conversations with our CMS project officer about this grant, and whether or not they wanted us to reduce a certain—a certain initiative. So right now we are hopeful that it is just percentage wise the same, but we will know more information in the coming weeks once we have time to digest this with CMS. We also have—and the Outcomes Accelerator is really focused in on what Dr. Oz and CMS is really asking a lot for was that make, you know, America Healthier Again, and really focus in on chronic disease. These initiatives really need to be focused in on improving health outcomes, and so we are creating an accelerator program for this percentage of the funding. The second one here is what we call our "Rural Health Care Flex Fund." We heard a lot from even on—way before this grant, we have heard a lot from our rural hospitals, critical access hospitals. Often they cannot afford to even buy the ambulance, or they cannot afford to, you know, the new x-ray machine, or the mammogram, you know. All the things that they need to support their community,

often, that technology or those resources are just unattainable. This Flex Fund is to support those one-time infrastructure needs for rural communities, and so we put about 20 percent of the annual award into that bucket. There will be an RFA- or RFP-kind of process for all of these, and so there will be procurements in some ways, or request for awards, and so people can apply for the funding. Malinda can speak more to some of those details if needed.

Then the third one here is the Workforce Recruitment and Rural Access Program called "RAP." The first one we were joking, it is a ROPE. The third one here is RAP. It is really supporting what we heard a lot from our rural communities is the inability to attract providers and physicians. We wanted originally to do a loan repayment program, a very large one, and I think we heard very loud and clear from Dr. Oz and others that they were not interested in that for what—for a variety of reasons. We went back to the drawing board with our partners and decided to really focus in on a rural, you know, GME kind of program helping find something like that, or programs like that. As well as incentives for physicians or any type of provider that is needed in a community, and a clinician incentives to—for them to move there. For example, helping with housing, bonuses—one time, you know—salaries or signing bonuses, those types of things. We are hopeful that 40, but we put a lot of funding into that bucket because we know that is a huge need. The other piece here is around Rural Health Innovation Technology Grant. This is also something that CMS really wanted to see in our application. That was the feedback we were getting. We had a lot of, I will just be honest, multiple vendors wanting this money and still to this day, and that is not always bad. But I also want to be mindful that we want to make sure that this funding is sustainable for communities and actually is going to improve health care. We want to be careful that it is not just a slush fund for every new idea, that these are meaningful evidence-based solutions. But there are a lot of telehealth and AI [Artificial Intelligence], even AI tools for consumers and for residents in rural communities that could help improve health, and so that is what this bucket really is for. There is more jar—there is more information in the application, but at a high level that is what these buckets are. The second one here is our shark—our SHARP Grant from special session, so thank you to this body. It is one-time $60 million, and it really is to support workforce capacity and sustainable results for care, and giving funding to help really build out our infrastructure. This funding, just a reminder we keep, we have already had a multiple requests, the money is not already ready. We need time, but also the money does not become available till next July, so I want to kind of put that out there. Once it is available, you know, we will be coming to IFC this summer to get some additional staff, and vendor support to actually do the RFP and the procurement process we need to do for that program. We are working and looking at the access report that needs to be developed as part of this program. I am going to stop here, Madam Chair, because I am sure there are a lot of questions, and we can open up from there.

Chair Brown-May:

Thank you. Members, questions?

Senator Titus:

Madam Chair?

Chair Brown-May:

Senator Titus.

Senator Titus:

Thank you, again, thank you for all of that. I am curious about the reimbursement for the providers, and wanting to make sure that the term "provider" is not just narrow into a physician. Because you mentioned the one-time funding for things in rural Nevada, such as a mammogram, which is a absolutely true, but we had a mammogram we just did not have somebody to run the mammogram. And so, that may not be what you think of as quote unquote a "provider". So reimbursement for lab technicians, x-ray technicians, and these kind of critical specialties that we need—wanted to make sure that that list umbrellas all of the things to take this new infrastructure money that you are now giving these hospitals, but with nobody to run them. It is not unlike the education, where we had laptops out there in these classrooms and they sat in boxes, because there is nobody to teach the kids how to use it. The same with this—you can give us all the infrastructure we want, but if we do not have somebody to push the buttons or trained to understand that it, it is not going to help us. Can you explain to me what that provider reimbursement pattern or reimbursement project looks like, and who it umbrellas, because there is a real need even from just a phlebotomist.

Deputy Director Southard:

Madam Chair, members of the Committee, thank you for the question. Yes, all those provider types that you mentioned are included in this and more. We are looking at a wide variety of health care providers to, you know, fulfill the infrastructure needs that we have in rural Nevada, and we want to ensure that they stay in rural Nevada as well. So everything related to the RAP initiative will be tied to a five-year rural service commitment from those providers.

Senator Titus:

Thank you. Thank you, Madam Chair.

Chair Brown-May:

Thank you, and then one follow-up. With regard to—while we applied for the $200 million grant over that five-year period, we have one awarded $180 million. I know that you noted that you are following up with CMS to figure out what was not funded. If you do not mind sharing that information, once it becomes available to you? I am also curious to know, was there something in the—in our grant that they just did not want to fund, or is it an overall percentage reduction?

Deputy Director Southard:

Madam Chair, members of the Committee. Thank you so much for the question. Yeah—so our application—the way that these grants are funded, it provides a funding formula. There is 50 percent of the funding is baseline funding that is awarded to all approved applicants. The other 50 percent is workload funding. That funding is split into another 50/50. So 50 percent of the workload funding is based upon a state's rural facility and population score, which is provided in the application in all of our rural demographics information and things of that nature. That score is set, and will not change throughout the life of the grant, so as soon as we submitted our application CMS calculated that score, and provided us the appropriate number of points based upon that score. The other 50 percent is based upon technical scores. The technical scores can go up or down depending on how a state performs each year of the grant. It goes back to the different initiatives that we wrote into the grant, the state policy actions that the state committed to in our application, and all

those, all those different variables within the grant. We have not received word from CMS on anything they did not like in our application. I do have a meeting with CMS next week to discuss how to submit our budget revision, which is due by the end of this month, and we will provide an update to this Committee. Thanks.

Chair Brown-May:

Thank you for that. Okay, I think we are ready to move on.

Director Weeks:

Thanks, Madam Chair. All right. We will talk a little bit about GME Advisory Committee. Again, that is Deputy Director Malinda Southard, who is overseeing this program. On the right here, we have a new website that is up and going. I will say this one actually has a lot of information is really, I think useful, hopefully you guys can check it out. This under SB 494 was transferred over to NVHA, before, it sat within OSIT [Nevada Governor's Office of Science, Innocation and Technology], and under SB 262 we got a couple of things. We got an additional $9 million, when you added in that into the current appropriations for this Committee and this Program, it did go up to about, you know, as you can see there—quite a bit of money. We did also get balance of forward authority, so if we are not able to spend all the money, we do not lose it, we can move it forward, which is great, because before that was kind of a problem. Also the focus with this funding is on infrastructure grants to help GME sites set up GME programs, and we know there have been challenges with that in the past. One of our first things that we, you know, really focus in on—it was really important to the Governor's Office and the Governor—was to get this Committee meeting. So we have already had, I want to say two meetings, and they have been very long. We have elected a Chair, we have already went through a scoring rubric for the proposals. We hired a vendor, Mercer, that has expertise in working on these types of initiatives nationwide, as well as leveraging Medicaid reimbursement increases to support providers to help this Committee and to support us. We are moving forward very fast actually, and I know we have another meeting coming up soon, and I think the meetings have been very productive. Our goal with this is to ensure that when we do select grant awards here soon for the summer, that it is a transparent process. We are really outlining that now with the Committee, and our goal is to start the procurement for these grants and awards in the spring of this year. Then hopefully, if all goes well—we have, you know—the Committee scores them, they make the recommendations to myself. Hopefully, everything is approvable, we will be issuing those awards this summer. Whether or not we spent all the money in the first round is a question about the types of applications we get, and whether or not we think they are actually viable. I will say there has been a lot of discussion about the overlap here with the Rural Health Transformation Grant as well as the other grant. So, we have been talking through how do we ensure that this funding goes to programs that would not otherwise qualify for those other funding sources, right? Because these are limited state only dollars and same with the SHARP Grant, but we want to make sure that we are leveraging as much of that federal funding as we can to support other programs too. That is part of the process that will be part of the Committee's review, and then I, as the Director, will hopefully be able to weigh some of that in the final selection, and looking at would this—would this opportunity be better served under the Rural Health Transformation Grant? For example, we can best ensure that we are fully maximizing our state dollars for these programs. I will stop there to answer any questions.

Chair Brown-May:

Thank you. Committee, questions? I see none here in the South. Feel free to go ahead.

Director Weeks:

Thank you, Madam Chair. All right. So, last but not least on this bucket is the Medicaid Provider Rate Assessment. I think many of you probably know about this, it is been around for a while. It is under state law [NRS] 422.2704; it is what we call our "Quadrennial Rate Review", our QRR, it is usually posted on our website. I think we are still in the process of—since the cyberattack of getting all that updated. We just finished our 2025 report, and we will be issuing our 2026 report, hopefully, by the end of the year. It is in process. As you can see on the right here, there are the provider types we will be looking at that. This program, or this effort really looks at assessing the reasonableness of rates as defined under the law, and it is based on cost reporting by providers. We have had some challenges with this—in this process. While it is valuable for us to look at—how are the costs being reported, and whether or not our rate actually meets the cost that they are reporting. There are challenges with this, for example, we have a very low rate for providers to self report their costs. We rarely get very—a good sample size, and that really, I think, affects the entire evaluation. We do our best with what we get, but often it does not give us a real picture. I would also say there is also a flaw, and when we look at cost reporting, when you think of these providers—their cost typically, especially, if they are Medicaid primarily funded providers through reimbursement—their costs really reflect the money we give them. It is kind of a self-fulfilling prophecy, right? If we pay you $100, you are definitely not going to hire anyone more that does not—you know, that $100 does not cover, right? So their costs really reflect what we pay them. So again, it is kind of this vicious cycle like, is this really reasonable? I, you know, so those are things we have been grappling with, and so some of our vendors we have been talking through. Are there other things? I think the nice thing that we do do in this analysis currently is look at other states. I think what we could be doing probably is—are states looking at other factors beyond cost? Maybe we should be pulling some of those factors in. Those are things that we are thinking that should be improved in this process, and maybe we should be including some of those things in the report, not just the bare, here is the cost versus our rate. Now, sometimes it is very shocking. Sometimes it is very clear we are—we have not increased our rate, for example, in decades, and that it is definitely telling when you look. But honestly, if someone—if we are not helping cover the cost, and it is a provider that is primarily a Medicaid provider and—that is all—they mostly see Medicaid, those providers right now would not be open, right? I think that is the challenge of cost-based reporting. That is why we want to look at—are there other things that we could be doing around rates, around quality incentives, outcomes, value, that value-based payment design to really get it increases, or should we be looking at market as well reasonableness compared to the commercial market, or Medicare, for example. So like I mentioned, we just posted 2025. It was really primarily focused on behavioral health. I think I brought this to this Committee, last time, during Interim Health with Chair Doñate, so some of that is still the same. A lot of these rates, thanks to this body, were addressed last session with the pro—hospital provider tax, thanks to our hospital partners for allowing us to use that funding for behavioral health needs in their communities. We are still in the process of getting that approved—all of them with CMS, but I think there are some real winds from that report that we—and ability for us to address those rates including occupational therapy and others. I will stop here, Madam Chair, and see if there are any questions.

Chair Brown-May:

Thank you. Members, questions? It is my understanding that we have listed the rates that will be reviewed over this next biennial cycle, and that each one of these rates is reviewed, although, it is not mandatory that we make adjustments to the rates even though we may have a recommendation. Is that accurate?

Director Weeks:

Madam Chair, yes, because if I did that I would not be able to pay for it. So anytime we increase the rates, we really, I mean there are times where we have a little extra funding and it is a low cost, right? So it—maybe it is a million dollars in our budget, we have a surplus, there is some flexibility for us to make those choices to help providers. But often these types of rate increases are significant—and if I, you know—I mean, it would be fiscally irresponsible I think of us as an agency to add all of these rate increases because we do not—it does not reflect the funding that we need from the Legislature. So one of the reasons we wanted to bring a lot of those last session to you, so you guys could help us fund them. Hopefully this session, this year, if there is money we will be looking at the results of 2026, and whether or not we can build out any of those into our proposals, or you guys can bring bills to also fund them. Thank you for that question.

Chair Brown-May:

Thank you for that statement. To that point, how do—there are a number of reports that are completed by your division or other state divisions that come to the Legislative body that are mandated reports. And like—I read six reports earlier this week, right? One of them was the Medicaid—a number of employees—employers with 50 or more employees that have folks enrolled in Medicaid, right? Which is a very important report, but that is one of a dozen or so, and I am being generous, right? Like there are more than a dozen reports that are completed. How are—is this a report that is completed and delivered to the Legislature that we can understand, as Legislators, when additional rate increases are required? So that as we go into a budget committee meeting, those are rates that we have an opportunity to consider, or alternatively is that just specifically handled within the Division and shared with the Executive?

Administrator Jensen:

Yeah, Madam Chair, Committee members. These reports we believe are really crucial to share as broadly as possible, particularly given they reflect data that our providers have submitted to us. So every single one of these reports is public, it is posted on our website. You will see the past, I believe it is seven years posted there from the beginning of this process. We are happy—I believe it is also directly shared with the Legislature, but we can confirm that, and develop a process to do so if it is not already. But that is typically posted in the fall to winter of every year. As we mentioned, that 2026 report is in process, the survey closed last month. We are processing that data, drafting the report, and it will be published the fall of this year.

Chair Brown-May:

Thank you. I appreciate the clarity around that. I would also say, as you talk about, what are you considering in a rate review? I think that is also essential given that there are providers that have overhead costs to operate a facility, and then other provider types that perhaps do not, right? That there are some provider types that the goal is to decrease the costs associated with institutional care by hypothetically providing a community-based service. As we are looking at those rates, I am curious to know the background information that is being considered before we go out and do a quadrennial rate review. I realize that there is a significant amount of detail relative to that, but I am just curious to know. Is there a questionnaire of some sort that we do internally in the state that identifies what type of rate, or provider are we reviewing, as we look at reasonableness?

Administrator Jensen:

Madam Chair, Committee members. That is a great question. It is a complicated process, and that is feedback we have heard directly from providers that have said, "It is not entirely clear what types of services you are asking us to include, and how to complete this report based on our specific delivery model." We actually surveyed providers this summer to ask their feedback, not on the actual cost, but on the process of submitting the cost. We got really significant and very useful feedback that we are happy to summarize and share if you would be interested. But a lot of it was, how do we better include information in the questionnaire that goes out to collect this data that specifies what we are looking for, and how we use it? Some providers would—for example, to your point—only include staffing costs, and that is not reflective of the total cost of delivering that service. And so based on that survey feedback, we included a little bit more detail in terms of how we would expect and hope to see overhead costs reflected in the overall cost of care. We recognize for some providers, they actually utilized actuarial services, or other kind of fiscal team members to make these calculations. That is not a resource available to most of our providers, however, and so we want to do our part to make this process as easy as possible. I am happy to follow up and share with you a link to what that survey looked like this past fall, so you can see kind of how that guidance is, and as always, we welcome feedback from providers on this. Our team had one-on-one conversations as well with numerous providers as well as provider associations, to better hear from them how that process is going, and how we can improve it, and also give them a chance to ask questions on that before it is submitted. So, work in progress, and we continue to welcome feedback to make this as straightforward as possible. Reflecting—knowing that each of these providers it is a very different process.

Chair Brown-May:

Thank you for that clarity. Okay, I think that is all the questions. We can move on.

Director Weeks:

Thanks, Madam Chair. All right, we are getting there, I promise. Medicaid, the last one here is Innovation Value. I wanted to talk a little bit about some of the projects. These are the ones I get excited about. I think they are kind of new and, and give us new opportunities. I want to talk a little bit about the Medicaid Express that passed last session, and what we are implementing with the exchange to really—especially help our managed care members, so they can shop, and choose plans, and get enrolled in real time. Also, All Payers Claims Database—where that is at, that was passed several sessions ago, and I want to—we want to give an update on the status of that. Centralized Credentialing—that went live, and talk a little bit about that, and maybe kind of hint where we want to go with that program. And then Value-Based Payment Initiative. Some of the efforts I mentioned earlier around our quality collaborative, and things that we are doing to try to really get better value for the dollar that we spend on health care in the state.

Hopefully this visual will be helpful. I want to give a quick overview of the Medicaid Express. On the left here, there is a bubble of the people, right? So this assumed there, does not matter, they do not know what they—obviously people that come to the Nevada Health Link do not often know—are they Medicaid or are they private market? Do they qualify for subsidies? The real goal here is to have that one-stop shop for individuals to come in, put their information in, and it gives them a—real time tells them, "Oh, you are Medicaid." If they are Managed Care eligible, which most of our population will be, or is at this point, they will move over to what we call the "Medicaid Express". There they can pick through the plans that they have available, compare networks, compare quality rankings, which is

something CMS is requiring that we start to implement. That will also be helpful to our members, and right now, there is just really not an avenue for that for our members. The goal here is that they, obviously it is a real time automated enrollment. This is going to take some time to implement, and I will walk through that in a minute, and kind of where we are at. But we anticipate, right now, about 90 percent of our enrollees really qualify for eligibility and enrollment through this portal. There are a percentage the folks that are what we call our "Non-MAGI" [Non-Modified Adjusted Gross Income]. It really is based on that tax return—the Modified Adjusted Gross Income, I think we have all seen that on our tax returns. That number there is really what this system focuses on. That is the same methodology that is used for people who shop on the exchange. That was the point under the ACA was to apply the same methodology, so individuals could go through one portal. And so if they are eligible under the MAGI bucket—they will, as you can see the arrow—they will go down to the Medicaid Express, pick their Managed Care Plan, compare providers and be done—no costs. If they are determined premium tax credit eligible to shop for or not, but eligible to shop for a qualified health plan, which includes a BBSP. They would then go to what you see today, which is our Silver State Health Insurance Exchange, and compare products, and be able to access any premium tax credits that they are eligible for. That is really the planned shopping experience that we want to create for our members, and to make it feel more like health insurance, and to remove any stigma that may be associated. One of the things we heard a lot about—a lot from our rural hospital partners on our tour is that they have individuals that really feel that there is stigma around this, and it is not like health insurance. We want to feel like health insurance. We want people to make educated decisions about the health plan they pick, and to understand the benefits that they are receiving, and so that is really the goal here. As I mentioned, it will—the Non-MAGI, which is the individuals that we consider our, our Medicaid age, blind, and disabled population, or anyone who is fee-for-service in that bucket—who needs sort of a more touch, more assistance—would be recommended to our Division of Social Services and individuals there to help assist them with their application. But the goal here is to really get most of our Medicaid population in real time, and allow them to shop for their products.

I am going to do the next slide, and then we will open it up for questions on that. Right now, I want to give an overview of who is leading this project, it is Sandie on our team. Once it is fully implemented, it will be overseen at the Exchange with Ann Jensen as well, at the Medicaid Program to ensure the rules are reflecting the Medicaid rules. This new solution, as I mentioned, was passed last session in our Governor's recommendation budget bill, and like it right now, we are in what we call "phase one". We just went to BOE, we are implementing—like a lot of states have already implemented, which is where the Exchange can determine eligibility. We are doing that first, and then the phase two and three, are where we really fully integrate the system of record, and really transition all those individuals into the exchange product. One thing, I want to mention here, that is valuable to our members as we look ahead at work requirements—is that this system will really allow us to help connect people with our employment resources at the state, help identify resources that help them find a job—educate them on that, but also help them see where they are in terms of meeting the work requirements. Our goal here is to really build this in, in a slick way, that is less manual, less paper, and so work requirements while they will be something some people will have to deal with, especially our adults without children—our expansion population. We are hopeful that this will be something that they can do in the privacy of their home, and ensure that they are able to understand where they are in meeting those requirements, and what resources are available to them—and to get, so they can stay, or get coverage—stay enrolled or get coverage. The phases two and three are going to take more time. We will be doing—we are already on the way right now to do our

platform RFP for our exchange for 2027, and this would be—just be rolling the fully integrated Medicaid component into that RFP as well. That will be going out for an RFP in 2027 for phases two and three. With that, I am going to open it up for questions. Thank you, Madam Chair.

Chair Brown-May:

Thank you. Members, questions? Okay, I do not see any. Thank you for that presentation. Feel free to move on.

Director Weeks:

All right. Thank you, Madam Chair. Sorry, I called Jennifer up, and then she—sorry Jen. Next slide will be All Payers Claims Database. This also is being led by Sandie Ruybalid on our team for the implementation, and once it is fully implemented, Deputy Allison Herzik will be overseeing sort of the use of this program, and setting up the Advisory Committee and all the functions around that. But it is live, and health plans have been submitting claims, which is exciting. We are hopeful that full implementation, which means we can start to really look at the data and clean it, and—see if we, you know—how we can access that data will be available in early February—next month, so it is really exciting. This will be a huge resource for the state, because we will be able to not only understand cost, and trends, and state coverage programs like Medicaid and PEBP, but also private market. So we can really see our people doing better, for example, in certain conditions that they are going to the ER [Emergency Room], for example. Are they different across our markets? What is going on in cost? All of that. I think it is going to be very useful to us. We are really hopeful, and Allison will be leading a new population health management strategy that really looks at all of our markets and trying to control costs, and making sure that we are aligning those efforts around population health. Hopefully we will be putting together here soon—to be announced of when, but a public use file as well, so the public can use some of this data in a way that really helps support research, and just an understanding of Nevada's marketplace for insurance. With that, I will open up for questions.

Chair Brown-May:

Thank you for that. I do not see any questions down here.

Director Weeks:

Thanks, Madam Chair. Hopefully I have lulled everyone into a deep sleep. No, I am kidding. All right, Centralized Credentialing. I want to give a quick update on this. It was Administrator Todd Rich. It is now Cynthia Leech who actually, originally, did the full implementation of this, and she will be overseeing this going forward. It is fully implemented. It is a one-stop shop for our Medicaid providers to be credentialed, so they do not have to go to every health carrier for that process, and they can get paid. These credentialing decisions are valid once they are determined by our vendor in the committee that has been put together, which includes our health plans as well as state members. They will be valid with all Managed Care Plans in our state that are Medicaid. One of the things that we are talking about, and exploring, and possibly for next session is the opportunity to expand this to other programs, maybe PEBP, and other opportunities where the credentialing here could be recognized in other markets. Providers really can get that done one-stop shop and not feel like they—once—they do Medicaid, they have to go to PEBP, and the private market. Is there a way where we can really expand that to make it really, really truly that one-stop shop for providers? I will open up for questions.

Chair Brown-May:

Thank you. Assemblymember Nadeem.

Assemblymember Nadeem:

Thank you, Madam Chair. I want to be clear with this one, that one-stop shop credentialing. If the provider is credentialed with Medicaid, he does not have to have the other insurances credentialed with the other insurances, or is it something different?

Director Weeks:

Madam Chair, it is something different. Prior to centralized credentialing in Medicaid, a provider would have to be credentialed by each of the managed care plans, right? In the past, it would be HPN [Health Plan of Nevada] would credential a provider, Molina would credential the provider, Silver Summit. It was just a process, and it is a lot of work for a provider, and there were all different timelines, and as much as we tried to streamline it; it still was clunky for providers. This process says "Okay, we are all going to do one process the state owns, the health plans are part of that process, but all the health plans that Medicaid uses honors that credentialing." I think what you are referring to is a goal that we have in the future—is a way—can we use this process for other markets to recognize the credentialing? There are obviously questions about which markets, and how far we should go with that. Those are things we are thinking through, and obviously look for feedback on that from lawmakers and stakeholders.

Assemblymember Nadeem:

Thank you so much. It is very helpful. Thank you.

Chair Brown-May:

Thank you. Members, any other questions? Seeing none, go ahead.

Director Weeks:

Okay, so close. Next is what I mentioned, our Value-Based Payment. One of the big efforts—there is a lot going on in this space, but I wanted to mention our—I mentioned earlier already—the Hospital Quality Collaborative. Ann Jensen and her team are leading this, with also Dylan Malmlov at the Patient Protection Commission—is participating. But we are going to be releasing here soon a Value-Based Payment Roadmap for our health hospitals, and our Managed Care Plans that we are working on with them. We are in the second year of our quality collaborative. It is really a requirement, actually, that they have to participate—same with the MCOs, it is in their contract. But the hospitals, it is in their provider tax arrangement where they get funding from our state-directed payments—they have to do a quality initiative or quality activity, and this is what we agreed to with CMS to do. We are hopeful that once we get moving on this—these are the four, you can see here—there are four primary areas we are focused on, is really value-based payment design around maternal health, care transitions, primary care, and behavioral health. This could include—runs the gamut from, you know—pay for performance, so if there is improvements they get paid more to—we are going to take on risk, and if we save money and do better, we get to keep the money—the provider does. There is a lot of ranges here, and we are working directly with those hospitals to figure out which one is the best one to work on where they do have—they need to put some effort in, but they cannot—it is something that they cannot succeed at. All of our value-based payment strategies must be in place for

some of these areas by Plan Year 2027, specifically for maternal health and care transitions. Care transitions is really what we think of as someone coming out of the hospital setting back into their community, or how quickly are they cycling back to the ER? What are we doing to make sure it is successful, so we can really get at those high-cost services that we should be able to avoid, if we do have a real workable care transition plan for individuals. The goal here is to really test this out in the Medicaid space with our hospital partners who also are all in the other markets and—same with our carriers—to see if there are opportunities to say if this is working so well on Medicaid. Can we do this in PEBP, for example, can we do this in our BBSP, and really allow providers to even be more successful. The bigger the population, often, the easier it is for them to perform well. When the sample size is bigger the chances are greater.

All right, last but not least is our fun 2025 Legislation Implementation. Here is a quick overview. I think we did this last session to, or last interim for you guys to give you a sense of what bills passed, and what is impacting the agency. We have about 83 bills that passed, or at least "legislative implementation streams" is what we are calling them across NVHA. These are all the projects that we are working on to implement for 2025. Surprisingly, it sometimes takes more than two years, so some, there are some even from last session of—a handful that are still trickling in. But right now, for example, the Division of Nevada Medicaid is working on 34 new bills and implementation projects, purchasing compliance—23, and then public employee benefits—12, and then consumer health services for bills from last session.

Then to give you a quick sense of where we are—28 of them, I would say almost actually 30, now, after looking at the deck—I just saw are complete. That is exciting, within a year, that is a huge win—I feel like. Nine are close to being complete, as you can see, seven are halfway, then we still have 39 that are less than 50 percent complete. Then some of them are just sitting out with CMS, or some of them are—had a delayed effective date in state law, so we are not pushing those as hard right now, because we are trying to prioritize our resources. We are seeking federal approval for 12 bills on the Medicaid side, including 11 state plan amendments, and 2 Medicaid waivers. That is much lower than last year, or last time I sat here. I think it was closer to 34 state plan amendments, so thank you for that. The next—we have—like I mentioned, we try to do stakeholdering around what we are working on every six months. Right now, we have another workshop coming up in January 27, where we will be going bill by bill and giving a status update—like red, yellow, green—kind of where we are at with it, what the challenges are, and then we usually open it up for public comment on questions.

Real quick—going forward, like I mentioned—we have our three-year strategic priorities that we have set forth, and we are working now on all the different objectives that fall under that, and we will be meeting with our senior leadership team soon to kind of start to assign and make sure we have got project leads on all of this. But we are looking at—these are our four goals, right, healthier Nevada, sustainable programs, reliable healthcare, and healthcare reimagined. As you can see under health improvement, there are a lot of areas and a lot of things that we are already doing to improve these now. But we are looking at new opportunities—some may require session activity, so we will be bringing those to you next session. Program viability, as you can see, we are looking at a lot of different modeling on market reforms that we can bring to this body. Workforce capacity we walked through a lot of those earlier, and then innovation, you know, there is some new things there that we are looking at—especially, even something I think that we do not talk enough about is health insurance literacy. What can we do to really help people understand how to use their health insurance effectively? That is something else at the Exchange and Jennifer Krupp is going to be working on. Then the one thing we did not talk about today is modern

technology across the board. How do we make licensing, for example, the application process, all of that easier? More automated, more real time, more AI—we could be leveraging AI in ways that we are not yet to help relieve some of the burden on our staff. And then our network alignment is another area where I think we could really be improving access, if we are incentivizing our providers to participate in all of our programs. We are looking at opportunities there. With that, Madam Chair, I am going to stand for questions.

Chair Brown-May:

Thank you, Director Weeks and your team for the robust presentation this morning. We appreciate you all being here. Members, questions? Yes, Senator.

Senator Doñate:

Thank you, Madam Chair. I had a quick question on the Medicaid managed care plan and the hospital quality collaborative. It looks like a reference is on the slide—a roadmap. Is that document complete, or is it still preliminary?

Director Weeks:

Madam Chair, it is almost complete. I am going to let Ann answer. I think it is going to be coming to a website near you very soon. Ann, do you want to give an update?

Administrator Jensen:

Yeah, absolutely. Madam Chair and Committee members. As Stacie mentioned, we have our quality collaborative meetings quarterly. Our MCO as well as our hospitals had a chance to preview and provide feedback on that, which we have incorporated into a final version. This will be published to our website within the next month; so look forward to sharing that more broadly. What you will see is very reflective of Stacie's summary on our primary areas of focus. We will be updating it in the year ahead with a final measure set of-of quality measures that our MCOs and hospitals have worked together to select. It will be a ongoing document, but hopefully, it will be helpful to really chart our work ahead.

Senator Doñate:

Thank you, Madam Chair, just for more commentary. I would appreciate once that process is complete, if you can go ahead and share it with us, and as well as any preliminary data that you are gathering. I have a strong interest, of course, in unnecessary ER visits and hospital readmissions, and so if there is anything that you can provide for that I would really appreciate it. Thank you.

Chair Brown-May:

Members, any other questions? Okay, hearing none.

I would like to say thank you, again, Director Weeks and your entire team. Thank you all for being here, and for offering such great commentary and education for all of our members today. Congratulations on the good work that you have done to date. I especially appreciate that 83 pieces of legislation that are being implemented by your collective divisions across the state. We as Legislators are always working hard to be able to support our constituents and to improve supports and services across Nevada. Collaboratively as we work together

with you—I am curious to know—do you have a particular resource that you would like Legislators to utilize within your division? Now that you have a Chief of Staff, is there a recommended way that you would like for the Legislators who are interested in working on health care policy to approach your division throughout the interim?

Director Weeks:

Thank you, Chair. I appreciate that question, because they—we do get a lot of requests that come in. If you can email Allison Herzik—her email is on this last slide. I think for lawmakers she will be your direct contact going forward. You are always welcome to email me too, I know many of you do, but I think if you want to start there—she always loops me in. But Ali can probably be more responsive at times than I can—I get a little buried now in my email, but thank you for that question.

Chair Brown-May:

Thank you for being here today. We appreciate you. Okay members, that leads us to a break point in our agenda. We are going to take a quick ten-minute break. Please do not disappear—ten-minute restroom break, grab a quick snack. We are going to come back and go through the second presentation in ten minutes, and then we will power through and get to lunch later this afternoon. With that, we will go ahead and take a quick recess.

AGENDA ITEM V—UPDATE FROM DEPARTMENT OF HUMAN SERVICES REGARDING IMPLEMENTATION OF SENATE BILL 494 (2025) AND OTHER LEGISLATIVE MEASURES PASSED DURING THE 83RD LEGISLATIVE SESSION, AND A REVIEW OF SERVICES WITH A WAITLIST PROVIDED BY THE AGING AND DISABILITY SERVICES DIVISION, DEPARTMENT OF HUMAN SERVICES

Chair Brown-May:

Okay members, our ten-minute break is concluded. If you will all—take your seats.

Senator Titus:

We can make it happen up here, Chair, if you want to.

Chair Brown-May:

That would be exceptional, thank you.

Senator Titus:

Please everybody, take your chairs.

Chair Brown-May:

Apparently, I am not very loud up in the North.

Senator Titus:

Actually, Chair, the speakers have been kind of going in and out, and it was somewhat difficult to hear some of the presenters in the South. I do not know if you had the same issue up—down there for us, but I think it is all better now. Thank you and everybody is quiet.

Chair Brown-May:

Thank you, excellent. Okay, we are officially back to order, and we would like to welcome our next presenter. I believe it is day two on the job for our brand-new Director of the new DHS. Director Rich, welcome to the table, and you may begin whenever you are ready.

Laura Rich, Director, DHS:

Thank you, Madam Chair, and members of the Committee. You are correct. This is my second day on the job, and it has been a few years since I have been in the hot seat, so please bear with me. Today we will be going over the DHS, the Director's Office overview a little bit, actually, Ms. Weeks did a really good job of covering SB 494. In the interest of time, I do not think we are going to cover that. I think we are going to skip that. We will go over a little bit about our organization—our ORG chart. We will talk about the fiscal and administrative overview of the DHS, and the bill implementations out of the 83rd Session and also the special session. Then we will have each of the divisions come up here, and the Division Administrators come up and speak to their own programs. Unfortunately, I do not have a lot to add today—in the future I will. I am going to hand it off to the Division Administrators to talk about their own programs: ADSD; DCFS; and DPBH, as well as the DSS. Next slide.

A little bit about the Director's Office. Our mission is—I am going to read it off the page here. The Nevada DHS promotes the health and well-being of its residents through the delivery or facilitation of a multitude of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of sufficiency. The Director's Office oversees all of the various programs, so as I said, ADSD, the DSS, DCFS, and Public Health. As well—under the Director's Office—we also have the Grants Management Unit, Office of Minority Health and Equity. We also oversee The Fund for Resilient Nevada, and The Fund for Healthy Nevada as well as Victims of Human Trafficking, Grave Support Trust Account, and then the Upper Payment Limit Holding Account as well.

A little bit about our, the Director's Office financial fiscal overview. Our Director's Office biennial budget totals—and this is just the Director's Office, not the department. Our biennial budget is about $272 million, and it is managed across five budget accounts. Within the Director's Office, we do have 35 positions that are approved through our SFY26 budget.

Yeah, let us skip the 494—Ms. Weeks did a really good job on that. I do not think we need to repeat that. She also talked about the agency reorganization—will not go into that either. We will go into the ORG chart. Just a little bit about DHS, we have three Deputy Directors. We have Christina who is sitting next to me, Christina Hadwick. We also have Ashley Kopp who is the Deputy Director of Admin Services, and then we have a vacant Deputy Director of Programs. We also have Administrators—ADSD, Rique Robb, who is out—she is the

Administrator of ADSD. Today, Jessica Adams will be speaking in her place. We also have Marla McDade-Williams, who is the Administrator of DCFS. Andrea Rivers the PHBH Administrator, and Robert Thompson, who is I believe in Las Vegas today, who is the Administrator of DSS.

A little bit about DHS Fiscal. Department of Human Services manages our biennial budget, is about $4.6 billion in state and federal funds. We have about 6,500—6,600 positions within our department, so it is—I believe the largest department in the state—565 of those positions went over out of the 7,000-ish went over to the NVHA during the transition last session.

A little bit about bills and the implementation out of the last Legislative session. The Department of Human Services is in the process of implementing 97 bills that came out of the last regular session. You will hear each—I am not going to go into them, because you are going to hear each division cover some of these in their portion of the presentation coming up. I will not talk a lot about these, but obviously this is a big undertaking; 97 bills—it is a lot of work for our department. We do also have, I think an attachment that covers the status of each of these bills as well and where we are at. In the 36th Special Session we had a few bills that came out of that as well, AB 4, SB 3, and SB 4. As on AB 4, it is basically a—it requires the state to identify educational resources related to opioid use disorder and making available information on peer recovery support services. Senate Bill 3—this bill allows the DSS to provide temporary assistance under extenuating circumstances. An example of this is the—covering the SNAP [Supplemental Nutrition Assistance Program] benefits during a government shutdown. That will not be a problem moving forward, hopefully; and then SB 4 provides DSS with necessary funds to help reduce the SNAP error rate, so that is really to ensure that we can keep that SNAP error rate under 6 percent and avoid federal penalties moving forward.

That is my little short portion—day two, and it is it is good to be back. It is been a few years since I have been here, but I am going to hand this off to ADSD. Go ahead. (Agenda Item V A-1) (Agenda Item V A-2)

Jessica Adams, Deputy Administrator, ADSD:

Good afternoon, Chair Brown-May, and members of the Committee. I am joined in the south by Deputy Administrator Samantha Jayme and Agency Manager Cheyenne Pasquale. Administrator Rique Robb does send her apologies for not being able to be here today. At ADSD our mission is to empower individuals and their support systems by providing resources for disabilities and aging. We connect Nevadans to services and improve their quality of life. We do this through a vision of Nevadans of all ages and abilities, have meaningful lives led with dignity and self-determination. We do serve people of all ages with disabilities as well as older adults and family caregivers.

For the ADSD fiscal and administrative overview; our biennial budgets total about $1.2 billion. Our funding comes from a very diverse mix of sources including state and federal funds, Medicaid insurance payments for services, Medicaid Administrative claiming, county reimbursements, and we do have a telephone surcharge revenue for our communication access services program. We manage these budgets across 18 different budget accounts. We currently have 1,434 jobs in the current biennium, and our current staff vacancy rate as of the end of December was about 12 percent.

Currently the priorities within ADSD—and on the next slide I will get into a little bit more about some of the services that we are doing—we have on-going growing caseloads. Our caseloads have been growing at rapid rates the last several years. Our main priority right now is really working on all of our different services, how they are being offered, the methodologies for those, how we are paying for those services, and are there ways maybe other states are doing something different that could work better here? I know for developmental services, we are going to be working very closely with Nevada Medicaid to see what other states might be doing as far as different sorts of waiver services. But that really is what we are. What we are focused on now is—how are we going to keep serving our growing caseloads, with the amount of money that we all know Nevada has? The other piece that we have been working on for a while, and this work keeps going. The ADSD has grown quite a lot over the last, I would say six to eight years. We keep evaluating our internal infrastructure, including fiscal staff oversight, making sure that we have everything that we need to make sure all of those 18 budgets are operating properly, and that we do not have any fraud, waste, or abuse going on.

This slide contains all of the different programs within ADSD; I will talk briefly about each of them. As I said, we do serve people of all ages with disabilities as well as older adults across every stage of life. Adult Protective Services (APS), within this program, we are committed to protecting and supporting vulnerable adults by investigating reports of abuse, neglect, self-neglect, exploitation, isolation, and abandonment. This program assists anybody who is 60 years or older, as well as any sort of vulnerable adult that is aged 18 to 59. The Autism Treatment Assistance Program, or ATAP, assists families with children who are 20 or who are under the age of 20 who have a current diagnosis of autism to access critical services such as applied behavior analysis and speech therapy. Developmental Services, or DS, is the largest program within ADSD—comprises about 70 percent of the total budget. This program empowers individuals with intellectual and developmental disabilities and their families at every stage of life through a wide range of different services and supports. This is done through three regional centers in the state, Sierra Regional Center (SRC) serving Washoe County, Desert Regional Center (DRC) serving urban Clark County, and then Rural Regional Center (RRC) serving the rest of the state. Developmental Services also operates a 24-hour intermediate care facility for individuals with intellectual disabilities down in the south, and that is licensed for 43 beds—it is an institutional level of care. The Individuals with Disabilities Education Act (IDEA Part C)—this provides oversight to the early intervention services across Nevada to ensure eligible children receive family-centered comprehensive services in their natural environment. This program just came over to ADSD in July after transferring from the Director's Office over to us, excuse me. The Long-Term Care Ombudsman Program [LTCOP], this program is dedicated to ensuring residents of long-term care facilities receive the highest quality of care and support. They advocate, address complaints, and conduct investigations for people living in nursing homes and other long-term care facilities. Nevada Early Intervention Services, or NEIS, assists infants and children from birth to three to reach their full potential through specialized instruction, audiology, physical therapy, occupational therapy, speech therapy, and vision services. Nevada 211 is a program that allows Nevadans to learn about and access different vital resources such as food, housing, health care. This is done through a website and a call center. The Office for Community Living (OCL) offers a variety of home- and community-based services and programs for older adults, people with physical disabilities, and family caregivers to ensure Nevadans can maintain their independence in the home and the community. Office for Consumer Health Assistance, or OCHA, this program empowers Nevadans to navigate their health care rights and responsibilities with confidence. The OCHA helps people understand their health insurance plans and also navigate workers compensation issues. Finally, we have the Office of the Attorney for the Rights of Older Persons and Persons with a Physical Disability, an Intellectual Disability, or a Developmental

Disability. We call this the Office of the Rights Attorney, and they provide technical assistance, education, and training to the Division, and others, as well as directing legislative and regulatory policy advocacy for individual rights. The ADSD was asked if we had any suggested reforms to various reports that we do, and I am going to send this one down to Cheyenne Pasquale to talk about.

Cheyenne Pasquale, Agency Manager, ADSD:

Thank you. The Hearing Aid Report which is required under [NRS] 427A.610, is one that we are looking at recommending reform to. Any individual who qualifies for a hearing aid under this program as written in statute today has hearing aid coverage through other health insurance, so the CHIP [Children's Health Insurance Program], Medicaid, or even our exchanges. We have not distributed any hearing aids since legislation was enacted, so it is good that there has been reforms to health insurance coverage. This really leads to an evaluation of the original intent of SB 203 [2019] and any necessary amendments.

Moving on to slide 17. I am going to start with AB 461, and then I will turn it over to my colleague. With AB 461, this bill required ADSD to do an outreach program regarding long-term care planning. There is a number of provisions under that. What we have done since looking at implementation is evaluating existing websites and resources to determine what has been created prior to the bill passing, and where we need to add to that. This work is naturally part of our Nevada Care Connection work—our No Wrong Door efforts. We have identified additional resources to be added to existing sites, and are working to reformat our long-term care planning portion of our Nevada Care Connection website—while also cross referencing resources that already exist on Nevada 211. This bill also requires outreach to targeted populations, and this work is currently covered by federal funding. However, that funding is due to expire in 2027, so we are really looking at creating materials, and having sustainable efforts beyond that federal funding. With that, we will turn it over to Sam.

Samantha Jayme, Deputy Administrator, ADSD:

Good morning. I am here to talk about AB 6; so AB 6 established Fetal Alcohol Spectrum Disorder Treatment Assistance Program. It is mouthful—under the Autism Treatment Assistance Program after our pilot period. We have been working with, internally, our policy unit to establish intake procedures, eligibility—we have been working with Medicaid on the home health model for Fetal Alcohol as well as internally with the regional centers as we are establishing those eligibility parameters. We continue to refine education and training efforts to support successful implementation. This is internally with our developmental specialists as well as externally with our providers that are interested in serving this community. As of January, we received a psychological development counselor that we are actively recruiting for, and we have received that list. We will start doing interviews and that person will lead these efforts. In conjunction with our policy unit, we are hoping to go live with a target date of March. For AB 514, so this goes into effect July 1, and AB 514 gives long-term care the authority to go into mental health facilities to investigate and assist providers, so this is a success for the mental health population. Our long-term care leaders are actively working with HCQC, they are setting—they have began to develop regulations to be ready for March of 2026, and will go to public workshop as well. In the meantime, we have been working on training our staff internally on mental health, so that we will be ready for that implementation too. For challenges and barriers, I will give that back to Jessica Adams.

Deputy Administrator Adams:

The one bill that ADSD has had a little bit of a challenge on is AB 368. This was a bill that authorizes a patient in certain covered facilities or a resident of a living community with persons, for persons with disabilities to request the installation and use of an electronic communication device in their living quarters or bedroom. This bill had a very short implementation timeline. It was signed by the Governor on June 3, with a going into effect on October 1; so less than four months for us to try to figure out policy, the bill was split in between two laws that impacted various programs that we had in different ways. Within NRS 449, we have not only the long-term care, ombudsman, and APS that are going into those licensed places. We needed to figure out what that policy was going to look like for them, but also that DRC ICF [Intermediate Care Facility] is licensed under 449. We had to put some real action as to what it would look like for someone to want a camera or other sort of communication device within their bedroom. Then NRS 435 was the other piece of the bill and that was for our supported living arrangements within developmental services—language was written a little bit differently. I think overall we still had some challenges trying to get this implemented, excuse me. Our policy was late, and one of the reasons as well we do have a draft policy out now, but all of our policies have to go through a public workshop. That is really hard to find a policy, draft a policy, get all of the feedback and then go to a public workshop within a four-month period. One that we are still working on, but we have had a little bit of challenge and delay in trying to get that going. Chair, we are going to go into our waitlist now. I did not know if you wanted us to have questions before the waitlist or wait until the end.

Chair Brown-May:

Thank you. Given that we are going to do all of ADSD, go ahead and finish the presentation relative to your division, and then we will take questions.

Deputy Administrator Adams:

Perfect. For the early intervention waitlist, we will send that down to Samantha Jayme.

Deputy Administrator Jayme:

For our early intervention waitlist, this is really only indicative of the state program. We do have part C here, if there are any system questions as well. We have had provider shortages in all regions, and so we have tried to mitigate some of this with telehealth. We have been actively recruiting, but we do have families that are, I do not want to say waitlist, but more of a delay because they will get those services that are mandated. Some of them have waited for over a year for in-person, relying on telehealth as a temporary service delivery model. Some families may be waiting for more than one service, but no family is currently waiting for all services; families are having developmental specialists, we are having some providers, and we are working on those. This really shows initially what those assessments look like, and so those assessments determine that ongoing frequency—does not necessarily mean that those are the services that they will end up getting, but they do have those assessment periods. You can see lined up by provider type, we thought that would be the easiest way to show of what our provider shortages really look like; then our ongoing services as well. We broke it down by region, which is the Reno, rural, and our southern region. I do want to point out, so this data was from end of November. We have since taken Nevada Early Intervention South out of rotation, due to our wait times, and the increased capacity in our community providers as well. I will give it back to Jessica Adams for Developmental Services.

Deputy Administrator Adams:

Developmental Services, so what you are seeing on these waitlists, service coordination is performed by regional center developmental specialist staff. Their job is to coordinate all services and resources that the person may need in order to live as independently as possible. This waitlist is due to the number of staff that we have available to us. In the last budget, our caseload growth was funded based on the actual caseloads that were being served in February of 2025. As those number of eligible people go beyond what we were serving in February of 2025; a waitlist had to start for service coordination. The priority one waitlist, those are for adults who have been found eligible, but they have experienced some sort of unexpected and sudden loss that could result in immediate care, and the inability to maintain their own health and safety. Priority two—everybody else who has been found eligible. You will see most of the people are falling into that priority two waitlist. They will be added into service coordination based on the date in which they have been found eligible, once we have people that are dropping out of services, or we have other ways in which that those regional center service coordinators have enough bandwidth to be able to serve more. The rest of the four services that are on here—these are all contracted services out to other contracted provider agencies. I am so sorry today, 80 percent of our developmental services budget goes to those four services that you see there. Supported Living Arrangement, or SLA services, those are done by certified providers in residential settings. They are the services that allow people to live out in the community safely, and they can be based, or given on a broad spectrum based on different individual need from a few hours a week, up to 24-hours a day. Jobs and day training services are also done by certified community providers, and these are various different services that help with job skills, finding jobs, or other sorts of meaningful activities that somebody does during the day. Respite is a self-directed service, so this is services for people that are living with their families. It is $125 a month or $475 a quarter, just for families to get a break and for somebody else to provide care to their loved ones. The self-directed family support services, these are for families with eligible children under the age of 18 that live in the family home. It is up to $670 a month, in which they can again self-direct the specialized treatment that they want their child to get during that time. I will note that right now, the regional centers, all three regional centers, for all four of these contracted categories—we are offering new services now. The waitlist are starting to come down some, for example, the reason why you see zero for RRC for respite and self-directed—is they were just able to offer everybody that was on the waitlist, that service. We are starting to offer some more services and hopefully these waitlists will keep going down. As Director Weeks mentioned, ADSD is the operating entity for four different 1915(c) waivers with Nevada Medicaid. This is the people that are currently served on each waiver along with the waitlist, so we have the Waiver for Individuals, Individuals with Intellectual and Developmental Disabilities, that is through Developmental Services, the Frail Elderly Waiver, and the Waiver for Persons with Physical Disabilities. The structured Family Caregiver Waiver is a brand-new waiver, so the reason why you are seeing zero people on it is that we are still trying to get that launched.

The final waitlist slide that we have for you is a few additional programs that we have within ADSD. The Community Services Options Program for the Elderly (COPE), and the Personal Assistant Services Program (PAS), those are both through the Office for Community Living. Most of this waitlist is currently due to—there was some funding abnormalities, and how the money came in, and so we actually have a work program going to the April IFC to be moving money from one budget to a different budget, and then we should be able to put some more people on to each of these programs. Then the Autism Treatment Assistance Program has a waitlist currently of 156 people. That is it for ADSD, and we are open for questions.

Chair Brown-May:

Thank you for your presentation. Members, questions?

Senator Titus:

Madam Chair?

Chair Brown-May:

Senator Titus.

Senator Titus:

Thank you, Madam Chair, and thank you for being at the table. Welcome, new Director—much appreciated that you are here and willing to assume this incredibly important tasks. A couple of questions, first, the 211 system is your responsibility. Is that correct? My concern is that we kind of have a silo of these numbers and want to make sure that they are communicating with each other. We have 988, 211, and of course 911. Can one—are you in the same programs where if someone dials 911 and they now wrote—referred to 988—at the same time, can 988 refer to 211? Do they communicate with each other?

Agency Manager Pasquale:

988 and 211 have been collaborating since the inception of 988, so they do a cross referral. Yes.

Senator Titus:

Do you have yet any numbers on—and you can get those to us if you would, you know—how many people are actually accessing that, and how many are getting referred? Because one of the goals of course is to keep them out of the ER, if possible; and just that mental health investment and making sure that who reaches out to those folks now, and it is not based on—we know the area code on your phone because that is not where they are. So, able to identify where that area code is, especially, in the behavioral health world—is very helpful. Thank you, Madam Chair.

Chair Brown-May:

Thank you, Senator. I do have a couple of questions. First, I want to say thank you for your reporting. I appreciate the detail around the waitlist, and some of the bill implementation pieces. There are also some bills or new pieces of legislation that were passed perhaps in the 2023 Session or 2021 Session. I am curious to know, if you are able to provide a report as to implementation of some of those bills long term? I would just like to point to, medication administration for jobs- and day-training providers, right? The law was passed, and I am getting reports from provider organizations that they are still waiting for approval from the Division to be able to deploy some of that stuff. I am just curious to know, if there is still outstanding pieces of legislation that you all are working to implement? I do not expect an answer today, but I am certainly, would look forward to having an update in the coming weeks.

Deputy Administrator Adams:

Yes, we actually do have spreadsheets for all of the past sessions. We can certainly look at those and get those to you. One of the things that I will note, because you mentioned the medication, it has taken some of the times when we have to do NAC [*Nevada Administrative Code*] changes; those regulations can take a very long time. The NAC for the medication for JDTs [Job and Day Training] was changed right before the last session—it finally went through. It is still not codified in NAC, so I think there might be some confusion happening there, but we will certainly get you all of that for the last several sessions.

Chair Brown-May:

Thank you, I appreciate that. Then relative to the comments about the AB 368, Assemblymember Carter's bill regarding cameras. I believe that based on the conversations I am having with my constituents who as I am sure you are aware, live in Betty's Village—many of them. In that there is a new residential opportunity for them to rent their own apartment. I am curious to know, are we looking at individual apartments as that SLA provider setting? Is that where some of the confusion is coming from, relative to the deployment of that camera bill, in that the resident is self-directing? I will just say again, I do not expect you to respond today because it is such a complex issue that I know that your division has been working through. But based on the conversations with my specific constituents who live in that community—they sign a lease—it is their apartment—they should have the opportunity to put in a Ring doorbell, if they want to, without the state saying they cannot. I think that families are afraid—I am going to rephrase that—I know families and individual residents are afraid that the state will refuse to serve them, if they put in a Ring doorbell. I think that is definitely a confusion piece that we need to work through outside of this meeting.

Deputy Administrator Adams:

Thank you. That is—I have not heard specifically about the Ring doorbell, and that is something that we have already dealt with other memos in the past. We can certainly look at that, but you are correct. Some of the language in which some of the definitions were within that bill, it is not incredibly clear what is considered a provider-operated residential SLA, because some people are living in their own places, they have their own leases, but they also have 24-hour services from SLAs. It is a little bit nuanced, and that is one of the things that we are definitely trying to still work through.

Chair Brown-May:

Thank you, I appreciate that. I have one last question relative to the waitlist. You have them broken out by category: supported living arrangements; jobs and day training; respite waitlists; self-directed; family supports. Are these unique individuals or families, or is there some duplication from one bucket to another?

Deputy Administrator Adams:

There is definitely going to be duplication between SLA and JDT—possibly between SLA, respite, those sorts of things. There is not going to be duplication within each of those waitlists. Like somebody could be on a waitlist for—we have five different types of JDT services, so somebody could be asking for any of those types. That is going to be counted as one person, but there certainly could be duplication between somebody wanting SLA and also wanting JDT.

Chair Brown-May:

Thank you for that. I appreciate the clarity. I am curious to know as we get better at data and managing data, if we could better track an individual, and what level of support are they receiving? So, that we know, are we serving everyone something, or are we just not serving people? I think that will help us as we look to the future of disability services.

Deputy Administrator Adams:

Yes. We actually just started a new case management system in July, that we are hoping to be able to get some of that better data out of. I can tell you though that roughly only about a third of people that are served by developmental services—we currently have a total caseload of 8,650 people. Only about a third of them are served by either an SLA or a JDT provider. So, two-thirds of the people served by developmental services really only have a service coordinator helping with them.

Chair Brown-May:

Thank you for that clarity, that was very important. Thank you for that. Members, any other questions? Okay, seeing none. Thank you so much for your presentation. I think next we have the DCFS. Is that correct, Director?

Marla McDade Williams, Administrator, DCFS:

Good afternoon, Madam Chair, and members of the Committee. I neglected to actually have all of my stuff and prepared here—so here we go. The first slide shows our mission and vision for—with the Division, really, you know, recognizing that Nevada's families are our future; and children, youth, and families thrive when they live in safe permanent settings. They experience a sense of sustainability, emotional—sustainable, emotional, and physical well-being, and receive support to consistently make positive choices for family, and for family and the common good.

The next slide is our fiscal administrative overview. Our budget is about $835 million, over the biennium. We have funding from a variety of sources including state and federal allocations, county reimbursements, assessments, fees and penalties. We have 21 budget accounts and approximately 1,136 positions that are approved in our legislatively approved budget.

In terms of our priorities—it is prevention, collaboration, and provision of services. Really as it relates to provision of services—the goal is to fill gaps in the system such as, you know, providing services to children who are underinsured or uninsured, right. If they have Medicaid coverage, you know, the hope is that there is an adequate network to provide those services. Then at the point that network is not sufficient or does not provide services to uninsured or underinsured, then we want to consider how we can meet that need in communities. We have three primarily—primary policy areas that are managed at the division. The first is juvenile justice—we have three correctional facilities, if you will, for juveniles. We have one in Elko, one in Caliente, and then one in Summit View; and Summit View houses the more higher-level offenders. Nevada Youth Training Center [NYTC] in Elko has 54 beds, Caliente has 64 beds, and then Summit View has 48 beds. We also manage Child Welfare which is foster care and adoption, as well as Child Protective Services [CPS]. For CPS, and foster care, and adoption, we manage—DCFS manages the 15 rural counties, Clark and Washoe manage child welfare within their respective counties. Then under Children's Mental Health, we have inpatient as well as outpatient services, and again, you know, our goal is to fill gaps in the community. Desert Willow Treatment Center—which is at

one point licensed as an acute facility as well as a psychiatric residential treatment facility, for youth—has 47 beds in four units, right now, providing treatment and psychiatric care to the highest needs youth in those respective settings. We are also doing a renovation project and as soon as that, when that renovation is done, we will have an additional 10 beds that we will be able to provide in the community. I do want to say—and I will talk about this a little bit later, but we have basically closed our acute unit because of a legislative measure that was passed that required us to do juvenile restoration services. With the closure of that acute unit, we are contracting with private hospitals, we pay for that acute stay for those who are uninsured, or underinsured, or unable to get that care, and then—I mean, that is the system that we have in place right now. We also have Psychiatric Residential Treatment Facility North, which we call "PRTF North" up in Reno. It again, also is 24-hour residential care—this is a staff-secured facility, so unlike Desert Willow, Desert Willow is a locked facility. PRTF North is a staff-secured facility as is, you know, NYTC and Caliente are juvenile facilities. Summit View is the only locked facility that we have for juveniles. Then we have a Mobile Crisis Response Team (MCRT), which provides mobile crisis response for assessment, intervention, and support only in Las Vegas at this time. That now runs, from 8 a.m. to 11 p.m., seven days a week.

Additional children's mental health, we have Wraparound in Nevada, which serves youth 3 to 18 with serious emotional disturbances and complex behavioral health needs. We have Early Childhood Mental Health Services and Children's Clinical Services that provide community-based outpatient, individual, and family-oriented mental health services up to 18 years of age. We have day treatment—we have Early Childhood Day Treatment for ages 3 to 6, and Latency Age Day Treatment for ages 7 to 11, and that is only in Southern Nevada. We also have an In-Home Clinical Services Team, which is a relatively small unit for us that kind of worked off of mobile crisis response, and this serves youth birth to 18 and their families, and it delivers individualized intensive clinical interventions in the home and community environment. We have the Childcare Consultation Program, serving children birth to 6 in early care and education settings, providing consultation, technical assistance and training. Again, we just note that we have a statutory responsibility for child welfare and juvenile justice services. We do not have a statutory responsibility to provide any children's mental health services. We have authorization to provide children's mental health services, and that is how we manage.

The one area, again, in being asked to look at the reports that we were asked to do, and whether or not there should be some reform. The one that came to mind relates to relinquishment of youth under NRS 433B.3398—and primarily, you know—looking at, again, as was noted earlier, the origin of the law. Is that really still what is in place today, and do we need to still do that same level of reporting, or should it somehow be revised to look differently based on the current landscape? In terms of legislative measures that were enacted, you know, I think we are pretty proud of AB 515, which relates to adoption assistance. The Legislature was generous enough last session to allow us to start making inroads into the—not reserved—but into the liability that has been there for adoption assistance. It is kind of a complicated issue but in removing the requirement that General Fund dollars were not able to roll over for past certain number of fiscal years, we also were asked to do a report on how we intend to spend the rest of this liability down. We had a deadline of February 15, to get that report done. Amber Howell, who works as a consultant for us has been working very diligently with Clark, Washoe Counties, and our Rural Child Welfare to ensure that that report gets done. We will be able to submit that to the Legislature on time. Victims of Crime Compensation always has a lot of bills every legislative session. I highlighted two here on the list; SB 62 and SB 87 that revise how the program is managed, you know, increasing benefits or revising them to ensure that they are more accessible to victims. One that I did not include on the list was AB 329 that

now—claimants now have up to 60 months from the date of a crime to make a claim where previously it was 24 months. Senate Bill 504 relates to extended young adult support services or what we call "extended foster care for youth 18 to 21." Again, this is was a very successful measure, and because we had done a lot of prework we were able to implement fully, basically on July 1, and that program is moving along. For our challenges, AB 467, which is the measure that allowed for restoration to competence for juvenile offenders. We were able to stand up the program, and that is not the issue. The issue is that, you know, to be able to take these youth we had to close our acute unit at Desert Willow. Closing the acute unit at Desert Willow also means that we are realizing reduced Medicaid reimbursement for youth that we would have been able to bill for in our acute unit. We cannot bill as Ms. Weeks noted earlier—right. Juveniles in the correctional system are not eligible for Medicaid, so we are not able to bill for any of these services. It also is a challenging population for us to serve. We have realized significant staff challenges and workers compensation claims, you know, that are increasing a little because these are just—it is just a different population for us to manage. Then the other measure is SB 372, which amended the law regarding what is considered abuse or neglect of a child, and provides that a person who is responsible for the safety or welfare of a child does not commit abuse or neglect of a child solely, because the person seeks to have the child admitted into a public or private mental health facility or hospital, if the behavioral health needs of the child pose a risk to the safety and welfare of the family. I mean that is the key provision of it, and what it has done is cause confusion with child protective services. Wondering at what point do you intervene with families who which we face? I want to say, unfortunately, it feels like every day a youth who has completed their program in a residential treatment facility is released to go home and their parents will not accept them back; and you know, we are faced with, you know, how we deal with those situations. We are working through it. We have gotten guidance from our Attorney General, but we still need to continue to work with the county jurisdictions as, you know, as well as potentially the courts to ensure that we are all on the same page on implementing that particular measure. That concludes my presentation. I am happy to answer any questions.

Chair Brown-May:

Thank you for your presentation. We will start with Senator Doñate.

Senator Doñate:

Thank you. I had a question on specifically—thank you, Chair. I have a question specifically on SB 372. It was my understanding when we passed that bill that it was specifically in the instance of—so and I have to be careful because I know we curated the legislative record specifically while were in session. But my understanding was, it is only the transmission of what we wrote into state law was only in the instance if you are referring your child to a facility it was not on the acceptance of them on the completion of a program. I guess, I am just trying to understand where the problems are occurring. Because from my understanding the reason why the law was implemented was in the only instance of "I am trying to help my child receive access to care, they are refusing to do so—me looking after my child should not count as a form of abuse," if it is in the best interest of protecting that child's needs. I guess I am just trying to understand how you are coming to that conclusion when we tried to clear that up in the process of passing that bill.

Administrator McDade Williams:

You know, Senator, I cannot speak for how others have come to their interpretation. I know how we, you know, want to treat the measure, which is not filing neglect charges solely because someone wants to commit their child. But, you do have to remember that for anyone to receive particularly, Medicaid reimbursement, they have to meet at a certain level of care to be cared for in a facility. I cannot just decide today my daughter is a problem, and I am going to commit her to a psychiatric residential treatment facility. She has to be diagnosed as needing that level of care. So, you are correct, you know, nobody would right now—we do not see those types of cases. What we see is the back end of them on release. We do not see them at prior, you know, the issue prior would be do they have an appropriate level of care that would qualify for them to be there?

Senator Doñate:

Thank you. In essence, I am trying to understand the complexity of interpretation for this. What would—as you are in the process of implementing the bill. Is it something that you can, is there a clarification, or definition, or circumstances that you guys are seeking to implement through NAC, or are you going to ask us as we are working through this process during the interim to submit a legislative change for further clarification? I guess I am trying to understand to what extent can this be solved through NAC or is it, are you mentioning that the hurdles that we are having are becoming difficult to implementation where we have to revise the bill?

Administrator McDade Williams:

I mean, honestly, right—we were responding to the request from this Committee to provide, you know, talk about some of the measures that have been more difficult for us to implement. I think we are really early on in this process right now of really just highlighting that it is an issue, and then we will continue to work with stakeholders to figure out if we need to come back with additional legislative changes, or if we can just within interpretation settle on a consistent way to implement.

Chair Brown-May:

Thank you. I am wondering if the Director of the NVHA could provide a little bit of clarity around additional information relative to this?

Director Weeks:

Administrator Marla McDade Williams is correct. This has become—it is kind of new—it came to our attention I think a couple of weeks ago. Understanding typically, if a family does not pick up their child, for example, out of a treatment facility—that child goes into the child welfare system, otherwise they are being held inappropriately in a residential treatment facility. The issue from our perspective, which we have been talking to DCFS about, and we will soon be talking to Washoe as well as Clark County about is the impact on our DOJ settlement agreement. This could be a huge issue for the state and could be a violation, because if we are not going to find a way to support these children we are having these facilities keep these kids too long when they are no longer appropriate for that setting. That it is an issue we are definitely working on and happy to work with Marla and others on language that may be needed, or things that we can do at Medicaid to let counties know that if they are going to continue to bill for Medicaid dollars, they need to be providing this type of support to children to ensure the DOJ agreement is complied with.

Chair Brown-May:

Thank you for that clarity. Okay, so I hear that it is in two primary counties that we are experiencing the difficulty, because the state is responsible for the rural county and child welfare services. Perhaps we could take this conversation more in detail and then offline to get to the root cause of, to find the solution. With that, Senator Titus.

Senator Titus:

Thank you, Madam Chair, and thank you for what you are doing. I am curious about page 25 on your presentation where you talked about the facilities, children, mental health services; and China Springs is in my District—it is not listed here. I was wondering about the relationship that the state has with China Springs, and we will probably do a deeper dive. It has been a conversation every session. But it, again, it is not mentioned anywhere. I want to know what that looks like and if you could give me a little update on that relationship.

Administrator McDade Williams:

China Springs is operated by Douglas County. The State of Nevada has been asked, well, DCFS through its budgeting process, has been asked to support China Springs financially. It is a juvenile detention facility, a county level juvenile detention facility. We do not have an adversarial relationship with China Springs. We provide funding for them, but they really are a county facility, so other counties throughout Nevada manage their own detention facilities without state assistance. But, I believe one of the reasons that China Springs receives state funding is because counties do want to send you there. So it is more, you know—those youth are moving out of their county, they are not Douglas County based youth. That there is, I believe, some public policy decision that, you know, maybe the state has a role in funding part of those activities, but it is not a state facility. It is simply a facility that is budgeted for us to transfer funding to them.

Senator Titus:

Thank you for that. I just wanted to make sure that that is on this Committee's radar. It is a conversation that we have on that facility because it is critically important to the rural areas that do not have their own facilities. Each county may have one or two children there, and I want to make sure that there continues to be that communication. Even though it is a county facility, the rural county send their children—even though they are teenagers—there are still children there. I want to make sure that conversation continues in the state continues to be an assistance to that—it is critical for rurals. Thank you, I wanted to make sure that still on the radar. Thank you.

Chair Brown-May:

Thank you, Senator Titus, for that and calling that out, and getting it on the record. I have a question with regard to mobile crisis. I believe in your presentation you noted that Clark County is doing mobile crisis and that it is really limited. It is my understanding though that there may be some in Washoe County also. Is that correct?

Administrator McDade Williams:

My apologies for confusing you. The DCFS manages mobile crisis response in Clark County. We previously managed mobile crisis response in Washoe County. However, we trans—Washoe County and DCFS went into discussion and Washoe County wanted to take it over themselves. We transferred the funding that we had for that program to Washoe County; so they—Washoe County manages its own rural mental—rural mobile crisis response is done by the DPBH. So DCFS, we actively manage mobile crisis response only in Clark County, right now.

Chair Brown-May:

Thank you for that clarity. Then, on a different topic, as I am sure you heard me ask earlier today with regard to timeliness of assessments. As part of the DOJ Settlement Agreement that we continue to talk about, kids come into the child welfare system, and then we have a delay with regard to assessments. You are working cooperatively with Clark County and Washoe County, right? The Division is working to provide the support across the rural parts of our state. How are you making progress relative to the timeliness of assessments as kids enter the system?

Administrator McDade Williams:

Honestly, I do not think it is a conversation I have had with Clark or Washoe County about youth that they take into the child welfare system. You know, in this bifurcated system that we have, right. We all have our respective roles to ensure that we are able to meet our requirements to do them. You know, when it comes to assessments though for the child welfare services—I would have to see if there are delays in that process. I am not aware of any delays in that process. What we often hear is that there are delays in, you know, extensive waiting list, for example, for kids to be assessed for autism. And you know, for someone to be assessed for autism, there is potentially a gap. I can tell you that we have—are in the process of implementing a program to kind of assist with our internal backlog of autism. Because we have recognized that is an issue, and so I—we authorized training for someone to do this. We bought the equipment, you know, we are getting ready to stand that up to help with the populations that come to us. Overall as a system—you know, again—I would have to verify whether or not that happens. There are assessments that we are required to do, for example, you know, assessing youth for, to see—determine if they were commercially or sexually exploited. There is an assessment tool that we use and that, you know, that tool is used, and I do not believe that there is a delay in it. It is more likely like what level of assessment that someone is looking for that there could be a delay, because there are not enough providers. But there are a lot of assessments that are done, not all of them are delayed—I would have to assess to see which are.

Chair Brown-May:

Thank you for that. I look forward to following up on that as we look at the timeliness of service delivery, right—just the identification of what supports are needed. Members, any other questions? Seeing and hearing none. Thank you so much for your presentation. We appreciate you, and we will now move on to the DPBH.

Andrea Rivers, Administrator, DPBH:

Good afternoon, Madam Chair, members of the Committee. Thank you for the opportunity to present today. I would like to start today's presentation with an overview of our mission, vision, and purpose. We are very proud of our mission to protect, promote, and improve the physical and behavioral health and safety of all people in Nevada, equitably and regardless of circumstances, so they can live their safest, longest, healthiest, and happiest life. The staff in our Division are very mission-driven, and I want to highlight the work they do daily to make Nevada's, excuse me—to make Nevadans lives happier, healthier, longer, and safer.

Under fiscal and administrative overview. We have a very large and diverse agency, as I know a lot of you are aware, with staff and services being offered across the state. Our biennial budget exceeds $1 billion. However, that amount will decrease as federal COVID monies end this year. We have 27 budget accounts each with unique programming efforts to serve the various needs of our residents and visitors. Many of our public and population-based programming is very reliant on federal funds. While our mental health services rely heavily on state general funds. There are almost 1,700 FTEs [full-time equivalent] within our agency. That does not count our contractors, and providers, and people that also help supplement our services. Our DPBH priorities—we are a large, and diverse, and offer many services to our communities that we serve. Our priorities are equally diverse, though I cannot have time enough today to cover all of our priorities. I wanted to highlight that we are focusing on three main categories: (1) organizational improvements focused on making us better agency; (2) consistently improving our direct services; and (3) supporting population health to reduce morbidity in Nevada. We have shared with this body in the past that we are actively seeking public health accreditation, and I am excited to report that we are now just waiting on a date for our site visit to finish that process. Within our direct services, we want to thank the Governor and the Legislative body for the much needed and unprecedented investments to improve forensic mental health services in the state. This is ranged from appropriated funding for jail-based mental health services to the investment to build a state of the art forensic mental health facility in southern Nevada. Additionally, Nevada is proud of the work, and the work to be done related to the crisis response system centered around the 988 system. We have highlighted two important reports in this survey, or excuse me—in our presentation today to illustrate our efforts to respond to state health needs, which includes our Silver State Improvement Plan (SSIP) as well as our recently finalized plan on behavioral health programs.

The Division of Public and Behavioral Health responsibilities. It is impossible for me to cover all the amazing programs that we have in our agency within this one presentation; so we have summarized our sections of responsibilities.

We have Administrative Services. This section is supported by a Deputy Administrator who oversees our Fiscal Services. This area supports 27 budgets, as noted previously, with federal, state funds, fees, and medical billing. Our contract unit currently supports 124 federal grants—this does not include private grants we may receive—362 executed subawards to partners and vendors throughout the state, and 139 contracts—that does not include MOUs [memorandum of understanding] or work orders. Our HR [human resources] and IT [information technology] systems are overseen by a chief operations officer. As already mentioned, we have nearly 1,700 employees and contractors throughout the state. This includes 24-hour facilities. Our IT manages and supports 140 systems, applications, and databases across DPBH as well as helping to support the DHS Director's Office programs and units. This is in addition to overseeing our data modernization efforts and

statewide field service teams. Our Public Information Office handles requests and information from external partners as we—including outreach efforts. In 2025, for the programs remaining with DPBH, not including those that went over to NVHA. We addressed 84 media inquiries, 55 public record requests, and over 139 total requests for information. Last, but not least, I would like to highlight our newest program, which is the Public Health Infrastructure and Improvement area. This section is overseen by an agency manager who oversees public health accreditation and quality improvement; cultural navigation and tribal services; workforce initiatives and the primary care office; and as well as public health investments such as the $15 million that the Governor and this body provided to support health districts and counties.

We then have our Community Service, or excuse me—our Community Health Services. This section is overseen by a deputy administrator and focuses on supporting the population-based programs for traditional, public, and behavioral health. These programs include overseeing direct services to targeted communities such as WIC—Women Infants and Children Program, and HIV [human immunodeficiency virus] services to programs designated and designed to support systems for overall health improvement. These services are heavily funded by categorical federal grants, so much of the work is done in partnership with both federal and local organizations.

Clinical Services, this section is overseen by deputy administrator as well as forensic director, and clinical experts. These services include inpatient and outpatient mental health services statewide as well as forensic mental health services.

Finally, we have our Prevention Planning and Response Services. This section is overseen by our Nevada's medical epidemiologists. The goal of the State Office of Epidemiology is to prevent and respond to a variety of public health issues through disease surveillance, standardized data collection, meaningful interpretation of data, statewide standards and centralized guidance, in order to improve health outcomes for our communities. There are also several programs that focus on preparing and responding to public health needs and emergencies in the community.

Okay, moving into suggested reporting reforms, we have a few listed here. As requested, we have reviewed and made some notes here. Starting with our Home Feeds Nevada Study. The Council on Food Security supported by the Office of Food Security within the DPBH has experienced a significant increase in workload following the 83rd Legislative Session. Including the addition of a Home Feeds Nevada Study—the study of a program administered by the Department of Agriculture. The study requires extensive coordination and research, and has necessitated increasing the Council on Food Security meetings from quarterly to monthly. Monthly meetings have proven challenging due to quorum requirements and scheduling constraints for Council members. The increased frequency has placed a substantial strain on the Office of Food Security staff who are responsible for preparing and submitting, five, annual reports to the LCB. Given the limited staffing and funding of the Office of Food Security—the additional reporting obligations have compromised some of the ability to effectively manage statutory responsibilities. Second is our Food for People Not Landfills annual report. The Food for Landfills annual report was established as a subcommittee of the Council for Food Security with all activities reported to and approved by the Council. As such, efforts are already documented in the Council for Food Security annual reporting. This report enhances duplicative of the efforts and reporting of the Office of Food Security by the Council of Food Security.

Kidney Disease Advisory Committee annual report—the Kidney Disease Advisory Committee continues to meet quarterly contingent on quorum, and remains committed to improving kidney disease outcomes in Nevada. However, the scope and volume of the Committee do not warrant a standalone annual report. Members actively engage in identifying grant opportunities and supporting public health efforts, but the limited avail—the availability of funding has proven challenging.

Okay, School Height and Weight Obesity report. We would like to merge, and propose formally merging these two reports that are legislatively required. We have done so over the past couple of years with great success and for having a comprehensive report. This merging of the two reports that are required annually has aligned reporting timelines better, integrated data presentation, operational efficiency, and improved stakeholder communication for both pockets and areas, as well as consistency with public health best practice.

The Diapering Resource Committee annual accounting report; NRS 42A.675 requires the Division to administer the Diapering Resources account submit an annual report to the Legislature describing any funds received, how funds were dispersed, the population served, and the purpose for which the funds were used during the prior fiscal year. This does require an annual reporting, but it has remained unfunded, and prior reports have consistently reflected no fiscal activity or expenditures. While reporting funding sources continues to be, or excuse me—while potential funding sources continue to be explored, opportunities are limited and time intensive, making meaningful progress to capture on an annual basis difficult. Any future funds would be administered under the oversight of the Administrator of DPBH, ensuring fiscal accountability through existing controls. Eliminating this standalone report would allow for more effective use of staff resources without reducing fiscal oversight or accountability. We also have the Diapering Resource Committee by annual research report. The Diapering Committee meets quarterly and fulfills advisory and research roles. However, biannual legislative reports does not meaningfully reflect the scope of impact of this work. We would like to propose transitioning to a 5-year reporting cycle, which would allow more meaningful progress to be demonstrated, reduced applicative reporting, and provide more outcome-focused information to the Legislature.

Maternal Mortality Review Committee report is a collaborative report between the Maternal Mortality Review Committee and the Advisory Committee of the Office of Minority Health and Equity—as well as including the chief medical officer. The report should detail a description of the incidences of maternal mortality and serve more—and severe maternal mortality reviewed pursuant to the respective 24 months of the reporting period provided in a manner that does not allow for the identification of any person; a summary of the disparities identified and reviewed as well as plans for corrective action to reduce maternal mortality and severe maternal morbidity in the state; recommendations from any Legislator or other changes to policy to reduce maternal mortality and severe maternal morbidity, or otherwise improve the delivery of health care in the state. It is noted that this report is necessary. However, revisions are recommended to avoid duplications with NRS 442.767 section E, which requires the department to compile and publish on the Internet—on an Internet website operated by the department, a report that consists of data concerning maternal moral mortality and severe maternal morbidity. This report, it is due annually on April 1. If the April 1 report continues to focus primarily on data as currently reflected in the dashboard, which can be further expanded. The December report, which is due, could be shifted to emphasize to the findings and recommendations resulting from cases reviewed conducted by the Maternal Mortality Review Committee. This approach would reduce redundant data reporting, and enhance the impact of the Review Committee's recommendations by ensuring they are clearly presented for review by leadership and

the LCB. Currently, the extensive data and narrative content of the December report tend to overshadow the Review Committee's core mission to prevent actionable items—recommendations aimed to preventing future maternal deaths.

Finally, we have our Early Hearing Detection and Intervention report. While we will not request any changes or recommendations to this report. We would like to note that we will be offering a data dashboard in the next six months that will offer data meaningfully and sufficiently, readily available, and this could be in replace of a hard copy report.

Okay, moving to bill—DPBH bill implementation. We have a lot in DPBH, and I know it was requested of another division. We would be happy to provide this Committee with a thorough documentation of where we are at with all of our implementation—bill implementations. We did want to highlight a few successes, including AB 326, which allowed for a Level IV Trauma Center in the State of Nevada. Carson Valley Health in the Carson Valley, Minden, Gardnerville area is officially the first Level IV Trauma Center in the State of Nevada—after we built out an inspection and certification process, increasing patient access to care. In regards to legislative challenges, we have faced a few. Assembly Bill 102, the Northern Nevada Public Health has formed an Exploratory Committee for establishing their own EMS [Emergency Medical Services] Office. Portions of this bill allowing you with EMS trainees is awaiting an FBI [Federal Bureau of Investigation] ruling for the legality of obtaining background checks on minors. This delay has been increased by the federal government shutdown. Assembly Bill 484 full implementation has been delayed due to differences in current data collection scope and methods across licensing boards. But work is continued through the Health Care Workforce Working Group for meaningful progress and continuation of efforts. Senate Bill 137, lack of appropriation on this bill has limited DPBH's ability to fully implement. However, we have been innovated to identify multiple low- to no-cost solutions that address the heart of the bill. Senate Bill 273 implementation is stalled for this bill as we have some vacant positions. Progress was further delayed by the state cybersecurity incident.

Finally, our DPBH waitlist information. Please note this is a snapshot from November 30, 2025, and our waitlists do change considerably—near daily. For our Statewide Forensics Waitlist, it consists of 213 individuals waiting for services, broken out by Clark County, Washoe County, and our rural counties. The Forensic Waitlist consists of individuals who have been found not competent to proceed to trial by a court in order to receive inpatient restoration treatment. We continue to partner with our county partners on ways to mitigate our Forensic Waitlist. Efforts include diversion programs, which involves consideration if an individual on the Waitlist has a lower level charge, and is appropriate to a lower-level care match to their mental health needs. When successful, people who are in diversion programs are taken off the Waitlist. We also have the January 2026 implementation of jail-based competency restoration efforts by Washoe County through the passage of AB 467 during the '25 Legislative Session. We expect this to have a favorable impact on the Statewide Waitlist. At this time, we do not have a jail-based restoration program in Clark County, but are working with Clark County partners to establish a full restoration program in the jail.

Okay, moving into our Inpatient Lists—waitinglists consists of individuals waiting for an inpatient bed within our civil hospitals. Individuals may be waiting for either local—waiting in either a local emergency room or local jails for a bed for psychiatric inpatient stabilization services. Currently, Ross and Neil, located in Clark County has 44 civil beds that are operational. Dini-Townsend, located in the Washoe County area has 30 civil beds that are budgeted. Outpatient services vary and offer various voluntary services such as medication clinic, counseling, and service coordination. I do have to tell you and apologize,

Madam Chair, and members of the Committee. We do have a error on this slide under the Northern Nevada Adult Mental Health Services. The waitlist type, inpatient count 24 is correct for November 30. Outpatient reflected is 978 on your slide, is incorrect. That number should reflect 65; 978—is the number of people we serve. It is not the waitlist, so my apologies that error has been made. Please note that under Northern Nevada Adult Mental Health Services Outpatient, the waitlist is 65 people, not 978. It is important to note that with outpatient, we have served 978 people as of that time in the north. For southern Nevada, we have served 2,700 people. That is our presentation today. We do have a number of subject matter experts to address any questions you may have, and we are happy to stand for any questions.

Chair Brown-May:

Thank you for your presentation. We will start here with Senator Doñate.

Senator Doñate:

Thank you, Madam Chair. I had a quick question regarding one of the bill implementations. It is my understanding that SB 312, which established the Tribal Health Authority is under the purview of DHS. If I recollect part of the public health improvement dollars were to be allocated towards the Tribal Health Authority to essentially hire a executive director within the 2026 to 2027 fiscal year. I want to make sure that we are on track to implementing that—hiring the person for it, now that we have the entity already established. I do not know if you can provide feedback on that.

Administrator Rivers:

Madam Chair, through you to Senator Doñate. Thank you very much for the question, Senator Doñate. I would be happy to provide a detailed follow-up to you regarding that, if that would be acceptable?

Chair Brown-May:

Thank you for that. We appreciate that. Anyone else, members, questions? Okay, seeing none. Thank you for your presentation. We appreciate you being here today.

Administrator Rivers:

Thank you so much. Happy New Year to you all.

Chair Brown-May:

Thank you. We will move to the DSS. Thank you for being here and for being patient today. You may begin when you are ready.

Robert Thompson, Administrator, DSS:

Good afternoon, Madam Chair, and Committee. I have with me, Deputy Cantrelle, who is over Program Eligibility and Service Delivery. On slide 37, we start with our mission. The mission of the DSS is to engage individuals, families, and community partners to promote safety, stability, and well-being of Nevadans. Our vision is to support individuals and families throughout all stages with their life, with the purpose of meeting immediate needs. We are really the safety net for Nevada, and everything we do is for the purpose of meeting Nevadans in crisis for food and medical needs. The DSS, our biennium budget is

approximately $1.1 billion. However, what is not part of that budget is the food stamp benefits—SNAP benefits that we issue. We issue over $2 billion during the biennium in food stamp benefits, and the last report that I read indicated that was over 10 percent of all food sales in Nevada for grocery stores. When we look at what we do, we are a customer-service based agency, and we always focus on the needs of our customers—the people coming in that need assistance. But, when we have these conversations we always have to remember that our customers are also the retailers, our customers are also you, our customers are our employees, and our customers are the Nevadans who are not on assistance to make sure those tax dollars are being spent appropriately. We always have all of those conversations with our customer-service base needs. Our budgets, we have nine budget accounts in our division. There is a typo on this slide, we do not have 2,288 positions, we have 2,472 positions. The 2,288 number is our full-time equivalents, but we also have additional intermittent positions that we use throughout the year, and our intermittent positions are also used as full-time positions. They are treated like all of our other employees—they are long term employees.

The DSS, with those staff that we have are over 25 offices. Our SNAP benefits—food stamp benefits is one of our largest programs. We take in approximately 30 to 40,000 applications for food stamp benefits. We oversee the TANF [Temporary Assistance for Needy Families] Program, which is cash assistance to families that have children that meet eligibility criteria. We have our Energy Assistance Program [EAP]. We currently do Medicaid eligibility on behalf of the NVHA. As we have heard through all the presentations, Medicaid eligibility will be transitioned away from—most of the Medicaid eligibility will be transitioned away from the DSS throughout the next biennium. We oversee Child Support Enforcement, Childcare Development, Childcare Licensing, and as of the 36th Special Session we now have a General Assistance Program. The General Assistance Program is a program that is, it is on the books if needed. It is not a program that is funded. They are not—there is not any employees assigned to that program. It is specifically a program in place should our lawmakers need to use it through our division to give out any special assistance due to extraordinary circumstances.

The division's priorities at this time—our highest priorities are SNAP error rate. Changes in the SNAP regulations; historically, all SNAP benefits have been paid for by the federal government and are currently being paid for by the federal government. That $1.1 billion a year that we issue. The changes in federal regulations now require states to pay part of that benefit, should the SNAP error rate go above 6 percent. A 6 percent error rate is a very difficult benchmark to meet, the agency is slightly over 6 percent at this time. Our agency is one of the most accurate states in the nation, but we are slightly over 6 percent. During special session we were allocated special funds to purchase technology that will assist us in that error rate. We are going through that process right now. The highest amount of errors that we have are client caused in our agency; not necessarily fraud. Fraud is actually very low, and I would not want to imply that our clients are causing fraud. Fraud, it is often mistakes, and it is often clients not reporting changes fast enough to let us update their case as required by the federal government. There is technology that is available. We are putting the technology in place to monitor our cases differently than we have in the past, so that we can act on those. The SNAP timeliness is always one of our most important topics that we stay targeted on. We are required by federal law to be timely with 95 percent of our cases. We do not have a problem meeting that benchmark. I began working in this agency in March of 1996, and there was a time when we were not timely. We were one of the worst states in the nation to be timely. Our cases are now processed quickly. We are not a safety net if we are not meeting the people's needs quick enough, right. If we are letting the cases set and not getting the food stamps out, then we are not doing our jobs. We are now the third most timely state in the nation in the food stamp program, and the first in the western

region. We are very proud of those benchmarks, but we have also learned through history that the older a case gets and sits, and is not processed—the higher chance of an error happening. Because the client's circumstances change, and they do not tell us about those changes in circumstance, so the case could end up being processed in error. Being timely not only ties to those customers meeting their needs fast enough, it also ties back into that error rate. We have got to keep our cases timely to keep that error rate down. We are very proud of those benchmarks of being the third most timely state in the nation, but that also ties into how accurate we are, and we are being very accurate. It is just not quite accurate enough for those federal benchmarks, and we are working very hard to bring those numbers to under 6 percent. The SNAP work requirements is also known as ABAWDs, able-bodied adults without dependents. We are reimplementing that due to requirements from the federal government, and we are going to see SNAP recipients who are currently eligible for SNAP, may not be eligible in the future. They must be working 20 hours per week to be able to receive the SNAP benefits if aged 18 through 64, unless they have children in the home that are under a certain age; unless they are disabled; unless they meet a very specific criteria. We are going to have to put those work requirements in place, so not only will we need to engage those customers to make sure that they have the ability to meet the work requirements and continue receiving their SNAP benefits. We will have to be monitoring these regulations, and if those cases are approved incorrectly, it increases our error rate. It all ties together into holistic view to make sure that the cases are timely and accurate, and we are meeting the needs of Nevadans, and also giving those Nevadans a path to meet the SNAP work requirements, should they choose to do so. A priority of ours is to continue working with the NVHA to make sure the Medicaid Express transition goes through—as needed by Director Weeks as she talked about so much today as we transition the Medicaid eligibility from the DSS over to the NVHA. We are seeing Childcare Waitlists, and that is a priority of ours to be watching those waitlists, and bringing those waitlists down whenever possible. One of the issues that we are facing—the childcare arena is that during the COVID event, all childcare funding increased—the childcare funding exploded. We had a lot of money in the childcare world. Childcare funding levels reduced to the levels prior to COVID from the federal government, but with today's rates. We are paying today's salaries, today's expenses, with yesterday's funding amounts—that has created waitlists.

We were asked to look at reporting requirements of the Division to see if we could make any suggestions on changes. The Childcare and Develop Biannual report measures the childcare state plan specific to children with a disability. This is report is required by NRS 422A, as of the 2019 Legislative Session. This information is captured in another report that could be shared upon request, and DSS is recommending that this reporting requirement be removed. The Food Stamp Exchange Program Projects, this report was helpful several years ago. However, states only visit other states with the request of food nutrition services or for special purposes, so we are not really reporting much on this report. We are recommending that this report could also be removed. Another report that we are recommending be relooked at is the Universal Energy Charge Report. It is required under NRS 702.280 on an annual basis. This report demonstrates that the EAP is expanding the Universal Energy Charge funds as intended and provides information on program details. While similar information is reviewed at the federal level, this federal report does not provide the same level in detail. We are providing a duplicate report for NRS, and we are suggesting that this report be removed.

The division implementation of our bills; SB 3 was created during the Silver State General Assistance Program. Our—the Silver State General Assistance Program was passed during special session, and that is a success. As I talked about, there is not anything for us to do at this time unless there is a crisis. The other three bills that we are mentioning today, they

are not necessarily challenges or barriers in moving the bills forward, but we did want to highlight them for you. Assembly Bill 202 renames the Virtual Early Childhood Family Engagement Pilot Program and it extends this program by two years. We are not having issues moving the bill forward. There have been delays in the RFP process, so we wanted to point that out. The challenge is not the intent of the bill, the challenge has just been the delay in the RFP process. Assembly Bill 220 established as a program to issue identification cards to unhoused individuals. The bill specifically indicated that we would be doing this as funding was available, and there is some challenge in identifying funding for that program. We believed during legislative session that we were going to be able to use opioid funds for that entire entire bill, and it has turned out after session that we are not going to be able to do it that way. We are looking for other funding sources including applying for grants, so while the bill does allow us—the bill specifically says as funding is available—so we are not out of compliance with the law. We are not able to move forward at this time unless we identify other funding. Then AB 352 requires a person who wants to conduct a cottage cosmetic boot operation such as—well I have lost my train of thought. When they want to sell food at the farmer's market they must apply for license with the Department of Agriculture. Our child support program must be able to spend those licenses if a pair is in noncompliance with their child support program. There is not necessarily challenges or barriers, but we are having to work with the Department of Agriculture, and the systems need to speak to each other—and there have been some delays in moving those forward. We can now take any questions.

Chair Brown-May:

Members, do we have any questions? Yes, go ahead Assemblymember.

Assemblymember Nadeem:

Thank you so much, Madam Chair. Thank you so much for explaining it so well, and I am so excited and happy to hear that we are third in this DSS. Thank you so much for the excellent work you are all are doing. My question is that for the food program, you are receiving 30 to 40,000 applications; how many are those are actually getting that benefits, and how we can improve that?

Administrator Thompson:

Ms. Cantrell will correct me if I speak wrong. But we—the approval rating in the food stamp program right now, I believe is approximately 85 percent. Approximately 85 percent are approved. Increasing the percentage probably is not the target. People that come in and apply that are not eligible, are not going to be eligible. People that are over income, we would not be able to aid them. We do provide resources and provide them with referrals to other resources such as food banks. The target that we are constantly trying to work on is reaching the eligible persons that have not applied. We would want to increase the application count, and we have a robust outreach program that we are increasing daily. We are putting more sites in that want us to go out. Historically, anyone that wanted to apply for food stamps had to come into a brick and mortar building and submit a paper application, but now we go out into the community with our staff, and we go out to the homeless shelters. We go out to any, actually, community partner that will have us, and we can set up shop maybe every day, maybe four hours a month, and set up a sign that we will be there four hours a month. The outreach program is what we use to increase those applications, and that is what we need to target to reach more people. I do not think it is necessarily going to increase the percentage of applications that we approve. It would be more reaching the people that are eligible that have never applied.

Assemblymember Nadeem:

Thank you so much for the great work. Thank you.

Chair Brown-May:

Next, we have Senator Doñate.

Senator Doñate:

Thank you so much, Madam Chair, and thank you so much for the presentation. I want to talk about some of the things that have happened during the interim between DSS, and hopefully, hopefully you can provide me some level of understanding. Earlier last week, I had the opportunity to read the Rural Transformation Fund Application that was submitted by the state, and on page 18 of that report that was prepared by the NVHA, it mentioned that DHS was responsible for submitting a waiver through SNAP. It mentions that it has the support of the Governor that would restrict the purchasing of certain foods for eligible recipients. It is my understanding that such proposal has not had any public deliberation or legislative input as it was not mentioned to IFC. I guess my first question is, can you provide us with an understanding of what the waiver entails, when the waiver was submitted, and where it is at today? As well as, who made the decision internally to apply and submit the application?

Administrator Thompson:

The policy decision to move forward with that waiver actually began when I first came in as Administrator. That was almost four years ago when the first conversation started under Director Whitley under the previous Governor. Director Whitley had come to me as the Administrator and asked us to move forward with pursuing these types of waivers to restrict sugar drinks. At that time, it was strictly sugar drinks. Through the conversations with Food Nutrition Services we did add in energy drinks and candy. Candy that was added to that were strictly sugar candies, candy that is 100 percent sugar. It is not candy bars, that is not the Snicker bars. It is strictly gummies or jelly beans, those types of, of sugars. I do think that is important to talk about while that waiver was part of the application that you are referring to. There is a second waiver that we are moving forward on to that is not part of that, because we do want to increase access to people that have food stamps to be able to buy hot food items—it was a two-fold conversation. It was restricting the sugar, which is—I believe I have answered the question that started under Richard Whitley. But, we also want to provide the opportunity to allow SNAP recipients to buy hot food in the grocery stores such as rotisserie chicken, to increase protein intake and for their convenience. We have also seen that often those rotisserie chickens are actually cheaper than buying full chickens or the raw chickens that they have to cook; and people that are sometimes homeless living in motel rooms do not have access to those hot foods—it was a two-fold conversation. It was the reducing sugar intake, but also increasing the convenience and buying hot foods; but the second one was not part of that grant. That is why it did not show up in that grant application. I am not sure I answered all of your questions; I think I missed something.

Senator Doñate:

Sure. I think, so the question—the difficulty that I am having, right? The conversation of the waiver regarding SNAP recipients being able to receive hot foods. We have had that discussion multiple times in Committee that, actually, was brought up back in the 2023 Legislative Session. This is from my understanding, at least since I have served in the Legislature, or I have heard that the division or the department is going after a waiver,

specifically, to start prohibiting the restriction of purchasing of certain foods. It is hard to have the balance where you are expanding access on one, and now you are deterring or eliminating the ability to purchase. I guess the question that I have is where is that applicant, or has already been submitted? And is it—or is it still in the deliberation process? Is it still subject to public input? Where are we in terms of implementing it?

Kelly Cantrell, Deputy Administrator, DSS:

The waiver has not yet been submitted. We are still talking to retailers. We are still talking to folks' states who have implemented. We are trying to—the definition of what is being excluded has been refined and refined again, so we have not submitted it yet. We have been talking with multiple entities outside of our division to try and narrow this down, and get this specifically as easy as possible for the retailers, and as comprehensive as possible, because we have seen some pitfalls with this waiver that has been stood up. But, we have not yet submitted, because we are still trying to refine the definitions of everything—we are close though.

Senator Doñate:

Thank you, as a further follow-up. I think one of the questions that is going to come up, which again, this is why public input is important. Is DSS prepared to navigate the complex challenges that is going to come with such changes to SNAP purchasing? Specifically, one, are we going to be prepared with the—navigating the complexity of lists that we are going to have to be prepared for, and the technical point of sale transaction that we are not going to have to track? On top of the administrative complexity with now having to look at purchasing behaviors of consumers and of individuals that rely on such public assistance. I think such question is important to ask because, as you may have seen, there are plenty of public health associations that mention the complexity of making such decision-making could be allocated and said—essentially when you stand up a restriction, or a limitation on such program. That same effort could be expanded on—I do not know—figuring out how we can make sure that grocery stores are more available in the ruals, or submitting waivers to ensure that people can purchase at farmers markets, or farms directly. Which I mean, we have had this conversation before. The question becomes, which one takes precedent? I want to make sure that you guys—if this is a waiver that you are going to go ahead and submit. Are you even prepared with the administrative capacity and the funding to even implement such requirement? I will let you answer that before I make my last comment on it.

Deputy Administrator Cantrell:

The evaluation portion of this waiver is intense—it is a heavy lift. We are today, at this moment, not 100 percent prepared to do this. We have—we plan to ask for an implementation date of February of 2028 to allow us to get a comprehensive plan, and to get the evaluation that there has to be surveys with grocery stores, we have to do one-on-one groups with customers. This is not an easy lift, but we know that it is going to take time. Yesterday I spoke with the associated food stores who represent 40 of the independent stores in rural communities and small, small retailers like Mario's on the west side. We know that the—what is in front of us—we know that there are entities that can provide the help you are talking about when it comes to the list of—Food Industry Associations is one of those that can help build a comprehensive list based on the definitions

that we put together; that we do not have funding for this at this time. We are in the exploration process of it, and we are talking to everyone, we are trying to get all the information so that we can have a comprehensive plan before rolling live, hopefully, in 2028. We—the retailers have told us they need as much time as absolutely possible to be able to meet the requirements of this, so we know we need time to do this.

Senator Doñate:

Thank you. That information is helpful. I think, just to round this out, if we are going to have a discussion on how we can improve access to healthier foods, right. I think that is kind of the point of why we have this Committee. Well, I think our Chair mentioned that we are going to talk about public health throughout this interim, and that is certainly a discussion point that we can have. The question is not whether we should restrict certain foods and so forth. I think the greater question that caused my level of concern and caution was the Executive Branch taking action, or certain agencies without legislative input, in terms of restriction public benefits, and that to me is a greater concern, because now we are starting to change consumer behavior without having the full deliberation of participation of the people—which can undermine the ability of services, which many of those in the rurals will often feel the hardest. I would caution that you do not proceed with such proposal until the Legislature has the ability to fully review it. Either in the ‘27—during this interim or the 2027 Legislative Session. Just because of the magnitude, and it sounds like you are—we are going to run into the roadblocks of administrative concerns and funding as well. I would implore you that you have that discussion internally as you move forward.

Chair Brown-May:

Thank you, Senator Titus.

Senator Titus:

Thank you, Chair. I will have a question for Director Rich at the end. But right now, since we went down this rabbit hole here regarding what we can define and purchase of using SNAP benefits. My question is, we currently have items that are already restricted on what you could purchase, correct, i.e., currently, we cannot purchase the hot foods. Currently, they cannot use it for alcohol. Currently, no cigarettes and those kind of things. It is not unheard of that there is already restrictions on purchasing using your SNAP benefits. Is that correct?

Deputy Administrator Cantrell:

That is correct.

Senator Titus:

Right, so it is not totally unthoughtful as we look to expand towards healthier foods. The reality is Senator Doñate mentioned, if we really want to help somebody have food access, purchasing already prepared foods—which was one of the prior limits—taking them home so they do not have to cook them, or maybe they just have a microwave. That makes good sense. At the same time as we are going to expand one side. If we are going to do a more of a whole body look, and what is really healthy, and who decides what is healthy or not. Looking at refined—the term was refining. Well, looking at refined sugars and perhaps what they are purchasing also on that list makes good sense regardless of whatever we settle on. I understand though that the impact is going to be on the small local down the road stores that sell a lot of this—the convenience stores, and so recognizing the impact, I appreciate that. But at the end of the day, the overall health of our society and the overall cost of

health care systems is all impacted by this. Listening to the small mom and pop stores that sell this food may be a good thing, but at the same time, we need to encourage them to find—you cannot sell cigarettes to them, you cannot sell alcohol, you are selling refined sugars. Maybe we encourage them to have more power bars in their store. Maybe we have, you know, encourage them to sell more healthy items—it is going to be a win-win for everybody. But right now there is a lot of paranoia—I think, oh my god, it is going to close this down—and that is not what the goal is. I do not think anybody on this Committee wants to attack retailers and stores, but what we have talked about the cost to society of health care, what we spend—$13 billion on health care, and some of this is that we do have a chance to make real change and perhaps it does require change of behavior. We encourage people with heart disease to go exercise. We encourage people with diabetes to change their behavior. So, it is not unheard of that we are actually trying to get people to buy into healthy lifestyles. I am excited about the conversation and I encourage, and I am excited that what you are doing is actually looking at the program, willing to say "Hey, maybe we should in addition to restricting alcohol and tobacco, maybe we should restrict refined sugars." But at the same time, offer that alternative and the stores to purchase healthy foods. It does not have to be the sky is falling narrative, I think, but the discussion has to be thorough, and implementation is going to be hard, and I think we all take ownership. I guess, Madam Chair, that was more of a statement than, than a question. Thank you for going off, and then when at the time, when we are done with this department, I will have a question for the overall, Director Rich.

Chair Brown-May:

Thank you, Senator. I appreciate your comments as well as Senator Doñate's. I think it is important that as we look at considering this, we really are identifying what is healthy in our communities, and I want to make sure that we do not eliminate my Polish pierogi, right. I mean, or my tortilla chips. I mean, those are very important parts of my diet that have three ingredients or less many times. I think it is important that we identify what is healthy and what are we eliminating, not just refined sugars. To that, I am going to say, can you tell this Committee is hangry? We have worked very long today, I appreciate your dedication, and your timeliness, and being here. Thank you so much. I would invite Director Rich back to the table as we do have a couple of posing questions for you. Thank you so much, Senator. Feel free to ask your question.

Senator Titus:

Thank you. First off, thanks everybody in all the departments for being here today, and really thorough what you do is pretty amazing, and I think just how many departments really it is to take care of the citizens in the state. I thank you for that. What I did not hear, and is a passion of mine and engaged in it—is who is in charge of who even cares about the hospice programs in this state? I did not hear hospice mentioned under any department. Who follows that—which department is hospice under?

Director Weeks:

Thanks for the wisdom of Director Whitley. It does live under me now, under HCQC—under licensing. But I will say Medicaid also plays an important role in monitoring access, and fraud, waste, and abuse. I would say two of those areas under the NVHA have some impact on hospice in terms of the licensing, oversight. Then obviously, Medicare at the federal level has a big interest in hospice.

Senator Titus:

Thank you for that. Because I, there is a really—there is a talk about health care vacuums, or voids, or areas where we just do not have it. In rural Nevada—recently had a patient die, could not get her hospice, because nobody would go out to this rural county; and it was very sad. When somebody says, "Listen, I came here to take care of my mom, and I am from Virginia, and I am going to do—if I could load her up, I would take her back to Virginia, because this will not happen in Virginia." It is sad, very sad. She has subsequently passed away in the last week. Very sad that we have put ourselves in this corner, so hearing more about hospice, how we can increase access to hospice, and who really has jurisdiction to that, and regulating that is forefront of my mind.

Director Weeks:

Yeah, and Madam Chair. I apologize, I know that was not a question. Senator, I wanted to say, I think it depends on network adequacy. If this individual was enrolled in a private carrier insurer, that would actually be under Division of Insurance (DOI). Do we require hospice to be in network, for example, to be adequate? I think some of those questions—if it was Medicaid, I think that it would be on us, and that would have been something our team would have had to help you and that patient's secure. Then when, if it comes, you know, so if it is in the exchange, if it is in the private market, even, I think to some extent—just generally the individual market, that would be DOI. It might be worth looking at network adequacy, standards, and obviously we should be looking on the licensing side to see—if we, how much, you know—what that process is, and sometimes there is provider abrasion, right, in the process of licensing. I think it could be a couple of pieces that might need to be looked at.

Senator Titus:

Thank you for that, and thank you, Madam Chair.

Chair Brown-May:

Thank you. Members, any other questions? Okay, seeing none.

Director Rich, I will ask you one last question that we asked a little bit earlier today. As you know, we have a number of Legislators that are very interested in the issues that you—report up through you. Is there a specific person or entity that you would like us as Legislators to contact with as we develop our policy priorities?

Director Rich:

Thank you so much for the question. You know, leading an agency, I think any department Director appreciates that. The more that lawmakers can come to us in advance and get our feedback—the better. You are all welcome to reach out to me directly or to reach out to the Administrators who are—oversee whatever program or that area specifically that, you know, that will be impacted. We are more than happy to, you know, to meet with you and discuss any potential legislation or issues that you want to bring up, but feel free to reach out to me directly or the Administrators.

Chair Brown-May:

Thank you for that. Again, I would like to thank each of you for being here to present to this Committee today. It has been a very robust presentation. We appreciate the detailed information for each of the divisions, and the issue areas, and as well as the recommendations of what we can continue to work on. We will officially close those presentations. Thank you, Director Rich for being here.

Move into the next item on our agenda, which is discussion of topics related to this interim Committee to be considered at future meetings.

AGENDA ITEM VI—DISCUSSION OF POSSIBLE TOPICS TO BE ADDRESSED AT FUTURE MEETINGS

Chair Brown-May:

At the beginning of the meeting members, we talked about what the work program—the policy brief that we have. You saw what we worked on during the last interim and during the last session. As a matter of just getting it back on the record, our priority issues of study during this interim are: maternal, fetal, and infant health; mental and behavioral health; public health; health care; workforce and health care innovation; and child welfare. All of our meetings for this Committee have been posted online, so the dates are already available. I would encourage you to mark your calendar, especially members of the public, if you are interested in these issue areas. At this time, I would like to ask our members. Are there additional or specific issues you would like to add for consideration as we move through the interim that we have not yet added? I am going to open it up to you. Is there anything you want to add? Go ahead, Senator Lange.

Senator Lange:

Thank you, Madam Chair. Last year—last session I had a bill, SB 250, which dealt with people owning their own health records and having health records all in one place. I think that it passed out of HHS and went to Finance, because it initially had a fiscal note. The fiscal note was removed, but it never was able to get out of Finance. I think that some of the people that had issues with that legislation are people that, frankly, are exempt from—would be exempt from that regulation. I would like us to take a look at that. I have been meeting with a broad coalition of health care people that are very interested in helping make something like this move forward; and if we could discuss it in the interim, that would be great.

Chair Brown-May:

Thank you, Senator, so noted. Members, any other topics?

Senator Titus:

Madam Chair?

Chair Brown-May:

Senator Titus.

Senator Titus:

Thank you. I was waiting for southern Nevada to come forward first. But if there is none, I have some ideas. First and foremost, Madam Chair, thank you for asking these departments to come up with their ideas on maybe burdensome regulations, reporting issues, and their own priorities. If perhaps we could have a staff get us a copy of those from each department instead of looking through all these documents and pages. If we could have a list of what the staff—the department's priorities were and then some of the individual—well all of the ones that they asked for. Perhaps that could decrease some of that burden of them reporting, et cetera. If we could have that in like a white paper or something that would be helpful, and that might help us, guide us going forward not just on a topic, but solutions.

As we talked about early into here in this process, we get 15 bills. There was probably 30, if not more, suggestions of improvement. It would be helpful, I think, if we had—since we are a single subject rule, when we would produce our BDRs. If we—if some of these report reforms and requirements—we could put into say a single bill; so that we are not using up—because there was 30 requests here that, you know, we have for 15 bills, and some of them are very specific on where they are going with that. It would be real helpful if we could have staff, our counsel, look at what one of these we could do, as a single perhaps BDR to say "Hey, lets—this reporting requirements, these all fall single topic, maybe single pages in the NRS." Maybe we could clarify that and then actually have a presentation on that—those subjects, on more details on why do the height and weight requirement, you know, maybe we could get into, you know, one bill or get that eliminated, and merge it into another bill or something along those lines. I think that would be very productive, because I would like us to see, even do better than we did last session. Although, getting 8 out of 14 is really probably the record for this Committee. I would like us to see—even do better with good use. We really truly have an opportunity to change the health care in this state. And some of the things that the department has already identified as really needing to happen, we really should be pursuing that. Thank you, Madam Chair.

Chair Brown-May:

Thank you, Senator, for that comment. I agree, which is why we asked for them to bring forward their recommendations. I think administratively there are burdens that we place that we do not recall having or requesting a report. Additionally, I would just like to note that while we are all—we are receiving the recommendations from each of the divisions that will come before us, and I encourage the public to do the same that I have asked for staff to follow-up, and ask for some additional details with regard to justification for each of those recommendations. There are times, I think, that the Legislature is requiring, or requesting, and passing a law to ask a division to do something, and so we want to make sure that we are not eliminating the progress that we are attempting to make while asking for revisions to decrease the administrative burden associated with just—the law. I thank you for that. Know that the staff will work on that report, and then we will share it with each of the members as we progress throughout this interim.

Members, are there any other recommendations that you would like to see as we progress to move forward?

Assemblymember Goulding:

Chair?

Chair Brown-May:

Go ahead, Assemblymember.

Assemblymember Goulding:

Thank you, Chair. I am very much looking forward to the February meeting that addresses maternal, fetal, and infant health. I am also interested in sort of a—focusing on health disparities; and particularly in that subject area.

Chair Brown-May:

Noted, thank you for that. Members, any other topics? Okay, thank you for that. We will go ahead and add that to the work session.

I do want to at this time bring up that there was originally on this agenda—the update with regard to H.R.1, and that federal piece of legislation that is affecting so many of our state departments and divisions. As you will note, our agenda went long today just with the two divisions, and all of the progress that we worked on in the last legislative session, and moving into this interim. As a result, we are requesting from a Legislative Commission an additional meeting for this Committee. We have preliminary approval, so we will look to add a seventh meeting that will specifically address the effects of H.R.1 on the state. Then we will invite each of the departments that is being affected. So, not typically in front of this Committee would be the Department of Agriculture; however, they will have a big part of that—the Department of Corrections. We are interested in learning about the federal effects that are going to have potential ramifications to so many of our departments. We will request a specific meeting. I would ask you—our current schedule—members, is about six weeks apart. We do have a break in between two of our meetings, and so I am curious to know if you would share your availability with staff? Between the March 31 and the May 12 meeting, we would look at identifying a seventh date. Feel free to reach out to staff, if you do not mind, with clarity around availability. I would ask you today, is 9 a.m. on a weekday appropriate for your schedule? Okay, I have a thumbs up in Carson. Okay, we have a thumbs up. Thank you for that clarity. Thank you.

Okay, thank you very much for that. We will now move to the next item on our agenda, which is the second public comment period.

AGENDA ITEM VII—PUBLIC COMMENT

Chair Brown-May:

For those of you who are here in physical locations, please move forward to the tables. Remember to clearly state and spell your name. You will have two minutes, and we will time each of our speakers. I would like to remind those who may be on the telephone line, if you would like to offer public comment on the telephone dial in. Dial 888 475 4499, and then provide the meeting ID which is 891 2994 9350, and press the pound sign. With that, we will go ahead and start here in Las Vegas. State and spell your name for the record. You may begin when you are ready.

Lee McAllister, Executive Director, Nevada Chapter of the American Academy of Pediatrics:

Good afternoon, Chair, and members of the Committee. I thank—appreciate having a moment to express my sincere appreciation for NVHA's presentation on school health today. On behalf of our 290 pediatrician members across the state, I want to say clearly, we stand ready to support this school health plan. For many of our pediatricians these are challenging times. We often find ourselves navigating a storm of barriers, families struggling to access care, the persistent noise of medical misinformation, and growing anxiety around life saving vaccines. In this landscape, the Nevada Medicaid School Health Plan is a genuine bright light—a green spot of growth in a difficult environment. Because schools are where the vast majority of our children are every day, this plan is a vital opportunity to meet them where they are within truth, safety, and care. To ensure this light reaches it is full potential school health must be anchored in evidence-based best practices. Our school health chapter champion Dr. JP Vilai is available to ensure we are adhering to the highest American Academy of Pediatric standards. One essential tool for this plan is the Nevada—is Nevada PAL [Pediatric Access Line]. This is a statewide grant funded peer-to-peer line that connects pediatric physicians and advanced practice providers with a child psychiatrist. It bridges the gap between the student in need and the specialized care they deserve, empowering school-based staff to provide a higher level of mental health support on the spot. We are deeply grateful for the vision shown by the NVHA, today. We look forward to being a partner and turning this plan into a reality for Nevada's children. Thank you.

Chair Brown-May:

Thank you. Okay, seeing no one else in Las Vegas for public comment. I do not see anyone at the table—thank you for that shift in Carson City. Let us go to the telephone lines. AVH, is there anyone on the telephone who would like to offer public comment at this time?

AVH:

Thank you, Chair. If you would like to provide public comment, please press *9 now to take your place in the queue. Again, to provide public comment via the phone line, please press *9 to join the queue.

Dora Martinez, Member of the Public:

Good day, Madam Chair, and members of the hardworking Committee. Chair, I want to thank you—take the opportunity to thank you. I do not know if you remember, but I remember when you did a presentation that one of the Silver State Self-Advocacy Conference, you said "When you see something, say something." And you came to me and you said "Dora, when you hear something activate for advocate for it." So, based on the presentation regarding work 20-hours on workweek, which is really great for people with disability who are, and want, and able to work to, to happen. And I am just letting you know that in the state of Nevada, we have, we have to help people like myself who are blind and other disability that wants to work. Yet some of us have been waiting, and we really want to do and be part of society, and work. So I am hoping that we can get a partnership with you and see if the book we have can get on board and, and help people who are able to to work. And thank you so much, Madam Chair. Thank you, and have a great year, and see you all soon. Thank you.

Chair Brown-May:

Thank you, Ms. Martinez. I do remember, and I appreciate that. So, absolutely, keep advocating.

AVH, is there anyone else on the telephone line?

AVH:

Caller with the phone number ending in 913, please press *6 to unmute yourself, and begin when ready.

A'Esha Goins, Black Joy Consulting:

Good afternoon. I am calling on behalf of SEIU [Service Employees International Union] Local 1107, and I just want to say I just appreciate the interim Committee for taking the time to listen to all of the reports. Also to the Chair, it is just so great to have someone that is interested in moving the conversation forward, especially as we relates to children behavior health services. I want to thank Ms. Stacie Weeks for her report in DCFS as well. I know that we are all working to get a solution for our youth with severe emotional disturbance cycle that are cycling inappropriate placements due to inadequate licensing framework and facility capacities. I just want to remind everyone that SEIU supports the no eject, no reject policy. But we support that, specifically, because we just want to ensure that our children in crisis are not turned away. And that we stand, especially I stand, to collaborate with the Committee and also the departments that are available for solutions. And I know that this has been a tough job and tough work, and so many things that we are learning—we are learning things in real time. And—but I want to just remind everyone that it is going to take a village to fix this. No one person can get it done and no one is pointing fingers. We are all available to get the work done, and I just appreciate you, and appreciate your time. Thank you.

Chair Brown-May:

Thank you, Ms. Goins, for being here with us all day.

AVH is there anyone else on the line? Hello?

Shannon Garner, Member of the Public:

Thank you for your time today. I am a mom of five kids with autism, and this year our insurance has become so expensive, and is making ABA [applied behavioral analysis] services not attainable for our family, which is a vital lifeline for us. I cannot imagine what other families are going through, but for us specifically, it is very challenging. We need attainable, affordable, ABA services for our family and our kids to be more independent, and more capable, and learn these important skills. I thank you so much for your time.

Chair Brown-May:

Thank you, before you hang up. Are you able to spell your name for us? I did not hear it at the very beginning.

AVH:

One moment, please, Chair.

Will the last caller please press *9 now, to raise their hand and rejoin the queue? If they are still on the line.

Shannon Garner, Member of the Public:

My name is Shannon Garner.

Chair Brown-May:

Thank you for that. Thank you for calling back in and making sure that we have your name for the record.

AVH:

If you have recently joined and would like to provide public comment. Please press *9 now to join the queue.

Chair, there are no additional callers choosing to provide public comment.

The following written public comments were submitted:

- Public Comment from Krista Luke, Member of Public (Agenda Item VII A);
- Public Comment from Elia Sverdlova, Member of Public (Agenda Item VII B); and
- Public Comment from Cynthia Cooper, Member of Public (Agenda Item VII C)

Chair Brown-May:

Thank you, AVH.

Seeing no other people here in-person, in Carson City or in Las Vegas wishing to offer public comment. We close that section of our meeting

Members, thank you so much for being here for this very first meeting. Our next meeting will be held on Tuesday, February 17, at 9 a.m., and officially today's meeting is adjourned.

AGENDA ITEM VIII—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 2:26 p.m.

Respectfully submitted,

_____

Serina Hale
Research Policy Assistant

_____

Davis H. Florence
Senior Policy Analyst

APPROVED BY:

_____

Assemblymember Tracy Brown-May, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II A	Steven Cohen, Member of the Public	Written Public Comment
Agenda Item II B	Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities	Written Public Comment
Agenda Item III	Davis Florence, Senior Policy Analyst, Reseach Division, Legislative Counsel Bureau [LCB] Anthony Ciaramella, Senior Policy Analyst, Research Division, LCB	Interim Committee Brief
Agenda Item IV	Stacie Weeks, Director, Nevada Health Authority [NVHA] Malinda Southard, Deputy Director, NVHA Ann Jensen, Administrator, Nevada Medicaid	PowerPoint Presentation
Agenda Item V A-1	Laura Rich, Director, Department of Human Services [DHS] Jessica Adams, Deputy Administrator, Aging and Disability Services [ADSD] Cheyenne Pasquale, Agency Manager, ADSD Samantha Jayme, Deputy Administrator, ADSD Marla McDade Williams, Administrator, Division of Child and Family Services [DCFS] Andrea Rivers, Administrator, Division of Public and Behavioral Health [DPBH]	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
	Robert Thompson, Administrator, Division of Social Services [DSS] Kelly Cantrelle, Deputy Administrator, DSS	
Agenda Item V A-2	Department of Human Services [DHS]	Implementation List
Agenda Item VII A	Krista Luke, Member of the Public	Written Public Comment
Agenda Item VII B	Elina Sverdlova, Member of the Public	Written Public Comment
Agenda Item VII C	Cynthia Cooper, Member of the Public	Written Public Comment

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