June 27, 2025

Diane Thornton, Acting Director
Legislative Counsel Bureau
401 South Carson Street
Caron City, NV 89701

RE: Patient Protection Commission July 1 Report

Dear Acting Director Thornton:

In accordance with Nevada Revised Statutes NRS 439.918.2.(a), the Patient Protection Commission (PPC) is respectfully submitting its twice-yearly report to provide updates regarding the meetings and activities of this Commission. The report must include, without limitation, a description of any issues identified as negatively impacting the quality, accessibility or affordability of health care in this state and any recommendations for legislation, regulations or other changes to policy or budgets to address those issues. If further information is required, please contact me at your convenience.

Respectfully,

Joseph Filippi Jr.

Joseph Filippi
Executive Director
Patient Protection Commission
jfilippi@dhhs.nv.gov
(775) 634-5420

cc:
Richard Whitley, Director, Nevada Department of Health and Human Services
Stacie Weeks, Director, Nevada Health Authority

Enclosures:

1. PPC July 1, 2025 Report
2. Summary Minutes for PPC Meetings (January-June 2024)

Semi-Annual Report of the Patient Protection Commission

July 2025

Patient Protection Commission

(NRS 439.908)

Joe Lombardo
Governor
State of Nevada

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I. Membership

Voting Commissioners

Dr. Ikram Khan, Chair
One member who is a provider of health care who operates a for-profit business to provide health care.

Marilyn Kirkpatrick, Vice Chair
One member who represents a nonprofit public hospital that is located in the county of this State that spends the largest amount of money on hospital care for indigent persons pursuant to chapter 428 of NRS.

Dr. Andria Peterson
One member who has expertise and experience in advocating for persons with special health care needs and has education and experience in health care.

Dr. Bayo Curry-Winchell
Dr. Mark Glyman
Two members who are persons with expertise and experience in advocating on behalf of patients.

Dr. Travis Walker
One member who is a physician or registered nurse who practices primarily at a federally-qualified health center.

Floriene Kahn
Representative of the General Public

Bethany Sexton
One member who represents the private nonprofit health insurer with the highest percentage of insureds in this State who are adversely impacted by social determinants of health.

Jalyn Behunin
One member who is a registered nurse who practices primarily at a nonprofit hospital.

Walter Davis
One member who has expertise and experience in advocating for persons who are not covered by a policy of health insurance.

Dr. Adam Porath
One member who is a pharmacist at a pharmacy not affiliated with any chain of pharmacies or a person who has expertise and experience in advocating on behalf of patients.

Ex-Officio (Nonvoting) Commissioners

***Richard Whitley**, Director, Nevada Department of Health and Human Services*

***Celestena Glover**, Executive Officer, Public Employees Benefits Program*

***Scott Kipper**, Insurance Commissioner, Nevada Division of Insurance*

***Russell Cook**, Executive Director, Silver State Health Insurance Exchange*

Commission Staff

***Joseph Filippi**, Executive Director*

***Dylan Malmlov**, Policy Analyst*

***Meybelin Rodriguez**, Executive Assistant*

II. Introduction

The Nevada Patient Protection Commission (PPC; Commission) is a public body located within the Executive Branch of state government. The PPC is comprised of 12 voting members and 4 nonvoting members with representation from across the health care spectrum, including advocates, providers, and industry professionals who are dedicated to improving health care in Nevada. Nevada Revised Statutes (NRS) 439.902-918 provides the PPC with statutory authority to systematically review issues related to the health care needs of residents of Nevada and the quality, accessibility, and affordability of health care in the state. This report is being submitted in accordance with NRS 439.918.2.(a), which requires the PPC to submit a semi-annual report to the Governor and the Legislature describing the meetings and activities of the Commission during the immediately preceding six months. The report must include, without limitation, a description of any issues identified as negatively impacting the quality, accessibility or affordability of health care in this state and any recommendations for legislation, regulations or other changes to policy or budgets to address those issues.

III. Meetings and Activities

Over the past six months, the Commission held three public meetings. The summary meeting minutes surrounding each meeting are attached for reference. For more information about these meetings and to view meeting materials, please go to: https://ppc.nv.gov/. Highlights of PPC meeting discussion and action items over the reporting period included:

- Overview of Nevada's Health Care Industry and Insurance Market
- Overview of AB 7 (2023) and Implementation Update Regarding Approved Regulation LCB File No. R173-24
- Update Regarding Nevada Health Insurance Claim Denial Data and Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance
- 83rd Legislative Session Update Regarding PPC Bills (SB29, SB34 and SB40)
- Review and Discuss PPC Policy Focus Areas for 2025-2026 Interim
- Discuss formation of certain subcommittees

IV. 83rd Legislative Session

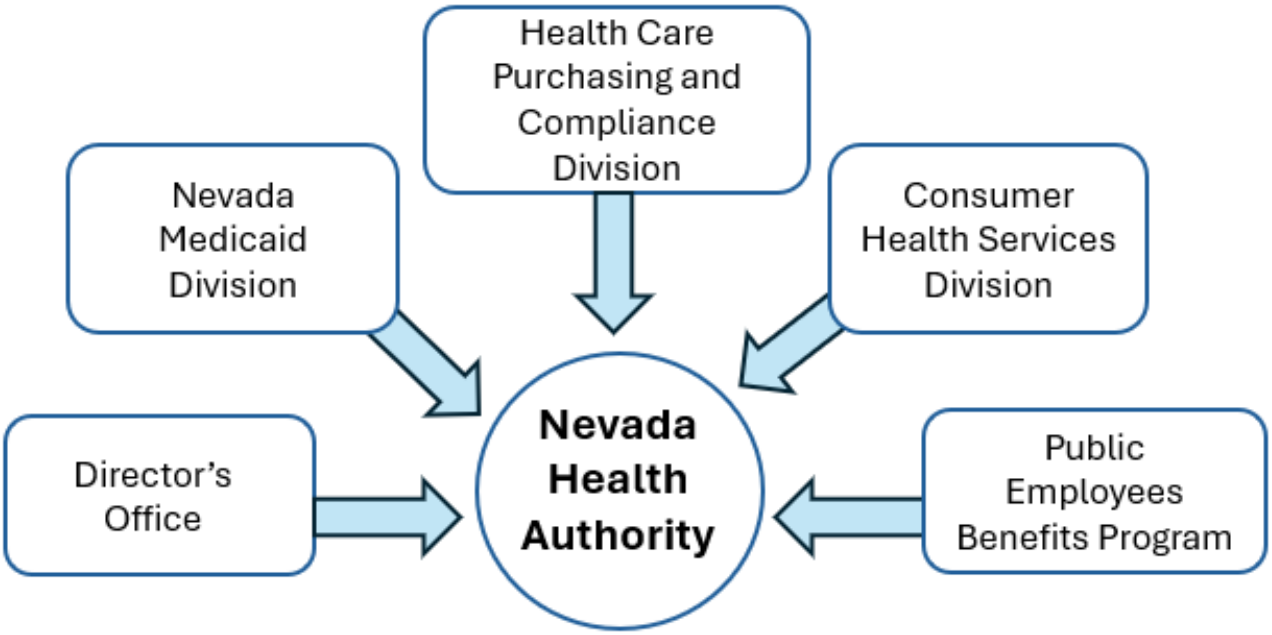
As part of the Commission's systematic review of health care, and in accordance with NRS 439.916.1(i), the PPC is responsible for reviewing proposed and enacted legislation, regulations and other changes to state and local policy related to health care in this State. The Commission's Executive Director and staff monitored hundreds of bills during the 83rd Legislative Session that relate to health care. This section of the report highlights a few bills the Governor signed into law that relate to the Commission's scope and will have substantial impact to Nevada's health care system.

Nevada Health Authority (SB 494)

On January 15th, during the State of the State Address, Governor Joe Lombardo announced his recommendation to reorganize the Nevada Department of Health and Human Services (DHHS) into two distinct entities – the Department of Human Services (DHS) and the Nevada Health Authority (NVHA). SB 494 establishes the Nevada Health Authority, a new department with the mission to improve access to health care that is safe, of high quality and affordable. According to the Governor, by splitting DHHS, the State's largest agency, the State of Nevada is streamlining operations to better serve Nevadans. The DHS will be primarily responsible for providing direct care services through 4 of the 5 existing DHHS divisions (Aging and Disability Services, Public and Behavioral Health, Child and Family Services, and Welfare and Supportive Services, which will be renamed the "Division of Social Services"). The Division of Health Care Finance and Policy will transfer under the new NVHA and be renamed "Nevada Medicaid", which will provide much-needed clarity for consumers, simplifying their search for information and improving their overall experience. The new Nevada Health Authority is intended to capitalize on the broad and strong purchasing power of the State when it comes to health insurance. Along with Nevada Medicaid, the Silver State Health Insurance Exchange (SSHIX) and the Public Employee's Benefit Plan (PEBP) will be housed under the umbrella of NVHA. By doing so, the state is strengthening its

buying power with insurers to cut a better deal for taxpayers while offering better insurance options to 1 in every 3 Nevadans – Medicaid members, those enrolled in the exchange, and state employees. This will help the State better maximize public dollars and lower the cost of health care for the State by consolidating resources.

Under the reorganization, the Nevada Health Authority will consist of three new divisions: the Medicaid Division, the Health Care Purchasing and Compliance Division and the Consumer Health Division. The Authority will also include a Director's Office and the Public Employees Benefits Program as shown in the diagram below.



The PPC will be housed within the new Consumer Health Division, which will also consist of the Silver State Health Insurance Exchange, Medicaid Express, the Public Option, and Nevada's Graduate Medical Education Grant fund. SB 494 also transfers from the Governor to the Director of the Nevada Health Authority the responsibility to appoint the members and Executive Director of the Commission. The PPC's statutory authority and scope will remain the same as currently outlined within NRS Chapter 439.

PPC Bills

Pursuant to NRS 218D.213, the Commission may submit up to three bill draft requests (BDRs) to the Nevada Legislature which relate to matters within its scope. In alignment with Governor Lombardo's Executive Order 2024-002, the Commission developed three BDRs intended to address the health care workforce needs of the state. The proposed legislation aimed to improve health care provider access, simplify the licensure process for health care professionals, and provide a higher return on state investments for healthcare workforce initiatives, including Graduate Medical Education (GME). Each proposed legislative measure was developed based upon recommendations received by the public and stakeholders, input from subject matter experts and available national and state data.

Unfortunately, the PPC's bills Senate Bill 29, Senate Bill 34 and Senate Bill 40 were not considered by the 83rd Nevada Legislature and were among the bills that failed to meet the first committee passage deadline on Friday, April 11th. Although the bills failed to pass, several other pieces of legislation were adopted that align with the Commission's legislative intent and recommendations to simplify the licensure process for health care professionals, reduce provider

administrative burdens and provide state investments for healthcare workforce initiatives, including Graduate Medical Education (GME).

Occupational Licensure

Nevada continues to rank below the national average when comparing the rate of health care professionals per capita. Occupational licensure compacts represent the gold standard of policy options for states to improve licensure portability and establish collective criteria for multistate practice. Interstate licensure compacts allow Nevada to:

- Support gainful employment of military personnel who move frequently;
- Expedite the deployment of healthcare professionals in the instance of a public health emergency;
- Create an accessible regulatory environment that supports health professions recruitment; and
- Enhance access to health care services, including telehealth.[1]

Prior to the 83rd Legislative Session, the State of Nevada was a member of five occupational interstate licensure compacts, including compacts for physicians, psychologists, and emergency medical services.[2] These compacts have proven to be beneficial to Nevadans by not only expediting the process for licensed professionals but also attracting new talent to the state and increasing access to care. The PPC's SB 34 requested Nevada enact five additional interstate licensure compacts for physician assistants, nurses, occupational therapists, physical therapists, audiologists and speech-language pathologists. The bill also recommended a study be conducted regarding the impacts each compact had on increasing access to health care services. During the 83rd Legislative Session there appeared to be bipartisan support for interstate licensure compact legislation, and legislation was introduced from both Democratic and Republican lawmakers. Among the eight health care licensure compacts bills introduced during session, the following bills were enacted by the Legislature, and signed into law by the Governor:

- AB163: Enters Nevada into the Counseling Compact.
- AB230: Enters Nevada into the Audiology and Speech-Language Pathology Compact.
- AB248: Enters Nevada into the Physical Therapy Compact.

In addition to interstate licensure compacts, the following bills will have substantial impact to health care occupational licensure and aim to provide Nevadans with greater access to health care professionals:

AB483 was sponsored by the Joint Interim Standing Committee on Health and Human Services and requires certain health care licensing boards to develop a process to expedite the process by giving priority review status to the initial license application of an applicant for a license or certificate who demonstrates that he or she intends to practice in a "historically underserved community". The bill applies to licensing boards created by NRS Chapter 630 (Physicians, Physician Assistants, Medical Assistants, Perfusionists, Anesthesiologist Assistants and Practitioners of Respiratory Care), NRS Chapter 631 (Dentistry), NRS Chapter 632 (Nursing) and NRS Chapter 633 (Osteopathic Medicine). By expediting the licensure process for these health care professionals, Nevada will increase access to care and prioritize licensure and onboarding for providers who wish to serve in underserved areas.

SB 124 allows internationally trained physicians to practice healthcare in Nevada. Authorizes the Board of Medical Examiners to issue a limited license to practice medicine to a graduate of a qualified foreign medical school who meets certain criteria and possesses certain qualifications. This creates a pathway for physicians who graduated from a medical

[1] National Governors Association. (n.d.). *Common State Policy Solutions to Support Health Professions Portability*. Retrieved from https://www.nga.org/wp-content/uploads/2022/10/State-Policy-Options-to-Support-Portability.pdf

[2] (National Center for Interstate Compacts Chart, 2024)

school and trained in other countries to hold a limited license and practice medicine under the supervision of licensed physician in certain facility types and settings. Once the holder of a limited license has completed at least two years of practice as a full-time physician and remains in good standing, the Board of Medical Examiners is required to issue an unrestricted license to this holder. The bills intent is to allow foreign medical school graduates to practice within Nevada with an unrestricted license in medically underserved areas and increase the physician workforce pipeline.

Graduate Medical Education (GME)

The PPC's SB 40 failed to pass, but would have established a Medicaid Workforce Account within the Department of Health and Human Services (DHHS) and aimed to provide a higher return on state investments for Graduate Medical Education (GME). SB262 also seeks to invest in GME and identify sustainable opportunities to expand the physician workforce pipeline. The bill received strong bipartisan support during the legislative session and was signed into law by the Governor. The bill transfers oversight of the GME Grant Program from the Governor's Office of Science, Innovation and Technology (OSIT) to the Nevada Health Authority. It appropriates $4.5 million per year ($9 million total) in the next biennium to the account. Funding allocated to the GME Grant Program account does not revert to the state general fund. The bill prohibits an institution that receives a grant through the program from eliminating or reducing the size of the GME program without the review and approval from the Department. This will help promote the sustainability of GME programs funded by the state, and ensure the Department is notified when a program seeks to reduce or eliminate services and reduce access to care. The bill additionally transfers the GME Grant Advisory Council, which is responsible for evaluating GME grant applications and providing recommendations to the Department concerning such applications. Additionally, the Council, in collaboration with the Department, is responsible for making recommendations regarding how to create and retain more GME programs and physicians to meet Nevada's healthcare needs. This includes exploring ways to use federal financial participation in Medicaid to support GME programs and enhance access to care for Medicaid recipients.

Health Care Workforce

Unfortunately, the Governor's "Nevada Health Care Access Act" (SB495) and the Senate Majority Leader's SB434 both failed to pass during the final days of the 120-day legislative session. As introduced, both bills similarly proposed the creation of a competitive grant program that must award grants for projects that address critical shortages in health care providers in Nevada. The bills required the Department of Health and Human Services to conduct a biennial health care workforce needs assessment, which includes a quantitative analysis of the health care workforce in this State; and compile a report of the results of the assessment. The last reprint of the SB434 appropriated $10 million to the grant program Account and the funding within the Account would not have reverted to State General Fund at end of each fiscal year. The bill imposed certain additional requirements for an entity to be eligible to receive such funding, such as securing matching funding (from federal source or other source) and in-kind services (infrastructure, healthcare staffing, services, research, etc.) that are equal to the amount of the award for a project. Both SB495 and SB434 align with the Commission's recent recommendation(s) to:

- Designate an agency or taskforce to lead statewide health care workforce efforts, conduct statewide assessments of health care workforce gaps, and convene state leaders and other health care industry stakeholders to develop and implement a health care workforce strategic plan.
- Assess existing State programs and funded projects to ensure they are effective in enhancing the state's health care workforce.
- Ensure state investments in workforce initiatives have a high return on investment for the state.

Such efforts are critical to reducing unnecessary duplication of activities and maximizing the use of limited funding and resources to address the critical shortage of health care providers. The following bills were signed into law and will also have an impact on healthcare workforce development in Nevada:

- AB484 expands the data required to be collected by the Department of Human Services and compiled into the Health Care Workforce Database established per NRS 439A.116. The bill requires additional data regarding health care providers to include: 1. The sex of an applicant; 2. Any other jurisdiction where the applicant holds the same type of license; 3. Whether the applicant utilizes telehealth in their practice; and 4. The types of patients the applicant serves.

- SB165 seeks to recognize a new profession known as "behavioral health and wellness practitioners", offer scholarship opportunities, and allow students to complete training in their chosen behavioral health field within Nevada, thereby supporting behavioral health workforce development. The bill directs the Department of Human Services to use opioid settlement dollars from the Fund for a Resilient Nevada to reimburse Nevada state universities and colleges for the costs associated with providing scholarships for students seeking behavioral health and wellness degrees, and degrees for providers that supervise behavioral health and wellness practitioners. The bill also aims to establish an American Psychological Association (APA) certified internship program in the state which is a full-time capstone residency program required for psychology licensure. Currently, students specializing in child psychology must leave Nevada to fulfill this training requirement and this bill aims to eliminate this, by providing funding to the University of Nevada, Las Vegas (UNLV) to establish a pediatric psychiatry residency program.

- SB266: allows certain behavioral health professionals, including marriage and family therapists, clinical alcohol and drug counselors or a licensed or certified alcohol and drug counselors, to qualify for student loan repayment through the Nevada Health Equity and Loan Assistance Program. To qualify, providers must be actively licensed, certified or registered in good standing in Nevada and willing to commit to providing healthcare services in rural or urban underserved communities in the state for at least five years of full-time clinical practice.

Pharmacy Benefit Managers (PBM)

- SB389 requires the Nevada Health Authority to select a single state pharmacy benefit manager (PBM) by January 1, 2030, to manage all prescription drug coverage for Medicaid and certain health benefit plans. It directs the department to establish methodologies for reimbursement rates, payment for prescription drugs, and benchmarks to assess drug cost data. The legislation also outlines specific duties and prohibitions for the pharmacy benefit manager and mandates that Medicaid managed care organizations contract with and utilize this PBM for the administration of pharmacy benefits, including requirements related to the coverage of drugs not listed as preferred.

Consumer Health Assistance

- AB343 seeks to increase health care price transparency for consumers by codifying in Nevada law the federal CMS Final Rule for price transparency (Sect. 14(1)(a)and(b) ref. 45 CFR Sect. 180.60). The bill requires hospitals to publish a report of shoppable services, costs of services they provide, as well as require the Department of Health and Human Services to publish the list, ensure compliance and take any action against and impose fines for hospitals who do not comply. Any collection of medical debt while a hospital is knowingly out of compliance would be considered a Deceptive Trade Practice and therefore subject to NRS 598 penalty and civil actions. The Governor's Consumer Health Advocate and Office of Consumer Health Assistance (OCHA) would be required to assist patients with the filing of these claims.

Prior Authorization and Insurance Claims

Prior authorization (PA) is a requirement by health insurance plans that mandates a health care provider obtain approval before prescribing certain medications or procedures. An insurance claim is a request for payment after services have been rendered. Within the PPC's January report, it recommended Nevada Medicaid review and streamline the health insurance PA process to address inefficiencies and unnecessary barriers to care. Specifically, the PPC suggested identifying and removing PAs required for services that are routinely approved and pose minimal risk of fraud, waste, and abuse. These requirements can add unnecessary administrative burdens for providers while delaying timely access to care for patients. Following the 83rd legislative session, several bills were signed into law by the Governor and align with the PPC's recommendations and aimed to reform prior authorization and insurance claim processes.

- AB52 requires payment of electronic health insurance claims within 21 days or within 30 days for non-electronically submitted claims. Requires information to be sent to providers regarding how to submit claims and how to appeal claim denials. The bill also requires insurers to submit annual report to Nevada Division of Insurance regarding number of claims failed to be paid timely. The bill exempts Nevada Medicaid and the Public Employee Benefits Program (PEBP) from these requirements. These measures aim to establish a reliable and prompt reimbursement system for healthcare providers, thereby fostering a conducive environment for the growth of medical practices and improving healthcare access for Nevada residents.
- AB463 requires insurers covering Medicaid, CHIP, and the public employee benefits program (PEBP) to post on their public websites a list of services that require prior authorization along with the clinical review criteria for these services. The legislation prohibits the requirement of prior authorization for emergency care and medically necessary services, and it prevents insurers from retroactively denying coverage when prior authorization was not required under the published policy at the time the service was provided. Additionally, the bill sets specific timeframes for responses, 48 hours for non-urgent requests and 24 hours for urgent requests, and mandates that both insurers and the Commissioner of Insurance periodically report on compliance and the outcomes of these provisions.

V. Potential Medicaid Cuts

As of January 2025, 1 in 4 Nevadans (823,570 enrollees) received health care coverage through Medicaid. Nevada Medicaid works in partnership with the federal Centers for Medicare & Medicaid Services (CMS) to assist in providing quality health care services for eligible individuals and families with low incomes and limited resources. Services are provided through a combination of traditional fee-for-service provider networks and managed care organizations. Historically, the federal government has guaranteed it will share with states the cost of all Medicaid expenditures, ensuring that the program is jointly financed without limits or caps. The federal government's commitment to match all a state's Medicaid expenditures makes it possible for states, in turn, to guarantee Medicaid coverage for all eligible individuals.

For most enrollees—including children, older adults, individuals with disabilities, and other adults not covered through Medicaid expansion—the federal government's share of Medicaid costs is determined by the "standard" medical Federal Medical Assistance Percentage (FMAP). The FMAP is computed from a formula that considers the average per capita income for each State relative to the national average. In Nevada, the current standard FMAP percentage is 59.80%, meaning on average, the state covers 40 cents, and the federal government covers 60 cents for every dollar spent on Nevada Medicaid recipients.[3] Nevada is among 40 States and D.C. who have implemented the Affordable Care Act (ACA) Medicaid expansion. For enrollees covered through ACA Medicaid expansion, states currently receive an

[3] KFF. (2025). *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*. Retrieved from https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

enhanced 90% FMAP, meaning the federal government covers 90 cents of every dollar spent on expansion enrollees.[4] According to research published by the National Bureau of Economic Research, Medicaid expansion has significantly reduced mortality rates among low-income adults. The study found that individuals who gained coverage through the states that expanded were 21% less likely to die each year compared to those who were uninsured. Furthermore, states that adopted Medicaid expansion collectively saved 27,400 live between 2010 and 2022.[5]

The U.S. Congress has been considering a variety of federal policy changes that would have significant impacts on the Medicaid program, widely expected to reduce enrollment and federal Medicaid funding to states. In February 2025, the Nevada Department of Health and Human Services shared a report on the estimated impact of potential federal Medicaid reductions. Among other impacts, the report notes that a reduction from 90% FMAP for the expansion population to traditional FMAP would translate to a reduction of $1.858 billion in federal matching funds over the next two years, impacting 300,000 Nevadans covered under expansion. The report also notes that a reduction in a provider tax from a six to a four percent tax would reduce revenue for children's behavioral health by $30 million in state revenues over two years and is estimated to reduce supplemental payments for hospitals by $693 million over the upcoming biennium. The report lists state options if there are federal reductions, including eligibility and benefit reductions and provider reimbursement rate reductions. During a February joint meeting of the Nevada Assembly and Senate Committees on Health and Human Services, state lawmakers acknowledged that federal cuts to Medicaid would cause harm to Nevada's already fragile healthcare system.

Any of the proposed reductions in federal Medicaid funding would have direct negative impacts to Nevada patients and overall access to care. Even with the successes of the ACA expansion, the State of Nevada currently has one of the highest uninsured rates in the nation.[6] Any reductions in Medicaid coverage would cause Nevada's uninsured population to increase and lead to these vulnerable populations to seek uncompensated care. When Nevada first expanded Medicaid in 2014, its uninsured rate dropped from 22% in 2012 to 12% in 2015, and it saw the largest percentage point decline in its rate of uninsured children, which dropped from 14.9% in 2013 to 7.6% in 2015.[7] If the ACA Medicaid expansion match rate was eliminated, Nevada Medicaid is projected to have the 4th highest reduction in Medicaid enrollment, with an estimated 42% enrollment decline (312,000). [8]

As part of the federal budget reconciliation process, on May 22nd, the federal House of Representatives passed language for the H.R.1 – One Big Beautiful Bill Act, which includes proposed healthcare and Medicaid reforms. According to the American Association of Medical Colleges (AAMC), the proposed legislation would reduce federal Medicaid spending by $625 billion over ten years through new restrictions on provider taxes and state-directed payments, limits on Medicaid eligibility and enrollment, and targeted cuts to the FMAP for states that choose to use state funds to support Medicaid coverage for undocumented individuals, among other policies.[9] This proposal did not include some of the most controversial changes that House Republicans have previously discussed, which would have included imposing per-capita spending caps or reducing FMAP for ACA expansion populations.

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[4] The Affordable Care Act (ACA) expanded Medicaid to adults with incomes up to 138% of the federal poverty level (FPL).

[5] Wyse, A., & Meyer, B. D. (2025, May). *Insurance and Mortality from the Universe of Low-Income Adults*. Retrieved from National Bureau of Economic Research: https://www.nber.org/papers/w33719

[6] Foundation, U. H. (2023). Uninsured in Nevada. Retrieved from America's Health Rankings: https://www.americashealthrankings.org/explore/measures/HealthInsurance/NV

[7] https://thenevadaindependent.com/article/a-brief-history-of-medicaid-in-nevada-and-the-people-who-depend-on-it

[8] KFF. (2025). Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates. Retrieved from https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/

[9] AAMC), A. o. (2025, May 13). *AAMC Statement Before the Energy and Commerce Committee U.S. House of Representatives* . Retrieved from https://www.aamc.org/media/83451/download?utm_source=sfmc&utm_medium=email&utm_campaign=highlights&utm_content=newsletter

A proposal that is advancing with a potential start date of December 31, 2026, is the work and community engagement requirements for Medicaid recipients between the ages of 19 and 64 without dependents. These individuals would be required to work, volunteer or attend school for 80 hours a month to qualify and maintain Medicaid coverage. Nevada Medicaid estimates that anywhere between 70,400 to 112,600 adult Nevadans enrolled in Medicaid today — between roughly 8 and 14 % of the state's Medicaid population — could go uninsured because of new rules that would require people prove they are working or looking for a job to receive coverage.[10] People who are pregnant, have disabilities, substance use disorders, are incarcerated, are or were formerly foster youth, or ineligible through the Indian Health Service would be exempt from the work requirements. The federal proposal also includes language that would change states' ability to finance their share of Medicaid spending through provider taxes and would result in a freeze to Nevada's existing provider tax rates, which allows them to remain, but prevents the state from establishing new provider taxes.

As of this writing, the language of the federal budget reconciliation bill is still being finalized, and it is unclear what the Senate may modify. The House and Senate must reconcile differences before the bill is sent to the President who can sign the bill into law or veto the bill. Due to the uncertainty at the federal level and the possibility for a reduction in federal Medicaid funding, it is unclear how the State will address potential budget shortfalls and what health care services may be reduced, cut or eliminated. In accordance with NRS 439.916.1(k), the Patient Protection Commission will continue to monitor and evaluate proposed and actual changes to federal health care policy to determine the impact of such changes on the cost and access to health care in this State.

VI. Commission Collaboration

NRS 439.918.1, paragraphs (a) and (b) requires the Commission to attempt to identify and facilitate collaboration between existing state governmental entities that study or address issues related to the quality, accessibility, and affordability of health care in this State. The Commission is willing to collaborate with any public, private or state governmental entity that studies or addresses issues related to the quality, accessibility, and affordability of health care in this State; and looks forward to continuing this practice through open communication with the Commission and offering direct collaboration from the Executive Director. It is anticipated that future collaboration efforts will be enhanced now that the PPC is located within the newly established Nevada Health Authority.

During the reporting period, the Executive Director collaborated with various state entities and working groups which relate to the scope of the Commission:

Nevada Division of Insurance Commissioner's Life & Health Advisory Subcommittee

Per NRS 629.095, the Commissioner of Insurance is required to develop a standardized form for use by insurers and other entities to obtain information related to the credentials of certain providers of health care. The Subcommittee discussed the need to revise the current *NDOI-901 Universal Credentialing Form*, which had not been updated since 2016. The Subcommittee discussed the need to remove intrusive and stigmatizing mental health questions, identify opportunities to shorten the form and develop a shorter form for provider re-credentialing. In February 2025, following feedback from the Subcommittee, the Division of Insurance revised the NDOI-901 Universal Credentialing Form and implemented an addendum form to allow healthcare providers to re-certify by simply attesting there had been no changes since the last credentialing form submission. The PPC Executive Director is grateful for the opportunity to

[10] Tabitha Mueller, G. B. (2025, May 18). *House GOP budget avoids Medicaid 'biggest fears,' but 98K Nevadans may yet lose coverage*. Retrieved from https://thenevadaindependent.com/article/house-gop-budget-avoids-medicaid-biggest-fears-but-98k-nevadans-may-yet-lose-coverage

collaborate with the Division of Insurance and the Subcommittee to reduce the administrative burden for insurers and health care providers by streamlining the universal credentialing form and re-credentialing process.

Direct Care Workforce (DCW) Peer-Learning Collaborative

The Executive Director participated in a cross-agency collaborative between July 2024 – March 2025 as part of DHHS's participation in the inaugural Peer Learning Collaboratives of the National Direct Care Workforce Strategies Center, a federally-funded project funded by the Administration for Community Living, U.S. Department of Health and Human Services. The DCW State Peer-Learning Collaborative focused on sharing best practices, innovative strategies, and proven models for growing the direct care workforce. Nevada joined a cohort along with state representatives from Vermont, Kentucky and Maine. Each state received technical assistance from a subject matter expert to accomplish one policy or program-related milestone. The experience provided an opportunity for the DHHS Divisions to work collaboratively toward a common goal and have honest conversations with other states about addressing direct care workforce challenges and learn about innovative solutions.

Nevada has one of the highest direct care worker shortages in the country, ranking 50th for number of direct care workers per 100,000 residents. During the technical assistance opportunity with the Direct Care Workforce Strategies Center, our state worked to better understand how this shortage affects our services in Nevada and outlined strategic options for our state to not only successfully recruit direct care workers, but also establish career pathways, provide training and professional development opportunities, develop robust compensation packages, and retain workers.

One of the ways Nevada is aiming to accomplish these goals is through a $2.9 million American Rescue Plan Act (ARPA) State Fiscal Recovery Funding project that the State of Nevada Aging and Disability Services Division (ADSD) was awarded to grow a Personal Care Attendant (PCA) workforce. To help ensure this project is successful and sustainable, the ADSD intends to apply for continued technical assistance which is available from July 2025 – March 2026. The PPC Executive Director intends to continue to contribute and participate in the cross-agency collaborative.

Health Care Workforce Working Group

In accordance with NRS 439A.116, the Department of Health and Human Services must establish and maintain a database of information collected from applicants for the renewal of a license, certificate or registration as a provider of health care. The Director must appoint members to the Health Care Workforce Working Group, who are responsible for analyzing data within the database and making recommendations for increasing health care provider recruitment and retention and improving health outcomes. The Director must also annually publish a report of data from the database and analyze the data to make reports to the Legislature and Executive Branch. In 2021, Senate Bill 379 established the database requirement, but did not appropriate funding for implementation. Unfortunately, due to lack of funding the database has not been implemented and thus the Working Group is unable to analyze the relevant workforce data. The PPC Executive Director was appointed as a member of the Working Group by the DHHS Director in July 2024 to serve a two-year term. The Working Group held two meetings in 2024 and discussed the importance of the health care provider database. The next meeting is scheduled for July 2025, which will likely revolve around opportunities for the state to secure necessary funding for the database implementation.

VII. Next Steps

The Commission has identified areas of focus, and prioritized reviewing issues related to primary care access and addressing issues related to women's health and reproductive care. The state continues to rank near the bottom in the

nation for prevention and treatment[11], women's health and reproductive care[12], and access to primary care providers[13]. This can largely be tied to the shortage of health care providers across the state and lack of access to affordable health care. The Commission is currently forming certain subcommittees, which will consist of Commission members and other subject matter experts to assist in the review of these additional priority areas. The Commission is scheduled to meet next on August 15th.

[11] U.S. Healthcare Rankings by State 2023 | Commonwealth Fund
[12] Women's Health and Reproductive Care 2024 | Commonwealth Fund
[13] Explore Primary Care Providers in Nevada | AHR

PATIENT PROTECTION COMMISSION – 2025 POLICY PRIORITIES

The purpose of this document is to summarize and contextualize commissioners' responses to the 2025 PPC survey to inform future policy priorities of the commission. The results of the survey will be used to focus the efforts of the Patient Protection Commission (PPC) over the next biennium. The Commission may decide to amend, remove, or add priority areas, or specific topical areas within each priority area.

HEALTH CARE DELIVERY AND PAYMENT TRANSFORMATION

1. **Health Care Access and Quality**
   a. ***Improve Primary and Preventative Care:*** increase access to routine preventative care; expand the primary care clinician workforce and increase the number of individuals with a primary care clinician.
   b. ***Improve Women's Health and Reproductive Care:*** increase access to timely and adequate prenatal and postpartum care, including enhancing screening and preventive services, improving health literacy, and ensuring network adequacy.
   c. ***Improve Care Transitions*:** improve systems to support care transitions; reduce reliance on higher levels of care; improvements in care coordination by increasing workforce and facility capacity; reduce unnecessary and burdensome regulatory requirements; develop payment systems to support care coordination; increase timely follow-up and medication management and reconciliation, and patient treatment involvement.
   d. ***Improve Behavioral Health:*** increase access to appropriate levels of care, decrease the over-reliance on higher levels of care than is medically necessary.
   e. ***Increase Quality and Patient Safeguards:*** establish targets for providers and insurers related to quality health outcomes; support review of regulatory requirements to promote safe patient environments; ensure training programs are effective and promote patient safety and culturally competent care.

2. **Health Payment Transformation**
   a. ***Alternative Payment Models****:* increase utilization of alternative reimbursement models, such as value-based payments or accountable care population-based payment models to reduce overall costs and deliver high-quality, coordinated care.

3. **Health Care System Development**
   a. ***Develop a Strategic Vision for Healthcare in Nevada:*** support the development of a strategic plan to improve the healthcare system, health outcomes, and health education across the state.
   b. ***Health Care Development Hub:*** support and leverage the development and utilization of economic incentives to attract health care businesses and development efforts across the state, like how the state has invested in other industries.

HEALTH EQUITY AND DISPARITIES

1. **Access to Care:**
   a. ***Increase Access to Care for Uninsured Individuals:*** support the development of policies to ensure equitable availability of essential medical services, promote health literacy, expanding community-based programs, and support initiatives to eliminate barriers to care.
2. **Disparities in Health Outcomes**

a. ***Decrease Disparities in Health Outcomes:*** increase health literacy in underserved and marginalized communities; increase training for culturally competent and age-appropriate care; provide equitable access to routine preventative care and screening.
b. ***Physical Access:*** transportation; availability; proximity; and scheduling.

HEALTH CARE WORKFORCE CHALLENGES

1. **Provider Shortage**
   a. ***Increase the Number of Providers:*** support initiatives to increase the supply of providers to support the access and quality of care in the state.
   b. ***Improve Training of Providers:*** support initiatives to expand the number of training programs and graduate medical education slots in the state; monitor the quality and efficacy of the training programs funded by state investments.
   c. ***Improve Recruitment and Retention of Providers:*** promote the development of the health care workforce by providing incentives, such as housing incentives, loan forgiveness, and other programs that effectively incentivize the recruitment and retention of health care providers.

2. **Barriers to Workforce Retention and Recruitment**
   a. ***Reimbursement Rates:*** ensure reimbursement rates for Medicaid and Medicare are comparable to the surrounding states, increase the rates of provider participation in the Medicaid quadrennial rate review (QRR) process; improve the rate of providers participating in Medicaid by increasing reimbursement rates.
   b. ***Reduce Administrative Burden:*** identify unnecessary and burdensome barriers to licensure for providers; identify unnecessary regulatory barriers that increase administrative complexity leading to provider reluctance to practice in the state.

HEALTH CARE COST CONTAINMENT AND AFFORDABILITY

1. **Pharmaceutical Pricing**
   a. ***Pharmacy/Prescription Drug Costs:*** evaluate the growing costs of pharmacy and prescription drug costs options to bend the cost curve; promote transparency, affordability, and value in prescription drug pricing by supporting policies that reduce costs for consumers, enhance competition and incentivize cost-effective prescribing practices.
   b. ***Cost Transparency:*** discuss increasing cost transparency by requiring pharmaceutical manufacturers, pharmacy benefit managers (PBMs), and insures to disclose drug pricing structures, rebates, and out-of-pocket costs; utilize available data (i.e. the All-Payer Claims Database) concerning insurance claims for medical services to assist in the development of health care policies to improve patient access to quality and affordable care.

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
January 17, 2025

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, January 17, 2025, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2025/2025/.

1. **Call to order: Roll call**
   By: Dr. Ikram Khan, Chairman

   The meeting was called to order at 9:10 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

   Commission Members Present
   Dr. Ikram Khan, Chair
   Marilyn Kirkpatrick, Vice Chair
   Dr. Andria Peterson
   Dr. Bayo Curry-Winchell
   Dr. Mark Glyman
   Bethany Sexton
   Flo Kahn
   Jalyn Behunin
   Walter Davis

   Commission Members Absent Excused
   Dr. Adam Porath

   Advisory Commission Members Present
   Scott Kipper, Insurance Commissioner, Division of Insurance (DOI); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP); Shannon Litz, Deputy Director on behalf of Richard Whitley, Director, Department of Health and Human Services

   Advisory Commission Members Absent Excused
   Russell Cook, Executive Director, Silver State Health Insurance Exchange
   Richard Whitley, Director, Department of Health and Human Services

Staff Present
Joseph Filippi, Executive Director, PPC; Dylan Malmlov, Policy Analyst, PPC

Guests Present
Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Lindsey Miller, Constituent Services, Governor's Office; Malinda Southard, Deputy Administrator, DHCFP; Sandie Ruybalid, Deputy Administrator, DHCFP; Todd Rich, Agency Manager, DHCFP; Sheri Guant, Social Services Program Specialist III, DHCFP; Maile Campbell, Lead Actuary, DOI; Adam Plain, Insurance Regulation Liaison, DOI; Autum Blattman, Regional Coordinator, ADSD; Janel Davis, Chief Operations Officer, Silver Sage Health Insurance Exchange; Meagan Ranson, Silver Sage Health Insurance Exchange; Kareen Filippi, Management Analyst III, WIC; Cathy Dinauer, NSBN; Allison Combs; Allison Herzik; Amy Shogren; Ana Bonillas; Blayne Osborn; Brian Evans; Brian Hefferan; Brian Walsh; Brooke Brumfield; Cheri Glockner; Cherylyn Rahr-Wood; Chris Bosse; Cooper Irvine; Cynthia Alejandre; Dan Musgrove; Deanna Yates; Dorothy Edwards; Edith Duarte; Elissa Secrist; Emma Rodriguez; Esther Badiata; Ian Graf; Jacqueline L. Nguyen; James Wadhams; Jason Bleak; Jeanne Gerow; Jennifer Lanahan; Jill Hinxman; Jimmy Lau; Joan Hall; John F Packham; Keibi Mejia; Laurie Curfman; Lea Cartwright; Luke Flanagan; Mari Nakashima Nielsen; Mark Funkhouser; Megan E Comlossy; Misty Grimmer; Patrick Kelly; Paul Young; Reagan Hart; Ryan Roa; Ryley Harris; Sabrina Schnur; Sarah Adler; Shawna Ross; Shelly Capurro; Stefanie Abraham; Stephanie Woodard; Steve Messinger; Tomas Hammond

2. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Jeanne Gerow, with the Nevada Hospital Association, provided public comment today. She shared a short video produced by the Nevada Hospital Association regarding the Nevada nursing shortage. The video is available on YouTube by clicking here. The video explained that Nevada is currently ranked 45th in the nation for Registered Nurses (RNs) and that there is a need for more than 3,000 RNs and Licensed Practical Nurses (LPNs) to reach the national average. Projections indicate that Nevada will remain among the top five states facing a severe nursing shortage. Currently, about 40% of Nevada's licensed RNs have an out-of-state address, indicating the true number of nurses Nevada needs. During the 2020 pandemic, the lack of an available workforce caused nurse burnout, increasing the shortage. Additionally, the number of nursing school graduates has not kept pace with Nevada's rapidly growing population. This has worsened the shortage, with qualified students being denied admission to Nevada nursing schools due to insufficient training slots.

3. **Informational: Introduction of New Commission Members**
By: Marilyn Kirkpatrick, Vice Chair

Vice Chair Kirkpatrick introduced PPC's new Commissioner, Dr. Mark Glyman, who then provided a brief introduction. Commissioner Glyman shared he is a trained medical doctor and dentist, both licensed in Nevada. He attended dental school at UCLA and medical school at Harvard Medical School, completing his training in a combined general surgery, maxillofacial, and craniofacial surgery program at Massachusetts General Hospital and Boston Children's Hospital. Currently, he serves as the Chief of Surgery at Southern Hills Hospital and has dedicated a significant portion of his career to public policy, with a focus on ensuring patient safety.

Chairman Khan welcomed Commissioner Glyman, acknowledging his extensive education and recognizing him as an incredible asset with a highly specialized subspecialty. He noted that Commissioner Glyman is deeply committed to patient advocacy and expressed enthusiasm about benefiting from his experience.

4. **For Possible Action: Review and Approve Meeting Minutes from December 13, 2024**

By: Dr. Ikram Khan, Chairman

Due to technical difficulties that occurred before the meeting, agenda item four will be moved to the next PPC meeting on March 14, 2025, for review and approval.

5. **Informational: Overview of Nevada's Health Care Industry and Insurance Market**
By: Scott Kipper, Insurance Commissioner, Nevada Division of Insurance

Insurance Commissioner Scott Kipper and Insurance Regulatory Liaison Adam Plain provided an informational overview of Nevada's Health Care Industry and Insurance Market. The presentation is available on the PPC webpage or by clicking here. Nevada's Division of Insurance (DOI) mission is to protect Nevada consumers and ensure that insurance carriers remain solvent. DOI regulates property, casualty, life, health, long-term care, title, service contracts, workers' compensation, funeral/burial pre-need, and bail bonds surety. Currently, Nevada has 1,485 authorized insurers, 140 of which are domestic carriers. Nevada's health insurance market represents the largest segment of direct written premiums, making up approximately 40% of the state's total. As part of this, DOI's role includes conducting analysis, reviewing, approving, or disapproving rates and forms, and reviewing insurers' rate and form filings to ensure a competitive and stable market. The Division reviews and approves policy forms used in the fully insured large group market (51 or more employees) but has no authority to review large group plans, provider networks, or drug formularies. Mr. Plain then discussed the Essential Health Benefit (EHB) benchmark, a federal law requiring states to select a benchmark plan regulated by the state, defining benefits in 10 categories that all applicable plans must cover. Beginning in Plan Year 2026, states may elect to add or remove EHB on a piecemeal basis, and starting in 2027, the generosity standard will no longer apply to EHB added piecemeal. The Advanced Payment of the Premium Tax Credit (APTC) is a provision designed to promote affordability in insurance by authorizing tax credits for individuals purchasing Qualified Health Plans through an Exchange, or alternatively, by paying the credit directly to the health insurer to offset the immediate cost of monthly premiums. Mr. Plain also explained the concept of Federal Defrayal, which aims to prevent states from exploiting the APTC formula to pass new state-mandated benefits. This ensures that the Affordable Care Act locks in the benefits that the federal government will pay for those who were in existence before December 31, 2011, as part of the state's EHB package. The primary responsibility of the states under defrayal is to identify which benefits are state-required and in addition to the EHB. Notably, Centers for Medicare and Medicaid Services (CMS) has been allowing states to use a claims-incurred calculation, as no state currently paying for defrayal makes the payments directly to the enrollees.

Vice Chair Kirkpatrick inquired about the limited number of insurance contracts and Medicaid managed care organizations (MCOs), asking if the DOI has the authority to monitor payments and billing practices. She noted issues with insurance companies requiring multiple pre-authorizations or changing billing methods for providers, such as anesthesiologists, and questioned whether the DOI could regulate these practices to align with other states. Mr. Plain explained that MCO-contracted providers and commercial insurance products are subject to Chapter 695G of the Nevada Revised Statutes, while the Division of Health Care Financing and Policy (DHCFP) imposes additional responsibilities and restrictions through contracts, including reimbursement procedures. Although Nevada has protections like a prompt pay statute requiring insurers to pay claims within a specific timeframe or face penalties, there are currently no specific provisions governing reimbursement agreements between providers and MCOs. He acknowledged that this issue needs further research. Vice Chair Kirkpatrick emphasized the difficulty patients and the private sector face adapting to constant insurance changes, questioning whether state legislation or federal support is needed to establish consistent standards and inform consumers of insurance methodology changes 180 days in advance of changes taking effect. Mr. Plain stated he could not recommend introducing legislation but noted Nevada has traditionally viewed such matters as contractual disputes between insurers and providers, making intervention uncommon. Vice Chair Kirkpatrick

stressed the importance of addressing this issue and mentioned a study would be helpful to determine what the proper notification time may be for insurance companies to provide notice to health care providers and patients regarding payment methodology changes including prompt payment regulations. Commissioner Curry-Winchell agreed, stating that current standards are unacceptable and highlighting the opportunity to improve practices to ensure better access to patient care.

Commissioner Peterson inquired about the EHB benchmark and whether it applies to Fee-for-Service (FFS) Medicaid. Mr. Plain clarified that it does not apply to FFS Medicaid but only to the regulated, fully insured market in Nevada.

Commissioner Kahn asked for clarification, asking if any additional benefit mandated by the state would become the state's responsibility and whether, in cases where such benefits result in premium increases, the enrollee would receive compensation, or the health plan provider would receive funds to offset the cost and keep premiums low. Mr. Plain provided a hypothetical example: if the 2025 legislative session mandates that rhinoplasty must be a covered benefit, and this causes premiums to rise by $20 per person per month, the state would classify it as a mandate exceeding the Essential Health Benefits (EHB) package. In such cases, Qualified Health Plan (QHP) issuers would perform the necessary calculations, and the state would be required to either pay consumers directly or compensate insurers by the specified amount per person per month to offset the cost. Commissioner Kahn then inquired, from a consumer perspective, how they could ensure that the premium would actually decrease by the specified amount. Mr. Plain responded that this question has been a topic of ongoing discussions with CMS over the past 12 months as part of the rate review and approval process.

Commissioner Kahn asked a follow-up question, noting that claims are often billed for the wholesale price of a drug, which can appear to reflect a high payment cost. However, on the back end, insurers may receive significant rebates on these drugs. She inquired how these rebates are incorporated into the claim-incurred basis to ensure insurers are paying only for their actual net cost after rebates. Mr. Plain acknowledged the question but stated he currently does not have an answer. He added that every state except Nevada is subject to defrayal on a medical benefit and mentioned that this issue is part of ongoing discussions with CMS.

Vice Chair Kirkpatrick agreed with Commissioner Kahn, stating that the topic of rebates is frequently mentioned but seems to rarely result in providing better health care or lowering insurance costs. She noted that she serves on a national board of over 4,000 counties and asked whether this topic should be brought up to a national conversation, given that Nevada is the only state discussing defrayal of a pharmaceutical benefit. She emphasized that the state should focus on lowering costs. Mr. Plain noted that CMS has been very reluctant to provide definitive information in writing that the Department of Insurance (DOI) can rely on. He stated that this is new territory for the state, and they are currently exploring ways to determine how any potential payment scenarios might work. Mr. Plain also expressed openness to any suggestions the Commission might have.

Commissioner Sexton commented on the insurer's perspective regarding rebates. She noted that, in general, rebates are considered during the actuarial analysis insurers conduct when determining premiums. She further explained that rebates are incorporated into the cost analysis as actuaries evaluate data related to rebates that may be accrued in connection with pharmacy costs.

Commissioner Peterson inquired whether the federal defrayal payment is related to the All-Payer Claims Database and how this information will help project the fiscal impact. Mr. Plain explained that when Nevada first started discussions with CMS about potential defrayal situations, the All-Payer Claims Database was not nearly as developed as it is today, or as he hopes it will be in the future. He also mentioned that, due to this, they had to conduct individual data calls to their licensed carriers and insurers to gather as much information as possible for their actuaries to review. He noted that the database will save the industry a tremendous amount of actuarial and administrative effort. Mr. Filippi added that, hopefully within the next year, the Commission can

receive a formal presentation on the All-Payer Claims Database (APCD), as it is still very new. Deputy Administrator Sandie Ruybalid provided more details regarding the timeline, noting that DHCFP expects to have three years of historical data by July of this year, as the database is currently in development.

Chairman Khan inquired about any historical data available from DOI regarding service denials over a specific period, such as six months to a year, and the denial of services to patients after being supported by information from the provider. He also asked about the percentage of cases denied at Level 1 that then go to level 2 or 3 appeal, noting that the challenge lies in the high rate of Level 1 denials, as denied services and claims can be burdensome to providers, patients, and their families. Mr. Plain noted that Nevada participates in the National Association of Insurance Commissioners (NAIC) program for the Market Conduct Annual Statement, which is filed each year by the health insurance and property and casualty insurance industries. He mentioned that the statements include questions on denial rates for claims, typically conducted by market segments, but he is unsure whether the NAIC makes the data publicly available. Chairman Khan then asked if Nevada has this information, to which Mr. Plain responded that Nevada does not have its own reporting but does have access to results filed by admitted insurers with the NAIC. Commissioner Glyman asked if there is a tracking mechanism to ensure providers are accurately self-reporting denials. Mr. Plain reiterated that he does not know if the NAIC's data is public but mentioned that the data undergoes checks for accuracy and that providers' data is audited by independent auditors who conduct claims run checks, including denials, with state regulators typically auditing this data every three years. Commissioner Glyman asked whether this process captures the number of denials on the initial basis, and Mr. Plain stated he would follow up with DOI for an answer and get back to the Commission.

Commissioner Peterson asked if Mr. Plain could comment on the recent Mental Health Parity and Addiction Equity Act and the efforts being made to bring insurers into compliance based on the NAIC's analysis. Insurance Commissioner Scott Kipper stated that the Division has received a grant from CMS to study various aspects of the state's marketplace, including NAIC compliance. He noted that the Division surveyed carriers last year, and the information gathered indicated that a deeper investigation is needed due to challenges in the marketplace. As a result, the Division is conducting an additional set of examinations. Chairman Khan requested that the DOI present specific data related to Nevada's denied claims and appeals at the next scheduled Commission meeting, along with an explanation if the information is not publicly available. He also requested additional information regarding the Mental Health Parity and Addiction Equity Act.

Commissioner Kahn asked Insurance Commissioner Kipper about his 2025 priorities regarding the healthcare space. Commissioner Kipper stated that his plan for the healthcare spectrum is to collaborate with the state Medicaid office on developing the Battle Born State Plans, which include the public option, and the reinsurance program directed by the Governor, with a go-live date of January 1, 2026. Commissioner Kahn then inquired whether the Division is reviewing the new FTC report discussing practices related to prescription drugs and the inflated costs of specialty generics. Insurance Commissioner Kipper confirmed that this will be part of their 2025 priorities. He noted that Pharmaceutical Benefits Managers (PBMs) are required to register with the Division as third-party administrators, placing them under the Division's regulatory oversight.

Commissioner Glyman commented on the topic previously raised by Chairman Khan, highlighting a hidden issue faced by providers in their offices: administrative staff often struggle to get in touch with insurance companies, leading to delays or the inability to schedule patients. This frequently results in frustration and, in some cases, delayed or denied care. He urged the Division of Insurance to address this issue by exploring uniform standards for insurance companies and potentially drafting legislative language to ensure providers can effectively contact insurers.

6. **Informational: Overview of AB 7 (2023) and Implementation Update Regarding Approved Regulation. LCB File No. R173-24**
By: Malinda Southard, DC, Deputy Administrator, Nevada Division of Health Care Financing and Policy

Malinda Southard, Deputy Administrator for the Nevada Division of Health Care Financing and Policy, shared a presentation on Assembly Bill (AB) 7 and its implementation, available on the PPC website or by clicking here. AB 7, originally proposed as Patient Protection Commission BDR 40-381 during the 2023 Legislative Session, mandates healthcare providers implement interoperable electronic health records (EHR) systems to allow patients electronic access to their records. Once passed, the Department of Health and Human Services (DHHS) was tasked with adopting regulations governing health information exchanges and the management, use, and confidentiality of EHR. An advisory group convened throughout 2024 to outline responsibilities, provide feedback, and finalize regulations, which were approved on June 17, 2024. The regulations emphasize flexible options for providers, direct patient access, and federal alignment. Compliance deadlines are July 1, 2024, for hospitals and practices with more than 20 employees; July 1, 2025, for all other providers; and January 1, 2030, for smaller practices and solo practitioners. A waiver process is available for providers unable to meet these deadlines. DHCFP is managing one-time funding grants for providers to comply with AB 7, available only until June 30, 2025.

7. **For Possible Action: Commission to recognize the implementation of AB7 (2023) and regulations LCB File No. R173-24 as meeting the requirements of NRS 439.918(1)(c)**
By: Dr. Ikram Khan, Chairman

Due to technical difficulties before the meeting, agenda item seven has been moved to the next meeting on March 14, 2025.

8. **For Possible Action: Discuss future meeting dates and topics**
By: Joseph Filippi, Executive Director

Due to technical difficulties before the meeting, agenda item eight has been moved to the next meeting on March 14, 2025.

9. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made.

10. **Adjournment**
By: Dr. Ikram Khan, Chairman

Vice Chair Kirkpatrick thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 10:45 AM.

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
March 14, 2025

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, March 14, 2025, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2025/2025/.

1. **Call to order: Roll call**
   By: Dr. Ikram Khan, Chairman

   The meeting was called to order at 9:00 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

   Commission Members Present
   Dr. Ikram Khan, Chair
   Marilyn Kirkpatrick, Vice Chair
   Dr. Adam Porath
   Dr. Bayo Curry-Winchell
   Dr. Mark Glyman
   Bethany Sexton
   Jalyn Behunin
   Walter Davis

   Commission Members Absent Excused
   Dr. Andria Peterson
   Flo Kahn

   Advisory Commission Members Present
   Scott Kipper, Insurance Commissioner, Division of Insurance (DOI); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP)

   Advisory Commission Members Absent Excused
   Russell Cook, Executive Director, Silver State Health Insurance Exchange
   Richard Whitley, Director, Department of Health and Human Services

   Staff Present

Joseph Filippi, Executive Director, PPC; Dylan Malmlov, Policy Analyst, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Guests Present
Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Stacie Weeks, Administrator, DHCFP; Todd Rich, Agency Manager, DHCFP; Casey Angres, Social Services Chief III, DHCFP; Krisann Taylor, Social Services Program Specialist II, DHCFP; Maria Tello Magana, Executive Assistant, DHHS; Adam Plain, Insurance Regulation Liaison, DOI; Kareen Filippi, Management Analyst III, WIC; Adam Porath; Amanda Lattin; Brooke Pellegrino; Casey Melvin; Cherylyn Rahr-Wood; Deanna Yates; Dobnei Remington; Eric R. Schmacker; Esther Badiata; Ian Graf; Jason Drake; Jason Bleak; Jeny Zendejas; John F Packham; Keibi Mejia; Kelsey Avery; Kim Jelinek; Linda Anderson; Nancy J Bowen; Priya Baliga; Reagan Hart; Renee Ruiz; Stephanie Woodard; Steve Messinger; Tomas Hammond, Travis West; Vanessa Oster; Yoana Ontiveros; Zachary Laskey; Zoë Houghton

2. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Renee Ruiz, Government Relations Representative and Community Organizer for National Nurses United in Nevada, provided public comment regarding SB34. In an earlier PPC meeting, Ms. Ruiz spoke in opposition to the Nurse Licensure Compact and provided the same comment today. She emphasized that the solution to the nursing shortage should not be a licensure compact, stating that the root of the problem lies in poor working conditions, lack of safe staffing ratios, and lack of respect for nurses. Ms. Ruiz also provided information regarding the opposition to the Nurse Licensure Compact, which can be found on the PPC webpage or by clicking here.

3. **Informational: Introduction of New Commissioner, Dr. Adam Porath**
By: Dr. Ikram Khan, Chairman

Newly appointed Commissioner Dr. Adam Porath is the current Vice President of Pharmacy at Renown and serves as the Treasurer for the Nevada State Board of Pharmacy. Commissioner Porath was born and raised in Reno, Nevada and attended pharmacy school at Idaho State University. He returned to Reno for his residency at Renown and has since been involved in various roles, including critical care and hospital administration, where he has worked for the past five years. For the last 15 years, Commissioner Porath has been actively involved in expanding the scope of practice for pharmacists within the state and is exploring ways to leverage their expertise.

4. **For Possible Action: Review and Approve Meeting Minutes from December 13, 2024, and January 17, 2025**
By: Dr. Ikram Khan, Chairman

Chairman Khan called for a motion to approve the meeting minutes from December 13, 2024, and January 17, 2025. Commissioner Glyman moved to approve the minutes as presented, and Commissioner Sexton seconded the motion. The motion carried, and the meeting minutes were approved unanimously.

5. **Informational: Update Regarding Nevada Health Insurance Claim Denial Data and Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance**
By: Scott Kipper, Insurance Commissioner, Nevada Division of Insurance

Scott Kipper, Insurance Commissioner for Nevada's Division of Insurance (DOI), provided an informational update on Nevada Health Insurance Claim Denial Data and compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). Commissioner Kipper first addressed claim denials, clarifying that the DOI does

not collect specific Nevada data. Instead, the information presented comes from the National Association of Insurance Commissioners. He stated that the ratio of claim denials to total claims received is approximately 15.7%, excluding pharmacy claims. This percentage includes denials for reasons such as patients being out of network or benefits not being covered. Additionally, 96% of in-network claims are paid within 30 days and 75% for pharmacy claims. Commissioner Kipper noted that the number of adverse determination grievances is one per 1,000 member-months. He then discussed the external review organization (ERO), which handles appeals when an insurance company denies a claim. He stated that the number of requested appeals per 1,000 member-months is 0.029, with 59% of determinations upheld for those who pursue an ERO review. Finally, Commissioner Kipper emphasized that the DOI has a fully staffed Consumer Affairs section. If a consumer believes they have been treated unfairly by an insurance company, they can appeal and file a complaint directly with the division.

Commissioner Glyman thanked Commissioner Kipper for the update and asked how many states do not currently compile information and data on claim denials. Commissioner Kipper stated that according to the Market Conduct Annual Statement program, every state should be reporting this data. Commissioner Glyman then asked whether Nevada's denial rate is similar to the rest of the country. Commissioner Kipper confirmed, stating that all 50 states have a similar regulatory structure. While there may be slight variations in the numbers, he does not believe Nevada's denial rate differs significantly from other states.

Commissioner Porath asked whether there is any data on the ratio of claim denials to total claims received, specifically regarding the percentage of claims that went through successful appeals and the overall paid claim rate. Commissioner Kipper stated that, given the total 15.7% claim denial rate, he believes the rate for claims that are successfully appealed would likely be approximately 0.5% of total claims, which would reduce that total denial rate to approximately 14.5% overall.

Chair Khan noted that claim denials may now be processed through an algorithmic system designed by insurance companies, allowing claims to be denied before reaching an insurance claims representative, according to a recent New York Time's article. He expressed concern that when a claim is denied, the appeals process can take several days or even weeks, creating financial hardships for patients who must pay out-of-pocket. Chair Khan asked if there are any prompt guidelines in place to reduce turnaround times for denied claims. Commissioner Kipper responded that the division has been given the opportunity to propose a Bill Draft Request (BDR) for the 2025 Legislative Session, focusing on prior authorization issues and processing timeframes as the current regulations date back 30–40 years. Commissioner Kipper also mentioned that the Governor addressed this concern in the State of the State in January and that the Governor's Office is also reviewing the issue.

Commissioner Curry-Winchell agreed with Chair Khan, emphasizing that, as a practicing physician, patients often worsen while waiting for prior authorization approvals. During this waiting period, physicians have no means to intervene. She argued that even if regulations are changed to reduce the turnaround time for prior authorizations and claim appeals, it does not address the issue of patients' health worsening during the delay. She stressed that healthcare providers should not rely on a non-individualized algorithm, as it does not improve patient care but rather delays the timely treatment that providers are trying to deliver.

Commissioner Glyman also agreed with Chair Khan, stating that as a practicing surgeon, he has witnessed firsthand the overflow of patients in emergency rooms and the shortage of available beds. This has resulted in patients being lined up against the walls while waiting for a room. He also noted that in some wards, single-patient rooms are now being doubled up due to the lack of space. He emphasized that long wait times for prior authorizations or appeals of denied claims directly contribute to this issue and urged for a shorter turnaround time.

Commissioner Sexton clarified that the Centers for Medicare and Medicaid Services (CMS) currently has set turnaround times, requiring many insurers to adhere to a 72-hour turnaround time and 24 hours for biomarker testing. She then asked Commissioner Kipper to confirm that he was referring specifically to denied claims rather than prior authorizations. Commissioner Kipper confirmed this.

Commissioner Kipper commented on the use of technology in processing claims and authorizations, stating that the National Association of Insurance Commissioners drafted a model bulletin to guide states in addressing the use of artificial intelligence. He explained that this model places the onus on insurance companies, requiring them to comply with state laws and regulations that may classify the use of algorithms or artificial intelligence as an unfair trade practice.

Commissioner Curry-Winchell asked Commissioner Kipper what mediums are being used to ensure Nevadans are aware of their ability to appeal and file a complaint directly with the division, as noted earlier. She stated that her office was unaware this was an option and inquired about the forms of media the DOI is using to spread the word. Commissioner Kipper responded that they are finalizing their social media platforms, such as Facebook and LinkedIn, but acknowledged there is still significant room for improvement. He added that they are exploring better alternatives for disseminating information, including working closely with this Commission to expand outreach efforts.

Adam Plain, Insurance Regulation Liaison with the Division of Insurance, stated that Assembly Bill 74 addresses prior authorizations, which was mentioned earlier. However, when discussing prior authorizations and adverse determination reporting, those topics are outlined in Assembly Bill 290 and Assembly Bill 295. Mr. Plain noted that Assembly Bill 295 focuses more specifically on the use of artificial intelligence in adverse determinations.

Commissioner Kipper then provided a brief update on compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), stating that NRS 687B.404 requires insurers and other health coverage providers to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008. Additionally, the statute mandates that the Division of Insurance and the Commissioner report data by July 1st and submit an annual compliance summary by December 31st. Commissioner Kipper noted that last year, the Division conducted an initial data call; however, the data was largely unusable and of poor quality, prompting a second data call. The results from these revealed significant challenges among carriers in complying with MHPAEA. Due to these findings, the Division will begin conducting desk audits and examinations of all carriers in the state marketplace regarding mental health parity, with efforts continuing into 2026. Commissioner Kipper stated that a preliminary report will be available later this year and will be shared with the Commission.

6. **For Possible Action: Commission to recognize the implementation of AB7 (2023) and regulations LCB File No. R173-24 as meeting the requirements of NRS 439.918(1)(c)**
By: Joseph Filippi, Executive Director

Mr. Filippi presented an actionable item for the Commission to recognize the implementation of AB7 and its regulations as meeting the required standards. The presentation is available on the PPC webpage or by clicking here. Per NRS 439.918(1)(c), the Commission is required to submit an annual plan to the Director of the Department of Health and Human Services to enhance access to patient medical records. However, Assembly Bill 7, which passed in the 2023 legislative session, closely aligns with this requirement. Mr. Filippi recommended that the Commission recognize the implementation of AB7, and regulations outlined in LCB File No. R173-24 as fulfilling the requirements of NRS 439.918(1)(c).

Deputy Attorney General Gabriel Lither clarified that the Commission has the option not to recognize this as meeting the requirements. Should the Commission choose to recognize and implement it but has additional concerns or questions, it can be tabled for discussion at a future PPC meeting.

Vice Chair Kirkpatrick agreed with the Commission recognizing this today, as she believes other regulations already cover these requirements. However, she noted that she is open to tabling it for a future meeting if needed. Commissioner Davis commented that he would prefer to table the discussion to allow more time for review.

Deputy Attorney General Lither asked if there is a set deadline for the Commission to take action on this, as he is unsure when the statute was assigned since it has not been formally recognized yet. Mr. Filippi stated that there is no specific deadline, as the statute only states that the Commission "shall adopt" these requirements. He added that he will ensure a representative from the Division of Healthcare Financing and Policy is present at the next meeting to speak on behalf of these regulations.

Chairman Khan called for a motion to table this item until the next PPC meeting. Vice Chair Kirkpatrick made the motion, and Commissioner Davis seconded it. The motion carried, and agenda item 6 will be tabled for the next PPC meeting.

7. **Informational: 83rd Legislative Session Update Regarding PPC Bills (SB29, SB34, and SB40)**
By: Joseph Filippi, Executive Director

Mr. Filippi provided an informational update on Senate Bills 29, 34, and 40. More details on the 83rd legislative session PPC Bills can be found on the PPC webpage or by clicking here. Senate Bill 29, which requires reimbursement through accountable care organizations, Medicaid provider surveys, and increased reimbursement rates for physicians and advanced practice registered nurses, and Senate Bill 40, which establishes the Medicaid Health Care Workforce Account, have been referred to the Senate Health and Human Services Committee. Senate Bill 34, which enacts interstate licensure compacts for nurses, physical therapists, audiologists, speech-language pathologists, occupational therapists, and physician assistants, has been referred to the Senate Commerce and Labor Committee. Currently, none of the bills have been scheduled for a hearing. Mr. Filippi stated that he has contacted the Senate Committee Chairs to possibly schedule hearings. Chair Khan has also submitted a letter to each Committee requesting their consideration. Mr. Filippi noted that April 11th is the first-house committee deadline, meaning that if these bills are not heard before then, they will die in committee.

Vice Chair Kirkpatrick emphasized the importance of the Commission independently asking the committee whether these bills will be heard. Mr. Filippi agreed, stating that as a state employee, he can only meet with legislators for informational purposes. However, Commissioners are free to speak on their own behalf, not on behalf of the Commission, and are encouraged to do so. Vice Chair Kirkpatrick noted that this is a common issue, stating that significant effort goes into drafting bills, but no one takes the extra step to push for hearings and passage. She urged the Commission to make that extra call to advocate for the bills.

8. **For Possible Action: Review and Discuss PPC Policy Focus Areas for 2025**
By: Joseph Filippi, Executive Director

Mr. Filippi discussed possible PPC Policy Focus Areas for 2025. The document is available on the PPC webpage or by clicking here. He stated that since the last PPC meeting in January, a survey was sent out to the Commissioners, requesting them to review certain information related to the state's ranking in different areas of healthcare and provide recommendations on future areas of focus for the Commission. The survey revealed that the four main priority areas for the Commission related to Health Care Delivery and Payment Transformation, Health Equity and Disparities, Health Care Workforce Challenges, and Health Care Cost Containment. For Health Care Delivery and Payment Transformation, the possible focus areas identified are access and quality, payment transformation, and health care system development. For Health Equity and Disparities, priorities include access to care, such as increasing access for uninsured individuals, and addressing disparities in health outcomes, such

as improving physical access to care. For Health Care Workforce Challenges, the possible focus areas are addressing provider shortages, with a focus on increasing the number of providers and improving provider training, and barriers to workforce retention and recruitment, such as increasing reimbursement rates. Finally, in the Health Care Cost Containment category, the survey identified pharmaceutical pricing, with a focus on pharmacy/prescription drug costs and cost transparency, as PPC priorities for 2025. Mr. Filippi noted that this is just the start of the conversation for future meetings regarding some of the areas the Commission would like to focus on. He stated that he will keep this as a running list for future areas of focus and discussion.

Chairman Khan thanked Mr. Filippi for this and asked if the focus areas could be narrowed down from now until the next PPC meeting so the Commissioners can better determine where to prioritize their efforts. Commissioner Sexton agreed, suggesting a forced ranking exercise to identify the top priorities. Commissioner Sexton also thanked Mr. Filippi for compiling all of this information, noting that the extensive content helped the Commission narrow down the areas they could focus on to make an impact. She also agreed with Vice Chair Kirkpatrick's earlier comment, stating that unless they concentrate on areas that can drive real change, they will continue to spin their wheels. Mr. Filippi acknowledged this, stating that he will work on an additional survey to rank and refine the highest priority focus areas for the Commission.

Commissioner Glyman stated that while he agrees they should narrow down the priorities, he also believes the Commission can address more than one issue at a time. He suggested that the document could be sent out to the Commissioners again to refine it further in the future but also emphasized the need to identify additional ways to protect patients beyond creating bills every biennium. He noted that they could explore working with certain boards and agencies to drive change in that manner as well. Mr. Filippi agreed, stating that the Commission also submits a semi-annual report to the Legislature and the Governor for consideration but noted that these reports could also be shared with other boards and agencies for their input. Vice Chair Kirkpatrick pointed out that the Joint Interim Health Committee is another venue where these priorities could be discussed once refined, allowing them to be divided among different groups.

Mr. Filippi called for a motion to accept the PPC Policy Priorities as presented, with the exception that they be narrowed down and ranked. Commissioner Sexton motioned to approve, and Commissioner Glyman seconded it. The motion carried, and the PPC Policy Priorities were approved unanimously.

9. **For Possible Action: Review and Approval of Future Meeting Dates**
By: Joseph Filippi, Executive Director

Mr. Filippi then discussed future PPC meeting dates for the Commission to consider and approve. He outlined the proposed meeting dates: June 20th, August 15th (which is still set to be in person in Las Vegas), October 17th, and December 19th. Mr. Filippi noted that Commissioners traveling to attend the in-person August meeting are eligible for reimbursement. He stated that he sent out an email earlier in the week with instructions on how to receive reimbursement. Those unable to attend in person will have a virtual option as well.

Chairman Khan called for a motion to approve the proposed PPC meeting dates as presented. Commissioner Davis made the motion, and Commissioner Glyman seconded it. The motion carried, and the proposed PPC meeting dates were approved unanimously.

10. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Travis West, a regulatory policy specialist with the National Nurses Organizing Committee and National Nurses United, representing nearly 225,000 nurses across all 50 states, provided public comment. He stated that their

union has deep concerns about shifting Medicaid patients to Accountable Care Organizations (ACOs) as outlined in SB29, arguing that it is likely to incentivize providers to reduce patient care. Mr. West stated that while SB29 is vague about payment systems, most ACOs receive a flat per-person amount for a group of enrollees and include at least one doctor group within a hospital system. If the ACO provides care for less than the per-person amount, they are eligible to keep the remainder as profit and divide it among participating organizations. However, if they provide care that costs more than this amount, they incur a loss. Mr. West argued that this system essentially shifts risk from the payer or insurer to doctors and hospitals, incentivizing less care by moving treatment to less costly settings and less skilled caregivers, thereby posing a significant risk to patients. He emphasized that decisions about care should be made by a patient and their doctor based on medical need and preferences and not on saving money for an ACO, since quality metrics alone cannot fix a misaligned system. Mr. West also stated that metrics-based incentive payments increase administrative complexity, which in turn wastes healthcare providers' time and rewards healthcare corporations. Mr. West urged the Commission to reconsider the reimbursement system outlined in SB29.

Dr. John Packham, Associate Dean with the Office of Statewide Initiatives at the University of Nevada, Reno School of Medicine and Co-Director of the Nevada Health Workforce Research Center, provided public comment. Dr. Packham informed the Commission that after the legislative session ends, the Commission is welcome to reach out to his office for information on health provider trends, workforce shortages, etc., as he is happy to speak on those topics. He noted that he likes to remain agnostic when it comes to the nature and scope of the current provider shortage and what proposed legislation might bring to solutions, stating that there are proposals that will move the needle on provider shortages and proposals that will hinder efforts to alleviate them. Dr. Packham also mentioned that he shared a report with Mr. Filippi regarding the nursing workforce supply in the state and is willing to speak on any of those issues at a future meeting if needed.

11. **Adjournment**
By: Dr. Ikram Khan, Chairman

Chair Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 10:30 AM.

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
June 20, 2025

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, June 20, 2025, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2025/2025/.

1. **Call to order: Roll call**
   By: Dr. Ikram Khan, Chairman

   The meeting was called to order at 9:00 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

   Commission Members Present
   Dr. Ikram Khan, Chair
   Marilyn Kirkpatrick, Vice Chair
   Dr. Andria Peterson
   Dr. Adam Porath
   Dr. Mark Glyman
   Dr. Travis Walker
   Flo Kahn
   Jalyn Behunin
   Walter Davis

   Commission Members Absent Excused
   Dr. Bayo Curry-Winchell
   Bethany Sexton

   Advisory Commission Members Present
   Scott Kipper, Insurance Commissioner, Division of Insurance (DOI); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP); Shannon Litz (on behalf of Richard Whitley), Deputy Director, Department of Health and Human Services; Janel Davis (on behalf of Russell Cook), Silver State Health Insurance Exchange

   Staff Present
   Joseph Filippi, Executive Director, PPC; Dylan Malmlov, Policy Analyst, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Guests Present

Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Malinda Southard, Deputy Administrator, DHCFP; Sandra Stone, Management Analyst IV, DCFS; Maria Tello Magana, Executive Assistant, DHHS; Devon Pickles, Health Program Specialist Trainee, DHHS; Lindsey Cook, Family Service Specialist, DHHS; Tiffany Davis, Executive Assistant, Silver State Health Insurance Exchange; Carrie Embree, Governor's Consumer Health Advisor, ADSD; Khadyja Carter, Chief, Office For Consumer Health Assistance; Allison Herzik; Amethyst Cozzolino; Amy Shogren; Ana Bonillas; Becky Bayley; Brooke Pellegrino; Casey Melvin; Chris Bosse; Esther Badiata; Esther Flores; Gabriele McGregor; Jason Drake; Jennifer Lanahan; John F Packham; Kenneth Kunke; Laurie Curfman; Linda Anderson; Nadine Kienhoefer; Patrick Kelly; Reagan Hart; Rebecca Preddie; Sabrina Schnur; Selina Verdin; Stephanie Woodard; Shelly Capurro; Tatiana Olivar; Tricia Schares; Zachary Laskey

2. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made during this agenda item.

3. **Informational: Introduction of New Commissioner, Dr. Travis Walker**
By: Dr. Ikram Khan, Chairman

Chairman Khan introduced the PPC's newly appointed Commissioner, Dr. Travis Walker. Commissioner Walker will serve as a physician practicing primarily at a federally qualified health center. He is a trained family physician who attended the University of Nevada, Reno. He is currently serving as the Chief Medical Officer for Community Health Alliance.

4. **For Possible Action: Review and Approve Meeting Minutes from March 14, 2025**
By: Dr. Ikram Khan, Chairman

Chairman Khan called for a motion to approve the meeting minutes from March 14th, 2025. Commissioner Glyman moved to approve the minutes as presented, and Commissioner Davis seconded the motion. The motion carried, and the meeting minutes were approved unanimously.

5. **For Possible Action: PPC to recognize the implementation of AB7 (2023) and regulations LCB File No. R173-24 as meeting the requirements of NRS 439.918(1)(c)**
By: Dr. Ikram Khan, Chairman

Mr. Filippi presented this actionable agenda item for the PPC to recognize the implementation of Assembly Bill 7 (AB7) and the related LCB File No. R173-24 regulations. The presentation is available on the PPC website or by clicking here. He reiterated that AB7, as passed during the 2023 legislative session, requires the Department of Health and Human Services (DHHS) to establish regulations mandating that healthcare providers implement interoperable electronic health record systems or participate in health information exchanges, allowing patients electronic access to their medical records. Per NRS 439.918(1)(c), the Commission is required to submit an annual plan to the Director of the Department of Health and Human Services to enhance access to patient medical records. However, the passage of AB7 and the associated regulations closely aligns with this statutory requirement. Mr. Filippi proposed that the Commission either recognize the implementation of AB7 and the regulations outlined in LCB File No. R173-24 as fulfilling the requirements of NRS 439.918(1)(c) or continue working on developing a separate plan and submitting annual updates to increase access to patient medical records.

Vice Chair Kirkpatrick asked for clarification on the agenda item, noting that the two options seemed somewhat contradictory. She questioned whether it would be beneficial to have a state plan in place, especially considering

that things are constantly changing at both the federal and state levels. She expressed concern that without a formal plan, new legislators may attempt to create their own, which makes her uneasy. Mr. Filippi responded that one of the challenges in creating the plan back in 2022 was the rapidly evolving nature of federal regulations. He explained that the intent of these state regulations is to ensure that healthcare providers remain in compliance with current federal and HIPAA requirements related to health information interoperability. Commissioner Porath agreed, stating that he believes the regulation was thoughtfully crafted to provide an on-ramp for different provider types to comply. He noted that it was written in a way that offers flexibility to accommodate both current laws and potential future changes.

Deputy Attorney General Gabriel Lither addressed Vice Chair Kirkpatrick's concern and asked whether there would be an opportunity for the Commission to reexamine this matter in the future. He noted that while the law originally called for an annual update, if the Commission were to vote in favor of recognizing these regulations, he wanted to confirm whether it would still be possible to revisit the issue if changes occur and the Commission wishes to reassess. Mr. Filippi confirmed that this is well within the Commission's scope of work, and if any concerns arise in the future, the Commission would have the ability to review the issue and provide recommendations as needed.

Commissioner Glyman asked how this differs from Senate Bill 378, which was vetoed by the Governor during the recent legislative session. He noted that the bill included extensive regulations to ensure patients could access their medical records from offices and providers. Commissioner Glyman inquired how the current approach diverges from that bill. Mr. Filippi responded that, had SB378 passed, it would have narrowed the scope of the regulations, requiring compliance from only certain types of healthcare providers rather than all. As a result, the current state regulations would have needed to be revised to align with the bill's changes. Malinda Southard, Deputy Administrator for the Division of Health Care Financing and Policy (DHCFP) added that SB378 would have also required the removal of the option for providers to utilize the health information exchange as a means of compliance. However, since the bill was vetoed, that option remains in place. She agreed with Mr. Filippi, emphasizing that the current regulations apply to a broad population of healthcare providers and medical facilities, including Emergency Medical Services (EMS).

Chair Khan stated that the LCB-filed regulations are very comprehensive and have been heavily discussed and debated. He expressed concern that without a foundational starting point like these well-crafted regulations, issues may arise due to ongoing changes in Medicaid at the federal level. He believes these regulations provide a strong starting point, and if necessary, the Commission can reevaluate them as changes arise that warrant their attention.

Chair Khan called for a motion to approve recognizing the regulations as meeting the as meeting the legislative intent found in the requirements of NRS 439.918(1)(c) and to reevaluate them in the future should any relevant changes come to the Commission's attention. Commissioner Glyman motioned for approval, and Commissioner Davis seconded the motion. The motion carried, and the recognition of Assembly Bill 7 and LCB File No. R173-24 was approved unanimously.

6. **Informational: 83rd Legislative Session Update**
   By: Joseph Filippi, Executive Director

Mr. Filippi provided an update to the Commission. The presentation is available of the PPC website or by clicking here. He noted that, unfortunately, the three bills proposed by the PPC, Senate Bills 29, 34, and 40 did not pass and failed to meet the first house committee deadline on April 11th. However, several other pieces of legislation were enacted and signed by the Governor that align with the legislative intent of the PPC's recommendations. Specifically, this legislation aims to simplify the licensure process for healthcare professionals, reduce

administrative burdens for providers, and invest in the healthcare workforce and Graduate Medical Education (GME). Assembly Bills 163, 230, and 248 streamline the process for providers to practice across state lines and expand the available provider network by reducing access barriers. Senate Bill 124 increases the diversity and pool of qualified physicians by authorizing internationally trained physicians to practice in Nevada. Senate Bill 262 transfers the existing GME grant program and Advisory Council from the Office of Science, Innovation, and Technology to the newly created Nevada Health Authority (NVHA) and includes a $9 million appropriation for GME grants. It also provides the department with greater oversight to assess and support the needs of existing GME programs. Additionally, Senate Bill 494 restructures the Department of Health and Human Services (DHHS) into two entities: the Department of Human Services (DHS) and the Nevada Health Authority (NVHA). The NVHA is designed to serve as the state's primary payer, purchaser, and policymaker for healthcare delivery, with the goal of ensuring that covered Nevadans have timely access to affordable health insurance and quality care. Nevada Medicaid, the Silver State Health Insurance Exchange, and the Public Employee Benefits Program will transition under NVHA, which is expected to provide healthcare coverage to one in every three Nevadans, approximately one million recipients statewide, and help the state better maximize public dollars and lower the overall cost of healthcare by consolidating resources. The PPC will also transition from DHHS to NVHA, moving into the Consumer Health Division. Stacie Weeks, the current Administrator of Nevada Medicaid and the incoming Director for NVHA will provide a formal update regarding the implementation during the next PPC meeting in August.

Commissioner Davis inquired about how health care facilities will be notified of the available providers resulting from Senate Bill 124. Additionally, he noted that there may be a limit to how many individuals one provider can supervise, which could create a cost associated with incentivizing providers to take on these additional supervisory roles. He wanted to ensure these considerations are taken into account as the state examines these limitations. Mr. Filippi stated that he would follow up on these questions offline and get back to Commissioner Davis but believes the bill includes language requiring these limited license providers to submit a letter from an in-state employer as part of the licensure process, essentially demonstrating that they have already applied for a position with a healthcare facility and are pending employment. Chairman Khan added that these supervision limitations are already established by the relevant medical boards and existing supervision guidelines. He noted that there are currently defined supervision requirements in place, such as Physician Assistants, where the supervision structure was established for international medical graduates on J-1 visas, and he expects similar limitations to be set by the respective boards for these providers. Commissioner Davis also commented that, to his understanding, the current supervision limit is typically up to three individuals, and that providers must submit a formal request to the board if they wish to supervise more than that.

Vice Chair Kirkpatrick stated that the separation of DHHS and NVHA is a positive change that will be very helpful and presents an opportunity in the early part of Fiscal Year 2026 to secure additional funding for GME. She emphasized that the primary goal has always been to allocate as much funding as possible toward building long-term sustainability for GME. She also noted that with upcoming federal changes, Nevada will have an opportunity to follow up and address some of those developments.

For Possible Action: Discuss PPC Focus Areas and Development of Subcommittees

By: Joseph Filippi, Executive Director

Mr. Filippi discussed the PPC's focus areas and the development of subcommittees. The presentation is available on the PPC website or by clicking here. According to the Governor's Health Care Policy Priorities, a top priority is addressing health care workforce and access-to-care challenges within the state. This includes improving access to primary care services, expanding Medicaid payment quality and outcome incentives, and supporting the buildout of Nevada's health care infrastructure. Based on survey results from PPC members, the top focus areas

identified were primary care, behavioral health, women's health, and health care workforce development. While behavioral health was recognized as a high priority, Mr. Filippi noted that many other entities and boards are already addressing behavioral health needs in the state and suggested that instead of creating a standalone subcommittee, the PPC could have a greater impact by integrating behavioral health interventions into other policy areas such as primary care. He reiterated that per NRS 439.912.2(a), the Commission may establish subcommittees and working groups composed of Commission members or other individuals, which expire after six months unless they are extended by Commission approval. Each subcommittee would be tasked with reviewing specific priority areas identified by the PPC. The PPC may then adopt recommendations made by the subcommittees and use them to help inform final Commission decisions and bill draft requests. Mr. Filippi then introduced two potential subcommittees for consideration, Primary Care and Women's Health, as they were among the top focus areas. Regarding the Primary Care Subcommittee, he emphasized the urgency for action, noting that Nevada has the highest average annual health care expenditure growth at 8.9% but ranks the lowest nationally in health care quality. He stated that primary care has the capacity to improve life expectancy, health outcomes, and reduce costs. Mr. Filippi noted that 22 states are currently reporting on primary care spending, with some defining and measuring spending targets. Other options to improve primary care include , reducing administrative burdens, and increasing coordinated care through alternative payment models (APMs). If approved, the subcommittee's potential focus areas could include establishing a state definition of primary care, evaluating current spending levels, identifying state policies to reform and invest in primary care, assessing the adequacy of the delivery system, and expanding Graduate Medical Education (GME) training in community-based primary care settings. The proposed primary care subcommittee would consist of approximately 15 voting members, with at least 20% from the PPC, and include a mix of provider types with experience in primary care, advocacy groups, commercial and private payers, and representatives from rural health and GME.

Chair Khan commented on the size of the potential subcommittee, suggesting that the Commission take the next couple of weeks to consider their interest in participating. He advised Mr. Filippi to look into the other organizations mentioned for potential representatives to serve on the subcommittee. Chair Khan also noted that these subcommittees would likely become more time-consuming and suggested appointing someone else to serve as chair and vice chair. Mr. Filippi agreed, stating that the application process is already in place and will be sent out via email. He confirmed that he plans to coordinate with the other organizations to secure appropriate representation for the subcommittee. Regarding time commitment, Mr. Filippi noted that he would prefer the subcommittees to begin by meeting on a monthly basis.

Vice Chair Kirkpatrick stated that important representation is missing from the proposed 15 voting members, specifically, a representative which oversees self-funded trust health programs. She emphasized that in Clark County, many individuals are using emergency rooms for their primary care needs rather than visiting primary care providers. She suggested that the Division of Insurance explore marketing efforts to clarify the difference between primary and emergency care, as many self-funded Nevadans are unaware of the distinction. She also noted that in Clark County alone, over 175,000 individuals are covered under self-funded trust programs, which differ significantly from private and commercial insurance. Mr. Filippi agreed and stated he is happy to include representation from a self-funded health plan to ensure patient population is appropriately represented.

Commissioner Porath also suggested adding another committee member, noting that at Renown, pharmacists are utilized for patient co-management and primary care. He explained that significant efforts have been made through the legislative process to create mechanisms for expanding collaborative practice models that address not only patient care needs but also physician burnout and support for chronic care teams. Commissioner Porath recommended considering this approach as part of the future care model and expressed willingness to serve as the subcommittee's representative, or to recommend another pharmacist for the role.

Vice Chair Kirkpatrick then suggested the possibility of splitting the subcommittee into two separate groups. She

expressed concern that members might become too focused on one particular topic during discussions, potentially losing sight of other important aspects of primary care. By reducing the number of voting members to eight or nine per group, each subcommittee could concentrate on specific components of primary care, such as the pharmacy aspect. Mr. Filippi acknowledged her comment and stated that this will be a priority of his, emphasizing that the purpose of these subcommittees is to bring together diverse representatives to ensure input and feedback.

Commissioner Davis asked whether, among the 15 voting members, the one provider member, specifically a social worker, would be classified as a behavioral health provider or if that would be considered a separate category. Mr. Filippi responded that while a social worker could potentially have experience in behavioral health , he envisioned the social worker to serve in the healthcare coordinator role. Commissioner Davis recommended that the commission include a dedicated behavioral health representative as part of the collaborative coordination efforts. He then inquired about the application process and where to find more information. Mr. Filippi stated that he has already prepared an online application process, which will be sent electronically and posted on the PPC website. He also noted that he would email the application to all Commissioners.

Chair Khan called for a motion for the Commission to approve the creation of a Primary Care Subcommittee. Commissioner Flo Kahn motioned to approve, and Commissioner Peterson seconded the motion. The motion passed, and the creation of the Primary Care Subcommittee was approved unanimously.

The second subcommittee under consideration relates to Women's Health and Reproductive Care. In 2024, Nevada was ranked 48th in this area, with rankings of 51st in health care quality and prevention, 49th in coverage, access, and affordability, and 39th in health and reproductive care outcomes. In response to these concerning figures, Mr. Filippi noted that there is a statewide commitment to improvement through recent legislative and policy actions. Specifically, Medicaid is currently developing a value-based payment program focused on maternal and infant health. Mr. Filippi emphasized the importance of this subcommittee, as it would provide the Commission an opportunity to explore the creation of a state-supported Perinatal Quality Collaborative (PQC). The Commission is uniquely positioned to drive change by turning data-driven recommendations into actionable policy. If approved, the subcommittee's key areas of focus would include reviewing available data and evaluating current issues affecting women's health, identifying state policies to enhance women's health and reproductive care, increasing access to adequate prenatal and postpartum care, developing strategies for a state PQC, and collaborating with Nevada Medicaid to provide feedback and recommendations on the maternal and infant health value-based payment program. The subcommittee would consist of 14 voting members, including at least two voting members from the PPC.

Commissioner Peterson stated that there is a strong emphasis on behavioral health in the outcomes from Nevada's Maternal Mortality Review Committee, which identified overdose as the number one cause of pregnancy-associated deaths. She believes this issue aligns closely with the Commission's interests in addressing behavioral health and primary care.

Chair Khan commented on the discussion, stating that Women's Health is frequently talked about, rightfully so, but often lacks meaningful research and actionable progress within the state. He noted that although the topic has been discussed in various committees across Nevada, there has been little to no advancement. He urged the Commission that, if they proceed with approving the creation of this subcommittee, they must commit the necessary time, effort, and energy to assembling the right people and developing thoughtful recommendations for potential legislation. Commissioner Glyman agreed, stating that the numbers have been abysmal over the past few years, regardless of how much funding has been allocated to address these issues. As a craniofacial surgeon who has worked in the community for the past 20 to 30 years, he emphasized that reimbursement for these types of procedures has steadily declined. He cautioned that while committees can propose grand ideas,

the fundamental issue is how to retain providers who can actually implement them. He added that there are currently almost no pediatric surgeons remaining, largely due to low reimbursement rates, and pointed out that Medicaid and Medicare reimbursements in Nevada are among the lowest in the country. For comparison, states like California and New York may offer reimbursement rates up to five times higher for the same procedure performed in Nevada.

Vice Chair Kirkpatrick agreed, adding that during the past legislative session, she frequently heard concerns from legislators who felt left out of PPC discussions. She suggested that the Commission make a conscious effort to involve them by, at a minimum, notifying the chairs of relevant health boards and ensuring that upcoming meetings, particularly those of the Women's Health Subcommittee, are on legislators' radars and that they receive copies of the agendas. Mr. Filippi agreed and stated that he is happy to add them to the PPC listserv to help spread awareness of upcoming meetings.

Commissioner Kahn suggested adding a representative focused on research and development in the Women's Health space to the proposed subcommittee. She stated that this would be helpful in identifying what innovations are in the pipeline, what is currently being researched, and what may be developed in the future. Such insights could not only inform the subcommittee's work but also potentially lead to improved outcomes and cost savings over time.

Commissioner Behunin stated that she fully supports the creation of these subcommittees, but noted that when reviewing the key focus areas, the scope of issues could feel overwhelming. She asked whether the intent of the subcommittees would be to narrow down their efforts to one or two specific objectives in order to meaningfully move the needle and focus on areas where real impact could be made. Chair Khan agreed that this is an important point, suggesting that when the subcommittees begin their work, the first meeting should be dedicated to identifying and prioritizing which objectives to focus on.

Mr. Filippi called for a motion for the Commission to approve the creation of a Women's Health and Reproductive Care Subcommittee. Commissioner Glyman motioned to approve, and Commissioner Peterson seconded the motion. The motion passed, and the creation of the Women's Health and Reproductive Care Subcommittee was approved unanimously.

Deputy Attorney General Gabriel Lither reminded the Commission that while these two subcommittees have been approved, the Commission retains the authority to establish additional subcommittees in the future, should they choose to do so.

7. **For Possible Action: Review and Approve Semi-Annual PPC Report required per NRS 439.918**
By: Joseph Filippi, Executive Director

Mr. Filippi then presented an actionable item which is to review and approve the Semi-annual PPC report per NRS 439.918. The PPC report is available on the PPC website or by clicking here. He reiterated that the PPC must submit a report every six months related to the meetings and activities of the Commission during the timeframe and must include, without limitation, a description of any issues identified as negatively impacting the quality, accessibility, and affordability of healthcare in the state. The report should also include recommendations for legislation, regulations or other changes to policy or budgets to address those issues.

Chair Khan opened the floor for a motion to approve the Semi-Annual PPC Report as presented. Commissioner Behunin moved to approve the motion, and Commissioner Davis seconded it. The motion carried, and the PPC Semi-Annual Report was unanimously approved.

Mr. Filippi briefly updated the Commission, stating that the next meeting will be held on August 15th. He noted that subcommittee members will likely be appointed around September, with the goal of beginning monthly

meetings thereafter. He reiterated that following this meeting, PPC staff will work on finalizing the subcommittee application and expressed hope that more information will be available by the August meeting.

8. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made during this agenda item.

9. **Adjournment**
By: Dr. Ikram Khan, Chairman

Chair Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 10:22 AM.