Legislative Counsel Bureau

Legislative Committee on Health Care

Bulletin No. 17-15

The primary responsibilities of the Legislative Committee on Health Care are set forth in *Nevada Revised Statutes* 439B.220 through 439B.227.

January 2017

LEGISLATIVE COMMITTEE ON HEALTH CARE

BULLETIN NO. 17-15

JANUARY 2017

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SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMITTEE ON HEALTH CARE

Nevada Revised Statutes (NRS) 439B.200

This summary presents the recommendations approved by the Legislative Committee on Health Care (LCHC) at its August 24, 2016, meeting. The LCHC submits the following recommendations and bill draft requests (BDRs) to the 79th Session of the Nevada Legislature:

PROPOSALS RELATING TO THE HEALTH CARE WORKFORCE

1. **Nurse Licensure Compact**—Send a letter to the Governor of the State of Nevada and the Director of the Department of Health and Human Services (DHHS) expressing the Committee's support for BDR 54–182, which would adopt the Nurse Licensure Compact.

2. **Health Professional Licensure Compacts**—Propose legislation to enact the:

   a. Recognition of Emergency Medical Services Personnel Licensure Interstate Compact; and

   b. Psychology Interjurisdictional Compact by redrafting the sections of Senate Bill 299 of the 2015 Legislative Session. **(BDR 40–351)**

3. **National Health Service Corps and Nurse Corps**—Send letters to medical facilities in Nevada that are eligible to serve as National Health Service Corps sites or Nurse Corps sites, strongly encouraging them to apply to and participate in these programs.

4. **Advanced Practice Registered Nurses**—Propose legislation to:

   a. Amend the following sections of NRS to allow advanced practice registered nurses (APRNs) to perform the following tasks, which currently may only be performed by a physician:

      i. NRS 440.380: Amend to allow an APRN to sign a death certificate;

      ii. NRS 482.3831 through 482.384: Amend to allow an APRN to make all applicable diagnoses and certifications authorizing a person with a disability to obtain a special license plate or a temporary parking placard or sticker; and

      iii. NRS 706.8842: Amend to include an APRN in the definition of "medical examiner," thereby allowing an APRN to issue a medical examiner's certificate for a taxicab commercial driver's license. **(BDR 40–352)**

5. **Graduate Medical Education Funding**—Send a letter to the Governor expressing the Committee's support for and urging continuation of a $5.25 million annual budget appropriation for graduate medical education (GME) in each year of the 2017–2019 Biennium.

6. **Graduate Medical Education**—Send a letter to Nevada's Congressional Delegation advocating for:

   a. No additional GME funding cuts; and

   b. Redistributing full-time equivalent GME slots to Nevada hospitals.

7. **State Employee Contracting**—Propose legislation to amend subsection 9 of NRS 333.705 to add "former state employees who are not receiving monetary retirement benefits through the Public Employee Retirement System of Nevada during the time period they are under contract" to the list of entities that are exempt from the prohibition on contracting with a former State employee for two years after the termination of the person's State employment. **(BDR 27–354)**

PROPOSALS RELATING TO PUBLIC HEALTH

8. **Body Mass Index Measurement in Schools**—Redraft Section 9 of Senate Bill 178 (2015) to reestablish the requirements below concerning measurement of the height and weight of a representative sample of pupils. These requirements had sunset in 2015. Specifically, amend NRS 392.420 to:

   a. Reestablish the requirement that the board of trustees of each school district in a county whose population is 100,000 or more (currently Clark and Washoe Counties) to direct school nurses, qualified health personnel, teachers who teach physical education or health, or other licensed educational personnel who have completed training in measuring the height and weight of a pupil provided by the school district to measure the height and weight of a representative sample of pupils who are enrolled in grades 4, 7, and 10 in the schools within the school district;

   b. Require the Division of Public and Behavioral Health (DPBH), DHHS, to determine the number of pupils necessary to include in the representative sample;

   c. Not require school authorities to provide notice to a student's parent or guardian before measuring the child's height or weight if it is not practicable to do so; and

   d. Require each school nurse or his or her designee to report the results to the Chief Medical Officer. **(BDR 34–353)**

9. **Vapor Products and Tobacco Products**—Propose legislation to:

   a. Amend NRS 202.2483, the "Nevada Clean Indoor Air Act," to prohibit the use of vapor products, as defined in NRS 202.2485, in all areas where tobacco smoking is prohibited; and

   b. Add new provisions that:

      i. Require nicotine containers used in vapor products to be sold in child resistant packaging, in accordance with the federal Poison Prevention Packaging Act of 1970 (15 U.S.C. §§ 1471 et seq. [2017]; and 16 C.F.R. § 1700 [2017]); and

      ii. Require labels on vapor products and alternative nicotine products to include ingredients, nicotine level, and age restrictions. **(BDR 15–355)**

PROPOSALS RELATING TO MEDICAID MANAGED CARE

10. **Medicaid Managed Care Expansion**—Send letters to the Governor and the Director of the DHHS urging consideration of the concerns and recommendations expressed by the National Alliance on Mental Illness, Nevada, in its June 16, 2016, letter to the LCHC, as the DHHS determines whether and how to expand Medicaid managed care to additional populations and geographic areas.

11. **Medicaid Managed Care Agreements/Request for Proposals**—Send a letter to the Division of Health Care Financing and Policy (DHCFP), DHHS, encouraging consideration of its relationship with Medicaid managed care organizations (MCOs) and requesting that the DHCFP clarify the following in future managed care requests for proposals and contracts:

   a. The State has the authority to oversee the performance of MCOs and must ensure that specific performance criteria are included in the MCO contract and measured at least monthly. The results of performance criteria must be transparent and shared publically, including on the DHCFP's website.

   b. The MCOs must administer their provider contracts in accordance with Medicaid policies unless mutually agreed upon otherwise and documented by the State and providers.

   c. Contracts between the State and MCOs must require each MCO to independently meet network adequacy standards, comparable to those established annually by Nevada's Division of Insurance, Department of Business and Industry, through direct contracting with providers and hospitals.

d. The State is responsible for final policy/claims appeal if an MCO and a provider cannot reach an agreement.

e. Geographic expansion of Medicaid managed care into the rural areas of Nevada will not occur until rural communities are ready.

PROPOSAL RELATING TO PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

12. **Physician Orders for Life-Sustaining Treatment**—Propose legislation to:

a. Amend NRS 449.535 through 449.690 to allow an APRN to make all diagnoses applicable to a declaration to withhold or withdraw life-sustaining treatment and accept such a declaration;

b. Amend subsection 2 of NRS 449.6946 to require providers of health care to honor a patient's most recent health care declaration, directive, or order to guide treatment instead of allowing a do-not-resuscitate identification that is on the person of a patient to take precedence over a subsequently executed Physician Order for Life-Sustaining Treatment (POLST) form;

c. Establish who may serve as a health care surrogate for purposes related to a POLST form, and authorize a health care surrogate to complete and sign a POLST form for a patient who lacks decisional capacity if the patient does not have a Durable Power of Attorney for Health Care or a legal guardian. Amend NRS to provide that:

i. A health care surrogate has authority to consent to or withhold consent for treatment for a patient lacking decisional capacity.

ii. The following individuals may act as a health care surrogate for a patient, in order of priority: (1) spouse; (2) adult child; (3) parent; (4) sibling; (5) nearest other adult relative; or (6) an adult who has exhibited special care and concern for the patient, who is familiar with the patient's values and willing and able to make health care decisions for the patient.

iii. Health care surrogates may not revoke a POLST form completed by a patient or his or her durable power of attorney or guardian, and a surrogate's consent is not valid if it conflicts with the patient's valid POLST form or advance directive.

iv. The physician has the right to determine fitness of a health care surrogate pursuant to the federal Privacy Act of 1974, 45 C.F.R. § 164.502(g) (2017).

v. If a health care provider, a patient's legal representative, or a patient's health care surrogate believes the patient has regained decisional capacity, the patient may be reexamined and a decision shall be entered into the medical record and the health care surrogate must be notified.

d. Establish that artificial nutrition and hydration must not be withheld from a patient who does not have an effective declaration as defined in NRS 449.600 or POLST form, unless a different desire is expressed in writing by the patient's health authorized representative or family member; and

e. Establish that life-sustaining treatment must not be withheld or withdrawn from a patient known to be pregnant, so long as it is probable that a fetus will develop to the point of live birth with continued application of life-sustaining treatment. **(BDR 40–365)**

PROPOSAL RELATING TO RARE DISEASES

13. **Medical Education for Residents**—Send letters to GME residency programs in Nevada expressing the Committee's awareness of, and concern for, the population of Nevadans who are at risk for, and affected by, rare diseases such as Postural Orthostatic Tachycardia Syndrome, Ehlers-Danlos syndrome, and numerous others. In each letter:

    a. Request that residency programs report to the LCHC and to the Senate and Assembly Committees on Health and Human Services on existing curriculum, requirements, and efforts to educate residents about rare disease, as well as future plans to include education and training on rare disease in residency curriculum;

    b. Provide data on the incidence of rare disease. According to the National Institutes of Health, U.S. Department of Health and Human Services, an estimated 25 million to 30 million Americans have 1 of the 7,000 known rare diseases; and

    c. Discuss the challenges experienced by those who have received a rare disease diagnosis due to the limited experience many providers have identifying and diagnosing such conditions. In addition, discuss promising therapies that are under development.

PROPOSALS RELATING TO CHILDREN'S HEALTH

14. **Children's Mental Health**—Send a letter to the Governor and the Director of the DHHS supporting the priorities of the Clark County Children's Mental Health Consortium, which include:

a. Restructuring the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families;

b. Providing mobile crisis intervention and stabilization services to Clark County youth in crisis;

c. Expanding access to family-to-family peer support services for the families of Clark County's children at risk for long-term institutional placement; and

d. Developing partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

15. **Posting of Child Abuse Hotline Number in Schools**—Propose legislation to amend NRS to require all public schools, including charter schools, to post the State and local (if applicable) child abuse hotline telephone number in a clearly visible location in a public area of the school. Specifically, amend NRS to:

a. Require each public school and charter school to post in a clearly visible location, in a public area of the school that is readily accessible to students, a sign that contains the toll-free hotline telephone number established by the Division of Child and Family Services (DCFS), DHHS, for reports of abuse or neglect pursuant to NRS 432B.200, and the local child abuse hotline, if one is available;

b. Authorize the Director of the DHHS to adopt rules and regulations relating to the size and location of the sign provided that, at a minimum, it shall:

i. Be in English and Spanish;

ii. Be 11 inches by 17 inches or larger;

iii. Include text in a font large enough to be clear, simple, and understandable to students;

iv. Be posted in a high traffic location at the eye level of students;

v. Contain the current telephone number for the DCFS child abuse and neglect hotline and the local child abuse hotline, if applicable, in bold print;

vi. Contain instructions for calling 9-1-1 in an emergency; and

vii. Contain instructions for accessing the DCFS's website for more information on reporting abuse and neglect; and

c. Authorize the DCFS to design a poster that complies with these requirements and distribute the poster to schools in hard copy form or in electronic form for printing. **(BDR 34–362)**

16. **Children's Health Insurance Program**—Send a letter to the DHHS encouraging the DHCFP to examine Nevada's Children's Health Insurance Program (CHIP) eligibility policies to provide health insurance coverage to lawfully residing immigrant children who have not been in the country for five years. In the letter, provide information regarding other states' eligibility policies, including the fact that CHIP programs in 29 states and the District of Columbia cover lawfully residing immigrant children without a five-year wait.

PROPOSALS RELATING TO AUTISM TREATMENT AND SERVICES IN NEVADA

17. **Autism Treatment Assistance Program and Medicaid**—Send a letter to the Director of the DHHS conveying the variety of concerns related to accessing services the Committee heard from numerous parents of children with autism, as well as providers of autism services. Include the following concerns:

    a. The reimbursement rate for services provided to adults with autism under the Medicaid Home and Community-Based Services (HCBS) Waiver, especially in rural areas. Specifically mentioned were concerns regarding the residential support services rate for severely impacted adults with autism, the need to authorize day habilitation services provided in the home at a higher reimbursement rate, and the Medicaid reimbursement rate for Board Certified Behavior Analysts (BCBAs) who provide services to adults on the Medicaid HCBS Waiver to match the reimbursement rate for services provided to children.

    b. Concerns expressed regarding Autism Treatment Assistance Program (ATAP) policies and programs include:

        i. Allowing parents to continue to be able to hire their own interventionists with the assistance of a fiscal agent;

        ii. Allowing payment to interventionists working under the supervision of a BCBA, without requiring a registered behavior technician (RBT) credential, until such time as there is a sufficient RBT workforce;

        iii. Delaying the transfer of Medicaid-eligible children to Medicaid providers for individual children until a Medicaid provider is available to seamlessly accept and treat the child; and

iv. Continuing to ramp up efforts to serve children through Medicaid providers, using their current providers as much as is practicable.

c. Concerns regarding Medicaid policy and programs include:

i. The need to review the RBT rate;

ii. Exploring with the Centers for Medicare and Medicaid Services the possibility of adopting the approach taken by ATAP to allow payment for services provided by an interventionist under the supervision of a BCBA for up to six months while the interventionist obtains an RBT credential;

iii. Supporting efforts to grow the State's BCBA and Board Certified Assistant Behavior Analyst (BCaBA) workforce through the higher education system and encourage the Department of Employment, Training and Rehabilitation to include the BCaBA and RBT in their programs; and

iv. The need to review available programs and reimbursement rates for adults with autism.

18. **Redefine Autism**—Propose legislation to:

a. Amend subsection 1 of NRS 427A.875 to authorize ATAP to provide and coordinate services to persons "diagnosed or determined, including, without limitation, through use of a standardized assessment" to have autism spectrum disorders, through 19 years of age; and

b. Amend NRS 287.0276, 427A.875, 689A.0435, 689B.0335, 689C.1655, 695C.1717, and 695G.1645 to redefine "autism spectrum disorder" as "a condition that meets the diagnostic criteria published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders or the edition that was in effect at the time of diagnosis." **(BDR 38–363)**

19. **Collaboration Between School and Out-of-School Applied Behavior Analysis Services**—Send a letter to the Superintendent of Public Instruction urging Nevada's Department of Education to develop a clear and consistent State policy, with guidance to school districts, for students with an Individualized Education Program (IEP) who require Applied Behavior Analysis (ABA) therapy. In developing the policy, the Department should consider:

a. Whether an IEP should be required to specify the number of weekly ABA hours needed by the student, with a distinction between the hours to be provided in school and out of school;

b. Specifying the credentials required of an ABA professional who assists in determining the total weekly ABA hours needed by the student;

c. Requiring collaboration for ABA services to maximize their effectiveness and to ensure continuity of service across environments;

d. Requiring schools to support access to ABA by endorsing the following or similar language in the IEP: "The IEP recognizes the student's need to receive medically necessary treatment, which may impact full-time school attendance. An adjusted schedule is supported to allow student to receive treatment, which may occur in and/or outside of the school environment without incurring truancy";

e. Requiring the school to encourage a parent, through written communication from the school, to invite the student's outside ABA professional(s) to participate in relevant IEP meetings; and

f. Allowing a student's out-of-school ABA Professional (i.e., BCBA or licensed psychologist)—who is funded by private insurance, Medicaid, or ATAP and who passes appropriate background checks—to observe the student in the school environment quarterly and/or allowing such a provider to support the student during the school day if the student's behavior impedes learning or if the student's history includes aggression, elopement, or suspension.

PROPOSAL RELATING TO MEDICAID REIMBURSEMENT RATES

20. **Medicaid Reimbursement Rates**—Send a letter to the Director of the DHHS expressing the Committee's support for continuing to conduct regular evaluations of Medicaid provider reimbursement rates. Specifically, recommend that the DHHS review reimbursement rates for personal care services; home health services; and providers of community-based, long-term services and supports. Include with the letter the written testimony received related to increasing rates for these specialties.

PROPOSALS RELATING TO HEALTH PROFESSION LICENSING AND LICENSING BOARDS

21. **Oversight of Health Profession Licensing Boards**—Send a letter to the Interim Finance Committee; the Sunset Subcommittee of the Legislative Commission; the Senate Committee on Commerce, Labor, and Energy; the Assembly Committee on Commerce and Labor; and the Governor, expressing the LCHC's concern regarding the lack of oversight of health profession licensing and licensing boards and its support for statutory changes necessary to provide such oversight. Specifically, express the Committee's concern regarding the:

a. Numerous complaints the Committee received related to various health care profession licensing boards;

b. General lack of oversight of health profession licensing boards and the need for accountability;

c. Investigation and appeals processes used by certain boards and the need for oversight over certain board decisions;

d. Lack of transparency with regard to licensure data, the inability of some boards to provide requested data, and the need to increase data reporting requirements;

e. Need for increased transparency and oversight of the finances of health profession licensing boards and for comprehensive, detailed reporting requirements to improve fiscal accountability;

f. Application and licensure inefficiencies and extended application timelines due to the systems used by certain boards;

g. Performance audit of the Board of Dental Examiners of Nevada by the Legislative Auditor and the refusal of the Board to accept 3 of the 14 recommendations made by the audit; and

h. Direct impact boards have on the health care workforce and their ability to exacerbate or improve the workforce shortage, as exemplified by the challenges the Governor's Social Workers in Schools program faced recruiting social workers and other qualified behavioral health providers in 2016.

22. **Behavioral Health Licensing Boards**—Propose legislation to:

a. Consolidate, under the State Board of Health within the DHHS, the behavioral health boards established in:

i. Chapter 641 ("Psychologists, Behavior Analysts, Assistant Behavior Analysts and Autism Behavior Interventionists") of NRS;

ii. Chapter 641A ("Marriage and Family Therapists and Clinical Professional Counselors") of NRS;

iii. Chapter 641B ("Social Workers") of NRS; and

iv. Chapter 641C ("Alcohol, Drug and Gambling Counselors") of NRS.

b. Amend NRS 439.030, which establishes the State Board of Health, to add four additional members to the Board appointed by the Governor, including:

   i. One member who is a psychologist or a BCBA;

   ii. One member who is a marriage and family therapist or a clinical professional counselor;

   iii. One member who is a social worker; and

   iv. One member who is an alcohol, drug, and gambling counselor and who has engaged in the practice of his or her specific profession in this State for not less than five years immediately prior to the appointment.

c. Require the Bureau of Health Care Quality and Compliance (HCQC), DPBH, DHHS, to assume responsibility for administration of licensure, investigations, and complaint resolution for all mental health professionals currently licensed in Chapters 641, 641A, 641B, and 641C of NRS.

d. Establish, under the State Board of Health, four profession-specific subcommittees through which each professional area licensed under Chapters 641 through 641C of NRS will make recommendations to the Board regarding licensure requirements, standards-of-practice, and regulations, as follows:

   i. One subcommittee will be established for each of the existing NRS behavioral health profession chapters (641, 641A, 641B, and 641C).

   ii. Each subcommittee will consist of three members who have been residents of this State for at least one year before appointment. If qualified, a subcommittee member may serve on more than one subcommittee. Subcommittees will be comprised of:

      (1) One member who is a member of the State Board of Health;

      (2) At least one member, but not more than two, who is licensed in the professional area he or she regulates and has five years of experience in the applicable profession; and

      (3) At least one member, but not more than two, who has served within the previous ten years as core or full-time faculty at a regionally accredited college or university in a program related to the applicable profession and has experience in the design and development of the curriculum of a related program.

iii. Subcommittee members are initially appointed by the State Board of Health. After initial appointment, the Governor shall appoint subcommittee members. A member first appointed by the Board shall continue to serve until appointed or replaced by the Governor. Initially, members will serve staggered terms.

iv. After the initial term, subcommittee members serve at the pleasure of the Governor of the State of Nevada for terms of three years. A member shall not serve more than two full consecutive terms.

v. Each member of a subcommittee is entitled to receive:

(1) A salary of not more than $80 per day, as fixed by the State Board of Health, while engaged in and necessarily spent in performance of his or her subcommittee duties; and

(2) A per diem allowance and travel expenses at a rate fixed by the State Board of Health, while engaged in the business of the subcommittee. The rate must not exceed the rate provided for State officers and employees generally.

vi. Each subcommittee shall annually elect a chair and secretary from its membership.

vii. Subcommittee members are personally immune from suit with respect to all acts done and actions taken in good faith and in furtherance of the purposes of this bill.

viii. Subcommittee members shall receive at least five hours of training as prescribed by the State Board of Health within one year after the member is initially appointed. Training must include instruction on ethics and open meeting requirements.

e. Require the State Board of Health to review each subcommittee's regulations before being submitted to the Legislative Commission for final approval to ensure that the regulations are in the best interest of the public and do not unnecessarily restrict individuals from entering or practicing the profession.

f. Establish that the HCQC shall be responsible for disciplining licensees, as follows:

i. The HCQC may establish in regulation peer review panels to evaluate complaints against similarly licensed behavioral health professionals;

ii. The State Board of Health may authorize continuing education credits to qualified behavioral health professionals who choose to serve on such peer review panels;

iii. The HCQC will conduct an investigation of a complaint against a behavioral health professional with the assistance of a peer review panel, if the HCQC decides to establish such panels;

iv. The results of an investigation of a complaint will be submitted to the appropriate subcommittee;

v. Based on the results of an investigation, each subcommittee shall recommend appropriate disciplinary action to the HCQC, if the recommendation is not license revocation. Recommendations of license revocation shall be submitted to the State Board of Health; and

vi. The HCQC or the State Board of Health, as applicable, will review recommendations for disciplinary action and discipline licensees.

g. Redirect board fees and funds generated through licensure and other funding streams from boards established pursuant to Chapters 641, 641A, 641B, and 641C of NRS to the DPBH to support the activities of licensure administration, investigation, and regulatory oversight for behavioral health professionals.

h. Require the State Board of Health to make necessary regulatory changes to existing regulation in Chapters 641, 641A, 641B, and 641C of *Nevada Administrative Code*, and develop new regulations to comply with these legislative changes.

i. Establish that any regulations adopted by boards established pursuant to Chapters 641, 641A, 641B, and 641C of NRS which do not conflict with the provisions outlined above remain in effect and may be enforced by the appropriate board until the State Board of Health adopts regulations to repeal or replace those regulations. Any regulations adopted by the above boards that conflict with these provisions are void.

j. Require the DHHS to develop a plan for transitioning from the existing licensing board structure to the new behavioral health profession licensing structure within the State Board of Health so that licensees and the public can follow and participate in the transition process. The plan must be presented at a meeting in compliance with the open meeting law and adopted at a second meeting in compliance with the open meeting law. Provisions of Chapter 233B ("Nevada Administrative Procedure Act") of NRS do not apply to this transition plan.

k. Contracts and agreements, disciplinary and administrative actions, and licenses issued by such boards remain in effect as if taken by the officer or entity to which the responsibility for the enforcement of such action has been transferred. **(BDR 54–410)**

PROPOSALS RELATING TO BEHAVIORAL HEALTH

23. **Behavioral Health Education for Law Enforcement**—Send a letter to the Directors of the Department of Public Safety and the DHHS and to the heads of local law enforcement expressing the Committee's support for the development of a statewide behavioral health education or training requirement for law enforcement officers.

24. **Mental Health Courts**—Send a letter to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the Director of the DHHS expressing the LCHC's support for mental health and other specialty courts, including:

    a. Encouragement and support for the development of additional residential substance abuse treatment beds and the establishment of treatment beds for people diagnosed with co-occurring disorders, as there are currently no such beds in the State;

    b. The Committee's continued support for providing funding for drug testing, housing, and transportation for specialty court participants; and

    c. Mention of the potential of public-private partnerships to assist in providing such funding.

25. **Crisis Intervention**—Send a letter to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the Director of the DHHS expressing the LCHC's support for the:

    a. Expansion of crisis intervention and jail diversion programs such as the Forensic Assessment Services Triage Team, Mobile Outreach Safety Team, and crisis intervention training; and

    b. Development of crisis stabilization centers in the State, where people experiencing a crisis related to a mental health condition can access services 24/7. This type of center can provide timely de-escalation, early intervention, and patient stabilization to prevent the need for higher levels—and more costly—care.

PROPOSALS RELATING TO AMBULATORY SURGICAL CENTERS

26. **Ambulatory Surgical Centers**—Propose legislation to:

    a. Amend Chapter 449 ("Medical Facilities and Other Related Entities") of NRS to prohibit an ambulatory surgical center from performing surgical services that routinely result in admission to another licensed medical facility within 24 hours after discharge from the surgical center;

b. Amend NRS 439A.250 to require the DHHS to impose a penalty on surgical centers for ambulatory patients, pursuant to NRS 439A.310, after sending two notices indicating that the center failed to submit the required information, or the information was incomplete or inaccurate; and

c. Amend subsection 2 of NRS 439A.280 to exempt NRS 439A.240 and 439A.250 from the programs and duties for which the DHHS can temporarily suspend if it determines sufficient funds are not available. **(BDR 40–364)**

REPORT TO THE 79TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE

I. INTRODUCTION

The Legislative Committee on Health Care (LCHC) is a permanent committee of the Nevada Legislature whose authorization and duties are set forth in *Nevada Revised Statutes* (NRS) 439B.200 through 439B.227. Established in 1987 to provide continuous oversight of health care matters, the LCHC oversees a broad spectrum of issues related to the quality, access, and cost of health care for all Nevadans. Specifically, the LCHC is responsible for: (1) reviewing and evaluating the quality and effectiveness of programs for the prevention of illness; (2) analyzing the overall system of medical care in the State to determine how to coordinate the provision of services, avoid duplication, and achieve the most efficient use of all available resources; (3) reviewing health insurance issues; (4) examining hospital-related issues, medical malpractice issues, and the health education system; and (5) reviewing certain health care regulations. In addition, various entities are statutorily required to submit certain reports to the LCHC throughout the interim.

The following legislators served as members of the LCHC during the 2015–2016 Interim:

Assemblyman James Oscarson, Chair
Senator Joseph (Joe) P. Hardy, M.D., Vice Chair
Senator Ben Kieckhefer
Senator Patricia (Pat) Spearman
Assemblywoman Teresa Benitez-Thompson
Assemblyman David M. Gardner

Legislative Counsel Bureau staff services were provided by:

Megan Comlossy, Senior Research Analyst, Research Division
Risa B. Lang, Chief Deputy Legislative Counsel, Legal Division
Eric Robbins, Deputy Legislative Counsel, Legal Division
Gayle Nadeau, Senior Research Secretary, Research Division

II. COMMITTEE ACTIVITIES

The LCHC held seven meetings during the 2015–2016 Interim, including a work session. All public hearings were conducted through simultaneous videoconferencing between legislative meeting rooms in the Grant Sawyer State Office Building in Las Vegas, Nevada, and the Legislative Building in Carson City, Nevada.

The LCHC considered a wide variety of topics relating to access to care, children's health, forensic behavioral health, health care workforce, health professional education programs, health professions licensing boards, insurance, managed care, Medicaid, mental and behavioral health, provider networks, and public health.

In addition, at the October 21, 2015, meeting of the Interim Finance Committee, Assemblyman Oscarson, Chair, LCHC, committed that the LCHC would hear regular updates from the Division of Child and Family Services (DCFS), Department of Health and Human Services (DHHS), on the federal Cooperative Agreement for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, otherwise known as the System of Care Grant. The DCFS presented at every LCHC meeting regarding progress on grant implementation.

During the work session on August 24, 2016, the Committee approved proposals for ten bill draft requests (BDRs) to be considered by the 79th Session of the Nevada Legislature. The BDRs concern: (1) health professional licensure compacts; (2) advanced practice registered nurses (APRNs); (3) State employee contracting; (4) body mass index measurement in schools; (5) vapor and tobacco products; (6) Physician Order for Life-Sustaining Treatment (POLST) forms; (7) posting of child abuse hotline telephone numbers in schools; (8) the definition of autism spectrum disorder (ASD); (9) behavioral health licensing boards; and (10) ambulatory surgical centers. Committee members authorized the Chair to send 16 letters to various agencies, legislative committees, and officials on behalf of the LCHC.

At the conclusion of the 2013–2014 Interim, the LCHC recommended eight BDRs to the 2015 Legislature. Legislative action resulting from those proposed bills is outlined in **Appendix B**.

For a list of BDRs recommended by the LCHC for consideration by the 2017 Legislature, please see **Appendix C**.

III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS TO THE 2017 NEVADA LEGISLATURE

A variety of issues was addressed at the meetings of the LCHC. This document summarizes only the issues for which the LCHC made recommendations, which relate to:

A. Health care workforce;

B. Public health;

C. Medicaid managed care;

D. Physician Order for Life-Sustaining Treatment forms;

E. Rare diseases;

F. Children's health;

G. Autism treatment and services;

H. Medicaid reimbursement rates;

I. Behavioral health;

J. Health profession licensing boards; and

K. Ambulatory surgical centers.

A. HEALTH CARE WORKFORCE

Nevada continues to face a severe shortage of health care providers. Although the number of health care professionals has grown steadily in recent years, it has not kept pace with increases in demand for care. Increased patient demand is largely due to population growth, an aging population, the expansion of health insurance coverage as a result of the Patient Protection and Affordable Care Act (ACA) of 2010 (Public Law 111-148), and economic growth. Compared to other states, Nevada has some of the worst provider-to-population ratios in the nation. According to John Packham, Ph.D., Director of Health Policy Research, Office of Statewide Initiatives, University of Nevada, Reno, School of Medicine, Nevada ranks 51st in nurse-to-population ratio, 48th in physician-to-population ratio, 47th in psychologist-to-population ratio, 38th in pharmacist-to-population ratio, and 34th in dentist-to-population ratio.

Health care providers also are poorly distributed throughout the State. The workforce shortage is more acute in rural and frontier communities. Approximately one in three Nevadans lives in a federally designated primary care health professional shortage area (HPSA), and one in two rural and frontier residents lives in a primary care HPSA. Similar statistics exist for dental HPSAs. In addition, more than one in two Nevadans (53.3 percent) lives in a mental health professional shortage area, and all rural and frontier residents live in areas that do not have sufficient mental health providers.

The Nevada Governor's 2014 Behavioral Health Workforce Pipeline Mapping Project, which engaged stakeholders to map requirements across behavioral health professionals, made numerous recommendations for improving the behavioral health care workforce. Many of these recommendations are also applicable to the primary care workforce.

The LCHC heard testimony from numerous individuals regarding the provider shortage, the Behavioral Health Workforce Pipeline Mapping Project, and major factors that influence the supply of health care professionals, including: (1) higher education programs and

capacity; (2) licensing and regulation; (3) provider recruitment and retention; and (4) State policy and budget.

Higher Education Programs and Capacity

The Committee received presentations about current and proposed programs to expand undergraduate and graduate medical and health profession programs offered by the Nevada System of Higher Education (NSHE), including the new school of medicine at the University of Nevada, Las Vegas. Combined, NSHE institutions offer 204 health sciences related degrees and certificates. Numerous representatives of NSHE institutions highlighted workforce development programs, including online and distance learning programs aimed at improving the health care workforce in rural and frontier parts of the State. The LCHC also heard testimony regarding existing and expanding programs at Roseman University of Health Sciences and Touro University Nevada.

In addition to other initiatives, the LCHC was encouraged to continue supporting and expanding graduate medical education (GME) in Nevada. Currently, there are more students who graduate from medical school in Nevada than there are in-state residency training slots—making Nevada a net exporter of medical school graduates. Enabling Nevada medical school graduates to finish their training in-State is critical to improve the workforce. Data show that 68 percent of residents stay where they complete medical school and residency training.

After hearing testimony regarding these issues, the LCHC agreed to:

- **Send a letter** to the Governor of the State of Nevada expressing the Committee's support for and urging continuation of a $5.25 million annual budget appropriation for GME in each year of the 2017–2019 Biennium; and

- **Send a letter** to Nevada's Congressional Delegation advocating for no additional GME funding cuts and redistributing full-time equivalent GME slots to Nevada hospitals.

Health Professions Licensing and Regulation

Health professions licensing and regulation also affect the health care workforce. Specifically, State policies that aim to increase licensure reciprocity can improve workforce development by making it easier for licensed health care professionals to obtain a license to practice in Nevada. The LCHC was encouraged to support interstate compacts, which rely on standard licensure requirements and help streamline licensure across states, including compacts related to nurses, psychologists, and emergency medical services personnel. A total of 25 states have enacted the Nurse Licensure Compact, which was significantly revised in 2015. As of July 2016, seven states had passed the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact, which requires ten signatories for activation. The Psychology Interjurisdictional Compact will become operational when enacted in seven states; to date, Arizona is the only state to do so.

The LCHC agreed to:

- **Send a letter** to the Governor and the Director of the DHHS expressing the Committee's support for BDR 54–182, which would adopt the Nurse Licensure Compact; and

- **Propose legislation** to enact the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact and the Psychology Interjurisdictional Compact (redraft sections of Senate Bill 299 of the 2015 Legislative Session enacting the Psychology Interjurisdictional Compact). **(BDR 40–351)**

The LCHC also heard testimony regarding the role APRNs play in reducing the provider shortage. In 2013, Assembly Bill 170 (Chapter 383, *Statutes of Nevada)* gave APRNs the authority to practice independently. However, according to the Nevada Advanced Practice Nurses Association (NAPNA), APRNs still do not have authority to complete many tasks. This means that a patient of an APRN is often required to see a second provider, such as a physician, because APRNs do not currently have statutory authority in Nevada to provide certain services that are within their scope of practice. The LCHC was urged to authorize APRNs to: (1) provide proof of disability for patients to obtain a disabled parking placard; (2) sign death certificates; (3) sign orders for POLST forms; (4) sign worker's compensation forms; and (5) sign medical certificates for taxi commercial driver licenses. In addition, representatives of NAPNA testified that APRNs face credentialing challenges that limit APRNs' ability to participate on insurance company, hospital, and health care facility provider panels.

Following deliberation on these recommendations, the LCHC agreed to:

- **Propose legislation** to allow APRNs to perform the following tasks, which currently may only be performed by a physician:

    1. Sign a death certificate (NRS 440.380);

    2. Make all applicable diagnoses and certifications authorizing a person with a disability to obtain a special license plate or a temporary parking placard or sticker (NRS 482.3831 through 482.384); and

    3. Issue a medical examiner's certificate for a taxicab commercial driver's license by including APRNs in the definition of "medical examiner" in NRS 706.8842. **(BDR 40–352)**

Provider Recruitment and Retention

Another key aspect of improving the health care workforce in Nevada is improving provider recruitment and retention. The LCHC heard testimony regarding numerous State and federal programs that provide targeted recruitment and retention, including the National Health

Service Corps, the NURSE Corps, and the Nevada Health Service Corps. Such programs typically offer loan repayment, scholarships, or other monetary incentives in exchange for a specified number of years of service—generally in a designated underserved area. Representatives from the Primary Care Office, Division of Public and Behavioral Health (DPBH), DHHS, indicated that eligible providers and facilities in Nevada do not currently take full advantage of these programs.

In an effort to encourage and increase participation in available recruitment and retention programs, the LCHC agreed to:

- **Send letters** to medical facilities in Nevada that are eligible to serve as National Health Service Corps sites or NURSE Corps sites, strongly encouraging them to apply to and participate in these programs.

State Policy

In addition, the LCHC heard testimony from the DPBH regarding challenges filling the State's public health workforce needs. According to a report from Trust for America's Health, across the nation, 41 percent of state public health departments have a vacancy rate of 10 percent or higher. In Nevada, the vacancy rate was 18.3 percent in State Fiscal Year (FY) 2015. According to the DPBH, replacing staff is both difficult and costly. Agency representatives indicated that one barrier to filling these vacancies is an existing statute that prohibits former State employees from working in a contract role for two years after being a State employee. As written, the law treats interns and students with graduate assistantships as former State employees. This prohibition makes it difficult to hire interns and others who have experience with the State agency. The DPBH indicated that it would prefer to be able to keep such public health professionals in the State, without having to take the extra step of seeking approval from the State Board of Examiners.

In response to testimony on this issue, the LCHC agreed to:

- **Propose legislation** to amend subsection 9 of NRS 333.705 to add "former state employees who are not receiving monetary retirement benefits through the Public Employee Retirement System of Nevada during the time period they are under contract" to the list of entities that are exempt from the prohibition on contracting with a former State employee for two years after the termination of the person's State employment. **(BDR 27–354)**

B. PUBLIC HEALTH

In Nevada, public health is the responsibility of both State and local governments. Public health is generally concerned with preventing health problems and disease, promoting healthy behaviors, and protecting the health of entire populations—whether neighborhoods, towns, cities, the State, or country. In describing the public health, Dr. John Packham provided the following, adapted from a story by Irving Zola:

> I'm standing by a swiftly flowing river and hear the cry of a drowning man. So, I jump into the river, put my arms around him, pull him to the shore, and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So, I jump into the river, reach him, pull him to the shore, and apply artificial respiration. Just as he begins to breathe, another cry for help. So back into the river again, reaching, pulling, applying, breathing, and then another yell. Again and again, without end, goes the sequence. You know, I'm so busy jumping in, pulling them to shore, applying artificial respiration that I have no time to see who is upstream pushing them all in.

Dr. Packham used this analogy to explain that public health represents the "upstream intervention" in population health, while the "downstream intervention" is what is traditionally thought of as medical care.

The LCHC heard testimony from the DPBH and local public health districts including Carson City Health and Human Services, Southern Nevada Health District, and Washoe County Health District. These entities provided information on a range of public health issues and urged the Committee to reinstate the collection of body mass index (BMI) data in schools. The previous statute requiring BMI data to be collected in grades 4, 7, and 10 sunsetted in 2015.

Recognizing the utility of BMI data, the LCHC agreed to:

- **Redraft** Section 9 of Senate Bill 178 (2015) to reestablish the requirements below concerning measurement of the height and weight of a representative sample of pupils. Specifically, the LCHC agreed to amend NRS 392.420 to:

  1. Reestablish the requirement that the board of trustees of each school district in a county whose population is 100,000 or more (currently Clark and Washoe Counties) to direct school nurses, qualified health personnel, teachers who teach physical education or health, or other licensed educational personnel who have completed training in measuring the height and weight of a pupil provided by the school district to measure the height and weight of a representative sample of pupils who are enrolled in grades 4, 7, and 10 in the schools within the school district;

  2. Require the DPBH to determine the number of pupils necessary to include in the representative sample;

  3. Not require school authorities to provide notice to a student's parent or guardian before measuring the child's height or weight if it is not practicable to do so; and

  4. Require each school nurse or his or her designee to report the results to the Chief Medical Officer. **(BDR 34–353)**

Another public health challenge presented during testimony is the prevalence of electronic nicotine delivery devices, commonly known as e-cigarettes, vape-pens, or vapors. These battery-powered devices allow users to simulate smoking by vaporizing and inhaling liquid nicotine, flavoring, and other chemicals. Electronic nicotine delivery devices are not currently regulated by the State or federal government, although the United States Food and Drug Administration has proposed regulations. Though research continues, the *American Society of Heating, Refrigeration, and Air-Conditioning Engineering Journal* concluded in June 2014 "that e-cigarettes emit harmful chemicals into the air and need to be regulated in the same manner as tobacco smoking." A study conducted by the Johns Hopkins Bloomberg School of Public Health found that e-cigarettes lower immunity to flu viruses and Streptococcus bacteria and that free radicals in the "vapor" they produced are damaging even if the product does not contain nicotine. However, some proponents of the devices argue that they function as a smoking cessation tool.

The use of e-cigarettes and similar devices has increased among Nevada high school students in recent years. According to the 2015 Youth Risk Behavior Survey, approximately 25 percent of Nevada high school students reported using e-cigarettes, compared to approximately 6 percent of students who used traditional cigarettes. Nationwide, recent decreases in use of tobacco products among youth have been offset by increased use of electronic nicotine delivery devices. Furthermore, a study published in *Nicotine & Tobacco Research* found that between 2011 and 2013, the use of e-cigarettes tripled among middle and high school students who did not smoke conventional cigarettes. Among those who had used an e-cigarette at least once, nearly 44 percent intended to smoke conventional cigarettes—more than twice the rate of those who had never smoked.

Currently, neither advertising nor access to minors is regulated by the State or the federal government. Between 2013 and 2015, 97 calls to the Nevada Poison Center were related to nicotine poisonings; 65 percent of those calls involved children under the age of 5.

In an effort to address these issues, the LCHC agreed to:

- **Propose legislation** to amend the "Nevada Clean Indoor Air Act" (NRS 202.2483) to prohibit the use of vapor products, as defined in NRS 202.2485, in all areas where tobacco smoking is prohibited. The legislation will add new provisions that require nicotine containers used in vapor products to be sold in child resistant packaging, in accordance with the federal Poison Prevention Packaging Act of 1970 (15 U.S.C. §§ 1471 et seq. [2017]; and 16 C.F.R. § 1700 [2017]) and require labels on vapor products and alternative nicotine products to include ingredients, nicotine level, and age restrictions. **(BDR 15–355)**

C. MEDICAID MANAGED CARE

In Nevada, Medicaid is provided both on a fee-for-service (FFS) basis and through two managed care organizations (MCOs). While all Medicaid recipients in urban Clark and Washoe Counties, who are not determined by the Social Security Administration to be disabled, are required to be enrolled in managed care, recipients outside of these areas are enrolled in Medicaid FFS. The MCOs maintain a network of providers, help patients navigate the health care system, and connect with providers. In contrast, Medicaid recipients under FFS can receive services from any provider enrolled with Medicaid and generally coordinate and manage their own care. Most, but not all, of the services included in the Medicaid State Plan are currently covered by managed care, and MCOs have flexibility to offer additional services as needed.

The DHHS is currently considering options for the future of Medicaid managed care in Nevada. Testimony provided by the Division of Health Care Financing and Policy (DHCFP), DHHS, otherwise known as Medicaid, indicated it is currently considering the following options:

- Increasing the number of managed care plans;
- Expanding managed care to additional regions or statewide;
- Including additional services not currently covered by managed care; and
- Expanding the population served by managed care to include aged, blind, or disabled individuals.

The DHCFP has held numerous joint "listening sessions" throughout the State to solicit feedback on these options.

The LCHC heard concerns regarding Medicaid managed care expansion from numerous individuals and groups. Generally, the LCHC was requested to urge the State to take caution in transitioning vulnerable populations, such as people with severe intellectual disabilities and the aged, blind, and disabled, into managed care plans.

In response to testimony, the LCHC agreed to:

- **Send letters** to the Governor and the Director of the DHHS urging consideration of the concerns and recommendations expressed by the National Alliance on Mental Illness, Nevada, in its June 16, 2016, letter to the LCHC, as the DHHS determines whether and how to expand Medicaid managed care to additional populations and geographic areas.

- **Send a letter** to the DHCFP encouraging consideration of its relationship with MCOs and requesting that DHCFP clarify the following in future managed care requests for proposals and contracts:

    1. The State has the authority to oversee the performance of MCOs and must ensure that specific performance criteria are included in the MCO contract and measured at least monthly. The results of performance criteria must be transparent and shared publicly, including on the DHCFP's website.

    2. The MCOs must administer their provider contracts in accordance with Medicaid policies unless mutually agreed upon otherwise and documented by the State and providers.

    3. Contracts between the State and MCOs must require each MCO to independently meet network adequacy standards, comparable to those established annually by Nevada's Division of Insurance, Department of Business and Industry, through direct contracting with providers and hospitals.

    4. The State is responsible for final policy/claims appeal if an MCO and a provider cannot reach an agreement.

    5. Geographic expansion of Medicaid managed care into the rural areas of Nevada will not occur until rural communities are ready.

D. PHYSICIAN ORDER FOR LIFE-SUSTAINING TREATMENT FORMS

The POLST program encourages planning for the end of life for seriously ill individuals. Patients and health care providers discuss available treatment options based on the patient's health condition and document the patient's preferences on a POLST form. The LCHC heard testimony from Sally Hardwick, President, Nevada POLST, regarding recommended changes to NRS 449.691 through 449.697, which establishes Nevada POLST statute.

In response to this testimony, the LCHC agreed to:

- **Propose legislation** to:

    1. Amend NRS 449.535 through 449.690 to allow an APRN to make all diagnoses applicable to a declaration to withhold or withdraw life-sustaining treatment and accept such a declaration;

    2. Amend subsection 2 of NRS 449.6946 to require providers of health care to honor a patient's most recent health care declaration, directive, or order to guide treatment instead of allowing a do-not-resuscitate identification that is on the person of a patient to take precedence over a subsequently executed POLST form;

3. Establish who may serve as a health care surrogate for purposes related to a POLST form, and authorize a health care surrogate to complete and sign a POLST form for a patient who lacks decisional capacity if the patient does not have a Durable Power of Attorney for Health Care or a legal guardian. Amend NRS to provide that:

   a. A health care surrogate has authority to consent to or withhold consent for treatment for a patient lacking decisional capacity.

   b. The following individuals may act as a health care surrogate for a patient, in order of priority: (1) spouse; (2) adult child; (3) parent; (4) sibling; (5) nearest other adult relative; or (6) an adult who has exhibited special care and concern for the patient, is familiar with the patient's values, and is willing and able to make health care decisions for the patient.

   c. Health care surrogates may not revoke a POLST form completed by a patient or his or her durable power of attorney or guardian, and a surrogate's consent is not valid if it conflicts with the patient's valid POLST form or advance directive.

   d. The physician has the right to determine fitness of a health care surrogate pursuant to the federal Privacy Act of 1974, 45 C.F.R. § 164.502(g) (2017).

   e. If a health care provider, a patient's legal representative, or a patient's health care surrogate believes the patient has regained decisional capacity, the patient may be reexamined and a decision shall be entered into the medical record and the health care surrogate must be notified.

4. Establish that artificial nutrition and hydration must not be withheld from a patient who does not have an effective declaration as defined in NRS 449.600 or POLST form, unless a different desire is expressed in writing by the patient's health authorized representative or family member; and

5. Establish that life-sustaining treatment must not be withheld or withdrawn from a patient known to be pregnant, so long as it is probable that a fetus will develop to the point of live birth with continued application of life-sustaining treatment. **(BDR 40–365)**

E. RARE DISEASES

The LCHC heard testimony at nearly every meeting from individuals who have rare diseases and the parents of children with rare diseases. Those who testified described the challenges individuals with rare diseases face in receiving an accurate diagnosis from a provider familiar with the disease and finding an in-state provider willing and knowledgeable in administering prescribed treatment.

Upon deliberating on this issue and how the Committee could assist, the LCHC agreed to:

- **Send letters** to GME residency programs in Nevada expressing the LCHC's awareness of, and concern for, the population of Nevadans who are at risk for, and affected by, rare diseases such as Postural Orthostatic Tachycardia Syndrome, Ehlers-Danlos syndrome, and numerous others. In each letter:

    1. Request that residency programs report to the LCHC and to the Senate and Assembly Committees on Health and Human Services on existing curriculum, requirements, and efforts to educate residents about rare diseases, as well as future plans to include education and training on rare diseases in residency curriculum;

    2. Provide data on the incidence of rare diseases. According to the National Institutes of Health, U.S. Department of Health and Human Services (HHS), an estimated 25 million to 30 million Americans have 1 of the 7,000 known rare diseases; and

    3. Discuss the challenges experienced by those who have received a rare disease diagnosis due to the limited experience many providers have identifying and diagnosing such conditions. In addition, discuss promising therapies that are under development.

F. CHILDREN'S HEALTH

The LCHC was presented with data on the status of children's health in Nevada, including information on indicators such as perinatal health and birth outcomes, immunizations, chronic disease, childhood obesity, oral health, mental health, and prevention efforts.

In addition, the three regional Children's Behavioral Health Consortia—Clark County, Rural Nevada, and Washoe County—each presented their priorities and recommendations for improving children's mental and behavioral health. The Consortia also discussed the lack of behavioral health care providers in Nevada, especially in rural Nevada, and the need to develop the behavioral health care workforce. The Nevada Office for Suicide Prevention, DPBH, DHHS, presented data on suicide and suicide ideation among youth in Nevada, as well as numerous prevention programs and the crisis intervention services it provides. Data provided on the State's mobile crisis response program indicate that the program continues to grow—responding to 2,504 hotline calls and 1,524 crises in the community, scheduling 400 appointments per month, and providing 608 families with family-to-family support.

The LCHC also heard updates regarding the Nevada System of Care Grant at each of its meetings. Awarded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), HHS, the four-year, $11 million grant will fund the development of sustainable infrastructure and services to improve mental health outcomes for children and youth with serious emotional disturbances and for their families in Nevada.

In response to testimony provided, the LCHC agreed to:

- **Send a letter** to the Governor and the Director of the DHHS supporting the priorities of the Clark County Children's Mental Health Consortium, which include:

    1. Restructuring the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families;

    2. Providing mobile crisis intervention and stabilization services to Clark County youth in crisis;

    3. Expanding access to family-to-family peer support services for the families of Clark County's children at risk for long-term institutional placement; and

    4. Developing partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

- **Propose legislation** to amend NRS to require all public schools, including charter schools, to post the State and local (if applicable) child abuse hotline telephone number in a clearly visible location in a public area of the school. Specifically, amend NRS to:

    1. Require each public and charter school to post in a clearly visible location, in a public area of the school that is readily accessible to students, a sign that contains the toll-free hotline telephone number established by the DCFS for reports of abuse or neglect pursuant to NRS 432B.200 and the local child abuse hotline, if one is available;

    2. Authorize the Director of the DHHS to adopt rules and regulations relating to the size and location of the sign provided that, at a minimum, it shall:

        a. Be in English and Spanish;

        b. Be 11 inches by 17 inches or larger;

        c. Include text in a font large enough to be clear, simple, and understandable to students;

        d. Be posted in a high-traffic location at the eye level of students;

        e. Contain the current telephone number for the DCFS child abuse and neglect hotline and the local child abuse hotline, if applicable, in bold print;

f. Contain instructions for calling 9-1-1 in an emergency; and

g. Contain instructions for accessing the DCFS's website for more information on reporting abuse and neglect; and

h. Authorize the DCFS to design a poster that complies with these requirements and distribute the poster to schools in hard copy form or in electronic form for printing. **(BDR 34–362)**

- **Send a letter** to the DHHS encouraging the DHCFP to examine Nevada's Children's Health Insurance Program (CHIP) eligibility policies to provide health insurance coverage to lawfully residing immigrant children who have not been in the country for five years. In the letter, provide information regarding other states' eligibility policies, including the fact that CHIP programs in 29 states and the District of Columbia cover lawfully residing immigrant children without a five-year wait.

G. AUTISM TREATMENT AND SERVICES

Approximately 7,100 children in Nevada have been diagnosed with autism spectrum disorder. The Autism Treatment Assistance Program (ATAP), Aging and Disability Services Division, DHHS, assists parents and caregivers with the cost of providing evidence-based treatment for children with autism up to age 19. The program does not fund all of a child's recommended hours of treatment, but it helps pay for services such as program training, development and supervision, and daily intervention hours. The ATAP assists families of children with autism regardless of insurance status or type—providing services to those who are uninsured or covered by Medicaid or private insurance. In 2013, the ATAP served 154 children and had a wait list of 320 children. By March 2016, the program was serving 648 children and had a wait list of 592 children; these children waited an average of 263 days to get into the program.

In July 2014, the federal Centers for Medicare and Medicaid Services (CMS) issued guidance requiring state Medicaid programs to cover medically necessary services for children with autism. Approximately 55 percent of the ATAP's current caseload is eligible for Medicaid, as are an estimated 30 percent of all Nevadan youth with autism. In Nevada, Medicaid began covering applied behavior analysis (ABA) services on January 1, 2016. Because Medicaid represents a new source of funding for many families already receiving services through the ATAP, the ATAP was able to increase its caseload from 589 children (with a wait list of 480 children) in FY 2015 to serve 648 children (with a wait list of 592 waiting an average of 263 days) in FY 2016. The ATAP anticipates the program will serve 836 children in FY 2017.

As part of implementing required coverage for ABA services for children, Medicaid requires a paraprofessional who provides ABA services to be credentialed as a "Registered Behavior Technician" (RBT) by the national Behavior Analyst Certification Board, Inc. During the 2015 Legislative Session, the Legislature passed Assembly Bill 6 (Chapter 156, *Statutes of*

Nevada), revising the definition of "autism behavior interventionist" to mean a person registered as an RBT. An RBT must be at least 18 years of age, have a high school diploma, or the equivalent, have 40 hours of training, pass two exams, complete a criminal background check, and be supervised by a board certified behavior analyst (BCBA) or a board certified assistant behavior analyst (BCaBA).

Private insurance previously required ABA providers to be licensed or certified. In an effort to maintain similar standards to Medicaid and private insurance, ATAP modified its policy to require all staff providing one-on-one ABA therapy to become an RBT, increased the hourly reimbursement rate from $25 to $31.31 to match Medicaid rate, and set time lines for all ATAP employees to obtain their RBT credential.

However, the LCHC heard testimony from parents of children with autism and from ABA providers who expressed concern over these changes, including the effect on access to and continuity of care as a result of requiring paraprofessionals to be credentialed, the $31.31 reimbursement rate, and the time line for transitioning eligible families to Medicaid providers and credentialed RBTs.

These concerns were magnified because of the severe shortage of ABA providers statewide. As of April 2016, 291 RBTs, 71 BCBAs, and 11 BCaBAs were licensed in Nevada. Estimates provided to the LCHC indicate Nevada needs an additional 3,260 to 4,037 RBTs and 184 to 484 BCBAs to meet the needs of children with autism.

Representatives of the ATAP committed to work with families to ensure a smooth transition from ABA providers not enrolled with Medicaid to Medicaid providers. The ATAP also indicated it will not stop providing services to families currently receiving ATAP funding and will coordinate services with the family's current and new provider to reduce gaps in services.

In addition, parents of children with autism encouraged the LCHC to consider the fact that children with autism become adults with autism. As adults, these individuals still require care and face challenges finding therapy providers due to the workforce shortage and low reimbursement rates.

In an effort to address the immediate and ongoing challenges related to accessing ABA services, and in an effort to increase the ABA workforce, the LCHC agreed to:

- **Send a letter** to the Director of the DHHS conveying the variety of concerns related to accessing services the Committee heard from numerous parents of children with autism, as well as providers of autism services. Include the following concerns:

    1. The reimbursement rate for services provided to adults with autism under the Medicaid Home and Community-Based Services (HCBS) Waiver, especially in rural areas. Specifically mentioned were concerns regarding the residential support services rate for severely impacted adults with autism, the need to authorize day

habilitation services provided in the home at a higher reimbursement rate, and the Medicaid reimbursement rate for BCBAs who provide services to adults on the Medicaid HCBS Waiver to match the reimbursement rate for services provided to children.

2. Concerns expressed regarding ATAP policies and programs include:

   a. Allowing parents to continue to be able to hire their own interventionists with the assistance of a fiscal agent;

   b. Allowing payment to interventionists working under the supervision of a BCBA, without requiring an RBT credential, until such time as there is a sufficient RBT workforce;

   c. Delaying the transfer of Medicaid-eligible children to Medicaid providers for individual children until a Medicaid provider is available to seamlessly accept and treat the child; and

   d. Continuing to ramp up efforts to serve children through Medicaid providers, using their current providers as much as is practicable.

3. Concerns regarding Medicaid policy and programs include:

   a. The need to review the RBT rate;

   b. Exploring with the CMS the possibility of adopting the approach taken by the ATAP to allow payment for services provided by an interventionist under the supervision of a BCBA for up to six months while the interventionist obtains an RBT credential;

   c. Supporting efforts to grow the State's BCBA and BCaBA workforce through the higher education system and encourage the Department of Employment, Training and Rehabilitation to include the BCaBA and RBT in its programs; and

   d. The need to review available programs and reimbursement rates for adults with autism.

- **Propose legislation** to amend subsection 1 of NRS 427A.875 to authorize the ATAP to provide and coordinate services to persons "diagnosed or determined, including, without limitation, through use of a standardized assessment" to have ASD, through 19 years of age; and amend NRS 287.0276, 427A.875, 689A.0435, 689B.0335, 689C.1655, 695C.1717, and 695G.1645 to redefine "autism spectrum disorder" as "a condition that meets the diagnostic criteria published in the current edition of the Diagnostic and

Statistical Manual of Mental Disorders or the edition that was in effect at the time of diagnosis." **(BDR 38–363)**

- **Send a letter** to the Superintendent of Public Instruction urging Nevada's Department of Education (NDE) to develop a clear and consistent State policy, with guidance to school districts, for students with an Individualized Education Program (IEP) who require ABA therapy. In developing the policy, the Department should consider:

  1. Whether an IEP should be required to specify the number of weekly ABA hours needed by the student, with a distinction between the hours to be provided in school and out of school;

  2. Specifying the credentials required of an ABA professional who assists in determining the total weekly ABA hours needed by the student;

  3. Requiring collaboration for ABA services to maximize their effectiveness and to ensure continuity of service across environments;

  4. Requiring schools to support access to ABA by endorsing the following or similar language in the IEP: "The IEP recognizes the student's need to receive medically necessary treatment, which may impact full-time school attendance. An adjusted schedule is supported to allow the student to receive treatment, which may occur in and/or outside of the school environment without incurring truancy";

  5. Requiring the school to encourage a parent, through written communication from the school, to invite the student's outside ABA professional(s) to participate in relevant IEP meetings; and

  6. Allowing a student's out-of-school ABA Professional (i.e., BCBA or licensed psychologist)—who is funded by private insurance, Medicaid, or ATAP and who passes appropriate background checks—to observe the student in the school environment quarterly and/or allowing such a provider to support the student during the school day if the student's behavior impedes learning or if the student's history includes aggression, elopement, or suspension.

H. MEDICAID REIMBURSEMENT RATES

The LCHC heard testimony from numerous entities and individuals at multiple meetings regarding Medicaid reimbursement rates and their influence on health professionals' willingness to enroll in Medicaid and provide services to Medicaid recipients. Testimony provided by various individuals indicated that low reimbursement rates influence provider participation in Medicaid, which directly affects the size of Medicaid's provider network and patient access to care. The DHCFP testified regarding its process for calculating, accessing, and changing reimbursement rates. Rates are calculated using different methodologies based

on language in the Medicaid State Plan. Most FFS rates are based on a percentage of Medicare rates. Significant rate changes are developed during budget planning and rates are reviewed on a five-year rolling basis. If an interim rate adjustment is needed, it can be made only if funding is available within the existing budget. However, the DHCFP also explained reimbursement increases are limited by available funding. As of the LCHC meeting on April 20, 2016, the following proposed rate changes were in process:

- Special care rates for behaviorally complex skilled nursing facility recipients;
- Multiple encounters for federally qualified health center providers;
- Pediatric enhancement for surgical codes (30000–39999);
- Emergency medical response for fire districts;
- Neonatal intensive care unit tiered rates;
- Community paramedicine reimbursements; and
- New residential treatment centers.

The LCHC also heard from numerous provider groups requesting increased Medicaid reimbursement rates, including rates for home health services, long-term services and supports, providers of personal care services, and RBTs. The LCHC agreed to:

- **Send a letter** to the Director of the DHHS expressing the Committee's support for continuing to conduct regular evaluations of Medicaid provider reimbursement rates. Specifically, recommend that the DHHS review reimbursement rates for personal care services; home health services; and providers of community-based, long-term services and supports. Include with the letter the written testimony received related to increasing rates for these specialties.

I. BEHAVIORAL HEALTH

Nearly one in five adults in Nevada (18.5 percent) had a mental illness in 2014, according to the SAMHSA. Of those individuals, more than 4 percent had a serious mental illness, which includes certain mental disorders that result in substantial impairment in carrying out major life activities. The State also faces a severe shortage of behavioral health professionals. All but one of the State's counties are federally designated mental health professional shortage area.

In Nevada, the DPBH is responsible for numerous behavioral health programs, including the oversight and operation of State-funded, community-based inpatient, outpatient, and forensic mental health programs and services. The State serves approximately 26,000 individuals each

year—including adults in urban areas and both adults and children in rural areas of the State—through the following programs:

- Psychiatric inpatient hospitals—Rawson-Neal Psychiatric Hospital and Dini-Townsend Psychiatric Hospital;
- Urban outpatient clinics—3 in Clark County and 1 in Washoe County;
- Rural outpatient clinics—18 in all rural counties; and
- Forensic inpatient hospitals—Lake's Crossing Center and Stein Hospital.

Prior to the 2010 federal ACA, the State provided most mental health care for the severely mentally ill in Nevada. Following implementation of the ACA, the number of insured individuals increased and so too did demand for services, as well as the complexity and acuity of needs. Because more individuals now have insurance, demand for services provided by the State at Northern Nevada Adult Mental Health Services and Southern Nevada Adult Mental Health Services has decreased as patients seek services from private providers in the community. The LCHC heard testimony regarding the DPBH's challenges and efforts to better integrate care, fill gaps in residential support services, and coordinate care for individuals with behavioral health disorders who need higher levels of care.

The LCHC also heard testimony regarding mental and behavioral health challenges, needs, and programs throughout the State. The behavioral health workforce shortage presents a serious challenge for individuals across the State. It is especially acute in rural counties—many of which do not have any behavioral health care providers. Individuals with mental illness in rural Nevada often end up in jail or in a rural hospital's small emergency department. In addition, while shortages exist across behavioral health professions, accessing psychiatric care and specialty psychiatry is especially difficult, for forensic patients, patients with co-occurring disorders, and those dually diagnosed with intellectual and developmental disabilities.

Recently, the DPBH funded three behavioral coordinators to coordinate behavioral health care in Clark County, Washoe County, and in the rural area encompassing Carson City, and Churchill, Douglas, and Lyon Counties. Though their specific scopes of work vary, behavioral health coordinators work to create partnerships and structures through which to collaborate to effectively address regional behavioral health needs. They engage stakeholders from otherwise siloed fields, such as courts, emergency medical services, health care, housing, law enforcement, and mental health to address the chronic "spin cycle" many individuals with mental illness experience—moving through the community, county jails, hospital emergency departments, and psychiatric inpatient hospitals without receiving the care they need. Diverting individuals with behavioral health issues from jail and connecting them with treatment in the community can help improve their lives and save taxpayer dollars.

Numerous programs are being implemented across the State to address these issues—some with help of the behavioral health coordinators. A few of these include:

- Assisted outpatient treatment—mandatory, court-ordered outpatient/community treatment, services, and supports;

- Crisis intervention training (CIT)—mental health training for first responders;

- Crossroads—supportive living and wraparound social services for individuals transitioning out of homelessness;

- Forensic Assessment Services Triage Teams (FASTT)—jail reentry case management services;

- Mental Health Court—specialty court for individuals with mental illness; and

- Mobile Outreach Safety Teams (MOST)—teams of law enforcement officers and behavioral health providers who respond to calls together.

Testifiers urged the LCHC to support 24/7 crisis centers to help divert individuals with mental health disorders from hospital emergency departments and jail.

In response to information provided and in an effort to address the ongoing challenges of individuals with mental and behavioral health disorders, the LCHC agreed to:

- **Send a letter** to the Directors of the Department of Public Safety and DHHS and to the heads of local law enforcement expressing the Committee's support for the development of a statewide behavioral health education/training requirement for law enforcement officers.

- **Send a letter** to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the Director of the DHHS expressing the LCHC's support for mental health and other specialty courts, including:

    1. Encouragement and support for the development of additional residential substance abuse treatment beds and the establishment of treatment beds for people diagnosed with co-occurring disorders, as there are currently no such beds in the State;

    2. The Committee's continued support for providing funding for drug testing, housing, and transportation for specialty court participants; and

    3. Mention of the potential of public-private partnerships to assist in providing such funding.

- **Send a letter** to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the Director of the DHHS expressing the LCHC's support for the:

    1. Expansion of crisis intervention and jail diversion programs such as FASTT, MOST, and CIT; and

    2. Development of crisis stabilization centers in the State, where people experiencing a crisis related to a mental health condition can access services 24/7. This type of center can provide timely de-escalation, early intervention, and patient stabilization to prevent the need for higher levels—and more costly—care.

J. HEALTH PROFESSION LICENSING BOARDS

In Nevada, 20 boards license and regulate health professionals. Although each board's powers and duties are slightly different, they are generally responsible for developing and enforcing standards and regulations, establishing licensure requirements, granting and renewing licenses, investigating complaints, processing applications, and taking disciplinary action.

Health profession licensing boards serve as the gateway between the pool of potential health care providers and the pool of licensed health care professionals available to serve Nevadans. They are in a position to facilitate the licensure application process while ensuring adherence to standards and regulations and protecting patient safety.

Throughout the 2015–2016 Interim, the LCHC heard concerns from numerous individuals and groups regarding health profession licensing boards. Testimony cited concerns over the amount of time between application submission and license issuance, lack of clarity and transparency regarding licensure requirements, poor communication between boards and applicants or licensees, and questionable investigation processes, among others. The LCHC also heard testimony from numerous boards.

Each board is an independent body. Members are appointed by the Governor, but neither the Executive Branch nor the Legislative Branch has direct regulatory or administrative oversight of the boards. In addition, in many cases, the only recourse applicants and licensees have to appeal adverse decisions by a board is to go to a hearing of the full board or file a lawsuit in court. For some applicants or licensees, the cost of such action is prohibitive.

In response to testimony provided throughout the interim, the LCHC agreed to:

- **Send a letter** to the Interim Finance Committee; the Sunset Subcommittee of the Legislative Commission; the Senate Committee on Commerce, Labor and Energy; the Assembly Committee on Commerce and Labor; and the Governor expressing the LCHC's concern regarding the lack of oversight of health profession licensing and licensing boards and its support for statutory changes necessary to provide such oversight. Specifically, express the Committee's concern regarding the:

1. Numerous complaints the Committee received related to various health care profession licensing boards;

2. General lack of oversight of health profession licensing boards and the need for accountability;

3. Investigation and appeals processes used by certain boards and the need for oversight over certain board decisions;

4. Lack of transparency with regard to licensure data, the inability of some boards to provide requested data, and the need to increase data reporting requirements;

5. Need for increased transparency and oversight of the finances of health profession licensing boards and for comprehensive, detailed reporting requirements to improve fiscal accountability;

6. Application and licensure inefficiencies and extended application timelines due to the systems used by certain boards;

7. Performance audit of the Board of Dental Examiners of Nevada by the Legislative Auditor and the refusal of the Board to accept 3 of the 14 recommendations made by the audit; and

8. Direct impact boards have on the health care workforce and their ability to exacerbate or improve the workforce shortage, as exemplified by the challenges the Governor's Social Workers in Schools Program faced recruiting social workers and other qualified behavioral health providers in 2016.

Concerns that applicants and licensees raised during testimony is exemplified in the challenge schools faced in recruiting behavioral health care providers for the Social Workers in Schools Program, which the LCHC heard on multiple occasions. In 2015, the Legislature approved $5.6 million and $11.2 million in FY 2016 and FY 2017, respectively, for this new program within NDE to provide contract funding to school districts and charter schools for social workers or other licensed mental health workers in schools. The program operates as a block grant to local school districts based on needs identified through a health screening survey.

In FY 2016, 161 behavioral health care provider positions were awarded based on school need. Due to the shortage in behavioral health care providers, however, recruiting providers proved challenging. A total of 153 providers were ultimately contracted or hired by 84 schools representing 12 school districts. According to testimony provided by the Office for a Safe and Respectful Learning Environment, NDE, barriers to recruiting highly qualified behavioral health care providers included:

- Differing licensure process expectations and time lines for similar behavioral health professionals;

- Prohibition or lack of clarity on use of telehealth to provide supervision for required clinical hours for licensure and lack of qualified mental health providers in rural and frontier Nevada to provide in-person supervision;

- Lack of clarity regarding requirements for clinical internship sites and prevalence of case-by-case decisions to approve clinical internship sites;

- Differing definitions across behavioral health licensing boards regarding reciprocal licenses; and

- Lack of board oversight and lack of a process for licensed behavioral health professionals to file complaints against or appeal board decisions.

In an effort to increase the number of behavioral health care providers in Nevada, streamline behavioral health profession licensing, and address some of the issues raised during testimony, the LCHC agreed to:

- **Propose legislation** to:

    1. Consolidate, under the State Board of Health (BOH) within the DHHS, the behavioral health boards established in:

        a. Chapter 641 ("Psychologists, Behavior Analysts, Assistant Behavior Analysts and Autism Behavior Interventionists") of NRS;

        b. Chapter 641A ("Marriage and Family Therapists and Clinical Professional Counselors") of NRS;

        c. Chapter 641B ("Social Workers") of NRS; and

        d. Chapter 641C ("Alcohol, Drug and Gambling Counselors") of NRS.

    2. Amend NRS 439.030, which establishes the BOH, to add four additional members to the Board appointed by the Governor, including:

        a. One member who is a psychologist or a BCBA;

        b. One member who is a marriage and family therapist or a clinical professional counselor;

        c. One member who is a social worker; and

d. One member who is an alcohol, drug, and gambling counselor and who has engaged in the practice of his or her specific profession in this State for not less than five years immediately prior to the appointment.

3. Require the Bureau of Health Care Quality and Compliance (HCQC), DPBH, DHHS, to assume responsibility for administration of licensure, investigations, and complaint resolution for all mental health professionals currently licensed in Chapters 641, 641A, 641B, and 641C of NRS.

4. Establish, under the BOH, four profession-specific subcommittees through which each professional area licensed under Chapters 641 through 641C of NRS will make recommendations to the Board regarding licensure requirements, standards of practice, and regulations, as follows:

   a. One subcommittee will be established for each of the existing NRS behavioral health profession chapters (641, 641A, 641B, and 641C).

   b. Each subcommittee will consist of three members who have been residents of this State for at least one year before appointment. If qualified, a subcommittee member may serve on more than one subcommittee: Subcommittees are comprised of:

      i. One member who is a member of the BOH;

      ii. At least one member, but not more than two, who is licensed in the professional area he or she regulates and has five years of experience in the applicable profession; and

      iii. At least one member, but not more than two, who has served within the previous ten years as core or full-time faculty at a regionally accredited college or university in a program related to the applicable profession and has experience in the design and development of the curriculum of a related program.

   c. Subcommittee members are initially appointed by the BOH. After initial appointment, the Governor shall appoint subcommittee members. A member first appointed by the Board shall continue to serve until appointed or replaced by the Governor. Initially, members will serve staggered terms.

   d. After the initial term, subcommittee members serve at the pleasure of the Governor for terms of three years. A member shall not serve more than two full consecutive terms.

e. Each member of a subcommittee is entitled to receive:

   i. A salary of not more than $80 per day, as fixed by the BOH, while engaged in and necessarily spent in performance of his or her subcommittee duties; and

   ii. A per diem allowance and travel expenses at a rate fixed by the BOH, while engaged in the business of the subcommittee. The rate must not exceed the rate provided for State officers and employees generally.

f. Each subcommittee shall annually elect a chair and secretary from its membership.

g. Subcommittee members are personally immune from suit with respect to all acts done and actions taken in good faith and in furtherance of the purposes of this bill.

h. Subcommittee members shall receive at least five hours of training as prescribed by the BOH within one year after the member is initially appointed. Training must include instruction on ethics and open meeting requirements.

5. Require the BOH to review each subcommittee's regulations before being submitted to the Legislative Commission for final approval to ensure that the regulations are in the best interest of the public and do not unnecessarily restrict individuals from entering or practicing the profession.

6. Establish that the HCQC shall be responsible for disciplining licensees, as follows:

   a. The HCQC may establish in regulation peer review panels to evaluate complaints against similarly licensed behavioral health professionals;

   b. The BOH may authorize continuing education credits to qualified behavioral health professionals who choose to serve on such peer review panels;

   c. The HCQC will conduct an investigation of a complaint against a behavioral health professional with the assistance of a peer review panel, if the HCQC decides to establish such panels;

   d. The results of an investigation of a complaint will be submitted to the appropriate subcommittee;

   e. Based on the results of an investigation, each subcommittee shall recommend appropriate disciplinary action to the HCQC, if the recommendation is not license revocation. Recommendations of license revocation shall be submitted to the BOH; and

f. The HCQC or the BOH, as applicable, will review recommendations for disciplinary action and discipline licensees.

7. Redirect board fees and funds generated through licensure and other funding streams from boards established pursuant to Chapters 641, 641A, 641B, and 641C of NRS to the DPBH to support the activities of licensure administration, investigation, and regulatory oversight for behavioral health professionals.

8. Require the BOH to make necessary regulatory changes to existing regulation in Chapters 641 ("Psychologists, Licensed Behavior Analysts, Licensed Assistant Behavior Analysts and Certified Autism Behavior Interventionists"), 641A, 641B, and 641C of *Nevada Administrative Code*, and develop new regulations to comply with these legislative changes.

9. Establish that any regulations adopted by boards established pursuant to Chapters 641, 641A, 641B, and 641C of NRS, which do not conflict with the provisions outlined above, remain in effect and may be enforced by the appropriate board until the BOH adopts regulations to repeal or replace those regulations. Any regulations adopted by the above boards that conflict with these provisions are void.

10. Require the DHHS to develop a plan for transitioning from the existing licensing board structure to the new behavioral health profession licensing structure within the BOH so that licensees and the public can follow and participate in the transition process. The plan must be presented at a meeting in compliance with the Open Meeting Law (OML) and adopted at a second meeting in compliance with the OML. Provisions of Chapter 233B ("Nevada Administrative Procedure Act") of NRS do not apply to this transition plan.

11. Contracts and agreements, disciplinary and administrative actions, and licenses issued by such boards remain in effect as if taken by the officer or entity to which the responsibility for the enforcement of such action has been transferred. **(BDR 54–410)**

K. AMBULATORY SURGICAL CENTERS

A "surgical center for ambulatory patients" is defined in Chapter 449 ("Medical Facilities and Other Related Entities") of NRS as a "facility with limited medical services available for diagnosis or treatment of patients by surgery where the patients' recovery, in the opinion of the surgeon, will not require care as a patient in the facility for more than 24 hours." The Nevada Hospital Association (NHA) urged the LCHC to revise statute related to such ambulatory surgical centers to ensure patient safety. Chair Oscarson informed the LCHC that the NHA and the Nevada Ambulatory Surgery Center Association (NASCA) were working collaboratively to address these concerns and develop statutory changes amenable to both organizations.

Following deliberations on this issue, the Committee agreed to propose initial legislation to be amended during the 2017 Legislative Session with language developed jointly by the NHA and NASCA. The Committee agreed to:

- **Propose legislation** to:

    1. Amend Chapter 449 of NRS to prohibit an ambulatory surgical center from performing surgical services that routinely result in admission to another licensed medical facility within 24 hours after discharge from the surgical center;

    2. Amend NRS 439A.250 to require the DHHS to impose a penalty on surgical centers for ambulatory patients, pursuant to NRS 439A.310, after sending two notices indicating that the center failed to submit the required information or the information was incomplete or inaccurate; and

    3. Amend subsection 2 of NRS 439A.280 to exempt NRS 439A.240 and 439A.250 from the programs and duties for which the DHHS can temporarily suspend if it determines sufficient funds are not available. **(BDR 40–364)**

IV. CONCLUSION

This report presents a summary of the bill drafts requested by LCHC members for discussion before the 2017 Nevada Legislature. In addition, this document provides information on various issues the Committee addressed during the 2015–2016 Interim. Persons wishing to have more specific information concerning these issues may find it useful to review the "Summary Minutes and Action Report" and related exhibits at: https://www.leg.state.nv.us/App/InterimCommittee/REL/Interim2015/Committee/252/Overview

V. APPENDICES

Page

APPENDIX A

Nevada Revised Statutes 439B.200

NRS 439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.

1. There is hereby established a Legislative Committee on Health Care consisting of three members of the Senate and three members of the Assembly, appointed by the Legislative Commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.
2. No member of the Committee may:
   (a) Have a financial interest in a health facility in this State;
   (b) Be a member of a board of directors or trustees of a health facility in this State;
   (c) Hold a position with a health facility in this State in which the Legislator exercises control over any policies established for the health facility; or
   (d) Receive a salary or other compensation from a health facility in this State.
3. The provisions of subsection 2 do not:
   (a) Prohibit a member of the Committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.
   (b) Prohibit a member of the Legislature from serving as a member of the Committee if:
      (1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and
      (2) Serving on the Committee would not materially affect any financial interest the member has in a health facility in a manner greater than that accruing to any other person who has a similar interest.
4. The Legislative Commission shall review and approve the budget and work program for the Committee and any changes to the budget or work program. The Legislative Commission shall select the Chair and Vice Chair of the Committee from among the members of the Committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The office of the Chair of the Committee must alternate each biennium between the houses of the Legislature.
5. Any member of the Committee who does not become a candidate for reelection or who is defeated for reelection continues to serve after the general election until the next regular or special session of the Legislature convenes.
6. Vacancies on the Committee must be filled in the same manner as original appointments.
7. The Committee shall report annually to the Legislative Commission concerning its activities and any recommendations.

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333; 1993, 2590; 2009, 1154, 1568)

APPENDIX B

Status of Bill Draft Requests From the 2013–2014 Interim

APPENDIX B

STATUS OF BILL DRAFT REQUESTS FROM THE 2013–2014 INTERIM

BDR	Summary	Bill	Status
13–504	Amends provisions concerning estates under guardianship.	A.B. 9	Pursuant to Joint Standing Rule No. 14.3.1, no further action allowed
54–62	Revises provisions governing licensing and practice of certain medical professionals.	–	Not Introduced
40–63	Revises provisions relating to the delivery of health care.	S.B. 6	Chapter 308, *Statutes of Nevada 2015*
39–64	Revises provisions governing the admission of persons with certain mental conditions to and the release of such persons from certain facilities and programs.	S.B. 7	Chapter 496, *Statutes of Nevada 2015*
57–65	Requires certain insurers to contract with any qualified provider of health care in certain circumstances.	A.B. 230	Pursuant to Joint Standing Rule No. 14.3.1, no further action allowed
40–66	Revises and expands provisions relating to obtaining, providing and administering auto-injectable epinephrine in certain circumstances.	A.B. 158	Chapter 127, *Statutes of Nevada 2015*
54–67	Revises provisions relating to autism spectrum disorders.	A.B. 6	Chapter 156, *Statutes of Nevada 2015*
14–68	Revises provisions relating to incompetent defendants.	S.B. 10	Pursuant to Joint Standing Rule No. 14.3.3, no further action allowed

APPENDIX C

Letters Approved by the Committee

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

COMMITTEES:
Chair
Health and Human Services
Member
Natural Resources, Agriculture, and Mining
Ways and Means

State of Nevada Assembly

Seventy-Eighth Session

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November 15, 2016

The Honorable Brian Sandoval
Governor of Nevada
101 North Carson Street, Suite 1
Carson City, Nevada 89701-4786

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

Dear Governor Sandoval and Director Whitley:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter expressing support for Bill Draft Request (BDR) 54-182, which would adopt the Nurse Licensure Compact.

The Committee heard testimony from various experts on the severe shortage of health care providers in Nevada. While the State has seen an increase in health care professionals, it has not kept pace with increasing demand. Nevada currently ranks 51st in the number of active licensed registered nurses and nurse practitioners per 100,000 population, compared to other states and the District of Columbia. In 2014, 762 registered nurses per 100,000 population were registered in Nevada, compared to the national average of 943 nurses per 100,000.

The Committee also received information regarding policies that aim to increase licensure reciprocity and improve workforce development by making it easier for licensed health care professionals to obtain a license to practice in Nevada. The Committee was encouraged to support interstate compacts, which rely on standard licensure requirements and help streamline licensure across states. Specifically, Nevada's State Board of Nursing recommended adopting the recently revised Nurse Licensure Compact, as established by the National Council on State Boards of Nursing. A total of 25 states have enacted the Nurse Licensure Compact.

Given that this interstate compact has the potential to increase the much needed health care workforce and to help ensure all Nevadans have access to qualified health care professionals, the Committee unanimously agreed to support BDR 54-182, which would adopt the Nurse Licensure Compact.

Thank you for considering this very important issue. If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170019

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

COMMITTEES:
Chair
Health and Human Services
Member
Natural Resources, Agriculture, and Mining
Ways and Means

State of Nevada Assembly

Seventy-Eighth Session

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November 14, 2016

This is an example of the letter sent to 313-licensed primary care, dental, and mental health care providers in Nevada regarding participation in the National Health Service Corps.

Practice Manager
Valley Pediatric and Specialty Center
3100 W Charleston Blvd, Suite 210
Las Vegas, NV 89102-1900

Dear Practice Manager:

On behalf of the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200), I write to strongly encourage you to apply to and participate in the National Health Service Corps (NHSC), a federal program available to help recruit and retain licensed primary care, dental, and mental health care providers.

The NHSC program allows providers at approved NHSC sites to competitively apply for up to $50,000 of tax-free loan repayment in return for two years of work at approved sites. This loan repayment is in addition to the salary of the provider and is a great incentive for both recruitment and retention.

As you are probably aware, Nevada continues to face a severe shortage of health care providers. Compared to other states, Nevada has some of the lowest provider-to-population ratios in the nation, ranking 48th in physician-to-population ratio, 51st in nurse-to-population ratio, 47th in psychologist-to-population ratio, and 34th in dentist-to-population ratio, according to the University of Nevada, Reno, School of Medicine. In addition, approximately one in three Nevadans lives in a federally designated primary care health professional shortage area (HPSA); slightly less than one in three Nevadans lives in dental HPSAs, and more than one in two Nevadans live in a mental HPSA—including all residents of rural and frontier Nevada.

Due to this dire shortage of health care providers and because your site serves a substantial Medicaid population, the Committee voted unanimously to strongly encourage you to participate in the NHSC program.

Eligible primary care, dental, and mental health care providers include the following:

- Certified Nurse Midwife
- Doctor of Dental Medicine
- Doctor of Dental Surgery
- Doctor of Osteopathy
- Health Service Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Marriage and Family Therapist
- Medical Doctor
- Nurse Practitioner
- Physician Assistant
- Psychiatric Nurse Specialist
- Registered Dental Hygienist

More information about this program is available at: http://www.nhsc.hrsa.gov/ loanrepayment/ loanrepaymentprogram.html.

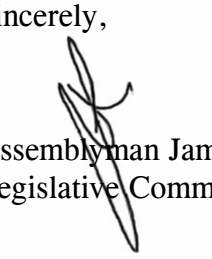
For your site to be approved, you must submit an application during the new site application cycle, which usually is open March through April. You can sign up for notifications at http://www.nhsc.hrsa.gov/emailsignup.html. To be eligible to apply a site must:

- Be located in a Health Professional Shortage Area that matches your provider's discipline. Find out if your address is in a HPSA by using the following online tool: https://datawarehouse.hrsa.gov/tools/ analyzers/geo/ShortageArea.aspx.
- Provide comprehensive primary care medical, dental, or mental and behavioral health services.
- Provide services regardless of a patient's ability to pay and offer a sliding discount fee schedule to those patients who qualify.
- Accept patients covered by Medicare, Medicaid, and Children's Health Insurance Program.

If you would like to become an approved site, please carefully review complete details about the site approval process at http://www.nhsc.hrsa.gov/sites/becomenhscapprovedsite /index.html. To speak directly with a State of Nevada employee who can answer questions regarding the NHSC, contact Scott Jones of the Nevada Primary Care Office at (775)-684-4047 or scottjones@health.nv.gov.

Thank you for providing much needed health care to the people of Nevada and for considering this opportunity. Please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlosssy@lcb.state.nv.us or (775) 684-6825.

Sincerely,



Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W163738

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

COMMITTEES:
Chair
Health and Human Services
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November 15, 2016

The Honorable Brian Sandoval
Governor of Nevada
101 North Carson Street, Suite 1
Carson City, Nevada 89701-4786

Dear Governor Sandoval:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter to express support for and urge continuation of a $5.25 million annual budget appropriation for graduate medical education in each year of the 2017–2019 Biennium.

The Committee heard testimony at multiple meetings related to the importance of graduate medical education in improving the health care workforce in Nevada. Currently, more students graduate from medical school in Nevada than in-State residency training slots can accommodate—making Nevada a net exporter of medical school graduates. Enabling medical school graduates to finish their training in Nevada is critical to improving the workforce. Data show that 68 percent of residents choose to live and practice where they complete medical school and residency training.

Continuing to appropriate funding to expand graduate medical education will help fund additional training slots in both new and existing medical school programs. As new medical schools open, and in an effort to address the shortage of health care providers, it is important to ensure that sufficient in-State training opportunities are available.

Thank you very much for considering this recommendation. If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170031

JAMES OSCARSON
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November 15, 2016

The Honorable Mark Amodei
222 Cannon House Office Building
United States House of Representatives
Washington, D.C. 20515-0001

Dear Representative Amodei:

During the 2015-2016 Legislative Interim, I served as chair of Nevada's Legislative Committee on Health Care (LCHC). As a result of hearings concerning Nevada's severe shortage of health care professionals and the effect this shortage has on patient access to care, the LCHC seeks the assistance of Nevada's Congressional Delegation. Specifically, the LCHC requests your assistance with increasing in-State graduate medical education (GME) opportunities.

Currently, more students graduate from medical school in Nevada than in-State residency training slots can accommodate—making Nevada a net exporter of medical school graduates. Enabling medical school graduates to finish their training in Nevada is critical to improving the workforce. Data show that 68 percent of residents live and practice where they complete medical school and residency training.

At the State level, we have taken steps to address this problem by increasing GME funding. In 2015, Governor Sandoval recommended and the Legislature approved a $5.25 million annual budget appropriation for GME in each year of the 2015-2017 Biennium. The LCHC is encouraging continuation of such funding for the 2017-2019 Biennium. Continuing to appropriate funding to expand graduate medical education will help fund additional training slots in both new and existing medical school programs. As new medical schools open in Nevada, it is more important than ever to ensure that sufficient in-State training opportunities are available.

To improve the much needed health care workforce in Nevada and to increase the number of Nevada-trained medical professionals who remain in and practice in the Silver State, the LCHC requests your assistance in ensuring that:

- No additional cuts are made to graduate medical education funding in Nevada; and
- Full-time equivalent GME slots are redistributed to Nevada hospitals.

Thank you for your partnership in improving the health care workforce in Nevada.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170032

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

COMMITTEES:
Chair
Health and Human Services
Member
Natural Resources, Agriculture, and Mining
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November 15, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

Marta Jensen, Acting Administrator
Division of Health Care Financing and Policy
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

Dear Director Whitley and Acting Administrator Jensen:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter encouraging consideration of the Division of Health Care Financing and Policy's (DHCFP) relationship with Medicaid managed care organizations (MCOs) and requesting that DHCFP clarify the following in future managed care requests for proposals and contracts:

- The State has the authority to oversee the performance of MCOs and must ensure that specific performance criteria are included in the MCO contract and measured at least monthly. The results of performance criteria must be transparent and shared publically, including on the DHCFP's website.

- The MCOs must administer their provider contracts in accordance with Medicaid policies unless mutually agreed upon otherwise and documented by the State and providers.

- Contracts between the State and MCOs must require each MCO to independently meet network adequacy standards, comparable to those established annually by Nevada's Division of Insurance, through direct contracting with providers and hospitals.

- The State is responsible for final policy/claims appeal if an MCO and a provider cannot reach an agreement.

- Geographic expansion of Medicaid managed care into the rural areas of Nevada will not occur until rural communities are ready.

The Committee heard from numerous individuals and entities concerned about the possible expansion of Medicaid managed care, as well as the performance of managed care organizations to date. Thank you for considering DHCFP's relationship with managed care organizations, recommendations for future contracts, and for taking steps to ensure all Medicaid recipients in Nevada have appropriate access to care.

If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170033

JAMES OSCARSON
ASSEMBLYMAN
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November 15, 2016

The Honorable Brian Sandoval
Governor of Nevada
101 North Carson Street, Suite 1
Carson City, Nevada 89701-4786

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

Dear Governor Sandoval and Director Whitley:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter urging consideration of the concerns and recommendations regarding Medicaid managed care expansion expressed by the National Alliance on Mental Illness, Nevada, in its June 16, 2016, letter to the Committee. This letter was endorsed by AARP Nevada, the Commission on the Services for People with Disabilities, Opportunity Village, and Washoe Legal Services.

Throughout the interim, the Committee heard concerns from numerous individuals and organizations regarding the possible expansion of Medicaid managed care to additional populations and geographic areas. Testifiers urged caution in transitioning vulnerable populations, such as individuals with severe intellectual disabilities and the aged, blind, and disabled, into managed care plans.

Among other things, the attached letter recommends:

- Considering the performance of Medicaid managed care plans to date—especially for the vulnerable populations already enrolled in managed care—prior to expanding to additional vulnerable populations; and

- Evaluating the adequacy of reimbursement rates for new managed care services for vulnerable populations and the effect of low reimbursement rates on provider networks and access to care.

The Committee also heard testimony from the Division of Health Care Financing and Policy, Department of Health and Human Services, regarding the Division's efforts to solicit feedback regarding possible Medicaid managed care expansion. I appreciate the Division taking the time to ensure that the needs of all Medicaid recipients, including the most vulnerable, have access to appropriate, high quality care.

Thank you for considering the concerns and recommendations in the attached letter. If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170034

NAMI Nevada
National Alliance on Mental Illness

June 16, 2016

Sen. Joe Hardy, M.D., Chairman
Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs
401 S. Carson Street, Room 3132
Carson City, Nevada 89701-4747

Assemblyman James Oscarson, Chairman
Legislative Committee on Health Care
401 S. Carson Street, Room 3132
Carson City, Nevada 89701-4747

Dear Chairs Hardy and Oscarson:

Each of your committees received presentations on the possible expansion of the Medicaid managed care program. A number of organizations, either during the presentations or in public comment, asked that the State take caution and care in transitioning some of Nevada's most vulnerable populations into managed care plans. Only behalf of the National Alliance of Mental Illness (NAMI) Nevada, I will summarize some of the most common concerns and make specific recommendations for each of your committees. It is my understanding that a number of other organizations will soon join in support of these recommendations.

BACKGROUND

Nevada Medicaid already requires low income families with children plus childless adults in Clark and Washoe counties who qualify for Medicaid because they reside in households whose income is below 138% of the federal poverty level to enroll in one of two managed care organizations. Others, including rural Nevadans, who qualify for Medicaid because they are aged, blind or disabled recipients of Supplemental Security Income (SSI), children in foster care, nursing home residents, "Katie Beckett" children living at home and persons receiving services through Medicaid waivers receive their care through fee for service. Moreover, Medicaid recipients of certain types of services such as hospice, targeted case management, adult day health care, long-term care and residential treatment centers are not enrolled in managed care.

Section 37 of SB 514 (2015) bill allows the Department of Health and Human Services to transition certain additional populations into managed care with the approval of the Interim Finance Committee (IFC). The Department has also conducted a number of Town Hall listening sessions to hear concerns from the public and those affected by this change.

On June 7, the Board of Examiners awarded a $400,000 contract to Navigant Consulting to make recommendations to the Department to improve oversight of Medicaid Managed Care Organizations (MCOs) and program financing. The scope of work also includes

NAMI Nevada • % Community Health Alliance, 680 S. Rock Blvd. • Reno, NV 89502
(775) 336-3090 • e-mail: info@naminevada.org
Web site: www.naminevada.org

recommendations for expanding Medicaid geographically and for populations beyond those receiving long-term services and supports.

HOW HAS MEDICAID MANAGED CARE PERFORMED IN NEVADA TO DATE?

Nevada is considering adding new vulnerable populations into Medicaid managed care without first analyzing the impact on the vulnerable populations already enrolled. Some of these vulnerable populations already enrolled in Medicaid managed care include the following:

Adults and youth with behavioral health needs. Prior to Medicaid expansion effective January 1, 2014, adults who had mental health needs received services primarily from Nevada's state-funded mental health programs. Now many of these individuals who qualify for Medicaid receive their behavioral health services through Medicaid for the first time in Clark and Washoe counties through the Medicaid MCOs. How have the MCOs performed when absorbing this new population?

- Is there an adequate provider network? What are the waiting times for services?
- Do individuals living with mental illness receive the type of case management they require?
- What has been the impact on hospitalization or incarceration rates of these individuals under the new system?

Children with developmental delays. How have the MCOs treated children with developmental delays needing occupational and speech therapy? Have providers been able to obtain timely approvals from Medicaid HMOs for medically necessary services?

Children with autism. A third, non-rural population has just been added to the responsibilities of the HMOs. Beginning January 1, 2016, children with autism have been able to receive Applied Behavioral Analysis (ABA) services through Medicaid. How have the HMOs adapted to serving this new population?

WHAT WOULD BE THE IMPACT OF MANAGED CARE ON A PROGRAM WHICH PAYS INADEQUATE RATES?

Many of the current rates for long-term services and supports were built upon rates established by a rate commission in 2002. As you know, many of these rates are now out of date.

- Will the MCOs be able to engage adequate providers?
- Will the MCOs be able to pay the same or higher rates utilizing their capitated funds?
- What are the impacts of narrow networks on access to services (In order to manage costs, MCOs sometimes reduce rates in exchange for patient volume? This often results in narrow provider networks with limited numbers of providers and larger patient volumes.)

WHAT ARE THE EXPERIENCES IN OTHER STATES WITH ADDING THESE VULNERABLE POPULATIONS TO MANAGED-CARE?

Each vulnerable population has been covered for some period of time through managed care in some other states. It is important that Navigant Consulting analyze what results are available from other states: vulnerable population by vulnerable population. For example, Kansas was the

first state to place its developmentally delayed adults into managed care on January 1, 2014[1]. Only a small handful of states have joined.

At least one state has rejected managed care for Medicaid and returned to a modified fee-for-service system. As a March 18, 2016 article[2] in the *Wall Street Journal* relates, since Connecticut made the switch to "managed fee for service"[3] in 2012, average cost per patient per month is down (from $718 to $670), doctor participation is up (by 7%) and administrative costs are down (from 12% to 5%).

The State needs to closely examine the experience of these vulnerable clients in states that have implemented MTLSS. Again, a series of important questions need to be asked:

- What was the impact of including these populations in managed care?
- Have these states required that providers offer more innovative models focused on independence, self-direction and a person centered approaches?

COMPLIANCE WITH LEGAL MANDATES

Delivery of services to persons with disabilities trigger legal mandates not present with the general Medicaid population. For example, the U.S. Supreme Court decision in Olmstead v. LC, 527 U.S. 581 (1999) held that states have the responsibility to provide services where possible in the least restrictive setting. States not in compliance are subject to investigation and corrective action by the Office of Civil Rights. Contracting with a private entity doesn't relieve the state of these legal obligations which also include:

- New CMS "person centered planning" requirements and federal home and community-based services regulations.[4] DHCFP has already expended a great deal of effort in preparing for these new rules.[5]
- Mental Health Parity and Addictions Equity Act (MHPAEA)[6]
- ACA Sec. 1557 non-discrimination rules [7]

Services to people with disabilities have been examined for innovative service delivery methods, some of which have been adopted by or are in the process of study by the state. Included have been host homes, micro-boards and Independent Service Organizations (ISOs). These models are also favored under Olmstead.

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[1] *Washington Post*, November 27, 2013 https://www.washingtonpost.com/national/health-science/in-kansas-medicaid-managed-care-system-to-take-over-developmental-disability-services/2013/11/27/6bfc6a50-56f1-11e3-835d-e7173847c7cc_story.html

[2] http://www.wsj.com/articles/connecticut-moves-away-from-private-insurers-to-administer-medicaid-program-1458325696

[3] A nonprofit administrator processes medical claims, but the state carries the financial risk

[4] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

[5] http://dhcfp.nv.gov/Home/WhatsNew/HCBS/

[6] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/medicaid-fact-sheet-parity.pdf

[7] http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

RECOMMENDATIONS

Foremost, we strongly urge the State to move cautiously and extend its evaluation beyond the fiscal impact of expanding Medicaid managed care to vulnerable populations. We recommend the following:

1. Before extending the managed-care experiment to additional and more vulnerable populations we should first evaluate the success of Nevada managed care over the last six years. We should look especially closely at the handling of disabled/vulnerable populations currently enrolled in Medicaid MCOs, particularly individuals enrolled since the 2014 Medicaid expansion.
2. The State evaluation vendor conduct very specialized focus groups with those in Nevada who would be affected by a shift to managed care on a population by population basis.
3. The State should evaluate the adequacy of current LTSS reimbursement rates before moving waiver clients to managed care. If rates are found to be inadequate to assure adequate access to care, rates should be raised before moving this population to Medicaid managed care. This will provide a more appropriate cost base in order to establish appropriate premiums paid to Medicaid MCOs.
4. The State should conduct a comprehensive access study on par with that required under new rules for the Medicaid fee-for-service program.
5. The State should evaluate the experience of similar Medicaid managed care expansions in other states. The evaluation should include "managed fee-for-service" or hybrid delivery systems like the program in place in Connecticut. The State also should consider voluntary Medicaid managed care enrollment for vulnerable populations as an option prior to mandatory enrollment in Medicaid managed care.
6. Before considering additional populations and communities, particularly rural communities, in Medicaid managed care, the State should conduct focus groups, town hall meetings and listening sessions to hear the needs and concerns of those affected on a population by population basis. Each has unique needs and concerns that should be addressed before moving them to managed care.
7. The State needs to determine whether current Medicaid fee-for-service and managed care programs are in compliance with legal mandates including its obligations under Olmstead, CMS person-centered planning rules, the MHPAEA, and the ACA non-discrimination rules.
8. The State should assure all LTSS waiver wait-lists are eliminated before transitioning these clients to Medicaid managed care.

It is critical that the results of these studies and analyses be made public and include an opportunity for public comment

Sincerely,

Sandra K. Stamates
NAMI Nevada, President

Charles Duarte
NAMI Nevada, Policy Chair

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

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VIA ELECTRONIC MAIL

December 23, 2016

This is an example of 11 letters sent to Graduate Medical Education entities in Nevada expressing the Health Care Committee's awareness of and concern for the population of Nevadans who are at risk for and affected by rare diseases.

Mason VanHouweling
Chief Executive Officer
University Medical Center
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

Dear Mr. VanHouweling:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter expressing the Committee's awareness of, and concern for, the population of Nevadans who are at risk for and affected by rare diseases such as Postural Orthostatic Tachycardia Syndrome, Ehlers-Danlos syndrome, and numerous others.

Nationwide, an estimated 25 to 30 million people, 10 percent of the population of the United States, have one of the 7,000 known rare diseases. Half of those affected by rare disease are children. By definition, rare diseases affect fewer than 200,000 people in the country. Because such diseases are uncommon, the process of receiving an accurate diagnosis often takes a significant amount of time and can be difficult and frustrating for the patient. The Committee heard testimony at nearly every meeting from individuals who have rare diseases and the parents of children with rare diseases. Those who testified described the challenges they face in receiving an accurate diagnosis from a provider familiar with the disease and finding an in-State provider willing and knowledgeable in administering prescribed treatment, often because health providers are unfamiliar or have limited experience with identifying and diagnosing such conditions.

In order to better serve Nevadans with rare diseases and to improve the number of health care providers in Nevada who are able to identify, diagnose, and treat such diseases, the Committee requests that all residency programs in Nevada, including yours, report the following to the Legislative Committee on Health Care and the Senate and Assembly Committees on Health and Human Services:

- Existing curriculum, requirements, and efforts to educate residents about rare disease; and

- Future plans to include education and training on rare disease in residency curriculum.

The Committee appreciates your consideration of this request and encourages you to evaluate how your residency program may be able to better educate medical providers on rare diseases.

If you have questions, or for additional information regarding how to report the requested information to these committees, please contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170035

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

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November 15, 2016

The Honorable Brian Sandoval
Governor of Nevada
101 North Carson Street, Suite 1
Carson City, Nevada 89701-4786

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

Dear Governor Sandoval and Director Whitley:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter expressing its support for the 2016 service priorities of the Clark County Children's Mental Health Consortium (CCCMHC). Assembly Bill 1 (Chapter 1, *Statutes of Nevada 2001, 17th Special Session*) created three regional Children' Mental Health Consortia in Nevada, one each in Clark County, Washoe County, and rural Nevada. Among other duties, the consortia are tasked with creating an annual plan for providing and improving mental health services for emotionally disturbed children and their families within each Consortium's jurisdiction.

The Committee heard testimony from all three Mental Health Consortia, which discussed the lack of behavioral health care providers in Nevada, especially in rural and frontier parts of the State, as well as the need to improve the behavioral health care workforce. Nationwide, approximately one in five youth ages 13 to 18 will experience a seriously debilitating mental health disorder in their lifetime. According to the National Institute of Mental Health, most mental illnesses begin in childhood or adolescence; half of youth and young adults with a mental health disorder develop the condition by age 14 and three-quarters by age 24. In addition, studies show that despite the prevalence of mental illness in young people, many do not receive screening or diagnosis, or have access to treatment.

The Committee wishes to express its support for the priorities of the Clark County Children's Mental Health Consortium, which include:

- Restructuring the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families;

- Continuing to provide mobile crisis intervention and stabilization services for Clark County youths in crisis;

- Expanding access to family-to-family peer support services for the families of Clark County's children at risk for long-term institutional placement; and

- Developing partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

Thank you for considering these priorities and the behavioral health of all children in Nevada.

Please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at (775) 684-6841 or megan.comlossy@lcb.state.nv.us, with any questions.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170036

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

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November 15, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706–2013

Dear Director Whitley:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter encouraging the Division of Health Care Financing and Policy (DHCFP) to examine Nevada's Children's Health Insurance Program (CHIP) eligibility policies to provide health insurance coverage to lawfully residing immigrant children who have not been in the country for five years.

Under the Children's Health Insurance Program Reauthorization Act of 2009, states have the option of providing CHIP and Medicaid coverage to lawfully residing children and pregnant women, without a five-year waiting period. Such coverage is available to children up to 19 years of age for CHIP or up to 21 years of age for Medicaid. According to Medicaid.gov, as of September 9, 2016, 21 states provide CHIP coverage to lawfully residing immigrant children within their first five years of having certain legal status and an additional 3 states provide such coverage to both children and pregnant women. In 23 states, lawfully residing immigrant children and pregnant women are eligible for Medicaid without waiting; in another 9 states such children are eligible for Medicaid without a wait; and in one state lawfully residing pregnant immigrant women are eligible for Medicaid without a wait.

The Committee discussed the importance of providing health insurance to children, including the benefits of early access to care. Committee members also noted the importance of considering the humanitarian component of providing health insurance coverage to children. In an effort to ensure that all lawfully residing immigrant children in Nevada have access to health care, the Committee urges you to examine the State's CHIP eligibility policies.

Thank you for considering this recommendation. If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170037
cc: Marta Jensen, Acting Administrator, DHCFP, DHHS

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

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November 15, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

Dear Director Whitley:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter conveying the concerns the Committee heard regarding accessing applied behavior analysis (ABA) services in Nevada. Numerous parents of children with autism, providers, and other concerned individuals testified in person at multiple Committee meetings, and many more submitted written testimony.

Because of the concerns the Committee heard, it dedicated the morning half of one of its meetings to this topic. At this meeting, representatives from both the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS), and the Aging and Disability Services Division (ADSD), DHHS, described recent changes to both Medicaid and the Autism Treatment Assistance Program and explained what to expect moving forward. The Committee appreciated the information both divisions provided.

In an effort to help DHHS address the immediate and ongoing challenges related to accessing ABA services and to increase the ABA workforce, the Committee agreed to send you the concerns below, as expressed by those who testified throughout the interim.

- The reimbursement rate for services provided to adults with autism under the Medicaid Home and Community-Based Services (HCBS) Waiver is too low, especially in rural areas. The Committee heard concerns regarding the residential support services rate for severely impacted adults with autism, the need to authorize day habilitation services provided in the home at a higher reimbursement rate, and the Medicaid reimbursement rate for Board Certified Behavior Analysts (BCBAs) who provide services to adults on the Medicaid HCBS Waiver to match the reimbursement rate for services provided to children.

- Concerns regarding Autism Treatment Assistance Program (ATAP) policies and programs include:
  - Allowing parents to continue to be able to hire their own interventionists with the assistance of a fiscal agent;
  - Allowing payment to interventionists working under the supervision of a BCBA, without requiring a registered behavior technician (RBT) credential, until such time as there is a sufficient RBT workforce;
  - Delaying the transfer of Medicaid-eligible children to Medicaid providers for individual children until a Medicaid provider is available to seamlessly accept and treat the child; and
  - Continuing to ramp up efforts to serve children through Medicaid providers, using their current providers as much as practicable.
- Concerns regarding Medicaid policy and programs include:
  - The need to review the RBT rate;
  - Exploring with the Centers for Medicare and Medicaid Services the possibility of adopting the approach taken by ATAP to allow payment for services provided by an interventionist under the supervision of a BCBA for up to six months while the interventionist obtains an RBT credential;
  - Supporting efforts to grow the State's BCBA and Board Certified Assistant Behavior Analyst (BCaBA) workforce through the higher education system, and encouraging the Department of Employment, Training and Rehabilitation to include the BCaBA and RBT in their programs; and
  - The need to review available programs and reimbursement rates for adults with autism.

Thank you for reviewing these concerns. If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170038
cc: Marta Jensen, Acting Administrator, DHCFP, DHHS
Edward Ableser, Administrator, ADSD, DHHS

JAMES OSCARSON
ASSEMBLYMAN
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COMMITTEES:
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November 15, 2016

Steve Canavero, Superintendent of Public Instruction
Nevada's Department of Education
700 East Fifth Street
Carson City, Nevada 89701-5096

Dear Superintendent Canavero:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter urging Nevada's Department of Education to develop a clear and consistent State policy and guidance to school districts regarding students who require Applied Behavior Analysis (ABA) therapy and have an Individualized Education Program (IEP).

Throughout the interim, the Committee heard from numerous parents of children with autism, providers of autism-related services, and other concerned individuals regarding challenges accessing ABA services for children with autism. Parents repeatedly described challenges ensuring their children receive the recommended number of ABA services each week—especially since such therapy must occur outside of regular school hours. Given the severe shortage of ABA providers in Nevada, parents face additional challenges securing ABA services outside of the regular school day, when demand for such services is highest. Parents also expressed concern over the lack of coordination between ABA providers outside of the school environment and those providing such services in schools.

In developing the State policy, the Committee encourages the Department to consider:

- Whether an IEP should be required to specify the number of weekly ABA hours needed by the student, with a distinction between the hours to be provided in school and out of school;

- Specifying the credentials required of an ABA professional who assists in determining the total weekly ABA hours needed by the student;

- Requiring collaboration for ABA services to maximize their effectiveness and to ensure continuity of service across environments;

- Requiring schools to support access to ABA by endorsing the following or similar language in the IEP: "The IEP recognizes the student's need to receive medically necessary treatment, which may impact full-time school attendance. An adjusted schedule is supported to allow a student to receive treatment, which may occur in and/or outside of the school environment without incurring truancy;"

- Requiring the school to encourage a parent, through written communication from the school, to invite the student's outside ABA professional(s) to participate in relevant IEP meetings; and

- Allowing a student's out-of-school ABA Professional (i.e., BCBA or licensed psychologist)—who is funded by private insurance, Medicaid, or ATAP and who passes appropriate background checks—to observe the student in the school environment quarterly and/or allowing such a provider to support the student during the school day if the student's behavior impedes learning or if the student's history includes elopement, suspension, or aggression.

Thank you for considering this recommendation. If you have any questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170039

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

COMMITTEES:
Chair
Health and Human Services
Member
Natural Resources, Agriculture, and Mining
Ways and Means

State of Nevada Assembly

Seventy-Eighth Session

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November 15, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

Dear Director Whitley:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter expressing the Committee's support for the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS), continuing to conduct regular evaluations of Medicaid provider reimbursement rates.

Throughout the interim, the Committee heard testimony from numerous entities and individuals regarding Medicaid reimbursement rates and their influence on health professionals' willingness to enroll in Medicaid and provide services to Medicaid recipients. This lack of participation directly affects the size of Medicaid's provider network and patient access to care. The Committee appreciates the DHCFP's testimony regarding the processes for calculating, accessing, and modifying reimbursement rates, during which DHCFP explained that rates are reviewed on a five-year rolling basis and significant rate changes are developed during budget planning.

In addition to supporting regular rate review, the Committee specifically recommends DHCFP review reimbursement rates for personal care services; home health services; and providers of community-based, long-term services and supports. Please see the enclosed letters the Committee received for additional information.

Thank you for considering this recommendation. If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170040
Encs.
cc: Marta Jensen, Acting Administrator, DHCFP, DHHS

Personal Care Association of NV
P.O. Box 11412
Reno, NV 89510
PCANV.org

Legislative Committee on Health Care
Chair James Oscarson
Solicitation of Recommendations

Recommendation: Require the Division of Health Care Financing and Policy to review Medicaid waiver programs and revamp the programs to ensure that funding covers the actual cost of personal care provided in the home (which may include personal residence, residential facility for groups, and assisted living setting), as personal care agency caregivers (NRS 449.1935) provide nonmedical services that include activities of daily living such as elimination of body waste, dressing and undressing, bathing, grooming, preparation of eating meals, laundry, shopping, cleaning, transportation, and other related needs to maintenance of personal hygiene.

Justification: Medicaid Personal Care Services (PCS) Reimbursement Rate Increase. The current Medicaid reimbursement rate for Personal Care Services is $4.25 for 15 minutes, which equates to $17 per hour. This rate has not changed since 2002. In 2009, the State of Nevada did approve an increase to $18.50 per hour but repealed it.

Desired New Reimbursement Rate: $5.25 for 15 minutes or $21 per hour.

1.) The national average for Private Pay home care is $21 per hour (source – Genworth study). The average total costs on this $21 per hour are about 80% or $16.80 per hour. This means that with a reimbursement rate of $17 per hour Nevada Medicaid PCS providers just break-even. They do not have a reasonable profit margin or incentive to participate in the Nevada PCS program. The labor and operating costs for Private Pay and/or Medicaid providers are basically the same.
2.) Since 2002, the total inflation rate has risen almost 30%. Source - (http://www.usinflationcalculator.com/inflation/historical-inflation-rates/)
3.) Medicaid does not reimburse travel costs between clients, yet it is a Federal requirement to pay caregivers travel time between assignments. Most

Medicaid clients have only a few hours a day of time, so most caregivers see multiple clients in a day.

4.) PCS Hourly wages now average about $10 per hour in Nevada.

5.) In 2015, Employers have had to comply with Affordable Care Act insurance requirements, which have increased insurance and overhead costs for providers.

6.) A new reimbursement rate would need to be tied to the minimum wage and any future increases because there is a direct correlation between reimbursement and the labor cost. PCS care is one-on-one; it is labor intensive. Currently, the State of Nevada minimum wage is $8.25 (without health benefits), which is 48% of $17 (existing reimbursement rate). However, the current market hourly wage is $10 per hour or 48% of $21 (proposed reimbursement rate). Consequently, if for example the minimum wage gets increased to $13 per hour, the reimbursement rate would need to increase in tandem to $27 per hour (which is 48%) in order to maintain financial viability of the providers. Without being tied to the minimum wage requirement, any increases to wages without a similar increase in rates can cause providers to stop providing Medicaid services.

To: Megan Comlossy
megan.comlossy@lcb.state.nv.us

From: Eva Medina, Program Manager, Consumer Direct Nevada (CDNV)
part of Consumer Direct Care Network
Re: Recommendations for the Legislative Committee on Health Care
Date: June 17th, 2016

Assemblyman Oscarson and Members of the Legislative Committee on Health Care,

Consumer Direct Nevada (CDNV) is an Intermediary Services Organization (ISO) serving over 500 children and adults who qualify for Medicaid and choose to self-direct their own personal care services. CDNV works with the consumer to hire, train, and manage caregivers providing the personal care. We operate the self-directed personal care model, which allows Medicaid consumers to self-direct care in their home, in both urban and rural areas.

CDNV is reimbursed by the Department of Health Care Financing and Policy (HCFP) at an hourly personal care services rate set by HCFP, which is then used to cover employer costs and wages for caregivers providing the services. Our funding comes from Medicaid dollars, and we are often subject to rate changes at the discretion of the state. We pay caregiver hourly wages directly out of personal care services reimbursement from the state. CDNV passes reimbursement for services directly onto caregivers through wage increases whenever possible. The purpose of this submission is to request that this committee implement a rate increase for Personal Care Services and other Medicaid provider rates.

CDNV operates services at the 2003 personal care reimbursement rate of $17.00 per hour, limiting our ability to pass periodic or annual wage increases onto caregivers since our rates do not increase. Lower caregiver wages make it challenging for us to recruit and retain caregivers for consumers who need them. Caregivers are required to complete an annual 8-hour training process for which CDNV bears the cost.

CDNV operates a lower profit margin compared to businesses whose primary funding comes from private, rather than public (Medicaid) taxpayer dollars. Stagnant reimbursement rates for services coupled with increased administrative costs resulting from the Affordable Care Act and new DoL overtime rules continue to strain our current business model. **In the interest of retaining Medicaid providers and consumer choice through adequate provider reimbursement rates, we respectfully request that the Legislature increase reimbursement rates for Medicaid providers in the upcoming 2017 legislative session.**

The following pages contain evidence of rising employer costs for CDNV. Please reach out with questions on any of the issues outlined in this submission. Thank you for your attention to this important matter in the safety and welfare of Medicaid consumers across Nevada.

Eva Medina-EvaM@consumerdirectcare.com
Program Manager
Consumer Direct Nevada

Variable costs supporting the need for a provider rate increase:

Various costs incurred by CDNV resulting from state and federal requirements are outlined below. This portion of our comment illustrates expenses that are paid directly out of the personal care reimbursement rate (which is still at the 2003 level of $17.00/hour). The costs are reflected in U.S. dollars. CDNV staff can provide the committee with more information upon request.

1. Nevada's Department of Public and Behavioral Health (DPBH) requires 8 hours of annual **training for caregivers** in order to continue providing services covering areas such as nutrition, hydration, bowel/bladder, lifting and moving, etc. Costs for trainings are borne by CDNV in the form of hourly rates paid to caregivers for completion. High caregiver turnover (due to low wages) escalates the cost of training further.

FiscYr	Total
2011	$ 15,567.26
2012	$ 24,204.10
2013	$ 24,407.72
2014	$ 59,733.45
2015	$ 25,346.18

2. CDNV pays **State Unemployment Tax (SUTA)** on behalf of each employee (caregiver), in addition to other tax rates. Due to high turnover rates, SUTA tax rates increase each year and must be paid out of consumer's budgets (and caregiver wages). SUTA rates have seen an annual increase from 2013-2015 from 2.93%, to 3.4%, staying at 3.4%, respectively.

3. Caregivers must undergo **CPR and First Aid instruction** prior to providing care in any consumer's home. CPR/First Aid costs are outlined as follows:

Descr		FiscYr	Total
CPR/First Aid		2011	$ 9,397.00
CPR/First Aid		2012	$ 13,725.90
CPR/First Aid		2013	$ 12,243.28
CPR/First Aid		2014	$ 30,196.16
CPR/First Aid		2015	$ 5,914.13
	Total	**2016**	**$ 71,476.47**

Nevadans for the
Common Good

6670 W. Cheyenne Avenue, Las Vegas, NV 89108

June 17, 2016

Assemblyman James Oscarson, Chairman
Legislative Committee on Health Care
401 S. Carson Street, Room 3132
Carson City, NV 89701-4747

Dear Chairman Oscarson:

Nevadans for the Common requests that the Legislative Committee on Health Care take action on three issues related to health care for the elderly and disabled populations.

Expansion of Medicaid Managed Care: Nevadans for the Common Good has researched and participated in discussions and HHS listening sessions on expansion of Medicaid managed care to the blind, elderly, and disabled populations. We have the same questions and concerns expressed by NAMI Nevada in the letter they just sent to you. **Nevadans for the Common Good endorses the recommendations they outline in their letter and encourages your committee to act on them.** We specifically request that all study and analyses conducted to reach a decision on this issue be transparent and include opportunities for involvement by all stakeholders.

Medicaid Reimbursement Rates for Community-based Service Providers: One of the recommendations in the NAMI Nevada letter addressed the inadequacy of the current LTSS reimbursement rates. Community-based service providers such as personal care and adult day care providers have not received a rate increase since 2002. These low rates impact access to care and quality of care for the vulnerable patients these providers serve. Because of the low rates providers have reduced the number of Medicaid patients they accept, provide less intensive services thus not accepting patients with complex needs, don't accept any Medicaid patients, or go out of business. All of this affects access to and quality of care for vulnerable patients at a time when demand for these services is expanding and will continue to expand. Without services to meet the demand many who could remain independent will need to be placed in a nursing home at a much higher cost to the state.

The low rates also have a profound effect on the direct-care workers in long-term care. These workers who are charged with caring for our most vulnerable loved ones are paid $10/hour on

average in Nevada. Data shows that 53% of direct care worker households are themselves on public assistance. For the patient this means paid care givers with less training and high turnover; both bad for quality and consistency of care. **We recommend that Medicaid reimbursement rates for community-based LTSS providers be increased to reflect current cost of living and a mechanism be established for regular adjustments.**

Meals on Wheels: Nevadans for the Common has also been gathering information on the Meals on Wheels Program which serves low income, home-bound seniors. This program provides a daily nutritious meal to thousands of Nevada seniors in large and small communities across the state. The health consequences of inadequate nutrition in terms of physical functioning, higher risk of disease, and premature institutionalization can be life threatening. Funding for this program is a combination of federal and state dollars with most states providing a greater portion than the federal government. In Nevada it is just the opposite with federal money covering approximately half of the $5.50 cost per meal and the state providing just $0.17 per meal. The remainder of the meal cost must be covered by the agency providing the meals which has resulted in people placed on waiting lists. **Nevadans for the Common Good recommends the state increase funding for this valuable program to cover the portion of meal cost not covered with federal dollars.**

All of the issues outlined here and in the NAMI letter affect the ability of vulnerable people to maintain their independence rather than being placed in a nursing or group home. This is a great cost to these individuals in terms of their autotomy and quality of life. It is also a great cost financially to the state.

Sincerely,

Barbara Paulsen

Barbara Paulsen
Nevadans for the Common Good Leader
(702) 561-5601
paulsenbnv@gmail.com

JAMES OSCARSON
ASSEMBLYMAN
District No. 36

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Member
Natural Resources, Agriculture, and Mining
Ways and Means

State of Nevada Assembly

Seventy-Eighth Session

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November 15, 2016

The Honorable Brian Sandoval
Governor of Nevada
101 North Carson Street, Suite 1
Carson City, Nevada 89701-4786

Dear Governor Sandoval:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter expressing the Committee's concern regarding the lack of oversight of health profession licensing boards and its support for statutory changes necessary to provide such oversight.

As you know, approximately 20 boards license and regulate health professionals in Nevada. Although each board's powers and duties are slightly different, they are generally responsible for establishing licensure requirements, processing applications, granting and renewing licenses, developing and enforcing standards and regulations, investigating complaints, and taking disciplinary action.

Health profession licensing boards are extremely important in both protecting public safety and licensing qualified health care providers. Their role becomes ever more critical in light of the severe health care workforce shortage, as boards serve as the gateway between the pool of potential health care providers and the pool of licensed health care professionals available to serve Nevadans. They are in a position to facilitate the licensure application process while ensuring adherence to standards and regulations and protecting patient safety.

Throughout the interim the Committee received testimony from a wide variety of Nevada licensed health professionals as well as nearly all of the health profession licensing boards. The Committee heard complaints about various licensing boards, general lack of oversight of boards, and the need for accountability. Testifiers cited concerns over the lack of clarity and transparency regarding licensure requirements, poor communication between boards and

applicants or licensees, the amount of time between application submission and license issuance, and questionable investigation processes, among others.

As a result of the information presented throughout the interim, the Committee agreed to share with you its concerns related to the following:

- Numerous complaints related to various health care profession licensing boards;
- General lack of oversight of health profession licensing boards and the need for accountability;
- Investigation and appeals processes used by certain boards and the need for oversight of certain board decisions;
- Lack of transparency with regard to licensure data, the inability of some boards to provide requested data, and the need to increase data reporting requirements;
- Need for increased transparency and oversight of the finances of health profession licensing boards and for comprehensive, detailed reporting requirements to improve fiscal accountability;
- Application and licensure inefficiencies and extended application timelines due to the systems used by certain boards;
- Performance audit of the Board of Dental Examiners of Nevada by the Legislative Auditor and the Board's response to certain recommendations made by the Auditor; and
- Direct impact boards have on the health care workforce and their ability to exacerbate the workforce shortage or to improve it, as exemplified by the challenges the Social Workers in Schools Program faced recruiting social workers and other qualified behavioral health providers in schools in 2016.

As you know, in Nevada, each health profession licensing board is an independent body. Members are appointed by the Governor, but neither the Executive Branch, nor the Legislative Branch, has direct regulatory or administrative oversight of the boards. In addition, in many cases, the only recourse applicants and licensees have to appeal adverse decisions by a board is to go to a hearing of the full board, or file a lawsuit in court. For some applicants or licensees, the cost of such action is prohibitive.

In an effort to address issues related to behavioral health licensing boards, the Committee voted to approve bill draft request (BDR) 54-410, consolidating under the State Board of Health, DHHS, the Board of Psychological Examiners, the Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors, the Board of Examiners for Social

Workers, and the Board of Examiners for Alcohol, Drug and Gambling Counselors. While this BDR aims to address concerns related to a few boards, it does not address all health profession licensing boards or all of the issues raised throughout the interim.

Thank you for considering the Committee's concerns. If you have any questions, or would like to discuss this issue further, please contact me at James.Oscarson@asm.state.nv.us, or Megan Comlossy, Committee Policy Analyst, at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170041
cc Assemblyman D. Paul Anderson, Chair, Interim Finance Committee
Senator James A. Settelmeyer, Chair, Sunset Subcommittee of the Legislative Commission

JAMES OSCARSON
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Member
Natural Resources, Agriculture, and Mining
Ways and Means

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November 15, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

James M. Wright, Director
Department of Public Safety
555 Wright Way
Carson City, Nevada 89701-5229

Dear Director Whitley and Director Wright:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter expressing the Committee's support for the development of a statewide behavioral health education/training requirement for law enforcement officers.

The Committee heard testimony regarding the fact that nearly one in five adults in Nevada (18.5 percent) had a mental illness in 2014 and, of those individuals, more than 4 percent had a serious mental illness that resulted in substantial impairment in carrying out major life activities. The Committee also received information regarding behavioral health challenges, needs, and programs throughout the State. As you are well aware, individuals with mental illness often interact with law enforcement officers, and in rural Nevada, often end up in jail or in a rural hospital's small emergency department.

Because of the high level of contact between law enforcement officers and those with mental illness and behavioral health disorders, and in an effort to address the ongoing challenges of individuals with mental and behavioral health disorders, the Committee strongly supports collaboration between your departments to develop of a statewide policy on behavioral health training for all law enforcement officers.

I appreciate your time and consideration of this recommendation and hope that the recommended training will benefit not only individuals with mental and behavioral health needs, but also the law enforcement and criminal justice systems. If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170042

JAMES OSCARSON
ASSEMBLYMAN
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November 28, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2013

Dear Director Whitley:

At its final meeting on August 24, 2016, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) unanimously voted to send you a letter expressing the Committee's support for mental health court and other specialty courts in Nevada and for the expansion and development of crisis intervention services and crisis stabilization centers throughout the State.

The Committee heard testimony regarding the need for services for those with mental illness and behavioral health disorders, and the success of mental health court, other specialty courts, and various jail diversion programs.

In response to this information, the Committee supports the development of additional residential substance abuse treatment beds and the establishment of treatment beds for people diagnosed with co-occurring disorders, as there are currently no such beds in the State. The Committee also supports funding housing, transportation, and drug testing for specialty court participants, and exploring how public-private partnerships may assist in providing such funding.

The Committee also received information regarding existing crisis intervention and jail diversion programs in Nevada, such as the Forensic Assessment Services Triage Team (FASTT), Mobile Outreach Safety Team (MOST), and crisis intervention training, and supports the expansion of such programs. Crisis intervention training, for example, has been shown to reduce the need for lethal force, increase jail diversion and reduce arrests for those with mental illness, reduce injuries for both officers and those with mental illness, and improve community relations, among other benefits.

In addition, the Committee heard from numerous individuals and organizations regarding the need to develop crisis stabilization centers in the State where people experiencing a crisis related to a mental health condition can access services 24 hours per day, 7 days per week. Crisis stabilization centers can provide timely de-escalation, early intervention, and patient stabilization to prevent the need for higher levels—and more costly—care.

Thank you for considering this recommendation. If you have questions, please do not hesitate to contact me at James.Oscarson@asm.state.nv.us, or Committee Policy Analyst Megan Comlossy at megan.comlossy@lcb.state.nv.us.

Sincerely,

Assemblyman James Oscarson, Chair
Legislative Committee on Health Care

JO/gn:W170043
cc: Senator Joyce Woodhouse, Chair, Senate Committee on Finance
Assemblywoman Maggie Carlton, Chair, Assembly Committee on Ways and Means

APPENDIX D

Suggested Legislation

APPENDIX D

Suggested Legislation

The following bill draft requests (BDRs) will be available during the 2017 Legislative Session or can be accessed after "Introduction" at the following website: http://www.leg.state.nv.us/Session/79th2017/BDRList/page.cfm?showAll=1.

BDR XX–351 Enacts certain interstate compacts relating to the provision of health care.

BDR 40–352 Authorizes an advanced practice registered nurse to perform certain tasks.

BDR 34–353 Requires the board of trustees of certain school districts to collect and report information on the height and weight of a representative sample of certain pupils.

BDR 27–354 Authorizes certain former state employees to enter into a contract for services with a using agency within two years of the termination of employment.

BDR 15–355 Imposes certain requirements concerning vapor products and alternative nicotine products.

BDR 34–362 Requires a public school to post a telephone number for a child abuse hotline.

BDR 38–363 Revises provisions relating to autism.

BDR 40–364 Revises provisions relating to ambulatory surgical centers.

BDR 40–365 Revises provisions governing end-of-life care.

BDR 54–410 Transfers responsibility for regulating certain mental health-related professions to the State Board of Health.

The following example explains the numbers preceding the dash in the BDRs above:

40–352 A number designates the NRS Title (i.e., Title 40) which encompasses the main subject of the bill draft.