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Legislative Committee on Health Care
(NRS 439B.200)

Legislative Counsel Bureau

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LEGISLATIVE COMMITTEE ON HEALTH CARE

Nevada Revised Statutes 439B.200

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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)

EXECUTIVE SUMMARY

The Legislative Committee on Health Care (LCHC) is a permanent committee of the Nevada Legislature whose authority and duties are set forth in 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 access, cost, and quality of health care for all Nevadans.

The LCHC held seven meetings, including two work sessions, during the 2017–2018 Interim. Having received a waiver from the Legislative Commission to meet after the August 31, 2018, deadline prescribed by NRS 439B.210, the LCHC completed its work on September 24, 2018.

Throughout the interim, the LCHC considered a wide range of topics relating to access to care, behavioral health, children's health, health insurance coverage and access to health care providers, oversight of certain home- and community-based services and living arrangements for individuals with mental illness in Nevada, prescription drug costs, public health, and substance abuse prevention and treatment.

During its work sessions on August 27 and September 24, 2018, the LCHC approved proposals for nine bill draft requests (BDRs) to be considered by the 80th Session of the Nevada Legislature. The BDRs concern:

1. Children's health care;
2. Data regarding providers of health care in Nevada;
3. Funding for family planning services;
4. Health insurance;
5. The Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired;
6. Public health funding and federally qualified health centers;
7. Residential facilities for groups, community-based living arrangements (CBLAs), and certain unregulated residential facilities;
8. Substance abuse prevention and treatment; and
9. Therapeutic diets.

In addition, LCHC members authorized the chair to include 3 statements of support in its final report and send 17 letters to various agencies, legislative committees, and officials on behalf of the LCHC.

SUMMARY OF RECOMMENDATIONS

This summary presents the recommendations approved by the LCHC at its meetings on August 27 and September 24, 2018. The BDRs will be forwarded to the Legislative Commission for transmittal to the 80th Session of the Nevada Legislature.

Recommendations for Legislation

Children's Health Care

1. Propose legislation to:

    a. Appropriate $500,000 per annum to the Department of Health and Human Services (DHHS) to provide monthly vouchers in the amount of $25 to participants in the Women, Infants, and Children program with children up to three years of age to support the purchase of diapers for families with limited financial resources on a first-come, first-served basis;

    b. Appropriate $250,000 per annum to support stipends, technical assistance, and training to enable child care providers to offer high-quality, nutritious foods and ample opportunities for physical activity, including:

        i. $50,000 per annum to the Division of Public and Behavioral Health (DPBH), DHHS, to subgrant to nonprofit organizations that provide training and technical assistance to child care providers on proper nutrition and physical activity; and

        ii. $200,000 per annum to the Nevada Silver State Stars Quality Rating and Improvement System (QRIS) to provide grants to QRIS-rated child care providers for facility improvements related to providing high-quality, nutritious food and ample physical activity;

    c. Authorize physicians to issue a standing order for asthma medication, such as albuterol inhalers and/or nebulizers for students with asthma;

    d. Amend NRS 442.700 to reflect current standards of the Council of State and Territorial Epidemiologists to improve data collected when children are tested for lead in order to identify at-risk populations and communities; and

    e. Amend Chapters 287, 422, 689A, 689B, 689C, 695A, 695B, 695C, and 695G of NRS to require insurance plans in Nevada to cover the cost of hearing aids for children. **(BDR 57–448)**

Data Regarding Providers of Health Care in Nevada

2. Propose legislation to:

    a. Require, as a condition of licensure and relicensure, all providers of health care who are licensed in Nevada to complete a data request developed by the Division of Insurance (DOI), Department of Business and Industry (B&I). The data request shall include the following:

        i. Name;

        ii. Mailing address;

        iii. Email address;

        iv. Physical practice location(s) and portion of time spent practicing at each location;

        v. Specialty;

        vi. Race/ethnicity;

        vii. Primary languages other than English; and

        viii. License status.

        The DOI may adopt regulations requiring additional areas of data collection, and it must develop and maintain a database to collect required data. Individualized data is confidential. Individualized deidentified data may be provided to governmental entities, and the DOI shall aggregate state-level data by license, which shall be public record; and

    b. Require the commissioner of insurance of the DOI to develop, prescribe for use, and make available a single, standardized form for use by insurers to notify health care providers who apply for, but are not credentialed, on a health insurance network's provider panel. The commissioner shall hold public hearings to seek input regarding the development of the form and must consider this input in developing the form. At a minimum, the form must indicate the reason for which a provider is not credentialed. **(BDR 54–527)**

Funding for Family Planning Services

3. Propose legislation to:

    a. Appropriate $12 million over the 2019–2021 Biennium to the Account for Family Planning (created by Senate Bill 122 [2017]);

b. Authorize the use of funds in the Account by local governments to contract with the state for community health nurses and other family planning health care providers in addition to the entities currently eligible for funding pursuant to NRS 442.725; and

c. Prohibit the administrator from discriminating based on the contraceptive method when awarding grants. **(BDR 40–446)**

Health Insurance

4. Propose legislation to:

a. Allow flexibility under Nevada law if federal law is amended to allow larger tobacco- or age-rating factors;

b. Authorize the commissioner of insurance of the DOI to enter into compacts to ensure essential insurance is available to Nevada residents and incorporate language to allow health benefit plans sold in contiguous states to be sold in Nevada when essential insurance is not available or is insufficient in the state;

c. Authorize the commissioner of insurance to apply for a state innovation waiver, in accordance with Section 1332 of the Patient Protection and Affordable Care Act (ACA);

d. Authorize the establishment of a reinsurance or high-risk pool program to mitigate the cost of health benefit plans in the individual market with the intent of helping to stabilize the individual health insurance market;

e. Impose restrictions on short-term health insurance policies currently defined within *Nevada Administrative Code* (NAC) into NRS; and

f. Repeal the right to annual enrollment with a 90-day waiting period as provided in NRS 687B.480. **(BDR 57–531)**

The Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired

5. Propose legislation to:

a. Change the name of the Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired to the Nevada Commission for the Deaf and Hard of Hearing;

b. Expand the Commission membership from 9 to 11 members;

c. Revise the Commission membership such that it includes:

i. One member (rather than three) who is a user of telecommunications relay services or the services of persons engaged in the practice of interpreting or the practice of real time captioning;

ii. One member who is a member of an advocacy organization that has a membership of persons who are deaf, hard of hearing, or speech impaired;

iii. One member who is hard of hearing;

iv. One member who is an employment specialist; and

v. One member who is a parent of a deaf child who is five years of age or younger;

d. Appropriate $50,000 from the State General Fund or tobacco settlement funds to the Commission in each fiscal year of the 2019–2021 Biennium for administrative, per diem, and travel costs of the Commission; and

e. Amend NRS 427A.797, Telecommunication Devices for the Deaf surcharge funds, to authorize a portion of the money in the account to be used to support a full-time director for the Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired. The director's compensation shall be determined by the Commission. **(BDR 38–449)**

Public Health Funding and Federally Qualified Health Centers

6. Propose legislation to:

a. Prohibit state funding from being allocated or subgranted to a federally qualified health center (FQHC) with executive staff who have been convicted of a felony or had their health care professional license revoked within the last 12 years;

b. Appropriate $5 per capita to build public health infrastructure and capacity that supports foundational public health services in Nevada and:

i. Require DHHS to establish a Public Health Improvement Fund whereby:

(1) The Fund must be utilized to improve public health and must be allocated based on population to public health agencies operating under Chapter 439 of NRS;

(2) The interest and income earned on the money in the Fund must, after deducting any applicable charges, be credited to the Fund. All claims against the Fund must be paid as other claims against the state are paid;

(3) The money in the Fund remains in the Fund and does not revert to the State General Fund at the end of any fiscal year;

(4) All money that is deposited or paid into the Fund is hereby appropriated to be used for any purpose authorized by the Legislature or DPBH for expenditure or allocation in accordance with the provisions of this BDR. Money expended from

the Fund must not be used to supplant existing methods of funding that are available to public agencies; and

(5) The Legislature may access money in the Fund in extraordinary circumstances and/or times of severe economic duress;

ii. Require eligible public health agencies to conduct a community needs assessment;

iii. Establish a process to evaluate the health and health needs of residents and establish a system to rank them for prioritizing funding; and

iv. Allocate money for direct expenditure by the health agencies operating under Chapter 439 of NRS in accordance with their identified needs and priorities relating to public health. **(BDR 40–529)**

Residential Facilities for Groups, Community-Based Living Arrangements, and Certain Unregulated Residential Facilities

7. Propose legislation to:

a. Direct DHHS to review unlicensed group housing arrangements that provide assistance, food, shelter, and/or limited supervision to a person with a mental illness, a person with an intellectual or physical disability, or a person who is aged or infirm to determine when such arrangements require regulation. The review must consider:

i. The impact of overregulation on housing arrangement options and affordable housing; and

ii. Reasonable quality and safety protections to safeguard vulnerable populations; and

b. Broaden the definition of a referral agency in NRS 449.0305 by expanding the requirement for licensure to include any business that provides referrals to residential facilities for groups and any group housing arrangements that provide assistance, food, shelter, or limited supervision to a person with a mental illness, a person with an intellectual or physical disability, or a person who is aged or infirm. **(BDR 40–526)**

Substance Abuse Prevention and Treatment

8. Propose legislation to:

a. Clarify certain provisions of Assembly Bill 474 (2017), including requiring that the State Board of Pharmacy and all professional and occupational licensing boards that regulate health care providers who are eligible to prescribe controlled substances must develop and disseminate a clarification or technical assistance advisory bulletin to help clarify the intent of the legislation and which drugs are affected by the legislation. **(BDR 54–447)**

Therapeutic Diets

9. Propose legislation to:

    a. Amend NRS 640E.260 to authorize a dietician to recommend a therapeutic diet without consulting a patient's physician;

    b. Require a medical facility, as defined in NRS 449.0151, to follow prescribed therapeutic diets, including the purchase of required food items so that dieticians can prepare a patient's prescribed diet; and

    c. Require medical facilities to document that prescribed therapeutic diets are being followed and, upon request, make such documentation available to staff of the Bureau of Health Care Quality and Compliance, DPBH, DHHS. **(BDR 40–445)**

Recommendations for Committee Action

Access to Care and Public Health

1. **Federally Qualified Health Centers**—Send a letter to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the director of DHHS:

    a. Expressing the LCHC's support for FQHCs and maintaining or increasing the $500,000 per annum appropriation from tobacco settlement revenue to fund a Health Center Incubator Project for expanded access to care, which was made during the 2017 Legislative Session; and

    b. Encouraging a review of opportunities to partner with FQHCs to leverage state funding to receive matching federal dollars to increase satellite sites, possibly through school-based clinics.

2. **Mobile Dental Van**—Send a letter to the director of DHHS encouraging continued funding to support the Mobile Dental Van Pilot Project in rural Nevada.

3. **Tobacco Policy**—Send letters to the Senate and Assembly Committees on Health and Human Services expressing the LCHC's support for legislation and policies that:

    a. Implement tougher fee-based tobacco retail licensing requirements;

    b. Increase funding for tobacco control; and

    c. Regulate and tax e-cigarettes and other vapor products.

Behavioral Health

4. **Services for Individuals With Mental Illness**—Send a letter to the director of DHHS expressing the LCHC's commitment to improve services for people with mental health issues and encouraging DPBH to pursue opportunities to:

    a. Build greater partnerships between local governments and social service programs;

    b. Coordinate with the National Alliance on Mental Illness Nevada to address concerns about housing and medications;

    c. Develop standards for adequate living conditions;

    d. Ensure access to affordable prescription drugs, which work for the individual patient, for mental health conditions;

    e. Expand access to treatment for the mentally ill and prevent overly restrictive state agency regulations, such as those imposing new or additional preauthorization requirements for Medicaid patients;

    f. Explore housing options, which utilize currently vacant buildings and facilities;

    g. Increase compensation to care providers; and

    h. Provide affordable, safe, and sanitary housing for the mentally ill.

5. **Assistance/Advocate for Individuals With Mental Illness**—Send a letter to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the director of DHHS expressing the LCHC's support for:

    a. Additional funding for the Office for Consumer Health Assistance, DHHS, to expand its staffing and its education programs for assisting the mentally ill and their families; or

    b. The establishment of an office of ombudsman or advocate for the mentally ill, possibly independent from DHHS.

Children's Health

6. **Insurance Coverage for Immigrant Children**—Send a letter to DHHS encouraging the Division of Health Care Financing and Policy (DHCFP) to evaluate the cost of adding all immigrant children residing in Nevada to Nevada's Children's Health Insurance Program's (CHIP's) eligibility policies and to analyze the cost of providing health insurance coverage to all children in Nevada, regardless of immigration status.

7. **Standing Orders for Asthma Medication**—Include a statement in the LCHC's final report indicating its support for authorizing physicians to issue a standing order for asthma medication, such as albuterol inhalers and/or nebulizers for students with asthma.

8. **Services for Children With Autism**—Send a letter to the Senate and Assembly Committees on Education and the Senate and Assembly Committees on Health and Human Services encouraging them to develop a joint study regarding barriers to, and strategies to best provide, intervention services for children with autism, including the impact of:

    a. Allowing Medicaid to reimburse for registered behavior technicians (RBTs) in training;

    b. Changing the compulsory education law to allow children diagnosed with autism to attend school half-day so they can receive intensive 1:1 applied behavioral analysis (ABA) services in their homes during the day;

    c. Creating a statewide magnet school program to produce RBTs;

    d. Mandating in-school access to insurance-funded RBTs for eligible children;

    e. Raising the reimbursement rates for RBTs so employers can raise wages; and

    f. Requesting a report prior to the 81st Legislative Session that includes information requested in the August 27, 2018, letter from Kelly Venci Gonzalez, Esq., Team Chief, Education Advocacy Program, Children's Attorneys Project, Legal Aid Center of Southern Nevada, to the LCHC regarding:

        i. Access to services through Nevada's Autism Treatment Assistance Program;

        ii. The number of children enrolled in Medicaid or CHIP who receive ABA services;

        iii. The number of ABA providers available to this population and how that impacts access to services;

        iv. Requirements for prior authorization to access ABA; and

        v. Additional related matters.

9. **Mental Health Services for Children**—Include a statement of support in the LCHC's final report for expanded access to quality mental health services for children and their families.

10. **Nevada Children's Behavioral Health Consortium**—Send letters to the governor of the State of Nevada and the director of DHHS expressing the LCHC's support for recommendations made by the Nevada Children's Behavioral Health Consortium at the Committee's July 17, 2018, meeting.

Health Insurance and Medicaid

11. **Medicaid Provider Participation**—Send a letter to the governor of the State of Nevada, the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the director of DHHS, strongly encouraging:

    a. The development of a "Diversity Plan of Action" to demonstrate Nevada Medicaid's and contracted managed care organizations' (MCOs) strategies for recruiting and retaining providers from underrepresented cultural, ethnic, and religious groups; and

    b. Increased reimbursement rates for Medicaid to improve provider participation and expand access to services.

12. **Medicaid Reimbursement Rates for Family Planning Providers**—Send a letter to the director of DHHS encouraging the evaluation of Medicaid rules and reimbursement rates to ensure that rates cover the costs of business for family planning providers.

13. **Medicaid Reimbursement for Community Health Centers**—Send a letter to the director of DHHS encouraging Medicaid to allow community health centers to bill Medicaid for services provided by community health workers (promotoras).

14. **Medicaid Prescription Drug Costs**—Include a statement of support in the LCHC's final report encouraging DHHS to analyze the following issues within Medicaid, including Medicaid MCOs:

    a. Disconnect between pharmacy reimbursement and overall costs to the Medicaid program (spread pricing);

    b. Impact of reductions in pharmacy reimbursement on access to care, particularly in rural communities;

    c. Lack of transparent data on pharmacy services; and

    d. Potential conflict of interest between a retail pharmacy chain affiliated with a Medicaid pharmacy benefit manager (PBM) and possible reductions in pharmacy reimbursements.

15. **Medicaid-Like Buy-in Health Insurance Program**—Send letters to the Senate and Assembly Committees on Health and Human Services expressing the LCHC's support for legislation creating a Medicaid-like buy-in program, such as that considered in AB 374 (2017).

16. **Health Insurance for Individuals With Chronic Conditions**—Send a letter to the Senate and Assembly Committees on Commerce and Labor supporting the development of options that enable individuals living with chronic illnesses to access health insurance plans that provide lifesaving treatments they otherwise may not be able to afford. Such health insurance options would provide that insurers offer the following:

a. At least one plan with a flat-dollar co-payment and no deductible for prescription medications in each of the four levels of plans and within each service area of the state;

b. A flat-dollar co-payment that includes all specialty tier medications; and

c. Co-payment rates that are reasonably graduated and proportionately related in drug formulary tier levels.

Substance Abuse Prevention and Treatment

17. **Prescribing Controlled Substances and AB 474 (2017)**—Send a letter to all professional and occupational licensing boards that regulate health care providers who are eligible to prescribe controlled substances, encouraging them to:

    a. Host and advertise virtual town hall meetings to allow providers and patients opportunities to share their input and feedback about their experiences with AB 474; and

    b. Host best practices workshops and offer continuing medical education to providers for attendance. This could be done via conference call, in-person, or webinar.

18. **Detoxification Facilities**—Send a letter to the director of DHHS and the administrator of DPBH expressing the LCHC's support for providing funding and/or assistance to ensure safe detoxification facilities are available across the state of Nevada.

Unregulated Congregate Care Living Arrangements

19. **Unregulated Congregate Care Living Arrangements**—Send a letter to DHHS encouraging:

    a. Proactive monitoring of business licenses to find license types or business names that may be operating unlicensed homes; and

    b. The development of a public education campaign regarding the limits and possible hazards of unregulated and unlicensed group homes.

Victim Services and Support

20. **Victim Services and Support**—Send letters to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing support for funding to maintain the service delivery infrastructure created to provide victim services and resources to assist individuals affected by the October 1, 2017, mass shooting in Las Vegas, Nevada.

I. INTRODUCTION

The authority and duties of the LCHC are codified in NRS 439B.200 through 439B.227. The LCHC oversees a broad spectrum of issues related to the access, cost, and quality of health care for all Nevadans. Specifically, the LCHC is responsible for:

- 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;
- Examining the health education system and hospital-related and medical malpractice issues;
- Reviewing certain health care regulations and the reports various entities are statutorily required to submit to the LCHC throughout the interim;
- Reviewing and evaluating the quality and effectiveness of programs for the prevention of illness; and
- Reviewing health insurance issues.

The LCHC held seven meetings, including two work sessions, during the 2017–2018 Interim. All of the meetings were conducted through simultaneous videoconferencing between legislative hearing rooms in the Grant Sawyer State Office Building in Las Vegas and the Legislative Building in Carson City. At each meeting the LCHC heard public testimony, and at certain meetings, regulations proposed or adopted by licensing boards were considered pursuant to NRS 439B.225. The following list provides a link to each meeting and a brief summary of the topics considered:

1. On January 11, 2018, the LCHC discussed the study required by SB 394 (2017) related to establishing a public health insurance option similar to Medicaid managed care, as well as methods to maintain current levels of health insurance coverage in Nevada. Specifically, the LCHC received information regarding the current insurance marketplace, Medicaid and private health insurance coverage, and the uninsured. The LCHC also received testimony regarding certain behavioral health care and substance abuse initiatives and an overview of public health prevention and wellness initiatives.

2. On February 20, 2018, the LCHC received information concerning the priorities of the Nevada Commission for Persons Who are Deaf, Hard of Hearing or Speech Impaired, Office of the Governor, and deliberated funding options to support a full-time director for the Commission, as required by SB 481 (2017). Additionally, Assemblyman Sprinkle presented his plan to work with stakeholders, other interested parties, and members of the public to establish the framework for a public health insurance option similar to Medicaid managed care. The LCHC discussed the study of group home rates required by AB 343 (2017) and received a presentation regarding a performance audit of CBLAs for adult mental health services (LA18-13) conducted by the Audit Division, Legislative Counsel Bureau (LCB). Further, the LCHC received updates on two initiatives aimed at addressing prescription drug abuse in Nevada. Health care professional licensing boards discussed implementation of AB 474 (2017) and Nevada's Office

of the Attorney General's "Prescription for Addiction" opioid initiative. Finally, state and county officials presented an overview of various social services and programs to assist individuals affected by the October 1, 2017, mass shooting in Las Vegas, Nevada.

3. On March 19, 2018, the LCHC received several presentations related to behavioral health, including updates regarding behavioral health professional licensing boards' implementation of AB 457 (2017); the membership and current priorities of each regional behavioral health policy board created by AB 366 (2017); Mobile Outreach Safety Teams and intervention services provided to persons with mental illness; and the oversight of CBLAs and unregulated residential facilities. The LCHC received an overview of the status of children's health in Nevada and an update regarding Nevada Check Up (NCU), a public health insurance program for children. Representatives of hospitals and other health care facilities outlined possible implications of federal changes to the 2010 federal ACA.

4. On April 24, 2018, public health entities from across Nevada informed the LCHC of the importance of foundational public health, described the current infrastructure, and explained the need for stable funding and structural support for the public health system. The Committee heard testimony regarding the unpredictable costs of medication and options to design prescription benefits that make the cost more predictable for individuals with chronic conditions. The LCHC received updates regarding health care facility ratings and staffing committee requirements pursuant to SB 482 (2017). Finally, the LCHC considered the work plan to study rates paid to group homes contracted with Southern Nevada Mental Health Services as required by AB 343 (2017).

5. On July 17, 2018, the LCHC received information regarding access to behavioral health services, treatment programs for children and adolescents, and barriers to accessing services for the treatment of autism. Representatives of Medicaid and private health insurance agencies discussed the process for determining which health care professionals are included in their networks of providers, how they review adequacy, and options to improve the credentialing process and patients' access to health care providers. The LCHC also received information concerning family planning, including an update regarding Title X funding and related provisions of SB 122 (2017) and AB 397 (2017). The final presentation outlined the process for distributing funding to support amphetamine and opioid abuse, prevention, and treatment in Nevada.

6. On August 27, 2018, representatives of each regional behavioral health policy board presented their policy priorities and recommendations. The LCHC received a presentation concerning antibiotic susceptibility, resistance, and stewardship in Nevada. In addition, the Nevada Commission for Persons Who are Deaf, Hard of Hearing or Speech Impaired provided an update regarding its activities and policy recommendations. The LCHC also heard a presentation regarding the prescription drug supply chain, pricing, and cost to the state. Finally, members of the LCHC deliberated and voted to advance various policy recommendations at the first of two work sessions.

7. On September 24, 2018, the LCHC received a presentation regarding rural health outreach from the Southern Nevada Health District. In addition, representatives of PBMs described their

role in the prescription drug supply chain. The Committee received a presentation concerning adverse childhood experiences and suicide risk among lesbian, gay, and bisexual high school students in Nevada. Assemblyman Sprinkle, presented a memorandum summarizing the activities of a working group he established to discuss the development of a program to offer a public health insurance option modeled after Medicaid managed care.

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2. Data regarding providers of health care in Nevada;

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6. Public health funding and federally qualified health centers;

7. Residential facilities for groups, CBLAs, and certain unregulated residential facilities;

8. Substance abuse prevention and treatment; and

9. Therapeutic diets.

In addition, LCHC members authorized the chair to include 3 statements of support in its final report and send 17 letters to various agencies, legislative committees, and officials on behalf of the LCHC.

More information about the LCHC's activities—including minutes, recordings of meetings, and copies of presentations and other exhibits—may be accessed on the Legislature's website for the 2017–2018 Interim.

II. BACKGROUND

Nevada struggles in a variety of areas related to health care. The *Best States 2018* rankings from *U.S. News & World Report* ranked Nevada 35th in health care, with health care access, health care quality, and public health as the three primary areas of review. Of the three categories, Nevada ranked lowest in health care access (42nd) and faired a bit better in quality (29th) and public health (30th). Two major factors affect a person's ability to access care: the cost of care and the availability of services. The cost of care is significantly affected by whether a person has health insurance, and while insurance coverage in Nevada has improved as a result of federal changes—which allowed for the expansion of Medicaid and the creation of online health insurance exchanges, or

marketplaces—11 percent of Nevadans remain uninsured. In addition, regardless of whether a person has health insurance, many in Nevada face challenges finding health care providers due to a severe shortage of nearly every type of health care professional. In fact, the vast majority of the state is recognized by the federal government as a health care professional shortage area. Throughout the interim, the LCHC received a variety of presentations and information to assist in the development of policies aimed at improving access, quality, and public health in Nevada.

III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS

During its work sessions on August 27 and September 24, 2018, the Legislative Committee on Health Care considered a total of 29 proposed actions for legislation, letters, or statements to include in its final report. Additional information regarding all recommendations considered is available in the Committee's work session documents for August 27 and September 24.

A. Access to Care, Federally Qualified Health Centers, and Public Health

At its meeting on January 11, 2018, the LCHC heard testimony regarding the uninsured in Nevada and the difficulty this population has accessing care. In 2016, Nevada had the ninth highest rate of uninsured residents among the states at 11.4 percent, a decrease from 22 percent in 2012. Among the uninsured is a large population that should be eligible for Medicaid. This group includes approximately 19 percent of Nevadans with income less than 138 percent of the federal poverty level ($16,934 for an individual or $33,534 for a family of four).

Individuals who are uninsured or underinsured often receive care at FQHCs, which receive funding from the federal government to provide primary care in underserved and high-need areas. All residents, regardless of their ability to pay, may access care at FQHCs; charges are determined by an income-based sliding fee scale. The number of FQHCs in Nevada increased in recent years, from 3 FQHCs operating 22 clinic sites and 4 mobile service vans in 2013 to 8 FQHCs operating 33 clinic sites and 4 mobile service vans in 2016. Three of these were newly funded in 2016. Over the same period, Nevada FQHCs experienced a 27 percent increase in patients served, from 70,014 to 88,962.

In addition to being a "safety-net" provider for the uninsured, FQHCs serve a disproportionate number of Medicaid patients. Approximately 44 percent of FQHC patients are covered by Medicaid; even Medicaid covers only 22 percent of the state's population. Furthermore, FQHCs are required to help their patients obtain appropriate health insurance. Recognizing the significant role FQHCs play in providing care to low-income Nevadans, in 2017, the state invested $500,000 per annum for expanded access to care. The LCHC supports maintaining or increasing FQHC funding and establishing parameters to make sure they retain the highest levels of staff and management.

Representatives of DPBH and local public health agencies presented at the LCHC's meetings on January 11 and April 24, 2018. State and local public health officials discussed the essential services of public health, the role of social determinants on a person's health and well-being, and how public health efforts have improved the health and wellness of Nevadans. The LCHC heard

testimony regarding the relationship between public health funding and crises events, the state's reliance on federal funding to address the basic tenets of public health, and the lack of state funding to provide flexibility in allocating resources to address public health priorities and issues.

Representatives from public health entities throughout the state emphasized the need for stable funding and support for the public health system in Nevada. According to testimony, designated state funding for public health could improve access to health care and social services, decrease mortality and morbidity associated with preventable injury and illness, improve substance abuse prevention, and help develop community-based approaches to address social determinants of health.

Following deliberations regarding FQHCs and public health in Nevada, the LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Prohibit state funding from being allocated or subgranted to a FQHC with executive staff who have been convicted of a felony or had their health care professional license revoked within the last 12 years;

b. Appropriate $5 per capita to build public health infrastructure and capacity that supports foundational public health services in Nevada and:

    i. Require DHHS to establish a Public Health Improvement Fund whereby:

        (1) The Fund must be utilized to improve public health and must be allocated based on population to public health agencies operating under Chapter 439 of NRS;

        (2) The interest and income earned on the money in the Fund must, after deducting any applicable charges, be credited to the Fund. All claims against the Fund must be paid as other claims against the state are paid;

        (3) The money in the Fund remains in the Fund and does not revert to the State General Fund at the end of any fiscal year;

        (4) All money that is deposited or paid into the Fund is hereby appropriated to be used for any purpose authorized by the Legislature or DPBH for expenditure or allocation in accordance with the provisions of this BDR. Money expended from the Fund must not be used to supplant existing methods of funding that are available to public agencies; and

        (5) The Legislature may access money in the Fund in extraordinary circumstances and/or times of severe economic duress;

ii. Require eligible public health agencies to conduct a community needs assessment;

iii. Establish a process to evaluate the health and health needs of residents and establish a system to rank them for prioritizing funding; and

iv. Allocate money for direct expenditure by the health agencies operating under Chapter 439 of NRS in accordance with their identified needs and priorities relating to public health. **(BDR 40–529)**

Recommendation 2

Send a letter to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the director of DHHS:

a. Expressing the LCHC's support for FQHCs and maintaining or increasing the $500,000 per annum appropriation from tobacco settlement revenue to fund a Health Center Incubator Project for expanded access to care, which was made during the 2017 Legislative Session; and

b. Encouraging a review of opportunities to partner with FQHCs to leverage state funding to receive matching federal dollars to increase satellite sites, possibly through school-based clinics.

The LCHC heard testimony at its meeting on September 24, 2018, regarding the effectiveness of the Mobile Dental Van Pilot Project in rural Nevada. Testimony indicated that clinics in Clark, Esmeralda, Nye, and White Pine Counties provided case management, cleanings, dental screenings, fluoride application, oral hygiene education, and sealants. Due to the lack of access to dental providers and the lack of dental insurance or financial ability to cover the cost of dental services, the clinics saw a varied population of adults and children, including those with and without dental insurance. In the United States, an average of 61 dentists are licensed for every dentists per 100,000 people; in Nevada, there are 54 dentists per 100,000. However, these numbers are drastically lower in Esmeralda (0), Nye (20), and White Pine (39) Counties.

Recognizing the benefit of the project, the LCHC agreed to:

Recommendation 3

Send a letter to the director of DHHS encouraging continued funding to support the Mobile Dental Van Pilot Project in rural Nevada.

Other public health issues presented during testimony are the frequency of tobacco use and nicotine delivery devices—also known as e-cigarettes, vape-pens, and vapors. According to the federal Centers for Disease Control and Prevention (CDC), smoking is the leading cause of preventable death and more than 16 million Americans have a disease caused by smoking. Each year, approximately 4,100 adult deaths are associated with smoking-related disease in Nevada. Nevada has adopted the CDC's National Tobacco Control Program goals: (1) eliminating exposure

to secondhand smoke; (2) promoting quitting among adults and youth; (3) preventing initiation among youth and young adults; and (4) identifying and eliminating tobacco-related disparities.

To provide support for addressing this public health issue, the LCHC agreed to:

Recommendation 4

Send letters to the Senate and Assembly Committees on Health and Human Services expressing the LCHC's support for legislation and policies that:

a. Implement tougher fee-based tobacco retail licensing requirements;

b. Increase funding for tobacco control; and

c. Regulate and tax e-cigarettes and other vapor products.

B. Behavioral Health

The LCHC heard considerable testimony regarding behavioral health programs and services at the meetings held on January 11, February 20, April 24, and September 24, 2018. Furthermore, the regional behavioral health policy boards, created by AB 366 (2017), presented their priorities and recommendations at the meeting on August 27, 2018. An overview regarding access to behavioral health services for children and adolescents was presented at the meeting on July 17, 2018. At its meeting on March 19, 2018, the LCHC heard from various behavioral health professional licensing boards regarding efforts to modernize their licensing application and renewal processes as required by AB 457 (2017).

According to Mental Health America, Nevada ranks 51st in mental health care in the United States. The community-based nonprofit organization evaluates factors such as the prevalence of mental illness and access to care and *The State of Mental Health in America, 2018* confirms many of the concerns professionals and advocates brought to the attention of the LCHC during the interim.

In addition, the state faces a shortage of behavioral health providers—ranking 38th and 45th per capita, respectively, in the number of psychologists and mental health and substance abuse counselors per 100,000 residents. Advocates stressed the effect these shortages have on accessing appropriate care or receiving a timely diagnosis. Finally, the lack of service coordination, particularly for individuals diagnosed with a serious mental illness, was repeated throughout the interim.

To encourage greater collaboration to address these challenges, the LCHC agreed to:

Recommendation 1

Send a letter to the director of DHHS expressing the LCHC's commitment to improve services for people with mental health issues and encouraging DPBH to pursue opportunities to:

a. Build greater partnerships between local governments and social service programs;

b. Coordinate with the National Alliance on Mental Illness Nevada to address concerns about housing and medications;

c. Develop standards for adequate living conditions;

d. Ensure access to affordable prescription drugs, which work for the individual patient, for mental health conditions;

e. Expand access to treatment for the mentally ill and prevent overly restrictive state agency regulations, such as those imposing new or additional preauthorization requirements for Medicaid patients;

f. Explore housing options, which utilize currently vacant buildings and facilities;

g. Increase compensation to care providers; and

h. Provide affordable, safe, and sanitary housing for the mentally ill.

Recommendation 2

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

a. Additional funding for the Office for Consumer Health Assistance to expand its staffing and its education programs for assisting the mentally ill and their families; or

b. The establishment of an office of ombudsman or advocate for the mentally ill, possibly independent from DHHS.

C. Children's Health

At its meeting on March 19, 2018, the LCHC received an overview of the status of children's health in Nevada and an update regarding NCU—the state's Children's Health Insurance Program.

Representatives of the Children's Advocacy Alliance and the Nevada Institute for Children's Research and Policy (NICRP), School of Community Health Sciences, University of Nevada, Las Vegas, presented data regarding children in Nevada and the results of the *2018 Nevada Children's Report Card*, on which Nevada received an overall grade of "D." The report card is divided into four categories, and the state received a "C" in children's safety, a "D" in children's health and economic well-being, and an "F" in school readiness. Based on the results of the report card, Children's Advocacy Alliance presented several priorities for the 2019 Legislative Session.

In addition, NICRP presented information regarding Nevada's low lead poisoning testing rates; fewer than 3 percent of children under six years of age are tested. Testimony indicated that testing all children and requiring demographic data would help identify populations at risk of lead poisoning. Representatives of NICRP also discussed the number of children in Nevada diagnosed with asthma, which affects approximately 8 percent of children in the United States.

Finally, the LCHC received information regarding the prevalence of children with hearing loss. The CDC indicates that approximately 2 to 3 out of 1,000 children in the United States are born with a detectable level of hearing loss in one or both ears. A child's ability to hear directly affects speech and language development and greatly influences academic attainment and social skill development. These challenges are lessened when children have access to hearing aids and other hearing assistive technology. One way to increase access to these devices is to require coverage for hearing aids for children. According to the American Speech-Language Hearing Association, 23 states require health benefit plans to cover the cost of hearing aids for children.

Recognizing a variety of opportunities to improve the health of Nevada's children, the LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Appropriate $500,000 per annum to DHHS to provide monthly vouchers in the amount of $25 to participants in the Women, Infants, and Children program with children up to three years of age to support the purchase of diapers for families with limited financial resources on a first-come, first-served basis;

b. Appropriate $250,000 per annum to support stipends, technical assistance, and training to enable child care providers to offer high-quality, nutritious foods and ample opportunities for physical activity, including:

    i. $50,000 per annum to DPBH to subgrant to nonprofit organizations that provide training and technical assistance to child care providers on proper nutrition and physical activity; and

    ii. $200,000 per annum to the Nevada Silver State Stars Quality Rating and Improvement System (QRIS) to provide grants to QRIS-rated child care providers for facility improvements related to providing high-quality, nutritious food and ample physical activity;

c. Authorize physicians to issue a standing order for asthma medication, such as albuterol inhalers and/or nebulizers for students with asthma;

d. Amend NRS 442.700 to reflect current standards of the Council of State and Territorial Epidemiologists to improve data collected when children are tested for lead in order to identify at-risk populations and communities; and

e. Amend Chapters 287, 422, 689A, 689B, 689C, 695A, 695B, 695C, and 695G of NRS to require insurance plans in Nevada to cover the cost of hearing aids for children. **(BDR 57–448)**

Recommendation 2

Send a letter to DHHS encouraging DHCFP to evaluate the cost of adding all immigrant children residing in the state to Nevada's CHIP's eligibility policies and to analyze the cost of providing health insurance coverage to all children in Nevada, regardless of immigration status.

Recommendation 3

Include a statement in the LCHC's final report indicating its support for authorizing physicians to issue a standing order for asthma medication, such as albuterol inhalers and/or nebulizers for students with asthma.

At its meeting on July 17, 2018, the LCHC received testimony regarding barriers to accessing services and programs for the treatment of autism in Nevada. Representatives of the Applied Behavioral Analysis Institute, the Lovaas Center, and the Aging and Disability Services Division (ADSD), DHHS, stressed the need to increase Medicaid reimbursement rates for intervention services for children with autism, as well as the number of behavior interventionists (BIs) and RBTs who provide some of these services. Representatives of ADSD noted that as of June 30, 2018, 672 children were actively receiving services through the Autism Treatment Assistance Program (ATAP) and 517 children were waiting to receive services. The average wait time was 431 days.

The LCHC was further challenged to provide leadership in coordinating access to services and programs for the treatment of autism for school-aged children. Testimony indicated that interventions cannot currently be fully integrated because providers do not have access to children during school hours, and fixed academic schedules and instructional hour requirements impede efforts to provide autism services.

Following further discussion, the LCHC agreed to:

Recommendation 4

Send a letter to the Senate and Assembly Committees on Education and the Senate and Assembly Committees on Health and Human Services encouraging them to develop a joint study regarding barriers to, and strategies to best provide, intervention services for children with autism, including the impact of:

a. Allowing Medicaid to reimburse for RBTs in training;

b. Changing the compulsory education law to allow children diagnosed with autism to attend school half-day so they can receive intensive 1:1 ABA services in their homes during the day;

c. Creating a statewide magnet school program to produce RBTs;

d. Mandating in-school access to insurance-funded RBTs for eligible children;

e. Raising the reimbursement rates for RBTs so employers can raise wages; and

f. Requesting a report prior to the 81st Legislative Session that includes information requested in the August 27, 2018, letter from Kelly Venci Gonzalez, Esq., Team Chief, Education Advocacy Program, Children's Attorneys Project, Legal Aid Center of Southern Nevada, to the LCHC regarding:

    i. Access to services through Nevada's ATAP;

    ii. The number of children enrolled in Medicaid or CHIP who receive ABA services;

    iii. The number of ABA providers available to this population and how that impacts access to services;

    iv. Requirements for prior authorization to access ABA; and

    v. Additional related matters.

On July 17, 2018, the LCHC heard from representatives of the Division of Child and Family Services, DHHS, and DHCFP regarding access to behavioral health services and treatment programs for children and adolescents in Nevada. Presenters noted that the workforce has been, and continues to be, insufficient to meet the demand for services for children and their families. In addition, low Medicaid reimbursement rates and the complexity of the billing process discourage providers from participating in Medicaid and NCU.

Representatives of the children's mental health consortia (NRS 433B.333) shared their priorities, which include restructuring the public children's behavioral health financing and delivery system to improve outcomes and create greater efficiencies, increasing the number of children's behavioral health providers, and increasing family support and coordination of services.

Recognizing the challenges faced by families in Nevada when accessing children's behavioral health services, the LCHC agreed to:

Recommendation 5

Include a statement of support in the LCHC's final report for expanded access to quality mental health services for children and their families.

Recommendation 6

Send letters to the governor of the State of Nevada and the director of DHHS expressing the LCHC's support for recommendations made by the Nevada Children's Behavioral Health Consortium at the Committee's meeting on July 17, 2018.

D. Data Regarding Providers of Health Care in Nevada

At its meeting on September 24, 2018, the LCHC received a presentation regarding the process Nevada health insurers use to determine whether their network of providers is adequate and diverse. Insurance industry representatives provided information about the regulatory structure, the process of building a network, contracting, provider credentialing, and innovations to expand choice and access for patients. According to presenters, a few challenges in determining network adequacy include difficulty analyzing wait times, consumers' health literacy, and the need to increase patients' use of care coordinators.

In addition, professionals in public health, workforce planning, and policy development stressed the importance of improving data collection across the health care system. A few areas that would benefit most from collecting and analyzing deidentified demographic data on patients and health care professionals include addressing health disparities, planning for workforce needs, and determining how best to use limited resources. Such data on health care professionals is not currently collected in Nevada. As the demographic profile of Nevada changes, diversity among health care professionals helps meet the demand for culturally competent care. Collecting demographic information about health care professionals will help insurance providers ensure their provider panels are as diverse as possible.

Finally, advocates for culturally competent care stressed the importance of ensuring that all providers who apply to be on a health insurance company's provider panel receive consistent responses regarding the reasons for their denial.

Following deliberation on these issues, the LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Require, as a condition of licensure and relicensure, all providers of health care who are licensed in Nevada to complete a data request developed by the DOI. The data request shall include the following:

    i. Name;

    ii. Mailing address;

    iii. Email address;

    iv. Physical practice location(s) and portion of time spent practicing at each location;

    v. Specialty;

    vi. Race/ethnicity;

vii. Primary languages other than English; and

viii. License status.

The DOI may adopt regulations requiring additional areas of data collection, and it must develop and maintain a database to collect required data. Individualized data is confidential. Individualized deidentified data may be provided to governmental entities, and the DOI shall aggregate state-level data by license, which shall be public record; and

b. Require the commissioner of insurance of the DOI to develop, prescribe for use, and make available a single, standardized form for use by insurers to notify health care providers who apply for, but are not credentialed, on a health insurance network's provider panel. The commissioner shall hold public hearings to seek input regarding the development of the form and must consider this input in developing the form. At a minimum, the form must indicate the reason for which a provider is not credentialed. **(BDR 54–527)**

E. Funding for Family Planning Services

During the 2017 Legislative Session, several measures were approved to improve access to family planning in Nevada. A new state family planning grant program and the Account for Family Planning were created with the passage of SB 122, and AB 397 provided $1 million in funding to DPBH to provide grants to local governmental entities and nonprofit organizations for certain family planning services. Advocates indicated that the funding was inadequate to meet the demands for service across the state. In addition, the funding allocated by AB 397 was awarded through family planning grants; however, it was not allocated to the family planning grant program and account established by SB 122. Finally, neither measure clearly indicated that funding could be used to contract with the state for community health nurses, a primary provider in rural Nevada.

To address these issues, the LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Appropriate $12 million over the 2019–2021 Biennium to the Account for Family Planning (created by SB 122 [2017]);

b. Authorize the use of funds in the Account by local governments to contract with the state for community health nurses and other family planning health care providers in addition to the entities currently eligible for funding pursuant to NRS 442.725; and

c. Prohibit the administrator from discriminating based on the contraceptive method when awarding grants. **(BDR 40–446)**

F. Health Insurance and Medicaid

The 2017 Legislature passed several measures to preserve certain coverage requirements of the 2010 federal ACA. However, the most comprehensive measure was vetoed by the governor. During the interim, the DOI prepared several policy options that would provide greater flexibly to the commissioner of insurance to respond to changes in, and facilitate stabilization of, the health insurance marketplace. Representatives of the Office of the Governor and DOI provided the LCHC with a summary of the legislative changes necessary to implement these policy options.

The LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Allow flexibility under Nevada law if federal law is amended to allow larger tobacco- or age-rating factors;

b. Authorize the commissioner of insurance to enter into compacts to ensure essential insurance is available to Nevada residents and incorporate language to allow health benefit plans sold in contiguous states to be sold in Nevada when essential insurance is not available or is insufficient in the state;

c. Authorize the commissioner of insurance to apply for a state innovation waiver, in accordance with Section 1332 of the Patient Protection and Affordable Care Act;

d. Authorize the establishment of a reinsurance or high-risk pool program to mitigate the cost of health benefit plans in the individual market with the intent of helping to stabilize the individual health insurance market;

e. Impose restrictions on short-term health insurance policies currently defined within NAC into NRS; and

f. Repeal the right to annual enrollment with a 90-day waiting period as provided in NRS 687B.480. **(BDR 57–531)**

At its meeting on July 17, 2018, the LCHC heard presentations on network adequacy and the process insurers use to add health care professionals to their list of preferred providers, referred to as credentialing or empaneling. The LCHC heard from medical professionals and insurers, including representatives of Medicaid MCOs. The majority of the discussion centered on ways to improve the overall process to ensure patients have access to care. Included in the discussion was the need for culturally competent care. Discrimination and racial disparities in health care are documented through research and studies. Advocates for developing a culturally competent health care system indicate that doing so is essential to reducing racial and ethnic disparities in health care. In addition, the Office of Minority Health, U.S. Department of Health and Human Services, notes that, “Culturally and linguistically appropriate services are respectful of and

responsive to the health beliefs, practices and needs of diverse patients." Through the interim, the LCHC deliberated the significance of culturally competent providers when accessing medical and behavioral health care.

Another topic that affects access to care is Medicaid reimbursement rates. This is especially significant because Medicaid and NCU collectively cover approximately 22 percent of Nevada's population. The LCHC heard testimony from health care providers regarding the impact of low Medicaid reimbursement rates on their ability to care for patients with Medicaid coverage. Even providers who accept Medicaid stressed the challenge of staying financially viable as their number of patients with Medicaid coverage increases.

Recognizing the significance of this issue, the LCHC agreed to:

Recommendation 2

Send a letter to the governor of the State of Nevada, the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the director of DHHS, strongly encouraging:

a. The development of a "Diversity Plan of Action" to demonstrate Nevada Medicaid's and contracted MCOs' strategies for recruiting and retaining providers from underrepresented cultural, ethnic, and religious groups; and

b. Increased reimbursement rates for Medicaid to improve provider participation and expand access to services.

Recommendation 3

Send a letter to the director of DHHS encouraging the evaluation of Medicaid rules and reimbursement rates to ensure that rates cover the costs of business for family planning providers.

Recommendation 4

Send a letter to the director of DHHS encouraging Medicaid to allow community health centers to bill Medicaid for services provided by community health workers (promotoras).

Recommendation 5

Include a statement of support in the LCHC's final report encouraging DHHS to analyze the following issues within Medicaid, including Medicaid MCOs:

a. Disconnect between pharmacy reimbursement and overall costs to the Medicaid program (spread pricing);

b. Impact of reductions in pharmacy reimbursement on access to care, particularly in rural communities;

c. Lack of transparent data on pharmacy services; and

d. Potential conflict of interest between a retail pharmacy chain affiliated with a Medicaid PBM and possible reductions in pharmacy reimbursements.

In 2017, the Nevada Legislature passed a measure to begin the first phase of establishing a program similar to Medicaid managed care as a public health insurance option, called the Nevada Care Plan (NCP). However, AB 374 was vetoed by the governor. Senate Bill 394, which was approved, required the LCHC to study, during the 2017–2018 Interim, opportunities to establish a similar program and make it available through the Silver State Health Insurance Exchange, among other things. The LCHC received an update regarding the status of health insurance coverage in Nevada at its meeting on January 11, 2018. Subsequently, Assemblyman Sprinkle presented information and updates on February 20, 2018, concerning a working group and planned public listening sessions focused on developing options for establishing the NCP and a final report on September 24, 2018.

Assemblyman Sprinkle agreed to submit a BDR to implement any legislative changes deemed necessary to establish the NCP. He further indicated that collaboration with the NCP working group would continue with the aim of establishing details necessary to develop a viable plan, such as the population to be covered and the administrative structure.

Thus, the LCHC agreed to:

Recommendation 6

Send letters to the Senate and Assembly Committees on Health and Human Services expressing the LCHC's support for legislation creating a Medicaid-like buy-in program, such as that considered in AB 374 (2017).

At its meeting on April 24, 2018, representatives of the Immune Deficiency Foundation, ACT for Nevada, the Leukemia and Lymphoma Society, and the American Cancer Society Cancer Action Network discussed the need for medications to manage and live with chronic health conditions. They underscored the high cost of medications and the role health insurance plays in helping individuals access needed prescriptions. Excessive co-pays can greatly reduce an individual's ability to purchase drugs, even with insurance. To address instability in out-of-pocket prescription costs, presenters advocated for legislation requiring health insurance providers to offer at least one plan with a flat-dollar co-payment for specialty tier medications. Advocates refer to this plan option as "co-pay choice" and stress the plan's ability to provide price predictability and subsequently increased access.

The LCHC requested additional information regarding the potential impact of co-pay choice plan options on insurance cost and the overall insurance marketplace in Nevada. Recognizing the insurance expertise developed by legislative colleagues who serve on commerce and labor committees, the LCHC agreed to:

Recommendation 7

Send a letter to the Senate and Assembly Committees on Commerce and Labor supporting the development of options that enable individuals living with chronic illnesses to access health insurance plans that provide lifesaving treatments they otherwise may not be able to afford. Such health insurance options would provide that insurers offer the following:

a. At least one plan with a flat-dollar co-payment and no deductible for prescription medications in each of the four levels of plans and within each service area of the state;

b. A flat-dollar co-payment that includes all specialty tier medications; and

c. Co-payment rates that are reasonably graduated and proportionately related in drug formulary tier levels.

G. The Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired

The LCHC heard from members of the Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired on February 20, April 24, and August 27, 2018. In addition to other recommendations, the Commission proposed revising its name and number of members to update nomenclature and represent greater diversity within the deaf community.

Senate Bill 481 (2017) charged the LCHC with studying grants and funding options to support a full-time director for the Commission. To evaluate potential funding options, the LCHC received information concerning funding of similar entities in other states and found that most are supported by state general fund appropriations or from a surcharge placed on all access lines for telecommunication services. In Nevada, the Telecommunication Device for the Deaf (TDD) surcharge is established pursuant to NRS 427A.797. The Public Utilities Commission of Nevada determines the amount to be charged. The charge is 7 cents per month on each access line in the state, while the rate is capped by statute at 8 cents per month. The LCHC discussed the option of using a portion of the TDD surcharge funding to support a full-time director for the Commission. However, statute and administrative code currently govern proper use of the TDD funds, and using the funds for another purpose would require a statutory amendment.

Following further input from advocates and others, the LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Change the name of the Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired to the Nevada Commission for the Deaf and Hard of Hearing;

b. Expand the Commission membership from 9 to 11 members;

c. Revise the Commission membership such that it includes:

   i. One member (rather than three) who is a user of telecommunications relay services or the services of persons engaged in the practice of interpreting or the practice of real time captioning;

   ii. One member who is a member of an advocacy organization that has a membership of persons who are deaf, hard of hearing, or speech impaired;

   iii. One member who is hard of hearing;

   iv. One member who is an employment specialist; and

   v. One member who is a parent of a deaf child who is five years of age or younger;

d. Appropriate $50,000 from the State General Fund or tobacco settlement funds to the Commission in each fiscal year of the 2019–2021 Biennium for administrative, per diem, and travel costs of the Commission; and

e. Amend NRS 427A.797, TDD surcharge funds, to authorize a portion of the money in the account to be used to support a full-time director for the Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired. The director's compensation shall be determined by the Commission. **(BDR 38–449)**

H. Residential Facilities for Groups, Community-Based Living Arrangements, and Certain Unregulated Residential Facilities

The LCHC addressed supportive housing, including residential facilities for groups, CBLAs, and unregulated residential facilities at meetings on February 20 and March 19, 2018. The LCHC specifically addressed the study required by AB 343 (2017) concerning rates paid to group homes contracted with Southern Nevada Adult Mental Health Services (SNAMHS) at its meetings on April 24 and September 24, 2018.

The LCHC received a summary report titled, *Department of Health and Human Services, Division of Public and Behavioral Health, Adult Mental Health Services Community-Based Living Arrangement Homes* (LA18-13), prepared by the Audit Division. The performance audit found serious issues and poor living conditions in the adult mental health services and CBLA homes. Representatives of the Audit Division inspected 37 of 105 homes providing services for Northern Nevada Adult Mental Health Services (NNAMHS) and SNAMHS clients and found seriously deficient conditions at all 37 homes. Providers typically operate more than one home. A subsequent report from the Audit Division, *Department of Health and Human Services, Division of Public and Behavioral Health, Adult Mental Health Services Community-Based Living Arrangement Homes Residential Services Payment* (LA18-24), found that these providers overbilled DPBH about $1.5 million in Fiscal Year 2016–2017.

In addition, the study required by AB 343, *Review and Evaluation of Congregate Care Living Arrangements for Individuals With Mental Illness in Nevada*, highlights a few key issues and challenges for these homes, including inconsistencies in the level of services provided, the amount of regulation, and reimbursement rates for residential facilities for groups and CBLAs. The review found that the continuum of mental health housing services in Nevada is not clearly delineated and disparities exist between an individual's level of need and the level of services provided. Further, the report also notes inconsistencies in funding mechanisms that are available to help serve individuals with an intellectual disability, the frail elderly, and those with a mental health condition in Nevada.

Lastly, DHHS provided testimony regarding the challenges unregulated facilities pose to vulnerable persons and made recommendations to increase oversight and educate the public about the differences in housing options.

In response to the information provided, the LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Direct DHHS to review unlicensed group housing arrangements that provide assistance, food, shelter, and/or limited supervision to a person with a mental illness, a person with an intellectual or physical disability, or a person who is aged or infirm to determine when such arrangements require regulation. The review must consider:

   i. The impact of overregulation on housing arrangement options and affordable housing; and

   ii. Reasonable quality and safety protections to safeguard vulnerable populations; and

b. Broaden the definition of a referral agency in NRS 449.0305 by expanding the requirement for licensure to include any business that provides referrals to residential facilities for groups and any group housing arrangements that provide assistance, food, shelter, or limited supervision to a person with a mental illness, a person with an intellectual or physical disability, or a person who is aged or infirm. **(BDR 40–526)**

Recommendation 2

Send a letter to DHHS encouraging:

a. Proactive monitoring of business licenses to find license types or business names that may be operating unlicensed homes; and

b. The development of a public education campaign regarding the limits and possible hazards of unregulated and unlicensed group homes.

I. Substance Abuse Prevention and Treatment

Similar to many parts of the country, the opioid epidemic has hit Nevada hard. The Legislature has worked over the years to address the problem in a variety of ways, including increasing access to treatment and overdose-reversing drugs, furthering improvements in prescribing and pain management practices, and improving public health opioid abuse surveillance. According to DPBH, in 2012, Nevada clinicians wrote 94 painkiller prescriptions for every 100 residents.

In 2017, the Legislature passed AB 474, which increases the use of the prescription drug monitoring program (PDMP), authorizing certain occupational licensing boards to access the PDMP database and requiring them to review and evaluate certain information and impose disciplinary action. The LCHC heard testimony regarding the implementation of AB 474 or substance abuse prevention and treatment at meetings on January 11, February 20, and July 17, 2018. Since enactment of the measure, the rate of opioid prescriptions per 100 Nevada residents decreased by 31 percent from January 2017 to May 2018. However, some providers expressed concerns regarding implementation of the new evaluation and disciplinary processes. In addition, several patients testified to their belief that the bill may have had a chilling effect in the provider community that limited patients' access to necessary medications.

Testimony from patient advocates and health care professionals stressed the importance of educating the provider community about the implications of the measure and the prevalence of opioid abuse problems in Nevada. In addition, substance abuse prevention and treatment professionals and advocates stressed the need for safe detoxification facilities across the state.

In response to the variety of concerns raised, the LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Clarify certain provisions of AB 474 (2017), including requiring that the State Board of Pharmacy and all professional and occupational licensing boards that regulate health care providers who are eligible to prescribe controlled substances must develop and disseminate a clarification or technical assistance advisory bulletin to help clarify the intent of the legislation and which drugs are affected by the legislation. **(BDR 54–447)**

Recommendation 2

Send a letter to all professional and occupational licensing boards that regulate health care providers who are eligible to prescribe controlled substances, encouraging them to:

a. Host and advertise virtual town hall meetings to allow providers and patients opportunities to share their input and feedback about their experiences with AB 474; and

b. Host best practices workshops and offer continuing medical education to providers for attendance. This could be done via conference call, in-person, or webinar.

Recommendation 3

Send a letter to the director of DHHS and the administrator of DPBH expressing the LCHC's support for providing funding and/or assistance to ensure safe detoxification facilities are available across the state of Nevada.

J. Therapeutic Diets

In 2014, the federal Centers for Medicare and Medicaid Services published a final rule revising 42 CFR § 482.28 (b) (2), specifying that, "all patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals." In addition to other provisions, this revision permitted hospitals to allow registered dietitians to order patient diets independently, without the approval of a physician or other practitioner.

At the meeting on February 20, 2018, representatives of the Nevada Academy of Nutrition and Dietetics requested the LCHC consider revising state law and regulations to allow diet-ordering privileges to dieticians in hospital settings. Proponents for the change indicated that allowing dieticians the ability to independently order diets, nutritional support, and supplements would lead to improved patient outcomes, reduced cost of health care, and shortened hospital stays.

Following further deliberations and additional research, the LCHC agreed to:

Recommendation 1

Propose legislation to:

a. Amend NRS 640E.260 to authorize a dietician to recommend a therapeutic diet without consulting a patient's physician;

b. Require a medical facility, as defined in NRS 449.0151, to follow prescribed therapeutic diets, including the purchase of required food items so that dieticians can prepare a patient's prescribed diet; and

c. Require medical facilities to document that prescribed therapeutic diets are being followed and, upon request, make such documentation available to staff of the Bureau of Health Care Quality and Compliance, DPBH, DHHS. **(BDR 40–445)**

K. Victim Services Support

At its meeting on February 20, 2018, the LCHC heard testimony regarding the response to a mass casualty shooting at a music festival in Las Vegas, Nevada, on October 1, 2017. According to the Las Vegas Metropolitan Police Department's criminal investigation report concerning the incident, 22,000 individuals attended the event, 58 people died, and approximately 869 people sustained physical injury. The LCHC received an update regarding the creation of the Vegas

Strong Resiliency Center and other resources available to help victims of the tragedy. Representatives from the state and Clark County stressed the need to provide victim services and resources, including behavioral health assistance. Testimony emphasized the value of supporting a service delivery infrastructure that is available in the future.

In response to testimony, the LCHC agreed to:

Recommendation 1

Send letters to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing support for funding to maintain the service delivery infrastructure created to provide victim services and resources to assist individuals affected by the October 1, 2017, mass shooting in Las Vegas, Nevada.

IV. SUGGESTED LEGISLATION

The following bill draft requests* will be available during the 2019 Legislative Session at the following website: https://www.leg.state.nv.us/App/NELIS/REL/80th2019/BDRs/List.

BDR 40–445 Revises provisions governing therapeutic diets.

BDR 40–446 Revises provisions governing the Account for Family Planning.

BDR 54–447 Requires certain professional licensing boards to clarify provisions governing prescriptions of controlled substances.

BDR 57–448 Revises provisions relating to the health of children.

BDR 38–449 Revises provisions relating to the Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired.

BDR 40–526 Revises provisions concerning certain residential facilities.

BDR 54–527 Requires the collection of certain data concerning providers of health care.

BDR 40–529 Revises provisions relating to public health.

BDR 57–531 Revises provisions relating to health insurance.

*The following explains the number or letter preceding the dash in the BDR number that is assigned by the Legal Division during the drafting process:

BDR 40–368 A number denotes the NRS Title (i.e., Title 40), which encompasses the main subject of the bill draft.

BDR R–369 The letter “R” denotes the bill draft is a resolution.

BDR S–370 The letter “S” denotes the bill draft is a special act.