MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Eighth Session
April 8, 2015

The Senate Committee on Health and Human Services was called to order by Chair Joe P. Hardy at 6:03 p.m. on Wednesday, April 8, 2015, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Joe P. Hardy, Chair
Senator Ben Kieckhefer, Vice Chair
Senator Mark Lipparelli
Senator Joyce Woodhouse
Senator Pat Spearman

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Eric Robbins, Counsel
Debra Carmichael, Committee Secretary

OTHERS PRESENT:

Donna Miller, Life Guard International, Inc.
Michael Hackett, Nevada Primary Care Association
Donald Farrimond, M.D., President, Nevada Academy of Family Physicians
Nancy Hook, MHSA, Executive Director, Nevada Primary Care Association
Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services
Keith Lee, Nevada Association of Health Plans
Joan Hall, President, Nevada Rural Hospital Partners, Inc.
Denise Selleck, CAE, Executive Director, Nevada Osteopathic Medical Association
Karla S. Brune

Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Gerald O'Brien, President, National Alliance on Mental Illness, Northern Nevada
Joe Tyler
Mary Wherry, R.N., M.S., Deputy Administrator of Community Services, Division of Public and Behavioral Health, Department of Health and Human Services
Kyle Devine, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services
Kevin Quint, Chief, Substance Abuse Prevention and Treatment Agency, Division of Public and Behavioral Health, Department of Health and Human Services

Chair Hardy:
I will start with the work session on Senate Bill (S.B.) 210.

SENATE BILL 210: Revises provisions relating to inspections of certain medical facilities and offices. (BDR 40-1132)

Marsheilah Lyons (Policy Analyst):
Senate Bill 210 sets forth the incentivizing provisions for medical facilities, or facilities for the dependent, that pass a periodic inspection. The supporting documents and the proposed conceptual amendment from Wendy Simons have been distributed (Exhibit C). The AARP sent letters to the Committee in support of the measure as amended.

Senator Kieckhefer:
The grading system that currently is in place on select facilities is very effective and exceptionally consumer friendly. The basic idea of expanding that onto other facility types is a significant step in the right direction. It is a motivator for facilities and a vehicle for consumers to get a better idea of the quality of care at facilities they are seeking for care. I support the amendment.

SENATOR LIPPARELLI MOVED TO AMEND AND DO PASS AS AMENDED S.B. 210.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will move on to S.B. 247.

SENATE BILL 247: Revises provisions governing new construction by or on behalf of health facilities. (BDR 40-981)

Ms. Lyons:
Senate Bill 247 prohibits a person from spending more than $2 million, or an amount specified by the Department of Health and Human Services, for new construction by or on behalf of a health facility in an incorporated city or unincorporated town whose population is less than 25,000 in a county whose population is 100,000 or more, without the approval of the director of the Department. An amendment was heard at the hearing on March 25, by the Division of Public and Behavioral Health. The supporting document and the proposed amendment have been distributed to the Committee (Exhibit D).

Chair Hardy:
This provides an opportunity for a Certificate of Need for a hospital so it can be assured it will make it.

Senator Kieckhefer:
On the amendment, is the prohibition on the physical construction of the new facility?

Chair Hardy:
Yes, that is what I understand.

SENATOR SPEARMAN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 247.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will go to S.B. 257.

SENATE BILL 257: Revises provisions relating to child care facilities. (BDR 38-97)

Ms. Lyons:
Senate Bill 257 requires individuals employed in a child care facility in Nevada (except a facility that provides care for ill children) to complete at least 12 hours of training devoted to the care, education and safety of children. This bill was heard on April 1. The amendment was presented by Senator Woodhouse at the hearing. Senator Woodhouse proposed to amend further the bill to require that a qualified staff member always be in the presence of any independent contractor working in a child care facility. That staff member would supervise children and ensure that they are safe. An alternative would be to require the Division of Public and Behavioral Health to place in regulation that a qualified staff member always be in the presence of any independent contractor working in a child care facility. The supporting documents and proposed amendment have been distributed (Exhibit E).

Chair Hardy:
Will S.B. 257 require a fiscal note if the Division is required to make a regulation?

Senator Kieckhefer:
If the bill directs them to enact a specific regulation, there is very little difference than just doing it.

SENATOR SPEARMAN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 257 WITH AMENDMENTS 1, 2 AND 3 IN EXHIBIT E.

SENATOR KIECKHEFER SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will move on to S.B. 288.

SENATE BILL 288: Revises provisions relating to prescribing controlled substances. (BDR 40-889)

Ms. Lyons:
One amendment has been proposed by Senator Denis. Supporting documents and the proposed amendment have been distributed (Exhibit F).

SENATOR SPEARMAN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 288.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will move on to S.B. 327.

SENATE BILL 327: Revises certain provisions governing air ambulances. (BDR 40-1017)

Ms. Lyons:
Senate Bill 327 provides for the minimum number of attendants and qualifications for those attendants aboard an air ambulance. Three amendments are included in the work session document (Exhibit G).

Senator Kieckhefer:
Do we have a consensus on the amendments?

Chair Hardy:
We have a consensus on amendments 1 and 2.

Senator Kieckhefer:
What are the objections to amendment 3?

Donna Miller (Life Guard International, Inc.):
I oppose amendment 3 because the health district is given the authority to develop a set of rules and regulations, but there is a mechanism for the providers to avoid those regulations.

Senator Kieckhefer:
It would preclude out-of-state transport agencies from coming into Clark County to pick up a patient unless they were licensed by the Division of Public and Behavioral Health in Clark County rather than the State. The County's regulations over the industry have very specific requirements such as residency of agency personnel. It requires the agencies to have employees who live in Clark County in order to pick up someone in the County.

Ms. Miller:
It is my understanding that a health district can be developed in a county if there are more than 700,000 people in that county, which is what southern Nevada has done. Southern Nevada Health District goes through a process to adopt regulations, and those regulations are adopted through the Medical Advisory Board. There is a reason they are developing regulations and require the agencies that are providing services to patients being picked up from Clark County to meet them. If they are given the right to develop regulations, they should also have the right to enforce those regulations. Otherwise, why develop the regulations if someone can go to a different area, be licensed and do business in Clark County?

Chair Hardy:
I am pulling S.B. 327 from this work session and will bring it back in the next work session. This will give everyone time to review the bill and find an acceptable comfort level. We will move to S.B. 359.

SENATE BILL 359: Requires a child care facility to grant priority in admission to certain children. (BDR 38-1014)

Ms. Lyons:
The supporting documents have been distributed (Exhibit H).

SENATOR WOODHOUSE MOVED TO DO PASS S.B. 359.

SENATOR LIPPARELLI SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will move on to S.B. 394.

SENATE BILL 394: Revises provisions relating to the protection of children. (BDR 38-264)

Ms. Lyons:
Senate Bill 394 provides that the "reasonable and prudent parent standard" be characterized by the use of careful and sensible parental decisions that maintain the health, safety and best interests of the child. I have distributed the supporting documents and the two proposed amendments (Exhibit I).

Chair Hardy:
My Proposed Amendment No. 9947 deletes sections 1–10 of S.B. 394. I have left the protection of children in the bill. Jill Tolles' proposed amendment makes verbiage changes.

Ms. Lyons:
Another amendment from the Nevada Network Against Domestic Violence that I distributed to the Committee earlier will be added to the work session. The Committee has heard testimony on this previously.

Chair Hardy:
This other amendment is compatible with the intent of S.B. 394.

SENATOR KIECKHEFER MOVED TO AMEND AND DO PASS AS AMENDED S.B. 394 WITH PROPOSED AMENDMENT 9947 AND MS. TOLLES' PROPOSED AMENDMENT.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will move on to S.B. 402.

SENATE BILL 402: Makes various changes concerning the prevention and treatment of obesity. (BDR 40-891)

Ms. Lyons:
Senate Bill 402 defines the term "obesity" in the preliminary chapter of *Nevada Revised Statutes* as a chronic disease having certain characteristics. I have distributed the supporting document for this bill (Exhibit J).

SENATOR WOODHOUSE MOVED TO DO PASS S.B. 402.

SENATOR KIECKHEFER SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We are moving on to S.B. 419.

SENATE BILL 419: Revises provisions relating to services for persons with disabilities. (BDR 38-978)

Ms. Lyons:
Senate Bill 419 creates a program within the Aging and Disability Services Division to provide services of independent living and assistive technology for persons who have recently become disabled. The supporting documents and amendments have been distributed (Exhibit K).

SENATOR KIECKHEFER MOVED TO AMEND AND DO PASS AS AMENDED S.B. 419 WITH PROPOSED AMENDMENT 6033 AND CHAIR HARDY'S CONCEPTUAL AMENDMENT.

SENATOR LIPPARELLI SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We are moving on to S.B. 458.

SENATE BILL 458: Revises provisions governing notifications to patients regarding breast density. (BDR 40-979)

Ms. Lyons:
The supporting document has been distributed (Exhibit L). No amendments are included for this measure.

Senator Kieckhefer:
I will be voting no on this bill. *Nevada Revised Statute* 457.1857 was established when A.B. No. 147 of the 77th Session was passed in June 2013 and has not been implemented yet. I understand and recognize the concern about scaring people, which is a legitimate concern, but we have not had the chance to see it implemented in its existing form.

SENATOR LIPPARELLI MOVED TO DO PASS S.B. 458.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR KIECKHEFER VOTED NO.)

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Chair Hardy:
We are moving on to S.B. 501.

SENATE BILL 501: Revises provisions relating to the State Dental Health Officer and the State Public Health Dental Hygienist. (BDR 40-1162)

Ms. Lyons:
Senate Bill 501 provides that the State Dental Officer and State Public Health Dental Hygienist may be contractors for the Division of Public and Behavioral Health. The supporting document and a proposed amendment from the Nevada Dental Hygienists Association have been distributed (Exhibit M).

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 501.

SENATOR LIPPARELLI SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will move on to Senate Concurrent Resolution (S.C.R.) 2.

SENATE CONCURRENT RESOLUTION 2: Encourages education of medical care providers and first responders regarding caring for persons with Alzheimer's disease. (BDR R-237)

Ms. Lyons:
No amendments are included in the measure. The supporting document has been distributed (Exhibit N).

SENATOR LIPPARELLI MOVED TO ADOPT S.C.R. 2.

SENATOR KIECKHEFER SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
The work session is closed. We will open the hearing on S.B. 6.

SENATE BILL 6: Revises provisions relating to the delivery of health care. (BDR 40-63)

Michael Hackett (Nevada Primary Care Association):
The medical home model is centered on patient health needs. The Patient-Centered Medical Home (PCMH) recognition model replaces episodic care driven by illness and patient complaints with coordinated care focused on the long-term health of the patient. In a patient-centered medical home, the

primary care provider leads a team of other providers in coordinating care for all patients' health care needs. The PCMH model is based on the concept that a strong primary care system can improve health quality. The PCMH model also seeks to improve care coordination, increase the value of health services provided, expand administrative and quality innovations, promote active patient and family involvement in health care and help control health care costs. Effective transformation of this model requires investment in health information technology, reform of current payment systems and other changes to the current methods of delivering health care. I am presenting an amendment to S.B. 6 that would delete the language in its entirety and replace it (Exhibit O). What is proposed in this amendment is a first step to fully implementing the PCMH model should Nevada choose to do so. It will provide for consumer awareness and protection, so consumers know a practice that calls itself a patient-centered medical home has been recognized, certified or accredited as one.

Donald Farrimond, M.D. (President, Nevada Academy of Family Physicians):
We were disappointed this bill was not fully heard in the 77th Session. Senate Bill 6 is much cleaner and much shorter. The Nevada Academy of Family Physicians supports this bill.

Senator Kieckhefer:
Can you explain section 9 and what it does with the antitrust laws? It appears the language creating the advisory council had been deleted in the proposed amendment. Is the advisory council referenced in section 11 a separate advisory council?

What we are trying to accomplish in this bill is by no means comprehensive in terms of fully implementing the PCMH model. There are necessary steps that must be taken to allow the State to move forward. Part of the effectiveness of the PCMH model is a payment model that is reflective of how health care is delivered. In order to come up with the payment model, the health care providers—in this case the PCMH and the insurers or the insurance contractors—need to talk to each other without being in violation of State or federal antitrust and collusion provisions. The provision is necessary to allow discussions.

Section 10 of the amendment allows to the Department of Health and Human Services to convene an advisory council.

Senator Kieckhefer:
Is there a definition of PCMH in statute?

Dr. Hackett:
No, there is not.

Nancy Hook, MHSA (Executive Director, Nevada Primary Care Association):
Across the Country, there are PCMH or health home initiatives in almost every state. Some of them are driven by the Centers for Medicare and Medicaid Services (CMS), some of them are private foundation-driven and some are governors' initiatives. Nevada is just beginning to look at health care reform moving from fee-for-service medicine to a more comprehensive payment, not driven by encounters or services. Going from volume, which is how health care services are being paid now, to value, which is looking at outcomes. Currently, Nevada has multiple providers and multiple practices that are already accredited by the National Committee for Quality Assurance, The Joint Commission or Accreditation Association for Ambulatory Health Care. As we move forward through health care reform, it is important to establish the foundation defining a PCMH. Senate Bill 6 is a small bill, but it needs to be done before the stakeholders come together to decide how to reform the health care system in Nevada.

Senator Kieckhefer:
If it is already being done, why do we need the bill?

Ms. Hook:
The delivery model is being implemented, but the payment reform is not. Providers are still being paid on a fee-for-service, encounter-based model. The more services provided, the more the providers are paid. We want to define the payment process in order to get to the conversation about how to pay the primary care doctors differently. It is a different model that puts the patients at the center and provides the services they need, not necessarily just doctor visits.

Senator Kieckhefer:
I support the model and concept, but I do not see how the bill gets us there. Would S.B. 6 get us closer to the goal as it was originally drafted?

Ms. Hook:
Senate Bill 6 is a complicated bill that was designed without all the stakeholders engaged in the conversation.

Senator Kieckhefer:
Is the payment the biggest barrier to implementing a PCMH?

Ms. Hook:
Yes, it is. There is a delivery model that is different from the current one, so the services are paid for differently.

Senator Kieckhefer:
Under this system, do you envision physicians operating under the same business structure or is it a primary care office that refers out to other providers that operate under a cost-sharing agreement?

Ms. Hook:
Eventually, the payment reforms will be looked at. There are multiple models in terms of the cost-sharing. The PCMH model suggests if more investment is put into primary care, the downstream costs will be decreased because more is being invested into prevention and primary care. That is a shift of the payment model for health care today.

Dr. Farrimond:
Several studies have been done throughout the Country that showed patient outcomes have improved. This is one of the biggest issues for Nevada. We are frequently in the bottom 5 percent to 10 percent in any health care outcome or determinant viewed. These studies have shown cost savings. When looking at ways to revise payment, we are not looking at primary care physicians wanting to earn more money; it is about a different way to be paid. Part of the difference in the payment structure comes from shared health care savings. What is saved by a third-party payer is part of the savings given to the physician for providing services such as overseeing all the diabetic patients and reviewing certain parameters and outcomes on a monthly or quarterly basis.

Senator Kieckhefer:
It sounds like we need section 9 badly, and everything else is permissive. Is that correct?

Dr. Farrimond:
That was the issue with S.B. No. 340 of the 77th Session. The language was not permissive. By making the language shorter and permissive, it will not necessarily generate a fiscal note.

Tracey D. Green, M.D. (Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services):
Often patients are dealing in communities with practices that state they are a PCMH. Without a definition and accrediting body recognition, those practices may not be a PCMH. Senate Bill 6 is about definition and consumer protection, allowing the patient to be aware that he or she is in fact receiving a true PCMH service. When looking at payment reform we need to look at patient-centered medical care. We normally rely solely on physicians. The PCMH looks at the continuity of care: care management, case management and the role of the nurse. The intent of the PCMH is to provide integrated, comprehensive patient-centered care. That is associated with payment reform, but I see that as two separate and difficult issues to align in one bill. For the Division of Public and Behavioral Health, one of the primary barriers to S.B. 6, as it was originally written, is to deliver the insurance piece that is suggested, which we could not do. From a fiscal perspective, we would have had to create an entire unit to do this. This bill does give a definition. It is about patient awareness, it provides access, and we hope it will incentivize our community to become accredited to provide better care for Nevadans.

Senator Kieckhefer:
Would the practices that are currently certified qualify under the definition?

Dr. Green:
Yes, those practices qualify. In section 5, paragraph (c) of Exhibit O, it states the practices must be recognized, certified or accredited by a national accrediting organization.

Senator Lipparelli:
I understand section 5, paragraphs (a) and (b) define a PCMH, but does section 9 give the Department and the commissioner the ability to adopt the regulations for the PCMH?

Mr. Hackett:
Yes, the definition of PCMH is essential to go forward. Section 9 does not adopt regulations in the whole spectrum of the PCMH model, but it allows the PCMH and the insurers to begin the discussion regarding, examining and assessing different payment models and determining which ones are most conducive to the PCMH model.

Senator Lipparelli:
I do not interpret section 9 that way. I do not have a baseline understanding on what is proposed in this bill.

Mr. Hackett:
When we went down this road during the 77th Session; the bill was more complex than what is being proposed here. The old bill created an office of PCMH, and the bureaucracy that goes with the creation. There would have been significant cost to implement this under those conditions. During our work this interim with stakeholders, we agreed to take a simpler, stripped-down approach to this issue, one that was without a fiscal burden on the State in order to get something going. Recognizing what other states have done along these lines, we thought this approach would be the best to get the State, should it choose to do this, engaged in the process. Senate Bill 6 is a stripped-down version of the bill heard in the 77th Session. The important aspect of this bill is defining PCMH, for consumer awareness and protection, so consumers and patients know a practice that calls itself PCMH is truly a PCMH. Consumers and patients should have the resource available to them to find out who and where those PCMH are.

This is not the "be all, end all" bill for PCMH and State requirements to bring this program online. It is an essential baby step to getting to that point. We never looked at this as being a one legislative session process as we recognized it would take many to get there. Senate Bill 6 is the first step to get us to the result.

Senator Lipparelli:
Is there a set of model legislations or regulations around that deal with PCMH that you are considering and we are just not there yet?

Mr. Hackett:
We have looked at several states and how they have implemented this. We looked at Maryland, Vermont, Ohio and Montana for implementation ideas. Based on where Nevada is right now, provisions from the Montana legislation were adapted and used in the amendment before you today.

Chair Hardy:
I am a doctor. Let us say I am paid $30 for seeing a patient. Therefore, I want to see more patients, so I can make more money. In a PCMH model, I would be interested in those patients who have some disease process that I could treat and prevent them from getting worse, I will save money for Medicare, Medicaid and insurance companies. There would be a payment difference. Instead of getting $30 a visit, I would get a specific amount of money, when I prove my patients have better blood pressure, lower weights or blood sugar. There is a nexus between my results and my payment. In other words, instead of being paid for how many widgets I make, I am paid for "did the widgets work?" The PCMH are a different kind of approach to medicine that allows "value" to the patient. Hence, a patient-centered medical home where the patient who has a problem knows me and I know the patient, and the patient can see me when needed. The patient knows the educational process because I spend resources with the dietician, with the nurse or with all the modalities that doctors use that otherwise would be referred out. It is an intensive way to look at a patient who needs me. If I did that with a visit, my $30 charge for the visit would be worth five times that, but I am not allowed to charge five times the visit charge, so I do not. That is why the "may" is inserted in the first line of section 9.

According to the federal antitrust laws, if I charge $30 and I put up a billboard that advertises I charge $30, I am violating the antitrust laws. The PCMH is a niche where the doctor can advertise the services offered and is paid for them in a different way without violating the antitrust laws.

Senator Kieckhefer:
What is preventing the creation of PCMH now? It sounds like some already exist and are certified. It sounds like our law allows this to happen aside from the

payment issue. If we were to create the greatest PCMH statute in the Country, what would it look like?

Dr. Farrimond:
Yes, it does have to do with money. There were three states in the Country that did not have PCMH language 2 years ago. We have at least 47 other states to rely on for language. It does have to do with how doctors are paid. From a primary care physician's point of view, it has to do with how disease is managed in the population. Health care outcomes and determinants are in the bottom 5 percent to 10 percent. The PCMH model helps doctors manage disease. The doctor can manage chronic obstructive pulmonary disease, back pain and diabetes by having a health information technology system that measures every aspect of a disease on a spreadsheet. The nurse would call the patient every month to provide information and ask how the patient is doing. These little steps add up to big outcomes that can get Nevadans out of the bottom 5 percent to 10 percent.

Yes, Nevada does have some accredited PCMH. They are not functioning as they should. It is a daunting task to go through the certification process. There are numerous check boxes and policies and real changes that are required to the doctor's practice to qualify it as a PCMH. The practices that have been certified are not practicing as PCMH because they are not reimbursed as such.

Yes, PCMH models have to do with changes to reimbursement, but that structure allows the doctor to spend more time with the patient. On the flip side, it is not spending more dollars; it is just rearranging the way the doctor is paid. The patient outcomes are better; insurers are also saving money. The CMS program has saved millions of dollars in the states that have implemented Medicare and Medicaid programs. It is a cost-savings program that realigns how payment is made. Without this legislation, while it is a baby step, there can be no discussion with the health care commissioner, the third-party payer, the CMS or Medicaid if there is no language that allows it to happen.

Senator Kieckhefer:
Is there anything in the statutes that precludes that type of relationship now?

Dr. Farrimond:
No, nothing in statute precludes that type of relationship, but it cannot happen without payment reform. It cannot cost a doctor more to see a patient than the doctor makes by seeing the patient.

Keith Lee (Nevada Association of Health Plans):
The Nevada Association of Health Plans (NAHP) supports S.B. 6. Several of our members do utilize the PCMH model. It is very effective in incentivizing for better outcomes, patient satisfaction and preventative disease factors. It is a model that does work. The PCMH that various members work with are accredited by one of the three national accrediting agencies. This is the wave of the future in terms of how payment is received, how we look at overall outcomes versus just a patient-by-patient situation and more importantly how patients are treated. The NAHP has concerns on section 16, "if it ain't broke, don't fix it." As stakeholders, we want to participate in developing the regulations and measurements that are necessary, but the measurements are already in place for our respective health plans that do this. We think this is very effective and see this as a good model. This bill will raise the awareness among patients, providers and payers. That is one of the values of this piece of legislation.

Joan Hall (President, Nevada Rural Hospital Partners):
The Nevada Rural Hospital Partners support S.B. 6. We recognize this is a baby step in a long process but we are happy it is starting.

Denise Selleck, CAE (Executive Director, Nevada Osteopathic Medical Association):
Osteopathic medicine has long been dedicated to patient-centered care and long-term outcomes of wellness and health. Many of our physicians fulfill a primary care role. We are still the No. 1 profession to provide primary care throughout the Country. This is a model that we have watched, particularly in areas like Ohio that has been doing this for over 20 years. We feel this is a good step for Nevada and want it to go forward. We have some things we would like to see included in the long-term process and have been in contact with Mr. Hackett. We are delighted to see this beginning step toward allowing physicians and patients to participate in this. We have discovered it is a matter of including the patients when managing their care. It seems what we have lost in health care is the idea of the old doctor down the road, who knew everybody in town and managed their care from cradle to grave. That doctor was aware

when the patient went into surgery, scrubbed in on the surgery and held the patient's hand through it all. The Nevada Osteopathic Medical Association would like to see physicians be more involved in and manage their patients care as opposed to referring the patient out and hoping for a report in the end. We think the PCMH will help that process.

Dr. Green:
The Division of Public and Behavioral Health and the Department of Health and Human Services are officially neutral on S.B. 6. With the definition, there are important elements to what are significant for moving health care forward in Nevada such as the enhanced access, emphasis on prevention and improved health outcomes. We are committed to providing the resource on the Website so consumers are aware where the accredited/certified PCMH are within their communities. We are also committed to working with the insurance commissioner and with Medicaid to move forward the payment reform.

Chair Hardy:
We will move on to S.B. 284.

SENATE BILL 284: Requires the State Plan for Medicaid to provide for certain nonmedical transportation. (BDR 38-974)

Senator Woodhouse:
I will read the written testimony from Senator Aaron Ford (Exhibit P).

Senator Kieckhefer:
Section 1, subsection 3 states that the State will provide transportation services to recipients of Medicaid traveling to and returning from services and activities not covered in subsection 1; subsection 1 states services under the State Plan for Medicaid. What would these people be going to and from?

Senator Woodhouse:
I cannot answer your question. I will get the answer from Senator Ford and provide that to you.

Senator Lipparelli:
What is the difference between section 1, subsection 1, that says the "Department shall, to the extent authorized by federal law, contract with a common motor carrier," and section 1, subsection 3, that says the "director

shall, to the extent authorized by federal law, include in the State Plan for Medicaid a requirement that the State will provide transportation services"? Is that what this bill does?

Senator Woodhouse:
I will check with Senator Ford and get back to you.

Chair Hardy:
It sounds like they go to many places that are not medically related with a $70 million fiscal note for the biennium.

Senator Kieckhefer:
Is the transportation for the grocery store?

Chair Hardy:
Yes, it is for the grocery store. There was no provision for transportation to places nonmedically related.

Senator Woodhouse:
That is correct; it is for transportation to other places not medically related. Many of us have experienced family members who did better staying in their own home, but did not have the transportation necessary to get to various places. I do not see it as going to the movies, but I do see it as going to the grocery store or the pharmacy. I will check with Senator Ford and verify the types of trips this bill addresses.

Senator Kieckhefer:
Is the intent of S.B. 284 to apply exclusively to recipients who are at risk of institutionalization?

Senator Woodhouse:
I will check with Senator Ford and get back to you.

Karla S. Brune:
I volunteer with organizations, such as the homeless shelter, where there is a drop-in program providing help. I have gotten to know people through volunteering and discovered how hard it is for them to find transportation to go to a support group. They have to walk all the way across town.

Chair Hardy:
There is a fiscal note on the bill, and we cannot pass the bill nor can we guarantee what will happen to the bill. This Committee recognizes there are needs for nonmedical transportation.

SENATOR LIPPARELLI MOVED TO REREFER S.B. 284 TO THE SENATE COMMITTEE ON FINANCE.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will move on to S.B. 422. I have proposed an amendment changing section 1 (Exhibit Q).

SENATE BILL 422: Allows for the continued inclusion of certain drugs on the list of preferred prescription drugs to be used for the Medicaid program. (BDR 38-1159)

Laurie Squartsoff (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
Senate Bill 422 would allow the Division of Healthcare Financing and Policy to continue to manage the atypical and typical anti-psychotic drugs on the preferred drug list. With the amendment, it extends the sunset language for the preferred drug list for the Nevada Medicaid Fee for Service Pharmacy program. By extending the prospective sunset language, the Division will be able to continue to manage its pharmacy benefit with the same practice that has been in effect since the 26th Special Session. The Division has proven the operational process of the preferred drug list is a transparent process that allows for stakeholder and prescriber input and has not shown any impediment to access to quality care for Nevada Medicaid patients. The bill is part of the Governor's recommended budget, and if this bill does not pass, there would be a total computable revenue shortfall of $1.3 million for fiscal year 2016 and $1.3 million for fiscal year 2017.

Chair Hardy:
Can you explain how a shortfall happens when more money is being paid for prescription medications?

Ms. Squartsoff:
If the medications are not on the preferred drug list, it eliminates the ability to have supplemental rebates. That is the impact on the budget.

Chair Hardy:
Is this a good thing?

Ms. Squartsoff:
Yes, it is a good thing to continue this.

Chair Hardy:
Will this require the Committee to send this bill on to the Senate Committee on Finance?

Ms. Squartsoff:
This is included in the Governor's budget.

Gerald O'Brien (President, National Alliance on Mental Illness, Northern Nevada):
I will read from my written testimony (Exhibit R).

Joe Tyler:
I have heard about mental health agencies going belly-up because of the lack of incentives. I have submitted my written testimony (Exhibit S).

Chair Hardy:
The Committee received written testimony from Donna Shibovich supporting S.B. 422 (Exhibit T).

SENATOR LIPPARELLI MOVED TO AMEND AND DO PASS AS AMENDED S.B. 422 WITH THE PROPOSED AMENDMENT FROM CHAIR HARDY.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
We will now move on to S.B. 489.

SENATE BILL 489: Provides for the regulation of peer support recovery organizations. (BDR 40-1191)

Mary Wherry, R.N., M.S. (Deputy Administrator of Community Services, Division of Public and Behavioral Health, Department of Health and Human Services):
Senate Bill 489 establishes a new provider type by creating licensure for and oversight of a peer support recovery organization. This is a budget bill and corresponds to budget account (BA) 101-3216 on which the Committee heard testimony February 11. The projected revenue raised in this bill is reflected in decision unit E-230 in BA 101-3216. It requires the Division to license peer support recovery organizations and requires the Division to generate regulations for proper licensure and oversight of peer support recovery organizations. The Substance Abuse and Mental Health Services Administration (SAMHSA) has been promoting peer and family support services for well over a decade. Peer support services are delivered by individuals who have common life experiences with the people they are serving. People with mental health and/or substance abuse disorders have a unique capacity to help each other based on shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer their support, strength and hope to their peers, which allows for personal growth, wellness promotion and recovery. Research has shown that peer support facilities facilitate recovery and reduce health care costs. Peers also provide assistance that promotes a sense of belonging within the community. Nevada Medicaid added mental health peer support as a covered benefit in 2005 based on these premises. Unfortunately, the mental health delivery system has not embraced this important support service. The Medicaid policy requires these individuals to be supervised by qualified mental health professionals and to be a part of a behavioral health community network. Peer supporters need to be high school graduates and in recovery from a mental illness or addiction. This agency model will provide the structure, support and accountability necessary to grow this important service and recovery-oriented system of care.

Senator Kieckhefer:
This is an already covered benefit, and this bill provides linguistic structure to get peer supporters certified as organizations that can be billed. Is that correct?

Ms. Wherry:
Yes, that is correct.

Chair Hardy:
Is this in the Governor's budget?

Ms. Wherry:
Yes, it is in the Governor's budget.

Kyle Devine (Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services):
We will utilize the same model we have for our personal care agencies.

Mr. Tyler:
I am a peer specialist in northern Nevada at the Dini-Townsend Psychiatric Hospital. The block grant that pays for the peer counselors does not allow us to collect Medicaid dollars because it would be double-billing.

Ms. Wherry:
Mr. Tyler has been an employee of the State for 15 years and has been a peer support specialist. The State has been using Mental Health Block Grant dollars to pay for the staff, but Medicaid has been covering this benefit since 2005. Instead of using federal Medicaid dollars to bill for those services, they have been using the block grant dollars. The Division of Public and Behavioral Health, especially with the cost-allocation plan, has been using Medicaid as a funding stream for the peer support specialist instead of the block grant. We have taken the staff off the block grant and moved them off the State General Fund to Medicaid billing to maximize those federal revenues. The goal is to grow the private sector for peer supporters and our concern is the private sector has not responded to Medicaid offering this coverage since 2005. Nobody in the private sector has embraced the peer support model, which is very atypical. In other states, peer supporters have been utilized as a cost-effective support in recovery for mental illness. Our assumption is because the Medicaid chapter is onerous, the peer supporters have to be a part of a behavioral health community network. The peer supporters have to be supervised by qualified mental health

professionals. If agencies could be created that manage those requirements and employ the peer support specialists, those individuals would not have to worry about administrative burden. Perhaps then we could create that kind of model in the community, where people will have peer supporters to utilize in their recovery.

Senator Lipparelli:
Is the definition of the peer support services, which is creating a framework for the people who perform the services, to be in a position to be paid for those services?

Senator Kieckhefer:
Yes, that is my understanding. Sections 1 and 3 identify the definitions and scope of service. Since it is already considered a billable service under the State Plan for Medicaid, S.B. 489 will allow them to bill.

Ms. Wherry:
The only budget aspect for the fiscal component is as it relates to the Bureau of Health Care Quality and Compliance (HCQC) doing the licensure of the agencies. The ability for the agencies to actually bill for the direct service is only to Medicaid.

Senator Kieckhefer:
These agencies are already able to bill Medicaid for this service, even though they are not licensed by the HCQC.

Ms. Wherry:
The individuals are able to bill Medicaid. So now, the individuals would have to be under the umbrella of an agency. In some ways, this model is like the personal care agencies. When Medicaid first established the personal care aides, they were individuals and there was fraud and abuse. The agencies were established to avoid that state. Medicaid regulated the agencies, but Medicaid is not a regulatory body, so the agencies were moved under HCQC, because it is a regulatory body. That was to take a tighter control over regulating them. If we are able to grow the peer supporters in the community, we have less fraud and abuse. Peer supporters are like personal care aides in that they are high school graduates, not necessarily sophisticated as medical professionals and in knowing how to navigate the complexities of payer system. Coming under an agency model, the agency is the one that will be regulated and held

accountable. The ability to bill Medicaid exists today. The agency would be the one billing for the services provided by the individual, just as it occurs today in Medicaid billing for personal care aides.

Senator Kieckhefer:
Section 4 states a person who is licensed pursuant to this chapter as a facility for the dependent or a medical facility and who employs persons to provide peer support services is not required to obtain an additional license as a peer support recovery organization. If a hospital provides peer support recovery, does it need a separate license if a patient is housed in any other medical facility?

Mr. Devine:
The way it is written, that would be true. When licensing the agency, the peer supporter must meet the minimum qualifications. When facilities for the dependent and medical facilities are licensed, it would be a duplication to license them as peer support agencies as well.

Senator Kieckhefer:
Is this bill trying to capture stand-alone peer support organizations?

Mr. Devine:
Yes, it is trying to capture stand-alone peer support organizations.

Senator Kieckhefer:
How many stand-alone peer support agencies are there?

Mr. Devine:
There are zero stand-alone peer support agencies.

Senator Kieckhefer:
If there are zero stand-alone peer support agencies and those that operate under a medical facility will not be licensed, who would be regulated under this bill?

Senator Lipparelli:
It is not compulsory, but if someone wanted to provide peer support services, section 3, subsection 1 of S.B. 489 would not require them to be licensed. The person could still perform services. Are we creating a mechanism that a peer supporter can be compensated? What is being accomplished by creating the definition?

Ms. Wherry:
What is being created is a business model that will employ people in the market because people are not taking advantage of this service now. An employment vehicle is being created. These policies have been in the Medicaid services manual for 10 years. The only agency that has taken advantage of the policy and not billed Medicaid is the State. Services are being pushed into the community as more people are struggling with their mental illness and moving into recovery. The managed care plans are becoming actively involved in serving the mentally ill population because they are not coming into the State's service delivery system. The SAMHSA has embraced this model because the peer supporter is the most cost-effective portion of the recovery system. Senate Bill 489 is a mode to get peer supporters to enter into the system. The bill is just a means to get the peer supporter employed.

Chair Hardy:
We are trying to save people and money by employing a lower paid person to interact with a person who usually requires high resources.

Ms. Wherry:
I created the peer support language in the Medicaid chapter when I was deputy at Medicaid. Nevada was one of the first states to offer this, and my appeal to CMS was that SAMHSA recognizes this as a part of the recovery model. So many people with mental illness have experienced harm by treatment providers, and they are very distrustful of medical professionals. When the mentally ill person can find someone who has walked in their moccasins and who has learned to be compliant with treatment regimens, learned to participate in therapy and learned to establish a trusting relationship with medical professionals, the person who has been struggling with recovery is more likely to engage with a peer who is fully engaged and compliant and move down the path. Research has shown that peers want to share the success, hope and resiliency they have experienced with other people who are coming behind them. That is the beauty of the model. We have not understood why peer supporters have not grown in Nevada. Medicaid has been willing to reimburse for the peer supporter, but no one has taken it up on it. We are hoping that "once we build it, they will come." Nevada has around 125 severely mentally ill people who do not have peer supporters and who could benefit greatly from having those kinds of models to bring them along with resiliency and hope. The severely mentally ill have no place to go to access the peer supporters and that is what we hope the agencies will provide them.

Senator Lipparelli:
I am concerned this bill creates a framework to mandate that the person be licensed as a peer supporter when that person may or may not want to be in the future. Will section 3, subsection 1, that states, "Do not require the person offering the supportive services to be licensed," be removed in future legislative sessions?

Ms. Wherry:
The intent of the bill is to require the agency to be licensed, not the peer supporter.

Senator Kieckhefer:
Right now, what agency that exists and offers peer support service would have to be licensed under this bill and not under another medical facility license?

Ms. Wherry:
There is no agency, right now. That is what we are trying to create.

Senator Kieckhefer:
Is a vehicle being created for a standalone peer support organization?

Ms. Wherry:
Yes, that is correct. Right now, Medicaid will reimburse an individual peer supporter who is supervised by a qualified mental health professional who is part of a behavioral health network. If agencies can be created and want to bill Medicaid, they will have to be a behavioral health community network and will be required to have a qualified mental health specialist who supervises a peer supporter. The agencies will manage the Medicaid policies, so the individual peer supporter would not have to figure out all that.

Senator Kieckhefer:
Would Alcohol Anonymous fit into this category?

Ms. Wherry:
It might if it wanted to have peer supporters; however, that is not typically the business they would want to get into. The National Association for Mental Illness would be a good example, if it wanted to create this as a business arm, it might want to open a peer support agency. When the personal care agencies were created in 2000, not one existed. By the end of 2000, there were

94 personal care agencies. Personal care aides serve a different population. I would be surprised if many peer support recovery agencies were created, because there are not many people with mental illness who need peer support and there is not a huge volume of people who are qualified to be peer supporters. At this time, there are 125-150 people who would want peer support.

Senator Kieckhefer:
Are there basic categories for an unlicensed person to meet?

Ms. Wherry:
Yes, that is correct.

Chair Hardy:
We will move on to S.B. 500.

SENATE BILL 500: Revises the requirements for licensure as a facility for the treatment of abuse of alcohol or drugs. (BDR 40-1160)

Kevin Quint (Chief, Substance Abuse Prevention and Treatment Agency, Division of Public and Behavioral Health, Department of Health and Human Services):
Senate Bill 500 is an agency bill. Current law stipulates that a residential facility for the treatment of alcohol and drugs should obtain a license from the HCQC only if it is also certified by Substance Abuse Prevention and Treatment Agency (SAPTA). The SAPTA is only required for those residential programs that are funded by SAPTA, which creates a very small group. This creates a situation in which a program not funded by SAPTA may choose not to be certified by SAPTA, which means it is not required to be licensed by HCQC. The result is that a program can legally operate in Nevada without licensure or certification. For example, if a complaint is filed against a program, there exists no authority for HCQC or SAPTA to field the complaint. Essentially, the current law creates a loophole in which unfunded, uncertified programs can legally operate at a substandard level and are not held to the same standards as other residential programs. Passage of S.B. 500 will provide the same standard for all residential alcohol and drug treatment programs to operate under and will create greater protection for consumers and their families.

Chair Hardy:
Does the Committee have to refer this bill to the Senate Committee on Finance?

Mr. Devine:
This is an agency bill, and the increased revenue was built into the Governor's budget.

Senator Kieckhefer:
How many additional facilities will you license under this new law?

Mr. Devine:
Currently, 20 of these facilities are licensed, and we are projecting perhaps 10 additional facilities to be licensed with the passage of this bill.

SENATOR KIECKHEFER MOVED TO DO PASS S.B. 500.

SENATOR LIPPARELLI SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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Chair Hardy:
Seeing no further business before the Committee, I adjourn the meeting at 7:58 p.m.

RESPECTFULLY SUBMITTED:

_____
Debra Carmichael,
Committee Secretary

APPROVED BY:

_____
Senator Joe P. Hardy, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit**		**Witness or Agency**	**Description**
	A	2		Agenda
	B	8		Attendance Roster
S.B. 210	C	4	Marsheilah Lyons	Work session document
S.B. 247	D	5	Marsheilah Lyons	Work session document
S.B. 257	E	2	Marsheilah Lyons	Work session document
S.B. 288	F	5	Marsheilah Lyons	Work session document
S.B. 327	G	5	Marsheilah Lyons	Work session document
S.B. 359	H	1	Marsheilah Lyons	Work session document
S.B. 394	I	11	Marsheilah Lyons	Work session document
S.B. 402	J	1	Marsheilah Lyons	Work session document
S.B. 419	K	6	Marsheilah Lyons	Work session document
S.B. 458	L	1	Marsheilah Lyons	Work session document
S.B. 501	M	2	Marsheilah Lyons	Work session document
S.C.R. 2	N	1	Marsheilah Lyons	Work session document
S.B. 6	O	2	Michael Hackett, Nevada Primary Care Association	Amendment
S.B. 284	P	3	Senator Woodhouse	Written testimony
S.B. 422	Q	1	Senator Hardy	Amendment
S.B. 422	R	1	Gerald O'Brien	Written testimony
S.B. 422	S	1	Joseph Tyler	Written testimony
S.B. 422	T	1	Senator Joe P. Hardy	Written testimony of Donna Shibovich