

**MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES**

**Seventy-ninth Session
May 3, 2017**

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 3:37 p.m. on Wednesday, May 3, 2017, 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 Pat Spearman, Chair
Senator Julia Ratti, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

GUEST LEGISLATORS PRESENT:

Senator Yvanna D. Cancela, Senatorial District No. 10
Assemblywoman Amber Joiner, Assembly District No. 24
Assemblyman James Oscarson, Assembly District No. 36
Assemblywoman Melissa Woodbury, Assembly District No. 23

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Martha Barnes, Committee Secretary

OTHERS PRESENT:

Steven L. Phillips, M.D., Treasurer, Nevada Physician Order for Life-Sustaining Treatment; President, Geriatric Specialty Care
Catherine O'Mara, Nevada State Medical Association
Barry Gold, AARP Nevada

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Michael Hackett, Nevada Academy of Physician Assistants; Nevada Public Health Association; Nevada Primary Care Association
Chelsea Capurro, Nevada Advance Practice Nurses Association; Health Services Coalition
Brooke Maylath, President, Transgender Allies Group
Jared Busker, Children's Advocacy Alliance
Jon Sasser, Legal Aid Center of Southern Nevada
Shannon Sprout, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Ryan Beaman, Clark County Firefighters Local 1908
Regan Comis, Nevada Association of Health Plans
Jan Crandy
Brian Patchett, CEO, Easter Seals Nevada
Stephanie Hill
Edward Ableser, Administrator, Aging and Disability Services Division, Department of Health and Human Services
George Ross, Hospital Corporation of America, Inc.; Touro University; Las Vegas HEALS
Bill Welch, Nevada Hospital Association
Paul Moradkhan, Las Vegas Metro Chamber of Commerce
Kelly Crompton, City of Las Vegas
Lisa Foster, State of Nevada Association of Providers
Mary Liveratti
Katherine Ryder, Director, A Team NV, Advocacy, Awareness, Advisement
Barbara Paulson, Nevadans for the Common Good
Jeffrey Klein, Chair, Legislative Subcommittee, Nevada Commission on Aging; President, Nevada Senior Services
Sam Lieberman, Easter Seals Nevada
Nancy Brune, Executive Director, Guinn Center for Policy Priorities
Ed Guthrie, Opportunity Village
Marta Jensen, Acting Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
John Yacenda, President, Nevada Silver Haired Legislative Forum

CHAIR SPEARMAN:

I will open the work session on Senate Bill (S.B.) 265.

SENATE BILL 265: Revises provisions relating to prescription drugs.
(BDR 40-809)

MEGAN COMLOSSY (Policy Analyst):

Senate Bill 265 was heard in Committee on March 29, as noted in the work session document ([Exhibit C](#)). The bill makes various changes related to prescription drugs. It requires the Department of Health and Human Services (DHHS) to identify essential prescription drugs for the treatment of diabetes; requires manufacturers of these drugs to submit information related to costs and to reimburse purchasers of those drugs if costs increase more than a certain amount each year; and requires that insurers are notified of imminent cost increases, among other things. The bill also requires pharmaceutical sales representatives to be licensed and report certain information annually. It authorizes students who attend private school, as well as certain employees, to self-administer medication for certain conditions, including diabetes.

Proposed Amendment 3888 to S.B. 265 is attached to the work session document and was proposed following the bill hearing.

SENATOR YVANNA D. CANCELA (Senatorial District No. 10):

The amendment clarifies language to ensure the changes can be properly enacted. The bulk of section 6 has been deleted, namely the language requiring a refund to be processed and returned to the consumer. Some language was challenged. Based on a recommendation from the Legislative Counsel Bureau, the language causing concern has been removed because there may be a conflict with the federal Commerce Clause. I kept the language allowing the Department of Health and Human Services to determine the total cost and development of essential diabetes drugs because it is the core of the bill.

Section 7 copies the transparency language from Assembly Bill (A.B.) 215.

ASSEMBLY BILL 215: Requires the reporting of certain information relating to prescription drugs. (BDR 57-284)

This language in S.B. 265 has broadened. Section 7, subsection 1, paragraph (a) addresses research and development language; paragraph (b) addresses the cost of producing the drug; paragraph (c) is the administrative cost and marketing; paragraph (d) is profit from the drug plus the overall profit from the drug to the manufacturer; paragraph (e) addresses the financial assistance provided by the manufacturer; paragraph (f) addresses the cost of coupons provided directly to consumers and the cost attributable to the redemption of those coupons to the manufacturer; paragraph (g) addresses the

wholesale acquisition of the drug; paragraph (h) addresses the history of increases in cost of the drug; paragraph (k) gives the DHHS discretion to require any additional information in order to create a proper report on drug pricing.

Section 7, subsection 2, indicates the report will go online on or before June 1 of each year.

Section 8 deals with the 90-day notification for price increases. This notification will now be given to the Department of Health and Human Services.

Section 9 addresses the nonprofit disclosure. This language has been significantly cleaned up to ensure we are capturing the correct information. Originally, we addressed only manufacturers and now it also includes contributions from trade groups, payments and donations. The section also addresses how the information should be posted on the nonprofit's Website.

Section 12 indicates all of the transparency language as well as the nonprofit disclosure which will be posted online on the DHHS Website.

Section 13 ensures the DHHS is not liable for inaccurate information.

Section 14 addresses the appropriate language for the DHHS to enact regulations to implement these provisions.

Sections 18 through 24 deal with the licensing of a pharmaceutical sales representative to be clear regarding what the pharmaceutical representative will be licensed for and what the licensing process will entail. It also allows for the DHHS to create such regulations. The deleted language references penalties and the disciplinary actions in the original bill.

Section 23 outlines what will be included in the annual report provided by the pharmaceutical representatives; specifically, a list of providers of health care whom the pharmaceutical representatives contacted. The application requests the name and manufacturer of each drug and each provider of health care to whom the pharmaceutical representative provided compensation, including gifts, food or free supplies and the values of such compensation.

Section 24 references business registration and whether or not the pharmaceutical representatives have a current registration.

Section 25 has been deleted.

Section 27 previously identified employers and schools regarding the self-administration of insulin. This section is now limited to schools to ensure we cover public, private and charter schools.

Section 30 leaves in language to ensure individuals are given notice as to whether or not the drugs that are on the list compiled by the DHHS will be removed from the formulary. The intent of the language is for those individuals shopping for individual policies to be made aware of the drugs that will or will not be on the formulary.

Section 44.5 outlines the dates for each provision of the bill to be enacted. Specifically, on November 1, the first list of drugs compiled by the Department of Health and Human Services will be complete and posted on the Website. On July 1, 2018 the Department will work with the manufacturers to ensure reports are submitted for any drug on the formulary. The first analysis from the Department will be provided on or before September 1, 2018. Section 45 clarifies that the act becomes effective on passage and approval of S.B. 265 and when the regulations need to be enacted.

While the rewrite in section 6 is in regard to the refund portion of the bill, there were some issues. I am still hopeful there is a process by which a refund can be created. I am looking at different options, but I am not prepared to present any to the Committee today.

SENATOR HARDY:

How is this bill going to decrease the cost to the consumer?

SENATOR CANCELA:

I sincerely believe increased transparency leads to decreased costs. When consumers have more information, they are able to make better decisions. We, as policymakers, can enact laws based on where we identify problems in the system if we have the data. I am confident, while this may not have a direct provision to return money to the consumer, it will provide us with the tools to make decisions about drug costs.

SENATOR HARDY:

If I were a manufacturer, I would ask the language to be broadened to include pharmacy benefit managers, retailers and wholesalers so there is more transparency. As the discount gets shared, it gets bigger and bigger. The bigger the start, the more percentage there is in dollars. I would like to see even more transparency than what is already written into the bill. I will be voting no today with a firm resolve to vote for the bill on the Senate Floor because I think it will be a good bill.

SENATOR HAMMOND:

When I first read the bill and heard testimony, I was sure there would not be enough time to process it during this Session. This is a huge issue that I felt warranted more time. There are numerous stakeholders and many moving parts. I found out there were provisions needing to be deleted and some provisions that could not be accomplished. When people came to talk to me about the bill, I said it might be something to look at again during the Interim. When people talked to me about the bill, it was in regard to the price caps. I did not want Nevada to be the state that put caps on pricing. It was not necessarily about the price caps but about all of us who are consumers who must understand the process. In the end, we want the price savings to be passed along to the consumer. We need to shine light on the entire process so the consumer is the winner but go a little bit further. Is that what you are still working toward?

SENATOR CANCELA:

When I first started working on this bill I asked for input from the stakeholders. Unfortunately, I received very little feedback, and the discussions are just now beginning. The problem begins at the top with the manufacturer. Every other cog in the system reacts to the price-setting behavior of the manufacturer. We only have 33 days left in the Session, and I want to make sure the bill will move as it has the potential to help so many people.

SENATOR HAMMOND:

Once we shine a light on this subject, we should be able to identify the difficulties. I want to vote yes today with a firm resolve to vote yes on the Senate Floor. I want us to make sure we have transparency on every level of the chain from the manufacturer down, so the consumer wins. The consumer needs to be getting the savings, rebates and refunds.

SENATOR CANCELA:

I am still open to having these conversations, but I am also aware of the politicking taking place around the Country on this issue which ends up with finger-pointing and inaction. I am not interested in ending this the same way. I want to make sure we do everything possible to vote out a good bill. I know the starting point is with the manufacturers, and that is my direction for the bill.

SENATOR HAMMOND:

We are on the same page. With the data being made available on the Internet, it will allow the consumer to make his or her own decision.

CHAIR SPEARMAN:

We are trying to get this language right for the consumers so someone who needs lifesaving drugs can afford those drugs, can afford to eat, can afford to pay their rent or mortgage and can afford to buy things for their children.

SENATOR RATTI:

I was a yes at the end of the hearing. I am a yes today. I am pretty sure I will be a yes when this bill comes to the Senate Floor for a vote. There is really good policy in this bill. I think if the bill passes in its current form, we would be making a huge difference with the families who are drowning by an escalation of drugs costs. It is not about blame or pointing fingers, it is about concrete things we can do to address a piece of this problem. I would not hold up the bill to make sure we address other pieces; I would be pushing this bill forward to ensure we are addressing the issues with good policy. I hope when we get to the Senate Floor vote, there is a way to get price management back into the bill without violating the Commerce Clause. Families with diabetes can no longer wait for the perfect solution. We need to provide a solution for these families, and we need it soon. I look forward to supporting the bill when it comes to the Senate Floor for a vote.

SENATOR WOODHOUSE:

You have made some great strides with the subject matter in this bill. Whether we can make anything further happen this Session, we will see; if not, we will continue to move forward. I was a yes after the hearing, I am a yes today, and I will be a yes on the Senate Floor.

CHAIR SPEARMAN:

I want to go back to something you said about the Commerce Clause and the refund. I was troubled about something I heard in the Senate Commerce, Labor and Energy Committee this morning when someone was testifying about changing formularies and costs in the middle of a plan. The numbers the person provided was one drug with a cost of \$700. By looking for something else that was comparable, they found a new cost of \$1. Another drug was \$84,000 a year or something like \$2,000 a pill. I am hoping that everyone who has a stake in this bill will at least come and talk to you as the sponsor.

I have heard pharmaceutical companies provide coupons with many of them being available online. I have also heard not everyone has a computer or the availability to access one. Of the people who need this help, most are senior citizens. If these people do not have a computer, they do not have access to the information proposed to be online. Even people who have a computer may not know to go online to look for coupons or discounts for their drugs.

I support the bill but wondered if you would be amenable to discussing a price reduction, for a period of time, to equal the amount being offered in coupons. There is usually some sort of actuarial formula to allow the printing of \$50 million worth of coupons and expect about half of them to be redeemed. Is there a way to reduce the cost of the drug to the equivalent of the discount in regard to the coupons? I do not even know if this could happen, but if a coupon reduces the cost of a drug, that tells me in the business process and marketing there is a formula to deduct a certain amount from the cost of the drug.

SENATOR CANCELA:

I would be open to looking into that option as a possibility with the help of the Legislative Counsel Bureau.

SENATOR HAMMOND:

From your questions it sounds like you are asking about the pharmacy benefit managers. That was the testimony I heard from listening to the Committee hearing this morning.

CHAIR SPEARMAN:

I am talking about the manufacturers which Senator Cancela said were the catalysts, and everything else is responding to the catalyst. With that being the case, the catalyst indicated they had coupons available. Instead of expecting

someone to go online because the business process includes the deduction if everyone cashes in, then why not provide the same reduction as the coupons?

SENATOR HAMMOND:

When I was listening this morning, those people who were against the bill were the pharmacy benefit managers who receive some of those rebates also. It is important to review the whole supply chain.

CHAIR SPEARMAN:

Everyone is responding to the catalyst, and that is what I want to address.

SENATOR RATTI MOVED TO AMEND AND DO PASS AS AMENDED
S.B. 265.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION PASSED. (SENATOR HARDY VOTED NO.)

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I will open the hearing on Assembly Bill 199.

ASSEMBLY BILL 199 (1st Reprint): Revises provisions relating to end-of-life care. (BDR 40-813)

ASSEMBLYWOMAN MELISSA WOODBURY (Assembly District No. 23):

I was happy to work on the language for this bill with Sally Hardwick, Chair, Nevada Physician Order for Life-Sustaining Treatment, but she could not be here to testify today.

Assembly Bill 199 makes various changes to the Physician Order for Life-Sustaining Treatment or POLST as a result of issues raised through the Interim Legislative Committee on Health Care. The POLST was first established in *Nevada Revised Statutes* (NRS) in 2013 when the Legislature unanimously passed A.B. No. 344 of the 77th Session. The bill before you aims to update the POLST process to conform with national practices. The POLST is a medical order that indicates the types of medical treatment a patient wishes to receive toward the end of life, giving terminally ill patients more control over their end-of-life care.

Such orders are maintained in the Secretary of State's Registry of Advance Directives for Health Care. Under existing law a physician can complete a POLST at the request of a patient diagnosed with a terminal condition who is expected to live for less than five years.

Assembly Bill 199 expands the types of providers who may diagnose a patient with a terminal condition, determine a patient's life expectancy and complete a POLST. It includes advance practice registered nurses (APRN) and physician assistants (PA) in addition to physicians. In keeping with this change, the bill revises the name of the POLST from Physician Order for Life-Sustaining Treatment to Provider Order for Life-Sustaining Treatment.

The bill also revises provisions governing the execution and revocation of a POLST form. Currently, a POLST may be completed or revoked only upon the request of a patient. Assembly Bill 199 provides it may be completed or revoked by an adult patient if the patient has the capacity to make decisions regarding the provision of life-resuscitating treatment and life-sustaining treatment. However, if a patient lacks the capacity to make such decisions, the bill authorizes a POLST to be completed or revoked by the patient's representative or certain surrogates. If the patient is a minor, his or her parent or legal guardian may complete or revoke a POLST.

The bill defines a patient's surrogate in order of priority as the patient's spouse, the adult child of the patient or a majority of the adult children available for consultation, the patient's parents, an adult sibling of the patient or a majority of adult siblings, the nearest other relative by blood or adoption, or an adult who has exhibited special care or concern for the patient who is familiar with the patient's values and is willing and able to make health care decisions for the patient.

Assembly Bill 199 also revises the standard for determining whether a patient has the capacity to request and execute a POLST. It removes references to a patient's competence and incompetence; instead it refers to having the capacity to make decisions. If a POLST is executed while a patient lacks decision-making capacity, but the patient regains such capacity, a physician, APRN or physician assistant must examine the patient and inform him or her of the POLST form. In addition, the patient must be given the opportunity to approve or revoke the POLST form. The patient's representative or surrogate must be informed of his or her decision.

Finally, if the directive or order in a patient's POLST conflicts with the patient's do not resuscitate identification, the POLST must be followed if it was executed more recently.

SENATOR JOSEPH P. HARDY (Senatorial District No. 12):

This bill came about through the efforts of Sally Hardwick who is the 40-year spouse of ER physician, Dr. Wayne Hardwick. Mrs. Hardwick has championed this concept for some time, and she is the one who deserves the credit for this bill. The bill allows a person to have some autonomy and lets the physician team, the physician's assistant or nurse practitioner know what the feelings of the heart are in regard to life-sustaining treatment.

STEVEN L. PHILLIPS, M.D. (Treasurer, Nevada Physician Order for Life-Sustaining Treatment; President, Geriatric Specialty Care):

I have been in Nevada since 1992 and worked all over the State. I am representing the Nevada POLST Board, and I am a practicing geriatrician with a house-call practice spanning from Gardnerville to Elko. These language changes speak to over 18 providers.

In rural Nevada, there is often difficulty finding a physician to care for someone, much less sign a POLST. I have worked with APRNs and PAs throughout my entire career, which goes back to my fellowship in geriatric medicine in 1985. In addition, the APRNs and PAs can write for very large opioid medications, yet they cannot be part of the end-of-life decision or signing of a POLST. The Centers for Medicare and Medicaid Services (CMS) does pay both APRNs and PAs, as well as physicians, to conduct end-of-life care planning and pays for the discussion. The federal government has recognized that APRNs and PAs have the ability to determine decisional capacity which further supports these changes.

At this time "substituted judgement" is a decision made only by someone who is deemed capable of making decisions regarding the POLST and/or someone who has an advance directive guardianship who can make that determination. This change allows a person to speak for the loved one who can no longer speak for himself or herself.

I served as a consultant for the state of Oregon when it passed the original POLST legislation back in the 1980s. I strongly support all of the proposed changes in A.B. 199.

CATHERINE O'MARA (Nevada State Medical Association):

The physician community is very much in support of A.B. 199 and the updates to the POLST process.

BARRY GOLD (AARP Nevada):

This bill is all about patients and their access to quality affordable health care. You have heard that APRNs and PAs are an important part of our health care provider network. They perform many services, and they are seen by many people as primary health care providers. They are the patient's access to receiving health care. The AARP was a big part of the original passing of the POLST, and this bill improves it.

The APRNs and PAs need the ability to work with their patients on these end-of-life decisions and complete the documents. These are difficult decisions between the individual and/or the family with their primary medical provider. The POLST is within their educational training and their expertise, and they need to be able to sign the forms.

The bill will help APRNs and PAs provide care for their patients, so AARP strongly supports this bill.

MICHAEL HACKETT (Nevada Academy of Physician Assistants):

We are in support of A.B. 199. I provided an exhibit for the Committee ([Exhibit D](#)) to better understand the classroom and clinical training the PAs complete when determining patient capacity and training for end-of-life measures. These classes include gerontology, medical ethics, behavioral medicine, clinical training in geriatrics, inpatient, internal medicine and a course of study in evaluating the capacity of an individual. The physician assistants are included in what will become a provider order for life-sustaining treatment. They understand the responsibilities associated with the execution and revocation of a POLST.

CHELSEA CAPURRO (Nevada Advance Practice Nurses Association):

We support A.B. 199.

CHAIR SPEARMAN:

I will close the hearing on A.B. 199 and open the hearing on A.B. 408.

ASSEMBLY BILL 408 (1st Reprint): Revises provisions relating to Medicaid and health insurance. (BDR 38-957)

ASSEMBLYWOMAN AMBER JOINER (Assembly District No. 24):

The purpose of this legislation is to include in NRS many of the health care protections that Nevada families currently have, thanks to the federal law. We must codify in law the key provisions of the federal Patient Protection and Affordable Care Act (ACA) so that whatever happens at the federal level, the key protections will remain in effect. I have included Proposed Amendment 4346 for the Committee to review ([Exhibit E](#)).

Before the ACA, we used to put everything in statute that we wanted insurance companies to cover. This picks up the same tradition. In the Assembly Committee process, we added the “whereas” clauses you see in the bill to make clear this particular bill only intends for insurance companies to cover what they are currently required to cover, no more and no less.

This is not the entire ACA. I have picked out the pieces that have provided the greatest protection to our families, and the ones I believe we need to secure in State law. While preparing for this bill hearing, I was reminded what our roles were like before the ACA came into effect.

There are many important changes made by this law. Women in Nevada used to be charged as much as 45 percent more than men for the same insurance coverage. Many plans did not cover maternity benefits. Many women who became pregnant were not able to find health insurance because it is considered a preexisting condition. We cannot return to that world.

In the old world, we had cancer patients who were dropped from their coverage because they cost too much to cover anymore. This bill will ensure some of these provisions do not occur again. There will be no copays or coinsurance for preventive care. This includes contraception, vision, rural health screenings for kids and immunizations. The bill also ensures there will be no denial, discrimination or higher costs based on health status, as happened with preexisting conditions. The bill ensures young adults can stay covered by their parents’ insurance until the age of 26. Carriers cannot drop coverage if a person becomes too sick or expensive to cover. Assembly Bill 408 looks like a long bill, but it repeats the same provisions in all of the health insurance plans.

I have provided a handout to the Committee with two bullet points ([Exhibit F](#)). These are the two topics I am still working on with the interested stakeholders. It has been difficult to draft this bill to include what is contained in the federal law. We are continuing to refine the bill to ensure it only contains what is currently in the ACA. To be specific, I have put the date of January 1, 2017, to make it very clear what coverage we are trying to match.

I have heard concerns that the language is not clear enough regarding retiree plans, spouses, the use of reasonable medical management techniques and coverage relating to the frequency and type of certain procedures and preventive services.

I will consider adding other provisions of the ACA, requiring coverage for all of the essential health benefits. If these benefits are added, I want to clarify there is no maximum limit on coverage of essential health benefits.

Without these protections being in law and with the federal situation being so uncertain, Nevadans could face a world without the basic protections we have come to expect.

SENATOR HARDY:

If there are changes at the federal level regarding the ACA, what is our obligation regarding the State match to federal dollars?

ASSEMBLYWOMAN JOINER:

Are you referring specifically to Medicaid?

SENATOR HARDY:

If we receive federal money for any program that requires a State match, how will we fill that gap?

ASSEMBLYWOMAN JOINER:

This bill does not make any mandates related to the provisions you are referencing. Prior to the ACA we would include any insurer wanting to provide insurance coverage in Nevada regarding autism or mental health had to be included. The things we have come to expect to be covered by our insurance companies will now be in State law, just in case coverage goes away at the federal level. The funding mechanism you are referencing is not addressed in this bill.

SENATOR HARDY:

Where does Medicaid stand in the bill?

ASSEMBLYWOMAN JOINER:

Medicaid is required to cover the same things as any other insurance company. Medicaid is covering these things now. For both the actuaries of the private insurance companies and for Medicaid, it is status quo. The costs should remain the same since these things are already covered.

SENATOR HARDY:

Do they keep the same Federal Medical Assistance Percentages?

ASSEMBLYWOMAN JOINER:

Yes.

MICHAEL HACKETT (Nevada Public Health Association; Nevada Primary Care Association):

The Nevada Public Health Association and the Nevada Primary Care Association both supported A.B. 408 when it was heard in the Assembly, and we are here to support the bill again today. We understand this is a work in progress and will continue to work on the language to ensure it is a workable bill.

BROOKE MAYLATH (Transgender Allies Group):

I am testifying about my experience over the past 11 years as a business consultant and strategic planning executive with several health care organizations throughout the West: California, Nevada and Louisiana. When we look at the issues of insurance, we want to be able to count on the insurance plan to cover us in the event of an injury, accident or catastrophe. For too long, prior to the ACA, the insurance companies followed their golden rule, as in "he who has the gold, rules."

Unfortunately, this process has often left the providers and the patients struggling to have appropriate coverage or to be paid appropriately. The negotiations that occur between the providers and the insurance companies often leave patients out of the conversations. This bill helps to shore up what patients can expect out of an insurance plan based on what they have become accustomed to over the past several years.

When reviewing the risk and planning for the cost of an insurance plan by an insurance company, I sympathize with them because of all the different variables. It is not just variables for the patient, but also the outside market forces. This maintains the same market forces, insisting that coverage for all patients has to be the same with the inclusion of preexisting conditions, welfare checks and screening services. We know these services bring the total health care cost down over a lifetime. When we manage chronic diseases and treat them when they are small it will not escalate to a point where treating the disease has become very expensive to cover.

Insurance companies have had a history prior to the ACA: if somebody became too sick or too injured the individual was kicked off the plan. What happens when that 20-year patient no longer has insurance? A doctor would be put in a difficult predicament when trying to continue to treat the patient without getting paid. This bill helps to protect the provider and the patient to maintain the status quo for Nevada residents purchasing insurance. All of these protections are fundamental to individual and public health because we are all connected through epidemiology and health care economics. Please vote for this bill for yourselves as well as your constituents.

JARED BUSKER (Children's Advocacy Alliance):
We are in full support of this legislation.

JON SASSER (Legal Aid Center of Southern Nevada):
We are in full support of this legislation. As a member of the Nevada Commission on Services for Persons With Disabilities, we are also in support of A.B. 408.

SHANNON SPROUT: (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):

The Division of Health Care Financing and Policy currently has approved Medicaid and Nevada Check Up State plans to address the requirements of the ACA to include preventive health care services, maternity and newborn care and coverage up to age 26 for adult children. Currently, Medicaid does not require enrolled persons to pay a deductible, copayment or coinsurance. As the State receives federal funding to support these activities, the bill, as written, has no fiscal impact to the Division. The Division is neutral. However, if the ACA is repealed and CMS no longer approves the State Plan, services identified within this bill would have to be covered 100 percent by the State General Fund.

CHELSEA CAPURRO (Health Services Coalition):

We are neutral on the bill as we continue to work with Assemblywoman Joiner to make sure the intent is to codify provisions of the ACA into NRS.

RYAN BEAMAN (Clark County Firefighters Local 1908):

We run our own self-funded, nonprofit health insurance for our members along with dependents and retirees. We have been working with the sponsor regarding some of our concerns about the ACA. We just saw the amendment, [Exhibit E](#), in regard to essential health benefits, and we have some concerns. There are limitations that can be enacted in regard to essential health benefits along with the option to opt out of mental health parity. These issues still need to be addressed.

REGAN COMIS (Nevada Association of Health Plans):

We support the bill and will continue to work with the sponsor regarding our concerns.

CHAIR SPEARMAN:

I will close the hearing on [A.B. 408](#) and open the hearing on [A.B. 304](#).

[ASSEMBLY BILL 304](#): Revises provisions relating to autism. (BDR 38-363)

ASSEMBLYMAN JAMES OSCARSON (Assembly District No. 36):

I am presenting [A.B. 304](#) as the Chair of the Interim Legislative Committee on Health Care pursuant to NRS 439B.200. The Committee is charged with reviewing and evaluating the quality and effectiveness of programs for the prevention of illness and analyzing the overall system of medical care in Nevada to determine how to coordinate services, avoid duplication and achieve the most efficient use of available resources.

Throughout the 2015-2016 Interim, the Committee considered a wide variety of issues and various matters related to services to the children with autism spectrum disorder. Parents of children with autism, as well as providers of autism services, shared their experiences through compelling and often emotion-filled testimony. We heard about the challenges and frustrations of parents and providers who are simply trying to do their best every day to ensure children receive the care they need.

Assembly Bill 304 is one of the ways the Committee chose to address some of the issues raised by these passionate, hardworking parents and providers. The bill was requested by Jan Crandy and Jon Sasser, Nevada's leading advocates for children with autism. I appreciate their tireless passion and dedication as they continue fighting for these kids.

JAN CRANDY:

I will read my written testimony ([Exhibit G](#)).

MR. SASSER:

I am offering a conceptual amendment ([Exhibit H](#)) to A.B. 304, and Assemblyman Oscarson is accepting it as a friendly amendment. Our plan is to expand these provisions to provide further access to children with autism. Our current law says that insurance companies cannot pay nor can the program bill for services provided by early intervention services for children under age three. Catching kids under the age of three to begin treatment is the key to any of them having a normal life, as opposed to dealing with this issue for the remainder of their lives.

The conceptual amendment for A.B. 304 has been vetted with representatives of the insurance industry to authorize Nevada's early intervention agencies to bill private insurance companies for applied behavioral analysis (ABA) therapy. There are some conditions. Insurance companies may add early intervention agency providers to their systems, and services will count against the ABA accumulators. The current autism mandate put an actuarial ceiling of \$72,000 on an annual benefit. The second change is a limitation on the ABA mandate providing that only credentialed persons can render these services. The people who are being paid by the private insurance company must meet the same criteria even if they are under the early intervention program.

SENATOR HARDY:

When you say the early intervention provider system and services will count against the ABA accumulators, will it change the insurance company investment and increase their premiums?

MR. SASSER:

It would not increase any obligation for the insurance companies, but it will add another category of providers who can be paid for performing these services.

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SENATOR HARDY:
Would it remain under the cap of \$72,000?

MR. SASSER:
Yes.

SENATOR HARDY:
Do we expect the insurance companies to agree?

Mr. Sasser:
I believe the insurance company representatives may be in the neutral position, but I am not aware of any opposition.

BRIAN PATCHETT (CEO, Easter Seals of Nevada):
I am Chair of the Nevada Commission on Services for Persons With Disabilities. I want to echo the previous speakers, and we support A.B. 304 with the conceptual amendment. Easter Seals is a provider of early intervention services and a provider of autism services. The amendment is a benefit and allows us to serve more kids and to provide better access and services for children, especially from birth to three years old. I support the bill.

SENATOR HARDY:
I serve on the board of Easter Seals.

STEPHANIE HILL:
I would like to add my support for A.B. 304. I am a parent advocate and am deeply grateful to those of you who have served on the Commission and this Committee.

Ms. COMIS:
We are neutral on A.B. 304 with the conceptual amendment and feel this will expand the number of providers to serve these children.

EDWARD ABLESER (Administrator, Aging and Disability Services Division, Department of Health and Human Services):
As the Division with the early intervention agency providing services from birth to three years old, we support the concept and idea of moving in the direction of the definition change. This is a good government bill. As to the friendly amendment, this will open doors for the Division to access other sources to

sustain the system we have for early intervention. We can see this benefiting many children in our system for comprehensive care rather than exiting our system and receiving isolated care.

CHAIR SPEARMAN:

I will close the hearing on A.B. 304 and open the hearing on A.B. 108.

ASSEMBLY BILL 108: Provides for the periodic review of Medicaid reimbursement rates. (BDR 38-209)

ASSEMBLYMAN JAMES OSCARSON (Assembly District No. 36):

In 2016, approximately 632,641 Nevadans had access to health care through the Medicaid program. Unfortunately, a health care professional shortage and concerns about the adequacy of reimbursement rates to providers threatened the patients' ability to receive care.

Currently, the Division of Health Care Financing and Policy in the Department of Health and Human Services reviews reimbursement rates on a five-year cycle. There are no Centers for Medicare and Medicaid Services (CMS) or statutory requirements for this review.

The Division has established a process for reviewing provider rate reimbursement which considers the current reimbursement rates for: Medicare for the same covered services, surrounding states for the same covered services, and like states with similar demographics and populations.

The Division follows the CMS nationally recognized methodology for rate-setting. This methodology includes assigned values as part of the rate calculation, which takes the type of work, practice expenses, malpractice and geographic location into consideration.

Additionally, Medicaid is held to the Upper Payment Limit pursuant to federal regulations. This provision prohibits Medicaid from exceeding what Medicare would reimburse for the same services in aggregate.

Assembly Bill 108 requires the Division of Health Care Financing and Policy to conduct such a review of Medicaid reimbursement rates every four years.

If the Division finds the rate of reimbursement for service or items does not reflect the actual cost, the measure requires the Division to calculate the rate of reimbursement that actually reflects the cost and to recommend that rate to the Director of the Department of Health and Human Services for possible inclusion in the State Plan for Medicaid.

Passing this bill will give the analysis we need to prioritize limited resources to make sure people have access to the best provider and care possible.

MR. GOLD:

This is all about patients' ability to access quality services. This bill will ensure there is an adequate number of providers to meet the needs of the patients. Too many providers have been unable to sustain their businesses or keep qualified staff because of the payment rate. Nevada needs to initiate a regular process to review the Medicaid provider rates and to properly fund them. The Medicaid population includes the frailest, vulnerable Nevadans who rely on long-term services and support to remain as independent as they can. On behalf of our 330,000 members across the State, AARP Nevada urges you to pass this bill.

MR. PATCHETT:

The discussion about reviewing rates has been going on for a very long time. We need to look at ways to adjust the rates. We support A.B. 108. On a four-year rotation there are many codes that must be reviewed. As providers of services for people with disabilities, quite often the current rates and the lack of significant rate increases for many years has resulted in some providers not adequately paying their staff or providing benefits. This is not a problem we have at Easter Seals, but it is a problem for some of the providers. My hope is that as we look at rates over the next few years, we could also see some increases in order to hire more qualified people. We support the bill.

MS. O'MARA:

I am here in support of A.B. 108. I would like to echo what the speaker before me said in terms of increasing providers for access to care. Assembly Bill 108 requires a look and another look four years later. This demonstrates an ongoing commitment from the State of Nevada to look at rates in order to make the rates equal the costs. An ongoing commitment is necessary for recruiting positions not only into the Medicaid program itself but into the State. If you can demonstrate to providers the State will be reviewing the rates every four years

and that providers may receive an increase, it is a good thing. I encourage you to add this to your list of reasons to support the bill.

GEORGE ROSS (Hospital Corporation of America, Inc.; Touro University; Las Vegas HEALS):

The main value of this bill is to make us take a close look at a major problem we have in our health care system, which is the systematic underfunding of Medicaid. We take great pride in giving startup funds creating new graduate medical education programs. We are proud of having Touro University as a medical school. However, if physicians cannot afford to stay here and practice because of our undercompensation for the Medicaid population, it is a real problem. We have to finish the whole program.

Similarly, Sunrise Hospital states two-fifths of their inpatients are Medicaid patients, about 56 percent of the emergency room patients are Medicaid patients and the hospital is undercompensated. Someone has to pay the difference, and it is those of us who have insurance coverage. This is one of the reasons we pay so much for insurance. This bill makes us look at the problem we have in Nevada. Other states receive 89 percent of costs reimbursed through Medicaid. In Nevada, 53 percent of costs are reimbursed through Medicaid. That is a stark difference.

The Economic Forum informed us we have \$90 million for the next biennium that we were not counting on. The money is going to children because of their family situations, economic status and their language because they need extra help. These same children also get sick. Many of these same children are in this situation because of the economic status of their family. These are the same folks who get treated by doctors and hospitals who take Medicaid patients. It is important to remember these children get sick and need treatment.

SENATOR HARDY:

I want to disclose that I work for Touro University and accept Medicaid patients in the clinic, but it does not affect me any more than anyone else.

BILL WELCH (Nevada Hospital Association):

This Legislature struggles every two years with evaluating the Medicaid budget and, where appropriate, making adjustments to fee schedules. By having a study conducted, it does not obligate you or create a fiscal note, but it provides a resource to make those very difficult decisions. The information will help the

Department of Health and Human Services create strong budgets, based on good information, to present to the Legislature. To the extent that this will help reimbursement rates when resources are available to adjust rates, it will increase the opportunity to bring more providers outside of the hospital community into the provider network for Medicaid recipients. This will help our Medicaid enrollees have appropriate access to health care. I encourage you to support A.B. 108.

PAUL MORADKHAN (Las Vegas Metro Chamber of Commerce):

The Chamber of Commerce would also like to offer support of A.B. 108. We believe this is good policy. The Southern Nevada Forum is a collaboration of hundreds of members getting together to identify problems. This is one of the issues that affects the whole State and we offer our support.

KELLY CROMPTON (City of Las Vegas):

This is a priority of the Southern Nevada Forum, and the City of Las Vegas is a member of that Forum. We feel this bill addresses providing encouragement for physicians to relocate to the Medical District in downtown Las Vegas. Addressing the Medicaid rates could help attract and keep physicians within that area. This is also the area where the University of Nevada, Las Vegas, School of Medicine will be located, which is important to growth in the area.

MR. BUSKER:

We support A.B. 108. We hope this does not turn into a rate study only, but as a State, we commit to increasing the reimbursement rate for Medicaid every four years.

MICHAEL HACKETT (Nevada Public Health Association):

We support A.B. 108. We believe this bill can benefit access to health care which is a benefit to the collective public health.

LISA FOSTER (State of Nevada Association of Providers):

State of Nevada Association of Providers is a group of providers of supported living arrangements, jobs and day training services. We support A.B. 108.

MARY LIVERATTI:

I worked for the Department of Health and Human Services for 33 years, and this legislation is desperately needed. I urge your support.

KATHERINE RYDER (Director, A Team NV, Advocacy, Awareness, Advisement):

I am here with my sister Janine Klein, as a member of A Team NV and the board of directors. Janine is a member and self-advocate. We are here today to share our story on behalf of the more than 500 members of the A Team. We are here in support of A.B. 108 and the request for a review of rates.

It is important that we first offer our thanks for the good work that is already being done by members of the Legislature and administrative leadership. We are grateful for the work you do and for your efforts to protect the interest of all Nevadans. Thank you.

While we are sincerely thankful for the services offered, we are here to report that services are not always easy to acquire nor consistent when you finally receive them. This is a scary situation that has real consequences. The lack of adequate provider reimbursement rates can have a significant impact on the availability of quality services.

Janine has been developmentally and intellectually delayed since birth, so even at 45 years old, she remains at a cognitive level of about three or four years of age. It is important for Janine to have consistency, routine and a stable environment. Changes in caregivers or staff, routines of daily activities and time of services tend to bring confusion and added stress to both myself and my sister/guardian and to Janine who has no comprehension or understanding why everything is changing in her life.

Janine has lived with me since January 2008. Every step of the way to ensure her services and support has been a difficult challenge. Janine requires assistance with all activities of daily living and verbal cueing during meals to prevent choking. She is never left unattended and requires a significant amount of care. To be successful, Janine's caregivers need to know, understand and respond to her unique communication skills or she will regress and react negatively toward others and herself.

Janine has difficulty with change and because of the way services are provided, new provider staff were being introduced almost every two to three months. Even our service coordinators from Desert Regional Center were changing every year, which hindered service delivery for Janine. Consistency is needed to be successful when the needs are as significant as ours. Quality of care begins with quality rates for services.

Residential and day training providers need adequate rates for services provided. A regular review of the rates is an essential first step to the process of supporting and improving services. This effort will help to support retaining the most valuable employees providing quality care for our Nevada residents. Quality staff, their experience and understanding of the specialized needed care along with the consistent care supports the well-being and quality of life for our most vulnerable citizens.

Please consider how well your family members would be cared for if they were in our shoes. We need your help to get and maintain quality services. A review of rates is essential to achieving that goal.

BARBARA PAULSON (Nevadans for the Common Good):

I have submitted my written testimony ([Exhibit I](#)). Medicaid reimbursement rates in Nevada for many home- and community-based services have not been increased in over ten years. This has caused real problems with access to care and continuity of care for the people who desperately need these services. Part of it is because of the low employment rate and the direct care workers in these areas. Many direct care workers who provide these home- and community-based services are making just above minimum wage. It is estimated that 50 percent of these workers are on some type of public assistance themselves. This translates into the quality of care and continuity of care for the clients they serve.

A parent with a disabled adult son requires a variety of high-level services and reports that a change in the caregiver is very disruptive. The new caregiver does not understand his verbal communication, his eating behaviors or his food preferences. The son had six different caregivers during a period of six months. This is what is happening because we do not have adequately trained and adequate numbers of providers in this area. Nevadans for the Common Good supports A.B. 108. We see this as a way to make a more systematic and comprehensive way of reviewing the rates for possible increases.

JEFFREY KLEIN (Chair, Legislative Subcommittee, Nevada Commission on Aging; President, Nevada Senior Services):

We cannot have a successful delivery system with access to care over time if we do not understand what it costs to deliver these services. We need an active and transparent effort to determine costs and address health care delivery in Nevada. We support A.B. 108.

SAM LIEBERMAN (Easter Seals Nevada):

With the medical school coming to the University of Nevada, Las Vegas, I am very proud we are addressing the issue of reimbursement rates for Medicaid. Some of the issues that would have been stigmas years ago are being dealt with in a productive and collaborative way. These rate increases are vital because it allows the agencies to hire more qualified staff who can serve clients at a higher level. This will benefit everyone in the community.

NANCY BRUNE (Executive Director, Guinn Center for Policy Priorities):

The Guinn Center is here to support A.B. 108 which provides for the periodic review of Medicaid reimbursement rates. Our entry point into this issue began last year when we received support from the Nevada Governor's Council on Developmental Disabilities. We looked at transportation barriers to community mobility and independence faced by individuals with developmental disabilities. We published a report in January of this year titled *Roadblocks, Transportation Barriers to Community Mobility and Independence*.

In the course of our research and interviews with various stakeholders around Nevada, we found that inadequately low Medicaid reimbursement rates have impacted the budgets of organizations providing various services for individuals with intellectual disabilities. We heard stories about broken vans sitting in the driveway of adult group homes because providers could not afford to maintain adequate delivery of high quality primary care and vehicles. Alternatively, even when group home vehicles were functioning, they were minimally used because the provider could not afford the cost of repair or maintenance. Inadequately low Medicaid reimbursement rates have compromised the ability of some organizations to provide high-quality services including transportation services to the adults for whom they provide care. This resulted in reduced independence and social mobility. The Guinn Center supports A.B. 108. We believe this is a critical step to ensure service providers are able to provide high-quality care for many individuals in our community.

ED GUTHRIE (Opportunity Village):

Opportunity Village has been providing services to folks with intellectual disabilities and their families since 1954. We have spent hours of volunteer time and private donations, as well as using State fees, to provide high-quality services. We need to ensure these rates are reviewed on a regular basis so we can continue to provide these high-quality services to people with intellectual

and other developmental disabilities. We urge your support for A.B. 108. I have also provided a copy of my written testimony ([Exhibit J](#)).

Ms. CRANDY:

Children with Autism in Nevada is in support of A.B. 108. When it began treating children with autism, Medicaid was supposed to treat 1,872 children by the end of June 2017. The most recent data shows it is serving less than 300 children. I believe that is because the Medicaid rate for the registered behavioral technician is too low, so we have a provider inadequacy. We need more providers to enroll. By addressing and reviewing these rates, we could get providers across the board to serve these disabilities and these individuals on Medicaid.

MARTA JENSEN (Acting Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):

We are neutral on A.B. 108, but I would like to offer some information for your consideration. We do review our rates on a five-year rolling calendar. We have approximately 258,000 rates to review. The exception is physician rates which are reviewed annually. Following the reviews, the reports are submitted to the Legislative Counsel Bureau on February 1 each year.

We do not believe there will be a fiscal impact with the bill as written. We have completed an internal restructure and can absorb the work when taking the five-year rolling review down to a four-year rolling review. Any information that is identified during this review does not include the rate increases as it only affects the reporting.

When we conduct rate reviews, the individual rates are posted on our Website with the date it was last reviewed. The date the change was implemented is also available. There may be a discrepancy on the Website following the rate review because we may not have the funding to implement that new rate.

VICE CHAIR RATTI:

Can you tell me when the next review is scheduled?

Ms. JENSEN:

The reviews happen at all times, so there is a review every month on the rolling calendar. The last report indicated about 20 different provider types had been reviewed.

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JOHN YACENDA (President, Nevada Silver Haired Legislative Forum):

We are neutral on the bill. There is a difference in policy regarding rate reimbursements for Medicaid. The legislation that covers our intention demands action to be taken, based on comparing rates to the cost of the consumer price index relative to medical care, on a yearly basis as opposed to the four years in this bill.

VICE CHAIR RATTI:

We will roll A.B. 46 to the next meeting.

ASSEMBLY BILL 46 (1st Reprint): Revises provisions governing services provided to persons with mental illness and other disabilities.
(BDR 39-132)

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VICE CHAIR RATTI:

Since there is no further business to come before the Committee, we are adjourned at 5:31 p.m.

RESPECTFULLY SUBMITTED:

Martha Barnes,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	Exhibit / # of pages		Witness / Entity	Description
	A	2		Agenda
	B	10		Attendance Roster
S.B. 265	C	36	Megan Comlossy / Policy Analyst	Work Session Document
A.B. 199	D	1	Michael Hackett / Nevada Academy of Physician Assistants	Written Testimony
A.B. 408	E	74	Assemblywoman Amber Joiner	Proposed Amendment 4346
A.B. 408	F	1	Assemblywoman Amber Joiner	Written Handout
A.B. 304	G	2	Jan Crandy	Written Testimony
A.B. 304	H	1	Jon Sasser	Conceptual Amendment
A.B. 108	I	1	Barbara Paulson / Nevadans for the Common Good	Written Testimony
A.B. 108	J	2	Ed Guthrie / Opportunity Village	Written Testimony