MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Eightieth Session
May 31, 2019

The Committee on Health and Human Services was called to order by Chairwoman Lesley E. Cohen at 1:59 p.m. on Friday, May 31, 2019, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Lesley E. Cohen, Chairwoman
Assemblyman Alex Assefa
Assemblywoman Bea Duran
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblyman John Hambrick
Assemblywoman Lisa Krasner
Assemblywoman Connie Munk
Assemblywoman Rochelle T. Nguyen
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblyman Richard Carrillo, Vice Chairman (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Christian Thauer, Committee Manager
Terry Horgan, Committee Secretary
Alejandra Medina, Committee Assistant

OTHERS PRESENT:

Cody L. Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Stephanie Woodard, Commissioner for Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services
Joanna Jacob, representing Dignity Health-St. Rose Dominican Neighborhood Hospitals
Kanani G. Espinoza, representing Nevada HAND, Inc.
Julia Peek, Deputy Director, Programs, Department of Health and Human Services
Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Tom Clark, representing Nevada Association of Health Plans
Tray Abney, representing America's Health Insurance Plans
Amanda Brazeau, representing Prominence Health Plans
Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada

Chairwoman Cohen:
[Roll was taken. Committee rules and protocol were explained.] We are going to start with Senate Bill 425 (1st Reprint) today.

Senate Bill 425 (1st Reprint): Requires the Director of the Department of Health and Human Services to amend the State Plan for Medicaid to provide certain additional home and community-based services. (BDR 38-919)

Cody L. Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
We very much appreciate your time. We are here to talk about supportive housing and tenancy supports. Senate Bill 425 (1st Reprint) requires the Department of Health and Human Services (DHHS) to add to the State Plan for Medicaid certain home- and community-based services. It helps me to think about this as the piece that Medicaid can do to help with homelessness. Medicaid is not allowed to pay for actual housing services, but we can help our recipients by providing the services they need to maintain and acquire stable housing.

Stephanie Woodard, Commissioner for Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services:
[A PowerPoint presentation accompanied this testimony (Exhibit C).] I am the Department of Health and Human Services' senior advisor on behavioral health. I want to walk you through the process we have endeavored to develop around the idea of supportive housing and tenancy supports. Supportive housing and tenancy supports have been advocated for in Nevada for quite some time [page 2, (Exhibit C)]. The Interagency Council on Homelessness has contemplated the need for supportive housing for several years. This has been one of the main recommendations that has come out of that group. We have also worked with the Centers for Medicare and Medicaid Services (CMS) to better understand

how we can optimize the options that are available to us as a state to bring supportive housing and tenancy supports to Nevada.

What is homelessness [page 3, (Exhibit C)]? We are using the broader definition of homelessness. The Housing and Urban Development (HUD) definition requires individuals to actually be homeless for 12 months in order for them to qualify for HUD services. We felt that it was much more proactive on our part to be able to use a broader definition of homelessness and reduce the need for someone to be in such a chronic state of homelessness for 12 months. We are actually using the U.S. Department of Health and Human Services' definition. Because the definition is broader, we believe it will help us to rapidly rehouse individuals instead of waiting for that one-year period to pass.

When we were trying to better understand what the current needs in Nevada were, we pulled data that is captured through our Homeless Management Information System (HMIS). The Continuums of Care in northern and southern Nevada and in the rural areas use the HMIS system to identify who has been assessed as being homeless [page 4]. As part of that entry into the Continuum of Care, individuals are provided what is called a "vulnerability assessment." We are using that vulnerability assessment to identify individuals who would make up the population that supportive housing supports through Medicaid would best serve.

When it comes to defining benefit eligibility, we identified that the Vulnerability Indices would be a good starting point for us [page 5]. We have broken those indices up into four tiers. Using the Vulnerability Indices, and in consultation with some federal partners as well as with the Continuums of Care, we felt the Tier I individuals would not really rise to the level of intensity of need to require these supportive housing supports. Again, for Tier IV, those individuals most likely would need a much greater level of support than what supportive housing at its evidence-based practice would be able to provide. CHAT is the Community Housing Assessment Tool that is used by the Continuum of Care in southern Nevada. The VI-SPDAT is the Vulnerability Index-Service Prioritization Decision Assistance Tool used in the rural areas and northern Nevada. We had them pull the data to determine the score ranges that would help us identify the population. From that, we were able to estimate the population that would be served at about 1,600.

We wanted to identify the individuals who had disabilities [page 6]. When we first contemplated supportive housing several iterations ago, the target population was individuals with behavioral health issues only. When we looked at the data to see how many individuals had self-reported disabilities across the continuum of disabilities, including physical or developmental disabilities, we found that if we only targeted behavioral health we would be missing out on an opportunity to really address all individuals with disabilities in the Continuums of Care. We also felt this was important because it supports community integration, making sure that individuals, regardless of their disability, had the necessary services and supports to remain in the community and remain housed.

The package of supportive housing services that we would be including in our benefit package includes tenancy supports [page 7]. An example would be something like advocacy with landlords to rent units. Individuals who are experiencing homelessness may have not been successfully housed for quite some time and may not understand how to actively engage in meaningful conversations about rent or understanding what the terms of a lease are, but also, it helps with eviction prevention. The case manager often acts as a liaison between the individual who is in supportive housing and the landlord or person that individual is renting from.

The housing case management is a central part of what we call supportive housing. Housing case managers provide a single point for the coordination of the services the individual receives and can act as a linkage and an advocate between the tenant, the service providers, and the property managers. They can also assist tenants in identifying their goals and developing a plan to achieve those goals. Case managers provide direct tenancy support such as ensuring that rent is paid, engaging participants in choices, and identifying the history of patterns that may have created a need to change their housing situation. Case managers can also assist in finding furnishings, acquiring cleaning supplies and household items, negotiating with landlords, and also teaching some housekeeping skills so that individuals most likely would be able to maintain their tenancy once they are housed.

The care coordination does promote a patient-centered care approach and helps to ensure that the beneficiaries receive complementary rather than duplicative services. This is incredibly important because home- and community-based services, which is where this service will reside within the Medicaid benefit, is for beneficiaries who likely can span clinical, social, behavioral, and community needs. So, we are really looking at all the global needs an individual may have that could potentially contribute to his or her success for maintaining housing.

One of the primary reasons we selected the supportive-housing model is because it has been around for quite some time and it has been tested and tried in multiple communities [page 8, (Exhibit C)]. The benefits and outcomes really do substantiate the savings that can occur when supportive housing is provided in addition to stable housing. Supportive housing generates significant cost savings to public systems. This has been found in several different states and cities where supportive housing as an evidence-based practice has been implemented. This includes a decreased use of homeless shelters, hospitals, emergency rooms, jails, and prisons. It reduces the cost of health care, shelter, and bed days for individuals who have been incarcerated. In New York and Portland, it has been found that supportive housing is no more, and sometimes even less, costly than services and supports that do not include supportive housing.

Cody Phinney:
Pages 9 and 10 (Exhibit C) provide some milestones of the work that have led to the proposal for this coverage including some of the community stakeholder work that has been done with the Division of Health Care Financing and Policy (DHCFP), consulting with CMS, and making sure we have guidance from them about the appropriate way to include this in our State Plan for Medicaid. There have been housing summits in various communities, and it is

included in the Governor's Budget at this point. The process of developing a very community-based, collaborative approach has been ongoing for some time.

Chairwoman Cohen:
Are there any questions?

Assemblyman Hambrick:
In your presentation, you said the homelessness had to be for a year. Is that cumulative or continuous?

Stephanie Woodard:
Typically, it is continuous. That is the HUD definition, but we are using the much broader definition. We wanted to make sure we were not inadvertently making individuals have to be homeless for such a prolonged period of time prior to our being able to provide an intervention that research has demonstrated can be very effective.

Assemblywoman Titus:
Earlier in your presentation, you mentioned 1,600 folks whom you have identified. Could you clarify that? Would you be identifying these people because they are already Medicaid recipients? Is that how they get referred to you for additional support? Are you going to identify them through social services agencies or health care providers? What is going to be that segue? How does this work?

Stephanie Woodard:
To answer the first part of your question, what we were trying to do is really get a better understanding of what the size of this population was regardless of Medicaid eligibility. We used the Continuums of Care and the Housing Management Information System to get a better sense of what the potential population would look like if we used these two Vulnerability Indices and those score ranges.

To the second part of your question, the way this typically works is for a home- and community-based services state plan amendment, which we would be using. It requires a neutral third party to provide an assessment to determine eligibility for the services. First, the individual would have to be a Medicaid beneficiary, and then the individual would be screened through the Continuums of Care using these Vulnerability Indices. That serves as a preliminary screen. The individual would then go on to be evaluated to ensure that the person met the requirements to be able to be a participant in this program.

Assemblywoman Titus:
There are folks who are Medicaid/Medicare eligible. Medicare does not offer any of this type of support, correct?

Cody Phinney:
That is my understanding, yes.

Assemblywoman Titus:
I have multiple Medicaid patients, and one of the things that is important when they have health issues—and we absolutely want to keep them in their homes—is that we offer them some services like grab bars, ramps, et cetera. Would this also be available to modify a rental and add assistance so that someone who has a need because of a disability can stay in a home that otherwise that individual would not be a good fit for?

Cody Phinney:
This program would be able to help coordinate those kinds of activities to maintain a home, but the actual work would be done by other programs—for example, grab bar installation.

Chairwoman Cohen:
We heard a lot this session about the lack of affordable housing throughout the state. How would this play into helping people get housing when we are having problems with housing as it is?

Stephanie Woodard:
This is really step 1, but it does not specifically address affordable housing. Certainly there is a need for affordable housing; however, these are really the services and supports necessary to assist an individual in accessing housing when and where affordable housing can be located.

Cody Phinney:
That is where I get to the idea that this is Medicaid's piece of the puzzle in keeping people with disabilities in homes or helping them find permanent homes.

Chairwoman Cohen:
How does this proposal work with the waivers the state is evaluating to increase supportive services for people with mental illness?

Cody Phinney:
This program is not limited to people with disabilities related to mental illness, so it could coordinate with some of those waivers. This is really based on meeting the criteria of those Vulnerability Indices regardless of diagnoses.

Chairwoman Cohen:
Are there any other questions? [There was no reply.] Seeing no additional questions, I will call up anyone in support.

Joanna Jacob, representing Dignity Health-St. Rose Dominican Neighborhood Hospitals:
I want to get on the record here, in this Committee. In Ms. Phinney's presentation, she talked about Medicaid being a piece of the whole. As a hospital system, Dignity feels that we are a piece of this as well. In 2016, Dignity Health-St. Rose in southern Nevada and our community foundation hosted a supportive housing institute. We did a training on how to

put these housing projects together that was attended by Medicaid, DHHS, the Housing Division within the Department of Business and Industry, Clark County, and a number of nonprofit organizations in southern Nevada. Actually, it is a little bit sad for me, because your Committee member, Assemblyman Tyrone Thompson, provided the welcome that day and was a wonderful guest and supporter of that effort.

I want to say thank you to Medicaid for pushing this forward. We are in support. This is something our system supports because we see this population as a frequent user in our hospital emergency rooms. We can see the acute need for affordable housing and supportive housing on top of that in southern Nevada.

Kanani G. Espinoza, representing Nevada HAND, Inc.:
Nevada HAND is the state's largest developer and provider of affordable housing. Nevada HAND spoke in the Senate, and we are in support of S.B. 425 (R1).

Chairwoman Cohen:
Is there anyone in opposition? [There was no reply.] Is there anyone neutral? [There was no reply.] Not seeing anyone, I will invite the presenters back up for closing remarks.

Cody Phinney:
I would like to go on the record as thanking Senator Cannizzaro very much for this opportunity and for your time today.

Chairwoman Cohen:
With that, I will end the hearing on S.B. 425 (R1) and open the hearing on Senate Bill 472 (1st Reprint).

Senate Bill 472 (1st Reprint): **Establishes a database of information concerning health insurance claims in this State. (BDR 40-1145)**

Julia Peek, Deputy Director, Programs, Department of Health and Human Services:
We are here today to present Senate Bill 472 (1st Reprint) on behalf of the Senate Committee on Commerce and Labor. I prepared a PowerPoint that I will go through quickly (Exhibit D), then we can walk through each section of the bill. This PowerPoint is posted on the Nevada Electronic Legislative Information System and there are copies available for the audience.

An all-payer claims database is a comprehensive, longitudinal database that looks at both billed charges and paid charges [page 2, (Exhibit D).] It has identifiable information on the patient, geographic location, medical needs, payer, et cetera. From a public health perspective, it allows us to assess the public health needs of the community by looking at what health care services are being accessed as well as any delays in accessing those services. This ranges from prescriptions to primary care to specialty care—all those types of services. It also is proprietary in some cases because it does have paid claims and billed charges, and that would all be kept confidential, as would the patient-level information. One thing to note is that the ERISA [Employee Retirement Income Security Act of 1974] plans are exempt from reporting. This is a federal requirement, so we lose about a third of the market; however, getting the bulk of the cases in Nevada would give us much more data than we have available to us today.

Here is what other states have done as far as adopting an all-payer claims database [page 3, (Exhibit D)]. Since this PowerPoint was prepared, there are other states moving forward with an all-payer claims database. Nationally and at the state level, attempts are being made to tackle health care access issues and controlling costs, so this database would be really complementary to several of the bills you have seen this session, including the bill relating to balanced or surprise billing. It would allow us to understand what is happening in that venue. Also, with the Patient Protection Commission, one of the things the Commission will be looking closely at is access to health care as well as payments and keeping costs down for the patient. This is a huge way that other states are using this information.

This page shows an example of how states that have adopted all-payer claims databases are seeing benefits [page 4]. On behalf of DHHS, we would now have access to population health-level data and also the ability to compare Medicaid rates and services based on third-party payer rates and services outside of Medicaid. It would allow the commission to have data to look at health reform and also to look at policy decisions. To give you an example of what we have used in the past, we have basically an all-payer claims database for Medicaid clients. We query that data for any number of reasons. If we get a question such as how many kids are going to emergency rooms for asthma attacks at a certain point in time, we do not have that data because it is not reported to public health. So, we can look at an all-payer claims database, in this case for Medicaid, and understand what that looks like in our population.

The other benefit we have seen with the Medicaid all-payer claims information is we can look at policy impact. After the opioid legislation passed last session, we looked at prescribing patterns and also at access to other services. This would allow us to look at it much more broadly than just looking at Medicaid.

This page is an example of what other states have published related to their all-payer claims database [page 5]. How commercial plans compare to Medicaid plans is clearly articulated. As part of this bill, we at DHHS would be required to report similar information to the public. These are some successes that have been posted nationally [page 6]. Rhode Island was looking at different costs related to avoidable emergency visits. Another looked at EpiPens and prescription drug costs. Those are really great examples of how we would also use it in Nevada.

In Nevada, we do not have chronic disease reporting outside of cancer, so that is really an unknown to us [page 7]. If you asked us today how many adults have hypertension, we could look at the Medicaid data. We could also look at some of our population health surveys. This data would actually tell us in real time what this looks like and also what other complications these individuals might be having. So, we can tell a much better story of what is happening at the individual level and at the population health level.

There are a number of different models states have used to fund this [page 8, (Exhibit D)]. One of the benefits available currently is at the federal level. The Centers for Medicare and Medicaid Services (CMS) is allowing us to have a 90/10 match on such projects. For every dollar, they would pay 90 cents of it. This is not a cheap investment, but for only 10 cents on the dollar, now is a really opportune time to do it. This opportunity will end, unfortunately, in fiscal year 2021, so if we do not move on getting the 90/10 match with CMS right now, we might lose the opportunity. We just do not know if this opportunity will happen again. The models other states have used to come up with the 10 percent include general fund appropriation— the model in front of you today; assessing fees for accessing the data if you are a researcher and the information is de-identified—cannot be tracked back to a payer or a patient; or fees assessed on the reports—in this case, the insurers.

I know you are a policy Committee, but I provided a slide on the possible fiscal impact [page 9]. I would note that this is from the original bill. The staffing remains, but we changed our method slightly and would not do full implementation on Day 1. In section 8 [subsection 3] of the bill you will see that we have the ability to establish an advisory committee. We see huge value in that and want to spend the first year of the biennium understanding how this should be reported, what data can be released, how it should be released, and just talking through those issues both with health care providers and health care payers. So the first year, all we are going to do are regulations and establish the advisory committee. In the second year will be the implementation, so this would be the implementation impact [page 9].

I have provided a couple of references for you if you want to learn more about it [page 10]. I want to note that a concern that has been brought to our attention is that you would have a vast amount of information on Nevada residents. We understand and appreciate that and do not take it lightly. In public health we have data from birth to death, so we already have highly sensitive data. On Medicaid claims, we have all their claims data at hand now. We have many policies, procedures, and mechanisms in place to ensure the security and confidentiality of those records. That is the same model we would use when we put this out as a request for proposal to pick a vendor to receive a database. We would ensure that those are in place.

Chairwoman Cohen:
We are a policy Committee, so I do not need you to speak to the fiscal note, but please, walk us through the bill.

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
The first seven sections of the bill provide definitions and terms that are used according to such a project. Section 8 of the bill requires DHHS to establish an all-payers claim database of information relating to health insurance claims resulting from medical, dental, or pharmaceutical benefits provided by the state. In establishing an all-payer claim system, the measure requires DHHS to establish a secure process for uploading the data and ensuring accuracy and consistency of those records. In addition, the data must not contain any patient

identifiers. In order for DHHS to carry out the provisions of the bill, section 8 also authorizes the establishment of an advisory committee, as was mentioned, to consider the maintenance and release of the data. The membership of such committee must include representatives from health care, health care facilities, health authorities, health maintenance organizations, private insurers, nonprofit organizations that represent consumers of health care services, and each of the two entities that submit data concerning the largest number of claims to the database.

Section 9 of the bill requires any public or private insurer that provides health benefits and is regulated under the state law to submit data to the database. Certain insurers regulated under federal law are not required to submit data to the database; however, they are authorized to do so if they choose. Sections 10 and 17 of the bill provide the confidentiality of the data contained in an all-payer claims data system. The all-payer claims data system will be compiled using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements currently in effect.

Section 11 requires a person or entity wishing to obtain data from the all-payer claim database to submit their request to DHHS. The request must include certain information including a description of the proposed use of the data, the measures to be taken to ensure the security of the data, and the method by which the data will be stored. Section 12 provides for conditions under which the data may be released by DHHS. The conditions differ depending on the sensitivity of the information requested, and this section also provides for the payment of a fee for individuals requesting data out of the database.

Section 13 relates to reporting requirements. The DHHS is required to publish a report at least annually concerning the quality, efficiency, and cost of health care in Nevada using the data out of the system. They are also required to post on the Internet an annual list of reports that are intended to be published with data from the all-payers claim database system. Sections 14 and 18 require DHHS to submit certain reports to the Legislature and Interim Finance Committee concerning the cost, performance, and effectiveness of such a system.

Section 15 provides legal protections. Section 16 requires DHHS to adopt regulations to carry out provisions of this program, including those relating to data to be included in the systems and the fees for obtaining data from the system [fee language in bill as introduced was deleted in 1st Reprint] as well as penalties for any unauthorized accesses. Section 20 provides provisions relating to implementing the system and also the effective dates.

Chairwoman Cohen:
Are there any questions?

Assemblywoman Titus:
Could we go back to your chart? I have a question about the chart that compared state Medicaid reimbursements to what insurers pay [page 5, (Exhibit D).] Looking at that chart, those figures are not what the fees are; those figures are what you are willing to pay based on a charge. We charge one fee regardless, but your reimbursement is different. Is that correct?

Julia Peek:
Yes, you are reading that correctly.

Assemblywoman Titus:
I just wanted to make sure folks do not think we charge a private insurer one price and Medicaid a different price. Those are your rates, and we are looking at coming to appropriate rates. Several bills in this session and in other sessions have gone through the Legislature about doing the research so we could fix those rates. Would that assist in developing better reimbursement ideas based on what the real world looks like?

Julia Peek:
Exactly. This is a complementary bill to several of the ones you have seen come through your Committees—looking at rates and access and other issues.

Assemblywoman Titus:
I know we are not a money committee, but I am on a money committee and ultimately will hear this bill. You mentioned that you are hoping to get a 90/10 split and you need to have it in by a date-certain because that offer will go away. Is the state prepared to do this if the split goes away entirely, when the state would be paying 100 percent?

Julia Peek:
Yes. We do see huge value in this. If for some reason this bill did not pass this session and we did not have the authority to do it now, we could come back next session. That is an option. We could also develop a similar system voluntarily and see if insurers will report that information to us and come up with a different way to fund the 10 percent in this example.

Assemblywoman Titus:
Because of diagnostic codes, you already have a lot of Medicaid information. For instance, you know the number of Medicaid claims for chronic obstructive pulmonary disorder because we submit those claims, so that is a pretty easy thing to track. The goal of this is to expand it to the private insurers so you can get statewide information because different populations are involved—the working poor who need some assistance, those who have great insurance plans, and then you have fully-funded Medicaid for those who are not working. So, this is going to give you a cross-demographic view of the health status of this population in Nevada.

Julia Peek:
I think you explained that beautifully. That is the expectation. When we have data for which we do not have a really solid dataset—such as for chronic diseases—we report out that data with huge caveats indicating that it is a very specific population and that the data cannot be attributed to the entire population. With the other datasets, we could tell that differently.

Chairwoman Cohen:
Are there any other questions? [There was no reply.] In the states where there are mature databases, are you seeing any surprises?

Julia Peek:
In the research I have looked at, it is interesting to look at policy changes in those states and then you can see the effects across different payers. You can see access issues as well because you can drill down by demographics, geographics, et cetera. There is a good amount of research and I can get back to you with specific lessons learned if it is helpful to you, but I have highlighted a few in the presentation.

Chairwoman Cohen:
How have other states influenced ERISA plans to participate in the database?

Julia Peek:
I do not know how other states have done it, but we have been talking in the halls with representatives of ERISA plans and told them that we would love to get their data. Giving it to us voluntarily is the only way we will get it at this point. Also, it looks as though there has been some motion or communication at the federal level to see if ERISA plans should report this data in some capacity or if they should have to report this data to a state. It is yet to be determined. Again, this would give us about two-thirds of the population, so that would be much better data than we have. We will tackle ERISA when we can.

Assemblyman Hafen:
Referring to the page showing key highlights of the successes [page 6, (Exhibit D)], there are three states that show successes. In your research, how many other states have adopted something like this other than those three and what kinds of results are they showing?

Julia Peek:
This data is from 2016, so there are states moving in this direction. States have reported that they have been doing a better job with hospital ER admissions. Also, targeted outreach and intervention is much easier with data like this. Access issues—if we see certain geographic areas that have huge delays in accessing a specialist, we can drill down a little more. The resource I provided at the end—the hyperlink—has a great amount of information on state successes as well as on some of the other questions asked today.

Assemblyman Hafen:
It looks as though roughly half the states are doing something along these lines and half are not. Is that an accurate statement?

Julia Peek:
Accurate.

Assemblyman Hafen:
I see this as a lot of data and a lot of work. I know we are not the financial committee, but it looks as though if we are stuck and do not get any matching funds, we are looking at about $30 million that we are going to have to find to fund this program. I do not know if the other states have seen a $30 million success rate or not, and that is information I would like to see.

Julia Peek:
I believe it is closer to $3 million for the total cost to implement.

Cody Phinney:
The total computable cost is closer to $3 million. With the 90 percent federal match, the cost to the State General Fund for the biennium is about $400,000.

Assemblyman Hafen:
So the $3 million fiscal note is all that is there and if we end up only paying 10 percent of that, it will only be about $300,000.

Chairwoman Cohen:
Are there other questions. [There was no reply.] Seeing no further questions, we will call up anyone in support. [There was no response.] I do not see anyone in support, so do we have anyone in opposition?

Tom Clark, representing Nevada Association of Health Plans:
We are the Association that is representative of the insurance companies that are contracted here in the state of Nevada. We have a number of concerns with this particular piece of legislation, and some of those concerns have been brought up in the questions that came previously. Currently, we know that about 19 states have implemented these types of programs. Some of those states have seen them to be much more costly than what has been anticipated from the front end. We ask the question, What if the 90 percent match does not come through? If that 90 percent match does not come through, it was testified to earlier that it could land on the insurers to pay the bill to make this happen. That would be a mandate that could possibly arrive in 2021, but it is still an unfunded mandate.

The other really important piece here is that only about 70 percent of the claims would be collected because the ERISA plans are not included. So, are we truly getting a full complex of the data that is going to be needed to make this an effective program? Let us take a look at the data from a policy perspective. I am quoting from section 4 of the bill:

> "Direct patient identifier" means data that directly identifies a patient, including, without limitation, a name, telephone number, social security number, number associated with a medical record, health plan beneficiary number, certificate or license number, vehicle identification number [VIN], serial number, license plate number, Internet address, electronic mail address, biometric identifier or photographic image.

We take security extremely seriously. It is the No. 1 priority that the patient data we have does not get hacked, leaked, or disrupted in any way.

Now, let us go to section 12, subsection 1 of the bill. "The Department may release data from the all-payer claims database that contains direct patient identifiers." All the information I listed previously that is a direct patient identifier "may" be sent out to the folks who apply for and want to collect the data if they are doing research or other things. There was a fee in the bill if you were to want to collect that data, but that fee was taken out of the bill yesterday.

The last part of the bill that really makes us nervous is almost in the last section of the bill and allows the Department to contract with a third-party contractor to manage this particular program. This data is incredibly important to us and the security of the patients we serve. Not only do we see the potential for costs in implementing the program down the road, there is a tremendous amount of cost to each of my Association members for the collection and submittal of this particular information, so that is going to be a cost that could have an impact on premiums. Lastly, the security of this data is a vital piece. We have seen other pieces of legislation try to ensure that this information does not get released, but we are concerned that this piece of legislation would make it vulnerable.

Assemblyman Hafen:
Do the current companies collect VIN numbers and license plate numbers of their customers?

Tom Clark:
I would have to check with each member, because I do not know that information off the top of my head. I could provide it: to what extent is that data information collected by the insurers. If they are required to collect that data, that would be an additional cost to the insurance companies.

Tray Abney, representing America's Health Insurance Plans:
We want to associate ourselves with the comments made by Mr. Clark. To his point, as well as to Dr. Titus's and Assemblyman Hafen's point, we have no guarantee that the federal government will pay 90 percent of this bill. At the same time this discussion is occurring here in Nevada and in other states, there is a discussion occurring at the national level. This issue may be addressed there—whether it is through a national database or through grants to each state to take care of this issue. As Mr. Clark mentioned, another concern is that this only affects about 70 percent of the market here in Nevada, so you are not going to get a complete picture of what is going on in this state. Finally, and we cannot emphasize this enough, there is the increased cost on the plans to comply—to be able to put together something like this. Nevada's health care plans already pay the highest premium tax in the United States, so any additional cost on plans for something like this could certainly have an effect on health care costs for every Nevadan at the end of the day.

Amanda Brazeau, representing Prominence Health Plans:
On behalf of Prominence Health Plans, we want to put our opposition to S.B. 472 (R1) on the record. We feel this piece of legislation has ambiguous language, requires carriers to disclose protected health information, and the data is already aggregated through the National Association of Insurance Commissioners. For these reasons, Prominence cannot support this bill.

Chairwoman Cohen:
We have seen that this is already happening in several states. Do you believe that health care costs have gone up in those states because of this? Can you tell us what is going on with your clients in those states?

Tom Clark:
Unfortunately, I do not have that type of data with me now. I just know that it has been implemented. Some states are in the process of implementation, but I do not have a specific answer to that question for you today.

Tray Abney:
I do not have that specific information, but we have been told that it has ended up being more expensive to implement in those states than what they thought it was going to cost at the beginning of the process.

Chairwoman Cohen:
Do you think you can give us the information?

Tray Abney:
I will do my best.

Chairwoman Cohen:
Do we have anyone else in opposition? [There was no reply.] Not seeing anyone, is there anyone in neutral?

Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada:
We have an ERISA-like plan. We are a self-funded, nonprofit plan. We have concerns that this cost is going to fall on us. We have 2,700 members and, to be honest, we cannot afford any additional costs because that means cutting coverage for our members or having to go back to the cities we work for and renegotiating our contracts.

Chairwoman Cohen:
I assume there is a similar situation in other states with firefighters who have, like you, ERISA-like plans. Do you know what has happened to their costs?

Todd Ingalsbee:
No, I do not. Each organization is very different. Some are self-funded ERISA plans, as is ours, so we pay a certain percentage out of our checks per month. We also get contributions

from our city, per check. Some of our 2,700 members' plans are through their city governments' insurance plans, but I do not have that. Again, I am not in favor of putting any additional costs on any of our members because that is a cut in coverage if we have to do that.

Assemblywoman Titus:
Maybe all members of this Committee know what the ERISA plans are, but maybe we should have a quick overview of what the differences are.

Chairwoman Cohen:
I think we have discussed this before, but our Policy Analyst, Ms. Lyons, is going to give us a little primer.

Marsheilah Lyons, Committee Policy Analyst:
The ERISA plans stem from the Employee Retirement Income Security Act of 1974. The intent was to protect the assets of millions of Americans who had funds placed in retirement plans during their working lives so those funds would be there when they retire. It is a federal law that sets minimum standards for retirement plans in private industry and allows for insurance coverage through those plans.

Chairwoman Cohen:
Thank you very much. Seeing no one else in neutral, I will ask the presenters to make closing remarks. Before you begin, we have a question from Assemblyman Hafen.

Assemblyman Hafen:
Prior testimony brought this up and pointed out that in section 4 the language talks about "direct patient identifier." Can you explain to me what the "biometric identifier" [section 4, line 16] information that would be provided and inputted into this system is?

Julia Peek:
Not being a clinician, I would assume some of the biometric data would be height and weight and some of those things that would be part of intake.

Assemblyman Hafen:
For the record, you are not looking for fingerprints or DNA or those sorts of biometrics? I have been Googling the phrase, and Wikipedia may not be accurate, so I just want to clarify that we are not gathering DNA and we are not trying to do facial recognition or retina scans or anything else, because that sounds very expensive.

Julia Peek:
Agreed. That was not our intention now or in the future.

I appreciate the comments that were made and we do want to work with that advisory group to define what is appropriate and helpful even to them. I want to note two very specific things: CMS has already funded this at 90/10 in other states, so luckily we are not first in this game. We will be coming about midway, so we know this is something CMS will support if we can get it done in the next two years. Again, I do not know what will happen because that legislation will end. Also, because we are a little late in the game, we already have a good idea of what it has cost other states, and that is how we arrived at the fiscal impact you see in front of you. Thank you again for considering this bill.

Dena Schmidt:
I just wanted to add that one of the concerns was with DHHS sharing information. The bill does require us to adopt regulations, so that would be defined—what could be shared and when it could be shared. All those things and how it could be shared would all be defined in regulations. It would not just be on a whim. I also want to remind everybody that in those states you may not see a direct cost reduction in health care costs; however, the population health initiatives that have been started and implemented in states that have adopted these all-payer claims databases to improve public health and population health have been tremendous. So, thank you for your consideration.

Chairwoman Cohen:
Thank you. Before I close out the hearing, this was a bill requested by Senator Pat Spearman, and she is still very much involved in it. Unfortunately, because of time constraints, she asked the folks from DHHS to help and fully present this bill today. We appreciate your doing that. With that, I will close the hearing on S.B. 472 (R1), and we are going to go into our work session for Senate Bill 540 (1st Reprint).

Senate Bill 540 (1st Reprint): Revises provisions relating to vulnerable persons. (BDR 14-1201)

Marsheilah Lyons, Committee Policy Analyst:
Members of the Committee should have before them the bill page for Senate Bill 540 (1st Reprint). The bill revises provisions related to vulnerable persons. It was heard yesterday. [Marsheilah Lyons read from the work session document (Exhibit E).] Senate Bill 540 (1st Reprint) extends various protective services to vulnerable individuals that are currently provided to older individuals. Specifically, it:

- Expands certain duties of the Aging and Disability Services Division of the Department of Health and Human Services to apply to vulnerable individuals;
- Revises existing statutes to create the same process for reporting the abuse, neglect, exploitation, isolation, or abandonment of older individuals and vulnerable individuals;
- Revises the name of the Unit for the Investigation and Prosecution of Crimes Against Older Persons within the Office of the Attorney General to include "vulnerable persons" and expands the Unit's authority to include certain protections for such individuals;
- Revises the name of the Repository for Information Concerning Crimes Against Older Persons to include "vulnerable persons" and requires the Repository to contain

records concerning the abuse, neglect, exploitation, isolation, or abandonment of such individuals; and
- Requires the sheriff of each county to designate an employee of the sheriff's department as a point of contact to the Division.

In addition, the bill authorizes reports concerning the abuse, neglect, exploitation, isolation, or abandonment of such individuals to be made available to the State Guardianship Compliance Office or an attorney who represents an older or vulnerable person in a guardianship proceeding. If such an attorney receives this information, the attorney must disclose the information to the court in a guardianship within 20 days of receipt of the information. There were no amendments for this measure.

Chairwoman Cohen:
Are there any questions? [There was no response.] Seeing no questions, I will take a motion to do pass.

> ASSEMBLYWOMAN GORELOW MADE A MOTION TO DO PASS SENATE BILL 540 (1ST REPRINT)
>
> ASSEMBLYWOMAN DURAN SECONDED THE MOTION.

Are there any comments? [There was no response.]

> THE MOTION PASSED. (ASSEMBLYMEN CARRILLO AND KRASNER WERE ABSENT FOR THE VOTE.)

I will assign the floor statement to Assemblywoman Gorelow. We will likely have another work session tomorrow or behind the bar tonight. Before we close, is there anyone for public comment? [There was no response.] Seeing no one who wishes to make public comment, we are adjourned [at 2:55 p.m.].

RESPECTFULLY SUBMITTED:

Terry Horgan
Committee Secretary

APPROVED BY:

Assemblywoman Lesley E. Cohen, Chairwoman

DATE: ______________________

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "State of Nevada, Department of Health and Human Services, *Supportive Housing and Tenancy Supports*," presented by Stephanie Woodard, Commissioner for Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services; and Cody L. Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, in support of Senate Bill 472 (1st Reprint).

Exhibit D is a copy of a PowerPoint presentation titled "State of Nevada, Department of Health and Human Services, *All-Payer Claims Database*," presented by Julia Peek, Deputy Director, Programs, Department of Health and Human Services, in support of Senate Bill 472 (1st Reprint).

Exhibit E is the Work Session Document for Senate Bill 540 (1st Reprint), dated May 31, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.