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

Eightieth Session
February 18, 2019

The Committee on Health and Human Services was called to order by Chair Michael C. Sprinkle at 1:51 p.m. on Monday, February 18, 2019, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, 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:

Assemblyman Michael C. Sprinkle, Chair
Assemblyman Richard Carrillo, Vice Chair
Assemblyman Alex Assefa
Assemblywoman Bea Duran
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblywoman Connie Munk
Assemblywoman Rochelle T. Nguyen
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblyman John Hambrick (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:

Kevin Dick, District Health Officer, Washoe County Health District
Brooke Maylath, President, Transgender Allies Group, Reno, Nevada
Heidi S. Parker, Executive Director, Immunize Nevada, Reno, Nevada
Michael Hackett, representing the Nevada Public Health Association
Joanna Jacob, representing Dignity Health–St. Rose Dominican Hospital; and Dignity Health–St. Rose Dominican Neighborhood Hospitals
Nicki Aaker, Director, Carson City Health and Human Services
Mari Nakashima, representing the Nevada State Medical Association
Michael Collins, Chair, Southern Nevada Health District Public Health Advisory Board
Corey Solferino, Lieutenant, Administrative Bureau, Legislative Liaison, Washoe County Sheriff's Office
Ben Schmauss, Government Relations Director, American Heart Association/American Stroke Association of Nevada
Nancy J. Bowen, Executive Director, Nevada Primary Care Association
Bill M. Welch, President/CEO, Nevada Hospital Association
Connie McMullen, representing the Personal Care Association of Nevada
George Ross, representing Hospital Corporation of America; and Sunrise Hospital and Medical Center, Las Vegas, Nevada
Joan Hall, President, Nevada Rural Hospital Partners
Chris Bosse, Vice President, Government Relations, Renown Health
Elisa Cafferata, representing Planned Parenthood Votes Nevada
Ellen Crecelius, Actuarial Economist, Division of Health Care Financing and Policy, Department of Health and Human Services

Chair Sprinkle:
[Roll was taken. Committee rules and protocol were explained.] We have two bills to hear today, and I am fortunate enough to be presenting both of them, so I will be turning the Committee over to my Vice Chair.

Vice Chair Carrillo:
We will open up the hearing on Assembly Bill 97.

Assembly Bill 97: Revises provisions relating to certain expenditures of money for public health. (BDR 40-529)

Assemblyman Michael C. Sprinkle, Assembly District No. 30:
This bill came out of the Legislative Committee on Health Care (LCHC) for the 2017-2018 Interim. It does two things: It prohibits the allocation of funds to Federally Qualified Health Centers (FQHCs) under certain circumstances, and it establishes an account from which the Division of Public and Behavioral Health (DPBH) within the Department of Health and Human Services (DHHS) can allocate money to designated local health authorities.

I want to give you some history. Representatives of DPBH and local public health authorities presented at the LCHC meetings on January 11, 2018, and April 24, 2018. State and local public health officials discussed the essential services of public health, the role of social determinants on a person's health and well-being, and how public health efforts have improved the health and wellness of Nevadans.

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

During the 2017 fiscal year, the State Health Access Data Assistance Center ranked Nevada 50th among the states and the District of Columbia in per capita public health funding, with per capita funding in Nevada at $7 per person. Only the state of Missouri ranked lower at $6 per person.

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

Assembly Bill 97, section 3, creates the Account for Public Health Improvement in the State General Fund and authorizes the Division of Public and Behavioral Health to allocate the funds to each health authority in an amount equal to the percentage of the population that resides in the health authority's jurisdiction. To address the means of funding this request, the measure will also be deliberated in the Assembly Committee on Ways and Means.

Kevin Dick, District Health Officer, Washoe County Health District:
This bill comes from a unified and collaborative effort of all the Nevada health authorities who worked together to provide the presentations to the interim Legislative Committee on Health Care. I want to thank Senator Pat Spearman, Chair of the interim committee, for proposing this bill draft request. You heard an overview of what the bill contains, and I will focus on the public health-funding portion of the bill (Exhibit C). As was mentioned, it establishes an account for the improvement of public health. That account is established in the State General Fund and administered by the Division of Public and Behavioral Health within the Department of Health and Human Services. The funds would be disbursed according to population. The current language in the bill provides for allocations, ". . . to each health district," and funds would be distributed in proportion to the population each entity serves. The health districts would receive funds for the populations within their districts, and the Division of Public and Behavioral Health would provide for the other populations within the state for whom it provides services.

Funding is to be utilized to support assessment of health and public health needs and to address prioritized needs that are identified in those assessments. The bill prohibits supplanting of other funds with the funds that would be distributed out of the account. Any portion of the funds remaining must not be expended but shall be returned to the State General Fund by September 17, 2021. This investment in public health is very important to improve the health of our population. It allows us to support data-driven, community-health assessment approaches to address priority health needs in our communities. Ultimately, the flexibility in this funding allows health authorities to address root causes and social determinants of health. By improving the health of our population in this manner, this investment can help with reducing health care costs and the economic burden of disease in Nevada. Having a healthier and more productive workforce population and healthier children who have less school absenteeism and are better able to learn can improve economic development and performance of the state.

As was mentioned, we are 50th in the nation in public health funding. Nevada's investment in public health is actually $6.75 per capita. Assembly Bill 97 would raise per capita funding annually over the biennium to the level of $9.25. The national median state investment in public health is $38.13 per capita, so half the states invest below that amount and half invest above it. The average national per capita investment is $36.11. For reference, Arizona is currently ranked 49th at $8.80, and Kansas, in 48th place, is at $12.10. So raising Nevada's per capita rate to $9.25 would bring us up to 49th in the nation.

Unfortunately, we here in Nevada have become numb to low rankings because we have so many of them. I want to provide a comparison for you to another area where Nevada ranks relatively low, but there is a lot of attention being paid to it—our K-12 education investment. Nevada is ranked 47th in the nation for K-12 education expenditure. In fiscal year 2018, that was $8,615 per student. The national average is $11,642 per student, so at 74 percent of the national average investment per student, Nevada is ranked 47th. When you look at the per capita spending on health care, our current per capita spending of $6.75 is less than 19 percent of the national average of $36.11. So our per capita public health funding is way below the national average compared with our per capita funding for education. Education is a very important priority and a public health determinant; I am not advising you to not look at education as a priority, but for comparison, we are doing much worse in public health investment. To be at a comparable 74 percent of the national average for public health expenditures, Nevada would need to invest $26.72 per capita, which is about $20 more than we invest now.

Last Monday I showed some pie charts of the total investment we as a nation make in health care spending. We have a similar situation here in Nevada, where we have vast sums of money invested in health care and very little money invested in public health. Without investing in public health, Nevada is going to be trapped in a situation where we will never be able to control and adequately fund our health care costs.

I would like to give you some perspective on local health department funding. Local governments face severe revenue constraints. They are imposed constitutionally and by state

statute, yet we lack state support for public health that other health departments across the country enjoy. On average, states across the country provide 21 percent of local health department budgets. In Nevada, the Southern Nevada Health District and the Washoe County Health District receive about 1 percent of funding from state funds. Carson City Health and Human Services receives about 4 percent of its funding from the state, but that includes funding for human services it provides. Our local health departments serve 93 percent of the state population, and that population continues to grow. The original intent the health authorities had in coming together and proposing increased funding was to secure a per capita caseload funding level so that, as our population increased, our funding would increase on a per capita basis.

The current language in the bill specifies that the distribution would be made to health districts at the local level. We would like to offer a friendly amendment that would change that language to "local health authorities," recognizing that Carson City Health and Human Services is not established as a district under statute—it is a local health authority established under *Nevada Revised Statutes* (NRS) Chapter 439. We would also suggest moving up the disbursement date of the funds. Under the bill, disbursement of funds is set to occur on December 31, 2019. We would like to see that disbursement occur earlier so we have a better opportunity to expend those funds in a meaningful manner over the course of the biennium.

There is also a federally qualified health center (FQHC) portion to the bill, and in looking at it, the language is very broad in its reference to FQHCs and other entities and could be interpreted quite broadly. We do not know what all that encompasses and are suggesting some refinement to that language.

I would also suggest that the Committee consider language in the bill that would allow funds to be retained within the account to assist with potential public health emergencies we could encounter. When the interim committee discussed this bill draft request, there was concern that if the funds all remained in the account, we might end up with a situation where the state faced other needs and yet this money was unavailable because it was in the account for public health improvement. I think we need to consider trying to at least allocate part of any remaining unspent funds to remain in the account up to a certain limit so we have funds for public health emergencies. One public health emergency everyone is aware of in the news today is the measles outbreak occurring in Clark County, Washington. When I prepared my remarks, I was going to explain to you that they had 53 cases as of last Friday; but, as of today, they now have 61 measles cases in that outbreak.

The Centers for Disease Control and Prevention (CDC) did a study of the cost of a measles outbreak and the health department response to that outbreak that occurred in Minnesota in 2011. The CDC estimated the cost of that response to be between $920,000 and $1.6 million. That outbreak in Minnesota had 21 measles cases, so there are potentially multiple millions of dollars in costs that a local health department could incur during its response to one of these outbreaks.

Following the flooding in Washoe County in 2017, there was much more standing water and mosquito-breeding habitat that remained throughout the spring and summer. We had to secure an additional $750,000 on top of our normal mosquito-abatement budget, to provide larvicide to prevent the mosquito population from growing. Washoe County still experienced 25 cases of West Nile virus disease that year—which was a record for our county. Twelve of those cases were neuroinvasive West Nile virus, which is a very severe form of the disease. Studies show that, between the health care costs and the economic impact, each case of neuroinvasive West Nile virus costs $440,000. So, we believe it would be prudent to let unspent funds accumulate to an established limit to provide for public health emergencies before reverting to the State General Fund.

The gorilla in the room on this bill is the $15 million appropriation. It is not included in the state's budget. We had been working with the Department of Health and Human Services. They had requested an enhancement for this but did not receive it. We believe there may be opportunities that might arise during this session that could provide revenues for this necessary investment. The other day, we talked about e-cigarettes and the idea that they should be included in other tobacco products and taxed. Under existing statute, that tax might be a revenue source.

The health authorities would like to work collaboratively with Assemblyman Sprinkle in regard to this proposed friendly amendment that would include a funding distribution for Carson City Health and Human Services in the bill. We would also like to see if we can move the distribution date for the funds forward. Additionally, we would like to explore this approach to see if there is a way to accumulate some reserves within that fund.

We would like to thank the Interim Legislative Committee on Health Care for sponsoring this legislation. We think it is a significant step forward in recognizing the need the state has to invest in public health and the significant opportunities for improvement in public health that can result from data-driven approaches to address our priority health determinants.

Assemblyman Sprinkle:
I was the vice chair of the Interim Legislative Committee on Health Care where this bill originated. Having spoken with the chairwoman of that committee this morning, we are amenable to the amendments that have been brought forward.

Section 5, subsection 1 and several other subsections talk about "If a member of the executive board." It should read "a member of the executive staff." There was discussion during the interim as to exactly who was being referred to there. I believe there will be more discussion post-hearing concerning changing that section, but I did want to relate that the chairwoman is amenable to having discussions about possible amendments.

Vice Chair Carrillo:
Are there any questions from Committee members?

Assemblywoman Titus:
As the Lyon County Public Health Officer for the past 35-plus years, I know that public health is a huge issue, and lack of funding is a huge issue. I appreciate the Interim Legislative Committee on Health Care recognizing that, so thank you for bringing this forward. How did federally qualified health centers become the designees? There are other public health needs, and in many of the rural areas, we do not have FQHCs—we have a rural health clinic or other hospital locations. I am anxious about how that terminology was included in the bill. That really narrows down who can receive these funds. Is that the appropriate place we want to put these funds? Typically, they give care as opposed to being public health agencies. We have heard the definitions of the differences between the two—one is health prevention and education and lifestyle maintenance; the other actually provides care.

Also, it is really important to recognize health care emergencies that are not expected, and measles is a wonderful example of how, all of a sudden, our public health limits can be overtaxed if we do not appreciate the need to save some money for those various emergencies.

Kevin Dick:
The bill is a little confusing because it is really two bills in one. The FQHCs' portion of the bill is distinct and separate from the Account for Public Health Improvement and the distribution of those funds based on population. The account distribution is set up to go to the public health agencies and not to the FQHCs, but the FQHC part of the bill has to do with prohibitions of distribution of other state and Medicaid funds to those FQHCs based on whether certain staff or executive board members had previously been convicted of certain crimes.

Assemblyman Thompson:
What is this bill really trying to do?

Assemblyman Sprinkle:
When I first read this bill, I was surprised that two different subjects were contained within it. I thought these were supposed to be two separate bills. That is what is causing some of this confusion.

Let us go back to sections 1, 2, and 3. Those sections are specific to creating this account and allocating dollars to public health causes. The health authorities will be receiving this money—upwards of $15 million if we can get this initial appropriation. How this money will be allocated will be up to the health authorities.

If you continue reading the bill, section 5 involves an entirely different subject. There were concerns raised that certain board members, especially board members on nonprofit organizations, including FQHCs, had prior convictions. The concern came specifically from the Chairwoman of the interim health committee about a situation she had become aware of. Because of certain convictions, she wanted to put limitations in place so that individuals

would be better vetted if they were having direct contact with patients. If that staff member had been convicted of a crime contained in NRS Chapter 449; that would limit the amount of money that could come to that entity. These are two completely separate issues. This is open to a lot of discussion, and there may be other people testifying who have concerns with that as well. I have already confirmed with the Chairwoman of the interim health committee that we will be open to looking at potential amendments.

Vice Chair Carrillo:
Are there any other questions from Committee members? [There was no reply.] I have one question. Does the Department of Health and Human Services currently grant money to the FQHCs?

Kevin Dick:
I am not in a position to answer that. I think a lot of their funding is federal funding that comes to the state.

Vice Chair Carrillo:
In section 3, subsection 5, the language states, "The Division may apply for and accept gifts, grants, bequests and donations from any source . . . ." What would be considered "any source"? Is that regarding private funds or are they from any source?

Kevin Dick:
To some extent, that is boilerplate Legislative Counsel Bureau (LCB) language that is thrown in so the entity can accept funding within different accounts when it may come from different benefactors.

Vice Chair Carrillo:
We will now take testimony in support of A.B. 97.

Brooke Maylath, President, Transgender Allies Group, Reno, Nevada:
I stand in support of the concept behind this bill. When we look at the effects of the lack of public health spending, we see that the burden falls primarily on marginalized communities, including the lesbian, gay, bisexual, and transgender communities and communities of color. Therefore, it is imperative that we find a way to fund and get these kinds of programs out there. Otherwise it can be a death sentence, because we do not necessarily have the money to afford treatment costs. Please support this bill.

Heidi S. Parker, Executive Director, Immunize Nevada, Reno, Nevada:
[Heidi Parker spoke from prepared text and included an attachment showing Nevada "Immunization Operations Funding 2009-2018" (Exhibit D).] We are Nevada's only statewide nonprofit dedicated to immunizations, and we save lives by promoting health and preventing disease. Along with many of our coalition partners, we are in support of Nevada investing in and prioritizing public health. With public health crises regularly occurring in our region, it is crucial that Nevada takes steps towards increasing its per capita spending for public health. Many entities rely heavily on public funding from the CDC and other federal

agencies, and as you can see from the attachment I shared [page 2, (Exhibit D)], funding for the Nevada State Immunization Program has been reduced over the last couple of years. Without a mechanism in place to replace these cuts, they have had to execute their program with the bare minimum of funding and resources. Additionally, there are potential missed opportunities when a funding match is needed or a supplemental grant prospect is identified. Now is the time to increase support for Nevada's public health advocates, programs, and infrastructure, as we all work diligently to carry out one of the most important jobs in our community—keeping people healthy, happy, and productive. We must invest appropriately in public health, and A.B. 97 is a positive step in that direction. I want to add that we are in support of the discussion around the FQHC language in the bill.

Michael Hackett, representing the Nevada Public Health Association:
We support A.B. 97 with the amendment that was proposed by Mr. Dick of the Washoe County Health District to broaden it to include local health authorities, and also to move up the date when funds are to be dispensed into the Account for Public Health Improvement. We have been involved in this effort going back to the 2016 Interim. Obviously, it is a very important piece of legislation for the public health community. The data that has been presented speaks for itself as to how important this issue is and how important it is that the state step up and improve its level of funding for public health in Nevada.

We do have some concerns over the FQHC piece that is in the bill. We appreciate the comments by Assemblyman Sprinkle to address and clarify some of the issues in that provision. Our concern is because we recognize the role that safety net providers such as the FQHCs play in protecting the public health and being part of our network.

Joanna Jacob, representing Dignity Health-St. Rose Dominican Hospital; and Dignity Health-St. Rose Dominican Neighborhood Hospitals:
We want to go on record in support of public health funding. We consider ourselves to be valuable community partners working on public health issues with many of our colleagues in southern Nevada. We take part in the community needs assessment in collaboration with the Southern Nevada Health District and other local nonprofits and community organizations. The priorities that came out of that needs assessment included awareness about public health funding in the state and, generally, access to health care. We consider this a really positive first step in helping us address those priorities.

Nicki Aaker, Director, Carson City Health and Human Services:
Last week I explained to you the composition of our Board of Health. I want to read into the record a support letter from one of our Board of Health members—Sheriff Ken Furlong:

> As a member of Carson City's Board of Health, I am in support of AB97 – Public Health Funding with the suggested amendments to replace "Health Districts" with "Health Authorities."
>
> Nevada needs to invest in public health in order to improve the health of Nevada's communities. This bill will establish an account for funding,

provide for distribution of funds based on population, and support the community health needs assessment approach to address health priorities within communities. By taking this approach, communities would be able to address health needs, and able to prioritize those needs.

The majority of Carson City Health and Human Services' (CCHHS) funding is federal, which is passed through from the state. These grants are very specific as to the projects that are worked on. Some of the areas for improvement that Carson City's 2017 Community Health Needs Assessment identified cannot be addressed by the local health department due to no flexible funding. These include: drug use, obesity, chronic diseases, and food insecurity. If this funding were available, these priority areas could be addressed within our community.

Mari Nakashima, representing the Nevada State Medical Association:
The Nevada State Medical Association supports A.B. 97. We believe that by allowing the local districts or authorities to use their data to identify areas in the community where these resources would be best utilized to serve their populations, Nevadans will be more directly and positively impacted. Additionally, we know that primary prevention is traditionally a focus of public health districts, and this investment will assist those medical professionals and others working directly within the community both plan out proactive programming and potentially provide resources to help in times of emergency.

Vice Chair Carrillo:
We will move to the south for testimony from those in support of A.B. 97.

Michael Collins, Chair, Southern Nevada Health District Public Health Advisory Board:
The fact that we are 50th out of 51 in funding entities like our health districts throughout the state is a problem I appreciate you approaching with this bill. Under the current bill, that would only bring Nevada up to 49th. It would be nice if there could be an amendment to increase that funding to bring Nevada more in line with the median funding throughout the United States.

This bill will fund efforts such as community health assessments that we have done in southern Nevada, allow us to implement a functional community health plan, and allow us to deal with emergency health crises and chronic disease issues that exist as a result of our current environment.

Corey Solferino, Lieutenant, Administrative Bureau, Legislative Liaison, Washoe County Sheriff's Office:
We want to register our support for A.B. 97. The second-largest detention facility in the state of Nevada, the Washoe County Detention Facility, has a generally unhealthy population when compared with a general sampling of the public. Our medical director recently did an assessment of the overall needs of the jail, and indicated that nearly half the jail population

qualified as being extremely ill. We believe this measure will dedicate a funding source and revenue to those people who desperately need access to public health.

Ben Schmauss, Government Relations Director, American Heart Association/American Stroke Association of Nevada:
I will read a statement from Tom McCoy of the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease (CWCD) who could not be here:

> The Advisory Council on the State Plan [sic] for Wellness and the Prevention of Chronic Disease was created to increase public knowledge and raise public awareness relating to wellness and chronic diseases and also to educate Nevadans about wellness, including behavioral health, proper nutrition, maintaining oral health, increasing physical fitness, preventing obesity and tobacco use, and the prevention of chronic diseases including arthritis, asthma, cancer, diabetes, cardiovascular disease, stroke, heart disease, and oral disease. The Council is a statutory entity—NRS 439.518—comprised of 13 Nevadans representing diverse health and health-related organizations, education, and business, and having as its purpose to advise and make recommendations regarding wellness and the prevention of chronic disease.
>
> During the August 2018 Council meeting, representatives from the local health authorities made presentations on public health funding in Nevada. In its October 18, 2018, quarterly meeting, based on that presentation, the CWCD voted to support a per capita funding approach for public health.

For over five years, I have been working on the topic of public health funding. I want to highlight the fact that public health funding can save the state a considerable amount of money as well as saving a lot of lives and heartache. Our Medicaid population has swollen to about 680,000 people from approximately 250,000 people five or six years ago.

Working for the American Heart Association and American Stroke Association, here are actual billed charges to Nevada residents in 2013: $954 million for coronary heart disease and $497 million for stroke. Stroke is something that costs a great amount of money and causes a great deal of pain and heartache for the families of those people who have strokes. We can prevent a lot of the strokes and keep a lot of people from suffering in our state.

The Medicaid population is about 49.4 percent hypertensive as opposed to the traditional population which is about 21 percent hypertensive. If you think about public health funding and addressing hypertension through the programs available, you can see just looking through the millions of dollars in billed charges in the state of Nevada that we could significantly reduce the costs to the state. It would also help people who are going through disability and pain and suffering with those diseases. Once again, we support the per capita funding approach to public health.

Vice Chair Carrillo:
Is there anyone in opposition to A.B. 97? [There was no reply.] Is there anyone who is neutral?

Nancy J. Bowen, Executive Director, Nevada Primary Care Association:
The Nevada Primary Care Association is a membership organization for the state's federally qualified health centers (FQHCs), also commonly known as community health centers. We have long considered community health centers to be the intersection between public health and primary care. For example, our member FQHCs are required by federal law to report how well they perform on preventive care such as cervical and colorectal cancer screening, weight and body mass index screening, tobacco screening, immunizations, and depression screening. These performance measures are informed by public health authorities and identified by the CDC. They also include an emphasis on chronic disease management with a specific focus on diabetes. In addition, the Nevada Primary Care Association and our members are deeply involved in the public health community in the state. We regularly participate in events and policy work hosted by the Nevada Public Health Association and Immunize Nevada. We also collaborate with the American Cancer Society—one of our associate members.

Our member FQHCs routinely partner with the local health districts in Carson City and in Clark and Washoe Counties. One reason FQHCs have been such a success, nationally and in the state, is the federal requirement that their boards be made up of a majority share of patients drawn from the communities served by the health centers to address their unique needs, policies, and operations.

There has been a growing call in this country and in the state for criminal justice reform. We have heard it named as a priority by the President and members of Congress on both sides of the aisle. The Governor addressed rehabilitative services to reduce recidivism in the State of the State Address. We have long supported increased funding for public health agencies in the state; indeed, we were happy to back a similar bill in the last session. This makes it difficult to not support A.B. 97 due to concerns with the inclusion of language restricting grant money for FQHCs which have directors, administrators, or managers with criminal backgrounds. We understand there must be an appropriate balance between protecting the state from grantees who would misuse our tax dollars, and keeping open opportunities for individuals with a criminal history to be represented in or employed by community health centers. We urge you to remove the grant restrictions from A.B. 97 and debate them separately.

Vice Chair Carrillo:
There appears to be no other neutral testimony from the south, so would you like to make any closing remarks?

Assemblyman Sprinkle:
You just heard pretty compelling testimony about why this is important. Obviously, the numbers are another issue and will be taken up in a separate committee. As far as the policy

behind what we are trying to do, we are a state that is growing and more people are moving here every day. We need to have strong, viable public health agencies and authorities looking out for us and encouraging preventive care to help avoid some of the costs to the state you heard about today. I strongly urge your support of this bill.

[(Exhibit E) was submitted but not discussed and will be included as an exhibit for the meeting.]

Vice Chair Carrillo:
We will close the hearing on A.B. 97 and open the hearing on Assembly Bill 116.

Assembly Bill 116: Provides for an actuarial study to determine the cost of revising certain Medicaid reimbursement rates. (BDR S-702)

Assemblyman Michael C. Sprinkle, Assembly District No. 30:
I am here today to present Assembly Bill 116. As I have worked in this Committee and also as a member of the Assembly Ways and Means Committee, I have seen that Medicare and Medicaid reimbursement rates have been significant issues since I was a freshman legislator. Over the last interim, it became obvious to me that we needed to understand what it was that was driving our State Plan for Medicaid reimbursement rates, and how by raising them, we could potentially solve so many different problems we frequently address in this body.

I went to the Division of Health Care Financing and Policy during the interim and asked them to tell me what it would take to raise our Medicaid reimbursement rates to 90 percent of Medicare's reimbursement rates. I wanted a fundamental basis to help understand what we are talking about. Every session, and this one is no exception, there are agencies whose rates increase for multiple reasons. Then there are other agencies that do not see an increase but see their rates decrease. We have a fixed budget, and we can only spend so much money. I will read to you their response, which will help explain why I believe we need to fund an actuarial study. Our staff is amazing, and they put a tremendous amount of time and effort into giving me a precise response, and I greatly appreciate that. Their response (Exhibit F) stated:

> The [Division of Health Care Financing and Policy] DHCFP estimates that aligning Medicaid rates with current 2018 Medicare rates would require additional General Fund appropriations of $85.9 million in [fiscal year] FY 2018 and $88.2 million in FY 2019, or a total of $174.1 million over the biennium, including the estimated impact to the state net benefit, as outlined in the agency's attached response memo. However, Fiscal staff notes that the division's response excludes managed care organizations, as well as a number of other Medicaid provider types. Therefore, the fiscal impact cited by the division is likely understated. Several in-depth actuarial analyses would be required to develop a more complete picture of the fiscal impact of aligning Medicaid and Medicare rates.

Again, I appreciate that candid response; however, it did not get me any closer to the answers and solutions I was looking for. I believe this body needs for us to understand Medicaid rates and how we can provide the higher Medicaid reimbursement rates that you will see in other states as compared to the state of Nevada's, which are extremely low. This is a question of where we stand and what it would take so that our reimbursement rates across the board—we are not picking winners and losers every two years—are more in line with the rest of the nation so we are giving our health care providers what they deserve.

Vice Chair Carrillo:
Are there questions from the Committee?

Assemblywoman Titus:
Thank you for bringing this forward. Time and again, although I see folks, I cannot refer them when it comes time for that all-important referral. It is my understanding that the rural providers are reimbursed by Medicaid for 48 percent of our costs—the costs of providing health care. Medicare reimburses us at the rate of 80 percent of our costs. That is how it stands currently in the rural areas. As a perspective, in the rural areas, 60 percent of our payer sources are Medicaid or Medicare, so the issues around the cost of doing business and how to get good health care are so important—not only for the rural areas, but for the urban areas as well. This affects the whole public health issue of getting patients good care. It will be interesting to see what the cost is.

Assemblyman Sprinkle:
That is the whole point and why I appreciated the candid response I got from our state agency. There are so many different aspects to what I am asking for; we really need this actuarial study to get to the heart of what you just mentioned. The rural areas are very different in some regard to the urban environments, and we need to have that look at what it is going to take across the board. That is why I believe we need this study.

Assemblywoman Nguyen:
Have other jurisdictions implemented these types of actuarial studies? What kinds of results might there have been? Have there been any national trends?

Assemblyman Sprinkle:
Nationwide, I do not know if others have looked at this because each state's Medicaid program is different. That is why doing our own actuarial study will get us some of the answers we are looking for.

Several state agencies have their own actuaries; however, we are talking about Medicaid and we are talking about the Division of Health Care Financing and Policy. That division is the one I went to, and I received their response. I trust them implicitly; this actuarial study is what they feel would be necessary for us to have accurate information. That is why I brought this bill forward.

Assemblyman Thompson:
I was wondering about the timeline. Because the narrative and discussion has been going on for a long time, is there any way we can make the timeline tighter? The bill reads, "On or before July 1, 2020 . . . ." Does the study start then, or is that when the study must be completed and reported back?

Assemblyman Sprinkle:
I do not have an answer. We want a very sound actuarial study and we want to give them the time they need to do a good job, but the sooner we can get the results, the better. Clarifying July 1, 2020, as either being the start or the end of the study and how soon it can be implemented are good questions, and I will follow up on them.

Assemblyman Assefa:
We know the reimbursement rates are low. What is the effect of low reimbursement rates on our health care system and on access to health care?

Assemblyman Sprinkle:
The first issue is network adequacy and the ability of providers to provide their services. When providers are looking at such low reimbursement rates, it makes it very difficult for them to take Medicaid patients and still stay in business. Providers have such high costs for the services they provide, and when we have such low reimbursement rates, it makes it very difficult for them to accept those Medicaid individuals as patients. Consequently, Medicaid patients are potentially going to have a very difficult time finding someone to help them with whatever their ailments are. That is probably the No. 1 issue and why we need to address it.

Vice Chair Carrillo:
Would you be looking at all rates, including mental and behavioral health and care coordination, as well?

Assemblyman Sprinkle:
That was my desire—any benefit provided through our Medicaid plan. As Assemblywoman Titus mentioned, that may differ depending on regional areas and whether the care would be fee-for-service or through managed care organizations. These would be the different things this actuarial study would take into account; but yes, specific to your question, any benefit Medicaid provides.

Vice Chair Carrillo:
Are there any other questions from Committee members? [There was no reply.] Is there anyone who wishes to speak in support of A.B. 116?

Bill M. Welch, President/CEO, Nevada Hospital Association:
One of the things I speak about on a regular basis to this Committee, and to other committees—particularly the money committees—is the inadequacy of funding for the Medicaid program. As Assemblyman Sprinkle indicated, we have never had good numbers across the spectrum of providers. This legislation will enable the Legislature, for the first

time, to create a basis from which it can begin to develop a strategy about how to get the state to where it needs to be.

Last week, I made a presentation to this Committee about safety net providers. If you will recall, the greatest amount of growth in utilization of our hospitals—both inpatient and outpatient, but particularly in the outpatient arena—was the Medicaid population. I also pointed out that the significant growth in outpatient Medicaid utilization was for nonemergent care. This goes to Assemblyman Assefa's question about the impact. We have a lot of consumers who end up having to come to hospital emergency rooms (ERs) for safety net services for nonemergent care. This legislation will begin to create a knowledge base, or a factual base, from which we can then begin to work together to get Nevada where it needs to be to ensure Medicaid recipients have access to the full spectrum of services they need.

Connie McMullen, representing the Personal Care Association of Nevada:
Personal care is covered by Medicaid under certain circumstances, and I agree that we need to get some answers. Medicaid is a huge issue; we have a growing population and the reimbursement is terrible for all the service providers. Medicaid reimbursement for personal care is $4.25 for 15 minutes of service.

I support this bill; I think we need it. Personal care, according to Assembly Bill 108 of the 79th Session, outlines, looks at, and reviews rates for certain providers every year. Personal care is to be reviewed during the second quarter of this year, and the Home and Community Based Waiver for the Frail Elderly is due to be reviewed during the fourth quarter. I have no expectation that any money will be funded for those, even though they will be reviewed. This bill may get us there, and I am hopeful.

George Ross, representing Hospital Corporation of America; and Sunrise Hospital and Medical Center, Las Vegas, Nevada:
We want to thank Assemblyman Sprinkle for bringing this bill forward. This is a critical need for Nevada at this moment. What I am going to say next is in no way a negative about the bill; however, we hope the bill will not be seen as delaying improvement of Medicaid reimbursement to hospitals for another two years.

Currently, Hospital Corporation of America (HCA) is the largest Medicaid provider among hospitals in the state. Over 22 percent of Clark County and about 24 percent of the state's Medicaid hospital patients are at Sunrise Hospital. Forty-two percent of our inpatients are Medicaid; fifty-six percent of our ER patients are Medicaid. Fifty-four percent of our costs are paid for by Medicaid. This is an untenable situation, as our losses are becoming immense. Only 16 percent of our patients are insured, so where do we find the revenue to cover that hole? When someone comes into our ER, we take care of that person no matter who they are or what their situation is. The other 10 percent of our patients are uninsured, so we are getting much less than half the cost of treating two-thirds of our ER patients.

It is a real problem and a real challenge. What is at stake is the ability of the hospital to continue to offer the high level of services it currently provides. Some of those services are

predominantly for Medicaid patients, and they are extraordinarily expensive for us to continue to carry. This bill is going in the right direction and asking exactly the right questions. We just hope it does not become a way for people to put off doing what the state should do for two more years. The last data comparing states, provided by the Henry J. Kaiser Family Foundation for fiscal year 2014, ranked Nevada dead last—just as we always are in everything else. That is something we cannot continue to be.

Joanna Jacob, representing Dignity Health-St. Rose Dominican Hospital; and Dignity Health-St. Rose Dominican Neighborhood Hospitals:
Dignity Health's neighborhood hospital project is for hospitals throughout the Las Vegas Valley. I want to echo the comments of Mr. Welch and Mr. Ross. We support the idea of an actuarial study to find out the facts behind where we need to be, and we thank Assemblyman Sprinkle for putting that tool in place.

Joan Hall, President, Nevada Rural Hospital Partners:
I want to echo everything that has been said. There is an access issue, as was mentioned by Assemblywoman Titus. We see the patients in rural Nevada: we identify an issue, but then there are no specialists who will accept them. Even critical access hospitals and their rural health clinics are reimbursed at a cost-based reimbursement. Even at cost, that does not leave the hospital any money to use to reinvest in new technology or new services. Our outpatients are what Assemblywoman Titus was talking about. We are reimbursed so low, and that is where the majority of our patients are. We hope you find the money so we can fund what we are going to find is the deficit.

Heidi S. Parker, Executive Director, Immunize Nevada, Reno, Nevada:
I would like to share with you a couple examples of how reimbursement rates affect immunizations. For many providers, reimbursement for the cost of vaccines is well under what providers are paying for their adult patients. Those rates have not kept up with the annual cost increases those providers are facing. Reimbursement for vaccine administration has disparities between provider types, and in the context of the previous discussion on public health funding, those entities are currently receiving substantially lower amounts for vaccine administration.

I also echo Assemblyman Sprinkle's comments about network adequacy. We see this having an impact on families who cannot find contracted Medicaid providers—they do not have a medical home—and the public health agencies are struggling to keep up with that demand. Immunizations are an essential health benefit covered not only by Medicaid but also by health insurance. Providers deserve to be reimbursed appropriately, and we support this study of these rates.

Brooke Maylath, President, Transgender Allies Group, Reno, Nevada:
The Medicaid population was expanded through the Affordable Care Act as were the services being offered. These expansions have been great lip service to the community, but if we do not have enough doctors in the network because the reimbursements are not high enough, it still creates a barrier for health care. Those types of barriers are harder on

marginalized communities, which, as a result, are taking the brunt of this. We need to have a system that adequately reimburses primary care providers in order to keep people out of the hospitals. Maintenance of health will help alleviate the problems we are seeing at places like Sunrise Hospital where primary care is effectively being issued out of the emergency rooms.

Speaking as a health care business consultant, we have to have reasonable rates that will at least cover most of the cost, because reimbursement of 54 percent of costs is not adequate. We are setting up our tertiary health care system to fail by under-reimbursing them. That will create a hole, a gap, in tertiary care for everyone—not just the Medicaid community. Being able to look at this actuarial base, finding a reasonable level of reimbursement, is critical for the businesses, the physicians, and for the patients in need of treatment. This is the right thing to do for every citizen in Nevada.

Mari Nakashima, representing the Nevada State Medical Association:
We want to thank Assemblyman Sprinkle for bringing reimbursement rates to the forefront. It is a conversation we have session after session, and we believe this study is moving in the right direction. The Nevada State Medical Association represents the physician community that cares for Nevada's Medicaid population. Many of our doctors view serving Medicaid patients, who are quite often the most vulnerable within our communities, as a moral obligation. The unfortunate reality is that payment rates and complex paperwork can make providing this necessary service more difficult at times. Nevada Medicaid recipients have difficulty accessing essential medical care. Because Medicaid does not cover the cost of providing the care, physicians who want to treat Medicaid patients have to carefully fit Medicaid patients into their schedules, capping the percentage of Medicaid patients they can accept. This is a problem that will become more pronounced if this population continues to grow further.

The Nevada State Medical Association believes this study is a positive first step in addressing the issues associated with Medicaid rates that are below regional averages, and we are ready to assist Assemblyman Sprinkle, the Committee, and the Department of Health and Human Services in this effort.

Michael Hackett, representing the Nevada Public Health Association:
We are also in support of this bill. One of our long-standing, overarching priorities has been to improve access to health care. Through the context of network adequacy and the role Medicaid plays in public health, this is something that is very important to us, and we want to be on the record in support of it.

Chris Bosse, Vice President, Government Relations, Renown Health:
Renown is one of the largest Medicaid providers of hospital services in northern Nevada. I want to echo what my colleagues have said today. Certainly, network adequacy and the challenges we face with adequate access to care are among the unintended consequences of Medicaid rates that have not been studied. We appreciate Assemblyman Sprinkle's efforts to bring this issue to light, and we encourage your support.

Elisa Cafferata, representing Planned Parenthood Votes Nevada:
I want to echo the support my colleagues have expressed. This is a very real challenge. Our affiliate in northern Nevada has figured out how to see Medicaid patients; however, our affiliate health centers in Las Vegas are still trying to figure out a way to make it pencil out to see these patients. They very much want Medicaid patients as part of their practice, but it is very challenging. This bill goes a long way toward addressing that issue and enabling us to see more patients.

Vice Chair Carrillo:
Is there anyone in the south who would like to testify in support of A.B. 116? [There was no reply.] Is there anyone in opposition to A.B. 116 in Carson City? [There was no reply.] Is there anyone in the south in opposition? [There was no reply.] Is there any neutral testimony on A.B. 116 in either Carson City or in the south?

Ellen Crecelius, Actuarial Economist, Division of Health Care Financing and Policy, Department of Health and Human Services:
I am the actuarial economist for Nevada Medicaid. I would like to explain the fiscal note we put on this bill. We requested an estimate from our contracted actuary for the cost of conducting this study (Exhibit G). The study would include analysis of inpatient hospital repricing; outpatient hospital repricing; and repricing for other provider types including physicians, durable medical equipment, labs, long-term care and skilled nursing; as well as projected expenditures including managed care capitation payments; analysis of our supplemental payment programs to see how they would change as the result of the 90-percent-of-Medicare prices; and also an analysis of enhanced federal funding opportunities that might be possibilities for the Division to discover because Nevada would be increasing its reimbursement rates. For the record, the cost of the analysis was $148,000. Half of that would come from the State General Fund and half would come from federal funds because the study would be eligible for our administrative match. When our contracted actuaries provided the analysis about how much it might cost, their estimated timeline was that it would take them 14 weeks once they received the data.

Vice Chair Carrillo:
There does not seem to be any more neutral testimony; however, we have a question.

Assemblyman Assefa:
For clarification, why do we need a study? Do we not know the actual cost of service provision? I feel as though we already know what the problem is—low reimbursement rates. Why are we not going directly to the solution—finding the money to increase the funding?

Assemblyman Sprinkle:
I will take the second part of your question first. That was where I went at the beginning—how much money do we need and how are we going to get it. When I made that request and received the entire response from the Division (Exhibit E), which is on the Nevada Electronic Legislative Information System (NELIS), that response will address the first part of your question. Why it is not just a simple matter to say that we need, for example, $100 million or

$200 million, is because there are so many different things that go into it. Having a third-party, unbiased actuarial study will give us the exact data we need. As you heard today, many people believe that is what we need to fundamentally change where we are going with reimbursement rates. It would be simple for me to say that I need $100 million; it would be very difficult for me to justify it without this study.

Vice Chair Carrillo:
Would you like to make any closing comments on A.B. 116?

Assemblyman Sprinkle:
I believe I just made them; however, I want to be certain everyone knows that the information in the Division's response is up on NELIS now. You will be able to read it and get a better understanding of the full response I received from our outstanding staff. If anyone has suggestions about how to make this better, I am always open to hearing whether any changes are needed; but otherwise, I urge your support for this bill.

Vice Chair Carrillo:
We will close the hearing on A.B. 116.

[Assemblyman Sprinkle reassumed the Chair.]

Chair Sprinkle:
At this point, I will move on to our next agenda item which is public comment. Does anyone wish to come forward under public comment? I see no one in northern Nevada. Is there anyone in southern Nevada? [There was no reply.] I will close public comment. We are adjourned [at 3:13 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblyman Michael C. Sprinkle, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a document titled "Public Health Funding in Nevada" supplied by Kevin Dick, District Health Officer, Washoe County Health District, in support of Assembly Bill 97.

Exhibit D is written testimony presented by Heidi S. Parker, Executive Director, Immunize Nevada, in support of Assembly Bill 97. Included is a document titled "Immunization Operations Funding 2009-2018," supplied by the Division of Public and Behavioral Health, Department of Health and Human Services, concerning the Nevada State Immunization Program.

Exhibit E is a letter dated February 24, 2019, addressed to Chairman Mike Sprinkle, Assembly Committee on Health & Human Services, submitted by Andy Maggi, Executive Director, Nevada Conservation League, in support of Assembly Bill 97.

Exhibit F is a copy of a memorandum titled "Legislative Request—Medicaid Reimbursement Rates" from Cathy Crocket, Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, dated April 12, 2018, addressed to Assemblyman Mike Sprinkle and supplied by Assemblyman Michael C. Sprinkle in support of Assembly Bill 116.

Exhibit G is a copy of a report titled "State of Nevada, Division of Health Care Financing and Policy, Actuarial Consultant Services—Project Proposal, Evaluation and Redesign of Medicaid Provider Reimbursement," authored by Jennifer Gerstorff, Consulting Actuary, Milliman, Inc., Seattle, Washington, dated December 24, 2018, supplied by Ellen Crecelius, Actuarial Economist, Division of Health Care Financing and Policy, Department of Health and Human Services, regarding Assembly Bill 116.