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

## Eighty-First Session
## May 7, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:02 p.m. on Friday, May 7, 2021, Online and 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/81st2021.

**COMMITTEE MEMBERS PRESENT:**

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Michelle Gorelow
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

**COMMITTEE MEMBERS ABSENT:**

Assemblywoman Annie Black (excused)
Assemblyman Gregory T. Hafen II (excused)

**GUEST LEGISLATORS PRESENT:**

None

**STAFF MEMBERS PRESENT:**

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Nick Christie, Committee Manager
Joan Waldock, Committee Secretary
Trinity Thom, Committee Assistant

**OTHERS PRESENT:**

Sara Cholhagian, Executive Director, Patient Protection Commission, Office of the Governor
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Gregory D. Ott, Chief Deputy Attorney General, Patient Protection Commission, Office of the Governor
Nancy Bowen, Chief Executive Officer, Nevada Primary Care Association
Kristyn Leonard, representing Nevada Advanced Practice Nurses Association
Marcus Conklin, representing Teladoc Health
Hailey Lindsley, representing Planned Parenthood Votes Nevada
Alex Camberos, Administrative Assistant, Battle Born Progress
Trey Delap, representing National Alliance on Mental Illness, Nevada
Tom Clark, representing Nevada Association of Health Plans
Julia Peek, M.H.A., C.P.M., Deputy Administrator, Community Health Services, Division of Public and Behavioral Health, Department of Health and Human Services

**Chair Nguyen:**
[Roll was called. Committee rules and protocol were explained.] We have one bill hearing. We will open the hearing on Senate Bill 5 (1st Reprint).

**Senate Bill 5 (1st Reprint): Makes changes relating to telehealth. (BDR 40-416)**

**Sara Cholhagian, Executive Director, Patient Protection Commission, Office of the Governor:**
Joining me for this presentation are Deputy Attorney General Greg Ott and Deputy Administrator DuAne Young from the Department of Health and Human Services (DHHS). It is an honor to come before you today to present Senate Bill 5 (1st Reprint) which originated as a recommendation for the Patient Protection Commission within the Office of the Governor as one of its priorities for the legislative session. The goal of this measure is to promote increased access to care and to make into law telehealth flexibilities that were granted during the COVID-19 public health emergency. This bill is an effort to recognize long-term recovery and a new normal for patient access to care.

I will start by providing an overview of the main provisions of the bill. I am happy to take any questions or go section by section if that is preferred. Chair Nguyen, if it is permissible, I will start with the first provision, relating to equitable access.

**Chair Nguyen:**
That sounds good.

**Sara Cholhagian:**
Sections 1, 2, 3, 5, and 6 relate to equitable access. They require DHHS, to the extent that resources are available, to establish a data dashboard that allows analysis of data relating to access to telehealth by different groups and populations in this state. Section 1, subsection 2, outlines those parameters for the dashboard. There are no provisions relating to a mandated data collection effort; rather, the intent is to utilize existing data. This is a first step to measure telehealth access. There is a requirement in section 2, subsection 1, paragraph (h), for the state to review the dashboard and evaluate policies to make such access more equitable. This is also required for other health policy boards in the state, specifically the Commission on Behavioral Health and the Regional Behavioral Health Policy Boards. In addition, there is also a provision that requires both DHHS and the Patient Protection Commission to make this data dashboard publicly available, posted on their website for public access and viewing.

I will pause to take any questions related to equitable access, unless you would like me to move on to the second part of this measure, which is related to the expansion of services.

**Chair Nguyen:**
We will take a short recess [at 1:08 p.m.]. I will call the Committee back to order [at 1:08 p.m.]. Ms. Cholhagian, would you do your entire presentation? We will ask questions at the end. I know there has been some talk about an amendment. I do not know if that is a new amendment, or if that is miscommunication.

**Sara Cholhagian:**
I will proceed with the remainder of the presentation that outlines the intent of this measure. When I conclude, I will highlight what the adopted amendment from the Senate did and where it stands. The adopted amendment did not change the intent of the outline of this measure.

The second part of this measure relates to expansion of services and access. Primarily, sections 4 and 8 through 16 compel private payers to reimburse providers on the same basis as the insurer provides coverage and reimbursement for health care services provided in person. Medicaid is already required to reimburse providers. Audio-only service is excluded from this reimbursement provision, but the technology is recognized as an allowable modality. The Commission voted to recognize that reimbursement should be kept on par with in-person care to give reluctant providers a reason to try telehealth and spur widespread adoption with the goal of increasing access. This legislation will encourage providers and patients to use virtual care alternatives to increase access to care.

As Chair Nguyen mentioned, the reprinted version of the bill includes Amendment 174, which was adopted and voted out unanimously by the Senate. It includes several provisions. There was an amendment from DHHS removing their fiscal concern related to the creation of the data dashboard, providing clarity there was no intent to have an unfunded mandate and recognizing there are resources the Department needs to have available in order to comply with this request. The adopted amendment addresses their fiscal concerns, and there is no fiscal impact to the state considered on this measure.

The other four adopted amendments include a revision of the definition of "telehealth," to provide that the term includes, without limitation, the delivery of services from a provider of health care to a patient at a different location through the use of synchronous and asynchronous store-and-forward interaction. The second amendment replaced the term "standard telephone" to reference "audio-only." The third one is a provision that prohibits health professional licensing boards from prohibiting licensees from establishing a patient-provider relationship via telehealth when it is clinically appropriate to do so and authorizes the State Board of Health of the Department of Health and Human Services to establish regulations prescribing requirements governing a process of establishing a patient-provider relationship via telehealth. That new provision can be found in section 8, subsection 4. The fourth amendment was an attempt to carve out workers' compensation from this mandate. There was no focus in the Commission's deliberations on workers' compensation; instead, it was an inclusion from the drafting decision. In a conceptual amendment, Chair Julia Ratti requested to remove provisions related to workers' compensation to comply—to carve them out of the requirement for payment parity.

That concludes my remarks.

**Chair Nguyen:**
Are Mr. Ott and Mr. Young available for questions? I see them nodding their heads. I will go to members' questions.

**Assemblywoman Titus:**
In section 1, subsection 1, paragraph (a), subparagraph (2), the data dashboard must "allow for the user . . . ." Who would the user be?

**Sara Cholhagian:**
The user, in this context, is a member of the public. The intent is to have this publicly displayed, and the user would be the public.

**Assemblywoman Titus:**
Section 1, subsection 2, paragraph (a), subparagraph (1), says that the dashboard shall have relevant information. What is considered "relevant?" Who will determine what "relevant information" is?

**Sara Cholhagian:**
I will do my best to answer this. Kyra Morgan, the Chief Biostatistician in the Division of Public and Behavioral Health in DHHS, will be heading this effort as a part of the Office of Analytics. She was not able to join us today. If I cannot answer this, I will follow up with you. My understanding is that the relevant information would be their interpretation of the requirements outlined in this bill in section 1, subsection 2.

**Assemblywoman Titus:**
In section 2, subsection 1, paragraph (h), what does it mean "to make such access more equitable"? Is it access to the dashboard? Is it access to telehealth? Is it access to health care in general? What access needs to be more equitable?

**Sara Cholhagian:**
Regarding the intent around this request for equitable access, the Commission wanted to make sure they address vulnerable populations that may not have great access to telehealth services. When you talk about the reference "to make such access more equitable," it means that if the data shows vulnerable populations or service areas with lower utilization rates, the Department must consider how to make those areas more equitable.

**Assemblywoman Titus:**
The reason I am asking these questions is, I am not sure where in the bill you decide what is relevant. The public goes on as the user. You have someone who is the user, but somebody else is collecting the data. With that data, is this platform somehow going to make health care more equitable? I do not see that pattern.

My next question is regarding section 4, subsection 1, paragraph (a). In your presentation, you mentioned you would not include audio-only. In telehealth for mental health, we were looking at more access. It has been a real issue. You are not recognizing we may need to have the availability of just audio. Not everyone has a phone with FaceTime for visual access. Not everybody has a computer. Sometimes, all they have is access to a landline phone, especially in my rural areas where we frequently do not have access to the Internet. I am curious why you would exclude the audio-only component.

**Sara Cholhagian:**
I will take the first part and reference the provision about users and looking at the data. That is aimed more as a public awareness and transparency effort to make sure the user has the ability to look at these policies and to keep policy and its consequences in the public eye. When you look at the review part in section 2, subsection 1(h), the key component of that is to review access and make sure, after the Department reviews access, they consider those evaluations in their policymaking decisions. The component for the user is to see it is a transparency effort to keep the public involved and aware of those decisions.

When it comes to audio-only and having a carve-out, you are absolutely right about making sure that there is continued access for the patient to be able to use the telephone, which is why the Commission voted to allow for audio-only to be preserved access as an allowable

technology. It just did not recognize it as an adequate platform to provide proper health care services like changing the standards. I think there was some discussion around whether it warrants the same reimbursement level. There was not enough comfort with the commissioners' deliberation to say that they must include audio-only as a part of the reimbursement mechanism, but they definitely wanted it, to contain access and allow it for a recognized modality.

**Assemblywoman Titus:**
In your opening statement, you talked about having parity with paying the telehealth providers with the brick-and-mortar providers because you wanted to encourage more providers to use telehealth so that, hopefully, you would increase access. This is my fourth session. At every session and in my career, I have advocated for access to health care. I am on board with that. I also understand the disparity in health care and those who are not able to seek health care. That is frequently out in the rural areas. Telehealth makes it helpful. I support the telehealth concept and have used it, especially for psychiatric patients. My concern is about offering parity in reimbursement for telehealth providers versus brick-and-mortar providers. In the contract world of health care, when you negotiate a contract with providers, you set what you are going to reimburse a provider. I am concerned about paying the same rate to telehealth providers and the brick-and-mortar person who stayed in a community and has tried to survive under health care regulations. The telehealth provider has no investment in the community and does not have to pay employees in the community. I am worried that, in the long run, you might do the opposite of what you are trying to do—create access to care—if telehealth becomes the only access to health care because you pushed everybody else out of business. I am concerned about the parity of reimbursement piece and how that will shape up for those providers who have dedicated their lives living in a community.

**Sara Cholhagian:**
I am not sure if there was a question. I do not know how to respond to that. During the Commission's deliberations, their focus was driven on increased access and providing another alternative delivery model for patients to receive services. There was not a deep discussion or deliberation on modifying brick-and-mortar businesses or changing the economics of some of the other smaller providers. It was around, How can we provide another option to make sure that increased access is here to stay?

**Assemblywoman Titus:**
Again, that is per other discussions we have had on a bill we heard just the other day about medical practices aligning and people leaving and signing into big groups. Part of this is the global discussion of how we really access care and all these little things that chip away at that. I just wanted to bring it to your attention.

**Assemblywoman Summers-Armstrong:**
I would like to ask a different question regarding audio-only. In the Assembly Committee on Judiciary, we had a bill about the police being able to use a telephone, an iPad, or some type of electronic device to have a person in crisis speak to someone who provided emotional

counseling. Part of that bill was not just that they talk on an iPad, but that they might be able to hold a phone up to someone and have them get some counseling. Would the audio-only exclusion affect that? That is a very important portion of the calls made by a Mobile Outreach Safety Team (MOST). In my community where we have many providers of homeless care and mental health services, we do not want an inadvertent conflict with those teams not being able to provide that service. Would you please respond?

**Sara Cholhagian:**
I understand and am empathetic to your concern. To give you some comfort, the audio-only carve-out is specifically related to the reimbursement provision. There is no restriction on the use of that modality to provide service. It is only meant for the reimbursement portion on the providers and payers, but not for the utilization of an audio service modality.

**Assemblywoman Summers-Armstrong:**
Would you please explain that a bit more? You are saying it only applies to the reimbursement portion. If the police are contracting with an organization to provide these services and they are being reimbursed by Medicaid—I do not know if they are, but if they were—could this interfere with that?

**Sara Cholhagian:**
What I meant by "the reimbursement portion" is there is no mandated requirement that it must be paid in parity with in-person care. This means that it can be billed and reimbursed; it does not mean that it is automatically mandated at the same level as in-person care. It would warrant reimbursement at the flexibility of the payer and provider discussion. It can still be allowed; it is just not a mandate that it is reimbursed at the same rate as in-person service. Perhaps, for more clarity, Deputy Administrator DuAne Young could explain that from the state side so you can see how that reimbursement would work.

**DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:**
I will give a little bit of history so that we can put this on the legislative record in this house as we did in the Senate. When we first went down this path to put this legislation forward, working with the Patient Protection Commission, we determined that the Centers for Medicare and Medicaid Services (CMS) had not made a ruling if audio-only communications for telehealth would continue outside of the public health emergency as they have been under the public health emergency. The Centers for Medicare and Medicaid Services has now ruled that if a provider is able to maintain the Health Insurance Portability and Accountability Act (HIPAA) and reasonable efforts of privacy, audio-only is included under the definition within the International Classification of Diseases, Tenth Revision, Clinical Modification, for the purposes of CMS reimbursement for telehealth. As it is, *Nevada Revised Statutes* (NRS) Chapter 422, as outlined within this bill, does not change. Medicaid already had reimbursement parity for telehealth and in-person services. This provision allows some guardrails for audio-only communication, meaning that, even though the Division has been paying at parity for audio-only communication through the public health emergency, if we were to ever get into an economic crisis or needed to adjust Medicaid's budget, we would not

have to pay for parity for telephone-only calls and could adjust the fee schedule and cost-based providers if necessary. These are appropriate guardrails. Other legislation being considered would expand audio-only. For that, the Division has placed a fiscal note because of the increased utilization the Division would see for audio-only, so this is an appropriate guardrail as the language is written now to keep that utilization and allow the Division the levers that it already had in NRS Chapter 422.

To go back to Assemblywoman Summers-Armstrong's question regarding crisis services, audio-only crisis behavioral health services are and have always been allowed through Medicaid policies. When a person is in a behavioral health crisis and calls a crisis line to speak with an enrolled professional, the professional can bill Medicaid for the crisis intervention. Those services are allowed. On these platforms, MOST officers were able, even before the pandemic, to bill for those services and would be able to continue to do so.

**Chair Nguyen:**
Are there any follow-up questions?

**Assemblywoman Summers-Armstrong:**
No. I appreciate this history and in-depth explanation because this is very concerning to many of us. We hear things in different houses and committees, and then you see there is a nexus. I just want to make sure that I am not making a mistake when I push the button.

**Assemblyman Orentlicher:**
On the parity of reimbursement, I understand the goal of encouraging providers to use telehealth, so that makes sense. On the other hand, I can see that the cost of providing telehealth services is lower than on-site services, so we might get into an over-reimbursement setting. If it turns out, after a couple of years, people and providers have gotten used to it and are willing, we have solved the access problem, but now we might have transitioned to an over-reimbursement. Would we have to come as a Legislature to amend this? Is there a way to give some sort of authority to eliminate it or sunset it without having to come back to the Legislature?

**Sara Cholhagian:**
I would defer to our attorney to answer your legal question. I would be hesitant to try to respond to something that is legal and technical in nature.

**Chair Nguyen:**
Ms. O'Krent, are you on the line and able to respond, or do you need additional time to do some research?

**Karly O'Krent, Committee Counsel:**
I can answer that question now. As the bill is currently drafted, they would have to come back and change those provisions to adjust the reimbursement rates.

**Assemblyman Orentlicher:**
If there is a way for us to revise this now so we can give some kind of ability to change this without having to change the statute, it would be worth considering.

**Chair Nguyen:**
Assemblyman Orentlicher, do you have any other follow-up questions?

**Assemblyman Orentlicher:**
No.

**Assemblywoman Peters:**
I have questions related to the intention of certain language. The first is a clarifying question about the data privacy and security of the dashboard, ensuring it meets with confidentiality standards and all of that. I wanted to make sure to get that on the record. The other piece is the definition of "different groups and populations" as mentioned in section 1, subsection 1, paragraph (a). It looks to me as if you outlined some of that in section 1, subsection 1, paragraph (a), subparagraph (2), but I want to make sure we have a clear understanding of what your intention of reviewing the access for different groups and populations means.

**Sara Cholhagian:**
I will defer to Kyra Morgan for additional follow-up. I will answer to the best of my ability. Because there are no mandated new data collection requirements in this bill, all the privacy and concerns are already embedded in their current operations and process and would align. The data dashboard is intended to be created utilizing existing resources. The security would follow what is already in place. To answer your question about the different demographics, the Commission wanted to make sure they captured all the right demographics to look at any potential vulnerable population. That language was provided by drafting, so the specifics of that and the feedback I received from Commission members were generally in agreement that it captured their intent. I have not heard any negative feedback about those parameters.

**Assemblywoman Peters:**
I would appreciate it if any follow-up information could come to the Committee so we can all see it.

My next question has to do with the second part of the bill. In your definition of "telehealth" in section 7, subsection 6, paragraph (d), you use the word "audio-visual." Do you mean that telehealth is only reimbursable if it uses both the audio and the visual mechanisms? I did a telehealth call and my video was on the wrong side of my computer. I was watching the screen and did not have the video on me. In that case, I did not have audio-visual interaction. Do you mean the best attempt at that? I just want to make sure we are not accidentally excluding certain practices or incidental actions—if someone is blind and cannot see the video, if someone is deaf and needs to use the texting mechanism of Zoom, those kinds of things.

**Sara Cholhagian:**
I will ask Deputy Administrator Young to opine on this part. I can tell you that the intent of the definition was to be all-inclusive of all the appropriate modalities. There was not an attempt to exclude any one technology, but I will defer to him to explain that in a more practical way than I can address.

**DuAne Young:**
The intent and the language in NRS Chapter 422 originally focused on the audio-visual impact of telehealth. As I mentioned earlier, audio-only was allowed only in instances of a behavioral health crisis or case management, not through other means. Since then, during the public health emergency, audio-only has been allowed. This language was crafted as a response to fix state law but not supersede federal law. The regulation through the Office for Civil Rights within the U.S. Department of Health and Human Services has been reversed and CMS has reversed course, so audio-only is allowable. This language only speaks to the reimbursement portion, but it does encapsulate existing language, the framework of NRS Chapter 422, and the new provision for audio-only as allowable by the federal government.

**Assemblywoman Peters:**
This question has to do with section 8, establishing regulations that allow a doctor and patient relationship via telehealth. Are there existing models of this in other states, or are we creating something from scratch with those regulations?

**Sara Cholhagian:**
I do not believe Nevada is creating anything new. The addition of the proposed amendment was provided through discussions with the American Telemedicine Association and Teladoc Health. I would like to get back to you to make sure I answer correctly. I believe this was model language provided through the American Telemedicine Association for Nevada to consider.

**Assemblywoman Peters:**
I was thinking about the time it takes to adopt regulations and if the drafting came up with brand-new language that was never used before. I wondered about the timeline for that, but it sounds like we may have something to start with while getting into that regulatory process.

**Assemblyman Matthews:**
I have a question on broadband access, as there is limited broadband in some cases. Will we be looking at the limits on broadband for our urban and rural areas since this might be a deterrent to access to telehealth in some cases? To what extent might you try to address that?

**Sara Cholhagian:**
That was a part of the deliberations of the Commission when they started discussing equitable access, asking what they could do to improve broadband access to vulnerable populations. Being mindful of the economic climate at the time, they did not want to put forth a measure that created an unfunded mandate to increase broadband access. They expressed their intent to try to increase access where appropriate. In this piece of legislation,

you will see answers may be found as soon as you start to collect some of the telehealth access and data and provide for the dashboard. It might be part of the conversation to see if there is an opportunity to identify certain vulnerable populations that could benefit from increased broadband access and resources dedicated to those areas.

**Assemblyman Matthews:**
To make sure I understand, it is part of the data collection. You anticipate that will include data on the need for providers and access to make sure we can provide these services in some instances. Do I understand you correctly? Will part of the data collection address that?

**Sara Cholhagian:**
Yes, but not necessarily data collection; it would be more data analysis. They are going to use data they already have and are already collecting in the state, but they will analyze access points and identify vulnerable populations. I think in discussions of potential solutions for further policies the thought about increased broadband to enhance equitable access would be a part of the deliberations.

**Assemblywoman Benitez-Thompson:**
I appreciate the ability to make sure we do this right. In section 4, subsection 1, it states, "The Director shall. . . ." We are talking about the State Plan of Medicaid, so this is just for Medicaid. *Nevada Revised Statutes* Chapter 442 is about child and maternal health. Will we see this language specific to section 4, subsection 1, paragraph (b), subparagraph (5), on categorizing the service provider through telehealth differently for purposes relating to coverage or reimbursement? Is that going to be specific to maternal and child health programs through Medicaid? It is a short bill. If we were touching every section of health care, it would be bigger. Is it only living in that one spot, or is it more comprehensive than that?

**Sara Cholhagian:**
The provision you are referencing is the drafting intent to make sure they capture that telehealth is not treated any differently than in-person care. It lives in that provision under child and maternal health, but it is not specific to just child and maternal health. Perhaps Ms. O'Krent could opine on that because I see it as a part of the drafting effort to make sure that telehealth services are not treated any differently than in-person care.

**Assemblywoman Benitez-Thompson:**
I scrolled down further, and I see it also in section 7 and NRS Chapter 616C, where we start getting into the insurance policies. That is where it is applied across all insurers of health care. Is that correct?

**Sara Cholhagian:**
That provision relates to workers' compensation, and it does not apply to workers' compensation provisions. You will see there is a separate definition of "telehealth" in section 7 of the bill. The intent for that section is to make sure that provisions requiring workers' compensation to comply with the billed audio-only and payment requirements are

not applicable to the workers' compensation program, but that provision is applicable to every other insurance carrier in the remaining sections 8 through 16.

**Assemblywoman Benitez-Thompson:**
I want to make sure I have my status quo right. The Centers for Medicare and Medicaid Services currently has temporary regulations out through the end of the pandemic that allow for Medicare and Medicaid payment. I think the one for Medicare is the 1135 waiver. That is the one that is living right now and is going to carry us through the end of the federal government's formal emergency declaration. Through that time, Medicare and Medicaid must have parity and allow for the telehealth services. Is that right? I was trying to figure out when I was reading the 1135 waiver, is it just billing parity?

**Sara Cholhagian:**
I am going to go back to what Deputy Administrator DuAne Young said about Medicaid. In 2015, Medicaid payment parity was codified into law. They already pay in parity. What the federal waiver did through the public health emergency was allowed reimbursement on the audio-only portion of it. Should that end, then the state would go back to the parity already in place. There is no modification to state Medicaid.

**Assemblywoman Benitez-Thompson:**
I am trying to figure out what the change is. We brought the bill to create a change. I see interested groups bringing amendments to this change. Obviously, there is a big shift. There is enough interest in this that it is a big shift. The other piece I was trying to figure out is that with the waiver, CMS was not going to audit for the clinician-patient relationship that had been established prior to using telehealth. We are going to say that we will allow the clinician-patient relationship to be established by regulations, and we are going to tell boards not to have a dozen different standards for a dozen different boards. Is that the bigger change here? I am trying to figure out why we have these big national groups submitting amendments to Nevada legislation. It would not matter if we were not changing it substantially, so I am trying to make sure what health care is going to look like in my state a year from now.

**Sara Cholhagian:**
There are two parts to that. First, we are going to go back to one of the larger provisions of this bill relating to reimbursement that compels private payers to reimburse on the same level as they provide for in-person services. Parity laws were established in 2015, but the reimbursement portion only applied to state Medicaid. This bill compels private payers to reimburse on the same basis as providing health care services in person. That is the bigger change for the private payers. There is not a modification for the state because they already pay in parity.

Second, the modification related to the health professionals' licensing boards got national attention and was about making sure that you protect access to care so the patient-provider relationship could still be, if clinically appropriate, allowed to be established via telehealth. It happens in practice; that provision makes sure there is nothing in law that could prevent it

from happening. That maintains alternative access for patients through telehealth services and is about being able to establish that relationship.

**Assemblywoman Benitez-Thompson:**
In my initial quick read, I had it backwards. When I said I wanted to figure out the status quo on parity between brick-and-mortar versus telehealth, I was thinking it was pieces of Medicaid, but not all of Medicaid. That is where we saw the references to the statute on child and maternal health. I also see statutes on private insurance, so it is the reverse of what I thought. Medicaid is doing it, but private insurance plans are not required to do it. That is a significant change.

Assemblywoman Titus and I were both in the building when we had the initial hearings on whether we would do telehealth. Some thought the sky would fall if we did telehealth or that we would have horrible care. Ultimately, it was a way to go. For areas of our state, telehealth made sense. The conversation was always about telehealth as a supplement; the gold standard of care is to get in through the door and see a physician. If that cannot happen or where that cannot happen, then you have telehealth. That is the way it has been conceptualized in statute. From my perspective, if we are going to mandate all insurers with the parity piece combined with talking about a patient-client relationship, we are drastically changing how health care will look in this state. I wanted to make sure I understood. The data collection is great and fine, but I worry about those two pieces coming together at once, and I worry about how that will impact our health care market.

To Assemblywoman Titus' point, we were talking about having worked in health care. Ten years ago, I worked for a tiny hospital where there were still nuns providing health care. Then the nuns got kicked out. Then it got sold. Then it was owned by a western-market conglomerate. Then a year and a half later, it was sold and went to a western United States corporation, and now it is a national corporation. I have seen that acquisition of health care. I have lived that acquisition of health care where every year and a half they say, We will keep the name the same so people in the community recognize the name and think we are the same, but the ownership is constantly changing. It is always going broader and up, it is not devolving. I wonder what this will look like for telehealth when we say health care can be provided by an investor group that is managing a telehealth corporation. That is my thought.

**Sara Cholhagian:**
I appreciate your perspective and understanding of the future. You do have a correct understanding of this piece of legislation. This is their attempt for a long-term recovery of the new normal and making sure the goal was patient access to care and having virtual alternatives to increase that access. You do have a correct understanding of the intent of this legislation.

**Chair Nguyen:**
Do you have any other follow-up questions?

**Assemblywoman Benitez-Thompson:**
No. I appreciate that and the ability to make sure I was thinking about it correctly.

**Chair Nguyen:**
I was going to go to Assemblywoman Krasner, but Assemblywoman Summers-Armstrong has a follow-up question related to what Assemblywoman Benitez-Thompson asked.

**Assemblywoman Summers-Armstrong:**
This is a good segue to ask on the record the question you and I discussed previously. If we have a provider who is only providing telehealth and does not have a brick-and-mortar location in Nevada, and a patient who does not want health care through telehealth is referred to him, now where are we? We are placing a patient in a situation of not being in control of how their health care is delivered. That needs to be considered. I would like you to speak to that because it really concerns me. What if that person wants health care in person, and the doctor tells them, I do not do that, or, You will have to wait because my new normal mode is telehealth? What happens to that patient? How will it increase access if they may not have an option?

**Sara Cholhagian:**
I appreciate your perspective and understand your concerns. This piece of legislation is aimed at providing access to care and giving patients alternative methods of delivery. For your scenario in which there may be a mandate from the provider to a patient that says they only are available via telehealth or in person, that is a valid concern. However, this piece of legislation does not address any of those mandates. It just provides another option. It maintains patients' ability to have an alternative method of accessing care.

**Assemblywoman Summers-Armstrong:**
I understand that is your intent, but we know that when we do not have clearly defined parameters, people will use their own judgment. We could very well see that the patient loses control and that the doctors or whomever they work for do the compelling about how service is delivered based upon profit and not based upon the best use and the best situation for their patients. As legislators, we are not in a position to allow people's good nature to drive what they do because we all know that is not what happens in reality. Oftentimes, it is corporate governance and profits that do.

**Assemblywoman Krasner:**
I have a few questions. The bill expands telehealth from audio-visual and emergency audio to now include audio-only, but the bill will not allow Medicaid to pay in parity for audio-only interactions with health care providers if there is not enough money to do so. Is that correct?

**Sara Cholhagian:**
That is not correct. There is not an expansion of services or an expansion of a different modality. I think your question relates to the reimbursement from the state on the audio-only. Deputy Administrator DuAne Young explained it and would be better equipped to

answer your concern. I think your question is related to the reimbursement of audio-only from the state perspective.

**Assemblywoman Krasner:**
Yes, it is.

**DuAne Young:**
I want to clarify in plain language: The existing parity for telehealth in NRS Chapter 422 was established in 2015 by the Legislature [Assembly Bill 292 of the 78th Session]. There was one provision of NRS Chapter 422 in that legislation that prohibited audio-only because there was a federal Medicaid provision through the U.S. Department of Health and Human Services Office for Civil Rights that did not allow audio-only or HIPAA-compliant platforms. During the public health emergency, the Trump Administration lifted that ban on audio-only as a promotion. Then CMS came back and said we did not have the authority to do that because we did not get permission from the Office for Civil Rights to do so. Under the Biden Administration, the Office for Civil Rights did not change the regulation; however, they formally changed the interpretation behind that regulation that said audio-only is included for telehealth as long as the provider can maintain reasonable privacy standards. That reversed the CMS's course to say it is allowable for reimbursement from the federal government for Medicaid services.

The language in this chapter removes that state provision so that it is allowable beyond the public health emergency. It also establishes through that one clause that Medicaid could and still does pay parity for audio-only communications, so it does not tie our hands.

To speak to Assemblywoman Summers-Armstrong's point about quality of care, we at Medicaid know that while we do our due diligence to gatekeep those providers, there are providers who would set up shop and not effectively provide care. We would be chasing those providers to make sure they uphold the standard of quality of care and are stewards of the state's and the federal government's resources. Not changing the existing language and allowing for a nonpayment parity allows us appropriate guardrails so we would not have to put a fiscal note on this. We would be able to control utilization, and it would allow us to say a provider must meet those standards of care and ensure they are serving the patients of Nevada as they are claiming to do.

**Assemblywoman Krasner:**
Back to my question: If a health care provider provides the initial consultation with the patient through audio-only and through telehealth, and if Medicaid is not going to have to pay parity if there is not money to do so for audio-only, why would a health care provider even do this? Why would you expect a health care provider to do this knowing they might not get paid for their services?

**DuAne Young:**
There would be payment. It may not be the same level of payment as if they were providing traditional telehealth. In establishing the policy based on the Legislature's decision in 2015,

we knew there were some infrastructure costs in telehealth, so I believe that is the reason the Department of Health and Human Services and Medicaid services supported the provision without an extended fiscal note. We knew there were some infrastructure into traditional telehealth equipment. We have providers who utilize audio-only. We have been paying them at parity through the public health emergency, but there are some providers that receive a Prospective Payment System (PPS) encounter rate. We have been paying them at parity through the public health emergency, but there are some providers who receive PPS encounter rates that are based on their costs. There are other providers who receive rates that are based solely on their costs. We know that audio-only has a lesser cost than traditional telehealth equipment or the infrastructure of full brick-and-mortar, so if those costs were to reduce, this would give us the flexibility to make adjustments based on their reduced costs. It is not to discourage providers from doing audio-only, but it does allow the provider to decide if the reimbursement is lowered at some point. They could make that business decision if it is advantageous for them. It also gives the state the leverage it needs within Medicaid policy to control the guardrails appropriately so we do not have to come back before the body of the Legislature to say we reached a shortfall; we can control the mechanisms within policy to have those appropriate fiscal and policy guardrails.

**Assemblywoman Krasner:**
I respectfully disagree with you. Furthermore, does a health care provider who provides services to somebody via telehealth get sued for any less amount for medical malpractice? Or are they also going to get sued for malpractice and then not be reimbursed by Medicaid in parity with this bill?

**DuAne Young:**
I am not equipped to answer a medical malpractice question. I do not practice law. I will defer to either Mr. Ott or Ms. O'Krent.

**Gregory D. Ott, Chief Deputy Attorney General, Patient Protection Commission, Office of the Governor:**
I would prefer you go to Ms. O'Krent.

**Chair Nguyen:**
Ms. O'Krent, are you able to answer the question, or will you need to follow up with Assemblywoman Krasner?

**Karly O'Krent:**
I will need to follow up and am happy to do that. I will send any information necessary to the Committee.

**Chair Nguyen:**
Assemblywoman Krasner, Ms. O'Krent will follow up with you. Do you have any further questions?

**Assemblywoman Krasner:**
No. I think this is bad policy. I do not think we would expect any other profession to not be paid in parity for doing their services in an alternate fashion when there is a need for such in that state, and we have already established there is a desperate need in this state.

**Chair Nguyen:**
This is a very important discussion we are having. I am looking to see if there are additional questions. Some people may have additional follow-up questions they want to ask to get on the record. [There were no additional questions.] We will begin testimony in support, opposition, and neutral on Senate Bill 5 (1st Reprint).

**Nancy Bowen, Chief Executive Officer, Nevada Primary Care Association:**
The Nevada Primary Care Association represents the state's Federally Qualified Health Centers. I am here in full support of S.B. 5 (R1). Our members provide integrated primary, behavioral, and dental health care to more than 107,000 Nevadans. The vast majority come from low-income households and are uninsured or on Medicaid. During the public health emergency, between 15 percent and 40 percent of health center visits have taken place over the phone. Our members found that patients did not always have access to devices and data plans that allowed for video telehealth visits. At first, these remote visits served to keep our patients and providers safe and to conserve scarce personal protective equipment. However, as many of us have found with video telehealth, other benefits soon became apparent. Patients took less time off work, did not have to arrange for child care, and were spared long trips on public transportation.

Patients agree this is an important tool to increase access to care. One health center patient said she would not be here today without audio-only visits. Another credited this modality with helping to manage their chronic disease and keep them out of the emergency room. These audio-only services have been reimbursed by Medicaid throughout the public health emergency. Allowing the benefit to expire would be taking existing access away from our most vulnerable sick residents. We urge the Committee to pass S.B. 5 (R1) to address this important issue.

**Kristyn Leonard, representing Nevada Advanced Practice Nurses Association:**
The Nevada Advanced Practice Nurses Association wants to put its support for S.B. 5 (R1) on the record because ensuring the availability of telehealth services is vital to increasing access to health care in the state.

**Marcus Conklin, representing Teladoc Health:**
We want to thank the Patient Protection Commission, Sara Cholhagian, and Chair Ratti for working diligently on this issue with us over these past four months. We are in full support of the bill. We urge passage.

**Hailey Lindsley, representing Planned Parenthood Votes Nevada:**
Planned Parenthood Votes Nevada is in favor of S.B. 5 (R1) because making telehealth accessible through the standard telephone would be a long-term investment in the health,

safety, and well-being of Nevadans. Not only does telemedicine help connect geographically isolated areas to vitally important health care, but it is also an essential tool in addressing the health disparities that exist for Black, Indigenous, and People of Color, rural, and medically underserved communities. In fact, the removal of restrictions and increased public and private coverage for telemedicine due to COVID-19 have allowed providers to see more patients safely and efficiently. This temporary expansion has provided a demonstration of what innovative, broadened access to telemedicine can do. Please, we urge you to support S.B. 5 (R1) and expand more equitable health care access for Nevadans.

**Alex Camberos, Administrative Assistant, Battle Born Progress:**
We support S.B. 5 (R1) because access to health care is a constant struggle for Nevadans. Telehealth has been expanded during the pandemic. We have seen more Nevadans able to access their doctors via this modality. Telehealth should be covered, and access should be increased. We should be using technology to advance and assist Nevadans in accessing the health care services they desperately need.

**Trey Delap, representing National Alliance on Mental Illness, Nevada:**
The National Alliance on Mental Illness (NAMI) is a grassroots mental health organization dedicated to building better lives for the more than 400,000 Nevadans affected by mental health concerns. I want to note a twinge of irony that I am calling in to deliver audio-only testimony via a telephone. Telephonic testimony was necessitated by the public health crisis, and we have adapted for the capabilities of the state and the public. I am hopeful that the information I provide now will be treated in parity as if I were delivering it in person. That is why S.B. 5 (R1) is so relevant: because it ensures that we are meeting people where they are, based on current realities, in a manner accessible to all.

The National Alliance on Mental Illness believes that public policies and practices should promote access to care for people with mental health conditions. Each year, NAMI Nevada's helpline answers 10,000 calls for information and assistance: 38 percent of the calls come from families or caregivers for people with mental concerns; 44 percent of the calls come from individuals inquiring about a variety of topics related to living with a mental health concern; 25 percent are regarding treatments; and 20 percent are regarding support, encouragement, and reassurance. The NAMI Nevada warmline has served over 600 people since October 2020. For those impacted by mental health, it is critical that persons be able to access assistance by any means available to them. For many people, a telephone with audio-only capability may be the only way to access information or support that would mean the difference between life and death. Senate Bill 5 (1st Reprint) advances an essential piece of an effective community-based resource so that all people have access to a basic human connection to get the best information or support at the right time. We urge your support.

**Chair Nguyen:**
[There were no more callers in support.]

[Exhibit C was submitted but not discussed and is included as an exhibit for the hearing.]

We will now begin testimony in opposition.

**Tom Clark, representing Nevada Association of Health Plans:**
We appreciate and have supported the Legislature's telehealth efforts in the past. We have given everyone the ability to be innovative with their health care services. As we continue to face the ripple effects of the pandemic, making sure patients can access care is our priority. Telehealth options allow patients to do so safely, securely, and conveniently from everywhere. We support the sections of S.B. 5 (R1) that allow for the data dashboard; however, we oppose the payment parity provisions mandated in Senate Bill 5 (1st Reprint). Insurers must continue to have flexibility to negotiate prices to keep health coverage costs affordable. Telehealth services must be comparable to the services provided in an office visit. Insurers and providers must be able to establish different reimbursement rates based on the clinical effectiveness and intensity of the visits. It is important that we can develop value-based arrangements with providers by focusing on health outcomes, not just the volume of services provided. This bill prohibits insurance companies from doing just that. The payment parity provisions are contradictory to telehealth cost-effectiveness. Telehealth can help reduce the cost of using the health care system and reduce provider visits, but not if it is mandated that the services be paid at the same rate as an in-person visit.

**Chair Nguyen:**
[There were no more callers in opposition.] Is there any testimony in neutral?

**Julia Peek, M.H.A., C.P.M., Deputy Administrator, Community Health Services, Division of Public and Behavioral Health, Department of Health and Human Services:**
The Division has provided testimony in neutral. Based on Amendment 174, we were able to remove our fiscal note, though it is still reflected in the Nevada Electronic Legislative Information System. My written testimony is reflected as well with a zero dollar State General Fund implementation for S.B. 5 (R1) [Exhibit D].

**Chair Nguyen:**
Do we have any other callers in neutral? [There were none.] At this time, I will turn it back over to presenters for any closing remarks.

**Sara Cholhagian:**
My concluding remarks are gratitude to the Committee for giving me the opportunity to present this important measure on behalf of the Patient Protection Commission. I appreciate your consideration.

**Chair Nguyen:**
With that, I will close the hearing on Senate Bill 5 (1st Reprint). At this time, we will go to our last agenda item, public comment. Is there anyone wishing to provide public comment? [There was no one.] Are there any comments from members? [There were none.]

We will not be having a Committee hearing on Monday, but I anticipate we will be having a meeting on Wednesday, May 12, 2021. I anticipate a work session, and if we receive any bills on Monday, we could hear them as well. This meeting is adjourned [at 2:20 p.m.].

RESPECTFULLY SUBMITTED:

_____
Joan Waldock
Committee Secretary

APPROVED BY:

_____
Assemblywoman Rochelle T. Nguyen, Chair

DATE: _____

## EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a packet of letters from various individuals and organizations, in support of Senate Bill 5 (1st Reprint).

Exhibit D is written testimony dated May 7, 2021, submitted by Julia Peek, M.H.A., C.P.M., Deputy Administrator, Community Health Services, Division of Public and Behavioral Health, Department of Health and Human Services, in neutral to Senate Bill 5 (1st Reprint).