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

Eighty-First Session
March 8, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:34 p.m. on Monday, March 8, 2021, Online. 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 Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services
Lea Case, representing Nevada Psychiatric Association
Kyra Morgan, Chief Biostatistician, Division of Public and Behavioral Health, Department of Health and Human Services
Lisa Durette, Assistant Professor and Fellowship Director, Child and Adolescent Psychiatry and Behavioral Health, University of Nevada, Las Vegas, School of Medicine
Robin Reedy, Executive Director, National Alliance on Mental Illness Nevada
Dan Musgrove, Chair, Clark County Children's Mental Health Consortium
Tom Clark, representing Nevada Association of Health Plans
Tray Abney, representing America's Health Insurance Plans
Steve Messinger, Policy Director, Nevada Primary Care Association
Jay Kolbet-Clausell, Program Manager, Nevada Community Health Worker Association
Kelly Bumgarner, Director of Health Policy, Children's Advocacy Alliance
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Katie Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican
Hiley Dobbs, Private Citizen, Reno, Nevada
Erik Schoen, Executive Director, Community Chest, Inc.
Noel Chounet, Private Citizen, Silver Springs, Nevada
Alex Bybee, Director of Strategic Partnerships, Communities In Schools of Nevada
Trey Delap, Director, Group Six Partners
Alisa Howard, Principal, Minority Health Consultants, Las Vegas, Nevada

Chair Nguyen:
[Roll was taken. The Chair reminded Committee members, witnesses, and members of the audience of Committee rules, protocol, and procedures for virtual meetings.]

I will now open the hearing on Assembly Bill 181.

Assembly Bill 181: Revises provisions relating to mental health. (BDR 40-522)

Assemblywoman Sarah Peters, Assembly District No. 24:
Thank you for hearing Assembly Bill 181, which is related to mental health today. There are two parts to the bill. The first piece of the bill relates to the collection of mental and behavioral health data from hospital providers. The second piece of the bill is related to mental health parity data collected from insurance providers. The focus of this bill is on the people—the patients—who are in need of services provided by both sides of the equation. Overwhelmingly, data presented to date regarding mental- and behavioral-related deaths by suicide and overdose have increased at alarming rates during the COVID-19 pandemic. I do

not think there is a single person in this room who can say that suicide is not a concern in the state of Nevada. We have consistently been identified as having some of the highest rates of suicide among most demographics published, including vulnerable populations such as veterans, LGBTQIA teens, and others.

The data gap identified by the Division of Public and Behavioral Health (DPBH), Department of Health and Human Services, exists at the moment a patient cries for help and services are initially provided. This means the moment a patient exhibits suicide ideation, self-harm, or other suicide risk indicators. That is where we need this data. Data on completed suicides or attempted suicides show that we are already too late with providing intervention services. This bill proposes collection of data prior to suicide attempts and identifies those patients, those family, and friends who need help today. I have with me Dr. Stephanie Woodard, Senior Advisor on Behavioral Health with DPBH who will briefly discuss this portion of the bill.

Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services:
I am here to present to you on sections 1 through 6 of A.B. 181, which establishes statutory authority for the Division of Public and Behavioral Health to require health facilities to report suicide attempts to the Division.

Assemblywoman Peters:
We have submitted a draft amendment [Exhibit C] regarding this piece of the bill, and I would like to direct Committee members to the Nevada Electronic Legislative Information System (NELIS) to see that amendment.

Stephanie Woodard:
Nationally, an individual dies by suicide every 11 minutes. More than ten Nevadans die by suicide every week, which is more than one person every day. According to the Centers for Disease Control and Prevention, Nevada has ranked in the top ten states for deaths by suicide, and while progress has been made, there is still a need to do more.

For several years, the primary data source we have used to develop our suicide prevention efforts has been fatality data as well as hospital billing and claims data. While these two data points are necessary in helping us understand suicide in Nevada, we know that they are not sufficient. Over the past two years, we have been working with hospitals and health systems to implement "Zero Suicide." The Zero Suicide initiative is grounded in the idea that suicide can be prevented and that detecting, assessing, and treating suicidality is effective. All of this is driven by data. The data we seek to collect through this reporting will help us all understand what is occurring—at a hospital level, a community level, as well as a statewide level—with a timely and accurate focus. The importance of this data, in addition to other indicators we collect on suicide, will help us to design and deploy responsive interventions to prevent suicide.

In 2017, similar legislation was passed as the opioid crisis was surging, and we recognized we needed to gather more timely data to detect changes in nonfatal overdoses happening across the state and in our communities. Using this data, we have been able to develop interventions, including mobile recovery outreach teams, to support individuals following nonfatal overdoses. We have seen the value of this kind of data informing action. We recognize the need to have a balanced approach for requiring data reporting. We are committed to taking steps to reduce as much of the burden of reporting as we can while ensuring the necessary data can be collected in a timely way. As Assemblywoman Peters mentioned, we have developed an amendment to the proposed legislation. The amendment places the statutory authority within *Nevada Revised Statutes* Chapter 441A. It is modeled on the overdose reporting that was established in 2017. Assembly Bill 181 would allow the Division to develop regulations that would further delineate the details of reporting requirements. The process of developing these regulations involved input from stakeholders and includes public workshops and hearings to ensure ample opportunity where input is considered.

Assemblywoman Peters:
I will now go to the second part of this bill which gets at another issue we see: mental health coverage. This is related to insurance coverage. Some of the most overwhelming conversations I have had with people are not about their heart medication, access to vaccines, or ability to schedule surgery; it is about access to mental and behavioral health services that patients need today. The federal government requires compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. This act is currently mentioned in our statutes; however, there is a lack of clarity in the health and insurance industry as to what parity methods are—what makes up parity. Consistently I hear from constituents and patients that their coverage misses the mark.

We are not proposing a prescription to remedy this parity ambiguity today. We are, however, requesting that the Division of Insurance, Department of Business and Industry, have the authority to proactively review parity metrics from insurance providers in the state, including PEBP [Public Employees' Benefits Program] and Medicaid, to determine what the baseline of parity is in Nevada. I have heard from the insurance industry that parity reporting is required by the federal government; however, the federal government is not the folks on the ground hearing the complaints from constituents and trying to assess and determine parity violations. That burden already falls to the state and even then, it is not proactive. The state process for addressing parity starts on the backs of our vulnerable populations who have felt that their right to parities of service have been violated. These individuals have to submit a complaint with supporting evidence to the Consumer Services Section of the Division of Insurance for review of their cases. This is usually done when the patients learn that the services they are looking for are not being covered and not accessible for their immediate needs. This bill requests that this activity be completed proactively rather than on the backs of the patients already in need of support.

An amendment to this bill will request that the Patient Protection Commission within in the Office of the Governor takes these two data streams and use them to assess and determine

adequacy of coverage from both the services and insurance sides for patients in Nevada. Although this bill requests data directly from the industry, this is a patient-centric bill, focusing on the two sides of the sword representing the burden of mental health care in our state.

I want to be clear that we are looking at an amendment for the second section [Exhibit D], but I do not think it was accessible on NELIS when we started this hearing. I will be sure it is sent to Committee members so you can see the conceptual amendment I have been working on with the Division of Insurance to create a less prescriptive statute around this issue and also to include the Patient Protection Commission directive to get this data from these two data streams.

I am not going to go through the sections of this bill, but there has been recent federal legislation related to the reporting requirements of insurance companies, and I have been working with the Division of Insurance to ensure that the language in this bill allows the Division of Insurance to incorporate those federal requirements while also meeting the desired parity outcomes proposed through adoption of this bill. The amendment will modify sections 7 through 9 to remove that prescriptive language.

At this time, I will pass the discussion on to Lea Case who will talk more about mental health parity coverage and what it means to the state of Nevada.

Lea Case, representing Nevada Psychiatric Association:
[Lea Case submitted a letter of support Exhibit E]. This bill requires a more proactive approach to compliance with the Mental Health Parity and Addiction Equity Act. From 2018 to 2020, 13 other states have passed legislation that is largely identical to A.B. 181 requiring insurers to submit the analyses to state regulators showing their compliance with the provisions of the federal parity act. There have been cases in *The New York Times* and in national news of big insurance companies that are not compliant with federal parity laws, but we do not always hear of that happening in our home state.

In July 2019, a Nevada Psychiatric Association member physician noticed that the behavioral health summary of services for a managed care company included processes that were applied more stringently than processes for medical/surgical benefits. Further, there were policies and processes in place for mental health and substance use services that did not have any comparable processes for medical/surgical services. The American Psychiatric Association and Nevada Psychiatric Association submitted a letter to Nevada Medicaid on August 8, 2019. We want to applaud Nevada Medicaid's quick action in opening an investigation and resolving the parity issue with the insurer on January 6, 2020.

This demonstrates a need for a proactive approach to parity compliance; if this psychiatrist had not taken personal time to investigate their patient's insurance policy to determine why they were being denied care, this complaint would not have been submitted and the insurer would continue to be noncompliant. Parity compliance should be determined by the experts

in parity and insurance regulation at the Division of Insurance before insurance products reach a consumer.

Chair Nguyen:
Thank you for that presentation. Are there questions from the Committee?

Assemblywoman Titus:
Thank you for bringing this forward. We can all agree that suicide is an incredibly important issue we need to deal with, and we have seen even more of it during this pandemic. You speak about timely data collection, and that is one of my concerns about this bill. When we have a potential suicide come through our emergency room (ER), et cetera, we do not make that determination right away. There could be toxicology issues, or sometimes it is a coroner's case because if they die within so many hours of coming into the ER, it becomes a coroner's case. So there is a delay in getting some information. What is a reasonable expectation about "timely notification"?

Stephanie Woodard:
It is a great question and something we would like to discuss during the regulatory development process. Currently, the billing and claims data that we have would, potentially, provide this information to us, but because of the lag, we are getting that data 90 to 120 days out. Certainly, anything sooner than that would be major progress. We also recognize that there is a need for syndromic surveillance data. Recently, we have been able to pull syndromic surveillance data related to suicide attempts and ideation from our emergency rooms. It is an incomplete data set because we are only getting about 80 percent of the reporting through syndromic surveillance, but we intend to use the syndromic surveillance really for that timely reporting so that we can have a finger on the pulse of what is happening statewide. When we use syndromic surveillance, we know we are sacrificing accuracy for timeliness because of the way that data is pulled from the EHRs [electronic health records]. We are really looking for this other dataset to be able to balance against the syndromic surveillance dataset, so we recognize that we may be sacrificing some of that timeliness but we will then be able to get the accuracy.

Assemblywoman Titus:
Do all hospitals have access to that surveillance set and data information? One of the problems I see here is the amount of reporting hospitals are required to do. You are not asking the provider to do this; you are asking the medical facility to do this. Who are the other folks who have to report this kind of data? Providers are already mandatory reporters for different levels of things, and this is another level of reporting that hospitals would have to do. The hospitals already have to do extensive reporting. Will they be using the same computer system? You mentioned electronic medical records (EMRs), and we know that many EMRs do not communicate with each other, so what is that going to look like? Once you have determined the time frame, will there be a fine if they do not follow through? I think the information is critical, but I am still worried about the process.

Stephanie Woodard:
For overdose reporting, hospitals currently have three different pathways. The first is probably the easiest because it allows for a data extraction to occur directly from the electronic health record. This data extraction is then placed in a file which is sent to the Division of Public and Behavioral Health. Another way is through a fax. We recognize that not all electronic health records have the capabilities nor maybe the sophistication to be able to develop and extract the data file, so the fax is an option several hospitals continue to use for overdose reporting. We have also worked with Bitfocus's Clarity, a vendor used by other hospitals to report into the Homeless Management Information System. We worked with them to develop a data platform for overdose reporting, and we are working with them currently to augment that report so hospitals using that for overdose reporting would be able to use it to satisfy the requirements of this bill.

Assemblywoman Titus:
I have looked at the bill and the proposed amendment involving sections 7 through 9 to remove the prescriptive language related to data collection. I have a question regarding that process of reporting. Conceptually, I think it is a good idea. As a provider, when I see a patient and I determine that the patient needs x, y, or z, it is very frustrating when we try to get prior authorization and the insurer says it is not covered or no, instead you have to do a, b, and c first. I think I understand what you are trying to achieve here, but I am wondering whether there are other mandatory descriptions in statute for when insurance companies deny a service? Is that listed anywhere, or would this be a unique thing to mental health parity? Are we asking the insurance companies to do something they already do and then add that to the list of reporting when they deny something, or are we looking at having them report if they have denied a mental health service? Do they have to disclose if that was not part of their original insurance contract? I am trying to clarify what they would have to report.

Assemblywoman Peters:
The language in the original bill was much more prescriptive than intended. At this time, the intention is to get a general baseline for what those parity metrics are in existing insurance coverage. One difficulty is that the interpretation of parity is inconsistent. In Nevada, we want to see what parity metrics are being met by these individual insurance companies in order to see the picture that patients are in. As you said, are they being denied service because of insurance coverage and whether that is equitable or not or inconsistent with industry parity. The revisions to this section would allow the Division of Insurance to promulgate regulations requiring that data collection piece, but not necessarily create the enforcement mechanisms you are describing that would be a blessing to this industry. That is one of the biggest complaints I hear: "I need the service but I cannot get it. My insurance will not cover it. It is too expensive on my own, or my child has special needs and I need them to be in this facility rather than in this other facility, but I cannot get there because I am forced to go here." Those kinds of issues will come at a later time once we have a better idea what those parity metrics will look like.

Assemblywoman Benitez-Thompson:
My question concerns the amendment and legislative intent. This would change from *Nevada Revised Statutes* (NRS) Chapter 449 to NRS Chapter 441A. As I read this, the intent is reporting on suicide attempts and suicide completions specific to opioids because that chapter is concerned with infectious disease and reporting on opioids. I imagine you are not just looking for that, but having it in the communicable disease chapter feels as though it is being narrowed. I imagine you would still want to know about a person presenting in the ER with a single gunshot wound to the head and those kinds of suicides. For the record, spell out why NRS Chapter 441A is the best place to house this language.

Stephanie Woodard:
Nevada Revised Statutes Chapter 441A includes all communicable diseases to be reported as well as overdoses from Assembly Bill 474 of the 79th Session. This would also allow us to collect and analyze that data as it relates to suicide. When it comes to behavioral health, we do not have the statutory authority to establish these kinds of reporting regulations, so we have to look to established authority within the public health side. *Nevada Revised Statutes* Chapter 441A has been the area of existing statute that seems to fit best when we are looking at collecting population health data like this.

Kyra Morgan, Chief Biostatistician, Division of Public and Behavioral Health, Department of Health and Human Services:
Nevada Revised Statutes Chapter 441A is also where we have all our real-time reportable conditions that require individual follow-up. By placing the overdose regulations there, the idea was that those were cases that potentially would require that really quick follow-up by a disease investigator. We wanted to mirror the regulation for suicide reporting to be similar to overdose reporting so that if we wanted to have that real-time communication with disease investigation, it would fall in line with how we do that for communicable diseases.

Assemblywoman Benitez-Thompson:
Right now, you are able to extrapolate the data, but you have to do it in an indirect way, so the goal is to make sure you are getting the data much more quickly. Could you talk about the difference between the status quo and the information you get—which is taking six months to a year—versus your goal for this legislation which would be to get it in days, weeks, or months? Would you clarify that?

Stephanie Woodard:
We currently have billing and claims data, so there is a dataset that pulls all the emergency room and hospital billing claims. That dataset typically has a 90- to 120-day lag. As Kyra Morgan mentioned, this allows us to do some of that follow-up. We hope we will be able to get this data in a much more timely way than looking at three to four months out. Exactly what that time period is would need to be determined during the regulatory development process. That is where we will be engaging with stakeholders to figure out what a reasonable time frame would be for us to expect to get this data.

Assemblywoman Benitez-Thompson:
For the record, right now, you are looking for when a provider has a known interaction with a person and knows that person attempted or completed suicide. You mean this to be different from what CMS [Centers for Medicare and Medicaid Services] and The Joint Commission have right now around sentinel events and those kinds of suicides, right?

Stephanie Woodard:
Yes, we are not seeking to find information related to sentinel events. We are looking to identify individuals who are presenting for care in an emergency room related to a suicide attempt.

Chair Nguyen:
There was an amendment by Mr. Tom Clark that is considered unfriendly at this time. Do you have an update on that?

Assemblywoman Peters:
I had an opportunity to talk to Mr. Clark and let him know that we were working with the Division of Insurance on an amendment to address their concerns. We will continue to work with them as stakeholders on that process to ensure that we are preparing something that is beneficial to Nevada. Hopefully, we can get to a neutral place with them.

Chair Nguyen:
It looks as though all the conceptual amendments Assemblywoman Peters referenced are now uploaded to NELIS under "Exhibits." Are there further questions?

Assemblywoman Benitez-Thompson:
I think it is important to talk about section 7 and going forward into the bill, but it makes the most sense to see what those amendments will look like and how the bill will read.

Assemblywoman Peters:
Yes, we are essentially gutting those sections, so asking questions about the language as it is written today would not be helpful. I have the Division of Insurance's proposed amendment language. It just showed in my email box, so I will have a chance to review it. I will send it around to the Committee when it is ready. I apologize for the delay, but we want to make sure that we are getting it right, especially in light of recent federal legislation. We want to make sure we are not duplicating any efforts.

Assemblywoman Benitez-Thompson:
I appreciate that and look forward to seeing what the conversation will be.

Chair Nguyen:
Are there further questions?

Assemblywoman Summers-Armstrong:
There has been discussion about various modes to share this data. Has there been any discussion about a singular software or singular data entry area where the data can be input, everyone can use it, and then it could be more easily extrapolated? Is that part of this discussion? Is there a possibility for there to be a private industry software or portal that could be shared across the different providers that would help facilitate this more quickly?

Assemblywoman Peters:
This bill does not address that issue. However, I know the Department of Health and Human Services (DHHS) has been working with stakeholders, including the hospitals, on how to make that line of data be as streamlined as possible so we are not creating an overburden on one side or the other. One of the advantages to creating a kind of raw database is that you can assimilate that data in a variety of ways. I believe that is being discussed in other areas and was presented through the Patient Protection Commission or the Interim Legislative Committee on Health Care; however, that is not a piece of what we are talking about today.

Stephanie Woodard:
There are three different ways hospitals can currently report, and we do not have a preference either way. We want to make it as least burdensome as possible. For those organizations that would prefer to use a manual-input database, we do have an overdose reporting database that is being reengineered to be able to collect all the data related to A.B. 181. Providers can also fax a report or they can do a data extract. The data extract seems to be the least burdensome because it will allow that data to be pulled directly from their electronic health record and then be batched in a data file that can then be analyzed by DHHS. We are open to other solutions, but as you mentioned, most other solutions would require some additional funding in order for us to be able to create a singular data repository.

Assemblywoman Summers-Armstrong:
I assume whether someone is reporting with a faxed document, or using the data extract, or the third option, data input, the questions, the answers, the data, is all consistent no matter what. When that data goes in, it is the same at the end, and you can then extrapolate that data to get the most accurate answers. Am I correct?

Stephanie Woodard:
Yes, regardless of the way the data is provided to DHHS, that data is reviewed and cleaned and then put into a file where the data can then be analyzed.

Assemblywoman Summers-Armstrong:
I appreciate the information. All of us are really concerned about mental health right now. I am seeing more discussions about mental health crises, whether they are connected with substance abuse or just in general in the African-American community, than I have ever seen before. In primetime television, we are seeing examples of folks seeking help, and they are making it normal and okay for folks in our community. There has been such a stigma about mental health issues. Anything we can do to help people find a way to get help is really important. I do not know how you speed up the process; I am sure you are working on that,

and I hope this legislation will help you do that. I am looking forward to reading all the amendments, and I appreciate you, Assemblywoman Peters, for bringing this forward.

Assemblywoman Peters:
Thank you. This is a really important issue, and something that touches all of us, whether directly or through friends and family who have looked for services or who have been in the web of mental health care in Nevada. The Department of Health and Human Services has been putting a huge amount of work into the idea of destigmatizing mental health services and those needs. It is a work in progress because it is not just patient-based; that stigma even includes the providers—even identifying and acknowledging that someone may or may not need those services has created stigmas in reporting. Trying to break down those barriers is a piece of this puzzle. The more we talk about it openly, the more we see it actively, and the more we hold folks accountable who may be the bottlenecks in this area, the better off our communities will be.

Chair Nguyen:
We will start taking testimony in support, opposition, and neutral. Please remember to clearly state and spell your name and limit your testimony to two minutes. We will begin with support testimony.

Lisa Durette, Assistant Professor and Fellowship Director, Child and Adolescent Psychiatry and Behavioral Health, University of Nevada, Las Vegas, School of Medicine:
I am a child and adolescent psychiatrist and run the training program at the University of Nevada, Las Vegas's School of Medicine. This whole bill has a lot of positives, but I want to speak about the importance of parity, especially as it pertains to the kids who are really struggling in our state. A recent report from the Milliman Institute shows that a child's mental health office visit is 10.1 or 1,000 percent times more likely to be out-of-network than a primary care office visit, which is twice as much as a mental health office visit for an adult. Furthermore, children's utilization of inpatient and outpatient facilities are 500 percent more likely to face out-of-network charges for behavioral health care than medical or surgical care. Additionally, spending for mental health care has not shifted and makes up only 2.4 percent of the overall health care expense. This is why it is so crucial that we have parity so children have equal access to mental health care as they do for physical health care access.

Our state currently ranks fifty-first in the nation for children's mental health services, according to Mental Health America (MHA). The fact that we lack parity through many of our insurers in this state is a crucial reason for which kids are not able to access timely care that they need which is critical at this time of the COVID-19 crisis—where we have seen our suicide rates in children as young as eight spiking in our cities and where we see high school failure and dropout at a higher rate than ever. We are in an enormous crisis and by having parity we will be able to get access to mental health care just like for cancer care, surgical care, and every other element of health care.

Robin Reedy, Executive Director, National Alliance on Mental Illness Nevada:
On behalf of NAMI Nevada, the state chapter of the National Alliance on Mental Illness, I would like to offer our support on the provision in A.B. 181 that addresses an issue of extraordinary significance to Nevadans—parity of health insurance coverage for mental health and substance use conditions. Because of current parity challenges, the disparities are glaring. In 2015, individuals in Nevada received outpatient behavioral health care out of network at a rate 3.21 times higher than primary care services, and 3.81 times higher than specialists for other health conditions. For individuals receiving inpatient behavioral health care out of network, the rate is 6.05 times higher than for other inpatient services. This means that Nevadans with mental illness cannot access or afford the care they deserve. When people with a mental health condition cannot access affordable mental health care, there is a steep personal cost that delays individuals being able to get well. There are also significant costs for the state. When Nevadans cannot get appropriate care, the state faces increased health care and other costs, from higher numbers of individuals ending up in jail, emergency departments, and on the streets, rather than getting the help they need. NAMI Nevada strongly supports the parity provision in A.B. 181, which would ensure health insurance compliance with state and federal parity laws. State and federal law mandates that mental health insurance coverage cannot be treated any differently than medical coverage, and A.B. 181 would help to make parity a reality for the many individuals and families in the state who need access to affordable mental health treatment. The people of Nevada deserve the opportunity to experience health and productivity. In support of this goal, NAMI Nevada urges public policy that ensures that all people have access to the right treatments at the right time. For this reason, we urge the Committee to support parity coverage for mental health and substance use conditions.

Chair Nguyen:
I would like to remind callers on the line to please limit your testimony to two minutes. You always have the opportunity to submit written comments including any you might have read during your testimony. May we go to the next caller in support, please.

Dan Musgrove, Chair, Clark County Children's Mental Health Consortium:
[Dan Musgrove submitted a copy of a letter to Barbara Richardson, Commissioner of Insurance, Department of Business and Industry Exhibit F]. I want to echo the comments of Dr. Lisa Durette, a former member of our consortium, as they relate to parity, especially for children's mental health. She referenced the Mental Health America report that puts Nevada fifty-first for youth mental health. One of the seven measures MHA used is children with private health insurance that does not cover mental or emotional problems. For this measure, Nevada ranks forty-fifth, with an average of 12.6 percent—or 13,000 children—not having mental or emotional health care coverage. That is shocking and tragic. On NELIS is a copy of a letter our consortium wrote to Barbara Richardson, Commissioner of Insurance, on February 17, about a week or so before this bill was introduced. We applaud the sponsor of the bill and her attempts to get information about what is covered by insurance plans. We know there are a lot of plans that do not cover those mental and emotional problems Dr. Durette talked about. These are not items parents can afford, so we applaud the intent of

this bill. We will want to see how the amendments come out, but anything that can be done to understand what those essential benefits for children's health care is absolutely necessary.

Chair Nguyen:
With no more callers in support, we will go to callers in opposition to A.B. 181.

Tom Clark, representing Nevada Association of Health Plans:
As was mentioned earlier, we have put forward an amendment, but based on the conceptual amendment Assemblywoman Peters has brought forward and the dialogue that is taking place with the Insurance Commissioner, our amendment may be moot. We look forward to working with the bill's sponsors, with the Commissioner, and all the other stakeholders to figure out primarily the areas around section 9.

Tray Abney, representing America's Health Insurance Plans:
We categorize our opposition to the bill as written as friendly. I would like to say ditto to Tom Clark's comments. Our main concern relates to a new federal law that was passed in January which already requires all the reporting foreseen in this bill. We were worried about duplication of efforts, but we had a very positive conversation with Assemblywoman Peters this morning. We are dedicated to working with her and the Division of Insurance to craft a solution that everyone is satisfied with. We look forward to seeing the bill with amendments. Again, I want to thank the bill's sponsor for working with us.

Chair Nguyen:
Are there any other callers in opposition? [There were none.] I will close opposition testimony. Do we have any callers in neutral? [There were none.] With that, I will close testimony and ask Assemblywoman Peters for any remarks she would like to make.

Assemblywoman Peters:
I want to acknowledge how many heads it has taken to get this piece of legislation to where it is today. It is a patient-centric piece of legislation related to mental health care and access. I would especially like to thank Dr. Stephanie Woodard and the Division of Public and Behavioral Health for bringing their part of this piece of legislation and working with stakeholders on the amendment. Additionally, thank you to the Nevada Psychiatric Association for bringing the other piece of this legislation. I want to also thank the Division of Insurance and Commissioner Richardson for working with me and other stakeholders on the pending amendment, and thank you, Committee, for hearing this important piece of legislation. I hope I can earn your support as we work on these final amendments.

Chair Nguyen:
I know we have been trying to work on this type of legislation for the better part of at least five years that I am aware of. With that, I will close the hearing on A.B. 181 and open the hearing on Assembly Bill 191.

Assembly Bill 191: Requires the State Plan for Medicaid to include coverage for the services of a community health worker under certain circumstances. (BDR 38-449)

Assemblyman David Orentlicher, Assembly District No. 20:
Assembly Bill 191 is sponsored by the Legislative Committee on Health Care, which considered a variety of public health issues during the 2019-2020 Interim. I was not a member of that Committee; however, Assemblywoman Cohen invited me to carry this bill this session, and I am honored to present it before you. This is a simple bill based on a very important principle: an ounce of prevention is worth a pound of cure. If we invest a small amount in public health efforts, we will not need to spend nearly as much on the treatment of disease. People will be much healthier and more productive. This bill will make sure our Medicaid program funds some of the very important services that community health workers (CHWs) deliver to promote the well-being of Nevadans. We are joined today by representatives of community health workers who will provide more information about why this bill is so valuable. In addition, DuAne Young from the Department of Health and Human Services will provide the agency's perspective.

Steve Messinger, Policy Director, Nevada Primary Care Association:
I would like to hand this over to Jay Kolbet-Clausell for his presentation.

Jay Kolbet-Clausell, Program Manager, Nevada Community Health Worker Association:
I am proud to see our state supporting community health workers. [Jay Kolbet-Clausell presented a PowerPoint Exhibit G as well as supplemental information Exhibit H]. Building a healthy community is like constructing a sound home [page 2, Exhibit G]. State leadership oversees skilled professionals who design systems, assemble resources, and assess needs. We will liberate costly resources when we equip providers to hire the CHW workforce. Like architects, doctors and nurses should not be tied up in follow-through when trained craftspeople can cut the tile or ensure that patients make progress on their health. Community health workers are community members who bridge the gaps in Nevada's health care system [page 3]. They come from rural and urban communities, so they represent the diversity of our state. Nevada ranks fiftieth in primary care providers according to the America's Health Rankings in 2020 [page 4]. Nevada began to address our health professional shortage by creating CHW training and certification. Using community health workers started 20 years ago in Texas and it has grown to include all but three states. In Nevada, this work has been going on since 2014 when the Division of Public and Behavioral Health, Department of Health and Human Services, piloted the program. Nearly 700 students completed CHW training through our association, and we work closely with the other two training schools in Reno and Las Vegas.

Community health workers have shared training [page 5] and they also specialize to meet the specific needs of each community. While one sets tile, another frames the structure. You can expect to see community health workers go by many names and serve in many different roles to meet the needs of each clinic.

Minority and rural communities are underrepresented in health care workforce education. The CHW model creates leaders in those communities and provides opportunities for professional advancement. Community health workers become social workers, nurses, and doctors who are more likely to return to the communities where they grew up [page 6]. The Division of Public and Behavioral Health found a $2 savings for every $1 spent [page 7]. Emergency room visits decreased by 14 percent, urgent care by 6 percent, acute admits by 18 percent, and repeat hospital visits reduced 20 percent.

Steve Messinger:
Section 1 of this bill requires the Director of the Department of Health and Human Services to include in the State Plan for Medicaid "the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse." Section 2 of this bill makes a conforming change to indicate that the provisions of section 1 will be administered in the same manner as the provisions of existing law governing the State Plan for Medicaid.

This bill relies on the definition of a community health worker established by Senate Bill 498 of the 78th Session. This definition in *Nevada Revised Statutes* 449.0027 is a natural person who:

1. Lives in or otherwise has a connection to the community in which he or she provides services.
2. Is trained by a provider of health care to provide certain services which do not require the community health worker to be licensed.
3. Provides services at the direction of a facility for the dependent, medical facility or provider of health care which may include, without limitation, outreach and the coordination of health care.

Kelly Bumgarner, Director of Health Policy, Children's Advocacy Alliance:
Our organization is proud to participate in the Strong Start Nevada initiative, working to create a statewide plan to connect pregnant moms, families, and children to service providers that support and enhance quality child care, education, and obstetric and pediatric care. Community health workers are an essential part of the Strong Start plan [page 9, Exhibit G]. The Strong Start initiative is championed by a coalition of over 25 stakeholder groups including clinicians, local and state governmental institutions, nonprofits, and parents. Together, we have developed a plan that relies upon CHWs to connect some of our most vulnerable and underserved residents to vital services and care. Our collaborative agrees that CHWs are the key to strengthening supports, and ultimately, families, in Nevada [page 10].

Community health workers meet with families in culturally competent and convenient ways in places like their child care centers, schools, or own homes to provide education on services and resources. For example, over 60,000 Nevada children are currently uninsured; however, we estimate that over half of those children qualify for Medicaid or CHIP [Children's Health Insurance Program]. Community health workers inform families of available programs and

how to access them in a way that makes them feel both comfortable and empowered. Our collaborative believes that CHWs are critical to bridging program coverage gaps [page 11].

Steve Messinger:
My association, the Nevada Primary Care Association, represents the Federally Qualified Health Centers (FQHCs) in the state. We have used CHWs in various ways over the past years, mostly because these are not reimbursed services through grant programs [page 12]. One program was funded through the Division of Public and Behavioral Health and it went to ensure that colorectal-cancer-screening rates were improved in FQHCs. That grant went to fund a position for a person to call these folks to remind them and encourage them to take these cancer screens. If this bill were to pass, those services would now be Medicaid-reimbursable. We like to think all the money we have spent on grant-funded CHWs over the years, how much further those grant dollars could have gone with the program this bill envisions. In addition to colorectal-cancer-screening CHWs, we also have diabetes educators, asthma risk evaluation—going into the home and evaluating what might trigger asthma and educating those patients about how to clean that up. We have cultural and linguistic interpretations, so sometimes CHWs are visiting a provider with their clients in order to make sure care is delivered in a language the person speaks but also in a way that can be understood.

This past year, with the rapid expansion of telehealth, we have found that a lot of our patients do not have the ability to access technology, or they have the technology but not the skills to access it. Sending CHWs is a very efficient way to get them connected to their provider remotely, where that is appropriate. Our association also has a lot of family planning—we have two grants, teen pregnancy prevention and a Title X family planning grant. Community health workers are very effective for engaging those populations—teenagers for the teen pregnancy and women of childbearing age for the Title X. The point here is that these are services currently being provided in Nevada. They would go much further if we made a small investment now.

DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
We are grateful to Assemblyman Orentlicher for providing us with the opportunity to speak today on behalf of the Division, as this bill directly impacts Medicaid. This is a medical-model program. My colleagues have done an excellent job explaining how that works in a chronic disease model. This is definitely a needed service within the state. This year, the Division was able to take some of those return-on-investment studies as well as other academic articles and apply them to a conservative estimate of savings so there is not a fiscal note. In fact, there is a projected savings that we would see. It goes without saying during the COVID-19 pandemic that having these types of services with those CHWs and agencies and FQHCs that had grants to use them have found them to be invaluable to the efforts of helping to protect Nevadans.

Chair Nguyen:
Do you have any final comments, Assemblyman Orentlicher?

Assemblyman Orentlicher:
I want to thank my copresenters for doing a very nice job laying out the issues, and I appreciate your time.

Chair Nguyen:
Thank you for stepping in and presenting this bill even though you did not do the work during the interim. We appreciate you stepping up and making your first bill presentation.
I have asked our policy analyst to send some links to Committee members. As you heard, this was a policy recommendation from the interim committee work, so if you want to review any of the policy conversations that took place during the interim, you would be able to do so.

Assemblywoman Gorelow:
Could someone explain the differences between a community health worker versus a medical assistant and what responsibilities and duties those two professions would perform versus other members of a medical team?

DuAne Young:
From a Medicaid billing perspective model, medical assistants are not enrolled separately. They facilitate the appointment through assisting the doctor with medical issues. The community health worker's job is promotion of education, training, outreach, and linkage. It is also very different from what we would have through targeted case management. That is a different service as well as peer-to-peer counseling. This is more of a direct educational role with the patients as opposed to actually assisting the doctor.

Assemblywoman Gorelow:
Thank you for the clarification. They are very distinctive roles and used for very different responsibilities and they are both very important, so I appreciate you clarifying that on the record.

Assemblywoman Titus:
Assemblyman Orentlicher, that was one of the best presentations I have seen on a bill, especially since you did not own this bill to start with. My question is in regard to the billing process. Section 1, subsection 1, lists the people you have identified who can order a community health worker to see a patient. I appreciate that you have included the physician assistants (PAs) and advanced practice registered nurses (APRNs). When I have introduced bills, I made certain that the language was all inclusive as concerns the providers. My question revolves around the billing process. Is it a national standard that community health workers are assigned national provider identifier (NPI) numbers? We all have to have an NPI number in order to bill, or would the billing be under the PA, APRN, or the physician's NPI? Are you looking at all CHWs getting NPI numbers?

DuAne Young:
Since we have matured in our philosophy and approach to this, we are looking to have them enroll separately and this would be a new provider type under their own NPI. Part of the

reason for that is because they will be utilized in some of our cost-based providers such as rural health clinics and FQHCs. This would allow us to track the data better and know what services are being provided under those different models by these providers.

Assemblywoman Titus:
I am happy to hear that because I think that is what needs to happen.

Chair Nguyen:
Is there anyone else who has questions? [There was no reply.] I will now go to testimony in support of A.B. 191.

Katie Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican:
[Katie Ryan also provided a letter in support Exhibit I]. I want to say how grateful we are to the interim Legislative Committee on Health Care that they took up this issue. During normal circumstances, Dignity Health-St. Rose Dominican has CHWs out in the communities where they are needed most, giving classes in both English and Spanish on a number of important public health topics and diseases. Going directly to these populations and helping them where they are is such an important part of health equity. During the pandemic, we have been doing a lot of this virtually, but we are really looking forward to getting back to our full schedule once we are closer to herd immunity.

Hiley Dobbs, Private Citizen, Reno, Nevada:
[Hiley Dobbs submitted a document in support Exhibit J]. I am a graduate student studying public health and a member of the Rural Nevada Health Network. As both a student and a future health care professional, I support this bill expanding access to community health workers through Medicaid reimbursement. Community health workers are trusted, culturally competent, cost-effective, trained, and certified professionals who work in a variety of settings under different titles—in schools as resource coordinators, in health centers as care coordinators, or in treatment centers, food banks, and tribal health centers. The services provided do not replace those of licensed health care providers but rather potentially prevent costly services and allow higher-level services such as ambulances and emergency rooms to operate at the top of their scopes.

Not only does passage of this bill improve the health of rural Nevadans, and all Nevadans, and minimize costs incurred, but it can also support job growth as medical centers that are already billing Medicaid would be able to hire community health workers. While change is difficult, it is critical to improve outcomes and reduce costs.

Erik Schoen, Executive Director, Community Chest, Inc.:
[Erik Schoen submitted a letter in support Exhibit K]. As the executive director of a nonprofit agency that has provided complementary health and human services across many rural Nevada counties for the past 30 years, I have seen firsthand the immense benefit that can come from utilizing community health workers who are from the communities that they are serving. Not only are they able to leverage their specific cultural expertise and

relationships for the benefit of others, they are also often able to do so at a much more affordable cost than other alternatives.

Our Resilient 8 Coalition, a demonstration project that has been federally funded for more than two years, has utilized community health workers as a primary services delivery strategy across eight rural Nevada counties. They have been able to work with inmates in at least two counties to develop robust release plans and linkages to needed services, provided dozens of trainings on the uses of naloxone, taken the lead in developing strategic plans for each of the counties to develop needed health and human service capacity, and more.

As well, I am also a licensed clinical professional counselor and as such, would like to plant a possible seed for enhancing A.B. 191. Because doctors, nurses, and social workers are in short supply everywhere, especially rural Nevada, and because the responsibility frequently falls on these three professions, consider expanding the pool of acceptable supervisors for CHWs to include other professions that already make it a practice to provide continuous supervision, including psychologists, school psychologists, clinical professional counselors, marriage and family therapists, and licensed clinical drug and alcohol counselors. This will help to support CHWs being able to work in a variety of nontraditional settings such as schools, nonprofit health and human services providers, and more.

Chair Nguyen:
You made recommendations that you wanted changes to A.B. 191. If that is the case, I would have to recategorize you as opposition testimony, but do you support the bill as it is written?

Erik Schoen:
I do support the bill as it is written.

Chair Nguyen:
Could we go to the next caller, please?

Noel Chounet, Private Citizen, Silver Springs, Nevada:
I am a community health worker in Silver Springs, and I have seen firsthand the positive effects that community health workers can have on our community members helping with the telehealth appointments, bridging that gap between providers and patients, and improving the health of clients and helping them to reach their goals. I do support this bill. After this foundation is built, it would be wonderful if we could expand it in the future to include other health care professionals as oversight for the CHWs to make this an even more flexible program, as we do work in a lot of nontraditional environments, but it is a wonderful start and I am looking forward to seeing where this takes us as we work to improve the health of our community and expand access.

Chair Nguyen:
I want to be clear. I know people want to go further and continue the conversation, but just for clarification, you are in support of the bill as written?

Noel Chounet:
Correct. I am in support of the bill as written.

Alex Bybee, Director of Strategic Partnerships, Communities In Schools of Nevada:
We are in support of A.B. 191. Communities In Schools of Nevada is the fifth-largest state office of the nation's leading evidence-based dropout prevention organization and we operate in the Clark, Elko, Humboldt, and Washoe County school districts. We have submitted a letter for the Committee, but I would like to highlight three reasons why the organization is supporting A.B. 191. Assembly Bill 191 will expand reimbursement of services provided by community health workers and that will enable a larger workforce of support for students and families in need. Second, it increases access to and knowledge about health care which is essential to increasing the overall well-being for Nevada's families, particularly for those living in poverty and experiencing other adverse circumstances. Finally, health care and social and emotional support have a direct nexus to academic achievement and are critical parts of a child's holistic development, and more community health workers being able to provide services and a bridge to care for these families will have an impact on school improvement and academic success. We have submitted a letter of support for the record that further elaborates why our organization does support A.B. 191 [Exhibit L].

Trey Delap, Director, Group Six Partners:
We are in support of A.B. 191. I had the privilege of instructing the first community health worker course at the College of Southern Nevada in the workforce development division. Nevada is catching up with valuing nonclinical supports with this bill. When we work with community health workers, the first competency of a CHW is individual connection with the communities they serve. This requires that they are sourced from the community they are going to serve and are acutely aware of the resources that are available and accessible in those communities. Most often, CHWs are addressing issues of justice in health care, access, and equity. They also are critical to improving and addressing social determinants of health and are perfect adjuncts to a clinical team for a holistic method of care. Dr. Andrew Taylor Still, the founder of osteopathy, said that to find health should be the object of the doctor. Anyone can find disease. It is this competency in connection to the community that gives CHWs a boost in their ability to help patients become advocates for their own health and ultimately realize good outcomes. This is a great step forward for the state of Nevada and I urge your support of A.B. 191.

Alisa Howard, Principal, Minority Health Consultants, Las Vegas, Nevada:
I am currently a community health worker instructor for the College of Southern Nevada, but I am speaking on behalf of my own company where I do hire CHWs. Community health workers are the bridge to social determinants of health—to bridging those gaps in our communities. Governor Sisolak has declared racism as a public health issue. How we can utilize CHWs with this issue is by helping, by hiring, supporting, and by paying CHWs—people who have come from the actual community who are experiencing these disparities, people who have the cultural competence of these disparities, people who have the cultural competence of their culture, of their race, of their people—people who can speak directly to health issues and health disparities in our state.

I have been teaching community health work for the past three years and I am very excited about this bill. I would appreciate it if everyone could get on board with supporting CHWs. I also sit on the policy board of NACHW, the National Association of Community Health Workers and we are discussing, nationwide, how to get policies implemented for community health work. There are lots of people on these calls in other states, people who have been doing this work for a lot more time than we have—20 or 30 years. They have given advice on how we can use CHWs and how we can get them paid through Medicaid reimbursement, so I am available to anyone who may need that information after this call.

Chair Nguyen:
Thank you, and I am sure the sponsor and the Committee appreciate everyone's willingness to have these conversations. May we have the next caller in support? [There was no one.] With that, I will close testimony in support. We will now go to testimony in opposition to A.B. 191. [There was none.] Is there anyone in neutral? [There was no one.]

Assemblyman Orentlicher, do you have any closing remarks?

Assemblyman Orentlicher:
I want to thank the interim Legislative Committee on Health Care for their hard work in producing this excellent bill and to my copresenters for providing their testimony. We often think that to improve health quality we have to spend more. Sometimes, we can get better quality at lower cost, and this is one of the important examples of that. I appreciate your consideration and I hope we can move this bill forward.

[Exhibit M was submitted but not discussed and will become part of the record.]

Chair Nguyen:
I will close the hearing on A.B. 191.

Committee members, we have two bill draft requests (BDRs) that require Committee introduction. We can introduce them both at once and take one vote, so I will do that at this time. Please note that voting in favor of introducing the BDRs from these interim committees does not imply a commitment to support the measure later. This action allows the BDR to become a bill and then it will be referred to the Committee for possible hearing after introduction on the floor.

The two BDRs for introduction today are BDR 38-385 which requires Medicaid to cover certain services for persons with cognitive impairment. Additionally, we have BDR 40-454 which requires training for unlicensed caregivers at certain facilities.

BDR 38-385—Requires Medicaid to cover certain services for persons with a cognitive impairment. (Later introduced as Assembly Bill 216.)

BDR 40-454—Requires training for unlicensed caregivers at certain facilities. (Later introduced as Assembly Bill 217.)

Do I have a motion to introduce both BDR 38-385 and BDR 40-454?

> ASSEMBLYWOMAN TITUS MADE A MOTION TO INTRODUCE BDR 38-385 AND BDR 40-454.
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Is there any discussion? [There was none.]

> THE MOTION PASSED. (ASSEMBLYWOMAN BENITEZ-THOMPSON WAS ABSENT FOR THE VOTE.)

Chair Nguyen:
At this time, we will begin public comment. [There was none.] Are there any comments from Committee members? [There were none.] This concludes our meeting for today. Meeting is adjourned [at 3:12 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
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 proposed amendment to Assembly Bill 181, dated March 8, 2021, presented and submitted by Assemblywoman Sarah Peters, Assembly District No. 24.

Exhibit D is a proposed conceptual amendment to Assembly Bill 181, presented and submitted by Assemblywoman Sarah Peters, Assembly District No. 24.

Exhibit E is a letter to Chair Nguyen and Members of the Assembly Health and Human Services Committee dated March 5, 2021, signed by Lesley Dickson, State Legislative Representative, Nevada Psychiatric Association, submitted by Lea Case, representing Nevada Psychiatric Association, in support of Assembly Bill 181.

Exhibit F is a copy of a letter to Barbara Richardson, Commissioner of Insurance, Department of Business and Industry, dated February 17, 2021, submitted by Dan Musgrove, Chair, Clark County Children's Mental Health Consortium, regarding insurance standards for children.

Exhibit G is a copy of a PowerPoint presentation titled "A.B. 191 – Health & Human Services: Medicaid reimbursements for Community Health Workers (CHWs)," dated March 8, 2021, presented by Kelly Bumgarner, Director of Health Policy, Children's Advocacy Alliance, Steve Messinger, Policy Director, Nevada Primary Care Association, and presented and submitted by Jay Kolbet-Clausell, Program Manager, Nevada Community Health Worker Association.

Exhibit H is a document titled "Adding Value to our Health Care Teams: Nevada's Community Health Workers," submitted by Jay Kolbet-Clausell, Program Manager, Nevada Community Health Worker Association.

Exhibit I is a letter to Chair Nguyen and Assembly Health and Human Services Committee Members, dated March 8, 2021, signed by Holly Lyman, Director, Community Health, Dignity Health-St. Rose Dominican, submitted by Katie Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican, in support of Assembly Bill 191.

Exhibit J is a document titled "AB191 Policy Brief: Medicaid Reimbursement For Community Health Workers," submitted by Hiley Dobbs, Private Citizen, Reno, Nevada, in support of Assembly Bill 191.

Exhibit K is a letter to Assembly Health and Human Services Committee Members, dated March 8, 2021, submitted by Erik Schoen, Executive Director, Community Chest, Inc., in support of Assembly Bill 191.

Exhibit L is a letter to Chair Nguyen and Members of the Assembly Committee on Health and Human Services, dated March 8, 2021, submitted by Alex Bybee, Director of Strategic Partnerships, Communities In Schools of Nevada, in support of Assembly Bill 191.

Exhibit M is a letter to Chair Nguyen and Members of the Committee, dated March 7, 2021, submitted by Sarah Adler, President, Healthy Communities Coalition of Lyon and Storey Counties, in support of Assembly Bill 191.