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

## Eighty-First Session
## March 10, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:32 p.m. on Wednesday, March 10, 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 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:**

Assemblywoman Teresa Benitez-Thompson (excused)

**GUEST LEGISLATORS PRESENT:**

Assemblywoman Lesley E. Cohen, Assembly District No. 29

**STAFF MEMBERS PRESENT:**

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

**OTHERS PRESENT:**

Nathan Slotnick, M.D., Private Citizen, Reno, Nevada
Kristine Hafner, Private Citizen, Las Vegas, Nevada
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
Lisa Swearingen, Chief, Eligibility and Payments, Division of Welfare and Supportive Services, Department of Health and Human Services
Katie Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican
Katie Robbins, representing Planned Parenthood Votes Nevada
Connor Cain, representing HCA Healthcare, and Sunrise Hospital and Medical Center
Tess Opferman, representing Nevada Women's Lobby
Lea Case, representing Nevada Psychiatric Association
Melissa Clement, representing Nevada Right to Life
Sequila Angkratok, representing Human Services Network
Lashonda Marve-Austin, Private Citizen, Las Vegas, Nevada
Quentin Savwoir, Deputy Director, Make It Work Nevada
Sarah Walton, Private Citizen, Reno, Nevada
Breana Lipscomb, representing Center for Reproductive Rights, New York, N.Y.
Ashley Dodson, representing Make It Work Nevada
Melissa Peek-Bullock, State Epidemiologist, Division of Public and Behavioral Health, Department of Health and Human Services
Elizabeth Kessler, Program Manager, Sexually Transmitted Diseases, Division of Public and Behavioral Health, Department of Health and Human Services
Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services
Bradley Mayer, representing Southern Nevada Health District
Bill Welch, President/CEO, Nevada Hospital Association
Joelle Gutman-Dodson, Government Affairs Liaison, Washoe County Health District
Hannah Baer, representing Coalition for Access to Prenatal Screening

**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 up the hearing on Assembly Bill 189. We introduced a committee bill that came out of the 2019-2020 Interim Legislative Committee on Health Care and we have decided that bill [Assembly Bill 193] and A.B. 189 are very similar, so you will see amendments already submitted by Assemblywoman Gorelow on the Nevada Electronic Legislative Information System. Rather than hear the same bill twice, we are probably going to incorporate that language and work that took place during the interim into A.B. 189.

**Assembly Bill 189: Establishes presumptive Medicaid eligibility for certain pregnant women. (BDR 38-130)**

**Assemblywoman Michelle Gorelow, Assembly District No. 35:**
I am a member of the Nevada Statewide Maternal and Child Health Coalition steering committee and I am the immediate past chair of the Southern Nevada Maternal and Child Health Coalition and immediate past cochair of the Statewide Maternal and Child Health Coalition. I served as a member of the National Governors Association Learning Network on Improving Birth Outcomes under Governor Sandoval, and I was part of the Nevada delegation to attend the Collaborative Improvement and Innovation Network to Reduce Fetal Mortality.

Assembly Bill 189 is about improving access to health care for pregnant women because we know that healthier moms mean healthier babies and lower costs for everyone. As Chair Nguyen mentioned, we will be including an amendment that is going to include all of Assembly Bill 193 [Exhibit C].

We have heard in this Committee that maternal mortality and morbidity are significant problems in the United States and in Nevada. The U.S. has one of the highest maternal mortality rates among developed countries, and Nevada is no exception, with 129 pregnancy-associated deaths between 2015 and 2019.

Another significant issue is preterm birth. A "preterm birth" is defined as any birth before 37 completed weeks of gestation. The reason we use 37 weeks even though 40 weeks is considered to be full-term is because we can be off on a due date for a pregnant mom by about 2 weeks. Thirty-seven weeks of gestation could actually be a 39-week gestation.

A preterm birth is divided into three categories based on gestational age:

- Extremely preterm babies that are born earlier than 28 weeks.
- Very preterm babies that are born between 28 and 32 weeks.
- Moderate or late preterm babies that are born between 32 and 37 weeks.

Each year in Nevada we have around 3,800 preterm births. The highest I remember seeing over the last 15 years was 5,400 births, so we have done a really good job reducing those preterm births. However, our preterm birth rate is still 10.7 percent, so the March of Dimes gives us a D+ on its annual report card.

The vast majority of preterm births, or about 85 percent, are moderate or late preterm—that is, born between 32 and 37 weeks of gestation, followed by about 9 percent being very preterm and about 6 percent being extremely preterm births.

When looking at the preterm birth rate and breaking it down to race and ethnicity, African-American women have the highest at 13.7 percent, Native-American women are second at 12.1 percent, Asian women are at 11 percent, and Hispanic and Caucasian women are about 9.6 percent and 9.8 percent, respectively.

Preterm birth and low birth weight are associated with significant economic, medical, and social costs as well. Preterm birth is not only the leading cause of neonatal mortality; it is also associated with short- and long-term disabilities and morbidities.

A 2007 review by the Institute of Medicine estimated the economic burden of preterm birth in the United States to be at least $26.2 billion in 2005 dollars. That averages about $51,600 per preterm birth. There have been some updated calculations that average preterm births to be between $65,000 and $76,000. However, the longer the baby is in a neonatal intensive care unit (NICU), the more that can be. A baby born at about 32 weeks averages about $280,000 a year. I read about triplets being born at 28 weeks. They all spent about two months in a NICU at a cost of $4 million.

While cost estimates vary, studies consistently show that they are the highest for extremely preterm infants, and increasing gestational age by just weeks can result in significant cost savings. This is intuitive, as early preterm babies generally require the most time in the hospital. In Nevada, the average length of stay for extremely preterm babies was anywhere from 54 to 78 days in recent years. The length of stay for very preterm babies was slightly lower—between 49 and 53 days. In contrast, the average length of stay for moderate or late preterm babies was only nine or ten days. For a full-term infant who may only stay one or two days in the hospital, that cost is roughly $2,500 to $2,900—a huge difference. My son, who was born in 2006, spent five days in the NICU and it cost $15,000. He was not a super sick baby; he had some feeding issues and some temperature control issues.

What do we do to increase the gestational age of babies born in Nevada? We improve prenatal care for moms. Nevada Medicaid is the single largest payor of births in the state, covering more than half the births statewide. As such, it is uniquely positioned to improve both maternal and child health outcomes. Assembly Bill 189 will improve access to prenatal care and other health services by extending Medicaid eligibility for pregnant women in Nevada. As introduced, A.B. 189 requires Medicaid to expedite enrollment for pregnant women through a policy of "presumptive eligibility" which allows health care providers to help women enroll in Medicaid without submitting a full application and receive early prenatal care.

Specifically, the bill requires the director of the Department of Health and Human Services (DHHS) to include authorization in the State Plan for Medicaid for a pregnant woman to enroll in Medicaid if she is determined to be presumptively eligible by a qualified provider. A qualified provider is an eligible entity for payment under the state's approved plan and is determined by the state to be capable of making determinations.

The period of Medicaid enrollment continues until the last day of the month after the month of enrollment during which a pregnant woman must submit a full Medicaid application for coverage to continue. I want to make sure this is on the record. The idea is that the woman does not wait until the end of that second month. We want that application to be in the process of going through while she is getting care so there is no lapse in care. We do not want her to wait until the end, and then it takes another 30 or 45 days for her to be approved.

We want that to be done while she is getting care so she can be approved and continue receiving that care.

This policy was also proposed by the 2019-2020 Interim Legislative Committee on Health Care. In fact, that committee voted unanimously to pursue a bill [Assembly Bill 193] that not only mirrors this requirement but also expands Medicaid coverage for pregnant women in three additional ways. Because the goals of the committee's bill, A.B. 193, were very similar, we decided to combine the two bills. That was with the approval of Assemblywoman Cohen, chair of the interim committee. This means adding provisions to A.B. 189 to require the director of DHHS, to the extent authorized by federal law, to expand Medicaid coverage for pregnant women in Nevada by allowing them to enroll in Medicaid if their household income is at or below 200 percent of the federal poverty level (FPL)—$25,760 for an individual or $53,000 for a family of four, up to the current threshold, which is now 165 percent. It would also prohibit DHHS from requiring a pregnant woman who is overwise eligible for Medicaid to live in the United States for a certain amount of time before enrolling in Medicaid. Currently, residing pregnant women who are lawful residents must wait five years before becoming eligible for Medicaid. We are looking to waive that.

We are also requiring DHHS to apply for a waiver from the federal government to allow a pregnant woman and her child to keep Medicaid coverage until 12 months after the child is born so she can be taken care of during the postpartum period. Currently, Medicaid coverage extends only 60 days postpartum, but the data show that 50 percent of maternal deaths occur after delivery and nearly 12 percent occur six weeks postpartum, meaning that maintaining access to care is critical in the year after childbirth. The federal government is looking at including this in the federal American Rescue Plan Act of 2021.

Nevada is not alone in considering or implementing any of these policies. According to the Kaiser Family Foundation, 42 states have higher income limits for pregnant women than Nevada, ranging from 171 percent of the FPL in Kansas to 380 percent of FPL in Iowa. Thirty states expedite Medicaid enrollment for pregnant women through presumptive eligibility. Twenty-five states allow lawfully residing pregnant immigrant women who are otherwise eligible to enroll, even if they have not lived in the United States for five years, and states are increasingly exploring the possibility of extending Medicaid coverage for up to 12 months postpartum.

Early prenatal care is defined as care during the first trimester, so 12 or 13 weeks of care. The U.S. average is 77.6 percent. As of 2019, Nevada was at 75.4 percent and ranked thirty-seventh. As early as 2016 we were forty-third, so we are doing better, but I know we can do even better than that.

Late to no prenatal care in the U.S. is 6.4 percent; Nevada is at 9.4 percent. The Healthy People objective would like to see that under 5 percent. When compared to other states, we rank 48 out of 52—we added Washington, D.C., and Puerto Rico. I know we can do much better than that.

Among the reasons we would like women to have early prenatal care is getting a due date. Is she pregnant with a single baby or with multiple babies? We can get a baseline for vitals: what is her blood pressure normally, what is her weight because we do not want her to gain too much weight. If blood pressure starts spiking during her pregnancy, it can be an indication of preeclampsia. We really do not know why some women develop it, but those who get it just have it during pregnancy and the only cure for it is to deliver the baby. She needs to be monitored because she can have a stroke. Those are things we want to check out.

We also want to test for sexually transmitted diseases (STDs). Nevada is one of the highest states for congenital syphilis, so we want to make sure we can test and treat women for STDs. We want to do interventions for women who may be using alcohol, tobacco products, or drugs—both prescription and nonprescription. We want to check for any chronic illnesses she may have. If she already has diabetes, we definitely want to monitor that, and some women will develop diabetes during pregnancy. We want to get her in as early as possible. At this time, I will turn this over to Dr. Nathan Slotnick.

**Nathan Slotnick, M.D., Private Citizen, Reno, Nevada:**
I am a high-risk obstetrician and medical geneticist. I have been in practice for many years, and I want to emphasize what Assemblywoman Gorelow stated—the singular thing we can do to identify, treat, and anticipate preterm labor is early prenatal care. Early prenatal care, absent prenatal care, or compromised prenatal care is a four-lane highway to preterm delivery. If we are trying to provide the best possible care for the pregnant women of the state of Nevada, early prenatal care is the best approach we can have.

**Assemblywoman Gorelow:**
Thank you, I appreciate your presenting on A.B. 189. I was going to have Dr. Brian Iriye, a perinatologist from Las Vegas, speak, but he had to take care of other patients and was unavailable. I do have Kristine Hafner who will tell us her story.

**Kristine Hafner, Private Citizen, Las Vegas, Nevada:**
Our adoptive daughter was born at approximately 33 weeks gestation with a condition called gastroschisis. This is when some, or in her case, all of her intestines were on the outside of her body at the time of birth. Her lower half was placed in a protective sterile sheet bag called a "silo" to keep her safe from infection for the first 48 hours until the first surgery could take place. Unfortunately, her intestines began to die off and continued to do so for the first two years of her life. As they died off, she had to return to surgery to have them removed. Skyler now only has half the intestines she should have. Skyler spent the first 13 months of her life in the hospital. She went from the NICU to the pediatric intensive care unit to try and discharge her. She, however, was considered too unstable to go home and was sent to a long-term nursing facility. Until Skyler was three-and-a-half years old and discharged to us, she lived between the hospital and the nursing facility. Though some children with this condition can tolerate food fed directly into their stomachs with tubes, Skyler has not been so fortunate. She is now dependent on a permanent IV that lives in her chest to meet her caloric needs. Even now with her home, she has her IV nutrition 14 hours a day, two pumps to infuse that, emergency medications with us at all times and continuous

feeding tubes 24 hours a day. This condition can happen naturally, but in Skyler's case it is believed to be caused by biological mom's drug involvement. Members of this Committee, this is why A.B. 189 is so important to pass and hopes to prevent or minimize this condition and life circumstances like Skyler's. Skyler's life could have been very different if help was available for bio-mom.

**Assemblywoman Gorelow:**
Did you mention to the Committee how much her medication is?

**Kristine Hafner:**
She is on Medicaid. We have been given estimates of anywhere from $650 a day to $2,500 a week. She is still considered to be rather unstable and it changes weekly, so what the medication costs changes weekly.

**Kelly Bumgarner, Director of Health Policy, Children's Advocacy Alliance:**
This is my daughter Miriam, and she is here today because I had complications that sent me to the emergency room early in my second trimester. I was able to visit the high-risk pregnancy center the next day and begin a course of treatment that kept us both alive and healthy. I am so grateful for the treatment I received, but I know if it had not been for my privilege, the color of my skin, my health insurance, or even the vehicle I used to get to all those appointments, the outcome might have been vastly different.

According to the Georgetown Center for Children and Families, Black and American Indian/Alaska Native women die from problems in pregnancy two to three times more than white women. Only one in three pregnant women living in Laughlin receives early prenatal care. In Washoe, one in five receives early care, which experts attribute to a disproportionate lack of care in its rural areas. No one experiencing the fear I felt that day should also have to worry about whether they can afford to see a doctor, find a doctor, or find a doctor who will properly address their concerns and save their baby's life.

The Children's Advocacy Alliance is thrilled to stand with Assemblywoman Gorelow and the statewide Strong Start Prenatal-to-Three collaborative in support of presumptive eligibility. The collaborative is alarmed by our state's maternal mortality and morbidity rates. We know that access to care increases utilization during early pregnancy. Centers for Disease Control and Prevention (CDC) data indicate significant increases in preconception health conversations with providers, folic acid consumption, and postpartum contraception use when women have access to Medicaid. We have established a multiyear statewide plan to increase Medicaid enrollment and utilization to improve health outcomes for low-income pregnant persons and babies. Our goals include presumptive eligibility, extending postpartum coverage, increasing the percentage of FPL at which pregnancy is Medicaid-eligible, and ensuring lawfully residing pregnant persons can access Medicaid.

Data show these actions increase the likelihood pregnant women will seek early care and have positive pregnancy and birth outcomes. Pre- and postnatal care are unique instances in which expanding coverages decreases not only adverse health outcomes, but also costs

to Medicaid and taxpayers. In 2007, the Institute of Medicine calculated a preterm birth typically resulted in a $33,000 bill while a full-term birth cost about $3,000. That is a difference of $30,000 per birth. Thank you for your consideration of these important efforts to protect moms and babies.

**Assemblywoman Gorelow:**
There are about 50,000 women who live in obstetric deserts in Nevada. Again, presumptive eligibility can help a lot of those women who have to travel long distances to get to a doctor. If we can presume them eligible and they can work on their application at the same time, we can get them the care they need.

**Chair Nguyen:**
Are there any questions? I also would encourage everyone to look at the interim committee work done on this topic. Our policy analyst, Patrick Ashton, will send information on this bill and the next bill we will be hearing today to Committee members so you can review some of the interim work done in preparation for these bill presentations.

**Assemblywoman Titus:**
Thank you for allowing me to be a cosponsor on this bill. I have been asking questions for a long time regarding presumptive eligibility and lowering Medicaid costs. I appreciate the testimony regarding the cost of premature delivery and the cost of taking care of these children. When these babies are born they are ours, so we take care of them. I have been arguing for a long time for them to be taken care of while they are still intrauterine and we can make them healthier babies when they are born. Eventually, they will be ours, and I would rather they be healthy Nevadans than being born with issues we continue to pay for.

For the record, I am going to argue this bill as being fiscally responsible because I believe the return-on-investment argument can be made here. What does it cost to have these women receive prenatal care? We heard about the cost of taking care of the babies after they are born if there is a problem, but what will this cost Medicaid? Did we get a fiscal note on this? What is the estimated cost per enrollee?

**Assemblywoman Gorelow:**
I got a fiscal note today. I totaled it up, and it is about $6.8 million. I would have to figure out what that would be per woman. When I was doing the math, at an average of $76,000, that is 90 babies whom we need to get to full-term and we will break even. With our preterm birth rate at about 3,800, I think that is doable. That is reducing our preterm births by 2 percent. With the Healthy People objective of having us at around 9.4 percent overall, that is more than 90 births. With 36,000 births, at 9 percent we would be looking at about 3,500. If we got those 90 births, we would be on our way toward that goal. If we meet our goal, we will surpass those 90 babies, and this is definitely cost effective.

**Assemblywoman Titus:**
That is the point I wanted to make on the record: It does not take many babies or many women to lower the overall costs. With a fiscal note of that size, I think we need to keep it in

perspective. The first response is going to be that it is too expensive, but I would say—not only emotionally but also physically for those who testified about the health of their children—that we cannot put a cost on that. However, in real dollars for the state, I think we need to document that.

The second thing to note is that we will only do this as allowed by the federal government. We will not be doing this at the risk of losing our Medicaid dollars, so we have to make sure we are in conjunction with federal government regulations.

**Chair Nguyen:**
Are there more questions?

**Assemblywoman Black:**
What qualified provider will decide if a patient is eligible? How does that process look? When a mom comes in and is visiting with her provider, is her provider going to ask those qualifying questions?

**Assemblywoman Gorelow:**
Yes, the provider will have to ask qualifying questions to make sure the woman would qualify for Medicaid. Not anybody can just say, Oh, I am going to be presumed eligible and get the care. If they do not meet the federal guidelines, then they cannot be presumed eligible. So there will be questions for the provider to ask the pregnant mom so we can make sure she would qualify as her application is being processed. In other states, the provider has to have a high acceptance rate for Medicaid—90 or 95 percent—and they are not just accepting anyone or presuming anyone eligible.

**Chair Nguyen:**
We have DuAne Young from Medicaid here who might be able to answer your question with more specificity.

**DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:**
These women would receive outpatient ambulatory services. In the period in which they were eligible, they would have 60 days to submit their full Medicaid application. Once being made fully Medicaid eligible, we would go back 90 days and cover all those other services that are outside the ambulatory outpatient services related to the pregnancy.

**Lisa Swearingen, Chief, Eligibility and Payments, Division of Welfare and Supportive Services, Department of Health and Human Services:**
We currently have a presumptive eligibility program in the hospitals. That is a process we have in place where they apply, they are certified, they are trained, and they have to meet certain criteria. We would do that with this other group. They would have to go through training, be certified, and then we have a quality control group that monitors to make sure they are meeting all the federal requirements. These individuals are eligible for two months, but it is actually the last day of the month following the month of enrollment. It could be

30 days because if someone applied on the 30th of a month, that person would only get to the end of the following month, so it is important that the providers work with these individuals to make sure they submit their Medicaid applications so we can get them enrolled sooner and make sure there is not a break in service.

**Assemblywoman Black:**
That may be where I am misunderstanding the sentence in section 1, subsection 1 where it states ". . . the last day of the month immediately following the month of enrollment without submitting an application for enrollment in Medicaid which includes additional proof of eligibility." Is that where you are getting the 60 days and the 90 days? That sentence just confuses me because how can you enroll for a month without submitting an application?

**Lisa Swearingen:**
Presumptive eligibility is for what we call "two months." If a person were to apply the first of March, that person would be eligible through presumptive eligibility through March and the end of April. Within the time period, the person has to submit a full Medicaid application and the verifications to be determined eligible for Medicaid. If the person applied at the end of March, it says it is the last day of the month following enrollment so that means the person would only get from March 31 through the end of April. That is a shortened window, but we are stressing that they get their applications submitted as soon as possible so we can get them full Medicaid.

**Chair Nguyen:**
Are there any other follow-up questions? [There were none.] At this time, we will take callers in support. Please remember to clearly state and spell your name. Testimony is limited to two minutes, and I would encourage you to provide any additional written testimony within 48 hours of the close of this hearing on A.B. 189.

**Katie Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican:**
We want to go on the record today as being in support of A.B. 189. I, too, had access to great prenatal care, including many of the high-risk pregnancy centers, and without that access, things could have been very different for my now three-and-a-half-year-old son Jack. Let us give that access to everyone.

**Katie Robbins, representing Planned Parenthood Votes Nevada:**
We are here to voice our support for A.B. 189. Presumptive eligibility serves the important role of providing immediate access to much-needed health care for pregnant women, while also putting them on a path to continued coverage. The importance of quality prenatal and postpartum care is well known. We are in support of making it easier for pregnant women to access these services. We strongly support A.B. 189 and urge the Committee to, as well.

**Connor Cain, representing HCA Healthcare, and Sunrise Hospital and Medical Center:**
I am testifying today in support of A.B. 189. I would like to first thank all the sponsors of this legislation, especially Assemblywoman Gorelow for all the work on this issue. I know

how important it is to her. I would be remiss if I did not thank Director Bierman and Director Whitley for always having an open door, especially as it relates to Medicaid. I also want to recognize Skyler's bravery and toughness. I am sure she is an inspiration to everyone listening or watching today.

As many of you are aware, Sunrise Hospital is the largest provider of Medicaid services in the state. It is something we are extremely proud of, but given that our state ranks forty-ninth in Medicaid expenditure per capita, it is also challenging. Roughly 4,500 babies are born every year at Sunrise Hospital, and about 80 percent of them are covered by Medicaid. The most vulnerable of these babies end up at the hospital's 72-bed NICU, which is the largest and most comprehensive in the region. It has nearly 1,000 patients annually and, by itself, results in significant losses every year due to low reimbursement rates. One of the most significant problems the hospital sees every day is the lack of prenatal care that many moms receive. We support A.B. 189 because we believe it can help lead to better outcomes for moms and babies. We also encourage you to continue to support [unintelligible] Medicaid funding.

**Tess Opferman, representing Nevada Women's Lobby:**
We want to thank Assemblywoman Gorelow for bringing this legislation forward which will allow pregnant women access to critical care during pregnancy, through the birth process, and through recovery. Nevada is in the top 12 states when it comes to the percentage of women who are uninsured during pregnancy. Please help ensure mothers and babies are healthy by giving access to necessary insurance through pregnancy by passing this key legislation.

**Lea Case, representing Nevada Psychiatric Association:**
The Nevada Psychiatric Association would like to express our support for A.B. 189 as amended, expanding postpartum Medicaid coverage from 60 days to 12 months following childbirth. According to the CDC's ERASEMM [Enhancing Reviews and Surveillance to Eliminate Maternal Mortality] update for the Western District, mental health conditions are the leading cause of preventable pregnancy-related deaths. I have submitted this information to the Committee secretary. These deaths, including suicides and overdoses, are more likely to occur between 43 days and one year after giving birth. Extending postpartum Medicaid coverage for a full year will give mothers continuity of care and access to appropriate treatment for any number of postpartum health issues, including postpartum depression and postpartum psychosis. Babies continue on Medicaid for one year after birth; continuing this coverage for the mother as well will ensure these babies have a healthy parent too.

**Melissa Clement, representing Nevada Right to Life:**
Nevada Right to Life wholeheartedly supports A.B. 189, and we thank the sponsor and all who worked on this very important legislation.

**Sequila Angkratok, representing Human Services Network:**
We are calling to voice our support of amended A.B. 189 on behalf of our many human services member organizations. As a new mother of two months, I cannot imagine having to

worry about health coverage during my pregnancy. Even with medical coverage, the physical and emotional stress of pregnancy can create a hostile environment for the infant and medical complications for the expectant mother. Lack of adequate and easily accessible medical coverage is an immense stressor no mother should have to endure.

I would like to highlight today that pregnant women in Nevada suffering low-income status, often persons of underserved Black and Brown communities, are already a tremendously vulnerable population. According to the CDC, Black mothers are two to three, to as much as five times more likely, dependent on age, to die in childbirth than a white woman. The Black infant mortality rate is well above double that of white infants. These women are already living under tremendous weight of significant disparities within our society, suffering from struggles with nutrition, income, trauma, et cetera. These women should never have to wonder how they will be able to survive childbirth or bear healthy babies. They deserve the basic human right of access to quality medical coverage both during pregnancy and postpartum.

**Lashonda Marve-Austin, Private Citizen, Las Vegas, Nevada:**
I am here today in support of A.B. 189 as it is amended. I went through postpartum depression with my daughter. I was not able to properly care for or nurse her. Having to put her on formula was something I did not want to do. Had I had the opportunity to have extended coverage through Medicaid, I think I probably would have been able to get support in order to care for my daughter the way I would have liked. I want to thank everyone who worked on the bill.

**Quentin Savwoir, Deputy Director, Make It Work Nevada:**
We work alongside Black women and Black families in the areas of economic justice, racial justice, and reproductive justice. We are thrilled that Assemblywoman Gorelow has brought this bill to the Committee and that you are hearing this measure, as we have long worked to build power to bring greater awareness to issues around maternal mortality in our country. The United States has become the most dangerous place in the developed world for a person to give birth. Assembly Bill 189 is a racial and reproductive justice issue that is the first step to shake the scourge of this unsettling statistic. By now I know you have all heard the research and data about how disparate the realities are for Black women, Brown women, and other melanated parents during childbirth. Their access to resources is limited. They are reporting subpar treatment by medical professionals, and, in some cases, they are dying.

The problem is so pervasive that we can safely assume this is happening in numerous communities throughout our country. The reality is sad in and of itself, but I cannot help but think about the children. I cannot help but think about how their lives would be more enhanced and enriched if we were proactive in providing mothers and parents with postpartum medical visits, supports, and additional care that is currently unavailable to Medicaid enrollees in our state. Current *Nevada Revised Statutes* (NRS) provides for 60 days of postpartum Medicaid coverage; however, this is not reflective of the needs of the mothers and birth parents that we organize and work alongside. Our community members frequently reference challenges related to fatigue, breastfeeding, and added stress when a

new baby comes home. This measure will expand the safety net for our community members who need a little extra support. At its core, A.B. 189 is about our children and how we intend to raise our children in this state. It meets the moment we find ourselves in as we try to bring greater equity to communities that have been historically overlooked or lacked access to care because of restrictive public policy. You all can help us continue making strides in the right direction by supporting A.B. 189. Make It Work Nevada supports this measure and urges bipartisan support.

**Sarah Walton, Private Citizen, Reno, Nevada:**
I am voicing support for A.B. 189. I am a birth and postpartum doula, a childbirth educator, and a midwife assistant. I am the owner of Bright Heart Birth Services, which is a small birth support and education agency, and a co-owner of Biggest Little Baby, which is a baby store and family resource center. I am the current sitting director at the nonprofit Reno Doula Project and the Truckee Meadows Birth Network. I have always been incredibly invested in my community. I am Nevada born, a single parent to a now-six-year-old. He was born while I was covered under Medicaid. I was lucky enough to have him in Portland where I had far more access to support and resources as a low-income pregnant person. I am now back in the Reno area. I moved back when I was six months postpartum and I did not have the same access when I got back here. I had the intention of creating and building more bridges for community support in the childbearing years in our area because I knew it was needed.

I have interacted with thousands of people in the community through my organizations and leadership through mentoring, free support groups, and sliding-scale doula support. A large percentage of the people I am supporting are either supporting Medicaid recipients or Medicaid recipients themselves. We are often supporting these folks before and after they are seen by medical professionals, so we are sometimes expected to shoulder the burden of things within the medical scope and not the role of doulas. Expanding Medicaid would really be great to include either earlier and later, and both. It would improve outcomes for the parents and the babies and the entire families and get them off to better starts and more secure beginnings as Nevadans.

**Breana Lipscomb, representing Center for Reproductive Rights, New York, N.Y.:**
I am the senior manager of the U.S. Maternal Health and Rights Initiative for the Center for Reproductive Rights. I am here to express support for the amended A.B. 189. I would like to focus on two provisions: presumptive eligibility and the extension of postpartum Medicaid coverage to 12 months.

Presumptive eligibility makes access to prenatal care simpler and less burdensome. One study found that presumptive eligibility policies increase the likelihood that pregnant women will obtain prenatal care in the first trimester by 30 percent. Inadequate prenatal care has been linked to preterm labor and low birth weight and many other adverse effects as indicated by Assemblywoman Gorelow. By removing a barrier to earlier prenatal care, presumptive eligibility encourages access to treatment and services that help improve the health of both moms and babies and may reduce future medical costs. The majority of states

are already implementing presumptive Medicaid eligibility for pregnant women, and this includes many states in our geographic region.

Regarding extending Medicaid coverage to 12 months after delivery, this is critical to making sure that birthing people have access to the critical health care services they need. We know that the majority of maternal deaths are preventable, and data show that 60 percent of the births in this state are covered by Medicaid, yet women are losing coverage only 60 days after delivery. Ensuring the full 12 months of postpartum coverage is an opportunity to have a major impact on the majority of pregnant and postpartum people in this state, so I urge you to pass A.B. 189 out of Committee. It creates an opportunity for women to achieve their optimal standard of maternal health and is one step closer to closing the maternal health racial disparity gap in Nevada.

**Ashley Dodson, representing Make It Work Nevada:**
I am a social worker and representative of Make It Work Nevada in support of A.B. 189 as it is amended. As a Black mother of five and previous recipient of Medicaid, I know the disparity firsthand of not having insurance coverage after the birth of a child. My maternal health was at risk for several factors including the trauma of being considered a high-risk pregnancy. Often after birth, due to my circumstances, it was a struggle to properly care after my children as the birth was daunting and traumatic. Not having access to continued care postpartum also prohibited me from giving my children the proper care they needed in their first weeks after birth and the necessary well-checks as well as my own health. I also ran into issues with securing quality affordable child care while working or reentering the work force. All these obstacles caused me to be under increased levels of stress and pressure which led to postpartum depression and anxiety. I then had to receive therapeutic services which I could not have covered due to lack of insurance and ability to pay cash due to lack of income. This caused me much headache and heartache because I did not have access to the resources I needed for myself or my children. My experiences did not go as planned because of the lack of insurance and proper care.

With Medicaid being expanded into a woman's fourth trimester, it will decrease other injustices Black women face such as pay inequity, affordable housing, and quality affordable child care. Racism, classism, and sexism have been tied directly to the health and wellness of Black mothers in this country. Black women are three to four times more likely to have pregnancy-related deaths than their white women counterparts. These numbers are staggering and traumatic. Imagine being a woman who, throughout your entire pregnancy and birth experience, is constantly thinking and knowing the high possibility you may not get to see your child. No woman should experience this as a result of lack of care and insurance. This narrative has to change. Again, I urge the Committee to support and pass A.B. 189 as amended.

**Chair Nguyen:**
Is there anyone else in support? [There was no one.] Are there any callers in opposition to A.B. 189? [There were none.] We will move to testimony in neutral.

**Lisa Swearingen:**
We want to thank Assemblywoman Gorelow and the Interim Legislative Committee on Health Care for bringing this bill forward. The Division of Welfare and Supportive Services would like to request amending the effective date of the bill to possibly July 2022, which would allow our agency time to develop and implement these changes. We do have a fiscal note attached to the bill for these system enhancements, but we look forward to working with Assemblywoman Gorelow and addressing any questions or comments that come up.

**Chair Nguyen:**
Do you have any closing remarks, Assemblywoman Gorelow?

**Assemblywoman Gorelow:**
As we have heard in the testimony, expanding Medicaid to pregnant women in Nevada is good for moms, it is good for babies, and it will help reduce the costs of preterm birth, not only in immediate NICU costs, but long-term costs as well. I would like to thank Dr. Slotnick for filling in at the last second to give us more information on prenatal care. I would also like to thank Kristine Hafner, Kelly Bumgarner, and everyone who called in today in support.

[Exhibit D and Exhibit E were submitted but not discussed and will become part of the record.]

**Chair Nguyen:**
I will close the hearing on A.B. 189 and open the hearing on Assembly Bill 192. Our Policy Analyst, Patrick Ashton, will send everyone a link so you may see some of the interim work that was done in consideration of this bill. This is another bill that came out of the work done by the Interim Legislative Committee on Health Care. Assemblywoman Cohen was on that committee and will present the bill.

**Assembly Bill 192: Revises provisions governing the testing of pregnant women for certain sexually transmitted infections. (BDR 40-453)**

**Assemblywoman Lesley E. Cohen, Assembly District No. 29:**
I am here today to present Assembly Bill 192 for your consideration. It is really important for the health of pregnant women and their babies. During the 2019-2020 Interim, I chaired the Legislative Committee on Health Care. Two of our priorities were public health and maternal and child health. This bill addresses both. I would like to note that there is a conceptual amendment that should be on the Nevada Electronic Legislative Information System [Exhibit F].

According to the Centers for Disease Control and Prevention (CDC), sexually transmitted diseases (STDs) can cause pregnancy complications and result in serious consequences for both mothers and developing babies. In 2019, the CDC identified newborn deaths from syphilis as "the most alarming threat" and emphasized the need to test all pregnant women for syphilis in line with CDC recommendations.

This is especially important in Nevada because in 2018, we had the highest rate of primary and secondary syphilis in the nation. The problem is especially acute in the Las Vegas-Henderson-Paradise region, which had the highest rates of primary and secondary syphilis of all metropolitan areas that report to the CDC. We also had the second-highest rate of congenital syphilis, which is when a mother with syphilis passes the infection on to her baby during pregnancy, and trends have not been moving in the right direction. According to the CDC, Nevada saw a 289 percent increase in congenital syphilis between 2015 and 2018.

Congenital syphilis can significantly affect a baby's health. It can cause miscarriage, stillbirth, prematurity, low birth weight, or even death. Up to 40 percent of babies born to women with untreated syphilis may be stillborn or die from the infection as a newborn. Congenital syphilis can also result in deformed bones, enlarged liver and spleen, brain and nerve problems, and a host of other health issues.

The good news is that both syphilis and congenital syphilis are preventable. Syphilis can be treated and cured with antibiotics, and congenital syphilis can be treated, though babies who have it need to be treated as soon as possible to reduce the risk of serious health conditions. However, the key to treatment and prevention is ensuring moms are tested for syphilis and receive prenatal care.

The bill aims to align Nevada's STD testing requirements with CDC recommendations. Section 1 requires physicians and other providers who are permitted by law to attend to pregnant women to ensure they are tested for chlamydia trachomatis, gonorrhea, hepatitis B, and hepatitis C, as recommended by the CDC. The physician or other person must ensure that samples are taken from the woman and submitted to a laboratory. However, subsection 3 provides that pregnant women may opt out of required testing.

Section 2 of the bill revises existing requirements related to syphilis testing for pregnant women. It revises who must conduct syphilis testing or ensure it is done, and when. The state has found an association between lack of prenatal care and congenital syphilis, and the goal of the bill is to reach pregnant women where they seek health care, regardless of whether they seek pregnancy-related services. For this reason, section 2, subsection 1, paragraph (c) requires hospital emergency departments and certain other medical facilities to test pregnant women for syphilis if they indicate they have not had recommended prenatal screenings and tests.

Section 2, subsection 2, paragraph (c) clarifies when syphilis testing must be done, including at delivery for pregnant women who:

- Should be routinely tested for syphilis, as recommended by the CDC.
- Live in areas designated by the Division of Public and Behavioral Health of the Department of Health and Human Services as having high syphilis rates.
- Did not receive prenatal care.
- Deliver a stillborn infant after 20 weeks of gestation.

Section 3 revises existing criminal penalties for failing to do required syphilis testing and instead assesses a civil penalty of not more than $500.

When the Legislative Committee on Health Care held its work session in September last year, we had not quite worked out all the details for this bill. However, over the past week, I met with the Nevada Hospital Association and the Division of Public and Behavioral Health to iron out a few amendments which should help achieve our goals in a way that the hospital emergency departments can implement.

I will go through the amendment with you. We replaced a reference to "laboratory approved by State Board of Health" in sections 1 and 2 of the bill with "a laboratory licensed pursuant to *Nevada Revised Statutes* (NRS) Chapter 652." Next, we deleted section 1, subsection 2, such that testing required by the section and done by the State Health Laboratory is not required to be done without charge. We clarified that hospital and emergency departments and medical facilities must ask women of childbearing age whether they are pregnant. That was defined by the CDC's definition of childbearing age. If the results of the blood test required in section 2 show that the pregnant woman is infected with syphilis, and if the result is received while the woman is in the emergency department or medical facility, they must commence treatment for syphilis. When they notify the local health authority of the confirmed case of syphilis as is required by existing law, they are also required to indicate the case involves a pregnant woman.

The next amendment revises subsection 5 of NRS 442.010. It provides that if a pregnant woman objects to the taking of a sample of blood or the serological test for any reason, the sample must not be taken and the test must not be performed. Existing law currently allows an objection only on a religious basis. Next, this requires health insurers and providers regulated by the state of Nevada to pay for the testing mandated by sections 1 and 2 of this bill. Our next change revises the list of medical facilities to which the requirements of the bill apply. We did not change "medical facility" in the NRS; we cut down which medical facilities need to comply with this. That list is on the amendment.

Finally, we clarified that section 2, subsection 1, paragraph (c) relates to "an emergency department in a hospital that evaluates or provides treatment to pregnant women." This intent is to have hospitals test pregnant women who are evaluated or treated in the emergency department, not just those who are admitted as inpatients. Sometimes you can be in a hospital for quite a long time, even days, and technically not be admitted to the hospital but still be in the emergency room having treatment.

**Melissa Peek-Bullock, State Epidemiologist, Division of Public and Behavioral Health, Department of Health and Human Services:**
We are available for any questions.

**Chair Nguyen:**
Does this match the CDC guidelines or are we requesting that all women be tested in the first and third trimester, or is it just the women who match these risk factors?

**Assemblywoman Cohen:**
We already have first and third trimester in our statutes.

**Elizabeth Kessler, Program Manager, Sexually Transmitted Diseases, Division of Public and Behavior Health, Department of Health and Human Services:**
This bill aligns with CDC guidance and we worded it in a way that for endemic areas, we can expand that testing when necessary. With our state being number one in our primary and secondary syphilis rates, and our congenital syphilis rates being second in the nation, we are identified by the CDC as one of the hot spots that should not just be looking at risk factors and should be screening all pregnant women.

**Assemblywoman Gorelow:**
Are we testing for HPV [human papilloma virus] and is it included in this bill? That seems to be an STD that a lot of women have who do not know it. I know it can cause some problems with babies.

**Elizabeth Kessler:**
Our office can check on that, but it was not included in this recommendation.

**Assemblywoman Titus:**
Just to be clear, there is already existing language that requires testing during various trimesters for syphilis. It is extremely troubling that Nevada ranks number one in congenital syphilis. We are looking for solutions for this, and testing is one. It may not decrease the number of cases of syphilis, but if we can fix the number of cases of congenital syphilis, it is wise to do so. I have questions regarding the bill specifically. I have a question regarding the terminology in section 1 on line 1, "Except as otherwise provided in subsection 3, a physician or other person permitted by law . . . ." Who are those "other persons" currently in Nevada "permitted by law" to attend a delivery?

**Elizabeth Kessler:**
Those "other persons" would encompass people like APRNs [advance practice registered nurses], midwives, and other health care personnel who may not necessarily be medical doctors or physicians.

**Assemblywoman Titus:**
Why use the terminology "other persons permitted by law" as opposed to leaving out physicians and just saying, "a health care provider"? That is what we have been going to.

Over the last several sessions, I have had bills trying to clean up the language regarding providers of health care. We have been using the term "health care provider." Is there any place in our statutes that uses that terminology—a person, a physician, or other persons permitted by law?

**Assemblywoman Cohen:**
We were trying to clarify. Certainly, there are other health care providers who attend upon pregnant women. We wanted to be sure we captured everyone; however, I can work with the Legal Division to be sure we have the phrasing right to encompass what we are trying to cover. When we first got the bill, we did discuss who it meant—who is covered. It does not mean a doula. We can continue to talk about that and make sure it is as concise as possible.

**Assemblywoman Titus:**
Good, because we continue to fix these bills after they go through. We have worked on the definition of "provider" for several sessions now, and it includes physician assistant and nurse midwife. The terminology was different, and I wanted clarification.

When we have heard these bills before, we are always concerned about the costs of doing these tests and who will be responsible for paying for these tests. Has Medicaid said that they will cover these tests if they are drawn in the emergency rooms?

**Assemblywoman Cohen:**
The hospital association had concerns about the costs and what the hospitals would be responsible for. It is my understanding that it will be covered by Medicaid, so the hospitals will be reimbursed, and obviously, they would also be reimbursed by regular insurance. That was something we addressed in the amendment to make sure that we were not leaving hospitals financially in the lurch with this.

**Assemblywoman Titus:**
I have not seen the amendment. This question is in regard to section 3 and the changing of the wording for consequences if a provider does not obtain these tests. It is already in statute that we as providers are mandated to do certain testing. It is already in statute that during this period of time there would be a consequence. You are taking that wording out and adding "a physician or other person" attending a woman who fails to perform this, including a hospital or medical facility. You are removing that as a misdemeanor but now putting in fines. How did you arrive at that? I am concerned about section 3, subsection 3, the enforcement through our Attorney General or district attorneys. I am concerned about the liability for the providers. I know we want to have a stick; I know we want to make sure they do this, but fines to the providers is a big pushback for me. Where did the $500 fine come from? Is that a standard penalty? Is that written somewhere else that if we, as providers, do not do our jobs there are other penalties, or is this unique to this bill?

**Assemblywoman Cohen:**
The most important part is that we took out the misdemeanor, which is in existing law. As you said, we need some way to enforce it. Five hundred dollars is an amount that is used

quite often in the NRS for civil penalties. We want to make sure we have an enforcement mechanism.

**Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services:**
Assemblywoman Cohen answered the question about whether Medicaid covers syphilis testing, and we do. We already cover it in the emergency room setting, in the clinic setting, and even in the inpatient delivery setting. That would already be included in the per diem rate for the hospital stay. Overall, Medicaid does cover syphilis.

**Assemblywoman Titus:**
You said it is covered in the Medicaid per diem rate. If you pay a flat rate to see a pregnant woman, they are not being reimbursed for the syphilis test.

**Erin Lynch:**
Right. For all inpatient services, whether very few services are performed or a lot of services are being performed, no matter what, a hospital is reimbursed a daily per diem rate.

**Assemblywoman Titus:**
So in actuality, whether that test is performed or not, they are going to get a flat rate. If they do that test, because they have to pay for that test, it may indeed cost them some money, correct?

**Erin Lynch:**
We are speaking about the inpatient side.

**Assemblywoman Titus:**
Correct.

**Erin Lynch:**
For the emergency room side, it would get reimbursed separately for that.

**Assemblywoman Titus:**
But not for the in-house.

**Chair Nguyen:**
Are there any other questions at this time from Committee members? [There were none.] I will go now to testimony in support, opposition, and neutral on A.B. 192. [The Chair reminded callers of the protocol and procedures for virtual meetings.] We will go to testimony in support of A.B. 192.

**Tess Opferman, representing Nevada Women's Lobby:**
One of the main goals of the Nevada Women's Lobby is to promote the health and well-being of women and families. It is a top priority of ours to help promote access to affordable health care. We are in full support of this legislation which will help give access to testing for

syphilis, benefiting both mom and baby. Thank you to Assemblywoman Cohen for bringing forward this legislation, and thank you to the Committee for your time.

**Bradley Mayer, representing Southern Nevada Health District:**
I am testifying in support. Nevada has been number one or number two in syphilis and congenital syphilis in recent years. Since 2014, cases have increased 1,333 percent. The problem is particularly acute among women who do not have prenatal care, so any opportunity we can get to find cases adds to the current efforts public health is taking to mitigate the spread of this disease. Earlier intervention is necessary to prevent babies being born with syphilis, so we urge your support.

**Bill Welch, President/CEO, Nevada Hospital Association:**
I would like to thank Assemblywoman Cohen for reaching out to the Nevada Hospital Association to inquire about our perspective on A.B. 192. I am speaking today in support of the amendment being presented by her on A.B. 192, and we look forward to working with her and others on the passage of A.B. 192. We think this is a good piece of legislation.

**Joelle Gutman-Dodson, Government Affairs Liaison, Washoe County Health District:**
We are here today in support of A.B. 192. We would like to thank the bill's sponsor, Assemblywoman Cohen, for bringing this bill forward. The Washoe County Health District supports expanding testing for sexually transmitted infections for pregnant women as outlined in this bill. As previously stated, Nevada ranks number two in the U.S. for congenital syphilis cases and in the top 15 states for chlamydia and gonorrhea, indicating the need for more screening to identify infections. We urge your support of this bill.

**Chair Nguyen:**
Can we go to our next caller in support? [There was no one.] Is there any testimony in opposition to A.B. 192? [There was none.] I know we have several people registered to testify in neutral.

**Erin Lynch:**
At the Division of Health Care Financing and Policy, otherwise known as Nevada Medicaid, we already cover STD testing, which includes syphilis, for pregnant women. We cover it in the emergency department setting, in the hospital setting, or in the clinic setting. We estimate that we would have a zero-dollar fiscal impact on this. The reason behind it is that we believe that the benefits of testing pregnant women for syphilis and preventing negative health outcomes to mom and baby far outweigh the costs of testing. We are neutral on this bill.

**Chair Nguyen:**
Is there anyone else who would like to present testimony in neutral? [There was no one.] I will turn this back over to Assemblywoman Cohen for any closing remarks.

**Assemblywoman Cohen:**
The Legislative Committee on Health Care chose to pursue this policy change because of its potential to improve the health of mothers and babies in Nevada and because congenital syphilis is preventable and both syphilis and congenital syphilis are treatable. We need to do better. By aligning STD testing with CDC guidelines and expanding testing requirements to hospital emergency departments and other medical facilities, we hope to be able to reach a broader population of pregnant women and reverse these unfortunate trends. I am open for more questions after the hearing if anyone has any. To Assemblywoman Titus's question about who is a provider, I believe we got that language out of NRS 442.008. I will talk to the Legal Division and get more clarification.

**Chair Nguyen:**
I will close the hearing on A.B. 192 and open the hearing on Assembly Bill 198.

**Assembly Bill 198: Requires Medicaid to cover certain genetic testing. (BDR 38-13)**

**Assemblywoman Lisa Krasner, Assembly District No. 26:**
Before I begin, I would like to note that I submitted a conceptual amendment which should be available on the Nevada Electronic Legislative Information System (NELIS) [Exhibit G].

Prenatal screenings are routine procedures during pregnancy that detect whether a fetus likely has certain health conditions or chromosomal abnormalities. Screening tests are not diagnostic; they only provide a probability that a particular condition exists. Nevada Medicaid is the single largest payor of births in our state. In recent years, it covered approximately 60 percent of all births statewide. Currently, Medicaid provides coverage for prenatal screenings, including blood panels, ultrasound exam, amniocentesis, and chorionic villus sampling.

Assembly Bill 198 requires the director of the Department of Health and Human Services to include in the State Plan for Medicaid coverage for noninvasive prenatal screening to detect birth defects in the fetus of a pregnant woman who is 40 years of age or older, if requested. The intent of this bill is to add noninvasive prenatal screening to the list of screenings that are already available and women can receive on Nevada Medicaid. This is also called Cell-Free DNA screening and is considered noninvasive because it screens for certain chromosomal abnormalities in a simple blood-drawn sample from a pregnant woman, in contrast with some other invasive methods such as amniocentesis or chorionic villus sampling. It carries no risk of miscarriage. Noninvasive prenatal screening can be conducted as early as during the first trimester.

The conceptual amendment on NELIS clarifies that the requirements of the bill only relate to noninvasive prenatal screening. It also clarifies that nothing in this bill shall be construed to grant, secure, or deny any right related to abortion or the funding thereof. I will now turn my time over to Dr. Nathan Slotnick. He will discuss the scientific and clinical importance of noninvasive prenatal screening and its utility in pregnancy.

**Nathan Slotnick, M.D., Private Citizen, Reno, Nevada:**
[Nathan Slotnick presented a PowerPoint Exhibit H.] I would like to thank Assemblywoman Krasner for her foresight and energy which have allowed us to address what I consider a singularly important component of health care for pregnant families and pregnant women, one that is frequently overlooked by underwriters and by Medicaid in the state of Nevada. I fully understand budgetary restrictions and COVID-19 issues having to do with the state coffers, so I will not address the issues of cost.

I am a perinatal geneticist in private practice in the state of Nevada since 2003 providing health care, perinatal services, and genetics to the population of the state. The goal of our discussion today will be to address a particular area in technology that has relatively recently come to fruition and has tremendous importance in terms of our health care. I have had a longstanding career in academics, research, and teaching. I have been involved in between 70,000 and 100,000 Nevada pregnancies providing care—ultrasound prenatal diagnosis. I have also provided medical genetics and genomic services through Renown and am currently medical director and clinical lead for reproductive health for Invitae Genomics Corporation [page 2].

My career is congruent with the development of screening for [unintelligible] and chromosomal abnormalities in pregnancy. My first publication was in this area many years ago and the issues having to do with this particular noninvasive testing protocol are ones I am intimately familiar with and have done much research on. "Screening means the identification among apparently healthy individuals of those who are sufficiently at risk of a specific disorder to justify a subsequent diagnostic test or procedure" [page 3]. This definition applies to medicine quite well, but screening is part of human nature. Every time we walk into a room and are faced with meeting new people, we are in a mode of screening when we evaluate them. Identifying a patient, identifying a person, evaluating that person, judging that person is part of what we do as human beings. In medicine, the issues of screening become even more profound and meaningful. In pregnancy, screening is a component of the initial and continuing evaluation. When I ask a patient her age when she is pregnant, I know that is a screening tool allowing me to get more information about what her potential risks for chromosomal abnormalities are. We have known for years that as a woman gets older, the risk of a chromosomal abnormality in pregnancy goes up. When I ask a woman her ethnic background, I know that is important as well as being a screening tool. We know that certain ethnic groups have certain genetic conditions more frequently found. When I ask a woman her religious background, I know there are genetic issues implicit in that question as well. I am Jewish. I know that as a Jew, my risk of having a child with Tay-Sachs disease is much elevated. All of these are components of screening and part and parcel of how we provide care to our pregnant women and pregnant families.

We are now on the fourth slide [page 4] labeled "Screening Tests vs. Diagnostic Tests." Let us discuss what a diagnostic test is. A diagnostic test is a high-sensitivity test with a very low rate of false positives and a very low rate of false negatives. A diagnostic test implies a diagnosis will be obtained. By definition, there is very little overlap between the affected and unaffected populations.

The next slide [page 5] tells what a screening is defined to be within the context of medical testing and what the applications are. Screening tests have a much different application in populations. There is a much broader population application for screening tests, and by definition, the sensitivity and specificity of screening tests are arbitrarily defined. The arbitrariness of screening tests relates to the definition either by a community or another defining agency that false positive and false negative rates can be determined and adjusted empirically. There can be significant overlap between affected and unaffected populations.

On the next slide [page 6] is a graphic demonstration. On the left you can see the properties of a test used for diagnosis. The unaffected population on the left and the affected population on the right have very little overlap, so the number of false positives and false negatives are very, very small for a diagnostic test. A screening test on the other hand can have a great deal of overlap between unaffected and affected populations. The area to the left of the dotted line on the right side of the slide will define what the false positive and false negative rates will be. You can move that discriminator and adjust it arbitrarily and can, if you choose, eliminate your false positive or false negative rates.

When these definitions were first applied to pregnancy, it allowed us to identify patients at risk for chromosome issues in pregnancy. The first definition of this was work we did when we defined the California Alpha Feto-Protein Screening Program [page 7]. This was defined by the Department of Public Health in the State of California—the genetics disease branch. At that time, it became obvious that patients who were carrying a pregnancy affected with spina bifida could be identified by measuring in the mother's serum a protein called alpha feto-protein. When those babies were identified, it became clear that their health could be improved by delivering them in a center where they could be addressed immediately and surgically corrected. What was not anticipated was that the alpha feto-protein test, back in the 1980s, also allowed us to identify patients at risk for a baby with Down syndrome. Since that time, in the last 30 years we have become much better at identifying these patients using different screening tools. The ability to provide this to patients has become routine and customary. The American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal-Fetal Medicine, and the National Society of Genetic Counselors have suggested that all patients be provided with the ability to identify what their risks are in pregnancy for a chromosome number abnormality.

The ability to do that is further expanded by our current development of DNA sequencing technologies [page 8]. This ability has become routine and customary and has allowed us to identify—with a high degree of sensitivity and specificity—pregnancies that are potentially at risk for chromosomal abnormality. We do that by taking advantage of the biology of the pregnancy. The interface between the placenta and the maternal uterine wall is dynamic [page 9]. The placenta is fetal in origin and because of the dynamism of this interface, some cells that are placental in origin will grow, divide, and some will die. If that placental cell dies and releases its contents, some of the fetal DNA indicated in white here, can cross into maternal circulation and we can identify, separate, and sequence the DNA of the fetus from a maternal blood sample. Remember, a maternal blood sample is not an at-risk procedure and does not put the pregnancy at risk at all. In this setting, we know fetal DNA has a much

shorter length than maternal DNA in circulation, and our ability to sequence that DNA has become available routinely and is offered to all pregnant women for this reason.

Using this cell-free DNA-based noninvasive prenatal screening tool, we are able to provide families and pregnant women with options [page 10, Exhibit H]. The first takeaway from this is that cell-free DNA-based noninvasive prenatal screening is increasingly utilized across all pregnancy risk groups. For the last ten years it has offered improved detection of fetal chromosomal abnormalities. Second, cell-free DNA-based noninvasive prenatal screening has been extensively studied in the general population with tens of thousands of patients and has shown to have very high positive predictive value compared to other status quo traditional screening tools. Third, there is a better detection of the chromosome number abnormalities that we can identify than in other screening tools. That leads to fewer invasive follow-up procedures, fewer amniocenteses, fewer chorionic villus samplings and by definition, fewer pregnancy-related losses. It is a safer test for both the mother and the fetus.

All major professional societies endorse or recognize this particular tool as a clinically valid screening option for all pregnancies [page 11]. As we know, there is a clear disparity in coverage and care for women based on factors such as age, location, and insurance coverage. We are striving for a single standard of care. It can provide better detection, fewer false positives, fewer invasive procedures, and fewer procedure-related miscarriages. In the next slide [page 12] we can see that the test is a remarkably powerful one. Not only is there a high positive predictive value, which is on the right side of the slide, but looking at the right bottom corner, there were essentially zero false negative results. Of 15,794 patients tested in this study, none of them were falsely identified as negative. It is therefore a perfect screening tool.

There are obvious health economic benefits, fewer invasive procedures, improved perinatal outcomes, and reductions in specialist referrals [page 13]. My experience with cell-free DNA testing in Nevada is that it is very well accepted by patients, by providers, and other clinicians [page 14]. It is very easily utilized both in private offices and clinics. One need not drive all the way to a center to have the test done; it can be provided in an office in Ely just as easily as it can be provided in Las Vegas. There is a very high comprehension of the test's strengths and weaknesses that clinicians, patients, and underwriters have. We recognize that there is unequal access to this particular test in Nevada geographically, demographically, and financially. It is such a great screening tool, because, as I said, the chance that it is wrong is very, very low [page 15]. We also know there are risks associated with diagnostic testing, and the cell-free test has a very low risk and leads to far fewer diagnostic procedures. It is, by definition, a safer choice, and the goal here is to provide better access and more equity in access to our patients and pregnant women in the state of Nevada.

**Chair Nguyen:**
Assemblywoman Krasner, do you have any additional parts to your presentation?

**Assemblywoman Krasner:**
No, I do not. We are available for questions.

**Chair Nguyen:**
Are there any questions?

**Assemblyman Orentlicher:**
Thank you, Assemblywoman Krasner, for bringing this bill forward. It is very important for all the reasons Dr. Slotnick talked about. I see the access will start at age 40. My sense is that obstetricians typically offer this earlier than age 40. How did you pick the age 40 threshold?

**Assemblywoman Krasner:**
According to Dr. Slotnick, the appropriate age is 35 and older. As Nevada has a budget deficit, and hoping to keep the fiscal note as low as possible, I asked for the age to be 40 and over, fully knowing and promising Dr. Slotnick that I would come back two years from now and change the age down to 35.

**Chair Nguyen:**
Are there other questions from Committee members?

**Assemblywoman Summers-Armstrong:**
Thank you so much for bringing this wonderful bill and Dr. Slotnick for a really interesting presentation. Has anyone done any research to see if we stick with the age of 40, how many births would we miss if we had not left it at age 35? Do we have any data that would show what the difference is? Assemblyman Orentlicher's question is valid. I had a late-in-life pregnancy my third time, had to go through all of this and have invasive tests. We are talking about discrepancies in delivery in communities of color, and we are talking about the number of births that are paid for by Medicaid. How many are we going to miss by leaving this at 40 instead of bringing it down to 35?

**Assemblywoman Krasner:**
It is not going to stay at 40. It is only going to be at 40 for two years until the next session. Then it is going to go back down to age 35. I asked DuAne Young from Medicaid to give me the statistics on age 40 and age 35, knowing we are in a budget deficit. For age 40, for two years, it is a little under $100,000. For age 35, for two years, it is $600,000. I am hoping to get this passed this session just for two years. I fully intend to come back two years from now and see if I can move the age down to 35.

**Nathan Slotnick:**
There is a distinction between what is considered to be high-risk and non-high-risk. There has been a cutoff established regarding patients at high risk for chromosomal number abnormality that has been established for many years, and that is age 35. The high-risk definition is one that has been accepted through a number of different societies including ACOG and the Society of Maternal-Fetal Medicine. The ability to provide services for this

noninvasive test, though, lags in Nevada. The access for a woman in Elko is different from a woman who lives in Reno or in Las Vegas. We are trying to initiate the conversation, the appreciation, and the definition and understand the science and clinical medicine behind it so that this can be an ongoing and dynamic approach to improving the health care for families and pregnant women in the state. It will not stop here; it will continue, and we will continue to discuss it as time moves on.

**Chair Nguyen:**
Assemblywoman Summers-Armstrong, does that answer your question?

**Assemblywoman Summers-Armstrong:**
It does. I understand Assemblywoman Krasner's thought process, and I am grateful that this is going to be a continuing conversation. When we are talking about maternal health and what we are delivering to our communities, sometimes we get caught up on the raw numbers and do not consider what it means if we do not institute things. Are we crunching the numbers to see how much it costs if we do not address some of these issues in vitro through prenatal and then end up with problems after birth? That is something to consider as we are crunching the numbers, but I appreciate this, Assemblywoman Krasner, and thank you very much.

**Chair Nguyen:**
Are there other questions from Committee members? [There was no reply.] Seeing none, we will begin testimony in support, opposition, and neutral. [The Chair reminded callers of the protocol and procedures for virtual meetings.]

**Connor Cain, representing HCA Healthcare, and Sunrise Hospital and Medical Center:**
We are in support of A.B. 198. I would like to thank Assemblywoman Krasner for her leadership and hard work on this incredibly important issue. Rather than repeat my prior testimony in support of A.B. 189, I will just say that covering genetic testing for birth defects is something that could lead to improved outcomes for many of the thousands of babies born every year in Sunrise Hospital who are covered by Medicaid. On a personal level, after a positive diagnostic test a little more than a year ago, my wife was able to get additional care from a high-risk pregnancy center, and today I can report that we have a happy and healthy eight-month-old baby girl.

**Melissa Clement, representing Nevada Right to Life:**
We support the amendment to A.B. 198 and we thank the sponsor for adding it. While we support testing so that a parent can prepare for a potentially adverse diagnosis, we are concerned that such a diagnosis could be used to screen out babies who are potentially less than perfect. That is certainly not the point of the bill, and we thank the sponsor again for her help.

**Hannah Baer, representing Coalition for Access to Prenatal Screening:**
[Hannah Baer submitted a letter in support Exhibit I]. The Coalition for Access to Prenatal Screening is a collaborative alliance of seven leading genetic testing companies in the

United States that seeks to improve access to noninvasive prenatal screening for all pregnant women. The coalition thanks the Assembly Committee on Health and Human Services for the opportunity to speak in support of A.B. 198, and the coalition thanks the bill sponsors and cosponsors for bringing attention to this important issue of access to prenatal screening.

Women enrolled in Nevada Medicaid currently do have access to maternal serum screening, including amniocentesis, which provides some information if there is an increased risk of giving birth to a child with a genetic disorder. Noninvasive prenatal screening (NIPS) provides the same information through a noninvasive simple maternal blood draw and is a safer and more accurate screening. A woman with an affected pregnancy may need to deliver her baby in a hospital equipped with resources to manage a high-risk birth and special-needs birth. The information NIPS provides helps to improve maternal health outcomes. State Medicaid programs and commercial payors recognize noninvasive prenatal screening as a sensitive and specific prenatal screening tool that should be offered to all pregnant women. Many of Nevada's surrounding states, including Oregon, Idaho, and California effective in 2022, cover this screening for all pregnant women. These are 3 of the 18 state Medicaid programs that cover NIPS for average risk pregnant women. Five of these 18 states' changes fall into the [unintelligible] Practice Bulletin 226 by the American College of Obstetricians and Gynecologists in August 2020 which recommends the screening regardless of age or risk. Furthermore, 25 state Medicaid programs cover the screening for women considered high-risk. In contrast, currently Nevada Medicaid remains one of only seven states and Washington, D.C., that deny this coverage to all pregnant women, even those considered high-risk.

On the commercial payor side, more than 65 plans nationally covering more than 200 million lives cover NIPS for average-risk women. This includes almost all Blue Cross Blue Shield plans, Aetna, UnitedHealthcare, Cigna, and Anthem. The majority of commercially covered lives enjoy access to noninvasive prenatal screening, and this creates a disparity of care for lower-income women who live in a state in which Medicaid denies coverage. In Nevada there is a disparity of care even within the Medicaid program, as all three of its managed care organizations provide coverage of noninvasive prenatal screening. Noninvasive prenatal screening provides better detection of common genetic disorders with a lower false positive rate resulting in fewer follow-up procedures and procedure-related losses. Since Nevada Medicaid's fee-for-service program does not currently cover the screening for any pregnant woman, it creates an environment that is less safe for the mother and child. In addition, there is a clear disparity in access to prenatal care for women in Nevada's Medicaid program, compared to their counterparts enrolled in commercial plans. Coalition for Access to Prenatal Screening members support A.B. 198, as this legislation seeks to reduce the gap in coverage and increase access to prenatal screening for Nevada Medicaid enrollees. This concludes my summary of the coverage landscape and trends regarding NIPS.

**Chair Nguyen:**
May we go to our next caller in support? [There were no more callers.] Do we have any callers in opposition to A.B. 198? [There were no callers.] Do we have any callers in neutral?

**Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services:**
Hopefully everyone can see this slide on the normal human karyotype [slide not made available]. Humans have 46 chromosomes and when they are paired up, there are 23 pairs. Things go awry when let us say a pair of chromosomes only has one chromosome, or it has three chromosomes. For instance, Down syndrome is trisomy 21, which means instead of having two chromosomes, there are actually three.

Now I will share another slide [Exhibit J]. This is what Nevada Medicaid covers for prenatal testing. These are all optional. We do not force any women to get tested. Prenatal screening and diagnostic testing are optional. Screening identifies the potential chance that a fetus has an abnormal number of chromosomes. When a screen comes back positive, there is a higher chance of there being an abnormality. When it comes back negative, there is a lower chance. Within screening there is a first trimester screen, second trimester screen, and then the noninvasive prenatal screening, which is also called cell-free DNA screening. In the first trimester screen they take a blood panel with an ultrasound, and it screens for trisomy 18 and Down syndrome.

**Chair Nguyen:**
Ms. Lynch, there might have been some confusion. We are taking testimony in neutral now. This may have been more appropriate during the presentation. I received the slides you are referencing, although I do not know if other Committee members did. Will you and Assemblywoman Krasner make sure you get those slides to our policy analyst so they can be distributed to the rest of the Committee.

**Erin Lynch:**
I was left out during the presentation and this was provided as an exhibit and is posted online.

**Chair Nguyen:**
How many slides do you have to present?

**Erin Lynch:**
Just this one slide.

**Chair Nguyen:**
Go ahead and continue.

**Erin Lynch:**
The second trimester screen also screens for the same chromosomal abnormalities and also screens for neuro tube defects. The first and second trimester screens are covered by Nevada

Medicaid. Obviously, the NIPS test is not covered. It does screen for one more trisomy, which is trisomy 13. On the diagnostic side, whenever a person tests positive for one of these prenatal screenings, the physician is probably going to recommend a diagnostic test to determine whether that fetus has that abnormality. Nevada Medicaid does cover karyotype testing. The samples are collected via amniocentesis or chorionic villus sampling testing. We also cover the FISH [fluorescence in situ hybridization] test which is the same type of process. We are in the process, and it is coming very soon, of covering the chromosomal microarray analysis test. We do not cover individual DNA tests. For instance, if you wanted to test the baby for cystic fibrosis, we do not cover those individual tests. We do allow for items that we do not cover to be overridden with the EPSDT [Early and Periodic Screening, Diagnostic, and Treatment] benefit as an exception when it is medically necessary for pregnant women under the age of 21. Also, at birth, Nevada Medicaid does cover newborn screening, which screens for 31 chromosomal DNA metabolic disorders.

An advantage is that NIPS screens for trisomy 13. The American Congress of Obstetricians and Gynecologists recommends that all women be offered prenatal screening regardless of age, but we currently only offer two types. This bill would offer a third type. You should also have information about the fiscal impact of this bill.

**Nathan Slotnick:**
There are screening tests and then there are screening tests. The currently available first trimester screening test will miss 20 percent of all Down syndrome pregnancies and does a terrible job with trisomy 18 and 13. That is why we are discussing this particular noninvasive test. The second trimester screen misses even more. The whole point of the process is to provide a better and safer test to the families and pregnant patients. Screening is not equal across the board. Newborn screening has nothing to do with chromosome issues. It is only for metabolic diseases and single gene abnormalities.

**Chair Nguyen:**
Does anyone have questions for Ms. Lynch or Dr. Slotnick regarding those two last slides that were presented?

**Assemblyman Orentlicher:**
I wanted to follow up on something you just said, Dr. Slotnick, which was that the tests we are not covering are more sensitive or more likely to pick up abnormalities than the tests we are using. Does that mean we can substitute the tests we are not using for the tests we are using and then address some of the fiscal concerns?

**Nathan Slotnick:**
That is the national approach right now—that we should use the DNA test for all pregnancies, for all women as a replacement for the currently available first trimester screening and second trimester screening, which is less sensitive and less specific.

**Assemblywoman Summers-Armstrong:**
If this more sensitive test was used in the second trimester, and we did not use the other less-effective test, could we ask DHHS how much money we would save based on the last two years of administering tests. If that number is equal to the difference between testing at 40 years and testing at 35, what would that look like?

**Erin Lynch:**
We will get back to you on that.

**Chair Nguyen:**
I do not see further questions. Is anyone available to testify in neutral? [There were no callers.] I will turn this back over to Assemblywoman Krasner for closing remarks.

**Assemblywoman Krasner:**
I hand-delivered this exhibit to each of your offices. It shows the prenatal screening tests currently available to Medicaid recipients in Nevada. I would like to thank Dr. Slotnick for his excellent presentation and I would appreciate your support of A.B. 198.

**Chair Nguyen:**
I will close the hearing on A.B. 198. Now we will take public comment. [There was none.] Are there any comments from Committee members before I close the meeting? [There was no reply.] We are adjourned [at 3:56 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 conceptual amendment to Assembly Bill 189, dated March 8, 2021, presented and submitted by Assemblywoman Michelle Gorelow, Assembly District No. 35.

Exhibit D is a letter dated March 10, 2021, submitted by Lauren Schwabauer, Private Citizen, Reno, Nevada, in support of Assembly Bill 189.

Exhibit E is a letter dated March 8, 2021, submitted by Nataly Arellano, Private Citizen, in support of Assembly Bill 189.

Exhibit F is a conceptual amendment to Assembly Bill 192, dated March 10, 2021, presented and submitted by Assemblywoman Lesley Cohen, Assembly District No. 29.

Exhibit G is a proposed amendment to Assembly Bill 198, dated March 9, 2021, presented and submitted by Assemblywoman Lisa Krasner, Assembly District No. 26.

Exhibit H is a copy of a PowerPoint presentation titled "Noninvasive Prenatal Screening: Innovations in Prenatal Care—A Nevada Perspective," dated March 10, 2021, presented and submitted by Nathan Slotnick, M.D., Private Citizen, Reno, Nevada, in support of Assembly Bill 198.

Exhibit I is a letter dated March 8, 2021, signed by Marily Rhudy, Secretary and Director, Coalition for Access to Prenatal Screening, submitted by Hannah Baer, representing Coalition for Access to Prenatal Screening, in support of Assembly Bill 198.

Exhibit J is a document titled "Prenatal Testing Two kinds of prenatal genetic tests—Screening & Diagnostic," presented and submitted by Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services, regarding Assembly Bill 198.