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

Eighty-First Session
March 24, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:35 p.m. on Wednesday, March 24, 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:

Assemblywoman Lesley E. Cohen, Assembly District No. 29
Assemblyman Howard Watts, Assembly District No. 15
Assemblywoman Brittney Miller, Assembly District No. 5

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Quentin Savwoir, Deputy Director, Make It Work Nevada
Alexandra Gunter, Doula, Reno Doula Project
Lauren Kalogridis, Program Manager, Thrive Wellness of Reno
Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services
Joanna Jacob, Government Affairs Manager, Clark County
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Ashley Dodson, representing Make It Work Nevada
Erika Minaberry, Private Citizen, Reno, Nevada
Tiara Moore, Housing Justice Organizer, Progressive Leadership Alliance of Nevada
Lashonda Marve-Austin, Private Citizen, Reno, Nevada
Tara Raines, Private Citizen, Las Vegas, Nevada
Cristina Hernandez, Private Citizen, Las Vegas, Nevada
Miaya Bennett, Private Citizen, Las Vegas, Nevada
Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services

Chair Nguyen:
[Roll was taken.] We are going to start the presentation for our Assembly bill today, and then we are going to move to our work session. At this time, I will open the hearing on Assembly Bill 256.

Assembly Bill 256: Provides for Medicaid coverage of doula services. (BDR 38-849)

Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6:
Today, I am presenting Assembly Bill 256, which would enable Medicaid coverage for nonmedical doula services. I would like to start this presentation by sharing a personal story. In 1987 I found out I was pregnant with my first child. I was living with my first husband in Visbek, West Germany. We were stationed at an Air Force forward operating location. The nearest military hospital was more than two hours away in Bremerhaven. Because of the distance, I was given the option to have my baby at a local German hospital. I did not know it at the time, but part of the continuum of care included a midwife. Her name was Geisela Busse. She was a stout, dark-haired, no-nonsense woman who spoke very little English. Although she had a firm demeanor, Frau Busse exuded kindness and competence, just what

this first-time mom needed to get through pregnancy and delivery while living over 5,000 miles from my mom, who would not be able to attend the birth.

Our first meeting was at my house with my landlord's wife as an interpreter. Frau Busse asked lots of questions and made suggestions on room temperature, baby bed, and how much time to put the baby in the window each day to get sunlight. In the weeks before delivery, I attended Lamaze and La Leche League classes at her home. She was my rock throughout the birthing process. Epidurals were not common practice there. Frau Busse got me through the birth process with breathing, concentration, touch, and encouragement. She visited me every day in the hospital after I gave birth. I am telling you this story to illustrate the difference it can make when a mom has support before, during, and after delivery.

Current best practice is to have a nonmedical doula providing support solely for the mom while the midwife or physician delivers and cares for the baby. I was lucky to have had an extremely skilled midwife who was able to attend me in the delivery room. If there had been any complications, her attention would have shifted, and rightfully so, to the baby and away from me. The goal of this bill is to ensure that both mom and baby have the individualized support they need throughout the entire birth process. At this time, I will hand the presentation over to Quentin Savwoir so he can explain how and why his organization is engaged in advocating for this bill.

Quentin Savwoir, Deputy Director, Make It Work Nevada:
We work alongside Black women and Black families to build power for economic, racial, and reproductive justice. Part of the mission of our organization is to advocate for the health and vitality of our community members. Assembly Bill 256 is anchored in that intention.

We are facing a national maternal health crisis in this country, as the United States is the most dangerous place in the developed world for an expectant parent to give birth. The reality is even more grim for Black women who die at a disproportionately higher rate than their counterparts. For every 100,000 live births, 43 Black women die. When I first heard this statistic, it devastated me. It devastated me because I could not help but think of all the new babies born into this world who would not have their mothers. I was overcome with grief, wondering how many new Nevadans would not immediately know the fierce protection, unconditional love, and comforting warmth of their mama.

It did not take long for us to find out that the national trends we are facing as a country are particularly present here in Nevada. We conducted field research in a series of focus groups in order to best understand the health needs of our community members. Our Black women's agenda survey, a survey of more than 1,000 Black women in Nevada, discovered that more than one-fifth of our respondents reported maternal health as their most preeminent and pressing issue. We also found that one-fifth of respondents reported feeling like they had no control over their bodies or the decisions associated with their bodies.

In the series of focus groups we hosted, we were able to dig a little deeper. It was in these conversations that we learned the troubling reality that postpartum has on parents. The

women and birth parents we spoke to talked about being stressed, fatigued, and experienced issues with breastfeeding amongst other hardships that a nonmedical doula would be capable of supporting a parent through. In these same conversations, nearly one-third of our participants reported not having access to prenatal care or prenatal services at all. Finally, these conversations with our community members revealed that doulas would be the most helpful resource during pregnancy, alongside parenting classes and resources to help with postpartum depression.

Our research and conversations culminated in the pursuit of this legislation. Expanding Medicaid to provide for doula services to expectant parents and mothers is the best way to help mitigate subpar birth outcomes, ensuring new Nevada children are getting a healthy and thriving start, and serve as a cost-saving measure for our state. Assembly Bill 256 is community-driven policy that, at its core, is about our Nevada children. What kind of Nevada do we want to see them born into? Hopefully, it is one where we see the value in their life before they even arrive. Hopefully, it is one where we ensure that the mother or birth parent has access to any and all the resources that can not only ensure a safe and healthy home birth, but also ensure a postpartum period that is met with support and ease, instead of trauma and stress. We can do something about this, and we should.

Alexandra Gunter, Doula, Reno Doula Project:
The Reno Doula Project was started in 2012 as a way to help mothers gain access to doulas. Historically, having a doula was a thing of privilege reserved for the upper class. Through the Reno Doula Project, we have been able to close this gap and increase access to doulas by reducing the cost through an income-based sliding scale, ensuring that women of all income levels are able to hire doulas.

There is no doubt that doulas provide a necessary service. Women who have doulas attend their births have lower rates of unnecessary interventions during their labors and higher rates of birthing satisfaction. More importantly, births attended by doulas have fewer neonatal intensive care unit admissions, higher rates of breastfeeding initiation, and a longer duration of breastfeeding. In Nevada, only 21 percent of our infants are still exclusively nursing at six months, when breast milk can be both lifesaving and cost-saving for Nevada families. We need to do anything we can to support that.

In addition to the Reno Doula Project, I am also the director of postpartum services at another doula company, Bright Heart Birth Services. Bright Heart has worked tirelessly to make the role of doula a legitimate role within this field. We are not medical professionals, but we are professionals. Careful attention to scope of practice, continued training, and commitment to our clients before, during, and after labor has paved a path for doulas to be well-regarded within my community. I am so happy to testify in support of more doulas at more births.

This past year, the Reno Doula Project has had the honor of accepting a sponsorship from Anthem Medicaid to provide 50 of their members with doulas starting in 2021. Anthem has put their money where their mouth is, both in terms of considering doula support as a

cost-saving measure and enriching service to their members. This sponsorship is an opportunity to further legitimize doulas within the field of perinatal support. People are watching us because they know what we are capable of. I thank you for your time today and ask for your support on this bill to include doula services as a Medicaid-covered benefit.

Lauren Kalogridis, Program Manager, Thrive Wellness of Reno:
I am a doula with Reno Doula Project, Bright Heart Birth, and the Anthem Medicaid project, as well as a perinatal psychotherapist and program manager at Thrive Wellness of Reno which has the only perinatal intensive mental health patient program in Nevada. I will share with you some statistics that back up some of what folks are speaking to in the narrative form [Exhibit C]. Of the 36,000 births that happen in Nevada annually, about one-third are performed by cesarean and about 10 percent are preterm births [page 2]—both of which have disproportionate numbers of Black women reflected in those demographics. As far as the maternal mortality crisis Quentin Savwoir referenced, Nevada is one of 48 states within the United States that over the last 20 years has seen a 27 percent increase in our maternal mortality rates. In Nevada in 2018, 76 percent of the deaths were people covered by Medicaid. Black and Native American women have significantly higher maternal mortality rates than white women. In national averages, there is a two- to five-times higher chance for a Black or Native American woman to die due to pregnancy-related causes than a white woman. In Nevada, Black women have been shown to be dying at rates twice as high as white women. In Nevada, our infant mortality rates increased 6 percent between 2016 and 2018. Again, this is a place where we see a racial disparity in that Black babies are twice as likely to die as white babies nationally [page 3].

Births represent a significant cost expenditure here. In Nevada, 61 percent of births are covered by Medicaid, and of the 20 most expensive hospitalization conditions covered by Medicaid, 5 of them are related to perinatal experiences [page 4]. Cesarean births are a huge piece of this, in that they cost twice as much as a vaginal birth, representing an additional $4,500 per client.

Doulas have been shown to meet what the U.S. Department of Health and Human Services National Quality Strategy calls the "Triple Aim," which is not only improving health outcomes and quality of care, but also increasing cost savings [page 5]. This is the Cochrane analysis, which shows that not only are doulas effective in decreasing cesarean births, almost by 30 percent, and preterm births, as well as other expensive and high-touch intervention such as vacuum extractions and epidurals [page 7], but it also increases the self-reports of clients who say they have more positive birth experiences with doulas.

When we factor in cost-saving potential, just factoring in the primary cesarean rate by reducing unnecessary primary cesareans, it reflects at least $15 million of projected savings a year. That is not including subsequent cesareans, costs associated with preterm births, and other high-cost interventions such as epidurals, et cetera.

I hope you will see that there is extensive evidence that backs up doulas as an intervention that meets the triple aim. A recent Cochrane Systemic Review indicated that all women

should have continuous support during labor, and that there are no known harms of doula care [page 8]. The American Journal of Obstetrics and Gynecology did an extensive review of 41 birth practices, and doulas were one of only three to receive an "A" grade. They recommended that continuous labor support, such as that provided by doulas, to be one of the most effective interventions to improve labor and delivery outcomes.

Thank you for your time and consideration and thinking about how this is really an intervention that serves so many purposes for the state of Nevada and the people who live here.

Assemblywoman Summers-Armstrong:
I am going to close this presentation with a screen shot. [unable to share screen]

Chair Nguyen:
You will have the opportunity to make a closing statement after the conclusion of testimony and questions, so we can come back to you. In the meantime, we can have someone from our technical services unit help you with that.

Assemblywoman Summers-Armstrong:
That is fine.

Chair Nguyen:
Do you have any other presenters?

Assemblywoman Summers-Armstrong:
No, that is it. You have heard our story. We will be available for questions.

Chair Nguyen:
At this time, I will pause the hearing on A.B. 256 and move into our work session. I will begin the work session with Assembly Bill 96. Mr. Ashton will provide a summary of the bill and the amendment.

Assembly Bill 96: Creates the Emergency Response Employees Mental Health Commission. (BDR 40-96)

Patrick Ashton, Committee Policy Analyst:
Just as a reminder, as nonpartisan staff I cannot advocate nor oppose any measures you will consider today. You should have received the work session document by email, and you can also find it on the Nevada Electronic Legislative Information System. Assembly Bill 96 was heard on March 17, 2021. The proposed amendment to this bill will replace the contents of A.B. 96, so I will go straight to the amendments. Attached is the proposed conceptual amendment for A.B. 96 [page 2, Exhibit D]. Assemblywoman Lesley E. Cohen proposes to replace the contents of A.B. 96 with the following provisions:

1. Add a section authorizing a governmental entity that licenses and regulates first responders to enter into a contract with a nonprofit organization to carry out a program to provide peer support counseling for first responders. Such contract must require the nonprofit organization to: (1) Establish and operate a toll-free hotline for emergency response employees; (2) Establish and maintain a network of peer support counselors to provide peer support counseling to persons who call the toll-free hotline; and (3) Establish and maintain an Internet website that provides certain information.

2. Require the Division of Public and Behavioral Health of the Department of Health and Human Services to post on an Internet website maintained by the Division information concerning peer support services available to emergency response employees.

3. To the extent of available funding, require the Division to collect and report certain information relating to suicide or suicide attempts by emergency response employees to the chief medical officer.

Chair Nguyen:
Are there any questions from Committee members before we take a motion? Seeing none, do I hear a motion to amend and do pass A.B. 96?

> ASSEMBLYWOMAN PETERS MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 96.
>
> ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblywoman Titus:
Although I certainly appreciate what the bill is attempting to do, I do not think it reaches or even comes close. I am concerned that there is some duplication of services. Mandating a toll-free hotline for first responders is also a duplication of services, and we really need to be concentrating on the "988" hotlines, so for that and several other reasons, I will be voting no on this bill.

Chair Nguyen:
Is there any other discussion from Committee members? [There was none.]

> THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

The motion carried. I will assign the floor statement to Assemblywoman Cohen.

Next, we will move on to Assembly Bill 192.

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

Patrick Ashton, Committee Policy Analyst:
The Committee heard Assembly Bill 192 on March 10, 2021. The bill requires a physician or other person who attends to a pregnant woman to examine and test the woman for certain sexually transmitted infections unless the woman opts out of such examination and testing.

Additionally, the bill:

- Requires an emergency department in a hospital or other medical facility admitting a pregnant woman to examine the woman for syphilis under certain circumstances;
- Revises the times at which a pregnant woman must be tested for syphilis;
- Replaces the misdemeanor violation for violating syphilis testing requirements with a civil penalty;
- Authorizes the imposition of a civil penalty against a person who violates the requirements concerning testing for certain sexually transmitted infections; and
- Removes the penalty for a pregnant woman who refuses treatment for syphilis.

Committee members, the attached conceptual amendment is a new version just provided to the Committee recently. The only change to the amendment is in item 5 of the bill, and you will also see an updated conceptual amendment attached to this bill page [page 3, Exhibit E].

Amendment 1 replaces references to "a laboratory approved by the State Board of Health" in sections 1 and 2 of the bill with "a laboratory licensed pursuant to Chapter 652 of NRS."

Amendment 2 removes provisions requiring that certain testing be done without charge.

Amendment 3 clarifies that hospital emergency departments and medical facilities must:

a. Ask women of childbearing age—as defined by the Centers for Disease Control and Prevention—whether they are pregnant.

b. Seek consent from the pregnant woman and commence treatment for syphilis if the blood test results show the woman is infected with syphilis and if the result is received while she is in the emergency department or medical facility.

c. Indicate the case involved a pregnant woman when notifying the local health authority of a confirmed case of syphilis in a pregnant woman.

Amendment 4 removes in section 5 of *Nevada Revised Statutes* 442.010 the condition that the pregnant woman may solely object to the taking of a blood sample or the serological test

based on the tenets or practices of her religion, thereby allowing a pregnant woman to object for any reason.

Amendment 5, and this is where the actual change happens, requires a health insurance provider regulated by the state of Nevada to pay for the examination and testing mandated by sections 1 and 2 of this bill, and clarifies that the insurer may not be required to pay more than the lowest rate prescribed by contract between the insurer and the facility, provider, or laboratory. The change refers to "the facility," and you can also find this in the conceptual amendment [page 3, Exhibit E].

Amendment 6 revises the list of other medical facilities to which the requirements of this bill apply, and a list of these facilities is in the work session document [page 2].

Amendment 7 clarifies in section 2, subsection 1, paragraph (c), that hospitals and other medical facilities must test all pregnant women who are evaluated or treated in an emergency department or other medical facility, regardless of their admission status.

Chair Nguyen:
Thank you for that summary. Do we have any questions from Committee members? Seeing none, do I have a motion to amend and do pass?

> ASSEMBLYWOMAN GORELOW MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 192.
>
> ASSEMBLYWOMAN PETERS SECONDED THE MOTION.

Is there any discussion on the bill?

Assemblywoman Titus:
Unfortunately, I will not be in support of this bill. I sat on the interim Legislative Committee on Health Care and we did address the fact that Nevada ranks number one in neonatal syphilis, which is not acceptable. Unfortunately, I do not feel this bill will solve that, and it also may expand some other concerns that we did not seek—asking that these tests be done, fining providers, extending it to not just labor and delivery or emergency hospitals but also to psychiatric hospitals, rural clinics, and mobile units that may not have that testing available on site, and then fining them if they do not give that test. The fact that these tests can take days to get back and then holding someone liable for those is not acceptable to me.

Chair Nguyen:
Is there any other discussion on the measure? We have the bill's sponsor present here.

Assemblywoman Lesley E. Cohen, Assembly District No. 29:
When this came out of the interim committee, it was unanimous except for Senator Hardy and Assemblywoman Titus. The concern they voiced was that the Department of Health and Human Services and the Nevada Hospital Association did not have an agreement. In fact,

they have just recently come to an agreement, which was why we were not able to have the complete work session document to you earlier. We actually reduced the number of medical facilities. We took out a lot of medical facilities compared with how the bill came out of the interim committee.

Chair Nguyen:
Madam Secretary, please call the roll.

> THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

I will assign this floor statement to Assemblywoman Cohen as well. Next, if we could begin the work session on Assembly Bill 181.

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

Patrick Ashton, Committee Policy Analyst:
The Committee heard Assembly Bill 181 on March 8, 2021. Committee members, please be advised that I sent you by email an updated work session document for A.B. 181 recently, and it is also updated on the Nevada Electronic Legislative Information System.

Assembly Bill 181 requires health insurers that provide health coverage for their employees to comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which prohibits group health plans and health insurance issuers that provide benefits for mental health or substance use disorders from imposing less favorable benefit limitations on those benefits than on medical and surgical benefits. The bill also requires each insurer or other organization subject to those requirements to submit to the commissioner of insurance a report containing certain information that demonstrates compliance with the Act. This bill also requires the State Board of Health of the Department of Health and Human Services to adopt regulations requiring certain medical facilities and facilities for the dependent to report information relating to suicide to the chief medical officer; and authorizes the Division of Public and Behavioral Health, Department of Health and Humans Services, to take certain actions against a facility that fails to report the required information.

Dr. Stephanie Woodard, Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services, has submitted the first amendment, and you will also see an attached memorandum titled "AB181 (BDR 40-522) Proposed Amendment" [pages 5-12, Exhibit F]. This amendment:

1. Removes language in the bill requiring certain facilities to report information relating to suicide to the chief medical officer. Instead, it requires certain individual providers of health care to provide such information to the chief medical officer using the same procedures as are currently used for providing information relating to communicable diseases and drug overdoses.

Next, Assemblywoman Peters proposes to amend the bill to:

2. Require the chief medical officer to annually submit to the executive director of the Patient Protection Commission, Office of the Governor, a written report summarizing any information relating to suicide received by him or her during the immediately preceding calendar year.

3. This amendment has been updated from the previous work session document I emailed to you last night. Remove from section 9 insurers or other organizations providing health care coverage pursuant to *Nevada Revised Statutes* (NRS) Chapter 287, thereby removing those entities from any requirement to adhere to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act and any reporting requirement prescribed in that section.

I will now move on to the conceptual amendment provided by the Division of Insurance of the Department of Business and Industry which is also attached to the work session document [pages 3 and 4, Exhibit F]. This amendment:

4. Clarifies that the Division will collect and aggregate, but not analyze, any information provided to the Division pursuant to section 9 of the bill.

5. Requires the commissioner to keep certain data confidential.

6. Requires the commissioner to annually submit to the executive director of the Patient Protection Commission, the Governor, and the Legislature, a written report, which aggregates certain information received by the commissioner.

7. Authorizes the commissioner to adopt regulations relating to the collection of certain information from certain insurers and other organizations providing health care coverage.

8. Clarifies that an insurer or other organization providing health coverage may provide a copy of a required federal report as required by Title II, Section 203, of the Consolidated Appropriations Act of 2021 to the commissioner that demonstrates compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. The commissioner may request supplemental information from these entities if the federal report does not fulfill all the mental health parity requirements set forth in federal law.

Chair Nguyen:
Committee, do you have any questions? I know Assemblywoman Peters would like to make a statement about the work session document and some of the amendments.

Assemblywoman Peters:
This was really a group effort, attacking the issues on both sides of what is the most important piece—the patient. I want to thank all the stakeholders who worked with me on this during the past couple of weeks and beyond. I want to clarify that in the amendment, I proposed to remove the NRS Chapter 287 reference in section 9. It really does not affect the bill's efficacy; it comes in line with the Mental Health Parity and Addiction Equity Act which already exempts those programs. I want to clarify that.

Assemblywoman Titus:
Thank you for the clarification, but I am looking at the amendment suggested by Dr. Stephanie Woodard, the green text. There is a lot of text being removed, but then it looks as though we are moving existing language from another statute, NRS 441A.120, "the Board shall adopt regulations . . . control of communicable diseases." I believe the Board already has regulations. Is that new statute, because it is in green, which would be new wording? It also talks about adding the green language concerning suicide statistics in blue. Are we changing where that chapter is? That language looks familiar, but it is written in green, so it looks like new language.

Assemblywoman Peters:
I believe Dr. Woodard is on the phone and can address that question.

Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services:
The conceptual amendment was not intending to change existing reporting requirements under that section of existing statute but was to add into that same area of language the reporting requirements for suicide.

Chair Nguyen:
Ms. O'Krent, do you want to confirm this?

Karly O'Krent, Committee Counsel:
That is correct. The green language in NRS 441.120 is existing language, but we have simply added the new requirements that will go into that same chapter.

Chair Nguyen:
Is there any further discussion on the matter? [There was none.] At this time, I will entertain a motion.

> ASSEMBLYWOMAN BENITEZ-THOMPSON MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 181.
>
> ASSEMBLYWOMAN PETERS SECONDED THE MOTION.

Is there any further discussion on the motion?

Assemblywoman Titus:
Unfortunately, I am going to vote no on this bill. I think there is a lot of language in the bill that is appropriate but premature and has not been really vetted. The consequences of this language, when we never did get a straight answer on a certain timetable, and I, as a provider, have concerns about possible suicide attempts versus accidental overdoses. I understand what we are trying to achieve; I think this bill does not do that and it may add extra complications with false information and false reporting.

Chair Nguyen:
Are there any further comments on the motion? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

I will assign the floor statement to Vice Chair Peters.

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

At this time, we will move on to our next bill, Assembly Bill 197. Mr. Ashton, please summarize the bill and any amendments.

Assembly Bill 197: Revises provisions relating to persons experiencing homelessness. (BDR 11-682)

Patrick Ashton, Committee Policy Analyst:
The Committee heard Assembly Bill 197 on March 17, 2021. It authorizes a minor who demonstrates through documentary proof that he or she is living apart from his or her parents or legal guardian to consent to certain health examinations or services provided by certain providers of health care for himself or herself or his or her child. The bill removes the requirement that a minor must have lived apart from his or her parents or legal guardian for a period of at least four months. Additionally, the bill prohibits a local or state health officer, a local board of health, a licensed provider of health care, or a public or private hospital from delaying or denying such examination or service because the minor refuses to consent to communication with his or her parent, parents, or legal guardian.

This bill also revises provisions that require the state registrar to provide birth certificates to a homeless person free of charge in certain circumstances by removing a requirement that the person must submit a signed affidavit on a form prescribed by the state registrar stating that the person is homeless. Instead, the person need only sign a statement that he or she is homeless. The state registrar is prohibited from requiring such a statement to be notarized.

Assemblyman Howard Watts proposes the following amendments to section 1 of the bill:

1. Replace "mother" with "parent" in subsection 1, paragraph (c) of *Nevada Revised Statutes* (NRS) 129.030; and

2. Replace "in a physician's judgment" with "in a judgment of provider of health care" in subsection 1, paragraph (d) of NRS 129.030.

Additionally, Joanna Jacob, Government Affairs Manager of Clark County, proposes the following amendment:

3. Revise the bill to add child welfare agencies, acting as a custodian of a child, with the intention to treat child welfare agencies the same as a parent or legal guardian.

You may also see the attached proposed amendment [page 2, Exhibit H].

Chair Nguyen:
Thank you for that summary of the bill. We also have here the bill's sponsor, Assemblyman Watts, and I believe he wants to make a statement regarding the bill. I appreciate everyone's patience. As you know, a lot of these bills came out not necessarily representing the intent some of the presenters assumed they would have, so there have been quite a few amendments and they have not all been drafted in their final forms yet.

Assemblyman Howard Watts, Assembly District No. 15:
I want to thank Assemblyman Orentlicher and Assemblywoman Titus whose suggestions led to the changes in proposed amendments 1 and 2. There have been questions from some of my colleagues about what impact this may have on consent for abortion care. A legal opinion was provided that says because Nevada's existing parental notification statutes remain facially unconstitutional, a minor in Nevada has an existing constitutional right to obtain an abortion under NRS 442.250 without parental consent if the minor gives informed consent under NRS 442.252 and NRS 442.253.

Assembly Bill 197 does not affect such an existing constitutional right. If, in the future, a minor does not have such an existing constitutional right, for example, if Nevada adopts parental notification requirements that are constitutionally permissible, then Assembly Bill 197 could, potentially, have some sort of impact, but as things stand right now, it would have no impact on the ability of minors to seek abortion care with or without the consent of a parent. I wanted to get that on the record.

Chair Nguyen:
Do we have any questions before we take a motion from Committee members?

Assemblywoman Titus:
Thank you, Assemblyman Watts, for that clarification and the additional language. I have a question about the amendment proposed by Clark County. The way I am reading it, it says, "The parent, parents, legal guardian, or custodian of a minor who receives an examination or services . . . are not liable for the payment for that examination . . ." [page 2]. Who is liable for the exam? Who pays for the cost of services? Who will be held accountable?

Assemblyman Watts:
For that question, I would defer to Clark County, if they are available. The intent they provided during the hearing was to add parity between custodians and parents and legal guardians under existing statute.

Chair Nguyen:
We have Ms. Joanna Jacob here to answer that question.

Joanna Jacob, Government Affairs Manager, Clark County:
Assemblyman Watts summarized our intent in adding that to section 1, subsection 7. The parents would not be liable for the cost if they did not consent. The guardian would not be liable for the cost of care if that was not consented to. I can see why that is the public policy being proposed here, and we were asking for parity in that sense. Clark County's child welfare tries to cover the cost for care of the children who are in our custody, and we make all efforts to do that, but we do have situations—runaways, et cetera. We tried to work with Arash Ghafoori and with the bill proponents behind this. We are hoping there are very few occasions when this will have to be invoked, but the intent is to treat us as a parent or legal guardian. The definition in the amendment—NRS 432B.060—for a custodian is actually defined as a person or government organization other than a parent or legal guardian. It is recognizing that legal status of the custodian when we have legal custody of the child.

Assemblywoman Titus:
I was surprised to see this language here, because the purpose of the bill, from what I see, is addressing when the minor does not have a parent, guardian, or custodian. Then, if they have those, they give the consent for treatment. This section of the bill does not address who will pay if the parent, legal guardian, or custodian does give authorization. We do not need this bill if they have received authorization, so I am wondering where that showed up in this bill.

Assemblyman Watts:
I want to note that this amendment was presented during the original hearing for the bill and there were no questions about it at that time. This justification for the amendment was provided then. The situation Ms. Jacob described was a runaway situation. Again, if the child is under the care of a custodian, then this would not apply; it is if a young person who has run away, is homeless, and is not currently under the care of a parent, guardian, or custodian.

Chair Nguyen:
Are there further questions from the Committee? Seeing none, I will entertain a motion.

> ASSEMBLYWOMAN BENITEZ-THOMPSON MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 197.
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Do we have any comments on the motion?

Assemblywoman Titus:
I appreciate what this bill is trying to do—get health care—having been in emergency rooms so many times where I could not treat a child who shows up with a broken arm or other injury until I got parental consent. At the same time, there are some concerns we have regarding this bill and the question we asked of our legal counsel, and some other concerns regarding parental rights. For that reason, unfortunately, I will have to vote no.

Chair Nguyen:
Are there further comments on the motion? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

I will assign the floor statement to Assemblyman Watts. If he is not available, we will have Assemblywoman Summers-Armstrong be the backup.

Next, we will move to Assembly Bill 217. Mr. Ashton, will you please summarize the bill and its amendment.

Assembly Bill 217: Requires training for unlicensed caregivers at certain facilities. (BDR 40-454)

Patrick Ashton, Committee Policy Analyst:
[Patrick Ashton presented the work session document, Exhibit I.] Assembly Bill 217 requires the administrator or other person in charge of designated medical facilities, facilities for the dependent, and other licensed facilities to ensure that each unlicensed caregiver at the facility completes certain training, including training on the topic of the control of infectious diseases. The measure requires the State Board of Health of the Department of Health and Human Services to adopt regulations prescribing training for unlicensed caregivers who provide care at such facilities. The administrator or other person in charge of such a facility shall ensure the implementation of best practices taught in the required training and shall develop, annually update, and provide to certain persons a written plan for the control of infectious diseases at the facility.

Finally, this bill requires the Division of Health Care Financing and Policy of the Department of Health and Human Services to post on the Internet a list of nationally recognized organizations that offer free or low-cost training that meets the requirement of those regulations. There were no amendments.

Chair Nguyen:
Assemblywoman Cohen is here. Do you have any further statements to make on this bill?

Assemblywoman Lesley E. Cohen, Assembly District No. 29:
This bill came out of the interim Legislative Committee on Health Care unanimously. I do not have any amendments, but there have been some stakeholders who did request that some

information be put on the record. Even though some of that was addressed at the hearing, I will quickly go through it. To be clear, when we are talking about unlicensed workers, we are not talking about friends and family caregivers. There is language in some statutes having to do with that, so that is not an issue here.

Additionally, to be very clear, it is the intent of this bill that the training be for no cost or at minimal cost. It is also the intent of the legislation not to add extra training hours, but to help the Department of Health and Human Services prioritize trainings to make sure unlicensed caregivers are given focused training based upon the most recent surveys and citations available. That is not saying that the Board cannot add extra training hours if they believe it is necessary, but we are not looking to duplicate any training people are already receiving.

Chair Nguyen:
Are there other questions from the Committee? [There were none.] Do we have a motion?

> ASSEMBLYWOMAN BENITEZ-THOMPSON MADE A MOTION TO DO PASS ASSEMBLY BILL 217.
>
> ASSEMBLYWOMAN PETERS SECONDED THE MOTION.

Do we have any comments on the motion?

Assemblyman Hafen:
I appreciate the bill's sponsor bringing this forward from the interim committee; however, I still have concerns over who is going to be covering this additional training, and therefore, at this time, I will vote no.

Chair Nguyen:
Are there other comments from Committee members on the motion? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

At this time, I will assign the floor statement to Assemblywoman Cohen, and the backup will be Assemblyman Orentlicher.

I will go back to Assembly Bill 216. Mr. Ashton, will you please summarize this bill and this amendment.

Assembly Bill 216: Requires Medicaid to cover certain services for persons with cognitive impairments. (BDR 38-385)

Patrick Ashton, Committee Policy Analyst:
Assembly Bill 216 requires the Director of the Department of Health and Human Services (DHHS) to include in the State Plan for Medicaid coverage for cognitive assessment and care

planning services for persons who exhibit signs or symptoms of cognitive impairment. The Committee heard this bill on March 15, 2021.

Dena Schmidt, Administrator, Aging and Disability Services Division, DHHS, proposes the following amendments to section 1 of the bill, which are also attached [page 2, Exhibit J]:

1. Revise subsection 1 to state that a person who "experiences" signs or symptoms of cognitive impairment instead of a person who "exhibits" them shall be included in the State Plan for Medicaid coverage for cognitive assessment and care planning services, with the intention to ensure self-reporting patients or caregivers are not precluded from these services.

2. Remove subsection 2, paragraph (d), "Judgment as it relates to safety awareness" from the definition of cognitive impairment to align it with medical terminology. Additionally, clarify that a person may have any one or all of the deficiencies outlined in this subsection.

Assemblywoman Titus proposes the following amendment to section 1, also attached [page 3]:

3. Revise subsection 2 to exclude from the definition of "cognitive impairment" any condition with temporary or reversible effects.

Chair Nguyen:
Do we have any questions from members of the Committee? [There were none.] Do I have a motion to amend and do pass Assembly Bill 216?

ASSEMBLYWOMAN TITUS MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 216.

ASSEMBLYWOMAN BLACK SECONDED THE MOTION.

Is there any discussion or comments on the motion?

Assemblyman Hafen:
I want to thank the bill presenter for reaching across the aisle and working with everyone to get this bill to a place where we could all support it.

Chair Nguyen:
I am sure Assemblywoman Gorelow appreciates that. Do we have any other comments on the motion? [There were none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign this floor statement to Assemblywoman Gorelow.

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

Now, we will go to our last bill, Assembly Bill 228. Mr. Ashton, please summarize the bill and its amendments.

Assembly Bill 228: Establishes provisions relating to children's advocacy centers. (BDR 38-358)

Patrick Ashton, Committee Policy Analyst:
The Committee heard Assembly Bill 228 on March 17, 2021. It provides for the establishment of children's advocacy centers where multidisciplinary teams work to investigate and help children recover from abuse and neglect and to hold perpetrators of abuse and neglect of children accountable. Requirements governing the credentialing and operation of such centers are specified in the bill. The bill also requires the governing body of each county and each child welfare agency to ensure, to the extent that money is available, that children who are victims of abuse or neglect have access to a multidisciplinary team through a children's advocacy center, and it creates the Account to Support Children's Advocacy Centers in the State General Fund, administered by the Division of Child and Family Services, and prescribes certain provisions related to the administration of the account.

Jesse Haw, Chair, Legislative Task Force, Children's Advocacy Centers of Nevada, proposes the following attached amendments [pages 4 and 5, Exhibit L]:

1. Revise section 6, subsection 1, paragraph (b), to clarify that a children's advocacy center must operate in accordance with the standards prescribed by the National Children's Alliance to the extent these standards do not conflict with federal or state law.

2. Clarify in section 6, subsection 4, that children do not have to be victims of abuse or neglect in order to access services of a children's advocacy center. Also, clarify that access to services is not limited to a multidisciplinary team.

3. Revise the bill to ensure all child welfare information can be shared with every member of a multidisciplinary team to support a child's case, including cases with allegations of sexual assault by a child's relative who is not a caregiver.

The next amendment is from the Nevada Justice Association [page 3]:

4. Revise section 6 to provide that a member of a children's advocacy center's multidisciplinary team is only immune from civil liability for any communication with this team. The immunity provisions in the bill for an employee or officer of a children's advocacy center are not modified by this amendment.

Assemblywoman Brittney Miller proposes the following amendment to section 6 [page 2]:

5. Revise subsection 3 to make available by court order confidential information maintained by a children's advocacy center pursuant to this subsection.

Chair Nguyen:
Assemblywoman Miller is here. I think she has some comments to make regarding some of the amendments that were recently added.

Assemblywoman Brittney Miller, Assembly District No. 5:
I would like to thank everyone involved. All of the amendments are friendly after a lot of hard work with multiple parties. The amendments are friendly, and there will be one more amendment submitted. That amendment will be to add additional signers. I knew that would not hold up the work session process, but I will give that to the Committee.

Chair Nguyen:
Do we have other comments?

Assemblywoman Titus:
I support this concept and think it is important. I appreciate everyone reaching out and there were excellent advocates on this bill. Looking at the amendment proposed by the Nevada Justice Association [page 3, Exhibit L], section 6, subsection 2, where "An employee or officer of a children's advocacy center or a member of a multidisciplinary team is immune from civil liability for any action or omission . . . ." You are striking "action or omission" out and only going to give them civil liability protection "for any intra-team communications made"? Are there statutes anywhere else that would give someone trying to do the right thing for these kids' immunity from civil liability? Are we opening up a potential litigation avenue for the Nevada Justice Association? I am having concerns now that I am seeing this amendment.

Assemblywoman Miller:
No, we are not. It is limiting, and that is where the word "intra" comes from so that the people within the actual advocacy team are protected. It is when we start going outside; for instance, if we brought in another social service or other agency or even licensed health care professionals who all are covered under their own protection and insurance. It was to rein it in because of the challenge of the definition of "good faith." "Good faith" covers a multitude of things. We want everyone in the children's advocacy center to be protected to do the reporting they need to do, to have the privileged conversations and communications they need to have, unless by court order, but to make sure it is specific to those who are trained and working within this multidisciplinary team.

Assemblywoman Titus:
As a teacher, you are a mandatory reporter for certain things; as a physician, I am a mandatory reporter for certain things. If I do it in good faith, I am protected. I report because I suspect child abuse. I report that, and I do it in good faith. If I see a broken arm in

the emergency room, I report it because of mandatory reporting, and they come back and tell me I have accused them of being child abusers and it is not true. I am protected because I did it in good faith. I want to make sure that folks who work at the advocacy center and that team are protected, so I needed clarification on that.

Assemblywoman Miller:
Thank you for that. That is exactly the example I used in negotiating these amendments. Sometimes it comes back unsubstantiated, but civil and criminal liability cannot come against us for doing what we did in good faith. We followed our protocol.

Chair Nguyen:
Do we have any more questions for Assemblywoman Miller or our legal counsel regarding the amendments? [There were none.] Do we have a motion?

> ASSEMBLYWOMAN BLACK MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 228.
>
> ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.

Are there any comments or discussion on the motion?

Assemblywoman Titus:
I am going to support this and vote it out of Committee with the right to change my vote because I still have some questions. I support it conceptually, but I want to make sure the amendments have not really changed it.

Chair Nguyen:
Are there any other comments on the motion? [There were none.]

> THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Miller. If she is not available, I will ask Assemblywoman Krasner to be backup.

We will now reopen the hearing on Assembly Bill 256. Assemblywoman Summers-Armstrong, if you would like to conclude your presentation, you are welcome to do so now.

Assembly Bill 256: Provides for Medicaid coverage of doula services. (BDR 38-849)

Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6:
I am ready for questions from the Committee.

Assemblyman Matthews:
Have other states adopted this and have provisions regarding this kind of coverage?

Assemblywoman Summers-Armstrong:
I will ask Quentin Savwoir to answer your question.

Quentin Savwoir, Deputy Director, Make It Work Nevada:
Yes, this has passed in nearly two dozen states. This particular legislation is actually modeled after what has transpired in Oregon. Since this passed in Oregon, they have seen significant cost savings to the state and a reduction in cesarean deliveries. Different states have implemented different models, but this legislation we are trying to pass in Nevada is modeled on what has happened in Oregon.

Assemblywoman Titus:
Thank you for your personal story, Assemblywoman Summers-Armstrong, for presenting this bill, and sharing some of your personal events. It is always good to know how and why these bills get started. My question revolves around current procedural terminology (CPT) coding and Medicaid reimbursement. Is the federal government okay with this?

Assemblywoman Summers-Armstrong:
Yes, that has been done in other states and I believe we have a representative from the Department of Health and Human Services who can speak to how that process works.

DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
There are a variety of CPT codes. Other states have set this up as either billing under the medical professional or a separate provider type. Much like community health workers, it has evolved over the years, and we would treat this as a separate provider type whose codes would be used in tandem with the supervising care physician.

Assemblywoman Titus:
Is there one fee for the services? Can it start at six months prior to delivery and does it follow for a year after? What does that scope look like?

DuAne Young:
The majority of the states we have looked at have a bundled version of the CPTs, and we have looked at that analysis separately. We have not really decided how we will handle it. Will they be separate visits, or will we do one bundled payment for both prenatal and postnatal services? Ms. Lynch will testify later to some of the ideas we have on policy, but we have not landed on what that methodology will be. Most states do a bundled payment.

Assemblywoman Titus:
As a provider, I have delivered hundreds of babies. The biggest risk for obstetrics and delivery is liability insurance and outcomes. Are they going to be mandated to have liability insurance? Who is going to be responsible for liability for bad outcomes?

DuAne Young:
There is a provision in the bill language as it is written that Medicaid would be the regulatory authority. That is not something we typically do, so we have spoken with Assemblywoman Summers-Armstrong about transferring that provision to the Department of Health and Human Services (DHHS) as a whole. The Bureau of Health Care Quality and Compliance (HCQC) most likely would have that oversight. That would be based on their practice model, and perhaps Lauren Kalogridis or Alexandra Gunter could speak to that—how they carry liability insurance in their model now. I do not believe that would fall directly under the provision of DHHS.

Assemblywoman Titus:
Will DHHS establish a scope of practice? Are you going to be mandated to do urinalysis for proteins and all those other things? Who will be liable if they suspect preeclampsia and those types of things? Who will set that scope of practice?

DuAne Young:
The scope of practice would really be defined by the CPT codes for what they can bill Medicaid. There would be certain provisions of the practice that will not be in billable CPT codes or not be covered services, but those would not be reimbursed by Medicaid. Those CPT codes are careful not to overstep or conflict with anything a physician or an advance practice registered nurse or nurse midwife is doing, but they are very specific and defined.

Chair Nguyen:
There may be someone who can clarify that the doulas are support advocates and not medical professionals or nurses.

Assemblywoman Summers-Armstrong:
I would like to ask Ms. Kalogridis to speak to the scope. In our exhibits on the Nevada Electronic Legislative Information System (NELIS), there is one showing a side-by-side comparison regarding what the role of a doula is.

Lauren Kalogridis, Program Manager, Thrive Wellness of Reno:
Doulas are not medical professionals, so it is strictly out of scope for us to be doing anything like urinalysis for proteins or assessing for signs of preeclampsia. We do not take blood pressure; we do not do cervical checks. Medical tasks are not within our role. It is really about the emotional support, about providing resources and referrals to extra care. For example, if we notice a client reporting to us signs such as swelling in their legs, headaches, or dizziness, we might say they need to call their provider. We might say, "This is something that is potentially risky, and you need to assess it with your provider."

As far as liability coverage, many doulas do carry their own professional liability coverage. CM&F is a common company that offers coverage for doulas independently, and that has more to do with the fact they come to our office space for prenatal services and if they trip and fall—those kinds of things. It is still not about medical birth outcomes.

Assemblywoman Titus:
My life was made easier if someone was with the person in labor to coach them, and I always recommended that couples get education and take birthing classes, et cetera. Having someone by your side—your best friend, your mom, your aunt, whomever—is always great. However, when you start hiring someone who is a professional coach, that is where I worry about the liability and scope of practice. What is the consequence if that person you hired does not recognize something or says something they should not? What are the consequences if they practice outside their scope of practice?

Assemblywoman Summers-Armstrong:
Ms. Gunter, you are in this space on a regular basis. Could you speak to that, please?

Alexandra Gunter, Doula, Reno Doula Project:
When Anthem sponsored us to provide doula coverage to 50 of their members, I realized we had a gap in our code of conduct. I put together a code of conduct for the Reno Doula Project. This is an example of making sure people are staying within their scope under our association. Doulas are not covered under the Health Insurance Portability and Accountability Act, but privacy is very important. We are not mandated reporters, but reporting is important. We have expectations of conduct and are reminding all our doulas that we are not medical professionals, we are not to perform medical tasks. Beyond that, if there is an emergency, we are responsible for calling 911. If any doula in our association were to act outside this, we now have processes to expel them from our association. I would hope other doula associations with reputations similar to what the Reno Doula Project has would follow a similar course—making these very clear and writing these out. It would not surprise me, if we are a covered service under Medicaid, that it would be required for more doulas to have agreements with associations and with Medicaid itself.

Assemblywoman Peters:
Thank you for bringing this bill. I cannot tell you, over the past eight years, as I had my three children and watched my friends have their children, how important doula services were to the well-being of the moms in those cases. Not everyone has a great relationship with their mom, or their sister, or their aunt, or even have them left. Sometimes you just need that support. It was invaluable for me. I had my sister in my case, but I do not know what I would have done without that support during my three births.

My question has to with the kind of training standards that already exist. Doulas go through a process of learning how to be effective in the space they offer services in. Can you talk a bit about what those training standards look like and what the breadth of services doulas are hired for can look like?

Assemblywoman Summers-Armstrong:
Ms. Gunter, would you please speak to your scope at the Reno Doula Project?

Alexandra Gunter:
There are a lot of training associations. Because doulas are not regulated, the trainings are not regulated, but they typically follow a similar format. It is a multiday workshop where we talk about what to cover during prenatals, how to stay within scope of practice during labor, how to act and conduct yourself during a hospital birth and during a home birth, also knowing that we are not doing unassisted births so there is always a medical professional there. Also going over red flags for postpartum. When doulas first came about in the United States, it was for the white and privileged, so numerous associations have created trainings that cover racial disparities. There are trainings by Black women for Black women and other women of color. Now there are even more trainings available, so it would be hard to say, "only one training" or "only these trainings are acceptable."

Certification is similar. Because doulas are not regulated, there is no way to know what a certification truly means. Again, making sure that whatever training association a doula is in, it at least covers scope of practice and at least covers certain aspects would be more important than making sure that each individual doula is certified or making sure that the trainings themselves are regulated. There is a lot of work to be done in that area, but I have a lot of faith in the trainings that are in existence already.

Assemblywoman Peters:
The thing that is really important to talk about is that not every person needs exactly the same thing and it is not like a math equation—it is really about those personal relationships—interviewing your provider for that service just like any other service you would ask for in the spectrum of your life. It is not a one-size-fits-all for everyone, and I think that is really valuable to have in the community.

My other question concerns the breadth of service. I know from my pregnancies that prenatal care was very specific about my baby and about my health, but the postpartum care was virtually nonexistent. Can you talk a bit about how you provide services both before, during, and after and how that can be unique to each service scenario?

Alexandra Gunter:
A typical model of care would be two prenatal appointments—not including an interview—so two prenatal appointments, the birth itself, and one postpartum visit. It is one postpartum visit at a minimum. You can, of course, add more. The postpartum visit typically happens about a week or, hopefully, two weeks after the birth. Doulas are not medically trained, but some of us are lactation professionals. We are not all lactation professionals; however, we are trained to notice red flags and to refer out. A lot of times, that friendship, that relationship you create with your doula, has them checking in on the mom more often via text message or phone conversations, depending on what the mom wants. Typically, it is one postnatal visit which usually happens before the postnatal visit with the obstetrician, so there is the ability to notice red flags before they would be seen in-office by a medical professional. They would then be encouraged to see their medical professional early.

Assemblywoman Peters:
What is important about this conversation is that doulas provide a unique and individualized service to people depending on what they need and to expecting parents depending on what they need. That can be a wraparound service complementary to the medical help and medical providers' services that are also regulated and taken into account and paid for through insurance processes during that birthing process. That is really important. One of the pieces we are just starting to fully acknowledge in the birthing community is the importance of mental health postnatal—mental health of moms and other parents. Without someone who can identify that or who is trained to identify that, it really leaves our populations vulnerable to those unexpected senses of depression that I know from experience you do not always see from the inside.

Assemblywoman Benitez-Thompson:
I have to admit, I am very naive concerning what a doula is and what they do. I am learning a lot. I believe I heard it said that doulas exist and that there is a certification process for them. I am assuming the community self-regulates and the community self-identifies. Is that how that is right now?

Alexandra Gunter:
Yes, I would say that we do self-regulate, and it is fairly important to self-regulate because we, as individuals, can be kicked out of a hospital and told not to come back as a doula. It could also negatively impact the reputation of the association we are under. Someone could say "We do not want any doulas from your association because they break rules, they do x, y, and z." It is very important that we are recognized as professionals and not to overstep. Of course, if we were to try to do a medical procedure, try to assess cervical dilation, tell a doctor they are wrong or to stop in the middle of a medical procedure, we could be trespassed from the hospital and asked to leave. We are very self-regulating to make sure we do not ruin the reputation of those who are trying to do very important work.

Assemblywoman Benitez-Thompson:
I am a licensed social worker. This is not calling for licensing, it is calling for registration. For most folks where there would be licensure, you are not allowed to represent yourself as being a member of the profession unless you were licensed as such. Regardless of your education and training in something, unless you are licensed, you will not be able to represent yourself as such, nor to hang out a shingle saying you were such. Would you want the same intent for this registration? If you were registered and had met the requirements that the Division of Health Care Financing and Policy of the Department of Health and Human Services puts out, would you then be able to represent yourself as a doula but those who are not registered would not be able to?

Alexandra Gunter:
I can see a situation where a registered doula will be very important, but in terms of a certified doula, that depends on the educational body you attended. For some associations, there are yearly fees and certain follow-up continuing education that for some women, especially lower-income women who are trying to make a living as doulas, can be prohibitive

to remaining a certified doula. I never certified as a birth doula, and I consider myself to still be an expert in this area. Having registered doulas within the state of Nevada so we can get reimbursement from Medicaid sounds completely reasonable, but in terms of requiring certification from the many different training bodies—because we are not regulated like a social worker or like a clinical psychologist—it does not look the same, so I do not think it would have the same effects.

Quentin Savwoir:
I wanted to add to what Alexandra Gunter was saying. I want to be careful about the language we are using. I know there is a lot of conversation in the Legislature [unintelligible].

Assemblywoman Peters:
I am having a lot of trouble understanding what you are saying. I do not know if it is the microphone, but I missed most of what you said.

Chair Nguyen:
I agree.

Assemblywoman Summers-Armstrong:
Mr. Savwoir, if you would turn off your camera, that might help. You may be having some issues with the Internet.

Quentin Savwoir:
I want to be very clear about the language we are using. What we are saying is we want doulas in the state to provide training, and we want them to provide documentation of training, for instance the training Ms. Gunter described—the multiday training where they are taught how to identify things that would need to be escalated to a medical professional. Again, this is a nonmedical role that is providing education, advocacy, emotional support, and all things we would be doing for our friends, for our family, just in a dynamic where you are having to coach an expectant parent or mother through their pregnancy process.

Assemblywoman Summers-Armstrong:
I had my last child in a hospital setting with folks who were certified and registered. I had a standard U.S.A. birth, and my youngest son was born healthy, we thought. Those folks who were certified and trained and who were supposed to take care of me and him set us up in a room that was freezing cold. He ended up under a heat lamp for six days because he got hypothermia. I think we need to make sure we are not conflating these roles. This is a support person for the mom. She is not a medical professional and we do not see anywhere any need for he or she to be certified, but registered, some type of process set up so there is training that is both culturally competent, that completely covers the scope of what we want birth doulas to do. We have amazing and intelligent women in our state who are in this space. They are more than able to work together with our government officials to come up with a scope of training that needs to be done so they can do this work for moms.

Assemblywoman Krasner:
My question is for Ms. Gunter. You were talking about doulas being able to help diagnose postpartum or mental health. Could you expand on that?

Alexandra Gunter:
We are not qualified to give an assessment, but we can point women into the direction of assessments, like the Edinburgh Postnatal Depression Scale, for example. We can say, "Why not fill this out? If you test in a particular way, it might be important to have a conversation with your provider about this." We are trained to recognize different types of perinatal mental health issues, so if we notice something, we are also able to point out that something may not necessarily be normal, and ask, "Do you think you need help in this area, or do you think perhaps getting in touch with a therapist or getting some group therapy, some support circles, could help you in this area?" Again, we are being very careful in our language when we speak to moms to not diagnose, to not say things like, "You have depression." We can say, "You know, this is not necessarily normal. Postpartum depression is something that could be happening in this situation; do you think you might want to explore this more with a professional?"

Staying within our scope has a lot to do with language and how we present things to moms, but definitely, mental health is a component of what we focus on, both prenatally and postpartum.

Lauren Kalogridis:
That is the exact intersection of a lot of my work, because I am a clinical social work intern, so I work as a perinatal psychotherapist treating clients with perinatal mood and anxiety disorders and anxiety depression. I also work as a doula, so the way I might describe the difference between the two is that they are not diagnosing, but they are noticing red flags. The beauty of a doula is that they are oftentimes in the home, oftentimes they have access to partners, oftentimes clients will end up sharing things about their experience emotionally with their doula prior to being able to be vulnerable with a therapist, and so they are getting inside information. What they probably need to do is just notice what is normal and what is not normal.

In Reno, we have done a lot of work recently, with Thrive Wellness of Reno particularly, in establishing really strong and swift referral systems between the Reno Doula Project, Bright Heart, and other doulas in the area with our mental health providers. If the doula sees something escalating quite quickly, they can reach out and say we need some intervention, some mental health interventions quickly. Twenty percent of people experience perinatal mood and anxiety disorder. That is quite underreported. The quicker we can get them into care, the better chance we have at intervening to protect the bonding and attachment experience between parents and children because that is so crucial and can escalate very swiftly into a number of adverse childhood experiences we see related to untreated perinatal mood and anxiety disorders. I hope that spoke to the bridge, but the distinction.

Assemblywoman Krasner:
I thought in the presentation they said that doulas are not certified, some are registered, and some are not. Some have the training, and some do not. If they are not all certified or all registered, and they are not all receiving the same training, how do we know they are able to spot these mental health issues or postpartum issues? Maybe one thinks it is and makes a report that is false, and the person is really not having a mental health issue.

Assemblywoman Summers-Armstrong:
Ms. Kalogridis, you have worked both here and in New York. Could you speak to the scope of training you have seen in both locales?

Lauren Kalogridis:
As far as the scope of training, topics that are generally covered as standard practice—for example, Dona International is one of the largest doula training organizations in the country. The downside of an organization like that is that it often does not have the culturally humble lens and the culturally sensitive lens that is so rooted in community issues, particularly in terms of the maternal mortality crisis for women of color and things like that. Just because there are differences in topics reflected in the different training orgs—for example, in New York I trained under the org called Ancient Song Doula Services. Ancient Song covered all the same things as Dona International, things like comfort measures, things like positions of the baby in utero, things like education about common scenarios in labor and helping people think through what their birth preferences would be, basics of breast feeding, things like that. In addition to all those standard core content areas, they also talked about the Black maternal mortality crisis in this country and the way that rates of sexual violence can show up to impact different communities more.

Part of the specifics about trying not to narrow in, saying, "we need you to certify under this one doula training organization," is that sometimes there is a risk of not meeting the whole needs of the community. I think that is what folks were speaking to earlier. As far as the piece around the risk of referring someone who might not actually have a perinatal mood and anxiety disorder—it is about preventive care in a lot of ways. There is not actually a detriment in the way that I see it as a mental health care professional, but if someone is getting to us, part of our job is to do the assessment. It is not the doula's job, it is our job to ask if a person needs case management services, do you need WIC [Special Supplemental Nutrition Program for Women, Infants, and Children], do you need outpatient therapy, do you need intense outpatient therapy? That is our scope of practice as a mental health professional, and we welcome people getting them to us even if the person is not in a full-blown perinatal mood and anxiety disorder stage.

Assemblywoman Summers-Armstrong:
Assemblywoman Krasner, she is speaking about her role as a social worker, being able to do the diagnosis—that is her role. She is interested in and encouraging the role that the doula, who has a relationship with that mom, may be able to see that there are issues that may need to be addressed and to have that relationship built that she can move her into the space of a health care professional to get her what she may want or may need. When we are talking

about the scope of the doula service, that doula is going to see that mom within the first or second week after the baby is born. Generally speaking, the post-birth appointment with the doctor is weeks out, and many things can happen, as far as mental health or any other situation, in between then. That doula has access to that mom; they have a relationship. That doula can assess the differences, they have that type of core training, and move that mom along to a professional so there can be an intervention before it becomes a crisis.

Assemblyman Hafen:
It was stated that there were approximately two dozen other states that are doing this reimbursement. Could you provide us with a breakdown of which states are requiring registered doulas versus certified doulas? I am curious to see what the other states are doing in that regard.

Assemblywoman Summers-Armstrong:
We will gather some data and get it out to the entire Committee.

Quentin Savwoir:
We are happy to follow up with the entire Committee with the information you requested, Assemblyman Hafen. I want to clarify that we are using a lot of terms, and I do not want the intention of the legislation to be confused. The registration we are discussing is for the purposes of Nevada's Medicaid Services office for purposes of accountability of how the funds are being spent. "Registration" in this legislation is talking about registering with the office of Medicaid within DHHS. Other states have set forth other provisions and have required doulas to be certified or licensed. That is not what we are proposing. There has been research that has proven that when you create additional barriers to entry, it does lack cultural competency and the trainings associated to help Black and Brown women and Native American women proves that consistently across all the studies. Again, I am happy to research and follow up with the Committee, but I want to make sure that we are using the proper terminology so we are not confusing the intention of what we are hoping to accomplish with Assembly Bill 256.

Assemblyman Hafen:
I want to make sure my question is very clear. In section 1, subsection 1, we are directing the director to address the "registered" doulas. In there it is very specific that this is for "registered" doulas, so my question is, what are other states doing? Are they doing the registered doula or are they doing the certified doulas, and that is the information I am requesting.

Chair Nguyen:
I am sure Assemblywoman Summers-Armstrong will get that information to Patrick Ashton, our committee policy analyst, and he will distribute it to the rest of the Committee.

Assemblywoman Peters:
I really appreciate this conversation and discussion around this variety of services doulas provide and how that functions. It is really important to acknowledge that doulas are hired to

focus on the moms, and everyone else is focused on the baby. When you give birth, your obstetrician focuses on the baby's health and your body's health. The pediatrician is focused on the baby's health; there is no one exclusively there to focus on the mom's well-being. As the mother of three kids, in the first three days after my babies were born, no one asked how I was doing. It was always about the baby. Having a doula who was specifically there, hired by the mom, to support her in those sometimes traumatic and vulnerable moments, is so important for the health and well-being of both mom and baby in the long run. I think that is very important to clarify.

Chair Nguyen:
At this time, we are going to hear testimony in support, opposition, and neutral on A.B. 256. We will begin testimony in support of A.B. 256.

Ashley Dodson, representing Make It Work Nevada:
I am a licensed social worker and representative of Make It Work Nevada in support of A.B. 256. I am also a Black mother of five children who has had several traumatic pregnancies and birthing experiences due to the lack of education, empathy during the birthing process, and care that I should have received during and after pregnancy. Lying on a table to give birth to a precious life can be mentally daunting when thoughts include, "Will I live and will my child live?" Alongside the emotional and mental abuse I endured while being threatened by a white male doctor who [unintelligible] with a cesarean section is told that if I did not hurry and push the baby out soon—after two hours of me pushing—and only receiving comfort from the nurse on duty, my fiancé, and mother. Had I had a doula, this most likely would have gone a different way. Assembly Bill 256 is about our mothers and our children and ensuring they have a wholesome and healthy start in their lives. Doulas play an essential role in providing care, support, and advocacy to mothers and birth parents before, during, and after the pregnancy. My personal experiences often left me advocating for myself, even through the most difficult part of the process—to push and deliver the baby. As you can imagine during that time, one is extremely exhausted and filled with anxiety.

Statistics show that preterm birth rates for Black women are especially higher than that of their white [audio was lost].

Assembly Bill 256 is the start of improving birth outcomes for mothers and birth parents in Nevada. This bill is community-driven public policy that tackles the racial and reproductive injustices that Black women and other communities of color face. In states that passed legislation similar to A.B. 256, they have shown cost savings to the state by reducing the amount of C-section births as well as birth parents reporting improved birth outcomes and overall experiences. As a Black mother first and foremost, I urge the Committee to support and pass A.B. 256.

Erika Minaberry, Private Citizen, Reno, Nevada:
I became a birth doula in 2015 after experiencing three traumatic births. My first birth ended in a cesarean section because I did not know what my rights were as a patient and I did not know what to expect with labor. Those two factors not only led to my cesarean, but also led

to massive struggles with breast feeding, postpartum depression, and six scar adhesions growing in my abdomen that had to be scraped out in a major abdominal surgery before they grew to the point of cutting off circulation to my organs. Medicaid will be covering that surgery. I became a doula because if I had doula support during my first birth, I would have been able to avoid the multiple costly health issues that were born from my ignorance of the labor process. Doulas provide that information as one of the core competencies of our work.

My story is not unique. The informational, physical, and emotional support we are trained to provide, statistically improves birth outcomes, mental health, and saves money. Considering the abysmal statistics America has in maternal and infant mortality, providing doula support for families makes sense both morally and economically. On behalf of struggling new parents too overwhelmed to testify, for all the parents who are mourning the loss of their babies, and for the babies who are mourning the loss of their parents, I implore you to please vote yes on A.B. 256.

Tiara Moore, Housing Justice Organizer, Progressive Leadership Alliance of Nevada:
I am here in support of A.B. 256. As the mother of six, I had a doula with my last child. My doula was not only important for not only being a part of the health care system but also part of the child's life as well. My last child, my one-year-old, we had a doula throughout our pregnancy, and I received very good care. Because of my doula, I was able to fully recover and my baby was very healthy. Doulas are an effective part of the health care system. The cultural competence of doulas is to provide support and care during the birth. With doulas assisting, mothers are four times less likely to have low-birth-weight babies, two times less likely to experience birth complications involving themselves and their babies, and less likely to receive cesarean sections. It helps with the breastfeeding process as well. They are there to support, and with my sixth child I was able to have that support, and with my seventh, I plan on having the support as well. Medicaid coverage for doulas will ensure that future Nevadans, regardless of their family's economic status, are born with the best possible outcomes. I encourage you to support A.B. 256.

Lashonda Marve-Austin, Private Citizen, Reno, Nevada:
I am a Black mother of three. I am in support of A.B. 256 because I lost nine children before giving birth to the two I have now. If I had that support, I think I would have known what questions I could have asked. They would have been able to recognize things that were not correct. I also had an issue with my three-year-old. I did not receive any postpartum care here in Nevada. I was distressed and I was not able to care for my child. I was threatened with my kids being removed from my home because I was not able to properly care for them because my mental capacity was not where it needed to be. After reaching out to my health care provider multiple times asking for a prenatal appointment, with them responding that they were overbooked, had a doula been available, she could have been there to advocate for me and also support me when I was falling and about to lose my children. I am in full support of A.B. 256.

Tara Raines, Private Citizen, Las Vegas, Nevada:
Thank you for the opportunity to speak in support of A.B. 256. I am speaking first in my capacity as a Black mother. I was fortunate to be able to afford doula care when delivering my daughter. Given what I knew about the Black maternal health crisis and the outcomes, it was important to me that a Black woman was present at my birth to advocate on my behalf. To me, her support was invaluable. She assisted us in preparing our home for my daughter before I delivered, she prepared me and my partner for what labor and delivery could look like, and she really helped set our expectations for what those first few days with our little one might bring. She was a pillar of strength as I labored, and she offered support both to me and also my partner during the long hours before my delivery. After the birth, my doula came to the home to help with tasks ranging from prepping meals to swaddling the baby to helping me figure out how to use the new Moby Wrap infant carrier I struggled with in those early days.

This support should be available to every birthing person who wants it. We know the presence of doulas reduces mental health crises after birth and increases breast feeding, which is important both to bonding but also has long-term nutrition and health outcomes. I implore you to pass this bill, as we in Nevada need this support.

Cristina Hernandez, Private Citizen, Las Vegas, Nevada:
I am here in support of A.B. 256. I have been a birth worker/doula since 2016 in Las Vegas. During my tenure, I have seen the impact doulas provide. Just last year, a local group of us were able to provide doula services via grant funding to victim survivors of sexual assault and domestic violence. We were able to see firsthand what we already knew—that it made a significant difference in the birth experiences and during the postpartum process for our clients. Having a doula is not a luxury, it is a necessity and one all birthing people should have access to. In closing, I also ask that you ensure you pay doulas a living wage and make language inclusive of all birthing people since not all birthing people identify as women.

Miaya Bennett, Private Citizen, Las Vegas, Nevada:
I am a Black mother advocating for this doula bill, A.B. 256. I have two young children, three and two years old. I had a doula so I know the importance of needing a doula because I know people who did not have them. On my journey of learning what it is to be a mother, to have a child, everything that you need to know before the baby comes—my doula was able to help me with that. I was able to take classes; I was able to learn about the truth and the myths about labor, about birth, about the child, about the expectancy of the baby, and what is to come. I feel like it is very important. I know that with my first child I had preeclampsia. I had to have an emergency C-section, and it would have been very scary had I not had my doula there to explain what preeclampsia was and make me feel better. My doctors were very straightforward. They did not care about me emotionally and how I was going to take the news. I assumed my pregnancy would go the way I wanted it to go. My doula was the only person who was able to make me understand why it was the safest for myself and for my child. She gave me the information I needed to educate me about what exactly I was going through and what I needed to do. I was looking to have a home birth with my son, and I did not get to have that home birth. I was blessed enough to be able to pay for all the

midwifery clinic needs, and then when I went to the hospital, I was not treated as a patient of the hospital because I did not have a specific doctor. I was using the doctor that was assigned to me through that hospital.

Chair Nguyen:
Will you wrap up your testimony, please. You are right at two minutes.

Miaya Bennett:
I just think it is very important to have a doula because they are able to help you learn the things you do not know and the things you need to know to be comfortable and for your own mental health.

Chair Nguyen:
We have been going for 15 minutes. I want to make sure I allocate enough time for neutral and opposition testimony. If you are still on the line and want to present testimony in support of this bill, please do so in writing. You can do so up to 48 hours after the conclusion of this hearing, and I would encourage you to do that.

At this time, we will go to any callers in opposition to this bill. [There were none.] Are there any callers in neutral?

Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services:
For A.B. 256, the Division of Health Care Financing and Policy has estimated a cost savings of covering doula services as part of the State Plan for Medicaid. This means that the benefits of covering doula services far outweigh the costs of reimbursing doulas for their services. Many studies have shown that doulas can assist in reducing preterm births, number of low-birth-weight babies, morbidity, mortality rates, neonatal intensive care unit admissions, depression, and anxiety. These studies have also shown us that doulas can assist with improving outcomes for mothers and babies with reduced cesarean rates by providing labor support toward a vaginal birth, decreased use of pain relief medications, and increased breastfeeding rates. All these outcomes help improve health care outcomes, lower health care costs, increase quality of care, and may even reduce health care disparities. Nevada Medicaid utilized many doula studies and the cost savings to Medicaid programs. Reviewing all of these, our analysis used the cost-saving methodologies in these studies to determine there would be a cost savings to Nevada Medicaid if we reimbursed doulas for their services. Overall, I am really pleased to say that our analysis resulted in a cost savings of over $1.2 million. That includes the medical side of our savings and our system costs, like having to create a new provider type and mapping codes. Overall, it would be a cost saving.

Additionally, as DuAne Young stated, the Division is also working with the bill's sponsor on the portion of the bill regarding oversight for registration for doulas. We are looking at how to figure that out. Also, I wanted to help answer the question about CPT codes. Even though we have not developed a policy and CPT codes to be billed like other states such as Oregon that have doulas, they have them bill their Medicaid program based upon the type of

delivery—whether it was a vaginal delivery, vaginal that turned into a cesarean, or vaginal after a previous cesarean—all those have different CPT codes. That would allow the Medicaid program to tie the doula to the type of birth that actually occurred. Even though it would have the same type of reimbursement, it would help tie the service provided to the outcome.

Chair Nguyen:
Ms. Lynch, will you please stay on the line? I know you are here to provide neutral testimony. Does anyone have any questions for Ms. Lynch?

Assemblywoman Titus:
You just testified that you are estimating a $1.2 million savings. Is that based on national data or are you using Nevada's data? We already have doulas here. Do you have any studies done in the state of Nevada that would be relevant? It sounds as though we have a significant population of doulas already who are involved in the process.

Also, do you have a fixed number that you would pay a doula? It sounds as though if there were bad outcomes, they would be paid more. For instance, if they ended up having a cesarean section, are you now going to stratify that and pay them more? I am curious about where you got your figures.

Erin Lynch:
We looked at national studies on Medicaid and applied those cost savings using Nevada Medicaid data. If it said that the national studies helped reduce Medicaid costs by $1,500 per birth, then we applied that to the number of births that occur in Nevada. Also, national studies say that only about 6 percent of births are attended by doulas, so we applied that type of percentage too, so it is like both, using national studies and then applying it to Nevada Medicaid data.

Assemblywoman Titus:
Maybe you could get this out to the entire Committee: were these studies done using a doula versus a coach? Certainly, if you have a loved one, a parent, or a coach there, versus no one at all, but what is the end number? How many did it really serve? I really researched this issue before this testimony today trying to find some actual factual double-blind studies and the end numbers. If you have that information, I would love to see it.

Chair Nguyen:
Obviously, we put you on the spot, but would you provide that information to Assemblywoman Titus? Obviously, with this data collection it is premature at this time, and I understand that you are using some national statistics as well as trying to incorporate them. If you can get whatever you have to the Committee, that would be helpful.

Erin Lynch:
There was a question about reimbursement. The analysis we conducted was mostly based upon other states such as Oregon. Oregon reimburses a bundled rate. Their rate is $350, no matter what the outcome is—whether it is a vaginal birth or a cesarean birth.

Chair Nguyen:
Thank you for that. Again, if you have any other follow-up information, I am sure it would be very helpful for the Committee members to be able to review. Do we have anyone else in neutral? [There was no one.] At this time, I will turn this back over to Assemblywoman Summers-Armstrong to make any closing remarks.

Assemblywoman Summers-Armstrong:
Thank you, Committee, I appreciate your listening attentively and asking such pointed and deep questions. I will refer all Committee members to NELIS. There are a number of exhibits from the March of Dimes [Exhibit M], the Department of Health and Human Services [Exhibit N], and even an excerpt from the National Vital Statistics System [Exhibit O]. These reports paint a stark picture of maternal deaths in our great state. This bill allows us to improve these statistics by focusing on moms. When moms do better, babies do better, and families do better.

I am going to conclude by sharing my screen. Doulas and birth support people are important. This woman, Frau Busse, helped me birth two beautiful sons in a foreign land, five thousand miles from my mother. The first picture is of the two of us in 1987 when she helped me birth my son Brandon. I was just a kid. The second picture is the two of us in 2013. My husband and I took a trip to Europe and made a side trip to see Frau Busse, and that is taken in her garden. This woman loved me when I needed her to. She cared for me when I needed someone to care for me; she wrapped me in her arms with love; she supported me. She saw me. She was a doula and she was a midwife. I was lucky that I had her, and I am asking that this Committee consider that every mother in the state of Nevada is worth it, and I hope you will support this bill.

Chair Nguyen:
Thank you, Assemblywoman Summers-Armstrong, for your presentation. At this time, I will close the hearing on A.B. 256.

[Exhibit P, Exhibit Q, Exhibit R, Exhibit S, and Exhibit T were submitted but not discussed and will become part of the record.]

We will now begin public comment. [There was none.] Are there any comments from members before we adjourn? [There were none.] We are adjourned [at 3:51 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 copy of a PowerPoint presentation titled "The Case for Expanding Medicaid to Include Doula Coverage," dated March 2021, presented and submitted by Lauren Kalogridis, Program Manager, Thrive Wellness of Reno.

Exhibit D is the Work Session Document for Assembly Bill 96, presented and submitted by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Assembly Bill 192, presented and submitted by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is the Work Session Document for Assembly Bill 181, presented and submitted by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is written testimony dated March 8, 2021, submitted by Robin Reedy, Executive Director, National Alliance on Mental Illness Nevada, in support of Assembly Bill 181.

Exhibit H is the Work Session Document for Assembly Bill 197, presented and submitted by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit I is the Work Session Document for Assembly Bill 217, presented and submitted by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit J is the Work Session Document for Assembly Bill 216, presented and submitted by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit K is a letter dated March 23, 2021, submitted by Susan DeMarois, Public Policy Director, Alzheimer's Association, in support of Assembly Bill 216.

Exhibit L is the Work Session Document for Assembly Bill 228, presented and submitted by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit M is a copyrighted article published by March of Dimes titled "2019 March of Dimes Report Card: Nevada," submitted by Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6.

Exhibit N is a document titled "Maternal Mortality Nevada, December 2018-2020," dated December 2020, prepared by the Office of Analytics, Department of Health and Human Services, submitted by Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6.

Exhibit O is a document titled "Nevada Preterm Birth Trend Data," submitted by Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6.

Exhibit P is a proposed amendment to Assembly Bill 256, submitted by Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6.

Exhibit Q is a proposed amendment to Assembly Bill 256, submitted by Quentin Savwoir, Deputy Director, Make It Work Nevada.

Exhibit R is a document titled "Doulas & Midwives," submitted by Quentin Savwoir, Deputy Director, Make It Work Nevada.

Exhibit S is a document titled "Published studies showing the cost savings of doula services to Medicaid programs," submitted by Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6.

Exhibit T is a letter submitted by Jollina Simpson, Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 256.