MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-first Session
May 6, 2021

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:43 p.m. on Thursday, May 6, 2021, Online and in Room 2134 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Dallas Harris
Senator Joseph P. Hardy
Senator Ben Kieckhefer

COMMITTEE MEMBERS ABSENT:

Senator Pat Spearman, Vice Chair (Excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Bea Duran, Assembly District No. 11
Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1
Assemblyman Tom Roberts, Assembly District No. 13
Assemblywoman Jill Tolles, Assembly District No. 25

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Vickie Polzien, Committee Secretary

OTHERS PRESENT:

Tara C. Raines, Ph.D., N.C.S.P.
Genevieve Burkett, Director of Nursing, Serenity Birth Center
Amber Falgout, Battle Born Progress
Jimmy Lau, Dignity Health-St. Rose Dominican

Lynn Chapman, Nevada Families for Freedom
Bob Russo
John Sande, IV, United Asset Management Services
Mike Cathcart, City of Henderson
Chad Christensen
Layke Martin, Nevada Dispensary Association
Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services
Christine Jones Brady, Second Assistant Attorney General, Office of the Attorney General
Sarah Adler, Vitality Unlimited; New Frontier Treatment Center
George A. Ross, Hospital Corporation of America
Courtney Hunter, Shatterproof
Kelsey Matthews, Shatterproof
Brenda Pearson, Ph.D., Clark County Education Association
Dagny Stapleton, Nevada Association of Counties
Maya Holmes, Health Care Research Manager, Culinary Health Fund
Bobbette Bond, Health Care Policy Director, Culinary Health Fund
Margot Chappel, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services

CHAIR RATTI:
I will open the hearing on A.B. 287.

ASSEMBLY BILL 287 (1st Reprint): Providing for the licensing and regulating of freestanding birthing centers. (BDR 40-799)

ASSEMBLYWOMAN DANIELE MONROE-MORENO (Assembly District No. 1):
I am here today to present A.B. 287, a measure providing for the licensing and regulation of freestanding birthing centers.

Assembly Bill No. 169 of the 80th Session was presented and passed, which established the Maternal Mortality Review Committee.

It was important to pass that legislation because maternal mortality was, and continues to be, rising in the U.S. as it declines elsewhere. We continue to be the only high-resource Country whose rates are rising.

Black women face significantly higher maternal mortality risk with 44 deaths per 100,000 live births compared to their White counterparts. Women of other races are at 13 to 14 deaths per every 100,000 live births.

This is 2021, and we are still battling maternal mortality issues as we come out of the Covid-19 pandemic. During the beginning of the pandemic, women found themselves forced to deliver without their partners and/or family members. That was needed for the safety and protection of hospital staff and other patients, and the decision was warranted. It placed undue stress on families and the pregnant woman as she went into labor and delivery.

People were looking for options and reached out to me, asking for information on freestanding birthing centers. There were constituents in my district not comfortable with giving birth at home but did not feel there were any other options.

Assembly Bill 287 defines a freestanding birthing center in section 11.

TARA C. RAINES, PH.D., N.C.S.P.:
As I show my presentation (Exhibit B) on freestanding birthing centers and why they would be beneficial for Nevadans, I will explain the definition of birthing centers, the rise in birthing center utilization in the U.S., some outcomes associated with birthing centers, potential cost savings, Strong Start data and how birthing centers close the gap on health disparities.

A birthing center is a safe healthcare facility where care is provided using the midwifery model of care. We think of a birthing center as a "Maxi-home vs. a Mini-hospital."

Birthing center care is integrated and guided by the principles of prevention, sensitivity, safety, appropriate medical intervention and cost-effectiveness. Using the midwifery model of care, the birthing center helps with the transition from pregnancy to parenthood.

Birthing centers respect and facilitate birthing persons' rights to make informed choices about their health care and the baby's based on the parent's values and beliefs. Birthing centers allow the participation of the birthing person's family and friends in the pregnancy, birth and immediate postpartum period.

In recent years, there has been a rise in birthing centers as they are found to give folks access to the births of their choice. In the U.S., there are 384 freestanding birthing centers, 11 of which are operated by Black owners. Birthing centers saw 19,871 births in 2018. Recent data shows roughly 0.5 percent of all U.S. births took place in birthing centers. This is a 200 percent increase over the past ten years.

Birthing centers in the midwifery model of care are associated with lower cesarean rates and improved outcomes after birth and postpartum, cost savings for individuals, states and Medicaid systems, and increased client satisfaction. Those choosing to deliver in birthing centers leave their births feeling empowered and excited as they enter into the journey of parenthood.

The U.S. is currently ranked worst of all developed countries in regard to birth outcomes. Mothers in the U.S. have a higher risk of mortality in childbirth despite spending more on the childbirth process. We are fifty-fifth in maternal mortality and two times higher than 37 other nations. We are thirty-third in infant mortality with 5.8 deaths per 1,000 live births. Racial disparities make this exponentially greater. Nationally, Medicaid pays for almost half of U.S. births.

According to the Centers for Disease Control and Prevention, 40 out of every 100,000 African-American birthing persons die during childbirth. This is more than three times the rate of their White peers. African Americans are three to four times more likely to suffer a severe disability after childbirth in a hospital.

In addition to what appears to be a safer option for women of color, birthing centers have demonstrated they are of great value. Among states reporting the payer on birth certificates, 42.3 percent of all U.S. births were covered by Medicaid. Current estimates suggest that rate in Nevada is 60 percent to 70 percent of births projected in the coming year will be covered by Medicaid. Childbirth is dominated by costly and unnecessary interventions.

Today's rate of cesarean births is almost 32 percent, which is up 50 percent since 1996, and the rate of inductions has surged in recent years.

A Washington, D.C., Medicaid study estimated cost savings of approximately $1,163 per birth using birthing centers and $11.6 million per 10,000 births.

Clark County issued 41,000 birth certificates last year. We estimated 60 percent of the Medicaid births were delivered in birthing centers, which is not likely. If this were true, the potential cost savings to Nevada would be $28 million. Those numbers are exaggerated; nevertheless, there would be cost savings to Nevada if Medicaid births were delivered in birthing centers.

If more pregnant beneficiaries accessed birthing centers for maternity care, there would be better birth outcomes, saving Medicaid funds. If an open-access model was allowed, where patients receive only prenatal care at the birthing center and then deliver in the hospital, the outcomes would be better. Many birthing centers use a group pregnancy model, which allows folks to develop community during the prenatal period. This encourages breast feeding and reduces incidents of postpartum depression. Medicaid beneficiaries have expressed satisfaction with birthing center care; however, nationally, only a small number of Medicaid beneficiaries are able to access this model for their births. State regulations, like the ones we are seeking to change today, can lead to that limitation.

Birthing centers have been identified in research that looks at the Strong Start models of prenatal care as an ideal model for promoting social support for parents in the early days of pregnancy. Midwifery model of care as delivery in birthing centers promotes the integration of family and community in the pregnancy and birthing process, and group prenatal care has been found to improve outcomes for birthing persons.

When looking at the Strong Start data on the birthing center midwifery model of care versus national data, we see the American Association of Birth Centers (AABC) data shows better outcomes, reducing the incidence of preterm birth, low birth weight, very low birth weight, primary cesarean and total cesarean births including repeat cesareans.

As it relates to race and the Black maternal health crisis, the AABC data suggests that for African-American birthing persons, the disparities were diminished, particularly the reduction in cesarean births and low birth weight babies using the birthing center and midwifery model of care.

Birthing center prenatal care is time-intensive and relationship-based. Midwives see fewer clients per day, allowing them to spend more time with the patients they support. This model has been incentivized because of these relationships,

and access to resources and support systems result in better outcomes and cost savings to Medicaid. This leads to an increase in body-fed babies, lower rates of cesarean, perinatal and postpartum interventions.

That concludes the testimony on my presentation on birthing centers. I would now like to share a personal story with you.

After becoming pregnant, I read and learned about the Black maternal health crisis, learned about high-profile Black women's difficulty with pregnancy and worried about entering the medical system. Serena Williams almost died when she found herself in the hospital with doctors who did not believe her.

I lost that pregnancy after receiving care from a medical provider that was so egregious, that when reported, I received a refund of all copays from my insurance provider in addition to a letter of apology. When I found myself pregnant with my oldest daughter, hospital care did not feel safe for me. I did not feel a home birth was a good fit for myself and my family.

At my first prenatal appointment, my obstetrician told me everything was fine and that I was at a 10 percent to 15 percent chance of miscarrying. The next day I met with a midwife at a birthing center who said I was doing fine and looking at an 85 percent to 90 percent chance of having a healthy baby. For me, it was the emphasis on the health and survival of my baby that empowered me to have the best pregnancy possible and made birthing centers a great fit for me. At the time, I was living in Colorado and was able to delivery in a birthing center.

Upon learning this was not an option for my friends in Nevada, I became passionate about promoting equity and access for everyone to have the births of their dreams.

ASSEMBLYWOMAN MONROE-MORENO:
There are continued conversations between the sponsors and the Department of Health and Human Services (DHHS) about a proposed amendment (Exhibit C).

SENATOR HARRIS:
How many states have certified birthing centers in place?

GENEVIEVE BURKETT (Director of Nursing, Serenity Birth Center):
I do not have a nationwide number.

DR. RAINES:
At this time, there are 37 states with freestanding birthing centers and regulations. The vast majority of these states use the Commission for the Accreditation of Birth Centers (CABC) guidelines for licensure and regulation.

SENATOR KIECKHEFER:
Are there requirements for relationships with hospitals in case of emergencies at a birthing center? The bill references a 30-mile distance allowed, which is a long way when someone is in distress.

ASSEMBLYWOMAN MONROE-MORENO:
You will hear opposition on the 30-mile distance. When creating the language for the bill, we heard from our rural communities that do not have hospitals, which is the reason we chose the 30-mile distance. In some of our urban communities, the nearest hospital is within 10 to 15 miles. The 30-mile distance was added to the bill so there would be some type of medical facility in our rural communities.

MS. BURKETT:
We are required by the State to develop a collaborating transfer relationship with our closest hospital. For us, it is University Medical Center in Las Vegas. We sent a certified letter requesting that relationship, and the center has not responded. The center must receive our patients, and we have a great working relationship with the labor and delivery and Neonatal Intensive Care Unit departments.

Our transfer rate is about 12 percent of our clients. Perhaps 1 percent to 2 percent of those clients are emergent. The remaining are those with prolonged labor or mothers who would like an epidural and would want to transfer. Every prenatal visit admission to the birthing center requires a risk assessment following State recommendations for women who risk out of birthing-center care as they must be low risk. We have gone above that and are in line with the CABC for the accreditation of birthing centers to ensure the women we care for are appropriate for our level of care.

DR. RAINES:
There are those not as excited as we are about this model of empowering and promoting equity for birthing persons. For that reason, it was stated that an attempt must be made to establish a relationship with a hospital. Requiring the relationship would be prohibitive and prevent people from opening birthing centers since that would put owners and operators at the mercy of the hospitals.

Safety is the No. 1 component of this work. There are folks who risk out of birthing centers long before they get to the end of their pregnancy or toward the end of their term. Do not think of it as a transfer in the heat of the moment, but it includes transfer at 36 weeks because of unregulated blood pressure, or at 32 weeks because an anomaly has been discovered. Those transfers occur before labor and delivery.

SENATOR KIECKHEFER:
The mothers giving birth in birthing centers are healthy, have had prenatal care and are set up for a successful, healthy outcome. Does the data you cited compare to the broader population of births or those who meet the same criteria of those giving birth in a birthing center?

DR. RAINES:
Part of what makes these mothers healthy and ready for a successful birth is the prenatal care they receive in the birthing center. My first visit included a nutrition class focusing on what I should be eating to keep my baby healthy and recourses to find the healthy food. It becomes apples to apples in that the model of care looks different in a hospital. The data is looking at a general population of those who went through birthing centers. Everyone does not start at a birthing center working out and physically fit; it is the same for those starting their prenatal care at a hospital.

ASSEMBLYWOMAN MONROE-MORENO:
My oldest daughter planned her first birth with the service of a midwife and home birth in a pool. I was able to be there and experience the birth while remembering giving birth to her. I was in labor when my car broke down on the side of the road between Arizona and California, taken by ambulance to a hospital and had no one there with me. My doctor had told me I was having false labor and it was fine for me to travel. I almost died giving birth to my

daughter because the medical professional in charge at the hospital did not believe the situation I was in.

My daughter knew about that and decided to do something different. She had more visits with her midwife than I had with my doctors during any of my pregnancies. Her midwife advised her she would gain weight during her pregnancy and provided her with healthy eating information and an exercise routine. The day my granddaughter was born, my daughter had her midwife, an RN in training to be a midwife, a midwife assistant and her best friend present. It was the most relaxing birth I have been a part of.

They embraced the entire family and spent time to get to know her where oftentimes our doctors do not have the time to do this. Her midwife also made her preregister at the hospital and build a relationship with the doctor so that if something were to go wrong, they would have that easy transfer. She had that option so many of our mothers do not have.

AMBER FALGOUT (Battle Born Progress):
Battle Born Progress supports A.B. 287. This bill prioritizes women and their options for giving birth in Nevada. As a mother, I recognize the importance of choosing the birthing plan that is right for you and your family. There are much better outcomes for newborns and mothers when mothers are given a choice in how to set up the birthing plan that works best for them.

Assembly Bill 287 will help make birthing centers a viable option for mothers and their babies.

JIMMY LAU (Dignity Health-St. Rose Dominican):
Dignity Health submitted a letter (Exhibit D) from G. Rodney Buzzas, Chief Medical Officer, which outlines our concerns. The first one is the distance required from the birthing center to the hospital. Thirty miles is too far, five miles would be a better alternative.

We are concerned about the lack of a qualified provider for a higher-level intervention that may be necessary during birth. Intubating an infant is generally a difficult task that would require a qualified provider.

The birthing center should have a bona fide relationship with a hospital for needed transfers.

LYNN CHAPMAN (Nevada Families for Freedom):
The Nevada Families for Freedom opposes a portion of A.B. 287. I will read from my written testimony (Exhibit E) in opposition.

BOB RUSSO:
I oppose changing the wording on the birth certificate where A.B. 287 refers to mothers as the person giving birth and fathers as the other persons. I fail to understand the reason for this change. We are here because of our biological mothers and fathers—to think otherwise is delusional. I grew up in an American Italian household where family is everything; mother, father, aunt, uncle and cousins. Each had their part to play in the family dynamic. I see the language adopted in the bill as another step toward undermining the family, another attempt to minimize the family unit which is the basis and foundation upon which a civil society exists. In many parts of the Country, fathers are absent from the lives of young adolescents. If you want to reduce crime, strengthen the family and improve the education of our children.

The thought of referring to my father as the other person is nauseating, even if just on the birth certificate. It is distasteful to my mother, who will be 97 years old later this month, to refer to her as the person giving birth. Where are people's rights to be called mothers and fathers on record and to be proud of that fact?

ASSEMBLYWOMAN MONROE-MORENO:
I appreciate the comments from Dignity Health. I drove from my house to the hospitals near me and there is not a hospital within five miles of my urban home, which makes five miles unreasonable.

Pregnant people cannot utilize a birthing center if they are experiencing a high-level birth. Mothers are monitored throughout the course of their pregnancy, and if for any reason a mother should be in a better place for delivery, the mother is transferred to the hospital early in the pregnancy.

The birthing center in Las Vegas has tried to build a relationship with University Medical Center, and the hospital has not been amenable. I would encourage, welcome and applaud hospitals working with birthing centers to build those relationships.

The world we live in has changed. I am adopted and have been looking for my birth mother and father for a number of years. I wanted to find out who they were for health reasons and to thank them for the choices they made. My parents are on my birth certificate, but my daughter and her wife are not a mother and father. This is the reason for the gender-neutral language in the bill. When hospitals make comments that there are better outcomes with births in hospitals, while I appreciate their opinions, the data does not support this.

DR. RAINES:
The opposition stated infant intubation cannot happen at birthing centers. I would like to clarify that midwives are trained in infant intubation.

SENATOR HARRIS:
I will close the hearing on A.B. 287 and open the hearing on A.B. 326.

ASSEMBLY BILL 326 (2nd Reprint): Revises provisions governing cannabis. (BDR 56-641)

ASSEMBLYMAN TOM ROBERTS (Assembly District No. 13):
Today I will be presenting A.B. 326 which revises the provisions governing cannabis. I will also be covering the proposed amendment (Exhibit F).

There are 36 states that have legalized medical marijuana and 15 states that have regulated adult use cannabis programs. Despite this, there is a thriving illegal market for marijuana and the reason is simple economics. Last April, the Las Vegas Metropolitan Police Department announced its largest indoor marijuana grow operation bust of over 5,700 individual plants weighing more than 860 pounds valued at nearly $9 million.

There are consequences to the black market. Unlicensed cannabis producers and retailers compete against legal dispensaries with lower tax collection and impact to State revenue. In fiscal year 2019-2020, State sales tax on cannabis products amounted to $53 million. The illegal operation I mentioned was producing close to $20 million a year tax-free. In addition, there is violent crime associated with the illicit black market.

Marijuana industry owners complain about how the black market continues to thrive in Las Vegas. From my time at the police department, we saw a decline in jury appeal for marijuana cases on the criminal side because it is now legal in

Nevada. I talked to prosecutors in the high-density drug trafficking section in the District Attorney's Office who highlighted things I had already known. Although we were getting some criminal prosecution, it was not as much as it was previously. They focused on going after those with violent priors, and many cases were not being prosecuted. As a result, law enforcement did not have an appetite to police this.

One prosecutor recommended I contact the State Contractors' Board. The gentleman who runs the enforcement division happens to be an ex-drug enforcement agent supervisor. He said they have civil infractions that go along with their criminal infractions, one of which goes after advertisers. You must advertise a specific way, and if this is not done, the Board can go after advertisers criminally and civilly; however, this bill only applies to civil penalties. If you conduct contracting business without a license, the Board has the ability to fine you. That money goes into the education program to educate the public on licensed and unlicensed contractors. It also helps support the enforcement effort.

I took NRS 624.720 and NRS 624.700 and drafted A.B. 326. This bill mirrors those statues providing civil infractions that would give law and code enforcement, the people trying to regulate the unregulated market, a tool other than criminal prosecution to those operating a business without a license and/or unlawful advertising.

Section 1.5, subsection 1 defines the civil penalty action to be taken and provides the money collected for the fine will be deposited into the city or county treasury. The district or city attorney will manage those violations.

Section 2, subsection 11, paragraph (f) added language to allow the Cannabis Board to regulate advertising. The Board will work with the industry so as not to be burdensome, allowing consumers to know it is a legitimate business they are ordering from.

In section 1.5, we left out the word advertise. I will be seeking an amendment to add that back in.

We had people asking for cleanup language on receivership for these businesses. We amended the bill on the Assembly Floor but did not get

everything into the bill we needed, which is the reason for the proposed amendment, Exhibit F.

JOHN SANDE, IV (United Asset Management Services):
United Asset Management Services is the first court-appointed receiver to operate in the cannabis industry. There may have been one prior to us in Washington. Receiverships are important when a business falls on hard times or creditors feel a business is not being run as it should. We have bankruptcy to protect business and creditors. In our instance, the business filed for bankruptcy protection and was rejected because under federal law cannabis is an illegal substance. The bankruptcy court felt the federal protections for those businesses did not apply to those types of businesses. The case was pushed to State court, which granted a receivership. As a result, we realized there were no laws that addressed this situation.

In working with the Office of the Attorney General and the Cannabis Compliance Board (CCB), we put together language giving the CCB the authority to establish qualifications for receiverships. The minimum qualifications you would expect a receiver to have is to fix the situation as a bankruptcy trustee might do. The amendment, Exhibit F, gives flexibility to the CCB. The bill originally stated they "shall" adopt regulations that establish those sections put into the bill. The amendment changes the wording to "may" adopt regulations and gives the CCB discretion, which the CCB felt would be the best.

SENATOR KIECKHEFER:
Under what process is an individual found to be liable for a violation? Who makes the determination on appeal rights for that person?

ASSEMBLYMAN ROBERTS:
The premise was to give the local courts jurisdiction. For instance, in the City of Henderson, it could be police officers or code enforcement who would issue a civil citation to those engaged in the actions highlighted in the bill and then go through the normal civil process. The original idea was to give the jurisdiction to the CCB Board; however, the Board lacks the civil attorneys and/or processes at this time, which is why we went with the local courts.

SENATOR KIECKHEFER:
Are there time limits for how long an establishment can be in receivership? Is there anything prohibiting a receiver from taking over full ownership?

MR. SANDE, IV:
Receivership is an equitable remedy of the court. The court presides over the receivership estate, and everything must be approved through the receivership. At this point in our case, the receiver has inventoried the assets, established relationships with cultivators and brought the company to a position where it could be transferred and sold to allow the creditors and employees who were owed back pay to recoup some of their money. That is in the process of being approved by the court. If the court wanted to establish limitations, it would have the discretion under its equitable powers to do so.

I am not aware of anything in the law that would require a certain period of time. The complexity of the business would determine how difficult of a case it would be to reestablish the business or what would need to happen in the best interest of the creditors and the receivership.

SENATOR KIECKHEFER:
At the court's discretion, you move out of receivership and into a new ownership structure. Are there opportunities for the receiver to convert into full ownership, or is a receivership a temporary management contract?

MR. SANDE, IV:
I am not aware that a receivership would become a full-time owner. The receiver is awarded and acts on behalf of the court. Typically, receiverships act similar to a trustee in bankruptcy where its job is to act on behalf of the court to reestablish the business and protect the assets in an organized fashion so they can be transferred or liquidated.

SENATOR HARDY:
There are licenses and permits for an establishment. Does the receiver run the business so it does not go down in value while waiting for someone to take over?

MR. SANDE, IV:
In most cases, it would work that way. For our example, the language would create a new agent card for receivership designation. The receiver has to obtain its own registered agent card and have the background check the CCB required of it to step in and operate the business. His charge from the court was to reestablish the business and protect the assets to the extent possible.

SENATOR HARDY:
If I was a receiver and wanted to keep the profits, is there a time limit on getting money back?

MR. SANDE, IV:
The receiver does not get to keep profits, they are putting them back into the business. They are able to charge an hourly fee, and those fees are reviewed by the court for reasonableness. The creditors have an opportunity to file protests if they feel anything is unreasonable, and the judge would be the person signing off on whether the fees were reasonable.

SENATOR HARDY:
Are these transactions cash-heavy?

MR. SANDE, IV:
Marijuana is in large part a cash-heavy business. In most instances, it is completely cash. There are some financial institutions that do accept debit cards and other financial arrangements some of the cannabis companies have.

SENATOR HARRIS:
I do not see discussion about how the $50,000 fine should be assessed. Is it based on quantity or number of violations? What factors are taken into consideration to determine whether the fine is zero or up to $50,000?

ASSEMBLYMAN ROBERTS:
We modeled this after the language of the State Contractors' Board. The Board bases it on the number of violations, size of the company and so on. Those are all factors taken into account by the hearing officer or judge. In that statute, it is silent and leaves discretion to those presiding over the hearings.

SENATOR HARRIS:
In the Board example, it is the Board that issues the fine, correct? We have the district attorney or city attorney issuing the fine.

ASSEMBLYMAN ROBERTS:
That is correct. It would be code enforcement and/or a business licensing entity that manages those businesses in those districts in concert with the city or district attorney.

MIKE CATHCART (City of Henderson):
The City of Henderson supports A.B. 326. Having another option to stop the illegal sale of cannabis is welcomed and helps lower the level of black market product competing with the well-regulated legal cannabis industry.

CHAD CHRISTENSEN:
I am part owner of Pisos Dispensary in Clark County. California has had up to 70 percent of the market of cannabis consumed illegally. If we considered that fact, the cannabis market may be the second-largest taxpayer in Nevada. We have two concerns; one is public health and the other is revenue to the State.

Black market or illegal cannabis is not tested, and the Legislature ensures Nevada has the most robust testing system to protect patients, consumers and visitors to our State. If someone assumes they are buying a legal product which is not legal and is detrimental to their health, it becomes bad national press.

We need to ensure the revenue from the sale of cannabis goes to the State, the schools and the programs we are working hard to fund. Imagine we cut the illegal number in half in Nevada to 35 percent; that would be a significant amount going to the State. This bill is a step in that direction.

LAYKE MARTIN (Nevada Dispensary Association):
The Nevada Dispensary Association supports A.B. 326. We want to thank Assemblyman Roberts for providing additional tools to combat dealers who market to organized crime. We are grateful for the flexibility to work with the industry to ensure required identification on advertising would not be a burden since the industry will help consumers distinguish ads for licensed versus unlicensed businesses. We support the amendment language to establish a process for receivership. As federal bankruptcy protection is not an option for cannabis businesses, statutory language and CCB regulations will help provide guidance for insolvent businesses and receiverships within the cannabis industry.

ASSEMBLYMAN ROBERTS:
This was a work in progress as it came out of drafting, and a number of changes were made. We will make additional changes and are agreeable to any the Committee may have. My objective is to give people a tool to lead unsuspecting tourists away from sites such as Weedmaps who skirt legitimate businesses in Nevada.

SENATOR HARRIS:
I will close the hearing on A.B. 326 and open the hearing on A.B. 374.

ASSEMBLY BILL 374 (1st Reprint): Establishes the Statewide Substance Use Response Working Group. (BDR 40-991)

ASSEMBLYWOMAN JILL TOLLES (Assembly District No. 25):
I am here today to present A.B. 374. In November of last year, the National Drug Helpline placed Nevada as one of 28 states on red alert for increased risk of death from overdoses of opioids and other drugs. The Covid-19 pandemic has amplified the existing opioid crisis. According to DHHS, Nevada has seen a 50 percent increase in opioid and fentanyl-involved drug overdose deaths since the onset of the pandemic.

The National Safety Council reports overdoses kill more of us than breast cancer, guns and car crashes combined. Our family was impacted by this crisis when one of our family members developed a dependency to pain medications after an accident at work. This led to dependency on street drugs and tragically ended with an overdose just before Christmas 2007.

In 2017, 626 Nevadans lost their lives, impacting countless brothers and sisters, mothers and fathers, children, spouses and friends. Addiction is treatable and preventable. There are 23 million people in recovery in the U.S. today. Recovery is not only possible but probable if one receives the right type of treatment and has access to support services.

Assembly Bill 374 establishes the Statewide Substance Use Response Working Group under the Office of the Attorney General. After discussions with stakeholders, there was a strong cry to convene an ongoing Statewide coordinated effort ensuring each entity is working in collaboration to identify gaps and employee evidence-based best practices to tackle issues of substance use disorder, behavioral health and other co-occurring disorders across Nevada. This bill is based on the direct input of the Attorney General, the Office of the Attorney General, DHHS, the National Association of Counties, Shatterproof and representatives of the mental health and recovery, prevention and treatment community.

Sections 5 through 7 establish the Nevada Statewide Substance Use Response Working Group adding membership, service requirements and other functions of the Working Group.

Section 6, subsection 2, outlines the membership of the group including the Attorney General or appointee, the Director of DHHS or appointee, representatives of local governments from Washoe, Clark and rural counties, law enforcement, health care recovery treatment and prevention communities, and Legislators.

It is my intention to add an amendment to the bill that would include representation from a hospital, considering hospitals are often on the frontlines, particularly in the emergency rooms, as well as K-12 representation per the request of the Clark County Education Association.

Section 10 outlines the duties of the group including making recommendations to DHHS on the use of monies and reporting to the Governor, Attorney General, Advisory Commission on the Administration of Justice and the Director of the Legislative Counsel Bureau.

Section 10.5 requires DHHS submit a report concerning the use of money received by the State from settlements, civil actions, gifts, grants or donations, and all other money spent by the State and each political subdivision for purposes relating to substance misuse and substance use disorders to the Working Group annually.

Section 14 states this legislation will become effective upon passage and approval.

STEPHANIE WOODARD, PSY.D. (Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services): The issues around substance use, misuse and addiction are complex and often involve an interplay between individual risk factors and environmental, social and economic conditions. Just as there is no one single driver contributing to the rising rates of substance misuse, addiction and overdose, there is also no one single solution.

During the preliminary work to address the methamphetamine and opioid crises, it was clear Nevada needed to implement strategies that crossed multiple

sectors including medicine, law enforcement, prevention, public health, and addiction treatment and recovery services. Such efforts led to the creation of the previous Attorney General's Substance Abuse Working Group and the sunsetted Governor's Opioid Accountability Task Force meetings where stakeholders engaged in data-driven discussions, supported needed policy and program development and implementation, reduced duplication of efforts and brought accountability and transparency to the process.

This intentional work across systems has led to coordinated strategies to address the crises at hand. As Nevada faces new challenges related to substance use addiction and overdose, we have seen it is not sufficient to establish groups to singularly focus on one issue or substance at a time. We need a comprehensive and collaborative approach.

The proposed Statewide Substance Response Working Group in A.B. 374 brings stakeholders together to develop comprehensive, evidence-based strategies and recommendations for preventions, early intervention, treatment, recovery, harm reduction, data sharing, criminal justice intervention and public policy. The focus of the Working Group will leverage and expand current efforts across departments and agencies to prevent and reduce substance use and enhance efforts through coordination and collaboration. It will introduce evidence-based prevention and intervention efforts to significantly reduce the burden of substance use.

Recommendations from the Working Group will include primary, secondary and tertiary prevention, access to harm reduction intervention services and overdose prevention strategies. This group will assess and evaluate existing pathways to treatment and recovery. It will work to understand how Nevadans access treatment and recovery support services from various points for individuals who interface with law enforcement or the criminal justice system. There will be a specific emphasis on deflection and diversion from the criminal justice system.

This Group will also work to improve and expand evidence-based or evidence-informed practices, procedures, and strategies for the treatment and support of individuals in recovery as well as specific recommendations for special populations.

The Working Group will support systems and programs for persons in recovery and recommend processes and regulations to ensure medications including

opioids and other controlled substances are prescribed appropriately and in accordance with existing NRS. The Group will examine qualitative and quantitative data to understand the risk factors contributing to substance use and the rates of substance use and addiction in Nevada, including across diverse and special populations. The Group will develop strategies and implementation plans to prevent and respond to overdose, set the efficacy and expand implementations of programs to educate youth and families about substance use and reduce harm associated with drug use.

This Group will improve coordination between local, State, federal law enforcement agencies and public health entities to enhance the communication of timely and relevant information and data. It will also evaluate current systems for sharing information between departments and agencies for the trafficking and distribution of licit and illicit substances. It will study the effects of substance abuse on the criminal justice system, the methods and resources to prevent the manufacture, trafficking and sale of substances, and the effectiveness of criminal and civil penalties, ultimately evaluating the impact of substance use disorders on the economy.

This Group will work to study, evaluate and provide recommendations toward the opioid settlement litigation funds the State will receive through the Office of the Attorney General.

In the absence of these formal convening groups, we have worked diligently to bring partners and invested stakeholders together to have these conversations, continuing to use the momentum developed in previous working groups, which has proven to be a challenge. Having a formal convening group to bring the necessary individuals together to do this important work will help Nevada make the necessary progress in addressing substance use.

CHRISTINE JONES BRADY (Second Assistant Attorney General, Office of the Attorney General):

The Office of the Attorney General supports A.B. 374 and is thankful to Assemblywoman Tolles for this bipartisan bill. Drug abuse and addiction knows no boundaries or parties. Who has not been personally impacted by problematic substance use or addiction?

The Office of the Attorney General will support this endeavor and the Substance Use Response Group by providing meeting space and ensuring public meetings comply with open meeting laws.

This Working Group consists of a diverse and dynamic group of professionals and citizens who will work hard to combat this Statewide problem.

SARAH ADLER (Vitality Unlimited; New Frontier Treatment Center):
My colleague Helen Foley had to leave so I will present her testimony in support of A.B. 374 from FirstMed Health and Wellness Center. In addition to traditional medical care, we provide mental health and substance addiction services to approximately 1,200 patients monthly. While we are proud of the services we provide, there are many roadblocks to quality care. A strong working group can help alleviate some of these problems to streamline the process and provide greater access with better outcomes to low-income and underserved populations.

Some opportunities include providing reimbursement for supportive services, such as case management for patients with substance use disorders, and allowing group therapy and peer support for medication-assisted treatment programs removing the barrier for dispensing suboxone for medication-assisted treatment-certified providers. The program should also pay for the initial phase of suboxone induction to prevent barriers to initiating care.

Many children and families come as a referral from schools, the Department of Child and Family Services, and the juvenile justice system. Because we connect our patients to external resources and have a robust group of providers, we are able to give a perspective of the lower-income patients generally affected by substance use. We would like a seat at the table or to join an advisory committee as the Working Group moves forward on this critical issue.

I will now give testimony for Vitality Unlimited and New Frontier Treatment Center supporting A.B. 374.

Addressing substance use disorders requires active work in prevention, residential treatment and community-based care to support recovery. The Substance Use Disorder Working Group proposal uses recognition of State and local entities throughout its language. We would like to cast a light on rural,

frontier, tribal and diverse communities and populations as specific communities we are confident will be addressed by this Working Group.

There is a need to look at workforce development. The Legislature has addressed the need for developing the behavioral health workforce. There is specific need related to licensed alcohol and drug counselors and licensed clinical alcohol and drug counselors. In Nevada, stigma is falling away from mental illness. We have developed many licensed professions that work with mental illness but are falling behind in our licensing of the alcohol and drug workforce.

We appreciate the support for Senate Bill (S.B.) 181, which removes one of the barriers mentioned earlier, and encourage the work of Assemblywoman Tolles and this bill to look at workforce development.

SENATE BILL 181 (1st Reprint): Revises provisions relating to alcohol and drug counselors. (BDR 54-558)

GEORGE A. ROSS (Hospital Corporation of America):
Hospital Corporation of America supports A.B. 374. All too often, hospitals see the unfortunate results of substance addiction and treat this issue every day. This bill is an impressive approach to helping address this problem by putting a group of people together that has been well chosen and blends into how the State works and how the group will meet and be supported.

MR. LAU:
Dignity Health-St. Rose Dominican supports A.B. 374. Hospitals are in a unique position in this nexus, largely because hospitals encounter people who may not have access to other healthcare options. An example would be a person who may not have a primary care provider ending up in an emergency room. At that point, hospitals have the ability to intervene and take steps to get that person into care. Dignity Health participates in this through various programs including its Empowered Program which focuses on pregnant women.

COURTNEY HUNTER (Shatterproof):
Shatterproof is a national nonprofit dedicated to reversing the addiction crisis and supports A.B. 374 for its impact on substance use and addiction in Nevada. At Shatterproof, we are focused on evidence-based solutions to ending this crisis. Having a stakeholder working group reviewing the data, assessing the

evidence and making informed solutions based on that evidence is a critical step forward, ultimately saving lives. A number of our core programs include looking at and assessing treatment quality, advancing behavioral health and integrating it into primary care settings.

We worked with Johns Hopkins University to provide guiding principles around how states are spending opioid settlement dollars. One of the principles is spending money to save lives. That means having dedicated funds making sure we are replacing dollars. Another principle is focusing on racial equity. We are accomplishing that through this stakeholder advisory group pulling together different types of community stakeholders to have a voice and seat at the table. If we not are alive, we cannot recover.

The final principle is transparency. Having the reporting mechanism within this group is an asset, providing a transparent record for the State and the Country.

KELSEY MATTHEWS (Shatterproof):
I am 23 years old and a Shatterproof Ambassador, the national nonprofit dedicated to reversing the addiction and overdose crisis. I am the founder of Treasuring Tracey, an addiction and overdose platform created in memory of my mother who passed away of an accidental drug overdose in 2016.

I have been blessed to have worked with many organizations in Las Vegas, including Teen Challenge. I serve on the Board of Directors at Hope Compassionate Healthcare, a nonprofit organization founded to provide comprehensive and integrated health care and filling the gaps in our healthcare system.

Personal life experiences have inspired me to join the fight against the addiction crisis and to pursue social work and a law degree to make an impact on the lives of others. Addiction is a family disease. The entire family unit suffers, which I can attest to firsthand. As a child, I was parentified over my mother and her struggle with addiction and functioned as one of her primary caretakers alongside my grandparents. This continued until her death in 2016 when I was 17 years old. I have seen things no child should see—witnessing my mother repeatedly overdose, finding myself at the hands of drug dealers and countless unimaginable things including being born addicted to cocaine.

People are dying, families are broken and children are losing their parents. Parents are burying their children. The crisis is a pandemic in and of itself. We need to get to the root of the problem in all its forms.

Looking back, I can see gaps in the system that exist today. There were times my mother looked for help and there was a severe lack of resources available to her for receiving adequate treatment from medical and mental health professionals. She was stigmatized and denied care due to insurance and financial reasons or providers being understaffed and unprepared. This is a sad reality in our communities.

The creation of the Statewide task force is necessary in the fight against this crisis. To be successful will take a team effort. We need a diverse team of people from all different backgrounds who possess lived experience with substance abuse disorders. Getting to the root of the crisis is going to require many things, including promoting and providing adequate and specialized behavioral health treatment and counseling. We need to ensure we have properly educated medical professionals and care providers with wraparound resources available to support families; work to reduce the stigma attached to substance use; and ensure patients seeking care are treated fairly and with compassion.

By creating a Statewide task force, we are giving people a chance to have their voices heard while coming together to be a part of the solution. In a time where division is running rampant, we need to stand united and work together to make a change in our communities.

I made my mother a promise that I would not allow her death to be in vain and one day I would use her story, our story, to make a difference.

BRENDA PEARSON, PH.D. (Clark County Education Association):
The Clark County Education Association (CCEA) supports A.B. 374 as amended. At the beginning of the pandemic, we realized stay-at-home orders were going to open up the potential for increased substance abuse. We must look at how we can work together as a community to put people and students in recovery together as we address substance abuse and overdose with our mental and behavioral professionals, wraparound services and programs preventing opioids on campus.

This Working Group will address substance abuse in our education system through the addition of a representative of K-12 education. Additionally, we have the opportunity to discuss and implement best practices leading to proactive support to address this issue. Clark County's Mission High School, the first comprehensive secondary school designed for students recovering from substance abuse, use and/or dependency, has brought hope and support to students in need. By adding K-12 to this Working Group, we can look at the successes of Mission High School and distribute health and human service and public outreach across the State to replicate the program.

As educators, we must do everything in our power to put our student's health first. The CCEA looks forward to supporting the development of this Working Group.

DAGNY STAPLETON (Nevada Association of Counties):
The Nevada Association of Counties supports A.B. 374. We appreciate the inclusion of county human services representatives and county law enforcement to the Working Group. There is an important nexus between the opioid crisis and many of the services counties provide including emergency response and human services.

ASSEMBLYWOMAN TOLLES:
This is meaningful legislation for myself and so many others. I will offer an amendment and open the invitation for anyone else to join as a cosponsor.

CHAIR RATTI:
I will close the hearing on A.B. 374 and open the hearing on A.B. 278.

ASSEMBLY BILL 278 (1st Reprint): Provides for the collection of certain information from physicians. (BDR 54-771)

ASSEMBLYWOMAN BEA DURAN (Assembly District No. 11):
I am here today to present A.B. 278 and will read from my written testimony (Exhibit G).

MAYA HOLMES (Health Care Research Manager, Culinary Health Fund):
Nevada has one of the largest physician shortage areas in the U.S.; we are forty-fifth in the Nation in providers per capita and fiftieth for primary providers. Nevada ranks forty-eighth in the Country for clinical care, forty-fourth for access

to care, forty-second due to adults avoiding care because of cost and forty-seventh in the Nation for quality of care.

Little is known about the specific market forces that may impact the physician shortage, access to affordability and quality, including basic information such as who owns or has purchased a physician practice in the State. Ownership of physician practices has changed dramatically over the last decade. In 2019, the American Medical Association announced that more physicians were employed than were independent for the first time. This is from national data based on periodic surveys. We do not have a comprehensive picture of our State that demonstrates trends in Nevada's healthcare market.

Some reports indicate hospitals now employ physicians who have been in private practice because of increasing overhead, reimbursement issues and the administrative responsibilities of ownership. The employment status of doctors may affect patient access. One study found employed physicians typically see fewer patients in a day on average than private practice physicians. Physician employment status can affect affordability. According to one study, hospital acquisitions of physicians increase physician prices an average of 14 percent, 33.5 percent for cardiologists and 20 percent for orthopedic providers. Numerous studies have shown private equity ownership of physician practices leads to higher prices.

Physician ownership can also affect referral patterns. A Stanford study showed physicians increased referrals to the hospitals who employed them and patients were more likely to be treated at a high-cost, low-quality hospital when their admitting physicians practice is owned by a hospital.

Assembly Bill 278 will allow policy makers, providers, patients and payers to understand critical trends in Nevada's healthcare market and their impact on physician volume, entity and practice. This bill adds to existing licensing renewal and biennial registration requirements, an internet link to a form developed by DHHS for physicians to indicate whether a physician is employed or independent, and if employed, where the physician practices and which entity owns that practice.

The Board of Medical Examiners and the State Board of Osteopathic Medicine are to include a link to these data requests and applications for license renewal and biennial registration. Applicants are required to respond but not subject to

disciplinary action or licensure or registration refusal for failure to do so. Any reporting on this data would be aggregated to protect provider privacy requirements and not reveal the identity of the physician.

Assembly Bill 278 requires DHHS to collect and maintain the information and prepare an annual report regarding physician practice and employment trends in Nevada and post the report on an internet website maintained by the Department.

It is critical that policy makers, public and private payers, and patients understand the role of entities like private equity and other major players that are consolidating the physician market to understand consolidation impact on access to quality and affordability. Because of our contracting, we know Neonatal Intensive Care Units and emergency room physician groups are now owned by private equity groups. We would like to see how that impacts price, access and contracting status over time. Without any reporting of who owns these and other practices, such trends will be impossible to evaluate.

The intent of this legislation is to add a brief data request to already required licensing registration reporting steps. The information will be known to the physician and will not add to the administrative burden. The information is already in the public domain but not available in an aggregated, accessible, meaningful and useful way for policy makers, providers, patients and payers; A.B. 278 will provide that.

BOBBETTE BOND (Health Care Policy Director, Culinary Health Fund):
In addition to the statistics you have heard today, the *Journal of the American Medical Association* has data on what has been happening with the Covid-19 crisis. There have been more private equity deals happening because of the Covid-19 crisis. In 2020, there were over 150 private equity deals closed in the second half of the year.

There are many factors that go into quality and access to health care. Nevada is struggling with this issue and physician density. We have been dramatically impacted by private equity acquisitions. As Ms. Holmes stated, we see that in our contracts but do not have a way to look at the data all together. Our history with the legislative process in the last 15 years has been healthcare transparency. We worked on hospital reporting and quality reporting, and in

2017 and 2019, we worked on prescription drug reporting. Last Session, we spent time with price bills, and there will be reporting coming from that.

We are one of the states that has the least amount of reporting on what is happening in the healthcare market. Health care is becoming a never-ending, unfortunate chase to provide access to quality while managing limited dollars.

One of our solutions it to track the impact of consolidation on pricing in a way we can monitor. This bill would provide a baseline without providing a lot of administrative overhead and without adding cost to the system. Physicians, when obtaining or renewing their license, provide basic information about who they are employed by. Is it a hospital, a large physician group or a solo practice? If so, what is the name of the practice and how many are in the group?

This would impact the Nevada State Board of Medical Examiners and State Board of Osteopathic Medicine. The limited information is needed for us to get a baseline so we can, over time, better see the impact of what is happening in the healthcare market. We realize if physicians are being licensed for the first time, they may not know how many people or physicians work in their offices; they would have to leave that area on the form blank.

We originally intended to add this information to the State Board application itself. During the last Assembly hearing, the Medical Board proposed an amendment to match S.B. 379, which would allow the information from that survey to be provided in a link the Board has on its application process. This link is intended to provide critical information about physician density in way we will see patterns.

SENATE BILL 379 (1st Reprint): Provides for the collection of certain data concerning providers of health care. (BDR 40-457)

This is more demographic data, not a survey with "yes" and "no" questions. There are no penalties if this information is not reported, but we are hopeful it will be so we have a way to track this information. The DHHS will have a role in making both of these bills merge together. This is in response to concerns from Senator Hardy about having two separate surveys coming from the Board.

CHAIR RATTI:
There have been references to S.B. 379 we previously heard in this Committee. We have checked with our legal counsel to ensure there is no conflict between the two bills that would need to be remedied. We have also checked with DHHS but should confirm with the Department if it can simultaneously implement the intent of both bills in an efficient way.

MARGOT CHAPPEL (Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services):
We can absorb this work and the two bills combined.

Remainder of page intentionally left blank, signature page to follow.

CHAIR RATTI:
I will close the hearing on A.B. 278 and seeing no public comment, the meeting is adjourned at 5:54 p.m.

RESPECTFULLY SUBMITTED:

Vickie Polzien,
Committee Secretary

APPROVED BY:

Senator Julia Ratti, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Begins on Page**	**Witness / Entity**	**Description**
	A	1		Agenda
A.B. 287	B	1	Assemblywoman Danielle Monroe-Moreno	Bill Presentation
A.B. 287	C	1	Assemblywoman Danielle Monroe-Moreno	Proposed Amendment
A.B. 287	D	1	Jimmy Lau / Dignity Health-St. Rose Dominican	Opposition Statement submitted by G. Rodney Buzzas
A.B. 287	E	1	Lynn Chapman / Nevada Families for Freedom	Opposition Statement
A.B. 326	F	1	Assemblyman Tom Roberts	Proposed Amendment
A.B. 278	G	1	Assemblywoman Bea Duran	Written Remarks