# MINUTES OF THE
# SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

## Eighty-first Session
## May 25, 2021

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:49 p.m. on Tuesday, May 25, 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 Pat Spearman, Vice Chair
Senator Dallas Harris
Senator Joseph P. Hardy
Senator Ben Kieckhefer

## GUEST LEGISLATORS PRESENT:

Assemblywoman Lesley E. Cohen, Assembly District No. 29
Assemblywoman Michelle Gorelow, Assembly District No. 35
Assemblyman David Orentlicher, Assembly District No. 20
Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6

## STAFF MEMBERS PRESENT:

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

## OTHERS PRESENT:

Mary Liveratti, Nevada Commission on Aging
Amy Peterson
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Barry Gold, AARP
Misty Grimmer, Alzheimer's Association

Erin Lynch, Social Services Chief III, Division of Healthcare Financing and Policy, Department of Health and Human Services
Jennifer Richards, Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services
Jay Kolbet-Clausell, MSW, Program Manager, Nevada Community Health Worker Association
Katie Roe Ryan, Dignity Health-St. Rose Dominican
Kendall Lyons, Children's Advocacy Alliance
Leann McAllister, Nevada Chapter of the American Academy of Pediatrics
Joan Hall, Nevada Rural Hospital Partners Foundation
Quentin Savwoir, Make it Work Nevada
Jolina Simpson, President, Kijiji Sisterhood
Lauren Kalogridis
Christine Saunders, Progressive Leadership Alliance of Nevada
Regan Comis, Anthem, Inc.
Jimmy Lau, Dignity Health-St. Rose Dominican
Amber Falgout, Battle Born Progress
Christina Hernandez
Emily Barney
Sarah Geowalton, Bright Heart Birth Services; Truckee Meadows BirthNetwork; Reno Doula Project
Jenna Cole
Katie Nease, Health Plan of Nevada
Bradley Mayer, Southern Nevada Health District; Washoe County Health District

CHAIR RATTI:
It is possible this is the last Senate Committee on Health and Human Services meeting this Session. This is my third Session on the Health and Human Services Committee, and each Session I had Senator Hardy and Senator Spearman with me. We are losing some great people to term limits this year. Given this could be the last opportunity, I will have Senator Hardy Chair this Committee meeting.

CHAIR HARDY:
I will open the hearing on Assembly Bill (A.B.) 216.

**ASSEMBLY BILL 216 (1st Reprint)**: Requires Medicaid to cover certain services for persons with cognitive impairments. (BDR 38-385)

**ASSEMBLYWOMAN MICHELLE GORELOW** (Assembly District No. 35):
I am here today to present A.B. 216. This bill mandates the State Plan for Medicaid to include coverage for cognitive assessment and care planning services provided to persons with symptoms of cognitive impairment—this would include Alzheimer's or dementia.

Alzheimer's disease is the single most expensive disease in the U.S., outpacing the cost of cancer and heart disease. An analysis by the Alzheimer's Association calculated the direct cost posed to caregivers totaled $305 billion in 2020, and the Association also estimates that Medicare and Medicaid covers 67 percent of the total cost.

There are several early intervention and detection strategies that can avoid the astronomical expenses associated with late-stage dementia and Alzheimer's. The Milken Institute released a report showing early diagnosis in the mild cognitive impairment stage could create cost savings as much as $7.9 trillion in U.S. health and long-term care expenditures by enabling better planning, management and care.

Assembly Bill 216 requires the State Plan for Medicaid cover the nonfederal share for cognitive assessment and care planning services for persons with cognitive impairment symptoms. By funding assessments and care planning, we can get ahead of cognitive decline to ensure those suffering, and their caregivers can manage the devastation of cognitive impairment. For families with members who may have Alzheimer's, this bill will ensure support services are in place as the disease progresses. This type of advanced care planning can prevent acute hospitalizations that can be traumatic for individuals and their families and generate unnecessary expenses to the healthcare system.

**MARY LIVERATTI** (Nevada Commission on Aging):
I am a volunteer with the Alzheimer's Association, AARP and the Nevada Commission on Aging, today representing the Nevada Commission on Aging. This bill will allow families with members suffering from cognitive impairment more time with physicians to do a thorough assessment and diagnosis and help with care planning.

Dementia is not just for seniors. Although we normally think of it as a disease of people over 65, the Alzheimer's Association estimates 5 percent of those with dementia have the young-onset form of Alzheimer's—this is 200,000 people in the U.S. According to data from Medicaid, between fiscal year 2016 and 2020, over 4,000 individuals under 65 already in the Medicaid program had a diagnosis of Alzheimer's disease or another dementia.

Dementia is more prevalent for individuals 65 and older. According to a 2015 survey conducted by the Department of Health and Human Services (DHHS), Nevada shows 16 percent, or 1 in 6 Nevadans between the ages of 45 and 64 reported worsening confusion and memory loss we call subjective cognitive decline (SCD). This condition is associated with later development of dementia, and nearly half of the people in this survey had not talked to a healthcare professional about their concerns.

Not all people who experience or report SCD go on to develop dementia or need this comprehensive service. A review of pertinent research conducted by graduate students at the University of Nevada Reno, School of Medicine, Sanford Center for Aging found between 5 percent and 8 percent of those who report SCD do develop mild cognitive decline or dementia.

Early and accurate diagnosis is important because young-onset dementia affects work, finance and family. Many times people are still employed when they develop dementia, and early and accurate diagnosis is crucial to rule out other potentially treatable conditions. To get the most appropriate treatment early in the disease process is important.

One day my father believed there was an intruder in his home and called the police. The police came; he did not believe they were the police and would not let them enter his home. I spoke with a member of the Alzheimer's Association who told me dementia does not usually present this quickly and I should take him to see a doctor. It turned out my father had a urinary tract infection which caused the confusion and delusion, and he was diagnosed and provided with the correct medication. It is important we have the correct screening because sometimes symptoms may not be dementia and can be treated appropriately.

Early and accurate diagnosis gives patients and their families more time to make important decisions about financial and legal issues. It allows individuals time to work with their employers on work accommodations, disability coverage or early retirement options. It allows individuals to apply for disability insurance and supplemental income benefits from the Social Security Administration. It allows individuals to access clinical trials ongoing across the Country. We will only find a cure with research.

The service we are asking for is already covered by Medicare and Tricare, and was added to those programs in 2018. While Nevada Medicaid does not cover it, there are 15 other states that have this service. We feel there is future cost savings through the Social Security Administration which has, for young-onset Alzheimer's disease, a condition under its Compassionate Allowances program giving anyone with the disease an expedited access to social security disability insurance and supplemental security income (SSI).

This can lead to significant savings to the State and our Medicaid program. After a two-year waiting period, individuals on SSI can become eligible for Medicare. This shifts the medical cost from Medicaid to the fully federally funded Medicare program leading to future savings.

SENATOR SPEARMAN:
There is a rare disease called Lewy body dementia. I am unaware if we have found anything to help those with this disease.

Covid-19 creates brain fog, and we are not yet aware of the side effects from this. Are there any studies looking into how this might link to early-onset dementia or Alzheimer's?

MS. LIVERATTI:
Think of dementia as vegetables. Lewy body, Alzheimer's, frontal and temporal issues are like carrots, celery and potatoes. Dementia is the overarching disease. We are doing research, but I have not heard anything specific to Covid-19. I had cancer and went through chemotherapy and experienced brain fog associated with that.

SENATOR SPEARMAN:
If they are not doing research on this, it may be worthwhile to do so because we do not know enough about the long-term effects of the virus.

AMY PETERSON:
My husband, Drew, celebrated his forty-seventh birthday living his dream as a 737 captain for a major airline. He had a degree in engineering and owned,

restored and maintained a fleet of vintage airplanes. He was an accomplished woodworker, avid reader, traveler and history buff.

A month after his birthday, he surrendered his pilot's license knowing he could no longer fly because he was making poor decisions. He was having trouble with numbers, and there were things he was experiencing he knew were not normal. I continued teaching for three years after his diagnosis, but when I came home I never knew whether my husband would be Dr. Jekyll or Mr. Hyde. The mood swings were increasing and depression was setting in, but he was very good at hiding and compensating for his condition.

I knew Alzheimer's ran in his family but never imagined it would present in a 47-year-old healthy man. His mother had Alzheimer's and passed away when she was 58 years old. He has two sisters, one of which has passed away. The other sister is in the middle to moderate stages of Alzheimer's.

Three years later, after MRIs, scans and tests, a DNA blood test confirmed a genetic mutation on the 14th chromosome, and another procedure confirmed elevated levels of tau protein in his spinal fluid. It was official—he had Alzheimer's disease. They referred to it as apolipoprotein E (APOe-4), a gene which is a rare form of Alzheimer's; that presents itself in young-onset and familial cases.

After the diagnosis, there was a flurry of getting the family trust in order, powers of attorney and financial considerations in place for a man who could no longer work. I could not return to work and became a fulltime caregiver because he could not be left alone. He was forced to take medical retirement 18 years before his planned retirement at age 65. A friend suggested we apply for SSI. We got the neurologist's diagnosis in writing, numerous psychological tests, and finally SSI was approved, which made him eligible for Medicare.

He eventually developed blood clots, both pulmonary and deep vein thrombosis, and became a wanderer and a fall risk. I was sleeping with one eye open and was myself experiencing atrial fibrillation. The last 18 months of my husband's life were spent in a nice, clean, safe small group home specializing in dementia where they tended to his every need, but they did not accept Medicare. Thankfully, SSI covered about 60 percent of his monthly care and the rest was an out-of-pocket expense. My husband took his last breath two weeks after his fifty-eighth birthday. My husband of thirty years was now gone, and I was a widow at 55 years of age.

I have been fortunate to volunteer for the Alzheimer's Association for the past five years doing educational presentations and facilitating caregiver support groups for the Senior Center for the Southern Nevada State Veterans Home in Boulder City.

My story is not unique and the caregivers I work with share similar stories.

DUANE YOUNG (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
A fiscal note was removed because we believe there are savings based on delaying care into nursing facilities and providing other services such as home health and personal care services.

BARRY GOLD (AARP):
Ms. Liveratti mentioned earlier that dementia is not just for seniors. Alzheimer's and all cognitive diseases can have a terrible impact on people earlier in their lives. On behalf of AARP, we support A.B. 216.

MISTY GRIMMER (Alzheimer's Association):
The Alzheimer's Association supports A.B. 216.

ERIN LYNCH (Social Services Chief III, Division of Health Care Financing and Policy, Department of Health and Human Services):
With the first reprint of the bill we have a fiscal note posted with a zero dollar impact.

JENNIFER RICHARDS (Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services):
This bill will have an impact on the populations the Division serves. This bill may reduce unnecessary guardianships and hospitalizations in our State, and the Division appreciates the insight on the fiscal note.

CHAIR HARDY:
I will entertain a motion on A.B. 216.

SENATOR KIECKHEFER MOVED TO DO PASS A.B. 216.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR HARDY:
I will close the hearing on A.B. 216 and open the hearing on A.B. 191.

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

ASSEMBLYMAN DAVID ORENTLICHER (Assembly District No. 20):
I am here to present A.B. 191 which requires Medicaid to reimburse services provided by community health workers. By doing so, this will increase the capacity of our healthcare system for prevention and early treatment leading to considerable cost savings.

JAY KOLBET-CLAUSELL, MSW (Program Manager, Nevada Community Health Worker Association):
Presenting this abridged A.B. 191 slide show, Medicaid reimbursements for community health workers, (Exhibit B), is a privilege. The full presentation was recorded in the March 8 Assembly Health and Human Services meeting.

Community health workers (CHW) are community members who bridge the gaps in Nevada's healthcare system. They come from underserved rural and urban communities and represent the diversity of our State in the medical service sector. Medical CHWs provide education and training for patient self-management and are defined in *Nevada Revised Statutes* (NRS) 449.0027.

The Division of Public and Behavioral Health studied CHW service in our State and found a nearly $2 savings for every $1 spent. Emergency room visits decreased 14 percent, urgent care visits by 6 percent, acute admissions by 18 percent, and repeat hospital visits by 20 percent when CHWs were utilized to manage chronic illnesses.

Additional information may be found on the Nevada Community Health Worker Association, <NVCHWA.org>, website. We have submitted a list of supporting groups (Exhibit C).

CHAIR HARDY:
What would it entail if we consider sharing the nonfederal portion of expenditures, and who will be paid, the physician, physician assistant (PA), advance practice registered nurse (APRN) or the CHW?

MR. YOUNG:
We would set this up as a separate provider type. The CHW would enroll in Medicaid but would be linked to a physician, APRN or PA. The CHW would bill with the enrollment link and be reimbursed as a separate provider type.

CHAIR HARDY:
Where does the money go?

MR. YOUNG:
The money goes to the enrolled provider. That provider could have another arrangement with the supervising provider who does the billing collectively for the group; this is not an arrangement Medicaid is involved in.

CHAIR HARDY:
So the money goes to the CHW under the auspices of the license of the physician, APRN or PA?

MR. YOUNG:
Correct.

SENATOR SPEARMAN:
What, if anything, are we doing to ensure CHWs are representative of the diverse communities in Nevada?

MR. YOUNG:
There is language in NRS that CHWs must be representative of the communities they serve. Existing CHWs utilized through community coalitions, local hospitals, qualified health centers and grants represent that community and bilingual or multilingual to reflect the needs of the community they serve.

SENATOR SPEARMAN:
Sometimes, NRS does not translate into reality. My concern would be that if we are going to implement this, we make sure to represent the communities we serve. We need to be intentional in reaching out to Black, Indigenous and People of Color (BIPOC) communities to ensure we partner with the people doing the work due to what happened during the Covid-19 pandemic.

MR. KOLBET-CLAUSELL:
This is a concern for the Community Health Worker Association. We do not have a diverse health workforce in Nevada, and CHWs are the easiest to work with. We are starting programs in high schools and bringing in new instructors who represent different communities. We have an instructor from Fernley and one from an urban Las Vegas community who will start in June. By representing everyone in those instructors and the work pool we have, we are able to bring in a more diverse workforce that can go on to social work positions or pursue higher nursing degrees.

SENATOR SPEARMAN:
As a State, we might do better by going to the people that know the people. By going to churches, fraternities, sororities, community organizations and listening sessions we can find out what to do differently and how often. We should have a way to relate to the community to develop trust. My fear is that if there is no intentionality about ensuring we are reaching out and acknowledging diversity, this bill will end up the same way any other bill ends; nothing will happen except for good intensions that go nowhere.

MR. KOLBET-CLAUSELL:
We are applying for funding to hire CHWs directly in these communities from every source we can find. We have Covid-19 relief funds specifically targeted to Latino and Native American tribal agencies. We are looking at updating our curriculum by bringing in consultants from the communities to review the language and work to address those issues.

CHAIR HARDY:
When a PA is working with a physician, there is typically an agreement in place. The State Board of Medical Examiners is interested in what that agreement is and that we have an official designation for who the physician is supervising. What are the ways those agreements have worked or are working?

MR. KOLBET-CLAUSELL:
Most states that have CHWs have a more broad supervision provision than what we are proposing. Our conservative method is a great way to start this program. These other programs will use social workers and different provider types to be supervisors. We are not proposing that. We are looking at a structured setup where CHWs will have a license that has been approved. They will be working with physicians, APRNs and PAs with a lot of support for the employer, the CHW Association and national partners. We know CHWs are qualified to do the work and able to connect to the tasks they are not able to perform.

I am looking at the responsivity and accountability piece. We want this program to be successful. We need more outreach workers to see clients. Assembly Bill 191 is looking to expand this so we do not demand so much of our healthcare systems. We are catching things early, teaching things in a culturally relevant way in the appropriate languages directly in the communities, schools, homes and churches where people live to build trusting relationships.

CHAIR HARDY:
*Nevada Revised Statutes* 449.0027 describes a CHW as an unlicensed person. Are you talking about licensing or certifying someone separate and distinct?

MR. KOLBET-CLAUSELL:
A CHW is not required to have a license to be called a CHW. For Medicaid reimbursement, that license will need to be pursued.

MR. YOUNG:
For the purposes of enrollment, the CHW will need to have a license and present it at the time of enrollment.

CHAIR HARDY:
Is there a license under a board and a fee for that license; is this in the bill?

MR. KOLBET-CLAUSELL:
This has been created and we are running classes for the licensing. Many employers are using the program even though it has not been tied to Medicaid. This bill is not about creating the program, this is about Medicaid reimbursing the staff serving Medicaid clients.

CHAIR HARDY:
Where in statute does the licensing appear? Does it appear in NRS chapter 222?

ERIC ROBBINS (Counsel):
Community health workers are not a licensed profession under Nevada law; however, CHW pools are licensed under chapter 449 of NRS.

CHAIR HARDY:
What defines a pool?

MR. ROBBINS:
Per NRS 449.0028:

> "Community health worker pool" means a person or agency which provides, for compensation and through its employees or by contract with community health workers, the services of community health workers to any natural person, medical facility or facility for the dependent. The term does not include an independent contractor who personally provides the services of a community health worker or a facility for the dependent or any medical facility other than a community health worker pool which provides the services of a community health worker.

If CHWs are working for another type of facility, they would be covered by that facility's license. If it is an entity that arranges for CHWs to provide services to people or facilities, they would be licensed as a community health worker pool.

CHAIR HARDY:
This bill would allow a pool to be paid and the pool would pay the CHW, but the CHW would not be an independent other than if they are working under the pool, correct?

MR. ROBBINS:
If CHWs are working for a facility, they would be paid through that facility. If they are working for a physician, APRN or PA in their individual capacity, they could be reimbursed through that provider.

CHAIR HARDY:
So the CHW would receive payment from the supervising physician, APRN or PA, or the pool?

MR. ROBBINS:
The CHWs would receive payment from the pool or facility they are working for.

SENATOR RATTI:
The CHW models I am familiar with are generally working for agencies including nonprofit agencies. They have to be supervised by the list of licensed professionals but not necessarily sponsored by them. The agency would pay the CHW and also pay the physician, APRN or PA, but it is not necessarily a direct pay relationship between the two. There must always be a supervisory relationship between the two, is that correct?

ASSEMBLYMAN ORENTLICHER:
That is correct.

MR. KOLBET-CLAUSELL:
The certification we have is through the Nevada Certification Board. It is not a license.

SENATOR RATTI:
This is similar to the peer support specialist bill we heard earlier this Session.

CHAIR HARDY:
The agency or facility would have requirements for whom they employ and supervise. Would the CHW be in a position to receive remuneration through this bill for the services he or she provides?

SENATOR RATTI:
Yes. The step moving forward is a sustainable business model that allows us to employ more critical members of the healthcare team.

SENATOR HARRIS:
Is it possible to partner with the Office of Minority Health and Equity to do outreach and gain cultural competency for the CHWs?

MR. KOLBET-CLAUSELL:
We are partnered with them and are looking at hiring some of their stakeholders for our staff.

MR. YOUNG:
We require licensure or certification, and in this case, certification as a requirement of enrollment. The physician, APRN or PA is the supervisor because they are the employed agencies, federally qualified health centers and a myriad of Medicaid providers. This would provide Medicaid providers the Medicaid reimbursement. The arrangement may be multivaried based upon current payment arrangements.

CHAIR HARDY:
Is there a criteria or curriculum for the CHW before they are hired, or is it up to the facility or agency that hires them to provide the scope of practice?

MR. KOLBET-CLAUSELL:
We do have a curriculum with the Nevada Certification Board and are looking at updating that curriculum. Those classes are an eight-week program that is ongoing and popular. There are two other programs in the State; one at the College of Southern Nevada and the other at Truckee Meadows Community College. All three work together and apply jointly for funding.

CHAIR HARDY:
This bill will provide a stream of income that will give CHWs the motivation to work within the system and expand healthcare delivery in shortage areas and BIPOC communities, and you are committed in that direction.

MR. KOLBET-CLAUSELL:
That is true.

KATIE ROE RYAN (Dignity Health-St. Rose Dominican):
Dignity Health provided a letter of support (Exhibit D) from Holly Lyman and are grateful the Interim committee on Health brought this up as one of its issues. During normal circumstances, we have CHWs and promotors out in the community teaching about disease and chronic conditions. It has been different with the pandemic, but we have been doing it virtually.

KENDALL LYONS (Children's Advocacy Alliance):
Children's Advocacy Alliance supports A.B. 191. I am a former CHW for a Medicaid managed care organization in Nevada and have seen firsthand how impactful a CHW is to families new to Nevada or the Medicaid system. The ability to connect directly with someone like a CHW who understands the complicated healthcare system and resource landscape in Nevada helps minimize the stress that makes accessing health care feel burdensome for many.

In my two years as a CHW, I connected people with their primary care physicians, advocated for them to ensure timely delivery of prescription medications and connected them with community-based resources that helped to minimize the barriers to care, such as transportation, energy and food assistance programs.

This bill will not only save the State money, it will help people; any legislation that can do both is good policy.

LEANN MCALLISTER (Nevada Chapter of the American Academy of Pediatrics):
I offer support for A.B. 191 on behalf of the Nevada Chapter of the American Academy of Pediatrics (Nevada AAP). Community health workers play a crucial role in the dissemination of medically accurate information to various communities. In one specific study, research showed CHWs significantly improved the health outcomes of children with asthma. They have great potential to improve key access to health care and increase families' adherence to provider's recommendations.

The Nevada AAP has more than 250 members, most of whom are board-certified pediatricians who provide both primary and specialty care. Members also include pediatric nurse practitioners, physician assistants, pediatric residents and medical students, all of whom live and work in Nevada and have dedicated their professional lives to the health of all children.

JOAN HALL (Nevada Rural Hospital Partners Foundation):
Nevada Rural Hospital Partners Foundation supports A.B. 191. Community health workers are trustworthy individuals who share life experiences and culture with those they serve. They are trained to navigate systems, such as health care, housing, insurance enrollment and transportation, and link community and clinical services to help people in their own communities lead healthier lives and understand disease and injury prevention measures.

During the Covid-19 pandemic, in the rural communities we saw firsthand the value when CHWs reached out to our migrant farm workers and tribal members with information and education on preventative measures, assistance in getting testing and vaccinations. Reimbursement for these services is important and more affordable than other alternatives. We have worked many years on this concept and urge your support for A.B. 191.

MS. LYNCH:
The Aging and Disability Division is neutral on A.B. 191 in that we have a cost savings that has been posted as a fiscal note.

CHAIR HARDY:
I will entertain a motion on A.B. 191.

SENATOR KIECKHEFER MOVED TO DO PASS A.B. 191.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR HARRIS WAS ABSENT FOR THE VOTE.)

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CHAIR HARDY:
I will close the hearing on A.B. 191 and open the hearing on A.B. 256.

**ASSEMBLY BILL 256 (1st Reprint)**: Provides for Medicaid coverage of doula services. (BDR 38-849)

ASSEMBLYWOMAN SHONDRA SUMMERS-ARMSTRONG (Assembly District No. 6):
I am here today to present A.B. 256 which will enable Medicaid coverage for nonmedical doula support services.

In January 1987, I found out I was pregnant with my first child. I was living with my first husband in the small town of Sispec, West Germany, at an Air Force forward operating location. The nearest military hospital was over two hours away in the port town of Gramerhoffen, West Germany. Because of the distance between where we lived and the military hospital, I was given the option of either going to Gramerhoffen two weeks before my due date and stay there until I gave birth or have services at the local German hospital. I decided to have the baby at the local hospital.

I did not know at the time that part of the continuum of care in that region was the services of a midwife. The midwife who helped me was a stout, dark haired, no-nonsense woman who spoke very little English. Although she had a firm demeanor, she exuded kindness and competence, which was just what I needed as a first-time mother 5,000 miles away from my mother. She provided everything I needed at that time. Our first meeting was at my home, and my landlord's wife acted as the interpreter. My midwife asked lots of questions and made suggestions such as placement of the baby in the window every day. I did not realize Black babies needed vitamin D and sunlight. She talked to me about how to position the baby during the day so he would not have aspirations and sudden infant death syndrome. I was able to attend Lamaze and La Leche League classes in her home. The first floor of her home was padded, and a dozen young mothers went there on a weekly basis for this training.

She was my rock during the birthing process. Epidurals are not common in their healthcare delivery system, and she helped me get through the breathing and concentration with touch and encouragement. After the baby was born, she visited me every day in the hospital. At that time, new mothers stayed in the hospital for six days. This woman, who acted as my mother, made sure I got the best care possible.

This story illustrates the difference it can make when a mother has support before, during and after delivery. Today's best practices tell us nonmedical doula services are great at providing support for the mother, which is the midwife's job, and the physician delivers the baby. When Quentin Savwoir came to me with this legislation, the first thing that came to mind was the amazing experience of the birth of my first son.

QUENTIN SAVWOIR (Make it Work Nevada):
Make it Work Nevada builds power around economic, racial and reproductive justice. Part of our mission is to advocate for the health and vitality of our community members, and A.B. 256 is anchored in that intention. We are facing a national maternal health crisis in this Country since the U.S. is the most dangerous place in the developed world for an expectant parent to give birth. The reality is even more dismal for Black women who die at disproportionately

higher rates than their counterparts. Forty-three Black women die every 100,000 live births; this is unacceptable in the greatest Nation on earth.

When I first learned of this statistic, it devastated me because I know how I feel about my own mother, and because I could not help think about all future Nevadans that would be born into this world without their mothers. I was overcome with grief wondering how many of these children would never know the unconditional love and comforting warmth of their mother. It did not take long to find out the national trends we are facing as a Country are particularly present right here in Nevada. We conducted field research and a series of focus groups to best understand the health needs of our community members.

Our Black women's agenda survey of more than 1,000 Black women in Nevada discovered that more than a fifth of respondents reported maternal health as their most preeminent and pressing issue. We also found that one-fifth of respondents reported feeling 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 we learned the troubling realities postpartum has on new parents. The women and birth parents we spoke to talked about feeling stressed and fatigued, and they experienced hardships with chest or breast feeding among other hardships that a nonmedical doula would be aptly capable of supporting a parent through.

In these same conversations, nearly a third of our participants reported not having access to prenatal care at all. These conversations culminated with our community members revealing doulas would be the most helpful resource during pregnancy alongside parenting classes and additional resources to help with postpartum depression.

Our research and conversations resulted in the pursuit of this legislation. Expanding Medicaid to provide doula services to mothers and expectant parents is one of the best ways to mitigate subpar birth outcomes, ensure new Nevadan children are getting a healthy and thriving start, and serve as a cost-saving measure for our State. There is immeasurable value in having support, guidance and an ally when navigating the logistics, uncertainty and newness of childbirth.

Research has found that mothers and expectant parents who have access to doulas have improved birth and overall health outcomes. Assembly Bill 256 is community-driven policy. At its core, it is about the type of future we want our children to have, one where we see value in their lives before they arrive—one where we ensure their mother or birth parent has access to any and all resources that can ensure a safe and healthy birth, and a postpartum period met with support and ease instead of trauma and stress. We can do something about this, and we should.

JOLINA SIMPSON (President, Kijiji Sisterhood):
Kijiji Sisterhood is a nonprofit in Las Vegas that supports Black and Brown birthing people through the prenatal, birth and postpartum process.

I want to talk about the real, intangible and necessary support having a doula provides in our communities. Doulas are a bridge for our birthing families. We sit in living rooms listening to the concerns, hopes and birthing plans, building relationships that connect to the hearts and desires of birthing families as they work to bring healthy babies into the world. Doulas are coach, confidant, teacher and hype man. We stand beside and hold space for our strong birthing people. Through education, conversation and support, we provide vital connections to understanding and navigating the birth process.

Doulas provide support and advocacy in ways our medical system often cannot. We feed the humanness of birthing persons. We care for them in the community because we care deeply for our community. Research shows doula care can help mitigate some of the negative social determinates of health, such as poverty and systemic racism, which can negatively impact birthing outcomes. Doula care provides clients with a sense of agency, feelings of personal security, respect and autonomy. They provide knowledge transference and connectedness. In communities of color, rural environments and low-income communities, this translates to better birth and postpartum outcomes.

Unfortunately, support is not always available to underresourced members of our community because the cost of being poor is high and their working dollars go toward maintaining households and navigating tenuous financial circumstances. Having a doula should not be a luxury.

Kijiji Sisterhood provides a continuity of care that brings community with us when we step into the hospital with our clients. We also provide support and resources to our clients when they go home. We have eyes, hands and hearts on our clients. We stand in the gap to provide resources to protect birthing persons and their new babies. Because we take time to build relationships with clients, we are often the first call when they have questions or concerns. We reaffirm them as parents and connect them with medical providers and community resources such as lactation professionals, affinity support groups and mental health providers.

Doula work is work. I have been a birth professional in Las Vegas for 18 years and have seen families choose unsupported birth and postpartum because they were unable to finance it. I have personally sat in the living rooms of postpartum families with mothers who are exhibiting suicidal ideation, and I stayed with those mothers until their partners could get home and provide support. We connected them with emotional, educational and medical support and, with their permission, provided reports to their care providers so they could be brought into the loop to support these families.

Doulas spend hours in direct, one-on-one care with each client. Doulas in communities will often reduce their fees or go unpaid to support families at their own financial expense. Paying community doulas is one way to support health and economic well-being within our communities. Simply because birthing persons are unable to pay for the expanding rates of private doula care does not mean they are any less deserving of this protection and support.

By allowing equitable Medicaid reimbursement, we can serve our communities in a way that is financially viable for birthing families, community and doulas.

ASSEMBLYWOMAN SUMMERS-ARMSTRONG:
Our next presenter, Lauren Kalogridis, has provided presentation (Exhibit E) she will review during her testimony on A.B. 256.

LAUREN KALOGRIDIS:
I am a psychotherapist focusing on perinatal mental health as well as doulas with Reno Doula Project and Bright Heart Birth Services. I am also the program manager of Thrive Wellness of Reno's It Takes a Village program, which is the only intensive outpatient mental health treatment program in Nevada specializing in the treatment of perinatal mood and anxiety disorders impacting upwards of 20 percent of birthing people. Those numbers are disproportionately high during the pandemic.

In my role at Thrive, I see high rates of perinatal mood and anxiety disorders and corresponding birth trauma, lack of social support concerning birth and other factors that doulas can directly reduce and positively impact.

Doulas are key referral resources who send struggling parents to us and link them to psychiatric and medical support, and community resource support they need and deserve. They leverage the trust and deep knowing they have of their clients to connect them to the care needed when things are most dire.

Beyond the central goal of preventing human suffering related to perinatal mental health struggles, it is also reasonable to assess doulas pose additional cost savings potential in terms of preventing and lessening the need for additional psychiatric and mental health treatment postpartum many insurers are paying for at great lengths. In this way, doula coverage is a powerful intervention, meeting the DHHS triple aim of improving health outcomes, quality of care and cost savings.

Doulas offer the continuity of care and strength-based human-centered support our healthcare system is sorely missing, a lack that disproportionately impacts the most at risk in our communities including folks on Medicaid. The expansion of Medicaid coverage in Nevada would benefit all parties involved from healthcare providers looking to improve birth outcomes, overextended nurses on labor and delivery floors, insurers looking for cost-saving opportunities and doulas hustling out of pocket to ensure people in their communities have access to the support they deserve. All birthing people deserve to have experiences that are supportive, safe and dignified.

CHAIR HARDY:
We have information on Cost Savings for Medicaid Programs (Exhibit F) and a Summary of Doula State Savings (Exhibit G) that have been provided to us. We also have a negative fiscal note, so this bill will save money.

SENATOR RATTI:
Unlike the first two bills we heard this Session, it looks like doula services are not no automatically eligible service for Medicaid, and it requires we apply for a waiver. Can anyone available walk us through the process for applying for the waiver and what the conditions of that waiver are?

MR. YOUNG:
The language in the bill is written as a State Plan or waiver. We do not have to apply for a waiver for these services since we can add this through the State Plan process and not have that additional financial impact.

SENATOR RATTI:
Would the intention be to put this in the next State Plan amendment?

MR. YOUNG:
Yes, the effective date is the first of the year. During the Interim, we would work with stakeholders on a provision in the bill stating we determine the enrollment based off the work with stakeholders. There are several different national recommendations and certifications we would apply this to. We would build the State, as well as the corresponding policy, and have that ready to roll out at the beginning of the year.

CHRISTINE SAUNDERS (Progressive Leadership Alliance of Nevada):
The Progressive Leadership Alliance of Nevada supports A.B. 256. Nevada has made a commitment to addressing maternal mortality, but there are still women who have been left behind. According to the National Academy for State Health Policy, Black and Indigenous women are three to four times more likely to die from pregnancy-related causes than White women.

Doulas are an effective part of the healthcare system. Culturally competent doulas are able to provide support and care to improve birth outcomes for women of color. Data shows doula-assisted mothers were four times less likely to have a low birthweight baby, two times less likely to experience a birth complication involving themselves or their babies, less likely to require a cesarean section and significantly more likely to initiate breastfeeding.

Medicaid coverage of doula care will ensure all future Nevadans, regardless of their family’s economic status, are born with the best possible health outcomes and support from the State.

MS. LYONS:
Children’s Advocacy Alliance supports A.B. 256.

REGAN COMIS (Anthem, Inc.):
Anthem, Inc., supports A.B. 256. According to America's health rankings, Nevada ranks forty-sixth of the 50 states when it comes to women and children's health, mostly due to the State's low position of population ratios. We also recognize women who are Medicaid beneficiaries are at the highest risk of poor birth outcomes in the U.S., and women of color are especially vulnerable and face many barriers when accessing doulas.

For these reasons, Anthem and the Reno Doula Project are working together to launch a new maternal health project in Washoe County with the intention to expand, making doula services available to our beneficiaries at no cost. As we look for ways to improve Nevada's maternal health and infant rankings, we support innovative solutions to improve health outcomes and believe doulas can help decrease mortality and improve birth outcomes for women and infants covered by Medicaid.

JIMMY LAU (Dignity Health-St. Rose Dominican):
Dignity Health-St. Rose Dominican supports A.B. 256.

AMBER FALGOUT (Battle Born Progress):
Battle Born Progress supports A.B. 256. This bill expands coverage for doulas and is right for mothers, especially mothers of color.

CHRISTINA HERNANDEZ:
I urge the committee to support A.B. 256.

EMILY BARNEY:
I work as a birth and postpartum doula with Bright Heart Birth Services, the Reno Doula Project and as a member of the Washoe County Doula Pilot Program sponsored by Anthem. I am a voice of many, and everyone has done an incredible job of advocating for doulas in the community. I support A.B. 256, especially for families of color who have not had access to doulas for far too long and need more resources to improve their birth outcomes and decrease the likelihood of negative birth outcomes in the maternal mortality crisis.

SARAH GEOWALTON (Bright Heart Birth Services; Truckee Meadows BirthNetwork; Reno Doula Project):
I am the sitting Director at Reno Doula Project which started in 2012 as a way to help parents access doula support. Historically, having a doula was

something only people of privilege were allowed to access. The Reno Doula Project's mission is to close the gap, placing the cost of a doula on an income-based sliding scale to ensure families of all income levels are able to hire a doula. This is an important and personal goal of mine.

There is no doubt that doulas provide a necessary service. Birthing people who have doulas attend their births have lower rates of unnecessary interventions during labor and higher rates of birthing satisfaction.

In addition to the Reno Doula Project, I am a birth and postpartum doula, a certified childbirth educator, owner of a local family resource center and the owner of Bright Heart Birth Services. Bright Heart works tirelessly to make the role of doula legitimate within the 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 the path for doulas to be well regarded in my community.

I support A.B. 256, doulas at more births, and including doula services into Medicaid-covered benefits Statewide for Nevadans.

JENNA COLE:
I am a postpartum doula for Bright Heart Birth Services and support A.B. 256.

KATIE NEASE (Health Plan of Nevada):
Health Plan of Nevada supports A.B. 256. Our focus and commitment is helping people in the community overcome health disparities and improve birth outcomes. This month, as part of this effort, we launched a doula pilot in Clark County to provide peer support to pregnant women through pregnancy, delivery and postpartum. We are working in collaboration with obstetrician-gynecologist providers to assemble this birth team. Our aim is to surround the expectant mother with support to meet her physical, emotional and psychosocial needs.

As we began having these conversations with doula organizations in the community, the cost of training and certification was identified as a barrier. To address this barrier and support diversity in the workforce, we provide scholarships to novices to become trained, certified doulas.

MS. LYNCH:
The Aging and Disability Services Division is neutral on A.B. 256.

ASSEMBLYWOMAN SUMMERS-ARMSTRONG:
Birth professionals, whether doula or midwife, impact the lives of birthing mothers. I would appreciate your support for this legislation.

CHAIR HARDY:
I will entertain a motion on A.B. 256.

SENATOR RATTI MOVED TO DO PASS A.B. 256.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR KIECKHEFER WAS ABSENT FOR THE VOTE.)

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CHAIR HARDY:
I will close the hearing on A.B. 256 and open the hearing on A.B. 192.

**ASSEMBLY BILL 192 (2nd Reprint)**: Revises provisions governing the testing of pregnant women for certain sexually transmitted infections. (BDR 40-453)

ASSEMBLYWOMAN LESLEY E. COHEN (Assembly District No. 29):
I am here to present A.B. 192 which came out of the Legislative Committee on Health Care from the 2019-2020 Interim. Two of the priorities for that Committee were public and maternal child health, and this bill addresses both.

According to the Centers for Disease Control and Prevention (CDC), sexually transmitted diseases can cause pregnancy complications and result in serious consequences for the mother and the developing baby. In 2019, the CDC identified newborn deaths from syphilis as “the most alarming threat” and emphasized the need to test all pregnant women for syphilis in line with CDC recommendations. In 2018, we had the highest rates of primary and secondary syphilis in the Nation.

This problem is acute in the Las Vegas, Henderson and Paradise region which had the highest rates of primary and secondary syphilis in all metropolitan areas that report to the CDC. We also had the second highest rate in congenital syphilis, which is when a mother with syphilis passes the infection on to her baby during pregnancy.

Unfortunately, trends have not been moving in the right direction for us. According to the CDC, Nevada saw a 289 percent increase in congenital syphilis between 2015 and 2018. Congenital syphilis can significantly affect a baby's health. It can cause miscarriage, stillborn births, prematurity, low birth weight or death. Up to 40 percent of babies born to women with untreated syphilis may be stillborn or die from the infection as a newborn. Congenital syphilis can also result in deformed bones, enlarged liver and spleen, brain and nerve problems, and a host of other health issues.

The good news is that both syphilis and congenital syphilis are preventable. Syphilis can be treated and cured with antibiotics, and congenital syphilis can also be treated. Babies who have it need to be treated as soon as possible to reduce their risk of serious conditions.

The key to treatment and prevention are ensuring mothers are tested for syphilis and receive prenatal care as necessary. Assembly Bill 192 aims to align Nevada's sexually transmitted disease testing requirements with CDC recommendations.

BRADLEY MAYER (Southern Nevada Health District; Washoe County Health District):
This is an important bill, and both Southern Nevada and Washoe County Health Districts support A.B. 192. We heard about Nevada's battle with syphilis, and our sexually transmitted disease rates are high across the board. Nevada is first for primary and secondary syphilis and second for congenital syphilis. There is more that needs to be done overtime, and we will need to continue to take a look at this.

MS. LYNCH:
The Aging and Disability Services Division is neutral on A.B. 192. Our fiscal note has a zero dollar impact.

CHAIR HARDY:
I will entertain a motion on A.B. 192.

SENATOR HARRIS MOVED TO DO PASS A.B. 192.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR KIECKHEFER WAS ABSENT FOR THE VOTE.)

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CHAIR HARDY:
I will close the hearing on A.B. 192. Seeing no public comment, the meeting is adjourned at 5:40 p.m.

RESPECTFULLY SUBMITTED:

______________________________
Vickie Polzien,
Committee Secretary

APPROVED BY:

_____________________________________________
Senator Joseph P. Hardy, Chair

DATE:______________________________________

| EXHIBIT SUMMARY | | | | |
|---|---|---|---|---|
| **Bill** | **Exhibit Letter** | **Begins on Page** | **Witness / Entity** | **Description** |
| | A | 1 | | Agenda |
| A.B. 191 | B | 1 | Jay Kolbet-Clausell / Community Health Worker Association | Medicaid Reimbursements for Community Health Workers Presentation |
| A.B. 191 | C | 1 | Jay Kolbet-Clausell / Community Health Worker Association | Support Statement / Various Groups |
| A.B. 191 | D | 1 | Katie Roe-Ryan / Dignity Health-St Rose Dominican | Support Letter submitted by Holly Lyman |
| A.B. 256 | E | 1 | Assemblywoman Shondra Sommers-Armstrong | Presentation for Expanding Medicaid to Include Doula Coverage submitted by Lauren Kalogridis |
| A.B. 256 | F | 1 | Senator Joseph P. Hardy | Published Studies for Cost Savings to Medicaid Programs, Public View |
| A.B. 256 | G | 1 | Senator Joseph P. Hardy | Summary of Doula State Savings |