MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-first Session
March 30, 2021

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:42 p.m. on Tuesday, March 30, 2021, Online. 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:

Senator Fabian Donate, Senatorial District No. 10
Senator Scott Hammond, Senatorial District No. 18
Senator Roberta Lange, Senatorial District No. 7
Senator Dina Neal, Senatorial District No. 4

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Olivia Whiteley, Refugee Advocacy Lab
Manuel Mederos
Deborah Silvera, Nevada Interpreters & Translators Association
Chloe Hsia, Asian Community Development Council
Bushra Dos Santos, Catholic Charities of Southern Nevada
Gillian Block, Nevada Coalition of Legal Service Providers
Bradley Mayer, Southern Nevada Health District
Joelle Gutman Dodson, Washoe County Health District

Grace Vergara-Mactal, Executive Director, Service Employees International Union
Vanessa Torti, Senior Home Care Coordinator, Service Employees International Union
Farren Epstein
Tess Opferman, Nevada Women's Lobby
Priscilla Maloney, American Federation of State, County and Municipal Employees
Erma Henderson
Terri Laird, Retired Public Employees of Nevada
Dawn Ralenkotter
Carol Matrone
Tyree Love
Tracey Richards
Rozetta Love
Cheryl Knight
Irma Nunez
Shawn Slatter, Right at Home Care; Personal Care Association of Nevada
Connie McMullen, Personal Care Association of Nevada
Beth Handler, M.P.H, Deputy Director, Programs, Department of Health and Humans Services
Joanna Jacob, Clark County
Cody L. Phinney, M.P.H., Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Kevin Schiller, Clark County
Jared Luke, City of Las Vegas
Kelly Crompton, City of Las Vegas
David Cherry, City of Henderson
Rachael Chesin, Caleb's Law
Dan Musgrove, Nevada Donor Network, Valley Health System
Brittney Perkins
Candace Wong
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Stacie Sasso, Executive Director, Health Services Coalition
Bobbette Bond, Director of Public Policy, Culinary Health Fund
Maya Holmes, Culinary Health Fund
Katherine Gudiksen, Senior Health Policy Researcher, The Source on Healthcare Price and Competition

Rusty McAllister, Nevada State American Federation of Labor and Congress of Industrial Organization
Juston Larsen
James Sullivan, Culinary Health Union
James Wadhams, Nevada Hospital Association
George Ross, HCA Healthcare
Katie Ryan, Dignity Health-St. Rose Dominican
Chris Bosse, Renown Health
Margot Chappel, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
Jaron Hildebrand, Nevada State Medical Association
Susan Fisher, Nevada State Society of Anesthesiologists
Jessica Ferrato, Association for Comprehensive Energy Psychology
Lindsay Knox, Nevada Orthopaedic Society
Tom Clark, Nevada Association of Health Plans

CHAIR RATTI:
I will open the hearing on Senate Bill (S.B.) 318.

SENATE BILL 318: Makes various changes relating to improving access to governmental services for persons with LEP. (BDR 40-955)

SENATOR FABIAN DONATE (Senatorial District No. 10):
I will read from my written remarks (Exhibit B).

OLIVIA WHITELEY (Refugee Advocacy Lab):
I will read from my written testimony (Exhibit C) as I review the presentation (Exhibit D) from the Refugee Advocacy Lab. Also, for your review, are the proposed amendment to S.B. 318 (Exhibit E), the Language Access Assessment and Planning Tool (Exhibit F) and the Department of Health and Human Services Language Access Policies (Exhibit G).

SENATOR KIECKHEFER:
The requirements of S.B 318 are for any and all languages. Are there thresholds for the top ten languages spoken? I am wondering about the workload for the State agencies and getting this done if we are targeting the pandemic and emergency declarations in the first few sections of the bill.

SENATOR DONATE:
The intention of S.B 318 is whatever is reasonable to help us navigate the Covid-19 pandemic. There are many languages around the world and many spoken in Nevada. As we start to vaccinate more people, it will be harder to reach those who do not want to be vaccinated or are on the verge of deciding this is what is best for them. For us to provide accurate information to those individuals, this needs to be done in a manner that respects their native language.

MS. WHITELEY:
Any requirement that an agency determines they must serve an individual with limited English proficiency (LEP) is proportionate to the language of the clients they serve. That determination begins with the agencies gathering data through the Covid-19 language access plan provisions on what the languages are of the individuals they serve. There is not a blanket mandate that all agencies must serve all languages, it is dependent on the needs of the clients of each individual agency.

The amended version of the bill sets the standard to be that an agency must take reasonable steps to ensure meaningful access. That is a flexible standard that agencies must follow and is consistent with what is required in federal law.

The Covid-19 provisions are dependent upon appropriation of federal funds. The reasonable steps an agency would take would also be dependent on what federal funding is allocated for these particular activities. Similarly, that would be true with the language access plan provisions. The implementation questions of those plans and policies will not be discussed until the 2023 Legislative Session.

SENATOR KIECKHEFER:
Does section 8 of the bill kick in two years after the termination of the Governor's Emergency Directive?

MS. WHITELEY:
Section 8 only removes the requirement that revisions of agency language access plans must include an evaluation of how the agency addresses language access needs during Covid-19.

SENATOR KIECKHEFER:
For the first two years following the Governor's termination of his Emergency Directive, the agencies are required to do a retrospective look at how they performed during the pandemic, correct?

MS. WHITELEY:
That is correct.

SENATOR HARDY:
When the bill references the Division, it says this is an unfunded mandate on the local governments, not the State, so the local governments are going to be held accountable. Which Division are we looking at?

MS. WHITELEY:
Section 2 of the bill requires the Division of Public and Behavioral Health to implement the Covid-19 related provisions. Sections 3 and 4 require local health districts or departments to implement those provisions.

In the proposed amendment, Exhibit E, section 3, subsection 6, and section 4, subsection 6 state "This shall be implemented to the extent that funding is available". The intent is that those provisions only become operative if monies from the American Rescue Plan are allocated for these purposes.

SENATOR HARDY:
So this does include the State as well as the Health District of the largest county.

MS. WHITELEY:
Yes, it does.

SENATOR KIECKHEFER:
The Additional Provision portion at the top of the proposed amendment, Exhibit E, is not incorporated into one of the sections of the bill. What is the intent of that section? The statement, "State assisted programs" meaning all programs that receive state funding is a lot. Is this specifically related to public health or does it include everything the State does?

SENATOR DONATE:
The intent of the bill is divided into two parts. The first part is Covid-19 oriented, and the second part is to revise the services we provide as a State and any needs and gaps. Also, to look at those gaps, see what we can improve, use these two years to identify what the gaps are, and in a future session, and if requests are warranted, make allocations to solve those disparities.

MS. WHITELEY:
The intent of the additional general provision is to provide local districts additional flexibility in implementation of the Covid-19 provisions and give agencies the flexibility in the implementation of the language access plan provisions. The standard to make reasonable effort, or to take reasonable steps to provide meaningful access, is the standard we are looking toward in order to allow agencies that flexibility.

In terms of the definitions of State assisted programs, this is modeled after the existing federal requirement that any federally conducted or federally assisted programs are required to assure language access from any subcontractors or grantees.

SENATOR KIECKHEFER:
Is this the language you have inserted into the different sections, or is it stand alone as a piece of the statute?

MS. WHITELEY:
It is drafted to do both. First, as an additional general standard set for the agencies both in terms of the language access plan and Covid-19 provision. Second, it is to be integrated throughout the language of the bill.

SENATOR HARDY:
To Senator Kieckhefer's point, will this apply to all State agencies that receive State funding?

MS. WHITELEY:
The Covid-19 provisions will only apply to the Division of Public and Behavioral Health and the local county health districts or departments. The requirement to draft, not to implement, a language access plan will apply to all State agencies.

SENATOR HARDY:
Can you delineate which sections of the bill do or do not relate to Covid-19?

MS. WHITELEY:
Sections 2, 3 and 4 are Covid-19 related and section 7 is related to the language access plan drafting requirement.

SENATOR HARDY:
The State assisted programs are only in sections 2, 3 and 4 for Covid-19?

MS. WHITELEY:
The State assisted requirement would fall under section 7 which requires agencies to develop the language access plan.

SENATOR HARDY:
Does the sentence relating to the language access plan drafting requirement belong to section 7 of the bill?

MS. WHITELEY:
Yes.

SENATOR KIECKHEFER:
Can you give an example of a state that has a good language access plan?

MS. WHITELEY:
There are states that have introduced similar legislation as well as the Division of Child and Family Services.

SENATOR KIECKHEFER:
Is this the exhibit on the legislative website, Exhibit G, from the Department of Health and Human Services (DHHS)?

MS. WHITELEY:
Yes. Pages 1 and 6 of the presentation set out the two policies from Division of Child and Family Services we think are the most developed and reflect the direction of what we would like to see through this piece of legislation.

MANUEL MEDEROS:
As the Language Access Specialist for the Northern Nevada International Center in Reno, I support S.B. 318 because it is critical that each Nevada agency is able to create their own language access plan. This plan will help State agencies meet the language needs of Nevadans experiencing significant barriers to accessing State services related to Covid-19 due to the lack of materials and information translated.

The Covid-19 pandemic has disrupted nearly every aspect of our lives and reached into almost every community in our State. The ability to keep one another safe and healthy depends on every Nevadan having access to credible information about how to prevent the spread of Covid-19, the types of support and services available, and how to comply with federal, State and local orders.

We know certain communities are disproportionally impacted by this pandemic. One way we can shift that is by meeting our obligations to communicate in ways acceptable, culturally and linguistically relevant.

The Language Bank at The Northern Nevada International Center provides 20 languages in person, 200 languages over the phone, and over 15 languages including American sign-language over video remote interpreting technology and documentation and translation in over 100 languages. All of these languages serve as just one example of the resources our State needs to stay culturally relevant. Many State agencies do not have access to the diverse services the language bank provides. Only Statewide planning and resources can expand language access for all equitably.

Covid-19 took my father's life a few months ago. Many times, my father asked me to interpret for him as not all the doctors and nurses understood him and were not able to communicate with him in his own language. We need S.B. 318 to ensure hundreds of communities can access life-saving information and care.

DEBORAH SILVERA (Nevada Interpreters & Translators Association):
The Nevada Interpreters & Translators Association supports S.B. 318. As language access professionals, we are intimately aware of the need for Nevadans with LEP to have access to all information regarding government services. This must include access to trained and qualified interpretation and translation services necessary for Nevadans to receive accurate and vital information regarding government services.

The use of machine translation aids such as Google Translate can lead to unwanted errors in conveying the intended message. This can range from comical to dangerous and serious communication.

Likewise, the use of untrained bilingual persons to interpret for family members, often minor children, is not only dangerous but ethically unsound. Senate Bill 318 supports this objective by requiring agencies to outline accurate credentialing and oversight of translators as in additional requirements, training, incentive and recruiting initiatives to support interpreters and translators.

Trained and qualified language access services are more critical during the Covid-19 crisis where a lack of accurate information can not only lead to unwanted individual health consequences, but can have a catastrophic effect on the community at large. All aspects of the public health effort to deal with Covid-19 require an informed public which ranges from testing to masking, immunizations and contract tracing. Senate Bill 318 requirements for additional Covid-19 language resources will help ensure all Nevadans receive accurate information about Covid-19 and will build trust between a populous that is often suspicious of public health agencies and have suffered disproportionately from the effects of the pandemic.

CHLOE HSIA (Asian Community Development Council):
The Asian Community Development Council supports S.B. 318. We are a community organization serving the fastest growing community in Nevada, providing the community with critical resources and services including open enrollment navigators and our food bank, among others. Language access is a crucial part of our work, and we see personally the gap that exists in communicating critical public health information to the community.

During this time last year, we translated Covid-19 response materials in Tagalog, Chinese, Korean, Vietnamese and Thai. There is a lot of misinformation on messaging sites, and providing expanded language access for everyone helps with health equity.

BUSHRA DOS SANTOS (Catholic Charities of Southern Nevada):
The Catholic Charities of Southern Nevada support S.B. 318. We are recognized as the State office for refugees. Through this program, we resettle hundreds of refugees each year from around the world who have fled their homes due to war and persecution. In 2020, we served over 1,200 refugee clients. Our

clients speak many languages including Arabic, Farsi, Dari, Swahili, Kinyerwanda and many others. Although our office provides robust services and adequate interpretation to our refugee clients, S.B. 318 is vital in ensuring all refugees and LEP individuals can access essential services across all government agencies.

The Covid-19 pandemic has amplified many challenges our refugees have in accessing these essential services. With a lack of adequate interpretation and limited office availability of government services due to the pandemic, our refugees have struggled with filing unemployment claims after being laid off, obtaining social security cards and applying for public assistance. In addition, the lack of Covid-19 information available in the languages our refugee clients speak, make it difficult to have equitable access to the same information their English speaking counterparts have, barring them from accessing appropriate care.

Statewide planning and resources are necessary to enhance language access for not only our refugee clients but all residents equitably. Senate Bill 318 is the first step in the process of identifying where the gaps in language services are and how they can be addressed to meet the growing needs of our population that is becoming increasingly diverse.

GILLIAN BLOCK (Nevada Coalition of Legal Service Providers):
The Nevada Coalition of Legal Service Providers supports S.B. 318. The legal aid providers in Nevada frequently serve with LEP, and generally identifying and addressing language access gaps is extremely important. Language barriers that already exist have become even steeper since the onset of the pandemic. Covid-19 has made it clear that many areas for language access are critical. The health information necessary for people to keep themselves and their families safe and prevent community spread has been rapidly evolving.

All Nevadans, regardless of language or national origins, should be able to learn about and access this information and the vital services for which they are eligible. Improving language access to people seeking health information, understanding public health recommendations, accessing testing, treatment and vaccine information is extremely important.

BRADLEY MAYER (Southern Nevada Health District):
The Southern Nevada Health District is neutral on S.B. 318. We had expressed concerns with how the bill was originally drafted. The proposed amendment, Exhibit E, is more permissive and is contingent upon funding being available to execute these new responsibilities. We will work with the sponsor to ensure the language does not create an unfunded mandate should the funding fluctuate or not be permanent.

JOELLE GUTMAN DODSON (Washoe County Health District):
The Washoe County Health District is neutral on S.B. 318, and I echo the comments from Mr. Mayer with the Southern Nevada Health District.

SENATOR DONATE:
I will read from my closing comments, Exhibit B.

CHAIR RATTI:
I will close the hearing on S.B. 318 and open the hearing on S.B. 340.

SENATE BILL 340: Revises provision relating to the wages and working conditions of certain employees. (BDR 53-573)

SENATOR DINA NEAL (Senatorial District No. 4):
The story of the home health care worker is compelling. A home health care worker took care of my father and was responsible for bathing him and placing him in his pajamas. I was brought into a world where I understood the life of the sick and the elderly. We were in a different position than most when we contracted for services. Because of the pandemic, my daughter and I worked virtually, so we were not faced with having to physically be at work and manage the care of a loved one. This is the reality for other families who do not have the capacity to work remotely.

These home health care workers matter because they have become a part of a tiny society that forms when people exist under one roof. Our ingress and egress revolves around the sick, and it is important these workers receive the proper training, transportation, reimbursement and other things listed in the bill. Taking care of the sick is something you will never imagine until you experience it and have to contract for services for an individual to come into your home that will allow you the two or four hours a day you need to pick up a prescription or simply eat.

Our focus was on one person. The two hours we contracted for a home health care worker allowed us the time to schedule doctors' appointments and the time to take care of the duties that worker could not do.

For the sick and elderly, the medicine reminders we think about today must remain on a schedule, and this medication cannot be missed; it must be consistent. Our home health care worker was integral in helping us remember when those medications were needed and at what time they were to be administered.

GRACE VERGARA-MACTAL, (Executive Director, Service Employees International Union):
I will read from my written testimony (Exhibit H) in support of S.B. 340.

VANESSA TORTI (Senior Home Care Coordinator, Service Employees International Union):
I will read from my written testimony (Exhibit I) in support of S.B. 340 and the proposed amendment (Exhibit J).

FARREN EPSTEIN:
I will read from my written testimony (Exhibit K) in support of S.B. 340.

CHAIR RATTI:
The State is one of the more significant payers of personal care assistants through our Medicaid and Home and Community Based Care waiver programs. What is interesting about S.B 340 is that everything is required by the Director of DHHS to perform investigations and make recommendations on pay. That same individual needs to be conscientious about the State's budget. It seems that whoever is put in charge will be in a position of being the steward of the personal care assistants in their professional situation. At the same time, they will be the steward of the budget that might be the cause for the personal care assistant situation not being the best. Is it intentional that everyone engaged in decisions is at the same table, or do you see any challenges in terms of the structure?

MS. TORTI:
In recognizing the tension of the situation, the unique thing we are trying to do is bring in voices that historically have not had a seat at the policy table. They need to bring the perspective of the employers of the caregivers and the

consumers who have not been able to have an equal footing in speaking to the structure of the Medicaid programs. It is particularly the people on the front line who are doing the work and are getting these services every day that know more about what needs to be done to fix home care in Nevada. It is time to listen to them and make them a part of the solution.

The State's oversight of this industry is disbursed over several State agencies. They include Medicaid and Health Care Quality and Compliance as the licensing entity over personal care agencies. The Labor Commissioner is over general employment. We need to bring in a multitude of voices and opinions in order to come up with the right solutions for this workforce.

CHAIR RATTI:
Do you see this more as a stakeholder engagement board or a labor relations board?

SENATOR NEAL:
It is set up to be both. One of the goals was to have a labor relations board because of the wage component, which is why they wanted the Labor Commissioner to be a part of it. We wanted to make sure if there was a wage issue, the Labor Commissioner would have authority.

The same concept was being considered for DHHS. Trying to find the home best suited initially started off as a home under the Labor Commission, but seemed it was better suited to be under DHHS. I would not say S.B 340 provides a traditional board, but it is trying to manifest all the goals the Service Employees International Union wanted by creating a blended task board.

CHAIR RATTI:
What tipped the scales to having authorization given to DHHS as opposed to the Labor Commission?

SENATOR NEAL:
The things to be done were better suited in terms of expertise for DHHS versus the Labor Commission. The Labor Commission focuses on wages and enforcement of failure to pay wages. It is better for DHHS to get involved with regard to the larger issues of employment standards for home care, training and systemic impact around home care employees. Many of those provisions are in sections 16 and 17 of the bill.

CHAIR RATTI:
Have other states done similar things, and if so, what are the results?

MS. TORTI:
I can point out the states that have wage board-enabling statutes. They are not specific to home care but have been used for other industries. They are Arizona, California, Colorado, New Jersey and New York. I am not able to speak to the details of those boards.

CHAIR RATTI:
Are they wage board specific leaning toward the labor relations board concept rather than the stakeholder engagement concept?

Ms. TORTI:
Yes.

SENATOR KIECKHEFER:
Is it common practice for wage boards to create differentiated minimum wages for different types of employees in each state?

MS. TORTI:
That has happened under the wage boards, speaking more specifically to practice in the home care industry. It is a practice within Medicaid in other states to set specific wage and compensation standards for this industry. It is common practice to set what percentage of the Medicaid reimbursement rate can be retained by the agency or what percent of the rate has to be passed on to a home health care worker in the form of compensation. Other states have set a specific minimum wage for home care workers. This has all been under the guidance and approval of the Centers for Medicare & Medicaid Services (CMS).

SENATOR KIECKHEFER:
The proposal before us would set a minimum wage outside of Medicaid reimbursement. It would be inclusive of Medicaid reimbursement but not exclusive to it, so it would be a minimum wage across the board for this job classification, regardless of whether they work for a Medicaid client or not.

MS. TORTI:
This would be specific to only publicly funded home care.

SENATOR KIECKHEFER:
Where in the bill is this stated?

MS. TORTI:
The workforce is defined in section 5, subsection 1, paragraph (a). A home care employee is a person who provides: "personal care services through a home care program as an employee of a home care employer that is an agency to provide personal care services in the home".

Section 8, subsection 1 states the: "'Home care program' means a program established by a state agency or local government which provides in the home personal care services..."

This section details the Medicaid State plan programs as examples of publicly funded home care.

SENATOR KIECKHEFER:
Why is this a better way to state it than to say agencies must give 85 percent of their reimbursement rates to employees?

MS. TORTI:
It would be up to the wage board to decide if that is the route of the recommendation around compensation for home care workers. It does not specifically say a recommendation has to be around the minimum wage; it could be a wage pass through as you described.

TESS OPFERMAN (Nevada Women's Lobby):
The Nevada Women's Lobby supports S.B. 340. This bill will help families, seniors, women and people of color. Of the roughly 13,000 home care workers in Nevada, more than three-quarter are female, and over one-quarter are women of color. These workers make a median wage of $11 an hour, and a median income of $15,500 per year. This leads to a high turnover rate in the home care industry. Caring, qualified workers are leaving the profession at a rapid pace.

We have an entire workforce trained to care for our aging parents and grandparents, allowing our family members to stay in their homes and get the services they need. We have to pay a living wage. These workers must have established training regulations and receive fair pay and benefits. Senate Bill 340 is a key solution and will help protect these workers. This

means that those caring for our family members are well trained, experienced and invested in their jobs.

PRISCILLA MALONEY (American Federation of State, County and Municipal Employees):
The American Federation of State, County and Municipal Employees support S.B. 340. We echo the comments of Ms. Opferman on behalf of the Nevada Women's Lobby.

ERMA HENDERSON:
I support S.B. 340 as a home care worker in Las Vegas. During the pandemic, I worked without proper personal protective equipment and was afraid of being infected and afraid I would bring Covid-19 home to my husband.

This bill will help ensure home care workers are protected when facing future viruses or another public health crisis. With S.B. 340, we can make sure all home care workers have the medical necessities to be safe. We urge you to pass this bill so home care workers are adequately paid and receive the benefits that are long overdue. Please respect us, protect us and pay us.

TERRI LAIRD (Retired Public Employees of Nevada):
Retired Public Employees of Nevada support S.B. 340. As we age, we sometimes need to receive specialized care, whether within the home where we are most comfortable or in a special care facility or hospital when necessary. When possible, care within our own homes is the preferable alternative and highly qualified home care professional caregivers are essential to make that possible. The last year has pointed out the dangerous conditions that sometimes present themselves in larger nursing home-type facilities where viruses can run rampant. This makes in-home care more preferable when possible. Senate Bill 340 seeks to create the home care workforce board needed in terms of working conditions for those that take care of seniors, the disabled and those unable to take care of themselves.

DAWN RALENKOTTER:
I support S.B. 340. I have been a home care worker for ten years. The low wage for home care workers in Nevada is $11.07 per hour. Most of us are struggling to pay high out-of-pocket cost with the low wages we are paid. We are getting too few hours to give our clients the care they need. Senate Bill 340 will help fix this problem.

The recertification training that I paid $40 for is not offered on a day that I can attend the class. I advised my client and employer about the need for a back-up caregiver and was advised they would attempt to cover my client. I was signed up for the training but did not have anyone to cover my client. The training was not what I expected, and I would like to know what that $40 paid for. This often happens with home care workers. My employer also wanted me to pay for fingerprints that had previously been paid for. I had to advocate for myself, letting my employer know they should be responsible for this cost. Every home care worker cannot advocate for themselves to hold employers accountable. Agencies need more oversight, and as caregivers, we need a voice as frontline workers.

CAROL MATRONE:
I support S.B. 340 for myself and on behalf of my daughter Maria who is challenged and needs maximum care for her activities of daily living. She first received personal care services in 2000 after orthopedic surgery. She resides in an intensive supported living arrangement. She had 24/7 care from personal care aids and direct support professionals through a subcontractor of Desert Regional Medical Center. I have been her unpaid caregiver for the last 30 years. I retired in 2020 from State service and dreamed of what retirement could be.

In November, we both had four Covid-19 tests. We had near misses from personal care attendants who traveled to numerous clients throughout their workday. When this occurred, the agencies would pull all providers from our home, and I was the last care provider standing. At that time, I decided to become a paid caregiver. I cover four regular shifts as well as extra shifts when there are no available personal care assistants. I am doing this physically taxing job at 63 years of age and my retirement is not a reality at this time.

I am speaking on behalf of the hundreds of personal care attendants who have filtered through my daughter's life since 2000. These providers often travel to 3 to 4 clients a day, all over the city, often working 10 to 14 hours a day to make a living that can support them and their families, barely making ends meet. Low pay, long hours, no travel stipends, inadequate training and no sick or paid time off plague these workers. They do not do this for the money, they do it from their heart and soul for our vulnerable Nevadans. Retention and recruitment of this workforce is paramount for our vulnerable citizens who receive the most complex care.

In the future, you may need a caregiver, be a caregiver or hire a caregiver, and your loved ones, or yourself, deserve one who is respected, protected and earning a decent living wage.

TYREE LOVE:
I support S.B. 340. I have been a caregiver for 12 years, and I am proud of what I do. I want to provide a high quality of care to my clients so they can stay safely in their homes rather than going to a nursing home. This is what they deserve, but it is hard to make a living at this profession. Even though helping senior citizens and people with disabilities has never been more important during this pandemic, most of my clients do not receive adequate hours from the State to receive the level of care they deserve.

It is frustrating for me as a caregiver because I cannot deliver the quality of care I know my clients deserve. I have to drive all over the city to provide a couple of hours of care for one client and then rush to one after another. Senate Bill 340 would help us improve the quality of care for all home care clients and 13,000 home care workers. It will provide workers and clients a seat at the table and a voice to express their concerns about the service clients need.

TRACEY RICHARDS:
I support S.B. 340. I have been in the caregiving field for over 15 years. As a home care worker, I am responsible for everything our clients cannot do for themselves. Many of our clients no longer have family or friends to help them, so they depend on us for everyday tasks. This includes bathing, feeding, using the bathroom, purchasing their groceries and cleaning around the house. My clients are getting a limited number of hours of care each week. What is worrisome is that some of our clients do not always get the hours of care they deserve. Unfortunately, in my experience it is the black clients experiencing those few hours of care. We know Black people face inequalities in the healthcare system in this Country. Covid-19 has affected the black communities more than others. We cannot allow that to continue and repeat these injustices in the home care industry. Home care workers such as myself and my clients need our voices heard and a seat at the table.

It is also a hardship for caregivers to pay for our fingerprints, tuberculosis tests, immunizations, certification training, CPR and first aid training just to start a job. I recently began working at a new agency and did not have the $65 for the fingerprints that I just had done for my previous employer. This impacted me

and kept me from caring for my client. Passing S.B. 340 will allow us to work with home care personal care agencies and the State to develop solutions to the serious inequalities many of us experience as home care workers and our clients face in their homes.

ROZETTA LOVE:
I support S.B. 340. I have been a home care worker for 11 years. We do this work because we care deeply about our clients and our community. We do not expect to get rich doing it, but we deserve to be treated fairly, and our clients deserve quality care. About half of home care workers cannot make a living doing this job. It is my hope that we can create good quality jobs with livable wages so that the next generation of home care workers can proudly take care of our loved ones in need of care.

CHERYL KNIGHT:
I support S.B. 340. Our system for caregivers and clients who need them is broken. This bill will provide those of us who are involved in the caregiving field a seat at the table to decide how to best manage the funds provided to the State for both clients and caregivers. It seems the State would rather pay for a hospital stay or put a client in a nursing home instead of paying a decent wage to a caregiver to provide care in the client's home. Many clients need more hours to be taken care of properly. Clients and caregivers need personal protective equipment provided to them at no cost to protect them.

As a caregiver, I can tell you that every client is different and broad sweeping rules about who gets what does not work. To be considered a front-line worker, caregivers need personal protective equipment, and training and education that is not at their own expense. There are those who burn out quickly because the pay is too low and half the workforce leaves the job within a year. When we pay so little, do not provide proper training, equipment and sick time, we prove as a State we do not value and respect these workers. People who are caring for others' personal needs deserve to be paid better.

Nevada needs people who are involved in this work to be a part of the process in making decisions on how to spend the allocated funds for our State. Without that, we have poorly run offices, underpaid workers, clients without enough care and consideration; the list is long. We need to fix the broken system, give the clients the hours they need for proper care and pay the workers a decent wage.

IRMA NUNEZ:
I support S.B. 340. I have been a home care worker for 12 years working for 3 agencies and caring for 7 patients. I am a diabetic, have personal health care issues and need to be under a doctor's care, which is costly. Five months ago, I had a medical issue and went to the emergency room. The bill was expensive. I provide care for others, but my job does not provide the benefit of caring for myself. Home care workers work all day and night to ensure the health of their clients. We would like our health taken care of as well. During the Covid-19 pandemic, we risked our lives to do our jobs. Senate Bill 340 will create the Board that will investigate whether home care providers have access to quality, affordable health care.

SHAWN SLATTER (Right at Home Care; Personal Care Association of Nevada):
I own and operate Right at Home Care, Las Vegas, one of the larger personal care agencies in Las Vegas, and oppose S.B. 340. I have been the provider and employer of choice for the last five consecutive years. Should the Committee not be aware, our industry is already regulated by the DHHS under regulation in the *Nevada Revised Statutes* (NRS) 449 that depicts and calls regulation into what we are supposed to be training and not training for.

Many of the speakers in support of S.B. 340 have spoken of various trainings and things they have paid for. In Nevada, it is illegal for any agency to require anyone to pay for their own training. Every agency is required to provide said training. Fingerprinting, health backgrounds, physician statements, and two-part tuberculosis tests are State-mandated by the Legislature that these employees must have in order to perform work in this industry. We do not have the budget to pay for these items. We are all in favor of increasing wages which often times is depicted by what Medicaid reimbursement rates are. Again, those are set by the Legislators. We understand there are bad apples in the industry. We have been working as an association with DHHS, as well as the Office of Labor Commissioner, to get those agencies to act accordingly and follow the labor laws. As an owner/operator, the leading provider and employer of choice, we do everything we can to take care of our personal care attendants.

There is also a letter of opposition provided by Advanced Personal Care Solutions (Exhibit L).

CONNIE MCMULLEN (Personal Care Association of Nevada):
I have submitted written testimony in opposition to S.B. 340 (Exhibit M).

BETH HANDLER, M.P.H. (Deputy Director, Programs, Department of Health and Humans Services):
The DHHS acknowledges the intent of S.B. 340 to assure equity, living wage and advance rights for home care providers. The Covid-19 pandemic magnified the need for home care employment standards and addressing inequities. Five states have existing statutes under their labor code enabling the creation of workforce boards, also referred to as wage boards. Portions of the authority of labor and wage standards in this bill would be new to DHHS authority, and a fiscal note will be required to create this type of infrastructure.

SENATOR NEAL:
This bill is about creating an industry standard so there is a place and a voice for the issues to be heard. Right now, there is no voice; there is no place outside of the employer.

CHAIR RATTI:
I will close the hearing on S.B. 340 and open the hearing on S.B. 309.

SENATE BILL 309: Establishes a reinvestment advisory committee in certain larger counties. (BDR 38-956)

SENATOR DINA NEAL (Senatorial District No. 4):
Senate Bill 309 has a unique origin. Assembly Bill No. 73 of the 80th Session was a bill that came from the City of Las Vegas which mandated local governments come together to find solutions for homelessness, and as a result we have S.B. 309.

JOANNA JACOB: (Clark County):
The working group for A.B. No. 73 of the 80th Session met approximately 12 times during the biennium, and we came up with recommendations to address homelessness. We also identified our needs, funding gaps and solutions we can use as a road and policy map going forward. Some items, such as funding which is a crucial component in Nevada, will have to wait in order to understand the challenges the Covid-19 pandemic posed on distinct local and government budgets.

The working group identified our system capacity to address homelessness as part of our efforts. We have worked on a regional basis to address homelessness. By the local government participating in that group, we have

collectively spent $55 million committed community-wide to address homelessness across our service continuum. One of the things we identified as the single largest barrier to the expansion of affordable housing and services in our region was funding. In housing alone in one year, $46 million to $55 million would be needed to address homelessness if we were to house our homeless population. Because of the Covid-19 pandemic, we are seeing an increase in newly homeless individuals and families.

The working group took steps to address homelessness and broke it into six areas. One area that is working well is the regional oversight framework Senator Dina Neal put forward in A.B. No. 73 of the 80th Session. One government working alone cannot address this on their own. We know we have significant needs in housing, behavioral health, services and intensive case management, coordination of data, prevention and intervention, and affordable housing and development incentives which make up the remaining categories.

The Senate Bill 309 working group built off one of those strategies, which is the regional oversight idea. Each member of the working group made joint recommendations, specifically taking advantage to leverage public and private partnerships to help us find solutions at the local and state government levels.

Examples of where this has worked and is underway in southern Nevada speak to what we are proposing in S.B. 309. We have managed care vendors who serve people mostly at risk for housing and need support. They often partner with local government to help with funding. In Arizona, as part of a community reinvestment initiative proposed in this Committee, one managed care organization (MCO) partnered with a local nonprofit to provide funding for a 500 unit supportive housing unit. They partnered with the local government to help build it and mix the funding. The MCO will provide case management and housing support for the people enrolled in their programs.

We have a program like that in southern Nevada. It started with a partnership between Clark County and Health Plan of Nevada and has since extended to all three MCOs called Hospital to Home, a rapid rehousing program for medically fragile and literally homeless households. We use our U.S. Department of Housing and Urban Development funding at the county level and partner with the MCOs to provide case management for their members in partnership with the nonprofit, Help of Southern Nevada. It has been successful, and to date, we have served 139 members through this program.

We looked at some of the things that are working in a way to continue this collaboration. The State has been researching ways to address how to maximize Medicaid solutions to reduce the rate of the uninsured and tackle some of the social determinates of health that act as barriers to accessing health care. Also finding ways to maximize community reinvestment dollars was a recommendation made to the State in a report done by Princeton University published in 2000.

Senate Bill 309 will allow a forum for collaboration between the State, counties, local governments, nonprofits and the managed care vendors selected in the forthcoming request for proposal (RFP), to identify opportunities and gaps we have in our existing service delivery continuum.

SENATOR KIECKHEFER:
Will it be a requirement that managed care organizations make an investment back into the community?

CODY L. PHINNEY M.P.H. (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
Our managed care RFP published on March 17, requires in the scope of work any vendors participating in our contract start January 2022 and participate in the community reinvestment fund as a portion of their pre-tax profits. This would be distributed by a plan the vendors would develop, and the State would approve.

SENATOR KIECKHEFER:
What portion of their pre-tax profits?

MS. PHINNEY:
The current scope of work is 3 percent of their pre-tax profits.

SENATOR KIECKHEFER:
This would be Nevada-based?

MS. PHINNEY:
For this program, yes.

SENATOR KIECKHEFER:
Are there other industries that participate in this fund? Managed care organizations are not the root cause of homelessness. We have contracts with other types of vendors such as hospitals and physicians; why MCOs?

MS. PHINNEY:
This is a program that has been implemented in other states, and the mechanism is allowable under the managed care guidelines from the CMS. Other types of vendors you mentioned would not fall into those managed care guidelines. That is the Medicaid aspect.

SENATOR KIECKHEFER:
Actuarially set, the per-member, per-month numbers are done absent of this calculation. Does this increase show how much we pay on a per-member, per-month level for states?

MS. PHINNEY:
Are you asking if this impacts the capitation rate?

SENATOR KIECKHEFER:
Yes.

MS. PHINNEY:
It is my understanding that it could. We are in the process of setting the capitation rates for 2022. I can confirm this with other states that have implemented such a plan.

SENATOR RATTI:
Why just Clark County if we are doing a Statewide bid on MCOs? Would the same structure apply to Washoe and rural Counties?

SENATOR NEAL:
Senate Bill 309 had focused on the south, including Mesquite and Boulder City. Because A.B. No. 73 of the 80th Session was brought by the south, there was a conversation that Washoe County does not have an interest in being a part of this structure; it was not a direct exclusion.

MS. JACOB:
The recommendation and the genesis for the working group committee came out of conversations among the regions in the south. We felt since we are facing such a tremendous need in southern Nevada, not to belabor the point, this report shows we have a significant gap. We felt we needed more people at the table to help address the gap. The bill is written permissively. In the amendment we worked on giving the Director of DHHS more discretion to appoint non-voting members that could build upon the Committee.

MS. PHINNEY:
Our RFP will be for Washoe and Clark Counties. It is possible it could expand, but it does not address the rural counties at this time.

CHAIR RATTI:
I will need someone from Washoe County to follow up with me on this to understand why they would not want funding for services.

It was stated the bill was written permissively. Would the bill as written allow for a similar structure set up in Washoe County?

MS. JACOB:
The language could be easily modified if needed; maybe permissive was not the correct term. There is some room for changes.

I do not represent Washoe County and cannot speak for them. I will have someone follow up on your funding question.

KEVIN SCHILLER (Clark County):
I agree with what Ms. Jacob stated. We had a meeting yesterday about the implications of addiction, behavioral health, medical access and all of the pieces significant in terms of making the dollar go farther. When you look at the Affordable Care Act (ACA) and the things that have changed, it is an alignment issue that from the days of County funding, social service and medical access. There are diverse community barriers to the medical front door. These partnerships exist and continue to evolve. We want to ensure we are aligning our service array with the ACA's array, create increased access and efficiency of funding. It is about making the dollar go farther where we have the opportunity.

If a client is in the hospital, they are paying ten times what they would pay for a provision of services we are providing in a program such as the Hospital to Home program, which is a win for the MCOs. For reinvestment purposes, we want to make sure that when the MCOs reinvest, we can align with their benefit in terms of what works for us.

In a crisis where we have a lot of one-shot funding coming, we are in an opportunistic time. At the ground level, we are where we must be in order to create that front door and access point with our large partners. The State is our largest partner, and we have mastered that. This is the wave of the future in terms of how we increase services levels.

On the managed care side, they have contracts and are accountable to those contracts, and our clients are their clients. This is the other piece in terms of where the gaps are and how the county funds a gap. Where we put our dollars to fund a gap is not necessarily covered in an MCO plan, but can create a service array for that hard to reach addicted client that may be in west Las Vegas or in a rural area.

SENATOR KIECKHEFER:
There are specific services that MCOs provide that qualify toward meeting a certain threshold, and the MCO's are required to provide a report. They get to dictate how they spend their money. If the effort is to try to direct how they spend their money why are they not on the advisory committee? Do MCOs require a contract for community reinvestment?

MS. PHINNEY:
They do not.

SENATOR KIECKHEFER:
Does the contract lay out the specific categories that qualify towards meeting that threshold?

MS. PHINNEY:
There are particular items in the current RFP that are specific. The vendors are required to provide a State-approved plan. If they provide a plan that does not adequately meet the advice of this Committee, we would be asking for a redrafted plan. This is a process we go through with the MCOs on a regular basis.

SENATOR KIECKHEFER:
What is the estimated dollar figure you expect to be contributed through the community reinvestment piece of the contract?

MS. PHINNEY:
I do not have that figure, but I will get it for the Committee.

MS. JACOB:
The intent is not to dictate that an MCO sit on an opportunity; that is why we wrote it as recommendations. We wrote it two ways. The bill states the local governments will be reporting to the MCOs because they have a plan requirement to deliver to the State. The reports that will be required are important for transparency for both the counties and the MCOs. You will see where we might be able to create these partnerships and know what is happening in the collaborations between the State, local government and managed care. This is why, in the proposed amendment (Exhibit N) we have the reporting going to both the Director of the DHHS and the Legislature through the annual report.

JARED LUKE (City of Las Vegas):
The City of Las Vegas supports S.B. 309. We appreciate collaborating and providing input to this group and look forward to developing creative measures to help those in need.

KELLY CROMPTON (City of Las Vegas):
The City of Las Vegas supports S.B. 309. I echo the remarks from our municipal colleague from Clark County.

DAVID CHERRY (City of Henderson):
The City of Henderson supports S.B. 309. The City of Henderson was an active participant in the A.B. No. 73 of the 80th Session working group which sought to create a regional focus on the issue of homelessness. The Committee envisioned S.B. 309 would present another opportunity to continue this focus and address other issues related to reinvesting funds in our community.

CHAIR RATTI:
I will close the hearing on S.B. 309 and open the hearing on S.B. 305.

SENATE BILL 305: Makes various changes relating to access to organ transplants for persons with disabilities. (BDR 40-40)

SENATOR SCOTT HAMMOND: (Senatorial District No. 18):
Senate Bill 305 prohibits certain providers of medical or related services from taking certain actions related to organ transplant solely on the basis of a person's disability.

It authorizes a person aggrieved by the failure of such providers to comply with certain requirements to institute a civil action for injunctive or other appropriate relief.

It prohibits an insurer from taking certain actions related to an organ transplant because the insured is a person with a disability. It prevents a provider of health care services from not placing a person with a disability on a transplant list, or placing a patient low on the transplant list because of their disability.

Senate Bill 305 does not take away a physician's ability to diagnose a patient and determine whether or not the patient is eligible or a good fit for a particular organ transplant.

We are attempting to ensure people with disabilities, whether intellectual or cognitive, are not denied an organ transplant because of their disability.

RACHAEL CHESIN (Caleb's Law):
Caleb's Law supports S.B. 305. Caleb's Law is an Act relating to health care and the organ transplant services for people with dishabilles described by Senator Hammond. My presentation (Exhibit O) will provide information on Caleb's Law.

I was born and raised in Las Vegas, and I am the Community Engagement Director of the nonprofit, The Just One Project. My son Caleb is a happy, healthy 22-month-old, and has Trisomy 21, Down syndrome, which means he has an extra copy of the 21st chromosome.

I recently heard a story about a little girl, not yet a year old, living with her family in Ohio and in need of a heart transplant. Her parents were told she was not eligible for a heart transplant, not because of her illness, but because she

had Down syndrome. The doctors determined that since she had an intellectual disability, her life was not worth saving because of an extra chromosome.

When I heard this story, I believed it had to be an anomaly, some type of doctors acting outside of standards of care. I heard many stories of others being denied organ transplants due to their disabilities. A young boy with autism, a small girl denied a kidney, a 5-month-old boy denied a heart due to a chromosomal disorder similar to Down syndrome.

I realized that if my son Caleb, who is healthy with no medical concerns to speak of other than being born prematurely, needed an organ tomorrow, it would be because of an accident or trauma. It would have nothing to do with his diagnosis of Down syndrome. Yet, studies show 85 percent of pediatric transplant centers would take Caleb's intellectual disability into account. Information shows 71 percent of heart programs indicate even mild or moderate cognitive impairment is enough to disqualify him from the organ transplant list. Transplant centers usually consider intellectual diagnosis's when deciding the eligibility of transplantation. Fifty-two percent of people with intellectual diagnosis receive a referral for a specialist evaluation, and 33 percent of those 52 percent referred are never evaluated.

In February 2019, the University of North Carolina (UNC) was forced to resolve an investigation by the United States Department of Health and Human Services after denying someone a heart transplant because of a learning disability. When their actions were challenged, UNC immediately reversed course with the United States Department of Health and Human Services issuing this statement from Director Roger Severino of the Office of Civil Rights; "Every life is precious and no one should be blocked from access to an organ transplant because of stereotypes about persons with disabilities. It is also against the law".

This is an important point and the reason I am here today to support the ban of organ transplant discrimination in Nevada. We are not asking the State to do anything new or to reinvent the wheel. Discrimination in medical services is already illegal under the federal Americans with Disabilities Act (ADA). The problem is enforcement. There is no way for you or I to enforce the ADA because it has no mechanism for enforcement. That leaves the State on our own to not just prove that discrimination but to give people an effective way to challenge discrimination when and where it happens.

This is where Caleb's Law comes in. Caleb's Law clarifies doctors, hospitals, transplant centers and other health care providers are prohibited from denying access to necessary organ transplants solely on the basis of a qualified individual's disability. It requires health care providers who are evaluating the likelihood of transplant success consider the full range of support available to help a person with a disability manage their post-operative care. It also includes a fast-track procedure for challenging discrimination and ensures people in urgent need of an organ transplant can obtain timely resolutions to their claim.

I have reached out to doctors across the State who head up multiple transplant centers throughout the Country. I also contacted the American Heart Association, the Children's Heart Center Nevada and Opportunity Village and have not heard one word of opposition to this bill. The response seems to be one of understanding. Senate Bill 305 represents a significant step forward in the protection of people with disabilities in Nevada.

Fifteen States have passed laws similar to this and another 13 have similar bills pending in 2021. In almost every instance, those bills were proposed because someone with a disability was in a desperate and immediate need of a life-saving transplant and was facing unfair discrimination.

SENATOR HARDY:
Are people with disabilities able to donate an organ?

MS. CHESIN:
This bill is specific to those needing an organ transplant.

DAN MUSGROVE (Nevada Donor Network):
A person with a disability can donate an organ. Typically, the caregiver of the person with a disability can authorize someone who is disabled to give the gift of life through organ donation.

Nevada Donor Network supports S.B. 305. Based on the population size we serve, the Nevada Donor Network has the distinction of being the most productive and successful organ procurement organization in the world. This is primarily because of how inclusive we are as an organization. Sadly, 20 people die each day in the United States waiting for the gift of life which never comes because of the shortage of organs available for transplantation. Among those

who parish every day, are the most vulnerable citizens who must be assured an equal chance at life and health, regardless of what disability they may have.

BRITTNEY PERKINS:
I support S.B. 305. I am a resident of Henderson, Nevada. I am an attorney, and the proud mother of a disabled daughter who at 4 months old had open heart surgery to repair a hole in her heart. She has the additional 21st chromosome which led to her mild cognitive delay or perpetual happiness. Because of her genetic make-up, if her heart repair had been unsuccessful, she could have been denied a heart transplant due to this genetic condition that has no bearing on the functionality of that transplant.

No parent should have to sit through that situation while their child is having surgery and financially shoulder the burden that should the procedure not be effective and their child require an organ transplant, they might not get one because their child wears the title of disabled. These individuals are somehow deemed less worthy of these life-saving measures. Times have changed and society has evolved. My daughter is entitled to the benefits of the equal protection clause and enforcement of the ADA.

There is no place left in this State for organ transplant discrimination. We often think a law is just a law until your child's life depends on it, and it takes on a new meaning. My child's life is worth living and saving.

CANDACE WONG:
I support S.B. 305. I am a registered nurse and have a five-year-old daughter who was born with Trisomy 21, Down syndrome. She communicates with her peers through an all-inclusive program, loves to rock climb, ride her bike and scooter and is active in every activity we partake in as a family. She is also active in the community, cleaning up trails at Mt. Charleston, Red Rock and in the Henderson area. Along with her twin sister and a friend of the family, we collect food and donations for Three Square and do walks throughout the community to help multiple organizations in the area raise awareness.

At five years of age, she has made an impact along with her fellow peers at school and in the community. She is entitled to the same benefits as her twin sister who does not have Trisomy 21. Both of them were born premature at 29 weeks and weighed less than 3 pounds. My daughter was born with duodenal atresia, had surgery, and a 5 percent chance of survival through the

neonatal intensive care unit. She is here today, surviving and leading all Pre-K standards just like her peers.

Every individual has different medical concerns and conditions, but each one should be evaluated prior to denying or accessing transplantation. A person with a disability such as Down syndrome can and has donated an organ as long as permission is given. They also vote and work. We have resources available to assist people with disabilities to be a part of the community. This is not a time when people with disabilities are forgotten or institutionalized. They are here and will continue to be a part of our community.

DUANE YOUNG (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
The Division of Health Care Financing and Policy is neutral to S.B. 305 and believes this is good public health policy; however, the Division does request a friendly amendment. The language states the provisions in S.B. 305 must go into the State plan. This is our contract with CMS, and this language would be best in our Medicaid Services Manual holding all providers and partners of Medicaid accountable to the language in the bill.

CHAIR RATTI:
The Committee's legal counsel has provided an answer to the question of people with disabilities donating an organ. Based on NRS 451.556, people with a disability can donate under the same circumstances as anyone else.

SENATOR HAMMOND:
I am amenable to the amendment proposed by Mr. Young. It fits in with what we are trying to accomplish; we want to ensure it is in the right place.

My legislative assistant provided me with an article from January 2020 quoting:

> "Every second counts when a sick child needs an organ transplant. But parents of people with disabilities may need years to get their children on the list.
>
> People with disabilities can be organ donors. They can give all their organs; there's no law against it. But if someone with a disability needs an organ transplant, that fact alone can get them removed from the list."

In a time when we are trying to equal things out, S.B. 305 seeks to do just that, bringing equality to the disabled community.

CHAIR RATTI:
I will close the hearing on S.B. 305 and open the hearing on S.B. 329.

SENATE BILL 329: Revises provisions relating to competition in health care markets. (BDR 40-998)

SENATOR ROBERTA LANGE (Senatorial District No. 7):
I will read from my written remarks (Exhibit P) as I present S.B. 329 and discuss the conceptual amendment (Exhibit Q).

STACIE SASSO (Executive Director, Health Services Coalition):
The Health Services Coalition represents 25 employer and union-sponsored health plans in southern Nevada, including MGM, Boyd Gaming, firefighters, police and numerous self-funded union plans, including culinary, electrical workers, plumbers and various other groups. The Coalition's main focus is to bring affordable quality health care to our estimated 300,000 clients in southern Nevada.

BOBBETTE BOND (Director of Public Policy, Culinary Health Fund):
We are a nonprofit fund that provides comprehensive benefits to 125,000 people in Las Vegas. We have two pharmacies and a large primary care center that had 40,000 visits the year before the Covid-19 pandemic started. We are a piece of the healthcare market, and our focus is on high-quality affordable health care and how to get there. We are aggressive about trying to be effective stewards of both private and public money for Nevada.

As Senator Lange outlined, there is an increasing consolidation in the healthcare industry, healthcare hospital systems buying other system and private equity buying up doctor groups. Experts expect that trend to continue with Covid-19 because of its impact on the healthcare industry. I have a presentation (Exhibit R) outlining some of these impacts.

We know consolidation is happening in Nevada, and our markets are already impacted. We do not yet have any line of sight into the impact of consolidation and its impact in Nevada. Price is a primary factor behind the United States high

health care costs compared to other nations, and consolidation and lack of competition is a critical factor in health care prices.

Prices in health care have increased must faster than inflation. Hospital prices in the United States have increased at a staggering pace over the last 20 years outstripping college tuition, wages and housing. According to CMS, hospital prices rose three times the rate of inflation between 1960 and 2016.

If prices did the same thing in the food market, we would pay $57 for a crate of oranges, $65 for a dozen eggs and $160 for a gallon of milk.

There are two kinds of industry consolidation. The first is horizontal. This is when one facility buys another like facility and are in the same place in the healthcare market. That is often a hospital to hospital merger. Studies repeatedly show this kind of consolidation results in higher prices without improving quality, which is what we are interested in. Academically, researchers found post-merger hospital prices increased 20 percent to 44 percent, and they were not associated with improved quality. It was modestly worse patient quality and patient experience.

The second industry consolidation is vertical. This is when one industry higher in the health care chain purchases or absorbs one lower on the chain, and when a large physician group purchases a specialty group. A recent study shows over a 4-year period, a 32 percent to 47 percent increase in prices with no quality improvement occurs when hospitals or physician groups merge. In the last 5 years, there has been $10 billion worth of consolidation private equity money alone coming into the healthcare market buying medical practices. We know this is happening and have personal experiences we see in contracts, but we do not have any line of sight policywise to see the system in Nevada, and that is why S.B. 329 was brought forward.

The private equity playbook in most industries is to leverage the debit to buy the company, cut costs and sell at a profit within three to five years at an annualized rate of return between 20 percent and 30 percent. It is not like buying cars. We are talking about people's health and lives, and when it becomes a monetary transaction, we are losing the things health care needs to have. State and federal authority exists to prevent competition and unfair stock practices that hurt competition, but health care deals fall below the radar, especially in Nevada. It takes a high level of an integrated merger in order for us

to be aware of it. Increasingly, states are looking at other ways to get their arms around understanding what is going on with competition and try to protect the healthcare market to keep it healthy and competitive.

MAYA HOLMES (Culinary Health Fund):
Senate Bill 329 will ensure Nevada has accessible data on what is happening in our healthcare markets to protect health care competition. This information is critical for the State, policymakers, patients, payers and other stakeholders in order to understand consolidation in our healthcare market and guide decisions that protect competition and patient choice. It will also ensure we address market players who are trying to use their market power to drive up prices and thwart competition based on price and quality.

This bill proposes prohibiting anticompetitive contracting practices hospitals and health care providers with market dominance can demand because payers have to have them in their markets.

There were recent settlements in two major anti-trust lawsuits; one in California involving the Sutter Health system and another in North Carolina. These settlements ended many of the anticompetitive contracting practices. However, the settlements did not set legal precedence, and they only apply to the health system involved in the lawsuits which were major multi-year lawsuits.

Anticompetitive contracting practices like all-or-nothing, anti-steering and anti-tiering prevent health plans from directing or incentivizing patients toward lower-cost, higher-quality care. These provisions prevent other hospitals from benefiting if they offer better deals or higher quality. They stop patients and health plans from shopping for and getting the best deal.

We are working with Senator Lange on some of the language involving self-funded plans, but that work will not change the substance of the conceptual amendment, Exhibit Q, and how we are proposing it will affect S.B. 329.

As a result of the conceptual amendment, Exhibit Q, the bill will have two primary provisions. First, the bill will require reporting on health care deals involving hospitals and physician groups 60 days after they have occurred. It would require basic summary information to be reported. That information is listed in the bill.

A portion of the bill requires DHHS to post the information contained in the notices on an internet website maintained by DHHS which is important for transparency. Connecticut has done this for several years. The DHHS would also prepare an annual report with the summary information regarding market transactions and concentration in health care based on those notices.

Second, the bill's other major provision would make specific anticompetitive contract provisions unfair trade practices, and those prohibited provisions would be void and severable. The specific contract provisions between hospitals, health systems, providers and health plans would be prohibited as an unfair trade practice and are anti-tiering and anti-steering clauses. These clauses essentially require health plans to place all health system hospitals in the most favorable tier with the lowest cost-sharing regardless of the rates they are charging or their quality.

The other anticompetitive provision prohibited would be all-or-nothing contracting. Some health systems demand an insurer include all the systems facilities in their network. This would be regardless of whether a plan needs the facilities for their members if it drives up health care costs or is a lower-quality facility.

KATHERINE GUDIKSEN (Senior Health Policy Researcher, The Source on Healthcare Price and Competition):
There are seven other states considering similar bills this Session to ban particular contract terms, anti-sharing, anti-steering or all-or-nothing contracting as shown in my presentation (Exhibit S). This creates unfair trade practices and these seven states ban them in those contracts. The federal government also considered similar language last Session, but it did not make it through Congress at the end of the Session. The Lower Health Care Costs Act of 2019 would have banned these provisions for all plans.

SENATOR HARDY:
Narrow networks seem to be anticompetitive. A physician cannot enter a contract that has certain provisions that restrain the ability of an insured to contract with other providers of health care. Is this going to create more of a narrow network but not allow a narrow network to happen?

MS. GUDIKSEN:
Senate Bill 329 would allow insurers to develop narrow networks so this would be another option. Many of the large health systems require their inclusion in a network, so it is hard for insurers to steer patients toward higher value, higher quality care. This bill would prevent that. It does not prevent insurers from creating narrow networks or physicians from entering narrow networks.

MS. BOND:
It also does not encourage them. It is not about narrow networks. What we are trying to do is make sure patients have the ability to use their copays, deductibles and their part of the health care costs to go to the facility that has the best quality. It is the opposite of what you are suggesting. We have large networks and want to keep all the current doctors and hospitals under contract. Patients need to have the ability with their own dollars to go within that network to the place they can receive the best quality and not be prohibited by a contract to do that.

SENATOR HARRIS:
In Nevada, the Attorney General has plenary powers to pursue deceptive and unfair practices. Can you explain why those powers are not sufficient to address this type of anticompetitive behavior?

MS. BOND:
There is another bill this Session to try to deal with some of this, but what we have heard from the Office of the Attorney General is they are not in the business of making any of this information public. For public policy reasons and to understand the ecosystem and the market, we need it to be public. They only handle issues at a high dollar threshold, similar to United Healthcare merging with Sierra Health Services which received a lot of action a decade ago from the Office of the Attorney General. Where you have one hospital buying another hospital or private equity in the market buying in small chunks, the Office of the Attorney General is not involved.

MS. HOLMES:
The other piece is that some of the contracts are opaque so people do not know they are confidential or what is contained in those contracts. This bill is making it explicitly clear that these are prohibited transactions under the Unfair Trade Practices Act.

SENATOR KIECKHEFER:
In the conceptual amendment, Exhibit Q, section 7, paragraph iii, what does it mean to place all members of a health care provider in the same tier of a tiered network plan?

MS. GUDIKSEN:
When insurers want to use tiered networks, they often divide a range of providers into different tiers with different cost-sharing; for example, the highest value or quality. They put the highest quality providers in one tier with the lowest cost-sharing so there would be some incentive for patients to choose them. Some large health systems with a hospital, Magnetic resonance imaging (MRI) clinic and a lab contractually require all of these services to be placed on the highest value tier even if they would not meet the quality or cost standards on their own. This would allow an insurer to divide providers based on quality to the different tiers or whatever standards they have for placing providers in tiers.

SENATOR KIECKHEFER:
Would providers place multiple or different doctors within the same practice in different tiers?

MS. GUDIKSEN:
Typically they would not. The one state that has this in law is Massachusetts, and they clearly have restrictions on how the tiers are divided which are typically by facility. For example, a group practice would be in one tier, but the hospital itself would be in another. The MRI and out-patient clinics might be in a separate tier.

SENATOR KIECKHEFER:
We have a for-profit healthcare system. The group practices and hospitals have business negotiations and contracts that take place between two private entities. For a provider to ask to be put into a specific tier would be a deceptive trade practice. Is that where we want to go?

MS. BOND:
We do not want to prevent our members from being able to have health care move towards high quality and high value because a contract is required and because the provider has the monopoly level control over the market. There is a requirement to serve the members you are contracted with but not let that be

prohibitive from having incentives where they are able to use other providers. There are contracts that do not allow this.

MS. HOLMES:
Market players are using their market dominance, which is their monopoly payer, preventing other providers and facilities from being able to compete on the basis of price and quality. The dominant provider is saying they can be in the same tier even though they charge more and have lower quality. They base that on the fact that they are so large they have to be in that network and can demand that.

SENATOR KIECKHEFER:
Does section 8 of the bill void the currently existing contract?

MS. BOND:
Not the contract, just that section of the contract that is the monopoly language. The rest of the contract stands.

RUSTY MCALLISTER (Nevada State American Federation of Labor Congress of Industrial Organization):
The Nevada State American Federation of Labor Congress of Industrial Organization supports S.B. 329. We believe the recording notifications regarding buy-outs and mergers are essential to our members' health plans. There have been many changes in the last five years. Mergers and buy-outs are becoming more of a regular practice, and private equity has found this is a great market to jump into. There are two emergency room groups in southern Nevada that are now owned by private equity groups. One of these groups tried to terminate the contract, or run out a contract of emergency rooms, simply so they could raise the rates. These notifications will help us to better advise our members, and control the cost of the limited amount of dollars we have.

We are supportive of the language that keeps providers of health care from having contracts that limit our members and plans from seeking out the best and most cost effective treatments that are important to them. The language in these contracts creates a monopoly scenario, and that is not good use of our limited health care dollars.

JUSTON LARSEN:
I am a Culinary Union member and have had asthma most of my life. I want to be an informed and empowered patient and need the information to better advocate for myself. I trust my culinary health fund to ensure I am going to get the best quality of care at the lowest price. I would like my culinary health fund advocate to provide advice on where it would be best for me to go that is safe, with a good medical professional and clinic that has the lowest co-pay amount. Right now, due to anti-steering and anti-tiering language in hospital contracts, my health fund is not able to give me the complete information I need and deserve. That is not right. Removing anticompetitive clauses from hospital contracts will allow my health fund to provide the complete information I need to meet my health needs.

JAMES SULLIVAN (Culinary Health Union):
The Culinary Health Union supports S.B. 329 because health care affordability, quality and access are critical concerns for culinary union members. Consolidation in the healthcare industry drives up prices but not the quality of our health care. Senate Bill 329 will take important steps to help understand how consolidation impacts our healthcare markets. It will stop anticompetitive contracting practices that prevent patients, employers and plans from shopping for and getting the best deals.

JAMES WADHAMS (Nevada Hospital Association):
The Nevada Hospital Association opposes S.B. 329. The Nevada Hospital Association members have not had a chance to review the conceptual amendment, Exhibit Q. Although we are in opposition, we have committed to continue to work with Senator Lange and any other stakeholders on this bill.

GEORGE ROSS (HCA Healthcare):
As the bill is drafted, and with the conceptual amendment, Exhibit Q, HCA Healthcare opposes S.B. 329. This bill would necessitate separate contracts for each hospital, ambulatory surgery center and urgent care center. We have carefully developed a system of care over many years with protocols and IT systems critical to organizing and coordinating care to get the right, most effective treatment for a person at the right time.

This bill, as written, with the amendment, Exhibit Q, would fragment care at the risk of duplication of services, destruct relationships, end value-based contracts and most likely raise costs.

Hospitals under an HCA contract with physician groups, such as emergency room groups, are not exclusive contracts. These physician groups are free to contract with any group they choose.

One can argue the only limits on an individual patient shopping for the best deal and doctors are the terms of his individual insurance plan, his or her out-of-network penalties, coinsurance and copays. The limitation is the narrow networks, not the providers or the hospitals.

KATIE RYAN (Dignity Health - St. Rose Dominican):
Dignity Health - St. Rose Dominican opposes the original version of S.B. 329 and the conceptual amendment, Exhibit Q, for the reasons cited by my colleagues. This bill is duplicative of A.B. 47 which we have been working on with the Office of the Attorney General on reporting of health care transactions.

Assembly Bill 47: Revises provisions relating to unfair trade practices. (BDR 52-425)

Also, the contracting restrictions piece of both the original version of the bill and the conceptual amendment, Exhibit Q, is problematic. It will make navigating health care coverage more difficult for patients while creating access to care and quality issues by interrupting the continuity of care.

CHRIS BOSSE (Renown Health):
Renown Health opposes S.B. 329 as drafted and the conceptual language provided which we have had for less than 24 hours and have not been able to determine all impacts of the bill.

As an integrated delivery system, Renown Health provides value to its patients and those employer groups and payers we contract with by being able to provide high quality care in the most cost effective setting, including the past year during the Covid-19 pandemic in the patient's home when appropriate. Excluding components of the delivery system we offer diminishes our ability to meet patient's needs. By connecting the components of the healthcare delivery system, we are able to coordinate care, hold components of the delivery system accountable to outcomes and improve communication between the levels of care and the patient.

Senate Bill 329 undermines components that nationally CMS has encouraged healthcare delivery systems to build through establishing accountable care organizations which have demonstrated the ability to improve quality and provide the most cost effective care.

Section 8 of the bill and the most recent amended language voids elements of existing contracts where rates have been established based on the entire framework of a current contract. This places a significant hardship on hospitals and healthcare delivery systems in Nevada who provide a discount based on a predicted number of patients. This will likely result in an unprecedented volume of contract renegotiations where prices will have to go up to sustain services in an environment of significant uncompensated costs related to government and uninsured cared provided.

DAN MUSGROVE (Valley Health System):
Valley Health System opposes S.B. 329. I echo the comments of my colleagues from HCA as well as Renown. The Valley Health System is eight hospitals Statewide, soon to be nine. It is that system of care that prevents fragmentation and delivers better care at a better cost to both our insured partners as well as our patients.

MARGOT CHAPPEL (Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services):
We have reviewed the bill and there is some fiscal impact we wanted to report. We will need to add staff because of the language in section 1 of the bill that identifies proposed statute language where offices would be responsible for setting up the website, collecting the data and analyzing and reporting the data.

JARON HILDEBRAND (Nevada State Medical Association):
The Nevada State Medical Association is in the neutral position on S.B. 329. First and foremost, we consider ourselves as a patient advocacy organization. We received the amendment, Exhibit Q, late yesterday, and we are waiting on feedback from our membership. Generally, we favor transparency and fully share the concerns of the bill sponsor regarding increasing the cost of health care. Many of our practices have been crushed during the Covid-19 pandemic, and we know the residual effects from this have yet to be seen in our small practices across the State.

We have some concerns with the reporting sections at the beginning of the bill. Most transactions are not a concern, and it cannot be emphasized enough the Attorney General already has the ability to intervene when there is a reason for concern. Increasing the thresholds for individual providers to a percentage of specialty markets and specifying a material change, should trigger the recording and would reduce our concerns. Including small joint ventures and management contracts, would be overwhelming and would not meet the intent of recordings.

We are still reviewing the second half of this bill and are working to fully understand the anti-steering and anti-tiering provisions that will affect the market. We support competition in the market and believe patients should have access to high-quality care. We do not want to take any contracting tools away from our small providers when negotiating with large corporations.

SUSAN FISHER (Nevada State Society of Anesthesiologists):
The Nevada State Society of Anesthesiologists is neutral on S.B. 329 with concerns for the same reasons expressed by Mr. Hildebrand. We fail to see how the bill will help with patient-physician relationships. We would like a better understanding of if the physician reports to one insurer what another insurer pays them for similar services, how this will help the patient or the provider. We are still analyzing the conceptual amendment, Exhibit Q, and how this bill interacts with the Attorney General's bill that is of a similar nature.

JESSICA FERRATO (Association for Comprehensive Energy Psychology):
The Association for Comprehensive Energy Psychology (ACEP) is neutral on S.B. 329. Health care transparency is a priority for ACEP. We are reviewing the changes from the conceptual amendment, Exhibit Q, and look forward to continuing to work with the sponsors.

LINDSAY KNOX (Nevada Orthopaedic Society):
The Nevada Orthopaedic Society is neutral on S.B. 329. We have not had time to review the conceptual amendment, Exhibit Q, and echo the comments made by Mr. Hildebrand and Ms. Fisher.

TOM CLARK (Nevada Association of Health Plans):
The Nevada Association of Health Plans is the private insurance carrier that makes up 19 percent of the market in Nevada, and we are in the neutral position on S.B. 329.

The work we have done with the sponsor has produced the conceptual amendment, Exhibit Q, giving private carriers the comfort level that allows us to be in the neutral position.

SENATOR LANGE:
This bill is about consolidation and transparency. We will continue to work with the stakeholder in an attempt to resolve the issues brought up today.

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

CHAIR RATTI:
I will close the hearing on S.B. 329. Seeing no public comment, this meeting is adjourned at 7:42 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
S.B. 318	B	1	Senator Fabian Donate	Remarks
S.B. 318	C	1	Olivia Whiteley / Refugee Advocacy Lab	Support Testimony
S.B. 318	D	1	Olivia Whiteley / Refugee Advocacy Lab	Bill Presentation
S.B. 318	E	1	Olivia Whiteley / Refugee Advocacy Lab	Proposed Amendment Revised
S.B. 318	F	1	Olivia Whiteley / Refugee Advocacy Lab	Language Access Assessment and Planning Tool, US Department of Justice
S.B. 318	G	1	Olivia Whiteley / Refugee Advocacy Lab	Language Access Policies, Department of Health and Human Services
S.B. 340	H	1	Grace Vergara-Mactal / Service Employees International Union	Written Testimony
S.B. 340	I	1	Vanessa Torti / Service Employees International Union	Written Testimony
S.B. 340	J	1	Vanessa Torti / Service Employees International Union	Proposed Amendment Revised
S.B. 340	K	1	Farren Epstein	Written Testimony
S.B. 340	L	1	Shawn Slatter / Right at Home Care; Personal Care Association of Nevada	Opposition Statement of Robert Crockett
S.B. 340	M	1	Connie McMullen / Personal Care Association of Nevada	Opposition Statement

S.B. 309	N	1	Joanna Jacob / Clark County	Proposed Amendment
S.B. 305	O	1	Rachael Chesin / Caleb's Law	Caleb's Law Presentation
S.B. 329	P	1	Senator Roberta Lange	Written Marks
S.B. 329	Q	1	Senator Roberta Lange	Proposed Conceptual Amendment
S.B. 329	R	1	Bobbette Bond / Culinary Health Fund	Bill Presentation
S.B. 329	S	1	Katherine Gudiksen / The Source on Healthcare Price and Competition	Similar Bills In State Legislatures Presentation