MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eighty-Second Session
April 12, 2023

The Committee on Commerce and Labor was called to order by Chair Elaine Marzola at 12:36 p.m. on Wednesday, April 12, 2023, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Elaine Marzola, Chair
Assemblywoman Sandra Jauregui, Vice Chair
Assemblywoman Shea Backus
Assemblyman Max Carter
Assemblywoman Bea Duran
Assemblywoman Melissa Hardy
Assemblywoman Heidi Kasama
Assemblywoman Daniele Monroe-Moreno
Assemblyman P.K. O'Neill
Assemblywoman Selena Torres
Assemblyman Steve Yeager
Assemblyman Toby Yurek

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman David Orentlicher, Assembly District No. 20
Assemblyman Gregory Koenig, Assembly District No. 38
Assemblywoman Angie Taylor, Assembly District No. 27

STAFF MEMBERS PRESENT:

Marjorie Paslov-Thomas, Committee Policy Analyst
Sam Quast, Committee Counsel

Joe Steigmeyer, Committee Counsel
Cyndi Latour, Committee Manager
Julie Axelson, Committee Secretary
Garrett Kingen, Committee Assistant

OTHERS PRESENT:

Haley Tanzman, Legislative Counsel, Uniform Law Commission
Miranda Hoover, representing Nevada Association of Nurse Anesthetists
Arthur Savignac, President, Nevada Association of Nurse Anesthetists
Quinn Shean, Managing Director, Tusk Venture Partners
Sheila Bray, Coordinator, Community Partnerships, University of Nevada, Reno
Greg Esposito, representing Nevada State Pipe Trades
Morgan McCarroll, Private Citizen, Reno, Nevada
Landon Mouritsen, Director of Anesthesia, Humboldt General Hospital
Jennifer Brown, Private Citizen, Carson City, Nevada
James Cooper, Private Citizen, Elko, Nevada
Marissa Wat, Private Citizen, Carson City, Nevada
Sarah Adler, representing Nevada Advanced Practice Nurses Association; FirstMed Health and Wellness; Vitality Unlimited; and New Frontier Treatment Center
Blayne Osborn, representing Nevada Rural Hospital Partners
Chad Brown, Private Citizen, Reno, Nevada
Joan Hall, representing LiCON Cooperative of Nevada; and President, Nevada Rural Hospital Partners
Robert Erickson, Private Citizen, Las Vegas, Nevada
Matthew Walker, PharmD, CEO, White Pine County Hospital District
Robyn Dunckhorst, CEO, Humboldt General Hospital
Tom Mann, representing ATA Action
Robert Carnahan, CEO, Banner Churchill Community Hospital
Paul Klein, representing Nevada Dental Association
Jerry Matsumura, representing Nevada State Society of Anesthesiologists
Susan L. Fisher, representing State Board of Osteopathic Medicine
Neena Laxalt, representing Board of Psychological Examiners
Marlene Lockard, representing Service Employees International Union Local 1107
Steven A. Saxe, Anesthesia Evaluation Committee Advisor, Nevada State Board of Dental Examiners
Mariah Smith, President, Nevada State Board of Optometry
Jonathan Mather, representing Nevada Optometric Association
Izack Tenorio, representing Churchill County
Steven Messinger, Policy Director, Nevada Primary Care Association
Tida Watkins, PharmD, Director of Pharmacy, Northern Nevada Hopes
Victor Salcido, Director, Government Affairs, Community Health Alliance
Netochi Adeolokun, Director, Clinical Pharmacy Services, Community Health Alliance
Faith Whittier, Chief Medical Officer, Northern Nevada Hopes

Jeani Pulsipher, PharmD, Clinical Pharmacy Specialist, Nevada Health Centers
Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Nancy Caddigan, Clinical Pharmacist, Washoe Tribal Health Center
Chinelo Nwaogbo, Director of Nursing, Washoe Tribal Health Center
Roxana Valeton, CEO, First Person Care Clinic
Todd Bleak, Manager, Pharmacy Services, Southern Nevada Community Health Center
Adam Porath, representing Nevada Society of Health System Pharmacists
Marissa Schwartz, representing Nevada Association of Health Plans

Chair Marzola:
[Roll was called and Committee rules and protocol explained.] Welcome, everyone here today. We will hear three bills: Assembly Bill 198, Assembly Bill 432, and Assembly Bill 434. We will also have a work session. We will start with our work session this afternoon. A work session is to take action on measures the Committee has heard. It is not customary for the Committee to take testimony or otherwise rehear the bills during work session. However, I may invite a witness to come forward for clarification or questions during our consideration of the measure. With that, we will begin with our work session, starting with Assembly Bill 270.

Assembly Bill 270: Provides for the licensure and regulation of anesthesiologist assistants. (BDR 54-714)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from work session document Exhibit C.] Assembly Bill 270 provides for the licensure and regulation of anesthesiologist assistants. It is sponsored by Assemblywoman Marzola and was heard in Committee on April 7, 2023.

There was a new bill page uploaded for the Committee members about an hour ago that includes an amendment from Michael Hillerby with Kaempfer Crowell law firm. That is to amend sections 7 and 46 of the bill to: (1) add specific provisions to allow anesthesiologist assistants to possess and administer medications and enter verbal or written chart orders in a patient's record as prescribed by the supervising anesthesiologist; and (2) reorganize and revise provisions governing the duties and responsibilities of an anesthesiologist assistant with respect to medication.

Chair Marzola:
Are there any questions? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 270.

ASSEMBLYWOMAN JAUREGUI MOVED TO AMEND AND DO PASS ASSEMBLY BILL 270.

ASSEMBLYMAN O'NEILL SECONDED THE MOTION.

Is there any discussion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will take the floor statement. Next is Assembly Bill 298.

Assembly Bill 298: Revises provisions governing housing. (BDR 10-249)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from work session document Exhibit D.] Assembly Bill 298 revises provisions governing housing. It is sponsored by Assemblywoman Jauregui and was heard on March 29, 2023.

There are three proposed amendments by the sponsor, John Norman, and Christine Hess. The first is to amend section 1 of the bill to prohibit a landlord from charging an application fee, or for credit reporting, or background checks for any minors who are members of the prospective tenant's household.

The second is to amend section 2, subsection 3, paragraph (o) of the bill to specify the manner in which variable costs and fixed fees must be set forth in the appendix containing an explanation of each fee that may be charged during the term of the rental agreement and the purpose for which the fee may be charged.

The third is to delete section 3 of the bill.

Chair Marzola:
Are there any questions?

Assemblywoman Jauregui:
I want to thank Assemblyman O'Neill. Amendment number two came at his suggestion when it came to variable fees and how we would outline those in the appendix. Assemblyman O'Neill, I took your input, and I did amend the bill to include that, so if a fee was variable, it would be outlined, and the property manager or landlord would not have to state a certain fee. That way, they are able to recover those costs.

Chair Marzola:
Are there any additional questions? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 298.

ASSEMBLYWOMAN MONROE-MORENO MOVED TO AMEND AND DO PASS ASSEMBLY BILL 298.

ASSEMBLYMAN YEAGER SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Jauregui. The next bill we will go to is Assembly Bill 392.

Assembly Bill 392: Makes various changes relating to property. (BDR 10-209)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from work session document, Exhibit E.] Assembly Bill 392 makes various changes relating to property. It is sponsored by Assemblywoman Kasama and was heard on April 5, 2023.

There is one proposed amendment by Mary Walker, representing Lyon County, and that is to amend section 1 of the bill on page 3, line 37 to delete "clerk" and replace it with "recorder."

Chair Marzola:
Are there any questions? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 392.

ASSEMBLYMAN CARTER MOVED TO AMEND AND DO PASS ASSEMBLY BILL 392.

ASSEMBLYWOMAN JAUREGUI SECONDED THE MOTION.

Is there any discussion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Kasama. The next bill we will go to is Assembly Bill 398.

Assembly Bill 398: Makes various changes relating to insurance. (BDR 57-1045)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from work session document Exhibit F.] Assembly Bill 398 makes various changes relating to insurance. It is sponsored by the Assembly Committee on Commerce and Labor. It was heard on April 10, 2023.

There is one proposed amendment by Justin Watkins, Board Member, Nevada Justice Association, and that deletes section 1, subsection 2 of the bill.

Chair Marzola:
Are there any questions? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 398.

ASSEMBLYWOMAN JAUREGUI MOVED TO AMEND AND DO PASS ASSEMBLY BILL 398.

ASSEMBLYMAN YUREK SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblywoman Backus:
I am going to vote this out of Committee, but I reserve the right to amend my vote on the floor because I am really struggling with the unintended consequences that will raise insurance. We have a lot of mandates in statute for health care providers and carrying medical professional liability insurance that could be impacted. I do not want a situation where we create barriers, so I will reserve my right to change my vote on the floor.

Assemblywoman Kasama:
I ditto that.

Chair Marzola:
Is there any further discussion on the motion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Torres. The next bill we will go to is Assembly Bill 410.

Assembly Bill 410: Revises provisions relating to industrial insurance. (BDR 53-1030)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from work session document Exhibit G.] Assembly Bill 410 revises provisions relating to industrial insurance. It is sponsored by Assemblywoman Jauregui and was heard on April 10, 2023.

There are two proposed amendments by the sponsor:

1. Eliminate the amendments to section 1 of the bill as drafted and instead:

a. Amend subsection 2 of section 1 to provide an exception from the provisions of subsection 2 which prohibits an ailment or disorder caused by gradual mental stimulus or any death or disability ensuing therefrom from being compensable under industrial insurance for certain injuries or diseases suffered by a first responder which are caused by stress, as described in subsection 4.

b. Amend subsection 4(b) to add "or a series of events" thereby providing that an injury or disease suffered by a first responder caused by stress, for which the primary cause was witnessing an event or series of events described in subsection 4(a), may be compensable under industrial insurance under certain circumstances.

2. Amend the bill to add Assemblyman Yeager, Assemblyman O'Neill, and Assemblywoman Monroe-Moreno as cosponsors.

Chair Marzola:
Are there any questions? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 410.

ASSEMBLYWOMAN MONROE-MORENO MOVED TO AMEND AND DO PASS ASSEMBLY BILL 410.

ASSEMBLYMAN O'NEILL SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Jauregui. The next bill we will hear is Assembly Bill 415.

Assembly Bill 415: Revises provisions relating to dispensing opticians. (BDR 54-846)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from work session document Exhibit H.] Assembly Bill 415 revises provisions relating to dispensing opticians. It is sponsored by Assemblywoman Taylor and was heard on March 31, 2023.

The executive director of the Board of Dispensing Opticians proposes 11 amendments.

1. Amend section 3 of the bill to revise the definition of "direct supervision."

2. Amend subsection 1 of section 8 of the bill to add "the issuance of licenses and."

3. Amend subsection 5(d) of section 8 of the bill to replace "1 month" with "30 days."

4. Amend subsection 6 of section 8 of the bill to delete the requirement that "the regulations adopted pursuant to this subsection must prohibit the reactivation of a license as a dispensing optician if the license is inactive for 10 consecutive years."

5. Amend section 9 of the bill to reduce the amount of the fee for an examination and initial license as a dispensing optician from $500 to $250.

6. Amend section 15 of the bill to: (1) allow for electronic verification and other methods of preparing work orders for ophthalmic dispensing; and (2) remove subsection 3(c), which excludes certain transfers of lenses, frames, or specially fabricated optical devices from the definition of "ophthalmic dispensing."

7. Amend subsection 4 of section 23 of the bill to remove redundant language providing an exception already provided for in the section.

8. Amend section 24 of the bill to allow an optical establishment to remain open in the absence of a licensed optician and require the establishment to post a sign notifying the public a licensed optician is not on duty.

9. Amend subsection 3 of section 25 of the bill to make a technical change to add "applicant who submits proof to the Board which shows to the satisfaction of the Board."

10. Amend section 27 of the bill to: (1) prohibit limited license holders from dispensing contact lenses or supervising the dispensing of contact lenses by an apprentice optician; and (2) authorize a person who holds an inactive limited license on January 31, 2023, to reactive his or her license in accordance with the provisions set forth in *Nevada Revised Statutes* 637.121, as those provisions existed before the effective date of the bill.

11. Amend section 28 of the bill to revise provisions concerning the supervision of an apprentice dispensing optician and delete provisions related to limited licenses, the substance of which has been moved to section 27.

Chair Marzola:
Are there any questions? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 415.

ASSEMBLYWOMAN TORRES MOVED TO AMEND AND DO PASS ASSEMBLY BILL 415.

ASSEMBLYWOMAN JAUREGUI SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Taylor. Next, we will move to Assembly Bill 437.

Assembly Bill 437: Limits the amount a provider of health care may charge for filling out certain forms associated with certain leaves of absence. (BDR 54-670)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from work session document Exhibit I.] Assembly Bill 437 limits the amount a provider of health care may charge for filling out certain forms associated with certain leaves of absence. This is sponsored by the Committee and was heard on April 10, 2023, and there are no proposed amendments.

Chair Marzola:
Are there any questions? [There were none.] I will entertain a motion to do pass Assembly Bill 437.

ASSEMBLYWOMAN JAUREGUI MADE A MOTION TO DO PASS ASSEMBLY BILL 437.

ASSEMBLYWOMAN TORRES SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblyman O'Neill:
I still have some reservations on A.B. 437. I will give it a yes, and it will stay that way most likely. I just want a little time to study a few parts and talk about some things. I wanted to make you aware of that.

Chair Marzola:
Is there any additional discussion on the bill? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will take that floor statement. Our last work session item is Assembly Bill 439.

Assembly Bill 439: Revises provisions governing contracts of insurance. (BDR 57-1044)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from work session document Exhibit J.] Assembly Bill 439 revises provisions governing contracts of insurance. It was sponsored by the Committee and was heard on April 10, 2023.

Kaylyn Kardavani, Associate Director of Government Affairs, Nevada Justice Association, proposes the following amendments:

1. Delete sections 1 through 3 and 9 through 14 of the bill.

2. Amend sections 4, 6, 7, 15, 17, 19, and 20 of the bill to revise the language set forth in those sections to provide that any arbitration provision in a policy of health insurance and other certain insurances is not binding upon the insured or any dependent of the insured.

3. Amend section 22 of the bill to repeal only *Nevada Revised Statutes* 689A.0403, 689B.067, 6889B.270, and 695C.267.

Chair Marzola:
Are there any questions? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 439.

> ASSEMBLYWOMAN JAUREGUI MOVED TO AMEND AND DO PASS ASSEMBLY BILL 439.
>
> ASSEMBLYWOMAN BACKUS SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

> THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Backus. We will now recess. [The Committee recessed at 12:50 p.m. and reconvened at 12:51 p.m.] I will now open the hearing on Assembly Bill 198, which revises provisions governing health care.

Assembly Bill 198: Revises provisions governing health care. (BDR 54-446)

Assemblyman David Orentlicher, Assembly District No. 20:
For my presentation on Assembly Bill 198, I am joined on Zoom by Haley Tanzman and Quinn Shean, who are part of the Uniform Law Commission project for the Uniform Telehealth Act. With me here are Miranda Hoover and Arthur Savignac to talk about the nurse anesthetist provision.

This is about promoting access to health care in Nevada, which is a serious problem. We do not have enough health care providers; we have problems with people finding a provider when they need one. Both of these provisions are designed to address the workforce shortage.

I will begin with the Uniform Telehealth Act, and I am going to start with the importance of telehealth. Maybe you live in an area where there is a serious shortage of health care professionals. Rural areas and sometimes urban areas have health care professional shortages. Having telehealth improves access for patients who live there. Maybe you do not have reliable transportation to get you to your doctor's office or the health clinic. With telehealth you can do it from your home. Maybe you want to keep your health care needs confidential and not lose your privacy by sitting in a waiting room with other patients. Telehealth allows you to keep your confidentiality.

Most of the provisions in A.B. 198 are designed to enact the Uniform Telehealth Act. This is an important proposal by the Uniform Law Commission to promote uniformity in state laws. In general, the Uniform Law Commission promotes uniformity in state laws on important topics. Uniformity will provide much value in the field of telehealth. If all states adopt this act, then you and your constituents will be able to receive care from your doctor or nurse when you are traveling out of state. If all states adopt this act, then medical experts in our state will be able to provide health care to their patients who live in neighboring states. I have heard from doctors in Las Vegas who have patients in Arizona and Utah and how much this will help them provide care so their patients do not have to drive two or three hours for every appointment.

Most of the bill is to enact the Uniform Telehealth Act. I will now go to my slides [Exhibit K]. The first important part of it is you can establish a patient/practitioner relationship via telehealth. We have already enacted that. This is an area where the Uniform Telehealth Act overlaps with current law. This is important because, again, if you are in a rural area, you do not have to make a trip to establish a relationship. That is already in existing law.

Telehealth is for a patient in Nevada and the practitioner is licensed in Nevada. That is the baseline. Again, this makes sure you can do it without having to meet in person first. Now, what if the practitioner is out of state?

There are some important provisions to facilitate telehealth when the practitioner is out of state. The first is to provide for registration; it is not licensure. Obviously, if they were licensed here, then they are able to practice in Nevada. This provides for the registration of out-of-state practitioners to provide telehealth services to patients while they are in Nevada. If you are struggling to find a practitioner, or your practitioner has moved out of state, we can register them. This allows practitioners who are licensed in their state as a nurse, a doctor, or psychologist to register, and they can provide telehealth services from their home office to patients in Nevada.

Registration does not allow them to provide live, in-person services; they have to be licensed for that. With registration, they can do telehealth from Utah, California, or Arizona. Again, it does not allow for in-person care. It also allows unregistered practitioners. If you are out of state, you are not licensed here, and you do not file for registration, you can still provide telehealth services to patients in Nevada for a few important services such as consultations.

Maybe a doctor in Nevada wants to consult with a doctor at the Mayo Clinic. This allows a doctor to do that without going through registration or licensure. Second opinions, specialty assessments, or follow-up care with existing patients are also included. If you are a doctor in another state, your patient is traveling to Nevada, and they need care while they are here, this allows them to contact their doctor back home, get care, and not have to find a doctor here.

This does not apply to patients who are out of state. This only concerns the patients in Nevada. If you are a practitioner here, and your patient goes out of state—on vacation in Florida—then you will be able to provide care. It is important to have uniformity so our patients here can do their traveling, and people from out of state can benefit when they are visiting Las Vegas.

This bill does not address payment for telehealth services by insurers. That is not in the act at all. Those are the basics. As I mentioned, Quinn Sheehan and Haley Tanzman are here, and I think Ms. Tanzman wants to make some remarks. They will both be available for questions. Let me go to Ms. Tanzman, and then I will come back and go over the nurse anesthetist provisions.

Haley Tanzman, Legislative Counsel, Uniform Law Commission:
The Uniform Law Commission (ULC) was organized in 1892 and is one of the oldest state organizations. It is designed to encourage interstate cooperation through uniformity in law. The ULC began drafting what would become the Uniform Telehealth Act in 2020, initiating a multiyear collaborative and nonpartisan process involving a multitude of policy experts, regulators, and stakeholders from various health care professions and industries. After careful study of the current telehealth landscape and an involved drafting process, we believe the resulting act represents the very best in telehealth policy.

The Uniform Telehealth Act facilitates access to telehealth services that are consistent with the applicable standard of care. The act recognizes the distinct ways practitioners can leverage telehealth to provide widespread assistance to patients in a more cost-effective and convenient matter. The Uniform Telehealth Act is also a powerful tool for health care equity, enabling patients to seek care from a qualified practitioner no matter where they are located. This is relevant nationwide, but especially in Nevada where there is a significant provider shortage, particularly in the mental health space.

The Uniform Telehealth Act has two broad goals. The first goal is to make clear that as a general matter, a practitioner who is licensed—or otherwise authorized to provide health care in a state in which a patient is located—may provide care through telehealth if doing so is consistent with the applicable professional practice standards and the practitioner's scope of practice as defined by the patient's state.

The second goal is to expand the circumstances under which qualified out-of-state practitioners are permitted to deliver telehealth services to patients located in the enacting state. This would create easier pathways for out-of-state practitioners to treat patients in

Nevada via telehealth. If a provider is not otherwise authorized to practice, such as by license, compact, or another exception to licensure, they may register with the appropriate Nevada board to deliver telehealth services to patients located in Nevada. Registrants must meet a number of requirements, such as holding an active and unrestricted license or certification, not being subject to a pending disciplinary investigation, and not having been recently disciplined. They also must have a registered agent in Nevada. The relevant board maintains authority to discipline or deny a registrant.

A similar registration model has been adopted in several states and has shown no increase in disciplinary action. The Uniform Telehealth Act implements a consistent regulatory framework and standards to enable the use of telehealth, while also including important patient protections to ensure patient safety and the appropriate use of telehealth services. The Uniform Telehealth Act recognizes that telehealth is merely a delivery method for health care, not a separate form of health care.

This act makes clear that any practitioner using telehealth must be licensed or otherwise certified to deliver care in the state, meet the same standard of care as for in-person health care services in the state, and must comply with all federal laws and other state laws.

We believe this act can be especially helpful for Nevada, which is currently facing a critical provider shortage and mental health crisis. Unfortunately, Nevada ranks last in the United States for overall mental health and second-lowest in the Mountain West for workforce availability, with only one provider available per 460 residents. While this act cannot solve this issue, it is sure to alleviate the provider shortage by enabling out-of-state providers to reach patients in Nevada. Thank you very much for your time and consideration, and thank you to Assemblyman Orentlicher for your hard work on A.B. 198.

Assemblyman Orentlicher:
I want to say one more thing about the telehealth portion. I did hear from the Board of Psychological Examiners about their concerns with the registration provision in section 13 of the bill, which would allow a psychologist who is licensed as a psychologist in another state to register here and then be able to deliver telehealth services from their home state to somebody living in Nevada. This is only telehealth; they cannot do in-person appointments with this registration process. When the representatives from the Board of Psychological Examiners talked to me, they observed that we have more stringent standards for licensing psychologists than some of the other states. Their concern in adopting the Telehealth Act as is, it could invite telehealth services by professionals who do not provide the highest quality of care. I took these concerns seriously because it is important that our residents have high quality care.

I explored options to accommodate their concerns with an amendment to the act. In the end, I decided not to propose an amendment and for important reasons. First, as Ms. Tanzman indicated, this Uniform Telehealth Act emerged from a multiyear drafting process with input from a broad range of stakeholders.

If you have not participated in a Uniform Law Commission drafting process, I encourage you to do so. You will be very heartened at the efforts people put in, like Assemblywoman Backus. You get a wide range of experts from all over the country.

This act was carefully vetted by experts in health care and law, and I think that makes for a strong presumption against revising the act. Second, as I indicated, uniformity is valuable in telehealth. If every state revised the act to suit its own purposes, you and your constituents might not be able to receive care from your doctor or nurse when you are traveling out of state.

Third, as Ms. Tanzman mentioned, the Board of Psychological Examiners will still have authority to intervene if out-of-state psychologists are not providing good care. These people have to be registered. They have to be approved with no disciplinary problems in the past. If there are any problems once they start delivering telehealth, our Board can take action against them. We have good safeguards.

There is good evidence this works because we can look to Florida for reassurance on the concerns of the Board. Florida enacted a registration process similar to the one in the Uniform Telehealth Act back in 2018. They got ahead of the curve. Florida also has stringent licensing standards for psychologists, even slightly more stringent than our standards in Nevada. I submitted a study of the Florida and Idaho experience as an exhibit [Exhibit L]. What that study shows is Florida has not seen problems with out of state psychologists delivering telehealth services.

Most importantly, as Ms. Tanzman said, we have a serious shortage of mental health professionals in Nevada. As a KFF [formerly Kaiser Family Foundation] report from this past September demonstrated, mental health care professionals are meeting only 29 percent of the needs for mental health services in Nevada. We need to address this shortage, and this act will do that.

I am not going to transition to section 24. This bill addresses our shortage of health care professionals in another way. Often, the only professionals authorized to deliver anesthesia in Nevada are certified registered nurse anesthetists (CRNA). Our current licensing rules can prevent CRNAs from providing care they are well qualified to provide. Hence, section 24 is included in the bill, and I am grateful to Miranda Hoover for alerting me to this need. Section 24 would provide for licensure of CRNAs as a type of advanced practice registered nurse (APRN), as section 24, subsection 1 says, "For the purpose of practicing as a certified registered nurse anesthetist . . . ." It is designed to ensure CRNAs can practice within the full scope of practice of a nurse anesthetist. Currently, there are barriers to doing that; hospitals are not letting them. If you are in an area where there is a shortage of anesthesiologists, you may not have an anesthetist for your procedure.

It also allows CRNAs to establish an independent practice from which they can contract to provide nurse anesthetist services. This is not a novel proposal. It brings us into line with 42 other states and the District of Columbia. They have this exact opportunity for CRNAs to

become licensed as a type of advanced practice registered nurse. We do not have to worry as these are well-charted waters. That is what I have to say, but I will turn to Ms. Hoover and Mr. Savignac if they want to amplify.

Miranda Hoover, representing Nevada Association of Nurse Anesthetists:
I am here with my colleague, the chair of the Nevada Association of Nurse Anesthetists, who I will introduce momentarily. We all know after 55 days of testimony that Nevada has an extreme doctor and provider shortage. Those gaps were only exacerbated during the COVID-19 pandemic. Today is a pivotal day in our state to address some of those gaps with highly qualified providers who are already in our state but are currently not able to practice within their full scope.

Today, Nevada gets the opportunity to hear and discuss what more than 42 states and the District of Columbia have already done. They have recognized in state law that CRNAs are advanced practice registered nurses. To be clear, giving CRNAs the designation of APRN does not give CRNAs the ability to open up a primary care practice, nor does it allow them to advise a patient by telehealth means. When you Google, "Are CRNAs APRNs," the resounding response you will get is yes. "A CRNA (certified registered nurse anesthetist or just 'nurse anesthetist') is an advanced practice registered nurse (APRN) who administers anesthesia and other medications. They also take care of and monitor people who receive or are recovering from anesthesia." This is a direct quote from the Cleveland Clinic.

With that, I will dive into section 24 of the bill. What does APRN status recognition for CRNAs mean? It means codifying the ability for CRNAs to order, possess, and administer, within their scope and environment, anesthetic agents. This is so they can work autonomously within very specific entities that are within their scope, such as hospitals, surgery centers, dental offices, and podiatry offices. Scope of practice is defined by the who, what, where, when, why, and how of nursing practice, including advanced practice nursing. Day to day, this defines the services that an APRN is permitted to undertake in keeping with the terms of their professional license. In layman's terms, this simply means there are layers to each designation even under the APRN umbrella, as each license must still work within their specified scope of practice based on their accreditation. We are asking for CRNAs to be classified as a type of advanced practice registered nurse.

It is important to note that section 24, subsection 2, paragraph (b) says that CRNAs may "Administer anesthetic agents to a person under the care of a licensed physician, a licensed dentist or a licensed pediatric physician." We are not here today asking for CRNAs to be granted the full independent practice.

As we go into section 24, subsection 3, you will notice we have built boundaries within the bill so other types of APRNs who are not licensed CRNAs cannot work outside of their practice by administering an anesthetic agent or anything that is specific to a CRNA's scope of practice. Section 24, subsection 5 offers that if the State Board of Nursing would like to require additional training, education, or experience for CRNAs, they have the ability to do so.

The remainder of section 24 outlines specific work that CRNAs are trained to perform and already do in our state, as well as all other states. We are simply codifying the language. Section 26 removes the CRNA license, as we are including it as an APRN license. You will note that APRN licenses are the exact same price as current CRNA licenses, and we are not seeking to change that. The remainder of the bill cleans up language to bring this chapter into conformity with the change of including CRNAs as APRNs.

With regard to education, one distinct comparison I would like to make in regard to a CRNA versus the general education of a different APRN, such as a nurse practitioner, is that APRN programs are 27 months on average versus a CRNA program which is upwards of 52 months on average. Graduates of nurse anesthesia programs have an average of 9,369 hours of clinical experience versus an APRN who is required to have at least two years or 2,000 hours of clinical experience.

Over the last couple of years, CRNAs have run into multiple issues in Nevada with being able to do their jobs simply because this language has not been codified in statute. Their scope is currently only spelled out in the *Nevada Administrative Code* (NAC). The intention here is to simply move the scope of practice language that CRNAs have in the NAC and codify it into modern law so they can continue providing quality patient care in Nevada and bring Nevada into conformity with the 40-plus other states that already recognize CRNAs as the advanced practice registered nurses they are. This will alleviate the question from regulatory entities about: (a) who has jurisdiction over CRNAs; and (b) to ensure CRNAs are able to practice within 100 percent of their education, training, and experience and thus being the health care professional they were trained to be.

If CRNAs had been able to practice within their full scope through the entirety of the COVID-19 pandemic, Nevada would have had more than 100 nurses able to move seamlessly throughout our most critical facilities during the worst health care crisis of our time.

I am submitting for the record a letter [Exhibit M] from James Cooper and Nathan Broadbent. They are CRNAs who work at the Elko County Hospital, where the only anesthesia care providers are CRNAs. The letter outlines what CRNAs did during the pandemic at the Elko Hospital and how crucial they were in being able to be used autonomously to provide care to COVID-19 patients across the hospital—including in the intensive care unit (ICU), where patients were at their most vulnerable. Because of the education, training, and experience CRNAs have, those at the Elko Hospital help to educate the ICU nurses, even when deficiencies were noticed and train them in specific critical care techniques. I will let you read the letter, but this summarizes just some of the important aspects CRNAs bring to their practice every day, because it is not just administering anesthetic agents that is their specialty. With that, I am going to pass the bill presentation over to my colleague, Arthur Savignac, the president of the Nevada Association of Nurse Anesthetists.

Arthur Savignac, President, Nevada Association of Nurse Anesthetists:
I would like to give a brief biography of what I have done in my career. I have been a registered nurse for 40 years. I am originally from the state of Massachusetts. For 33 years, I have been a CRNA. I did my training at Walter Reed Army Medical Center in Washington, D.C., graduating in December 1990.

For 15 years, I practiced anesthesia in the Army. I traveled all over the world, providing anesthesia services to soldiers everywhere. Of note, one of my most significant opportunities was to be selected by surgeons and other anesthetists to be a member of Joint Special Operations Command's Joint Medical Augmentation Unit to provide care to special operations warriors around the world, providing anesthesia care, trauma care, and resuscitative care as needed. Certified registered nurse anesthetists were chosen for this role primarily—not just that we know how to do anesthesia—in the event we had an issue with medical evacuation of a patient from some foreign land. Certified registered nurse anesthetists were able, as critical care nurses as well, to provide care to these patients, these soldiers who deserve the best. We did that very well.

Other assignments I had in the military included training. For four years, from 1998 to 2002, I was a program director, teaching nurse anesthetist students at Madigan Army Medical Center in Tacoma, Washington. Training these soldiers, these anesthetists who deployed around the world to Iraq and Afghanistan when the war on terror broke out, and watching them save lives around the world brought us great pride. In addition, at Madigan, I was also a member of the root cause analysis team. Any time there is a medical event, a critical event that occurs in any medical facility, a team is assembled, and an investigation is performed. As part of that investigating team, we learned many different things about how critical events do occur. That has provided me with an insight on a lot of different issues and how to prevent bad occurrences from happening in hospitals, primarily in Nevada, where we worked.

My family and I moved to Elko in 2008. We were in Elko providing anesthesia care for nine years. In Elko, we had four anesthesia providers, all CRNAs. We worked 24/7, 365 days a year. In nine years, we never once missed a call. We never once had a surgery that was canceled because we were not available. We provided expert anesthesia care in obstetrics, in general surgery, in pediatric dentistry, in urology, and every specialty that was available in Elko. In the decade that I was there, we provided approximately 35,000 anesthetics, averaging about 3,500 a year in the in the city of Elko, with both the hospital and the surgery center that is now closed. As you can see, our numbers support the quality of care provided by CRNAs in Elko and around the state.

What we seek is APRN status and prescriptive authority. The prescriptive authority we are looking for is not the ability to write prescriptions to patients who are going to be discharged from the facility. What we look for is prescriptive authority that allows us to administer medication to patients in the hospital, within the scope of our training and practice. This is

involved preoperatively, intraoperatively, and postoperatively. These medications essentially need to be administered within seconds. We need to be able to provide these medications without the necessity of obtaining a written order from some other provider.

Certified registered nurse anesthetists practice this way—and have practiced this way—in the state of Nevada for decades, especially in rural areas like Elko, Ely, Mesquite, Winnemucca, Fallon, and Fernley. These areas are almost exclusively staffed by CRNAs, and removing the ability for them to provide these medications and to provide them with a prescription we need to obtain could be potentially catastrophic to these patients.

The *Nevada Revised Statutes* (NRS) have been interpreted in a manner confusing to other medical specialties. Passage of this bill will provide clarity and uniformity across the spectrum of medical treatment facilities in this state. I would like to refer again to Elko. I would like to summarize one paragraph from the letter that was submitted by Ms. Hoover [Exhibit M]. At the hospital in Elko, many key people and providers, including CRNAs, prepared an emergency plan for when the community would be stricken with a surge of virus-related cases. In September 2021, the emergency plan was enacted, and all elective surgical cases were canceled. The CRNAs were freed from elective surgery to use their broad and wide-ranging anesthesia experiences and extensive critical care backgrounds to help with the patient surge at the hospital.

The nursing background was essential. The anesthesia knowledge was critical and lifesaving in Elko. It has demonstrated that the capacity of CRNAs to provide anesthesia care is there, and we would be doing a disservice to the citizens of the state if we do not provide CRNAs the ability to provide the care on a timely basis that our patients need.

In closing, I am here on behalf of the 125, give or take, CNRAs in the state of Nevada. These providers are rarely heard of, precisely because the safe care we provide goes on across the state. We work every day 24/7 in operating rooms, obstetrics suites, the MRIs, the medical offices, dental offices, emergency rooms, and the clinics of the vast majority of medical facilities in the state. I also have numbers from Winnemucca and Mesquite. I mentioned previously that Elko had 35,000 cases, Winnemucca had 11,000, and Mesquite had 11,000 safe anesthetics provided by CRNAs over that previous decade. I have not included the population centers. Certified registered nurse anesthetists do practice in Washoe and Clark Counties, primarily as members of an anesthesia care team, so getting exact numbers is difficult. For the rural areas of Nevada, we have established CRNAs exclusively providing the care, and we need to continue this.

Recruiting CRNAs to Nevada has been a challenge; not being acknowledged as APRNs has been an issue. People do not want to work or move here because they have found they are not recognized. Their practice is not recognized, and they do not feel comfortable coming here. We hope by obtaining this APRN status we will be able to recruit.

Additionally, there are two CRNA schools opening in Nevada—one at the University of Nevada, Las Vegas, and one at Roseman University in Las Vegas. We trust they will be matriculating students starting in 2024. Graduates of advanced practice programs will typically choose to remain in the state in which they have trained. By having these schools, having APRN status, and having the ability to retain these people, we hope we can alleviate the shortage of anesthesia providers in this state.

I implore you to provide us with legal recognition and status as APRNs. This includes having the full prescriptive authority under the guidelines of the facilities we provide anesthesia services for. This will enable us to make split-second decisions for lifesaving drugs required for safe administration and safe anesthesia care. The citizens of the state of Nevada need access to safe and timely anesthesia care every day and in every setting. Certified registered nurse anesthetists are there every day, and have been there every day, for at least the last 40 years in the state. As APRNs, the quality of care our patients have received for decades will be assured in the future. Madam Chair and Committee, I thank you for your time. If you have any questions, I will gladly entertain them.

Assemblyman Orentlicher:
Thank you for giving us the time. We are ready for questions.

Assemblywoman Jauregui:
I have a question on section 24. We previously heard another bill about how anesthesia assistants can operate, but they are required to operate under the supervision of a physician. There is nowhere in section 24 that says CRNAs would have to be under the supervision of a physician, correct? So, this would be a CRNA acting independently with no doctor's oversight.

Miranda Hoover:
Currently, the way CRNAs practice in the state, as Mr. Savignac mentioned, is in the rural areas they do not have to be under the supervision of a physician. They work within the hospital setting as part of the hospital care team, and they work under the hospital's guidelines, such as the hospital's DEA number. They do the same thing in the urban areas. Most of the CRNAs who work within Washoe and Clark Counties work within that anesthesia care team. Thus, they are either employed specifically by an anesthesiology group, which is then contracted with the hospital and surgery centers, or within a care team such as that. You are correct. Again, I did want to mention that based on section 24, subsection 2, paragraph (b), the patients themselves still have to be under the care of a licensed physician, licensed dentist, or a licensed pediatric physician.

Assemblywoman Jauregui:
Under the care of physician could be the surgeon who is not an anesthesiologist. If someone is going in for surgery, they would be under the care of the surgeon who does not specialize in anesthesiology. With that, where does the liability come in? Who is liable? Who carries the insurance, that liability product, in case there is an instance where something goes wrong?

Arthur Savignac:
When we worked in Elko, the way we operated was we had a medical director of our anesthesia department. We had quarterly meetings with him, and he basically was our go-between with the anesthesia department and the hospital if we had any issues that needed to be handled. As far as malpractice goes, every provider carries their own malpractice insurance. If there is an issue, the provider who has the issue is the one who is liable if it is proven they were at fault. That is why we carry malpractice insurance. Typically, unless there was some surgical malpractice or some surgical issue, the surgeon would not be involved.

Assemblywoman Jauregui:
Is the medical director a physician? With malpractice, are CRNAs required to carry their own malpractice insurance?

Arthur Savignac:
Yes. Our medical director was a general surgeon whom we worked with daily; he knew of our capacity to provide safe anesthesia care. And yes, each individual provides their own malpractice insurance.

Assemblyman Carter:
I apologize in advance for the bipolar nature of these questions. What do these two issues have to do with each other? They are not linked together at all, and it makes no sense why they are both in the same bill. How many other states have enacted this telehealth legislation? Is there some type of compact or reciprocity agreement to provide the other way around?

Assemblyman Orentlicher:
This Uniform Act was just approved last summer; no state has had time to enact it yet. I am hoping we will—and other states are considering it. A fair number of states, as I mentioned, Florida, anticipated the act by adopting very similar provisions. We already have some provisions, such as the ability to establish a relationship. Many of the provisions are already in state statute, but this is a very new act. It is too soon to have a track record of adoption.

Assemblywoman Monroe-Moreno:
Along the lines of Assemblyman Carter's question, no other states have enacted it? Do you know if there are any other legislatures in session right now that are debating and discussing the issue?

Assemblyman Orentlicher:
I will defer to Ms. Shean or Ms. Tanzman for this one. Sure.

Quinn Shean, Managing Director, Tusk Venture Partners:
Currently, I believe there are three states and the District of Columbia that have already introduced the legislation this session. As Assemblyman Orentlicher mentioned, it was just

finalized in July after a two-and-one-half year process. This is the first session it could be introduced. Also, as he mentioned, every provision that is included within the act has been adopted by another state, including some provisions that Nevada has already adopted.

Assemblywoman Monroe-Moreno:
Of those four states that have introduced the legislation, can you tell us the progress of that legislation right now?

Quinn Shean:
I believe they, too, are in committee, and one is pending introduction right now.

Assemblywoman Monroe-Moreno:
Could you tell us the four states? I believe it is Washington, D.C., Nevada, Rhode Island, and Washington. Is that correct?

Quinn Shean:
That is correct, yes.

Assemblywoman Monroe-Moreno:
Since we are in committee, what is the other state that is in committee with the legislation?

Quinn Shean:
I believe it is in committee in Rhode Island, and it is pending introduction in Washington, D.C.

Assemblyman Yurek:
I appreciate your efforts in how this bill has been pitched on both issues that are contained here and its attempt to increase access to health care, which we know is a problem. As I sit here and consider bills this session and how they are pitched in that regard, I am always concerned about increasing the availability and access to health care but potentially compromising the quality of the care we are giving and the long-term implications of that. I will be honest, I tell you that on both sides of this bill, I have some concerns.

I would like to focus on the first portion, which is the telehealth. If you will forgive me, I just came out of a marathon session on medical malpractice, so my mind is leaning that way. In that hearing we discussed the standard of care. This is relatively new. I looked at section 9, pages 3 and 4, and it basically permits out-of-state doctors. It says, " 'State' means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands or any other territory or possession subject to the jurisdiction of the United States. The term includes a federally recognized Indian tribe." When we are talking about the quality of care and the standard of care, I can imagine there is going to be quite a diversity of standards of care there. We are trying to protect our in-state patients. What standard of care would you propose would apply where maybe some telehealth went wrong and led to some sort of injury?

Quinn Shean:
The standard of care that would apply is the standard of care in Nevada. To take a step back, as telehealth is currently practiced in Nevada, a provider who is in California and a federal Indian tribe in Tennessee who has a Nevada license is authorized to deliver care through telehealth delivery to Nevada patients right now, whether or not this bill passes. They are expected to follow the standard of care and practice in Nevada. Our bill does not change that. What it changes is the authorization and what types of providers are allowed to deliver telehealth. It still recognizes providers who have a Nevada license. It recognizes providers who are authorized through various occupation compacts to deliver care via telehealth. It sets up a registration model. As part of that registration, out-of-state providers—in addition to the requirements Ms. Tanzman mentioned—are expected to follow the Nevada standard of care just as out-of-state providers who are licensed are able to do so. For those providers who fail to do so, the Nevada regulatory boards retain their authority with registered practitioners, as well as licensed practitioners, to enforce those standards.

Assemblyman Yurek:
I hear you saying the Nevada standard of care would apply. My understanding is it could be, let us say state X on the other side of the country where their standard of care differs significantly from Nevada. If they are licensed there and are going to reach out through a registration process, they could practice telehealth in Nevada with no experience in Nevada. How could we be offered any sort of assurances they would understand, appreciate, and practice within our standard of care?

Quinn Shean:
To take a step back, Nevada already authorizes an out-of-state provider in Tennessee, for example, who might have a different type of standard of care, to practice in Nevada without having ever stepped foot in Nevada. It goes through a license where the procedure is they are verified as to good standing, go through the entire licensing process, and has a license in the state of Nevada, which can be revoked by the State Board of Medical Examiners. The registration process operates similarly. It is a streamlined process. The practitioner has to be in good standing. They have to be licensed in the state where they are residing and delivering care via telehealth, as I mentioned with the expectation. I think we also have to recognize the reality right now that there are providers outside the state of Nevada who are delivering care.

The second point, which Assemblyman Orentlicher mentioned in introducing the bill, is we have evidence for the last two and a half years that all 50 states, including Nevada, had modifications on their licensure or waiver to enhance cross-border care. We did not see a significant increase in discipline.

Our committee looked at this significantly with experts from across the country, providers, and patients giving input as well. One question was, how do we leverage telehealth to its full potential to meet patient access needs while retaining the standard of care? Some people

proposed full reciprocity. If you are licensed anywhere, you are able to treat patients in another state. Our committee felt that did not give boards enough authority over providers who were serving patients in their state.

We looked at a lot of models and looked at streamlining certain provisions for those that are not opening up facilities within the state—such as a registration model—as a pathway that balanced both access and accountability. As we said, other states, such as Delaware, West Virginia, Florida, and Arizona have implemented this. It has been used by a variety of practitioners. We have heard that in Florida many of the health systems are using it to deal with shortages; specialists are using it. Other parts of the act are used to treat college students who are across state lines. As I mentioned, we heard from experts as to the issues of cross-border care, and this is where the registration model came from.

Assemblyman Orentlicher:
I would like to add a couple of things. There are not different standards of care in different states. Doctors, nurses, and psychologists observe the same general standard of care. There can be differences in what you need to do to qualify for a license. Once you are licensed, there is a national standard of care. Obviously, there are variations. If you are practicing in Winnemucca, you do not have a Level 1 Trauma Center, so we do not expect you to provide Level 1 trauma care as you would if you were University Medical Center of Southern Nevada. Given whatever resources you have, it is the same standard of care nationwide.

As we have seen, we have good evidence from the lifting of COVID-19 restrictions and Florida and the other states that have adopted these rules. We do not foresee any problems. We are concerned about having qualified people licensed; every state worries about that. That is why we do not see problems. I would not bring this bill if I thought this would undermine the quality of care.

I brought this bill because, as you heard, this was a carefully vetted bill. One of the unfortunate realities and part of the reason why we have shortages of health care professionals is there are artificial barriers to practice. Some of the requirements are justified on the basis of ensuring quality of care, but some are designed to keep out competition. That is what professional groups try to do. They try to maintain their advantage and not open too much to competition. Unfortunately, we have gone too far with the artificial barriers, and this is an important way to address the problem. As I said before, we only have enough mental health professionals to meet 20 percent of the needs. If you were in the Assembly Committee on Judiciary this morning, you heard about the shortages in a lot of specialties. If we do not allow telehealth, we are going to make it very hard to address the shortage of health care access in Nevada.

Assemblywoman Jauregui:
I know all too well the shortage of the health care workforce. We hear it almost on a daily basis in this Committee. I want to ask all the questions I have to make sure I have a full understanding. My question is going to be on section 19. Having sat on Commerce and Labor for four sessions, we hear a lot about the provider-patient relationship and how

important that is. Can you walk me through that? How does an out-of-state doctor through an in-state provider establish a provider-patient relationship? I know from hearing in different fields of health care how important that is. There was a bill, I think three sessions ago, that dealt with veterinarians where they stressed how important it is, even when it comes to animal care, establishing that patient-provider relationship. That out-of-state doctor is not going to establish an in-person relationship. How does that happen?

Quinn Shean:
I was pulling this up as we talked because I do not know if this was mentioned in any of the testimony submitted. The Federation of State Medical Boards was looking at this at the exact same time as the Uniform Law Commission. They were also rethinking their telemedicine policy, which had been adopted in 2014. They recently released it last year. In their policy they reiterated what is already the law in all 50 states across the country, including Nevada, that a physician, for example, can establish a patient relationship via telehealth, both through synchronous and asynchronous types of communication, where appropriate. They go through the list in detail as to things that need to be a part of that.

It is also dependent on the condition and making sure the provider has the necessary information from the patient verifying identity and disclosing the identity of the provider, since telehealth is not going to be an appropriate care setting to form a relationship. In some cases, it will be, and it might be the best one, depending on their circumstances, such as their ability to seek care elsewhere or where they are located. As with other health care settings, that discretion is left up to the provider based on their educational training as to whether they can meet the standard of care. I am happy to provide that where the Federation goes through all the steps they believe are necessary in a telehealth context to form that relationship.

Assemblyman Orentlicher:
The ability to establish a relationship is already in code. That is the first part of the slide [Exhibit K]. It is in NRS 629.515. We have already done that. Section 19 of this bill talks about a Nevada nurse or doctor and their relationship with a patient here and the Nevada practitioner wants to consult via telehealth with a specialist out of state. You are in Winnemucca, you think the patient has a particular kind of cancer, and you want to talk to somebody at MD Anderson Cancer Center or Memorial Sloan Kettering Cancer Center for guidance about this kind of cancer. This allows you to make that call and have that doctor from the specialty center consult with you.

Assemblywoman Duran:
How is that going to work for your billing purposes? I know we are having issues with that as it is right now. Are you going to need a referral from your insurance to get this doctor? Do you know anything about how that is going to be handled?

Assemblyman Orentlicher:
I do not know, and this act does not address insurance. If Ms. Shean or Ms. Tanzman have something to add, please do.

Quinn Shean:
Was this in reference to whether the insurance is going to cover a second opinion consult from out of state or just generally? I am not familiar with the particulars of Nevada's coverage requirements as to telehealth services. Many payers have encouraged the use of telehealth and do cover it as an in-network service. With specific out-of-state consults, I am not sure of the policy on that. This is really about the authorization for those out-of-state providers to consult with an in-state provider or provide a specialty opinion consult to a patient without having to be licensed in the state. I am not sure of the particulars of payment there.

Assemblywoman Duran:
My concern is if this comes back to an unforeseen consequence for the patient to be billed for something like this. I think that needs to be figured out because it will fall back on the patient. It is going to be harder for them.

Assemblywoman Hardy:
I am going to go back to section 24. We just passed Assembly Bill 270 out of the Committee, which talks about the certified anesthesiologist assistants. Now we have CRNAs. I am just trying to understand. In that bill, the anesthesiologist assistants are required to have supervision of an anesthesiologist. In this bill, it is saying CRNAs would not have that. I am trying to understand the difference and why it would be different for these two, as neither are doctors. That is not their education, although they are very highly educated in what they do.

Miranda Hoover:
Yes, there are very clear differences. Certified registered nurse anesthetists are nurses. After 2025, not only will they all be required to have a master's degree, but they will also be required to have a doctorate in practicing anesthesia for nurses. Anesthesia assistants are assistants. They are not registered nurses. I will let Mr. Savignac take the rest of that.

Arthur Savignac:
One thing I want to establish is that anesthesia safety standards are uniform across all levels of practice. When there are monitoring requirements where a patient gets monitored for every anesthetic, they are equally applied by both CRNAs and anesthesiologists.

When we train, we typically train at the same facility that an anesthesiologist may train at. The type of care is the same; the type of patients we see are the same. I will not say there is a uniformity of education, but the standards that are applied to every patient interaction are the same. This is the type of anesthesia care that has been provided by CRNAs in this state for 40 years and in the United States for over 100 years.

Assemblyman Orentlicher:
I would just like to add to your question about the distinction. One parallel distinction you might think about is physician assistants have to be associated with a physician. It often

varies with states, but it is not unusual to say they cannot have an independent practice, and they have to be associated with a physician. An APRN might be able to have an independent practice and not have to be supervised by a physician.

Assemblywoman Hardy:
Thank you for your answers. That is what I am trying to understand, but I am still having difficulty with this. We are talking about a patient putting their life in the hands of that person giving him or her the anesthesia. I think that is a little bit different than an APRN situation. In my mind, that is more serious when you are having surgery and being given anesthesia. I am trying to understand this and make that distinction in my mind. I honestly have a little difficulty with their not being supervised by an anesthesiologist in this situation.

Miranda Hoover:
I am happy to provide you a cross comparison spreadsheet I have. Of course, we have been very involved in A.B. 270. I am happy to provide that to the Committee for additional reference. If you have any questions, please let me know.

Chair Marzola:
I have a quick question. As it stands right now, a CRNA has to be under the supervision of an anesthesiologist, correct?

Arthur Savignac:
Certified registered nurse anesthetists can practice in multiple different environments. They can practice under medical direction with an anesthesiologist; they can practice as part of an anesthesia care team. Basically, it is more of a collaborative environment where CRNAs and anesthesiologists may formulate an anesthesia care plan for the patient for that day. They can practice autonomously, which is the way the vast majority of anesthesia in rural areas in this state are provided. Again, I have provided some numbers that will tell you the safety level of anesthesia care that is provided on a daily basis in the state, both elective and emergent. The training CRNAs receive allows us to practice in these environments.

Chair Marzola:
Thank you for that clarification. Are there any additional questions? [There were none.] We will go to support testimony. Is there anyone wishing to testify in support of A.B. 198?

Sheila Bray, Coordinator, Community Partnerships, University of Nevada, Reno:
We would like to voice our support for A.B. 198. We thank Assemblyman Orentlicher for bringing forth this bill. Section 24 specifically will allow CRNAs to be considered APRNs, granting them full practice authority in our state. This is important for our university's Orvis School of Nursing and will help with faculty recruitment, the ability to find clinical practicum placements for our students, and bring more CRNAs to the state. As mentioned in this bill presentation, investment in our health care system is a vital workforce need for our state. This provision is a good step in that direction. Thank you, and we urge your support of A.B. 198.

Greg Esposito, representing Nevada State Pipe Trades:
I may be the only nonmedical-related professional in the room. Telehealth has been a boon to my membership and their families. A lot of my members have recurring injuries, such as a strained back or a bad knee from the work they do. They do not need to go back to see a doctor; they do not need to take the time to make an appointment to go into the facility. Telehealth has enabled them to quickly connect with their doctor and get the prescription or referral they need. Expanding the availability of doctors and expanding the availability of appointments would be really helpful to my membership and other construction workers in the state.

On a personal level, as somebody who is neurodivergent, I need to see my psychiatrist every month or every two months in order to get my medication. I do not actually have to go in anymore. I can get that prescription through telehealth, which was not an option before. Any expansion of telehealth where there are more providers or more ability for people to meet their medical needs without having to go into a facility, we are in support of.

Morgan McCarroll, Private Citizen, Reno, Nevada:
I am an anesthesiologist in northern Nevada, and I have practiced here for about 20 years. I have also had the pleasure of practicing in California, Washington, Montana, and New Jersey. I went to medical school in Louisiana. In those states, I have had the pleasure of working in the team care model with nurse anesthetists as well as working beside nurse anesthetists at the height of the COVID-19 pandemic in New Jersey. I have been very impressed with the quality of care provided by nurse anesthetists and the professional collaboration we have had over those years.

In my current position as a chair of anesthesia, I am well aware of the needs for health care providers in northern Nevada and the difficulty to recruit people to this area, both physicians and nurse anesthetists. One of the concerns nurse anesthetists from out of state have expressed to me is not having advanced practitioner status in this state and the lack of recognition of that. I feel A.B. 198 would address that and allow us to recruit more nurse anesthetists, and thus provide better quality health care than we are able to now with our stressed environment. With that, I will yield for any questions.

Landon Mouritsen, Director of Anesthesia, Humboldt General Hospital:
[Written testimony was submitted, Exhibit N.] I am a CRNA along with four others there. Recently, I responded to a code in the emergency room and saw a little baby on the table being resuscitated. The emergency room physician had attempted three times to put a breathing tube in that baby. I asked if I could try and was able to secure that breathing tube and help that baby breathe. That baby is the same age as my little girl, and that is who I saw on the table when I put that breathing tube in. It is hurtful to be marginalized as a nurse, with physicians being the end all, be all. We have very similar training. I have ten years of training and education to be a CRNA.

Studies show it is no safer to receive care from an anesthesiologist than from a nurse anesthetist. Recently, the State Board of Pharmacy has restricted us from ordering medications, and this bill will help us be recognized as advanced practice nurses, as I think we have adequate training to be recognized in that capacity. We shut down an operating room in Winnemucca today so I could come and testify because the service we provide independently is so important to our community. I love my community, and I think my family and the fellow members of my community deserve to receive anesthesia care. We will not be able to currently without nurse anesthetists.

Jennifer Brown, Private Citizen, Carson City, Nevada:
[Submitted letter in support, Exhibit O.] I am the chief CRNA at Carson Tahoe Regional Medical Center. I have been a nurse for 20 years and a CRNA for 14 years. I hold an APRN license in Hawaii, Maine, and Alaska. Additionally, I hold a DEA license in Alaska in order to perform anesthesia in those states. I am reminded again and again that CRNAs are one of the best-kept secrets in health care. So many people have no idea we even exist. Yet, nurses have been delivering anesthesia independently since before anesthesiologists, who are a specialty of physicians. In fact, nurses have been delivering anesthesia for the U.S. Military since the Civil War. That is over 150 years.

Today, there are 44,000 CRNAs and 31,000 anesthesiologists practicing in the United States. That is 13,000 more CRNAs than physicians. At Carson Tahoe, our anesthesia team consists of ten CRNAs and three anesthesiologists. Studies show that CRNAs and physicians provide the same quality of anesthesia care. That is why in every state, teams consist of a mix of CRNAs and physicians.

Sometimes, bills are meant to fix the language of previous bills; bills that were not perfectly written. This is one of those times. The purpose of this bill is to align Nevada law with health care across the nation. Everyone knows we need more health care workers. This bill will fix confusing language that scares CRNAs away. Please pass A.B. 198 and bring more health care workers to Nevada.

James Cooper, Private Citizen, Elko, Nevada:
[A letter in support was submitted, Exhibit P.] I am a CRNA who has been practicing for over 23 years in Elko, Nevada. That was after completing my training at the Mayo Clinic in Rochester, Minnesota. Over these 23 years, I have complied with the provisions that were set in the NRS and the NAC Chapters 632 and 449, which detail the practice of nursing and how a CRNA can practice in a medical facility in the state.

I have worked alongside my fellow CRNAs without the supervision of an anesthesiologist providing anesthesia to over 70,000 patients in Elko. I have personally performed more than 15,000 anesthetics, ranging from routine procedures like tonsillectomies, gallbladders, and cesarean sections, to emergency cases such as appendectomies and fractured arms. Additionally, I have provided anesthesia for gunshot wounds to the abdomen, trauma from

automobile accidents, ruptured spleens, lacerated livers, and post-delivery hemorrhages of new mothers. All of these are life threatening, and all of these were performed in the operating rooms in Elko without an anesthesiologist.

Despite Elko being a relatively small town, we face similar life-threatening emergencies that larger cities like Las Vegas and Reno have. Therefore, it is essential for our surgeons and communities to have well-trained anesthesia providers who can provide competent anesthesia services. The state of Nevada recognizes the need for CRNAs to practice at the pinnacle of our profession since traumas, emergencies, and routine cases happen everywhere, and not everywhere is there a practicing anesthesiologist.

I want to emphasize A.B. 198 is not a change to the governing provision or scope of practice for nurse anesthetists. Instead, it will recognize CRNAs as advanced practice nurses, which we have always been. I urge you to pass A.B. 198.

Marissa Wat, Private Citizen, Carson City, Nevada:
[A letter in support was submitted, Exhibit Q.] I am a CRNA here in Carson City, and I am here to share what I have been going through since I moved to Nevada. I moved here about three years ago. Since I moved here, I have worked in two hospitals, two surgery centers, and independent gastroenterology centers as well. I have worked in all the practices you have heard today. I worked in supervisory practice, medical direction, and as an independent provider here in Nevada.

I want to say that A.B. 198 will recognize us as we need to be recognized, advanced practice nurses. Already, the majority of states in the United States recognize us as advanced practice nurses. Nevada is behind the times. This bill will not necessarily mean all nurse anesthetists will now practice independently. We will still practice in care teams and also as independent providers in certain areas that need them. It will increase access to care in these areas, especially rural areas. For our communities, this is very important. As I told you, I have worked in all these different areas because of the tenuous health care environment here in northern Nevada. I am hoping A.B. 198 will help stabilize that environment and provide more access to care for our communities.

Sarah Adler, representing Nevada Advanced Practice Nurses Association; FirstMed Health and Wellness; Vitality Unlimited; and New Frontier Treatment Center:
These clients of mine who are providers of health care and behavioral health care to rural Nevada are in strong support of the telehealth provisions of the bill. Telehealth is essential to create access to providers and to reach patients in a timely and cost-effective manner. For example, FirstMed Health and Wellness, which is a federally qualified health center in Las Vegas, is providing psychiatry and mental health services to William Bee Ririe Hospital in Ely. The judicial court there asked for FirstMed to assist them with creating an alternative court.

Turning to section 24, on behalf of the Nevada Advanced Practice Nurses Association, we are 100 percent in support of section 24 of the bill. Advanced practice registered nurses take pride in their independent practice authority and being fully accountable to their license. This has created greater access to primary and specialty care. It is time to do the same for access to anesthesia services, including the carefully defined prescriptive authority you find in the bill. I think it is very important to emphasize the ability to create seamless service throughout a community, in the multiple places in the community, that are in need of anesthesia care.

In section 5, the State Board of Nursing is in charge of further defining "scope of practice." They do a great job in protecting the public health and welfare for APRNs and will do the same for CRNAs. We ask you to join 42 other states in declaring CRNAs as APRNs.

Blayne Osborn, representing Nevada Rural Hospital Partners:
We are here in support of A.B. 198, both the telehealth and CRNA provisions, which I want to expand upon briefly. Five days ago, in this Committee, we heard staggering numbers about the critical shortage of anesthesia services in the state. This shortage is exacerbated in rural Nevada where our member hospitals cannot get anesthesiologists. Instead, our rural communities rely on CRNAs.

Nevada Administrative Code 632.500 already allows CRNAs to select, order, and administer anesthetics. However, in September 2020, the State Board of Pharmacy issued an advisory opinion that, subject to the limitations of NRS 453.375 and 454.213, registered nurses, and therefore CRNAs, may only possess and administer anesthetic agents at the direction of a practitioner or pursuant to a chart order. Sadly, there are only three critical access hospitals in Fallon, Ely, and Winnemucca that are still able to provide obstetrics and routine delivery services. The only sources of anesthesia for these patients are CRNAs. This discrepancy affects their scope and puts those services at risk. We need your help to solve this issue for rural Nevada.

Chad Brown, Private Citizen, Reno, Nevada:
I am way out of my league here. I am not in the health care industry, but I feel you have made a safe space for me to have a confession. Fifteen years ago, I learned there was such a thing as a certified registered nurse anesthetist. The first thing I said when I heard about that was, "Oh, that is new. How nice they are letting nurses do that now." That is embarrassing. I said it in the presence of a nurse anesthetist.

As we have been told today multiple times, I learned nurses have been providing anesthesia since the Civil War. They were providing anesthesia when anesthesia was first invented by surgeons and dentists. They wanted to perform their surgery and dental work, and they quickly trained their nurses how to do that to take over that specialty. At the time, I did what any grown man would do when he finds he has been living in a world that is not exactly what he thought. I ran to my mother. She informed me throughout the multiple procedures I had as a child, most of those had anesthesia delivered by CRNAs, and I did not even know they existed.

The next thing I learned was there are 30 percent more CRNAs practicing in the United States than anesthesiologists. That is earth-shattering news. What it taught me is for 100 years, the vast majority of anesthesia in the United States has been delivered by nurses, by CRNAs, and not anesthesiologists. I had absolutely no idea.

Since then, I have read probably between 75 and 100 studies in the health care business related to anesthesia. Another one of my ideas was shattered. I thought doctors or anesthesiologists were performing at a higher level and the nurses were somewhere below that. I hear a lot of that echoed today. In fact, zero studies said that. What they said is they are both performing at the same level of care, which was astonishing to me, but I still try to learn as old as I am.

Joan Hall, representing LiCON Cooperative of Nevada:
LiCON Cooperative of Nevada is the self-insured medical malpractice insurance company Nevada Rural Hospital Partners runs. It provides liability insurance for eight of our rural hospitals. First, I want to say CRNAs have provided anesthesia services in rural Nevada for nearly 40 years, or at least 40 years that I am aware of. The anesthesia at my cesarean section, done in Yerington, was provided by a CRNA. Her name was Rosemary DuPree. She was medically trained in the Army, lived in Hawthorne, and provided all of the anesthesia for rural Nevada. She had a following with the Highway Patrol. They would lead the way each time a different hospital needed her.

Our insurance company has had obstetrical malpractice cases. We have had surgical malpractice cases, but we have never had an anesthesia malpractice case. Our CRNAs work under the direction and supervision of their obstetrical doctors or their surgical doctors.

Robert Erickson, Private Citizen, Las Vegas, Nevada:
[Written testimony was submitted, Exhibit R.] I have been a registered nurse for nearly 15 years as well as a CRNA for 8 years. I have worked in Las Vegas and Carson City. As a CRNA, it is vital to Nevada citizens that health care be delivered with minimal barriers. The goal of this bill is to use the language in the NAC to update our nursing statute to ensure regulatory compliance, as our language was last updated 30 years ago in 1993.

I hold a leadership role with a major anesthesiology group in Las Vegas, and I interview interested and qualified out-of-state CRNAs. Questions regarding practice in our state arise in the interview process and regarding state CRNA practice restrictions. The hesitation of potential health care providers coming into the state is partially due to the current statute as interpreted that limits scope of practice. As CRNAs, we hope this issue can be resolved at this time, as Nevada is one of the last states to recognize CRNAs to be licensed as APRNs.

If this legislation does not pass, the potential ramifications include restricting patient access by shutting down surgical services, a facility staffed by CRNAs, which disproportionately affects Nevada's rural constituents as well as CRNA educational programs. As we address the anesthesiology provider shortage, two CRNA schools are actively in the process of opening here in Nevada, and we have been a clinical site for CRNA students for over two

years here in Las Vegas. A CRNA has prepared the rigorous education training at the masters or doctoral level to provide the full spectrum of patients' anesthesia-related care for individuals across the lifespan. We ask you to pass this bill that establishes the Nevada CRNA specialty as advanced practice nursing status, as it is in other states across the country.

Matthew Walker, PharmD, CEO, White Pine County Hospital District:
I am in support of A.B. 198, as its focus is to increase access to care. As many of you know, Ely, Nevada, is very isolated. Our hospital and clinics are the only form of health care for over 200 miles. We provide a myriad of services beyond general care, and most of our specialties come in a few days a month and provide elective services, which is sufficient for our volumes. This model works great to bring elective services to many of Nevada's most rural and vulnerable populations. Anesthesia, however, is a little bit different. When someone needs emergent care or comes in to deliver a baby, we cannot schedule that. That requires 24/7 coverage. Due to our low volumes, we do not have enough patients to support the pay of an anesthesiologist, which is required to cover 24/7, 365 days a year. Also, per our prior testimony, there are not enough anesthesiologists to go around as is. We currently have two nurse anesthetists who rotate and cover the facility 24/7, 365 days a year. The cost for these two nurse anesthetists is equivalent to one anesthesiologist. We feel strongly that with good communication and collaboration between our surgeons and nurse anesthetists, we can continue to provide high-quality services to our emergent and elective patients with a model that has proven to be very effective over the past 20 years. Supporting A.B. 198 will continue to allow care for our rural at-risk patients.

Robyn Dunckhorst, CEO, Humboldt General Hospital:
I am the chief executive officer at Humboldt General Hospital (HGH) in Winnemucca, as well as a 23-year practicing registered nurse within our facility. On behalf of our facility and the access to health care for rural residents of Humboldt County, I thank you for the opportunity today to testify in support of A.B. 198.

To serve and provide thorough access to care for rural patients in our community is very important for us to be able to continue to provide obstetrical services, emergency services, and surgery within our coverage area. In order to do that, certified registered nurse anesthetists being able to work within the full scope of their practice is a very imperative piece of our puzzle. Currently CRNAs practice with oversight of surgeons and other doctors here at HGH, but they are beyond qualified to do this independently and as an APRN.

I have personally worked the entirety of my career with CRNAs at my side, and there is no one I trust more with airways, critical medications, aesthetic agents, and dangerous drugs more than our CRNAs. Their rigorous and competitive schooling process easily rallies against the most advanced, graduate-level clinical nursing degrees such as all other APRNs.

With escalating inflationary costs, health care provider labor shortage issues, and costs of health care delivery in Nevada, now is the time to support health care providers and allow for maximum usage of well-trained providers such as CRNAs, who are the answer to the

delivery of surgeries, specifically obstetrical services and surgery in rural areas. To put it bluntly, rural facilities cannot easily afford, find, or retain anesthesiologists in rural areas because there is a shortage of them as well. The demand in the metropolitan area is just too great.

To fail rural communities by not supporting this bill would be very unfortunate, as we are the disparity. We are where underserved patients could have catastrophic outcomes if CRNAs are not supported, and we are not able to continue to recruit and retain CRNAs due to their lack of ability to get your support with the APRN status and full prescriptive authority. Simply put, CRNAs have earned it. They are qualified and deserve this. I trust them with my life and my family's life and surgery. Thank you for allowing me to speak today, and I urge you to support this bill.

Tom Mann, representing ATA Action:
We are the American Telemedicine Association's affiliated trade organization focused on policy advocacy. First off, I want to thank you for inviting testimony on this legislation and for all your work to advance access to telehealth in Nevada. I will keep this brief as a lot of our sentiments here already been spoken about earlier. ATA Action was a close observer of the two-year process by the ULC to develop this language, which included perspectives from providers, patients, legal experts, and other health care stakeholders. ATA Action fully supports the outcome of all that work and believes this legislation will greatly expand access to health care and fulfills many of ATA's core policy principles.

By ensuring access to health providers, the legislation expands the total pool of providers for patients to choose from, as well as greater patient choice for how that care is delivered, including from the comfort of their own home or office, as long as the standard of care is met. The legislation allows many different health care professionals to offer telehealth services in addition to physicians, including APRNs, physician assistants, and others. Additionally, the legislation's licensure and registration provisions remove barriers on access, and continuity of care will empower state boards to monitor for safe care delivery and provider discipline.

I would say ATA Action had submitted a letter of support to the Committee that we did not see listed in the exhibits. We will resubmit that following the hearing [Exhibit S]. Thank you again for listening to our testimony and for supporting telehealth. Please do not hesitate to reach out to ATA Action with any questions.

Robert Carnahan, CEO, Banner Churchill Community Hospital:
I am a nurse, but I am also the CEO of Banner Churchill Community Hospital here in Fallon, Nevada. Like everyone who spoke before me, we at Banner Churchill would like to support A.B. 198. Our hospital and physicians support the ability for CRNAs to prescribe and dispense all anesthetic medications they are trained to provide. There is a highly collaborative approach between our surgeons and CRNAs. They are highly involved in

patient care and those positive outcomes for patients. The physicians value the delivery of anesthesia care the CRNAs provide as well as that valued respect for them. Our CRNAs have provided years of safe care with zero opportunities.

Not having CRNAs with the ability to prescribe anesthetic agents will definitely put us at risk for discontinuing services in our Nevada community and that access for Nevadans' care as well. Exclusively for us, we also support the Naval Air Station Fallon, and not having CRNAs here to help us out could jeopardize our obstetrics and gynecological (ob-gyn) program. We deliver a lot of kiddos for the Naval Air Station here. With limited access to ob-gyn services—obviously in rural communities, as was mentioned there are three that provide this service—it is imperative CRNAs have this prescriptive capacity.

This is happening in other states as well. Wyoming approved this a couple of years back for CRNAs to have this prescriptive authority. It is so hard to get CRNAs in our facility. A few years ago, we had to go to a vendor—a contractor group—because we were unable to recruit our own. It seems like it gets worse. We had to fly a CRNA from Tennessee out today to help us with our surgeries tomorrow because we were lacking CRNAs for our surgery schedules. Every day, it seems to be getting worse. We are in support of this.

[Exhibit T, Exhibit U, Exhibit V, Exhibit W, Exhibit X, Exhibit Y, Exhibit Z, Exhibit AA, Exhibit BB, Exhibit CC, and Exhibit DD were submitted but not discussed and will become part of the record.]

Chair Marzola:
Is there anyone else in support of A.B. 198? [There was no one.] We will move to testimony in opposition to A.B. 198. Is there anyone wishing to testify in opposition?

Paul Klein, representing Nevada Dental Association:
We applaud the bill's effort to increase access to care. That is something we care about. Our issue is specifically with section 24, subsection 2, paragraph (b), where a CRNA could go into a dental practice without the oversight of a credentialed dentist. Currently, in statute, that dentist who oversees that work has to have a special credential. We are diluting that oversight which creates malpractice issues, like Assemblyman Yurek and Assemblywoman Jauregui said. We would appreciate if "a licensed dentist" would be carved out from section 24, subsection 2, paragraph (b). I apologize for not bringing it forward before this, but I will make myself available to work on this before the deadline.

Jerry Matsumura, representing Nevada State Society of Anesthesiologists:
I am here to give testimony opposing A.B. 198 based on page 12, section 24. While I am the one who also presented data that there is a shortage of anesthesia providers, the Nevada State Society of Anesthesiologists feels that it should not be at the cost of patient safety. Essentially, this prescriptive authority is going to give the nurse anesthetists independent practice in the state. I do understand they have given testimony that they have APRN status in 44 other states. That is probably correct, and that is probably at the state statute level.

However, according to the *Code of Federal Regulations*, the conditions of participation for Medicare and Medicaid, 42 CFR § 416.42, and if you indulge me, let me just read this because it sounds clear to me. It says, "Anesthetics must be administered by . . . ," and then they discuss an anesthesiologist, a Doctor of Medicine, and under the category of a certified registered nurse anesthetist "as defined in § 410.69(b) of this chapter . . . unless exempted in accordance with paragraph (c) of this section, the anesthetist must be under the supervision of the operating physician . . . [or] of an anesthesiologist" who is immediately available.

The exception is basically what we consider, and all the anesthesiologists and nursing anesthetists in the room are familiar with, a "Governor's opt out." The Governor has the ability to opt out after consulting with the State Board of Medical Examiners and State Board of Nursing. Nevada is not an opt-out state, and there are only 22 states, not 44 states, that have opted out. At the federal level, they still have to follow the conditions of participation with Medicare and Medicaid.

They consider the NAC an outdated law. Yes, it was created in the early 1990s. Even though it is an older law, it was brought up for potential change, and it was turned down. In outpatient surgery centers and hospitals, according to the NAC—and I can read the numbers and provide them to you, or you can look them up in the NRS—it does require supervision of a CRNA by the operating practitioner or an anesthesiologist.

Susan L. Fisher, representing State Board of Osteopathic Medicine:
[Submitted a document, Exhibit EE.] The State Board of Osteopathic Medicine is neutral on most of the provisions of A.B. 198. However, they are opposed to section 24. If that was amended out, they might possibly move to support, but with that section, they are opposed.

Dr. Matsumura covered a number of things I was going to talk about. Governor Lombardo has not opted out of the federal provisions—CRNAs would not be able to practice autonomously or be reimbursed by Medicaid or Medicare because Nevada is not an opt-out state.

I would also like to correct something Ms. Hoover put on the record. She referred to certified anesthesiologist assistants (CAA) as "just assistants." That is incorrect. These are highly trained professionals, just as CRNAs are highly trained professionals. Both of these areas of medicine are very important to the state of Nevada and across the nation. Most certified anesthesiologist assistants have a master's degree, and most of them have premedical education. They have a lot of biology and chemistry in their undergraduate degrees. They are required to have a bachelor's degree before they can even apply to a CAA program. I would also note even though we are focusing on this bill, the CAA bill you just passed out of this body unanimously earlier today requires they practice under a physician anesthesiologist, not just a physician.

Neena Laxalt, representing Board of Psychological Examiners:
You heard earlier the sponsor did say the Board of Psychological Examiners did start talking to him last winter about the telehealth section of his bill. As you may know, the

Psychological Board is part of the NowPsych compact, which is one of the few compacts Nevada has joined over the last several years, and they have been in it for quite a while now. There are 36 states that are part of that compact, and they have developed a telehealth, telepsychology I believe they call it, portion to that compact. There is a difference between the compact and what this bill does under the Uniform Telehealth Act. Yes, it requires the same standard of care, as the sponsor said. The concern of the Board was that it does not require the same level of education and training for these people. The compact does require similar training and education. We believe this would conflict with the compact and how that is run in our statutes and perhaps our endorsement statutes. With that, if you have any questions, I have a letter [Exhibit FF] I can provide from our Board president that will help answer any further questions.

Marlene Lockard, representing Service Employees International Union Local 1107:
We oppose A.B. 198 but not section 24 of the bill. We feel the lack of a physical presence and direct contact with patients can hinder the ability of telehealth nurses to accurately assess and diagnose health conditions. Physical examination is a critical aspect of health care, and without the ability to perform hands-on assessments, telehealth nurses may miss important signs or symptoms that could lead to misdiagnosis or incomplete care.

Secondly, communication can be challenging in the telehealth setting. Technical issues such as poor video or audio quality can disrupt the flow of conversation and impede effective communication between the telehealth nurse and the patient. I would like to point out how that happened with our first Zoom participant from Las Vegas. The picture froze, and the language was garbled. We missed part of her presentation.

I have more information but, in the interest of time, I will not present it. I would like to point out on page 5 of the bill in section 13, subsection 1, paragraph (b), it says, "Holds an active, unrestricted license or certification in another state that is substantially equivalent to the registration for which the applicant is applying." On one last note, the fact that this bill requires the health care provider to register is in conflict with the earlier compact bill we heard on Friday.

Steven A. Saxe, Anesthesia Evaluation Committee Advisor, Nevada State Board of Dental Examiners:
I am president of the Nevada State Society of Oral and Maxillofacial Surgeons, a Democrat residing in Assembly District 37, and a board-certified oral and maxillofacial surgeon, practicing the specialty of dentistry and licensed to administer general anesthesia in Nevada for more than 30 years. I am also employed for many years by our Board of Dental Examiners of Nevada to conduct inspections and examinations of dental offices and dentists for state permits who deliver general anesthesia in their offices.

I am here to address specifically page 12, section 24, subsection 2, paragraph (b), ". . . under the care of a . . . licensed dentist . . . ." The specific conflicts are too numerous to outline in the context of this timed testimony. If one were to read the first paragraph from the Legislative Counsel Bureau attached to A.B. 198, to summarize, it is clearly threatening the

safety of Nevadans. I believe this bill and this section should be defeated and go back to the Legislative Counsel Bureau to address the many conflicts that are present with dentistry's Chapter 631 in NRS and NAC.

Over the past 40 years, Nevadans have been protected by those dentists who adhere to specific criteria in their education and in their office settings to assure patient safety during the delivery of general anesthesia. Most dentists in Nevada do not possess the academic credentials or anesthesia-trained teams in their offices to oversee a nurse anesthetist to deliver general anesthesia. Nor are their offices properly designed or equipped to handle the delivery of anesthesia or the potential emergencies that may occur.

In addition, the transportation of controlled substances—in light of our current opioid crisis—may be a problem for Nevadans. The various divisions and boards were surveyed on their fiscal impact of A.B. 198, but there were no questionnaires on the safety and accountability of A.B. 198 to our patients' health and well-being.

I implore you all to vote no on A.B. 198. This is not about politics. Assembly Bill 198 is a very dangerous and poorly written piece of legislation. The Board of Dental Examiners of Nevada specifically has a fully functional anesthesia committee to resolve the obvious conflicts. This is the only way to maintain patient safety measures. Currently, CRNAs are working in Nevada dental offices without the dentist having the appropriate credentials to deliver general anesthesia. This is unlawful.

Lastly, the way to address workforce shortages and access to care in Nevada is not to lower our current quality standards to jeopardize the safety of Nevadans. Yes, there are different standards of care, even within our own state of Nevada, as rurals have a different set of standards than our urban areas.

Chair Marzola:
Is there anyone else wishing to testify in opposition? [There was no one.] We will move on to neutral testimony. Is there anyone wishing to testify in neutral to A.B. 198? [There was no one.] Assemblyman Orentlicher, would you like to give any closing remarks?

Assemblyman Orentlicher:
The main reason for this, as I indicated, is our workforce shortage. We have to use all the tools in our toolbox and all of them are important. I am glad you have addressed them in other bills. Some of them are pipeline bills, and that is good. We need to build our pipeline. That is going to take time.

What is important about both parts of this bill is they will have an immediate impact. Expanding access to telehealth will create better access for patients. You heard Mr. Esposito who has trouble taking time off work. We are going to get an immediate impact for the CRNAs in our rural communities, who are the only people there to deliver anesthesia. We are going to get an immediate impact to address our access problems.

Second, when it comes to quality, those are the right questions to ask. All the evidence shows the quality of care will be just as good with this expansion. We are not asking for new practitioners or different kinds of care. We are saying let them practice to the full extent of their abilities. We want to use them because we do not have enough practitioners. We do not want to use them at 80 percent capacity or 60 percent capacity, we need to use them at 100 percent.

With regard to quality, we will see improvements because the patients who need that specialized care—where there are only a few doctors in the country—may not be able to fly to the Mayo Clinic, New York, or Houston. I can, but not every patient can. For them to get that access, telehealth gives them the access they cannot otherwise afford.

Finally, on the dental provisions, as Mr. Klein indicated, he did not have a chance to speak to me beforehand. I am not sure I understand the problem, but I will certainly talk to him and make sure we are not doing anything to compromise quality of care in the dental setting. Thank you for your time. I will touch bases with all of you. I want to make sure you are as comfortable as I am with this bill so we can get it moving forward.

Chair Marzola:
Thank you, Assemblyman Orentlicher. I will now close the hearing on A.B. 198. We will move to our next bill. I will open the hearing on Assembly Bill 432, which revises provisions governing optometry.

Assembly Bill 432: Revises provisions governing optometry. (BDR 54-929)

Assemblyman Gregory Koenig, Assembly District No. 38:
I am here today with the Nevada State Board of Optometry, and I want to keep it short. I know we are oversaturated with bill hearings at this point. I have been accused of this being an omnibus bill, but I hope we can get through it quickly regardless. There are a handful of housekeeping changes, a few definitions, and some things that are important and need to happen for the Nevada State Board of Optometry.

The thing that attracted me to this bill is telemedicine, and I hope at this point we do not have telemedicine fatigue because that is the point I want to bring forward today. Here in Carson City, I feel like I am kind of in one little universe, and at home is a whole different universe, and they tickle the edges of each other. This is a bill where my two universes collide, since I am an optometrist and a legislator. It is the telemedicine part that got me excited about this bill.

I want to ask your forgiveness if I have already told you this story, but I think it illustrates how I foresee this telemedicine working in optometry and how it can be a huge benefit for my rural patients. I have practices in Fallon, Fernley, and Yerington. Those are fairly small towns. In my Fallon practice, I looked up the demographics last weekend when I was home, and I have over 500 patients from either Tonopah or Round Mountain. It can take someone coming from Round Mountain almost three hours to get to my practice for an eye exam.

If they were getting contact lenses, I would do a comprehensive exam, and do all the things required that we will be talking about here a little bit later. As long as they did not have too crazy of a prescription, I would find them a trial pair of contacts, put them on their eyes, make sure the patient sees well, make sure they fit right, and everything was healthy. Then, I would say, This is a trial pair of contacts. I need to see you back in a week for a five-minute follow-up to make sure they are working.

For my Fallon patients, they can drive the five minutes to get to my office, no big deal. But my patients from Round Mountain have another six hours in the car to come visit me a week later for a five-minute contact check on contacts that 90-plus percent of the time are working just fine. The initial visit would have to be in person. I would check them and could call them in a week and say, Are your contacts working okay? Are they comfortable? Are you seeing well? If they say yes, at that point I envision myself finalizing the prescription and giving it to them. They can order contacts from me, 1800contacts, or whoever they want to use. It is their prescription at that point.

If there are issues and they say, My left eye is not quite good or They bugged me here and there, at that point they would have to come back for another exam. At least for the majority of those patients, it would save them six hours of driving for a five-minute check. For me, that is a huge benefit for my rural constituents because they do not have the access. That is how I envision this working.

I want to make one quick note. This bill originally dropped with the two-thirds designation. There were four lines they said caused that. I am not sure we agreed with them, but we removed those four lines from the bill. At this point, from what I am told, it should be a majority vote. With that, I will turn it over to my colleague, Mariah Smith, who will quickly summarize the bill.

Mariah Smith, President, Nevada State Board of Optometry:
[An overview of A.B. 432 was submitted, Exhibit GG.] Thank you for letting us present A.B. 432 today. Instead of going through section by section, I am going to summarize the major points of the bill and allow you to ask questions. One of the things this bill is doing is defining a comprehensive eye exam and limiting certain teleoptometric services if the patient has not received a comprehensive eye examine in the previous two years. It outlaws the issuance of a prescription for a corrective lens, engaging in synchronous or asynchronous optometric telemedicine, and monitoring a patient remotely, unless the optometrist has performed the comprehensive eye exam in the last two-year period.

A brief definition of asynchronous versus synchronous: asynchronous means not face-to-face or not in real time. For example, one of the things we are allowing for in this bill is a consultative report if a patient is under the care of another physician in another facility—and say, for example, they take a picture of a fundus, a retina, and it is transmitted to an optometrist for a consultative report to either recommend further in-person care or not—that would be an example of asynchronous care. Synchronous care is face-to-face, either teleconference or maybe even phone, but in real time. That is synchronous care.

This bill outlines the parameters of optometric telemedicine. The measure restricts optometric telemedicine to procedures and interactions that meet the standard of care in optometry. It clarifies the transfer of ownership of an optometrist practice upon the death of the owner and offers the heirs a one-year time period to sell or dissolve the practice. That is because in Nevada, we require an optometrist to own an optometric practice and no one else, so the care is dictated by the doctor providing it, and not some outside entity who might not have the patient's best interest in mind.

It provides the standards of supervision of interns and residents who have not yet obtained a license to practice in Nevada. Unfortunately, we have had instances in Nevada where we have had interns at a practice left on their own without the doctor who was designated as their overseer. They just left them. We need some sort of structure so that patient is still being protected.

It reduces the initial license fee for veterans by one half. It allows the Board to require applicants to be fingerprinted before practicing optometry in Nevada—not requiring it outright but allowing us to require it if we decide to do that. It allows the Board to issue a citation as an additional disciplinary tool as recommended by the Office of the Attorney General, and not the district attorney's office as your materials have written.

It reinforces the concept that the doctor must be able to schedule, practice, prescribe, and treat as they see fit without overbearing direction from a management service provider. It includes optometrists as eligible laboratory directors under Clinical Lab Improvement Amendments (CLIA). That has been an oversight for a while. We have been allowed to be the sample collectors for CLIA; we have not been allowed to be the medical facility director for CLIA. That creates a conflict of interest if we have to get a medical doctor to sign off so we can do TearLab or InflammaDry, which are very simple tear sample tests for certain conditions. There creates a relationship between the two where you pat my back, and I will pat yours. If we are our own medical directors for CLIA, then we get around that relationship.

We ask that you amend and do pass Proposed Amendment 3544 [Exhibit HH] that was released yesterday. Do you have any questions for us?

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

Chair Marzola:
Before we go forward, have you submitted an amendment [Exhibit HH]?

Assemblyman Koenig:
I was not aware of the change that needed to be done as far as Attorney General versus district attorney.

Mariah Smith:
Those were only in the bullet points I put together and submitted last night as the overview for the bill [Exhibit GG]. It has nothing to do with the amendment [Exhibit HH] that was submitted yesterday.

Assemblyman Koenig:
So, yes, we have submitted the amendment [Exhibit HH]. I was thinking we might have to do another one.

Chair Marzola:
We do not have any amendments.

Assemblyman Koenig:
I am not sure then.

Mariah Smith:
I am not totally sure of the process, but I have the printed amendment [Exhibit HH] in front of me that was produced April 11, 2023.

Chair Marzola:
Can you resubmit that to the committee manager after our hearing today? You said a couple of lines changed which removed the two-thirds. Which lines are those?

Mariah Smith:
It was section 26, which was going to require the owners of a practice to resubmit the list of owners to the Board every five years with a fee associated with it.

Assemblyman Koenig:
We removed that from the bill.

Assemblyman Yurek:
We have heard a lot of telehealth bills, including one big one in our last hearing. I do not mean this to be snarky at all. In your recommendation for telehealth here, is there anything in there that would allow an unlicensed Nevada optometrist who is registered here but may, for example, be licensed in Puerto Rico to be able to practice telemedicine here under your bill?

Mariah Smith:
No, they need to be licensed in Nevada.

Assemblyman Koenig:
The intent is by not having anything in here at all, this is happening right now. There are doctors from out of state doing complete exams over the Internet because we do not have anything here saying they cannot. By our putting down some parameters of what telemedicine looks like in optometry, we are hoping this can stop that.

Mariah Smith:
There are not any people remotely who are trying to practice in Nevada right now. I do think there is a new branch of teleoptometry that is a little bit different than how you classically think about telemedicine, where the patient is remote and they call on the doctor. There is a branch of optometry that is emerging called doctor remote telemedicine. It is not part of our bill, but that is something that needs to be addressed upcoming. They are attempting to do a synchronous telemedicine exam via teleconferencing with equipment that is operated remotely by the doctor who is at another place. The patient still needs to physically show up to the exam room. I believe that is the only way a practitioner who is outside of Nevada state lines would be able to do a comprehensive exam at this point. That is not part of our bill. Our bill is Nevada licensed optometrists providing care to a Nevada resident.

Assemblywoman Backus:
I want to make sure because I get a little nervous when a statement is said that a doctor from out of state is doing telehealth in the state of Nevada, and we do not have a provision for it outside of the executive orders that were put in place during COVID-19. My understanding would be that a provider would be practicing in violation of Nevada law because Nevada law would only allow those to practice in Nevada who are licensed in Nevada right now. I want to make sure that is the way things are going.

Mariah Smith:
Yes, ma'am.

Chair Marzola:
Are there any additional questions? [There were none.] We will move to testimony in support of A.B. 432. Is there anyone wishing to testify in support?

Jonathan Mather, representing Nevada Optometric Association:
I am an optometrist here in Carson City. I have been practicing here for ten years, and on behalf of the Nevada Optometric Association, a group of optometrists statewide in Nevada, we are in support of the Board, their bill, the amendment [Exhibit HH], and the language as it currently exists.

Izack Tenorio, representing Churchill County:
We urge the Committee to support this bill. This bill will save rural Nevadans time, money, and a long commute. We think it is important for rural Nevadans to get the services they need.

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.] We will move to testimony in opposition to A.B. 432. Is there anyone wishing to testify in opposition? [There was no one.] We will move to testimony in neutral. Is there anyone wishing to testify in neutral to A.B. 432? [There was no one.] Assemblyman Koenig, would you like to give any final remarks?

Assemblyman Koenig:
I urge your support of this bill. As I said, it would make a difference to the rural Nevadans. It is going to be passed for all of Nevada, and Nevadans throughout the state can benefit, but it is an extra benefit for those of my constituents who live hours away from health care.

Chair Marzola:
Thank you. I will now close the hearing on A.B. 432. We will move to our next bill. I will now open the hearing on Assembly Bill 434, which revises provisions governing prescription medication.

Assembly Bill 434: Revises provisions governing prescription drugs. (BDR 57-652)

Assemblywoman Angie Taylor, Assembly District No. 27:
Thank you for the opportunity to present Assembly Bill 434. I am going to have my copresenters introduce themselves, and we will talk a little about the bill.

Steven Messinger, Policy Director, Nevada Primary Care Association:
My name is Steve Messinger. I am the policy director with the Nevada Primary Care Association.

Tida Watkins, PharmD, Director of Pharmacy, Northern Nevada Hopes:
I am Tida Watkins, Director of Pharmacy from Northern Nevada Hopes here in Reno.

Assemblywoman Taylor:
We are going to talk about A.B. 434, which revises provisions governing discounted prescription drugs purchased through the 340B Program. I want to make sure you have the background information on the federal 340B drug pricing program [Exhibit JJ, Exhibit KK, and Exhibit LL]. This program was established in section 340B of the Public Health Service Act, which requires pharmaceutical manufacturers to provide discounts on prescription drugs purchased by so called "covered entities." These include federally qualified health centers (FQHC); certain hospitals; disease-specific providers, for example, for human immunodeficient virus (HIV); and other safety net providers. Federally qualified health centers are federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Northern Nevada Hopes is one of them, and I am so proud to have them presenting with me today.

The program discounts are identical in dollar value to the rebates that manufacturers are required to provide under the Medicaid Drug Rebate Program. Additionally, the program allows covered entities to charge health insurers, except Medicaid, the market price on these discounted drugs. The generated revenue from the difference, or the spread, between the discounted prices and the market price supports needed programs and services for low income, uninsured, and underinsured patients who are served by these covered entities. The FQHCs are able to buy drugs at a discounted price but are to be reimbursed at the retail price. The spread in that generates money for programs and services for underserved communities. Again, Northern Nevada Hopes is an example of that.

Congress created the 340B Program back in 1992 to allow safety net providers the same access to discounted prescription drugs that the Medicaid Drug Rebate Program, which passed in 1990, allows for state Medicaid programs. It is the same discount for those organizations serving those communities. Prior to the creation of 340B, the majority of health centers were unable to provide pharmacy services. Due to the lower prices available, under the 340B program, the vast majority of health centers can now provide pharmacy local services, which is a much-needed service in those communities.

Additionally, savings generated under 340B enable health centers to invest and support many other programs and services they may otherwise be unable to financially sustain, such as ensuring low-income, uninsured, and underinsured patients can afford prescriptions. A current challenge for the FQHCs and other 340B providers is a range of practices referred to as "discriminatory contracting." There are several problems with this. Covered entities contract with pharmacy benefit managers (PBM), their private insurers, and Medicaid. Private insurers and Medicaid managed care organizations manage or receive reimbursement for their prescription drug benefit plans. This includes prescription drugs purchased through the 340B Program. They are offering covered entities contracts that effectively transfer the 340B discount savings from the covered entities and their underserved patients to themselves.

Other common discriminatory practices from PBMs, insurers, and managed care organizations (MCO) are refusing to cover drug purchases under 340B—either directly or by refusing to allow 340B pharmacies to participate in the networks and charging more than fair market value or seeking profit sharing—because they buy at a lower rate and can get reimbursed at a higher rate. They are charging more than fair market value—or let us split the difference or share the spread—in exchange for services involving 340B drugs.

At least 23 states across the nation have passed legislation protecting 340B savings for safety net providers. However, in Nevada there is no law to protect these practices. Covered entities must often accept the lower reimbursement rates largely impacting their ability to retain savings on these drugs. Without these savings, these health centers must reconsider programs and services they are able to provide for low-income patients and programs that use their support.

This past interim period, the Joint Interim Standing Committee on Health and Human Services considered and passed several recommendations related to pharmaceutical drug pricing. Recommendations made by the Committee relating to the 340B Program were transferred into this bill in an effort to end discriminatory contracting in our state.

In a nutshell, A.B. 434 addresses HIV treatment and the 340B Program. The Division of Public and Behavioral Health, Department of Health and Human Services, administers a Nevada medication assistance program (NMAP), also known as the AIDS Drug Assistance Program, which is authorized under part B of the federal Ryan White HIV/AIDS Program.

It aims to support low-income individuals living with acquired immunodeficiency syndrome (AIDS) or HIV who possess limited or no coverage from private insurance, Medicaid, or Medicare.

Ryan White clinics provide support and are among the 340B covered entities. These covered providers also offer needed prescription drugs to individuals living with HIV in Nevada. Both NMAP and Ryan White clinics can claim rebates or receive discounts when giving HIV prescription drugs to their patients. Here is the tricky part. A patient can be enrolled in both NMAP and in a Ryan White clinic, but the rebate or discount for HIV drugs can only be claimed by one entity for such a patient, not both. Apparently there has been some confusion as to which provider can receive the rebate or the discounted price, and the intention of this bill will provide clarity by providing Ryan White clinics with these discounts.

With your permission, Madam Chair, I would like to walk through a couple of sections of the bill. Sections 1, 3, 6, and 7 prohibit the PBMs and certain health providers or carriers from discriminating against a covered entity that participates in the 340B Program to purchase drugs at a discounted rate or pharmacy that contracts with such an entity with regard to reimbursement. Second, it prohibits them from taking certain actions to limit the ability of such an entity or pharmacy to receive the full benefit of participating in that program. Third, it prohibits them from excluding such an entity or pharmacy from an insurance network because the entity or pharmacy participates in the program. We call all of these discriminatory practices that I mentioned earlier.

Also, it will restrict the ability of a person to receive a 340B drug, or taking certain other actions to limit the participation of an entity or pharmacy in the program—in other words, taking away the benefit of these local health organizations from benefiting from the program. Sections 8 and 9 prohibit NMAP from denying the request from a covered provider or contract pharmacy to participate in the network of the program in certain circumstances or engaging in a certain discrimination against the covered provider or contract. In other words, it ends the discriminatory practices.

The NMAP must take certain actions and refrain from certain activity to ensure the covered provider in the 340B Program purchases drugs at a discounted rate, or a pharmacy that contracts with such a provider, to receive the full benefit of participating in the program. Again, this is what allows these organizations to provide those services in the underserved community. I know that could be as clear as mud, and that is why I am here with some experts to answer questions for you. Hopefully, we can provide this clarity and allow these organizations to continue to deliver these really important services in our underserved communities.

Steven Messinger:
I would like to start by thanking Chair Marzola and the Committee, also, the members of Interim Health and Human Services Committee who vetted this bill and voted unanimously to request it. I would also like to thank Chair Peters of Assembly Health and Human

Services who ended up with this bill this session, even though it is not in her committee. Of course, I would like to thank Assemblywoman Taylor, who looks like she is gunning for my job with that excellent summary.

Just a quick idea on who you are serving as far as our FQHCs. In 2021, which was the last year we had data, we served more than 32,000 uninsured patients. That all has to be paid for in some way, and it gets paid for with our federal grant and 340B dollars. We served nearly 46,000 Medicaid patients, so these savings are going to our most underserved Nevadans. Seventy percent were racial or ethnic minorities; 91 percent had income of under 200 percent of the federal poverty level; and 27 percent are best served in a language other than English. More than a quarter of our services are not in English. Our clinics also serve rural areas that do not have a lot of other access to health care, including Elko County, Austin, Amargosa Valley, and Mesquite.

To retouch on a couple of things Assemblywoman Taylor did a great job putting in full context. The vocabulary you are looking for here is "covered entity." That is the federal term for the clinics that are allowed to receive 340B dollars. We rattled off a short list of them, but particularly the critical access hospitals, the Title X clinics, and sexually transmitted diseases (STDs) clinics. Your public health authorities are getting access to these kinds of dollars. Of course, the Ryan White clinics have access.

Again, the four simple things this bill does is it requires payers to reimburse at no less than the national wholesale drug acquisition cost. It requires 340B reimbursement for drugs dispensed in a contract pharmacy; it prohibits insurers from steering patients away from a 340B pharmacy; it settles the question of which provider—between the state HIV insurance assistance program and Ryan White HIV providers—is able to capture the 340B revenue by placing that right with the providers and settling that question.

We also have Tida Watkins from Northern Nevada Hopes to give a brief statement on what this looks like on the ground in the clinic.

Tida Watkins:
Northern Nevada Hopes is a FQHC in Reno, and I have been a pharmacist in the state of Nevada for the last 17 years. Today, I come to you as an advocate for my patients. Currently, pharmacy benefit managers can force patients to use their own mail order pharmacies to increase their profits and exclude 340B covered entities and their pharmacies from their networks entirely, taking away the right for patients to choose where they may receive their medications. This can cause barriers to care, such as transportation and inadvertent costs to the patient.

Patients have also been told they can only use a mail order pharmacy or a specialty pharmacy for HIV medications. Some PBMs will not even allow our pharmacy to mail out prescriptions to our patients, thus restricting access to their medications. With the revenue generated by 340B, our pharmacy is able to provide additional support, such as mail delivery, adherence packaging, and medication therapy management at no cost to our patients.

The 340B Program also allows Northern Nevada Hopes to provide wraparound care for our patients, which includes housing assistance, substance use treatment, sexual health and testing, and case management.

The NMAP is also a covered entity, but the intent of the 340B Program is to help Ryan White providers, like Hopes, to stretch their financial resources to reach more financially vulnerable HIV patients and deliver comprehensive services, such as HIV testing, prevention treatment, HIV education, and behavioral health. Allowing NMAP to claim 340B discounts will eliminate these comprehensive services from Ryan White providers and would have a negative impact on patient care. If PBMs continue to lower reimbursement rates for covered entities like Hopes, Northern Nevada Hopes would not be able to provide critical wraparound quality care to the underserved residents of northern Nevada who are in dire need of assistance.

Assemblywoman Taylor:
We stand for questions. I want to note there are over 200,000 Nevadans that stand in the gap in terms of providing the service. We are coming before you to help clean this up and make sure the funds from the 340B prescription program, and the savings, go where they are intended to go so these services and wraparound services can continue to be provided.

Assemblywoman Hardy:
Since my time in the Legislature, I have learned a lot about prescription drugs and all of the complexities that go into this. I learned about this particular program, which I think is amazing. You talked about the number of patients and people it helps. Could you share the dollar amount we are talking about that is available to these clinics and entities to help these Nevadans?

Steven Messinger:
We know from a survey which surveyed all the FQHCs that it was about 16 percent larger on average than their federal grant. All I have is an estimate for you, but we know our federal grant is worth about $26 million a year. For our program for just the FQHCs, we estimate it to be about $31 million a year. Ms. Watkins may have more to add because that is going to look different in a Ryan White clinic than it does at an average FQHC.

Tida Watkins:
Our budget report just came out, and for FQHCs, we are required to show where all the funding and grant money goes. I would be more than happy to send that out to you, so you can see where it is. Again, with just the grantee money and not having the 340B revenue, clinics like us cannot operate the additional services without that funding.

Chair Marzola:
Are there any additional questions? [There were none.]

Assemblywoman Taylor:
There is also an amendment [Exhibit MM]. It is on the Nevada Electronic Legislative Information System, and I want to draw your attention to if you have not had an opportunity to view that as well. If there are questions on that, then we can answer those as well.

Chair Marzola:
We do have the amendment. I will now open up for testimony in support of A.B. 434. Is there anyone wishing to testify in support?

Victor Salcido, Director, Government Affairs, Community Health Alliance:
I am a proud team member at Community Health Alliance, which is an FQHC that operates six different health clinics in Washoe County. You heard a lot today about FQHCs, and there is a lot that goes into that designation. For the purposes of this testimony, what I can tell you is we offer primary care regardless of a person's ability to pay for that care or not. That means we do not turn a single person away, whether they are insured, whether they can pay, whether we never hear from them again. That being said, we are not a free clinic, meaning we do have to make ends meet somehow, and the way we do that is really through two streams of revenue. It is federal grants and this program we are talking about here today.

The other thing of note is what this program allows us to do. It allows us to offer all the other auxiliary services that are so needed in our communities. For example, at Community Health Alliance, we offer mental and behavioral health services. Again, when we offer those services, we cannot turn anyone away for an inability to pay. We offer a program that is a food prescription program. What that means is for many of our patients who suffer from diabetes, not only do they come and get their medicine and health checks to treat their symptoms, but we are able to offer them a food prescription, and they can go down the hall at many of our clinics and receive a bag of groceries that is meant to treat and help them with their diabetes.

None of those services are revenue generators. The only way we are able to offer those services is through this program. Joining 22 other states that have already put these protections in place would allow us to then plan fiscally for the next budget years and forward knowing that we have the stream of revenue and are able to offer programs such as this.

Netochi Adeolokun, Director, Clinical Pharmacy Services, Community Health Alliance:
We are an FQHC here in Reno. As a pharmacist at an FQHC, I see that uninsured patients receive guideline-recommended medications for affordable pricing; for example, a medication for treating blood clots like Xarelto. Xarelto could cost $500 at a regular pharmacy, but our patients can receive Xarelto for less than $15 to treat their blood clots or whatever it may be. These 340B savings, as everyone has said, are reinvested back into the organization to support our clinic. If insurance companies continue to dictate prescription reimbursement, it will be a barrier to care for our uninsured population. Please support A.B. 434.

Faith Whittier, Chief Medical Officer, Northern Nevada Hopes:
I am a board-certified obstetrician and gynecologist. I am here today as an obstetrician and an advocate to speak on behalf of our at-risk moms and babies that rely on our discounted 340B medications, and the savings from the program that we use to get these moms connected to early prenatal care. Unfortunately, in this country we are seeing rates of STDs rising with more than 2.5 million cases of STDs reported in 2021, jumping 7 percent in one year. The highest reported cases are in our youth ages 15 to 24 that make up almost half of the new STD cases each year.

The state of Nevada ranked first for primary and secondary syphilis and number four for babies born with congenital syphilis. In 2021, syphilis caused 220 stillbirths and infant deaths. This is a devastating disease that is 100 percent preventable. Also, we are seeing more moms presenting with coinfections, such as syphilis and HIV. This has placed a heavy reliance on our 340B Program in this fight to get these moms and babies connected to treatment.

Many of these at-risk moms are suffering from substance abuse, homelessness, and a multitude of factors that keep them disconnected from our health care system. Numbers from the Centers for Disease Control and Prevention show the number of pregnant women with opioid addictions presenting in labor quadrupled from 1999 to 2014. We all know the opioid fentanyl epidemic has only worsened. If we lose this vital 340B funding, we will see more untreated HIV-positive moms with transmission rates to their newborns between 15 and 45 percent, instead of the 1 to 2 percent transmission rate we can achieve with affordable access to these medications.

This is a battle we cannot afford to lose in the state of Nevada, with some of the highest STD rates across our country. I ask for your support in maintaining the 340B Program and the lifesaving access it provides to our moms and newborns in fighting preventable diseases and saving lives.

Jeani Pulsipher, PharmD, Clinical Pharmacy Specialist, Nevada Health Centers:
We operate an in-house 340B pharmacy here in Carson City. Nevada Health Centers has been around for over 45 years and is the largest FQHC in Nevada. Each year, we serve approximately 50,000 patients with 18 health centers in urban, rural, and frontier communities throughout Nevada, which includes three mobile units and three in-house pharmacies. Nevada Health Centers also has six rural dispensary sites, one dispensary to serve the homeless, and four clinical pharmacists integrated into patient care teams. We have 48 contract pharmacies throughout Nevada to help provide access to patients, and we currently offer mail out services to patients with limited pharmacy access.

The 340B Program allows Nevada Health Centers to purchase discounted outpatient drugs to reduce the price of medications to our patients and enhance patient compliance. Annual 340B revenue for Nevada Health Centers is almost $8 million, and it is reinvested to support affordable medications; expanded pharmacy access; clinical pharmacy services including

chronic disease management, diabetes education, and management; HIV prep; hepatitis C treatment; expanded access to services such as preventative and restorative dental; mobile medical dental and mammography programs; and we offer a sliding scale fee and more.

Nevada Health Centers has already seen a $1.5 million impact due to the contract pharmacy restrictions. Manufacturer restrictions mean patients are experiencing higher drug prices for certain medications when purchased at contract pharmacies. The PBMs and insurers are reducing reimbursement to 340B pharmacies and siphoning 340B savings and revenue away from health centers and underserved patients. For example, the pharmaceutical manufacturer, GSK, started restrictions in May. That means losing access to 340B discounted inhalers for uninsured patients at our contract pharmacies. An example of this is an Advair inhaler, which is used to treat patients with COPD and asthma. That patient would normally get that for $21 at our contract pharmacy. That same medication is going to cost over $500 for the same patient after these restrictions go into effect. We appreciate the opportunity to speak about 340B and encourage the support of A.B. 434.

Joan Hall, President, Nevada Rural Hospital Partners:
We have 13 critical access hospitals and their 17 affiliated rural health clinics. We provide care to only 10 percent of Nevada's population, but in 90 percent of its land mass. We are also an eligible provider for the 340B Program and would like to thank Assemblywoman Taylor and the Primary Care Association for bringing this very important bill to us. We urge your support.

Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
I was not going to speak on this bill, but after hearing what the FQHCs are experiencing with the PBMs, again, as all of you know, I am a big advocate for some type of reform on these PBMs we have in our state. I listened to the stories about these patients who so desperately need this medical help. These entities are standing in the way, and it really bothers me. We see it in the practice of pharmacy in the retail end, too, which leads to some independent pharmacies not being able to provide the care they need to their patients in the state of Nevada. I come in support of the FQHCs and getting some type of PBM reform this session. Otherwise, we have to wait two more years before we see some kind of relief. I thank this Committee. I am going to keep this brief. Thank you for doing the hard work, and I thank Assemblywoman Taylor for bringing this forward.

Sarah Adler, representing FirstMed Health and Wellness:
FirstMed Health and Wellness is an FQHC in Clark County with clinics in Assembly Districts 10, 20, and 7. FirstMed's Chief Executive Officer, Angela Quinn, would like to acknowledge her colleagues and say that FirstMed provides similar health care services due to 340B. What I would summarize is the 340B resources give FirstMed bandwidth. They have been asked by the Department of Family Services in Clark County to be the health care provider to foster children in Clark County. That takes additional resources to do that properly. They were asked by Clark County Social Services to apply for

a Housing and Urban Development grant to provide health care and housing to medically fragile individuals. They can do that kind of extra work because of these additional resources.

I already mentioned today they have joined hands with the William Bee Ririe Hospital in Ely, Nevada, providing psychiatric and children's and adults mental health care, which is not otherwise available. They do not make money doing that. They see that as their mission. They appreciate these flexible resources and urge you to pass A.B. 434.

Nancy Caddigan, Clinical Pharmacist, Washoe Tribal Health Center:
We understand this is a very important bill. It is going to help all of the underserved patients throughout the state of Nevada. It is also going to help the money to go where it is supposed to go, which is to help the underserved and not line the pockets of the insurance companies and the PBMs. Thank you for your help.

Chinelo Nwaogbo, Director of Nursing, Washoe Tribal Health Center:
I am in support of A.B. 434. The 340B drug pricing program is designed to decrease outpatient prescription drug costs for FQHCs. The key advantage of this program is the support it provides for the underprivileged population, particularly those receiving care at the Washoe Tribal Health Center.

I would touch base on the advantage of A.B. 434 for these individuals and the positive influence it has on the health care facility. First, it enhances affordability of the medication. Second, it helps with expansion of health care services. Third, it also boosts medication compliance and reinforces community health services. Assembly Bill 434 has played a crucial role in enhancing medication affordability and health care service quality for the underprivileged population by making medication more accessible and enabling facilities to reinvest in the services. I urge you to support this bill.

Roxana Valeton, CEO, First Person Care Clinic:
I am here to voice our full support for A.B. 434 and to share with you the impact the 340B drug discount program has had on our community health center. The 340B Program has been critical in helping our safety net facility pay for free or discounted medical services, transportation services to medical appointments for our patients, food assistance programs for homeless patients, medical education, and more. This program expands the reach of community-based health providers and directly improves patient care.

I would like to share with you the story of one of our patients who has been receiving biweekly medical infusion of intravenous immunoglobulin treatment without having to worry about her expensive and unaffordable insurance copayments for over six years now. Without this infusion, she will lose the ability to walk and eventually lose her ability to breathe. First Person has been her main resource for medical care for almost everything, not only our dental program and infusion center, but our food bank has all been instrumental in her

continued health and well-being. She expressed gratitude for the incredible people who work at our clinic and believes she would not have survived this long without the ability to participate in the 340B Program's discounted rates.

The financial stability of the 340B Program is paramount to the care of our underserved communities. Assembly Bill 434 could help protect the integrity of this program, and, in turn, save the ability of community-based health providers like ours to continue to deliver high quality care to those who need it most. We urge you to support this bill.

Todd Bleak, Manager, Pharmacy Services, Southern Nevada Community Health Center:
As an FQHC, we offer clinics for primary care, HIV care, sexual health, and family planning services. The savings we have realized from the 340B Program supports the health center in providing services for the uninsured and underserved in our community. It has supported our health center in three key areas: provision of low-cost medications for the uninsured, implementation of mental health services, and the expansion of our HIV treatment and prevention services.

We are using the 340B Program to support our mission of the health center to provide health care to the underserved in our community in accordance with the intent of 340B legislation. Assembly Bill 434 protects this work by ensuring we receive the same reimbursement that other providers receive for the same service. I request the Committee support A.B. 434 as amended, so our health center and other 340B providers are supported by the program to continue this work. Thank you for your consideration.

Adam Porath, representing Nevada Society of Health System Pharmacists:
In my day job, I am the vice president of pharmacy at Renown Health. Renown Regional Medical Center is a 340B-covered entity as a disproportionate share hospital. It is a designation given by the federal government for hospitals taking care of a disproportionate share of Medicaid and indigent patients.

There was a question earlier as far as the magnitude of the benefit. For Renown Regional Medical Center, in calendar year 2022, the benefit was $29 million. As was mentioned previously, in addition to FQHCs, the 340B Program supports all of the critical access hospitals, community health centers, health departments, Indian health clinics, and Ryan White clinics throughout our state. The savings on the medications purchased through the program are essential to literally keep the doors open at many of these facilities.

Recently, several commercial payers and associated PBMs have made moves to limit the potential benefit to 340B-covered entities by reimbursing less for medications that are covered under the program and dispenses outpatient prescriptions to their members. Additionally, and somewhat unique to hospitals, payers and PBMs have limited access to particular medications like chemotherapy and other infusions, prohibiting 340B-covered entities from using 340B meds for their members. Instead, they require their members only have access to these medications through their external specialty pharmacies and expect

340B facilities like ours would administer these medications for them. This is a process known as white bagging, and it not only short circuits the typical inventory controls hospitals have, but also creates potential patient safety issues because we cannot use our typical bedside barcoding technology that is tied to charging for medications.

Ultimately, I want to say we support A.B. 434. I think it is a great step to help preserve the original intent of the 340B Program covered entities when we are taking care of commercially insured patients. Similar legislation was recently introduced in Congress to protect the 340B Act [PROTECT 340B Act] with bipartisan support. We support the bill as written.

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.] We will move to testimony in opposition to A.B. 434. Is there anyone wishing to testify in opposition?

Marissa Schwartz, representing Nevada Association of Health Plans:
Nevada Association of Health Plans is a statewide trade association representing ten member companies providing commercial health insurance and government programs to Nevadans. Thank you for taking the time to listen to me testify in what I am calling friendly opposition of this bill, A.B. 434. While some of our members had a recent conversation with the proponents of the bill, we did express to them we have concerns on the Medicaid and commercial side and the potential impacts of this legislation.

On the Medicaid side, there is current 340B guidance from the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services, which is appropriate and a good way for the state to realize the savings from the 340B pricing. There should be discussion before reversing the careful policy DHCFP implemented, which would regulate 340B discounts in Nevada. Unfortunately, this legislation does have the potential to open the door to more risks, including higher net drug spending, more contract pharmacies, and attendant misidentification claims.

Today's current setup through DHCFP works well to keep the 340B Program regulated and eliminates the risk of duplicate discounts, diversion, and rebate invoice disputes. We would appreciate further discussion with the FQHCs and other stakeholders on this bill, and we are happy to make available our plans to pharmacists and others who are at the table and regularly deal with 340B.

Chair Marzola:
Is there anyone else wishing to testify in opposition? [There was no one.] We will move to neutral testimony. Is there anyone wishing to testify in neutral on A.B. 434? [There was no one.] Assemblywoman Taylor, would you like to give any final remarks?

Assemblywoman Taylor:
We appreciate this opportunity to present A.B. 434 to the Committee and want to remind you of what is going on in our country. We are all anticipating the unwinding of Medicare, and

that could potentially leave 200,000 Nevadans with a coverage gap. We are asking Nevada to join 24 other states to help close this gap. This is a way to provide critical prescription drugs to the underserved. Here is the best part: at no cost. We stand ready to continue to speak with the opposition to hopefully get them to a place of being neutral. We think this is a way to go forward to protect this program, the intention of this program, to provide this service, and we are asking for your support.

Chair Mazola:
Thank you, Assemblywoman Taylor. I will close the hearing on A.B. 434. I will now open up for public comment. Is there anyone wishing to give public comment? [Public comment was heard.] This concludes our meeting for today. Our next meeting will be Friday, April 14, 2023, at the call of the Chair. The meeting is adjourned [at 3:49 p.m.].

RESPECTFULLY SUBMITTED:

_____
Julie Axelson
Committee Secretary

APPROVED BY:

_____
Assemblywoman Elaine Marzola, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Assembly Bill 270, presented by Marjorie Paslov-Thomas, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is the Work Session Document for Assembly Bill 298, presented by Marjorie Paslov-Thomas, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Assembly Bill 392, presented by Marjorie Paslov-Thomas, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is the Work Session Document for Assembly Bill 398, presented by Marjorie Paslov-Thomas, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is the Work Session Document for Assembly Bill 410, presented by Marjorie Paslov-Thomas, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit H is the Work Session Document for Assembly Bill 415, presented by Marjorie Paslov-Thomas, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit I is the Work Session Document for Assembly Bill 437, presented by Marjorie Paslov-Thomas, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit J is the Work Session Document for Assembly Bill 439, presented by Marjorie Paslov-Thomas, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit K is a copy of a PowerPoint presentation titled "A.B. 198 – Promoting access to health care," presented by Assemblyman David Orentlicher, Assembly District No. 20.

Exhibit L is a copyrighted article published by Cicero Institute titled "Few Disciplinary Issues with Out-of-State Telehealth," dated January 2023, submitted by Assemblyman David Orentlicher, Assembly District No. 20.

Exhibit M is a letter submitted by Nathan Broadbent, Private Citizen, Elko, Nevada, in support of Assembly Bill 198.

Exhibit N is written testimony submitted by Landon Mouritsen, Director of Anesthesia, Humboldt General Hospital, in support of Assembly Bill 198.

Exhibit O is a letter dated April 9, 2023, submitted by Jennifer Brown, Private Citizen, Carson City, Nevada, in support of Assembly Bill 198.

Exhibit P is a letter submitted by James Cooper, Private Citizen, Elko, Nevada, in support of Assembly Bill 198.

Exhibit Q is a letter submitted by Marissa Wat, Private Citizen, Carson City, Nevada, in support of Assembly Bill 198.

Exhibit R is written testimony dated April 12, 2023, submitted by Robert Erickson, Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 198.

Exhibit S is a letter dated March 13, 2023, submitted by Kyle Zebley, Executive Director, ATA Action, in support of Assembly Bill 198.

Exhibit T is a letter dated April 11, 2023, submitted by Krista Drobac, Executive Director, Alliance for Connected Care, in support of Assembly Bill 198.

Exhibit U is a copy of an email submitted by Kathleen Lewis, Private Citizen, Winnemucca, Nevada, in support of Assembly Bill 198.

Exhibit V is a copy of an email submitted by Ashlee Zuniga Garcia, Private Citizen, in support of Assembly Bill 198.

Exhibit W is a copy of an email submitted by Kylie Lewis, Private Citizen, Winnemucca, Nevada, in support of Assembly Bill 198.

Exhibit X is a letter submitted by Donna Vlahos, Surgical Services Manager, Humboldt General Hospital, in support of Assembly Bill 198.

Exhibit Y is a letter submitted by Maria Moore, State Director, AARP Nevada, in support of Assembly Bill 198.

Exhibit Z is a letter submitted by Cher Alvarez, Inventory Clerk, Humboldt General Hospital, in support of Assembly Bill 198.

Exhibit AA is a letter dated April 10, 2023, submitted by Patrick D. Kelly, President and CEO, Nevada Hospital Association, in support of Assembly Bill 198.

Exhibit BB is a letter submitted by Tori Stephen, Materials Management Director/Recall Coordinator, Humboldt General Hospital, in support of Assembly Bill 198.

Exhibit CC is a letter dated April 11, 2023, submitted by Amie Ruckman, MSN, RN, Private Citizen, Reno, Nevada, in support of Assembly Bill 198.

Exhibit DD is a packet of letters in support of Assembly Bill 198.

Exhibit EE is a document titled "42 CFR 482.52," submitted by Susan L. Fisher, representing State Board of Osteopathic Medicine, regarding Assembly Bill 198.

Exhibit FF is a letter submitted by Whitney Koch Owens, PsyD, Board President, State Board of Psychological Examiners, in opposition to Assembly Bill 198.

Exhibit GG is a document titled "Overview of AB 432," submitted by Mariah Smith, President, State Board of Optometry, regarding Assembly Bill 432.

Exhibit HH is a proposed amendment to Assembly Bill 198, presented by Mariah Smith, President, Nevada State Board of Optometry, and submitted by Assemblyman Gregory Koenig, Assembly District No. 38.

Exhibit II is a document titled "Ophthalmologist, Optometrist or Optician?," submitted by Mariah Smith, President, Nevada State Board of Optometry, regarding Assembly Bill 432.

Exhibit JJ is a copy of a PowerPoint presentation titled "How Health Centers Use 340B," submitted and presented by Assemblywoman Angie Taylor, Assembly District No. 27.

Exhibit KK is a document titled "Preserving Nevada's Health Safety Net," submitted by Assemblywoman Angie Taylor, Assembly District No. 27, regarding Assembly Bill 434.

Exhibit LL is a document titled "Health Centers, 340B, and Discriminatory Contracting," submitted by Assemblywoman Angie Taylor, Assembly District No. 27, regarding Assembly Bill 434.

Exhibit MM is a proposed amendment to Assembly Bill 434, submitted by Steven Messinger, Policy Director, Nevada Primary Care Association, regarding Assembly Bill 434.