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

Eighty-Second Session
March 17, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:33 p.m. on Friday, March 17, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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 Sarah Peters, Chair
Assemblyman David Orentlicher, Vice Chair
Assemblywoman Cecelia González
Assemblywoman Michelle Gorelow
Assemblyman Ken Gray
Assemblyman Gregory T. Hafen II
Assemblyman Brian Hibbetts
Assemblyman Gregory Koenig
Assemblywoman Sabra Newby
Assemblyman Duy Nguyen
Assemblywoman Angie Taylor
Assemblywoman Clara Thomas

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Eric Robbins, Committee Counsel
Shuruk Ismail, Committee Manager
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Marla McDade Williams, Deputy Director, Programs, Department of Health and Human Services
Jimmy Lau, representing Dignity Health-St. Rose Dominican; and Quest Diagnostics, Inc.
Sarah Cummings, State Director, State of Nevada Association of Providers
Ricky D. Gourrier, Sr., representing Opportunity Village
Dora Martinez, Private Citizen, Reno, Nevada
Zach Bucher, Government Affairs Officer, Government and Community Affairs, City of Las Vegas
Marlene Lockard, representing Service Employees International Union Local 1107
Constance McMullen, representing Personal Care Association of Nevada; Member, Governor's Commission on Aging, Aging and Disability Services Policy Subcommittee; and Private Citizen, Reno, Nevada
Molly Walt, Chair, Nevada Lifespan Respite Care Coalition
Maria Moore, State Director, AARP Nevada
Eric Wilcox, Chair, Nevada Commission for Persons Who Are Deaf and Hard of Hearing
Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities
Randy Johnson, Director, Government Affairs, Cancer Action Network, American Cancer Society
Lee S. Schwartzberg, M.D., FACP, Chief, Medical Oncology and Hematology, William N. Pennington Cancer Institute, Renown Health; Professor, Clinical Medicine, University of Nevada, Reno School of Medicine
Rapesh J. Parikh, M.D., Medical Oncologist, Comprehensive Cancer Centers of Nevada
Cari Herington, Executive Director, Nevada Cancer Coalition
Barry Cole, Private Citizen, Las Vegas, Nevada
Tom Clark, representing Nevada Society for Dermatologists and Dermatologic Surgery
Tom McCoy, Executive Director, State Government Affairs, Nevada Chronic Care Collaborative
JoAnna Strother, Senior Director, Advocacy, American Lung Association
Dana Sullivan Kilroy, representing Foley Public Affairs; and Nevada Association of Health Plans

Stacie Sasso, Executive Director, Health Services Coalition
Sarah Watkins, Interim Executive Director, Nevada State Medical Association
Wesley Falconer, Chief Operating Officer, Cancer Care Specialists, Reno, Nevada

Chair Peters:
[Roll was called. Committee rules and protocols were explained.] On the agenda today, we have five bills to work session. The first bill on work session is Assembly Bill 24.

Assembly Bill 24: Revises the membership of the Committee on Emergency Medical Services. (BDR 40-222)

Patrick Ashton, Committee Policy Analyst:
As nonpartisan staff, I can neither advocate nor oppose any measures that will be considered today.

[Read from Exhibit C.] Assembly Bill 24 was sponsored by the Department of Health and Human Services, Division of Public and Behavioral Health, and was heard in this Committee on February 22, 2023. The bill adds a member to the Committee on Emergency Medical Services who is appointed by the committee and who is employed by or volunteers with an agency, organization, or other operator that provides emergency medical services on tribal land.

Chris McHan, Emergency Medical Services Chief, Elko County Ambulance Service, proposed conceptual amendments to section 1 of A.B. 24, amending *Nevada Revised Statutes* 450B.151 as follows:

1. Delete amended language in subsection 1, and instead, increase from 9 to 11 the number of members appointed by the State Board of Health to the Committee on Emergency Medical Services.

2. Add to subsection 3 one member who is employed or serves as a volunteer with a third-service governmental agency that provides emergency medical services but who is not part of another government service, such as a fire department or law enforcement.

3. Revise subsection 4 to require the State Board of Health, instead of the committee, to appoint to the committee one member who is employed by or volunteers with an agency, organization, or other operator that provides emergency medical services on tribal land.

4. Make conforming changes for the other subsections, as applicable.

Please see the attached letter of intent from Mr. McHan [page 2, Exhibit C].

Chair Peters:
Are there any questions from Committee members. [There were none.] I will entertain a motion to amend and do pass Assembly Bill 24.

> ASSEMBLYMAN NGUYEN MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 24.

> ASSEMBLYWOMAN GONZÁLEZ SECONDED THE MOTION.

Are there any questions or comments on the motion? [There were none.]

> THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman González. The next bill on work session is Assembly Bill 40.

Assembly Bill 40: Revises provisions related to inspections of food establishments. (BDR 40-223)

Patrick Ashton, Committee Policy Analyst:
[Read from Exhibit D.] Assembly Bill 40 was heard on February 22, 2023. The bill requires the inclusion of an electronic mail address in an application to a health authority for a permit to operate a food establishment by which the health authority may communicate with the applicant and send any inspection report form or other notice.

The bill authorizes a health authority to furnish an electronic original food inspection report form after such an inspection and to serve an inspection report form or other written notice on a permit holder by sending the notice to the electronic mail address provided by the permit holder.

Cody Phinney, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services, proposed the attached amendment [page 2, Exhibit D] during the bill hearing. The intent is to authorize but not require electronic communication via email between food establishment applicants or operators and health authorities; except for notices related to the suspension or revocation of permits that must not be provided via electronic communication.

Chair Peters:
Are there any questions from the Committee? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 40.

> ASSEMBLYWOMAN GORELOW MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 40.

> ASSEMBLYMAN GRAY SECONDED THE MOTION.

Are there any questions or comments on the motion? [There were none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Newby. The next bill on work session is Assembly Bill 138.

Assembly Bill 138: Provides Medicaid coverage for certain types of behavioral health integration services. (BDR 38-332)

Patrick Ashton, Committee Policy Analyst:
[Read from Exhibit E.] Assembly Bill 138 was heard on February 20, 2022, and was sponsored by the Joint Interim Standing Committee on Health and Human Services. The bill requires the Director of the Department of Health and Human Services to pay the nonfederal share of expenditures incurred for certain behavioral health services that are delivered through evidence-based, behavioral health integration models, including, without limitation, collaborative care management services.

There were no amendments to this bill.

Chair Peters:
Are there any questions from the Committee? [There were none.] I will entertain a motion to do pass Assembly Bill 138.

ASSEMBLYWOMAN NEWBY MADE A MOTION TO DO PASS ASSEMBLY BILL 138.

ASSEMBLYWOMAN TAYLOR SECONDED THE MOTION.

Are there any questions or comments on the motion? [There were none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to myself. The next bill on work session is Assembly Bill 178.

Assembly Bill 178: Revises provisions governing emergency medical services. (BDR 40-730)

Patrick Ashton, Committee Policy Analyst:
[Read from Exhibit F.] Assembly Bill 178 was heard in this Committee on March 10, 2023. The bill extends from one year to five years the length of a permit issued by a health authority for the operation of an ambulance, air ambulance, or fire-fighting vehicle. Any permit issued on or before October 1, 2023, expires on July 1, 2024, and any renewal of such a permit expires five years following the date of renewal.

Finally, the bill requires operators to notify the permitting health authority about any change in ownership or control within 90 days after the change occurs.

During the bill hearing, Tom Clark, Owner, Tom Clark Solutions, proposed to amend Assembly Bill 178 with the intent to reduce from five to two years the length of a permit issued or renewed by a health authority for an ambulance, air ambulance, or fire-fighting vehicle [page 2, Exhibit F].

Chair Peters:
Are there any questions from the Committee? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 178.

> ASSEMBLYMAN GRAY MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 178.
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> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Are there any questions or comments on the motion? [There were none.]

> THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblyman Gurr. The next bill on work session is Assembly Bill 215.

Assembly Bill 215: Revises the residency requirements for appointment as a member on the Nevada Silver Haired Legislative Forum. (BDR 38-456)

Patrick Ashton, Committee Policy Analyst:
[Read from [Exhibit G.] Assembly Bill 215 was heard in this Committee on March 6, 2023. The bill revises the residency requirements for a person to be eligible for appointment to the Nevada Silver Haired Legislative Forum by decreasing from three years to one year the time a person is required to have been a registered voter in the senatorial district of the senator who nominates the person for appointment to the Forum.

There were no amendments to the bill.

Chair Peters:
Are there any questions from the Committee? [There were none.] I will entertain a motion to do pass Assembly Bill 215.

> ASSEMBLYMAN HAFEN MADE A MOTION TO DO PASS ASSEMBLY BILL 215.
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> ASSEMBLYWOMAN THOMAS SECONDED THE MOTION.

Are there any questions or comments on the motion? [There were none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Gorelow.

I would like to take a moment to thank our sign language interpreter. Thank you so much for bearing with us, as I spoke rather quickly to get us through that work session. I will close the work session. We have three bill hearings from Assemblywoman Brown-May and then one from myself. As a side note, we are trying to move through four bills today. I am setting a time limit on the presentations. I have approximately 15 minutes scheduled for each bill. I would like to be through the first three bills by 2:30 p.m. if possible. I will open the hearing on Assembly Bill 99.

Assembly Bill 99: Revises provisions governing Medicaid rates of reimbursement. (BDR 38-564)

Assemblywoman Tracy Brown-May, Assembly District No. 42:
I love that we have a time limit today, and we will certainly do our best to move through all of these bills expeditiously. I would also like to thank our American Sign Language interpreter, who is here with us today, and will be with us throughout this hearing in particular. The last bill we will hear today is relevant to the Nevada Commission for Persons Who Are Deaf and Hard of Hearing. Thank you for indulging us today and allowing us to have the inclusion during today's hearing.

Assembly Bill 99 had an amendment that we are going to discuss today. Please disregard your printed copies, as there is a conceptual amendment [Exhibit H]. Patrick Ashton, the committee policy analyst, should have received this amendment some time ago.

Assembly Bill 99 is about helping to ensure we are conducting studies to provide factual information. As background, this bill requires the Director of the Department of Health and Human Services (DHHS) to take action necessary to increase certain federally approved reimbursement rates, to consider annual cost-of-living increases, as well as Medicaid reimbursement rates.

We know that DHHS has thousands of rates through the Division of Health Care Financing and Policy, so we have narrowed the scope of this just a little bit. The Division is currently required by law to complete a comprehensive rate review for each of the Medicaid provider types to determine if the current reimbursement rates accurately reflect the cost of those reimbursement rates. They identify for each provider type once every four years what the rates of reimbursement are. When Nevada Medicaid identifies a rate for reimbursement that is inaccurate, it recommends a recalculated rate to the Director of DHHS that covers the cost of services for possible inclusion in the Medicaid State Plan.

As members of this Committee, I am sure you understand the complexity of the Medicaid State Plan and the number of rates that go into the State Plan. We have a federally approved State Plan for Medicaid that comes through the Division of Health Care Financing and Policy, Department of Health and Human Services, in the state of Nevada and is approved federally for those reimbursement rates.

A problem was discovered during the pandemic with some of the providers who receive reimbursement rates through the Medicaid State Plan. When the local director of DHHS approves a rate increase, sometimes there is already a maximum allowable rate that has been identified in the Nevada Medicaid State Plan that has been filed with the federal government. While we might, as a state, approve an increase in reimbursement rates, if the corresponding paperwork is not done with Medicaid federally, providers cannot receive payment for the increased reimbursement rate. This was an issue identified during the pandemic, particularly with disability-support service provider organizations. There was an emergency rate approved through DHHS, Aging and Disability Services Division, for one-to-one supports for people who had high support needs. Although the state had done the increased reimbursement rate as a way to shore up the provider network and ensure sustainability in that service delivery model, the federal documentation was not filed to increase the maximum allowable reimbursement rate. Therefore, there is some ambiguity with regard to whose responsibility it is and how it falls within the state of Nevada.

In working with DHHS, the Aging and Disability Services Division, and the Office of Finance within the Office of the Governor, it was identified that we could delineate whose responsibility it is to fill out the maximum allowable rate (MAR) paperwork with the federal government to increase the rates approved by the Nevada Medicaid State Plan.

I will walk the Committee through the conceptual amendment [Exhibit H]. Item 1 is to amend *Nevada Revised Statutes* (NRS) 422.2704 to require the Division of Health Care Financing and Policy to submit a report of its findings from the quadrennial rate reviews to the Joint Interim Standing Committee on Health and Human Services and the Interim Finance Committee. It identifies the dates, so we are asking that the quadrennial rate review be shared with the committees of the legislative body.

Item 2 requires the Division to conduct a study to determine the cost to the State General Fund of increasing the rates of reimbursement provided to long-term care providers to account for the increase in the cost of living as compared to the date when the rate of reimbursement was most recently established. When quadrennial rate reviews are done, inflation rates are not always taken into consideration. We are not looking at rate reviews except for every four years because there are too many rates to review. This would have us look at potential cost-of-living increases to ensure we do not lose control of the rates. It would also annually adjust the rates of reimbursement provided to long-term care providers to account for future increases in the cost of living. We are only asking for information and recommendations.

Item 3 requires the Division to compile a report summarizing its findings from the study described in item 2 and submit the report to the Interim Finance Committee for the 83rd Session no later than November 14, 2024. The report must include recommendations necessary to effectuate an increase in reimbursement for long-term care providers—and this is the important part—including any statutory changes needed to authorize the Director to implement such increases and any necessary federal approvals. That is the part that directs DHHS to complete the federally required documentation to increase the MAR should the Medicaid State Plan need to be adjusted.

Item 4 defines "long-term care provider" for the purposes of items 2 and 3 to mean providers of home and community-based waiver services pursuant to NRS Chapter 422 and any other providers enrolled in Medicaid that provide long-term care recipients of Medicaid, including residential and day provider organizations.

That, in its entirety, is the bill. With us in the audience, in case you have technical questions relative to how this would play out, is Marla McDade Williams, the Deputy Director for DHHS here in Nevada. I am happy to stand for questions.

Chair Peters:
To clarify for the Committee, we are talking about Medicaid, which is a complex financial insurance institution in the state. Without the administrator of that, some of our questions may not be able to be answered today, but I will open the hearing for questions. [There were none.]

I do have a question for you. On the date for the quadrennial review process, is that in line with how those dates currently align? How did you pick that January 31 date?

Assemblywoman Tracy Brown-May:
Yes, they are currently in alignment with what the Division has recommended for what is in process for their existing quadrennial rate review for these rates.

Chair Peters:
I am looking at items 2 and 3. I want to clarify for the record, this is a one-time study request that will be completed by November of next year. Just so the Committee knows, that is after the interim committees submit their bill requests, which is that August deadline. Can you talk about why we picked November?

Assemblywoman Brown-May:
Historically, this is meant to address a historical issue relative to the need to correspond the federal maximum allowable rates with rates approved by the Division to cover the cost for Medicaid services. For example, the intellectual disabilities rate study was completed in 2002. From 2002, there were incremental rate increases for that provider-rate type. The rate reviews are done over a period of time and recommendations are made for our Medicaid State Plan. When the next rate study came around, it was right before the pandemic. The rate study identified a rate deficiency of a significant percent—it was about 26.9 percent.

We finally got a rate study, but we never looked at cost-of-living adjustments throughout that period of time. Really, this is about getting us to shift how we look at the rates of the state, how we look at what the cost of a rate is, and how we figure inflation in. While this might not affect the next biennium and the next budgeting, it is going to get us a lot further ahead than 2002 to 2022. It is about shifting how we look at the rates to ensure we are accounting for some costs of living as we go forward. I hope that answered your question.

Chair Peters:
That helps to clarify. We do have a question from Assemblywoman Newby.

Assemblywoman Newby:
With the amendment, I noticed it is restricted to the long-term care providers. I am wondering if this systemic issue you have identified was because there was confusion about who needed to file the necessary paperwork. Does that exist for other rates and other aspects? If it does, it seems like it is more of a systemic issue.

Assemblywoman Brown-May:
With your permission, I would like to defer to Ms. McDade Williams. She could potentially answer that question more accurately.

Marla McDade Williams, Deputy Director, Programs, Department of Health and Human Services:
That is not a question I actually have an answer for. In fact, this whole discussion is brand new to me. It was not in the forefront of my mind. I am prepared to answer questions about the quadrennial rate review and the fact that, yes, we do review rates. We propose those in our budget. Sometimes we propose them, sometimes we do not propose them, but they are out there for people to see when we do the rates.

You are correct that it is a much broader discussion as it relates to the process that we use for conducting the rate review. In some cases, we are looking at assessing rates in surrounding states and then determining what rates we want to move forward. If the Legislature determines they want us to be looking at the higher rate and not the median or lower rates, we could benefit from having that type of direction in the overall process. We could benefit from having direction about what we put in our budget or do not put in our budget based on the rate review.

I am not certain of the internal process. Definitely, legislation directing us to make sure we follow the process is not going to hurt anything, but I would like to do more work on how that is working. It does not really make a lot of sense to me about why we would not follow something through the process unless it was a timeliness issue. I will get back to you on that piece.

Chair Peters:
We appreciate the follow-up.

Assemblywoman Thomas:
This is worth looking into. My question has to do with the Consumer Price Index (CPI). Currently, I believe for the western states, it is 5.6 percent. Are you looking at that when you are looking at your rates to adjust for payments to doctors?

Marla McDade Williams:
My understanding is we are looking at other states and the rates they are paying, then assessing the rates we are paying, and then determining a rate that we move forward. If those other states are including CPI in their rates, then it is likely the rate we end up looking at incudes that. I would have to go back to do more specific research to see which other states are including CPI in their rereviews.

Assemblywoman Thomas:
I would appreciate that. I think we would have an accurate assessment.

Chair Peters:
Are there any other questions from the Committee before we move into testimony? [There were none.] We will move into support testimony for Assembly Bill 99. I am not going to limit individual testimony, but I want to let you know we are trying to limit testimony in total to 10 to 15 minutes. I will invite those in support in Carson City and Las Vegas, then we will move to the phones.

Jimmy Lau, representing Dignity Health-St. Rose Dominican; and Quest Diagnostics, Inc.:
We are in support of this bill.

Sarah Cummings, State Director, State of Nevada Association of Providers:
The State of Nevada Association of Providers' (SNAP) 22-member organizations are in full support of A.B. 99. The bill requires the State to conduct regular reviews of Medicaid rates in relation to federal cost-of-living adjustments. These rates and dollars pay providers, such as those in SNAP, to meet the needs of services with individuals with intellectual disabilities. Our provider network employs thousands of Nevadans to support individuals. Passage of this bill is essential in sustaining these important services.

Ricky D. Gourrier, Sr., representing Opportunity Village:
Opportunity Village agrees with the language of A.B. 99 and would like to thank the Assemblywoman for bringing this legislation forward. We believe in supporting this legislation because this will create a great tool that will empower the Department to modernize rates so providers like Opportunity Village can continue serving vulnerable populations who need services.

Chair Peters:
Is there anyone else in Carson City or Las Vegas who would like to testify in support? [There was no one.] Are there any callers on the public line in support of A.B. 99?

Dora Martinez, Private Citizen, Reno, Nevada:
Thank you to the sponsor, and I appreciate your supporting this bill.

Zach Bucher, Government Affairs Officer, Government and Community Affairs, City of Las Vegas:
We are here today in support of A.B. 99. The City of Las Vegas, including Mayor Goodman and the Las Vegas City Council, have long championed the idea of increasing Medicaid reimbursement rates in an effort to attract and retain quality medical providers in our community for our residents. This bill would help address this exact issue, while making sure we stay on the good side of the federal government. We are thankful to the sponsor for bringing this important legislation.

Marlene Lockard, representing Service Employees International Union Local 1107:
We are very much in support of this bill. We thank the Assemblywoman for bringing it forward and identifying and bringing a solution to a long-term problem within the system. We hope this is the beginning of parity throughout the Medicaid plan.

Chair Peters:
Are there any other callers waiting to testify in support? [There were none.]

We will move to testimony in opposition. Is there anyone in Carson City or Las Vegas who would like to provide opposition testimony? [There was no one.] Is there anyone on the phone waiting to provide opposition testimony? [There was no one.] We will move to neutral testimony. Is there anyone in Carson City or Las Vegas who would like to provide neutral testimony?

Constance McMullen, representing Personal Care Association of Nevada:
I originally provided written testimony in favor of this bill [Exhibit I]. As I read the amendment, it changed my opinion. I support what the bill brings, but personal care is nonmedical. We work with all of these waivers and provide services to all these populations from the lifespan to death. We believe we should be included when they look at reviewing the rates, and the cost of living is a great idea. But we should have been included. We are all listed among that category under facilities of the dependent in our license. We should be included with all of these. When they decide if they are going to change a rate for those who are providing long-term care and support, which we also do, we should be included. If not, we should be out of the facilities for the dependent and be held to a lesser standard in our licensing.

Chair Peters:
Thank you for your comments. It sounds like it would be worth having a conversation. Is there anyone else waiting to provide neutral testimony in Carson City or Las Vegas? [There was no one.] Is there anyone waiting on the public line to provide neutral testimony? [There was no one.] I have been informed the sponsor has no closing remarks. I will close the hearing on Assembly Bill 99. I will open the hearing on Assembly Bill 100.

Assembly Bill 100: Provides for various programs and studies relating to caregivers. (BDR S-562)

Assemblywoman Tracy Brown-May, Assembly District No. 42:
I am here to present Assembly Bill 100. Joining me today is Molly Walt, who is the Chair of Nevada Lifespan Respite Care Coalition (NLRCC). Also, in our audience today, I would like to draw your attention to Cheryl Dinnell, Executive Director of NLRCC. She is here to address specific questions, should we have any. Her son is also with us today, Eric Dinnell. As you can see, Ms. Dinnell is a caregiver herself.

I would like to draw your attention to the amendment [Exhibit K], which is available on the Nevada Electronic Legislative Information System (NELIS). I will be walking through the amendment, as there was a great deal of work done there.

By way of background, family caregivers are an integral part of providing adequate care to individuals with care needs in our community. Many of us are caregivers to our family members. It is important to develop ways to support caregivers.

Throughout the pandemic, it was identified that our caregivers are more needed than ever before in our history. Some of us care for people with health conditions or disabilities. We provide personal care. You heard earlier how important personal care is. We complete household chores. For some of us, we just need emotional support. There is a lot of complexity to being a family member and how we care for the people we love.

COVID-19 brought an increased level of expectation and work on our family caregivers. Too often, we do not know who they are. It is important that we focus on improving the support resources available to our caregivers. In order to do that, we have to figure out who and where they are, so we can build the support systems around them.

I would like to introduce you to Molly Walt. She has a number of things she would like to talk to us about.

Molly Walt, Chair, Nevada Lifespan Respite Care Coalition:
I am honored to be here to present Assembly Bill 100. Thank you, Assemblywoman Brown-May, for sponsoring this bill. Nevada Lifespan Respite Care Coalition's mission is to support caregivers in our community by promoting awareness to access to coordination and advocacy for respite services in Nevada throughout the lifespan. We strive to bring awareness and acceptance to respite care as a typical experience and valued service, and that this service fits the needs and choices of the consumers.

The Coalition is composed of representatives from across Nevada's private/public sectors as well as family caregivers. If there are unpaid caregivers, there is no training. Many caregivers are not mentally or physically prepared to become caregivers, let alone financially stable. Existing systems, such as long-term services, health care, and other services must take notice of these needs and ensure family caregivers are offered support and services to protect their own well-being. This can only be done by recognizing family caregivers and the role that they have in ensuring positive outcomes for their loved ones. Currently, Nevada does not have a system to recognize a caregiver's role, such as assessments to address the health and well-being of that family caregiver, even at logical points such as hospital discharge planning.

Being a caregiver myself, I can personally testify to the importance of caregiver assessments. My father and I had absolutely no idea caring for my mother would be so difficult. The doctors, hospital, and rehabilitation facility sent my mother home with my elderly father with no instructions on how to care for her, and they did not speak to him about what the physical demands of caring for my mom would be.

In recognition of the pressures and demands of caregiving, there are several national initiatives that emphasize the importance of caregiver assessments. It is important that the caregiver assessment be required to acknowledge and support the needs of informal family caregivers and facilitate the individual's linkage to needed support. The Older Americans Act has been amended to allow the caregiver assessments in the National Family Caregivers Support Program, allowing agencies to utilize assessments in the determination of services to be provided. We need to know who these caregivers are.

Guidance from the U.S. Centers for Medicare and Medicaid Services with the U.S. Department of Health and Human Services, on the Balancing Incentive Program acknowledges the importance of caregiver assessments. The Centers for Medicare and Medicaid Services recommended family caregiver needs assessments be considered best practices, recognizing that families and/or caregivers often have needs outside those needs specific to the individual eligible for services. These needs are typically connected to caregiver stress, a need for information and referral, support groups, and/or respite care. An assessment process that incorporates components tied to caregiver needs will result in a more well-rounded assessment of the service and support needs for the whole family.

The purpose of this legislation is to establish a process to be incorporated into the service systems to assess caregiver willingness, ability, and needs to provide care. The legislation also requires data from these assessments to be reported and used for planning for caregiver support systems throughout the state. This is the first step.

Assemblywoman Brown-May:
As you heard Ms. Walt say, this assessment really is the first step. Caregiving can be overwhelming, stressful, isolating, and can cause additional complications to our family members that we are not prepared to deal with. The lack of data on the capabilities, the needs, and the quality of life of our family members is driving this bill. This bill is the compilation of ideas that came out of many meetings during the interim with the Nevada Lifespan Respite Care Coalition. This is a group of people who are here to support our family members in providing care and to identify who our caregivers are.

It is only the beginning of the process. My mom and dad live in Florida. My dad is 90 years old, and my mom is 86 years old. My mom has advanced Alzheimer's disease. A 90-year-old man is her primary caregiver. There is no one in Florida who knows that there is a woman who is a hundred percent dependent on a 90-year-old man. If something happens to him, what happens to her? So many of our families are affected by this. Until we know who our family caregivers are, we cannot build support systems around them. With your permission, I will walk you through the amendment.

This is about providing a study relating to caregivers for the Department of Health and Human Services (DHHS) to develop and implement a pilot program—so this is not ongoing, it is a pilot program—to administer assessments to family caregivers and directing the Department to conduct certain studies relating to caregivers.

Section 1, subsection 1 of the amendment states the Department of Health and Human Services shall, during this next interim, develop evidence-based and culturally sensitive assessments to be administered to family caregivers by the Aging and Disability Services Division. There are a number of examples that exist in states across our country, so we do not have to recreate the wheel. The idea is to determine the willingness and ability of our existing family caregivers to continue to provide long-term support services, which costs the state less money if we can keep family caregivers caring for their family members. It also aims to measure the extent, quality, value, and effect of social determinants of health, and what risk factors related to stress and depression are having on those family members.

We also want to establish a process for gathering the data collected through the assessments that are developed pursuant to this section, and then develop and implement a pilot program to administer the assessments, which the Division feels confident it has the ability to do. This would be administered through the Aging and Disability Services Division for existing waiver participants, meaning all the folks who are currently receiving home and community-based services waiver supports through the Aging and Disability Services Division. It would become part of a pilot program for this caregiver assessment to identify who our caregivers are and what quality questions we want to ask them to determine where they are.

Section 2 of the amendment states that on or before June 30, 2024, and June 30, 2025, the Department will compile the report concerning the data they have collected. They will then publish the report on a website and then issue it to this legislative body, the Nevada Lifespan Respite Care Coalition, and the Nevada Commission on Aging within DHHS. They will take all of that informed data and deliver it to a number of coalitions and boards to assess the data.

There was an initial, large fiscal note because we wanted to do this for everyone who is being discharged from a hospital setting, but we do not have the pilot program set up. We do not even know what the assessment should look like until we do the initial pilot study. The fiscal note has been significantly reduced. The Division is amenable to launching this pilot program. I will stand for questions.

Chair Peters:
Are there any questions from the members?

Assemblywoman González:
I may have missed it, so this could just be a clarifying question. You stated the problem is we do not know who is being a caregiver, and this bill would enable a study. The amendment just says enable and development of programs. Do we have any idea of how we would find these caregivers?

Assemblywoman Brown-May:
I do not know if the conceptual amendment really identifies it well, but the concept we are currently working on is identifying every person who is served through the Aging and Disability Services Division (ADSD) on a home and community-based services (HCBS) waiver. It currently comes through ADSD and would become part of the initial pilot study. The reason that is necessary is because many of our HCBS programs serve adults. While they might be an adult with a developmental disability, intellectual disability, or other disability, they are adults. We do not often look at who a caregiver is for an adult because they should be their own guardians in many instances.

This pilot program would enable ADSD to look at families differently, holistically, to identify who is really giving care or who the caregivers in our society are. We can then begin to flush out what the data is we need to identify and then how we can track it. The pilot program would start just with ADSD and home and community-based services waiver recipients being served by that Division.

Assemblywoman González:
Can you talk about that certification and what it is for those of us who do not know?

Assemblywoman Brown-May:
The Aging and Disability Services Division works with the Division of Health Care Financing and Policy in an interlocal agreement. The Aging and Disability Services Division currently operates three HCBS waiver programs that serve our population. We have a physical disabilities waiver, the intellectual and developmental disabilities waiver, and the frail elder waiver. People must be qualified through ADSD in order to receive the services that are identified in each of those programs. The goal of the HCBS is to keep people in the community, not in long-term care facilities or hospitals. By going through the HCBS programs that currently exist, we have an opportunity to consider what the next program is to develop to keep people in the community with high levels of support.

Assemblywoman Taylor:
I, too, am a caregiver to my mom. I applaud the efforts in this bill. This question is also clarifying. Is the target to find those caregivers who are caregivers for persons who are recipients of Medicaid, or are we trying to get an assessment of everyone across the state?

Assemblywoman Brown-May:
Initially, we are going to have to start with a small, pilot population to identify what the data is we need to gather to be able to develop the support systems. Eventually, we should be able to do this assessment for everyone. We are going to have to figure out the right entry point to make sure every family is able to identify whether they are a caregiver and how we get them the long-term support they need to keep their family healthy.

Assemblywoman Taylor:
For the pilot program, it will just be targeted toward those who are recipients of Medicaid to get a reflection. I do not know if there is a way to find those who are not on Medicaid, because those families do not need to sign up. However, it may give us different data if we look at those who are caring for people who are not on Medicaid. If there is a way to include that in the pilot, it may provide some different data. That may be something to consider.

Assemblywoman Brown-May:
That is a great suggestion. I certainly look forward to working with other proponents of this bill to continue to expand the scope so we can further identify caregivers in our community.

Assemblyman Hibbetts:
I am trying to clarify. I am going to truncate some of what the amendment says [page 1, Exhibit K]. In section 1, it says DHHS, during the interim, shall develop "culturally sensitive assessments to be administered to family caregivers by the Division." Then it says, such assessments must "assess the capacity of each caregiver to provide all necessary care, including, without limitation, any activities of daily living and instrumental activities of daily living," which is good. Earlier, you stated as a state we are unable to identify who our caregivers are. If we are unable to identify who are caregivers are, how are we going to survey them? If we are unable to identify who our caregivers are, if we could survey them, how does the Division know they could use the pilot with the existing personnel and have any idea how much this could cost?

Assemblywoman Brown-May:
You are right. Currently, we cannot identify who they are. We have gone to people who specifically need care that we know of to begin to identify what questions we are going to ask—the Medicare population. Ideally, if we could have done what we wanted to do in the initial rollout, we would have surveyed every patient in a hospital setting, because it starts with a level of care. Unfortunately, we do not even know what questions to ask yet. We can figure out where to go to start to identify who needs care, but we do not have the mechanisms in place within the state to do that. That is why this pilot program is essential. It will begin to help us identify who they are.

As a good example, folks with intellectual and developmental disabilities are considered adults who are their own guardians. Many of them have caregivers who have not been identified by the Division because we do not ask those questions because we are serving adults. Now, this gives us the opportunity to ask those questions. We are directing the Division to start this pilot program, which they have agreed to and feel it can be funded by grant dollars. The Division is amenable to this and agrees we need to do this. This cost will be significantly less than if we were to roll out a program that we do not know how to roll out across the entire state. Eventually, we would like to step through that process. This is how we begin to identify who our caregivers are.

Chair Peters:
Assemblyman Hibbetts, were you asking how much it would cost the state to cover these caregivers, or are you asking how much it would cost to run the study and pilot program?

Assemblyman Hibbetts:
I was referring to the cost to run the program, not the coverage.

My follow-up is, you said the Division is amenable to this; they want to do it, and they think it is good policy. Is there a specific statute that is preventing them from doing this now?

Assemblywoman Brown-May:
I am not aware of anything preventing the Division from doing this, other than not being directed to do it currently. The Caregiver Coalition brought forth the recommendations to the Division. By giving the Division the authority to do that study, we can bump it up on the priority list. I do not have the answer, but I am happy to track that for you.

Assemblyman Hibbetts:
My only concern is if there is nothing preventing the Division from doing it, why do they not just do it, so we do not need to pass another law?

Chair Peters:
I appreciate the question. This is the process we go through in having and engaging the resources of the state through the legislative level. We will move on to Assemblyman Gray.

Assemblyman Gray:
The way I am looking at it, this is one of those things with the best of intentions. One of the first sentences in the proposed law is culturally sensitive. I took care of both my parents, and my dad lived with us for quite a while. It would have been a cold day in hell before I would have let someone come in and assess the way I was taking care of him. It is our responsibility as family members to take care of these people, and you said we need to know who they are. I am just not seeing where the State has the responsibility in this, especially when you are mandating it for recipients of the waiver. If they are asking for help or reaching out, that is great, but I have a hard time thinking the government needs to know this information. I am waiting for you to sell me on why it is a good idea.

Assemblywoman Brown-May:
I could respond in many, many ways. This is not the government saying you are going to be assessed in what the quality of care is you are providing for your family. It would certainly be our ability to stand up a program to walk alongside you in that care. As a caregiver, I know how stressful it is, the hours, and the unwillingness of families to have to lean on

someone for help. If the nurse knocked on my dad's door today and said she was there to help, how can I help you, he is going to let her in, but I need to know he is there. It is really about shoring up our families in order to be able to keep family members in the house longer at a higher quality of care without having to go to a long-term support care setting.

There is going to come a day when my mom is going to have to be moved into a long-term memory care facility. That is going to devastate my dad. This is not about taking control. I am going to get emotional because it is really personal. It is about identifying what my dad needs, and what all of our family caregivers need, to keep their loved ones at home, safe, fed, and have quality care, and for us to provide the program to walk alongside them to continue that. Every family deserves to be served at home. Until we know that families need help, we cannot serve them. That is really what this is. It is not about taking your power away; it is about giving you more power to keep your family member at home.

Assemblyman Gray:
That is a much better answer than what I have heard so far. However, I still question the mandate. Why not make it voluntary? I think you would get far better answers and far better participation.

Assemblywoman Brown-May:
We are not mandating that families participate in this study. We are mandating that the Division roll the study out to help identify who those caregivers are. If anyone refused to fill out a study, no one is going to twist their arm and make them do it.

Assemblyman Hafen:
I think most of you know my family dynamics. I know when my father spent months in rehabilitation, my mother was there by his side getting the kind of training you are discussing, such as how to prevent her own injuries and how to deal with the mental stress that goes along with everything. I think some of the comments refer to us trying to take care of grandma and grandpa. That is not what we are doing here. I just want you to clarify that this is for people with serious disabilities who need additional assistance, whether it is mental or physical, and not just taking care of our older generations. Could you clarify that I am seeing this correctly, and that it is also completely voluntary.

Assemblywoman Brown-May:
That is a hundred percent correct. It is completely voluntary. Yes, it is about taking care of people who have high support needs and how we walk alongside them to help. I want to draw your attention to Cheryl Dinnell, who is the executive director of Nevada Lifespan Respite Care Coalition. She is patiently waiting here with her son, Eric Dinnell.

Eric Dinnell is a person who receives services through the Division. We do not know that Ms. Dinnell is the primary caregiver. Most recently, Ms. Dinnell's husband had a stroke. She is now the primary caregiver for her husband at home and her adult son with a disability. How do we walk alongside Ms. Dinnell to make sure we know she is there, and how do we help her? It is really about the additional training and support we can provide families to help keep them whole in their homes.

Chair Peters:
We will move to support testimony for Assembly Bill 100. Is there anyone in Carson City or Las Vegas wishing to provide support testimony?

Constance McMullen, Member, Governor's Commission on Aging, Aging and Disability Services Policy Subcommittee:
After having sat on four strategic plans in this state over the past 20 years, and an *Olmstead* update, this would be great. This kind of information is needed. Oftentimes, caregivers succumb to disability and lose their own lives caring for a loved one. It is a difficult business. We would like to know all those details because, personally, I would like to see them paid.

On the personal care side, the association I represent oftentimes intermittently takes care of those family caregivers. You can assess us and ask those questions of us any time.

Sarah Cummings, State Director, State of Nevada Association of Providers:
Our member organization provides services to intellectually disabled individuals throughout the state. The State of Nevada Association of Providers supports A.B. 100 because every day we see how important family caregivers are in meeting the needs of these individuals. They play a crucial role in the continuance of care that the disabled individuals may require. Assuring that caregivers feel supported and have complex needs met to provide care for their loved ones is extremely important, not only to the individuals being cared for, but also for their caregivers.

Maria Moore, State Director, AARP Nevada:
I am representing AARP's 347,000 members here in the state. Support for family caregivers, and caregiver assessments in particular, are the top priority for AARP. That is no secret. Improving and expanding access to caregiver needs assessment is one of the top priorities outlined within AARP caregiving guiding advocacy principles. Family support is often essential for helping older people and adults with disabilities continue to live at home and in the community. The work of family caregivers can be demanding—physically, emotionally, and financially. If caregiver needs are not accessed and addressed, their own health and well-being may be at risk, which may lead to burnout, affecting their own ability to continue providing care in the community.

The decline in caregiving self-reported health is concerning and indicates that support for caregivers and their recipients would be even more critical. Providing high-quality care often also requires an understanding of the family caregiver situation. Caregivers who cannot care for themselves may become unable to care for others.

For these reasons, family caregiver needs assessments are important components of a person- and family-centered care planning process at home and in community-based services. We support the proposal by Assemblywoman Brown-May to develop a culturally competent family caregiver needs assessment. We urge the state to ensure that the assessment reflects the varying experience and needs of the diverse communities within Nevada and ensure the needs assessment measures not only the ability of the family caregivers but also identifies the needs and challenges specific to what caregivers are facing, and if those needs may be addressed within new and existing programs. Thank you for the opportunity to testify; and thank you, Assemblywoman Brown-May, for bringing this important legislation.

Ricky D. Gourrier, Sr., representing Opportunity Village:
We are here today in full support of this legislation because we understand how important it is to do this study and pilot program to identify family caregivers across our state.

Chair Peters:
Is there anyone else in Carson City or Las Vegas who would like to provide support testimony? [There was no one.] Is there anyone on the public line wishing to provide support testimony on A.B. 100?

Dora Martinez, Private Citizen, Reno, Nevada:
I ditto the prior commentaries, and thank you to the sponsor for this bill.

Marlene Lockard, representing Service Employees International Union Local 1107:
We are very much in support of A.B. 100. We have been working tirelessly to improve the quality of life for personal caregivers. We believe this data is essential, as Nevada has one of the fastest-growing senior populations. The need for more caregivers is paramount. We need to know where we are and what the full need is in our state.

Chair Peters:
Are there any other callers waiting to provide support testimony? [There were none.]

[Exhibit J in support of A.B. 100 was submitted but not discussed and is included as an exhibit of the hearing.]

We will move to opposition testimony. Is there anyone in Carson City or Las Vegas wishing to provide opposition testimony? [There was no one.] Is there anyone on the public line waiting to provide opposition testimony? [There was no one.] Is there anyone in Carson City or Las Vegas to provide neutral testimony on A.B. 100? [There was no one.] Is there anyone on the public line wishing to provide neutral testimony? [There was no one.] Are there any closing remarks from the bill sponsor? [There were none.]

I will close the hearing on Assembly Bill 100 and open the hearing for Assembly Bill 206.

Assembly Bill 206: Revises provisions governing the Nevada Commission for Persons Who Are Deaf and Hard of Hearing. (BDR 38-563)

Assemblywoman Tracy Brown-May, Assembly District No. 42:
Assembly Bill 206 has no amendments. This bill is simple; it adds a twelfth member to the Nevada Commission for Persons Who Are Deaf and Hard of Hearing. This bill is the reason we invited our sign language interpreter here today. This bill also requires that the member be registered with the Aging and Disability Services Division, Department of Health and Human Services, as an American Sign Language (ASL) interpreter.

Before we walk through the bill, I would like to introduce you to Eric Wilcox. He is the chair of the Nevada Commission for Persons Who Are Deaf and Hard of Hearing. He is going to help present Assembly Bill 206 and provide some background information.

Eric Wilcox, Chair, Nevada Commission for Persons Who Are Deaf and Hard of Hearing:
I am the parent of a deaf child. Before I give some brief background comments, let me add my thanks for having the sign language interpreter here for this entire session and for having a split screen here in the room. I would encourage the technical services unit to make sure the split screen appears consistently during the entire hearing on the live stream because I am not sure that is the case today. There is some room for improvement.

The mission of the Nevada Commission for Persons Who Are Deaf and Hard of Hearing is to ensure that all Nevadans have equal and full access to resources, services, and opportunities in all aspects of community life. It is the goal of many disability advocacy groups to improve educational opportunities, access to communication, and to improve representation for people who are deaf and hard of hearing.

Currently, there is no seat reserved on the Commission for an ASL interpreter. This presents a lack of representation and support for the very community the Commission seeks to serve. For many in the deaf community, ASL is their language. American Sign Language is a key pillar of the deaf culture and is central to the identity of many in the deaf community. American Sign Language interpreters must be fluent, not only in the language of ASL, but in the deaf culture, and in tune to the dialects and expressive preferences of the individuals they are serving. American Sign Language interpreters are vital for ensuring access in all aspects of public life for deaf individuals, and as such, are an accessibility afforded to the deaf under the Americans with Disabilities Act.

In the past five years, the Commission has conducted a series of town hall meetings with the deaf and hard of hearing communities across the state. One consistent element of feedback we have heard from every community is there is a large deficit in both the number and the quality of available interpreters in Nevada. The state has taken several steps to address this deficit, including recently revising the *Nevada Administrative Code* to increase the standards for working as an interpreter in the state. However, the state needs to improve resources to support the pool of interpreters working in the state. There are limited opportunities in Nevada for training new interpreters or building skills among current registered interpreters.

To help us determine the path for making these improvements, the Commission needs input from someone who is registered with the Nevada Registry of Interpreters for the Deaf, which is maintained by the Communication Access Services Program with the Aging and Disability Services Division and, therefore, is someone who has the knowledge of standards for working as an interpreter, knowledge of the systems of training and developing interpreting skills, knowledge of the practice of interpreting, and the ethical and cultural standards of that practice.

American Sign Language interpreters are valuable allies and partners to the Nevada Deaf Commission and of the deaf community throughout the state. We wish to invite a voice from their ranks to join us at the table and help us with the vital work we are doing on behalf of the deaf and hard of hearing individuals in Nevada. Therefore, we at the Commission thank the Assembly Committee on Health and Human Services for your consideration of our request to add this seat to our Commission.

Chair Peters:
We are going to go ahead and move into questions since the Committee has had the opportunity to read the bill.

Assemblyman Nguyen:
Assemblywoman Brown-May, you bring amazing energy to this Committee. It is awesome to make the revisions and include this additional member. However, I think committees usually operate better at this level with an odd number. I am wondering why we do not have it as an odd number versus an even number just in case of a tie that needs to be broken. The second part of my question is, now that you are including someone from the profession and going to an even number, I would encourage thinking about adding another person who is fluent in another language outside American Sign Language, so there could be perspective in terms of the growing population in our state of the diverse communities we all represent.

Assemblywoman Brown-May:
Those are great recommendations. We would certainly be happy to consider that as we go forward. The recommendation to add one member with experience in ASL to the Commission came directly from the Commission members, but I am happy to take your suggestion back and talk it through.

Chair Peters:
The thought of the even number versus odd number was not answered. Do you have a thought of whether that is helpful?

Assemblywoman Brown-May:
I do not know if any vote has ever been that close to warrant the concern about an even or odd number. I am happy to take that back to the Commission and see what their recommendation is.

Chair Peters:
Are there any other questions from the Committee. [There were none.] We will move into testimony in support of A.B. 206 from those in Carson City and Las Vegas.

Constance McMullen, Member, Governor's Commission on Aging, Aging and Disability Services Policy Subcommittee:
I support this bill. They have worked so hard to bring all these issues forward throughout the years, and they are so necessary.

Chair Peters:
I have a couple of friends in the ASL translation community, and I know they would appreciate this effort as well. We do have someone in Las Vegas to provide support testimony.

Ricky D. Gourrier, Sr., representing Opportunity Village:
We support this legislation and look forward to working with Assemblywoman Brown-May moving forward.

Chair Peters:
Seeing no one else in Carson City or Las Vegas, we will move to the phone lines. Is there anyone on the public line who would like to testify in support of A.B. 206? [There was no one.] We will move to opposition testimony. Is there anyone in Carson City or Las Vegas wishing to testify in opposition? [There was no one.] Is there anyone on the public line who would like to provide opposition testimony? [There was no one.] Is there anyone wishing to provide neutral testimony in Carson City or Las Vegas? [There was no one.] Is there anyone on the public line who would like to provide neutral testimony?

Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities:
I echo all the comments that were made today. We held town halls with the Commission for Persons Who Are Deaf and Hard of Hearing last year. The overall consensus was the increased need for interpreter services in Nevada. Adding an interpreter seat to the Commission will increase access to those who are deaf and hard of hearing in Nevada and reduce barriers to accessing information that is vital to their lifestyle.

Chair Peters:
Are there any other callers to testify in neutral? [There were none.] The sponsor is waiving her final remarks. I will close the hearing on Assembly Bill 206. I will pass the gavel to Vice Chair Orentlicher.

[Assemblyman Orentlicher assumed the Chair.]

Vice Chair Orentlicher:
I will open the hearing for Assembly Bill 155.

Assembly Bill 155: Establishes provisions relating to biomarker testing. (BDR 40-305)

Assemblywoman Sarah Peters, Assembly District No. 24:
Cancer has touched us all, whether a friend, family member, or ourselves. Diagnosis and treatment can be a long and stressful process with many ups and downs. Today, we will talk about what biomarker technology is and how biomarker testing is used at different times in the treatment process.

My copresenters today will discuss the vision for this legislation and the impact to patients treated with the process inclusive of biomarker testing. We have a bit to go through today, so I will hand the presentation off to my copresenters.

Randy Johnson, Director, Government Affairs, Cancer Action Network, American Cancer Society:
There is a proposed conceptual amendment [Exhibit L] on Assembly Bill 155 in your packet, which I would like to go over. The original bill that was presented had a lot of extra language we did not intend to have. The proposed conceptual amendment is an attempt to clarify and clean up some of that language.

The overall intent is to limit the scope of the bill to health insurance coverage requirements for biomarker testing. We are removing from the bill the preamble on page 2, lines 1 through 14, and page 3, lines 1 through 28; sections 2 through 10 and section 31 relating to the Task Force on Precision Medicine and Biomarker Testing; section 12, provisions that establish the month of March as Precision Medicine and Biomarker Testing Awareness Month and require that the Governor annually issue a proclamation to raise awareness of biomarker testing; and sections 28 and 29 that require the Department of Health and Human Services to contract with a college, university, or another qualified entity that conducts research in the field of public health to study the awareness of and access to precision medicine and biomarker testing.

Item 2 [page 1, Exhibit L] will revise the definition of "biomarker" and "biomarker testing" in subsection 3, paragraphs (a) and (b) of section 12. You will see that language on the amendment.

Item 3 will revise sections 15, 17, 19, 20, 22 through 24, and section 27, subsection 1, that require various public and private health insurers to provide certain coverage for biomarker testing as follows: Item 3a of the amendment would require health insurers to cover biomarker testing for "appropriate" management and "ongoing" monitoring of a disease or condition. You will see the language on the amendment. Item 3b [page 2, Exhibit L], adds new paragraphs (a) and (b) to those sections listed above, revising language regarding medical and scientific evidence supporting biomarker testing and adding additional items related to the United Stated Food and Drug Administration (FDA). Again, you will see the new language on page 2 of the amendment. Item 3c revises language that "Nationally recognized clinical practice guidelines" are informed by an assessment of the "risks" instead of "costs" of alternative options for care.

Item 4 makes other conforming changes as necessary throughout the bill.

I would also like to clarify for the record, it is not our intent to widen or narrow the population of people who can order a test. If you have any questions on the proposed amendment, I would be happy to help.

Assemblywoman Peters:
I want to clarify that I did check with the Legal Division of the Legislative Counsel Bureau before we started today. What we are proposing is a new type of laboratory. Anyone who can write a prescription or require lab work for a person would be included under this bill. However, those labs are limited to a handful of types of physicians, who will be listed in a new subsection (d), section 3 of the amendment. It could also include optometrists, podiatrists, and dieticians. I think there was one more, but I will have Legal draft that and provide everyone with the information on who would be able to prescribe these labs.

Our presentation today [Exhibit M] had some information on where biomarkers come and go, but we are a little crunched for time. I know most of you want to get home to your families and have flights you would like to make. We have a physician here who has some history in biomarkers and oncology. I would like to offer an opportunity to share some of his experience.

Lee S. Schwartzberg, M.D., FACP, Chief, Medical Oncology and Hematology, William N. Pennington Cancer Institute, Renown Health; Professor, Clinical Medicine, University of Nevada, Reno School of Medicine:
I have been a practicing medical oncologist and clinical cancer researcher for over 30 years. I have seen the field transform from a situation where we gave treatments that were not necessarily based on the individual's type of cancer or their underlying characteristics. It was somewhat generic or empirical. As a result, only a fraction of individuals actually benefited from any given treatment. We made small advances over time. In the last ten years, as we have understood the biology of cancer better, we now understand we can find a particular characteristic of each cancer and target that cancer with drugs that can be developed to specifically take care of what is in the cancer that is not in normal cells. This is true: precision, personalized medicine gives the right therapy to the right patient at the right time.

In doing so, the advances have been remarkable. What we have found is more individuals are responding, their cancers are shrinking, they are living longer; in many cases even for people who have advanced cancer, it can become a chronic disease. In addition, many of these therapies, although not all, are oral therapies and can be given as little as one single pill a day to get pretty remarkable results.

Biomarkers are characteristics found in a cell, tissue, or blood that we can test for and that will then tell us something about the individual's vulnerability for a disease. We can then design drugs that work against that specific vulnerability, sparing normal tissue so there are not as many side effects. There are many different biomarkers. What we are asking for here is the ability to have every individual in the state have access to testing for biomarkers, which are truly lifesaving in the right setting.

Assemblywoman Peters:
I want to clarify because there has been some confusion on when biomarkers are appropriate. Biomarker testing is not preventative, and it is not diagnostic. It is used post diagnosis to indicate best treatment. This is limited to folks who are already being treated for a disease that has a biomarker test available.

In the presentation, there is a slide [page 6, Exhibit M] that looks at how many biomarker tests are available on the market. There are only approximately 79 biomarker tests available on the market to date. However, the benefit to the population that have those biomarkers expressed can be hugely impactful in the treatment of their disease.

Unless there are other components my copresenters want to talk about, we can move into questions.

Assemblywoman Thomas:
I have a comment. I want to say this is amazing science. I am impressed, especially when I did my own brief research and saw that Alzheimer's disease and dementia can also have a biomarker. I am so impressed with the way science is going to make us better. Thank you for bringing this bill.

Assemblywoman Newby:
I echo my colleague's sentiments. I was once in a book club and made everyone read *The Emperor of All Maladies*, which is the history of cancer and cancer treatment. We have come a long way since that time. Interestingly, I was never asked to pick a book again for that book club.

I understand there is going to be an additional cost to add or do this biomarker testing. Can you speak about the possibility of more tailoring of those treatments to result in fewer treatments tried and fewer, more aggressive steps being taken, thus perhaps leading to cost savings?

Lee Schwartzberg:
You are exactly right. The tests themselves are typically not very expensive relative to other diagnostic tests. However, the value they generate is huge. If a test is positive, it gives an indication for a particular type of treatment. In the past, without knowing that, we were treating large groups of individuals to benefit some. We do not know the characteristics in those large groups if we do not do biomarker testing.

With biomarker testing, we might treat a small percentage of each disease. It is worth pointing out that cancer—as was mentioned in the best book ever written on cancer—has really changed from a couple of diseases that are named for the organ where it starts. In each organ, there are many different subgroups. Lung cancer is probably the best example of this.

Lung cancer used to be one or two groups defined by what it looked like under the microscope. Now we see most lung cancers are small groups of individual genes that are altered. In the last ten years, for two-thirds of lung cancer, we now have a specific therapy targeting sometimes 1 percent of patients, sometimes 10 percent, sometimes 25 percent. They are the first-line treatments. Patients do better if they have biomarker testing and they know that the result is to get the right treatment to get them the best result long term.

In terms of cost, there have been numerous studies looking at the cost of treating with precision medicine, or the right therapy for a target that is found by a biomarker. If you look at all the downstream costs, you are saving money because you are treating more people more effectively when you know what to treat with.

Assemblyman Gray:
You touched on what I was going to get at. I looked at the fiscal note for this and I about choked. When you can target the actual disease you are fighting, you can better know what you are going to fight and what tools to bring to the fight. In a former life, I was in clinical research, and I wish these tools had been available at the time. You are not taking the shotgun approach anymore. I believe you will have better patient outcomes, less money spent, and there will actually be better results in the long run. I was going to ask you to justify one thing, but I think you have already covered it. Whoever did this fiscal note needs to have their head examined.

Assemblywoman Peters:
There may have been a fundamental misunderstanding of the intention of the language of the bill. When the bill's first draft came out, it was large. A lot of information was unnecessary for what we were trying to get at. I will sit down with Medicaid and ask them about the fiscal note, and we will try to bring that down. We will make sure we address that issue.

Assemblyman Gray:
This is good science, good treatment, with good patient outcomes. Thank you for taking that back to them. If you need someone else to fight, I will go with you.

Assemblyman Koenig:
We talked today only about cancer and cancer treatments. I would like to ask if what I do would be covered. We use the term biomarker, and that might be used in a different sense, but I use it to determine what the chances of someone getting macular degeneration is. When I do an eye examination and look at their macula, if I see certain things that are suspicious, a few years ago I would do the biomarker test. I would do the cheap swab, send it in, and the lab would come up with the genetic makeup and tell me the percentage of chance of these individuals getting macular degeneration. Just by looking at it, I cannot always tell. Some people who look a certain way get it and some people do not.

If I tell patients they have a potential of having macular degeneration, especially if it is in the family history, and then I have the information I get back from what we call the biomarker test—you might say it is the wrong definition for what I am doing—if they are higher risk, I am going to bring them back every three to six months to do further testing. I would measure the thickness of their macula every six months. If it starts to thin, we also worry about it. Mine is more preventative and tells me who to monitor more closely until they actually have it. At that time, I typically refer them to the specialist. The specialist will ask me not to send the patients unless they actually have it. Would what I am doing fall under this?

Lee Schwartzberg:
Yes, that is a type of biomarker. Biomarkers have a broad potential range in the sense that they can be used to be predictive or even prognostic, which tells you the natural history. It depends on the accuracy of the biomarker. We can use them in a prediagnosis state, which is what you are describing very well. They have some utility there. Depending on the accuracy of the test, it may be very good to help hone your examination and determine how often to see the patient, or it may not be particularly good.

For the context we are talking about here, it is more about biomarkers that direct a therapy. There is a whole group of biomarkers for prediction, and we will be seeing more of them across many different diseases. It is not limited to cancer, as you stated, and we can find biomarkers in other diseases as well. The focus here is on a biomarker that helps influence what will be used to treat a specific disease.

Assemblywoman Peters:
We are in active negotiations with an insurance company right now on what is intended to be covered. I think some of that is dependent on the availability and cost, in some cases. However, you raise a good question in the case of optical diagnoses. The potential of a patient to have a disease that is treated in a certain way falls into an interesting gap. I will take this question as we move forward in flushing out the amendment with our stakeholders. I will get back to you as to whether that will be included or not.

Assemblyman Koenig:
I have not done that test for a few years because it was not getting paid for. It was hit and miss. Sometimes it would be paid, sometimes it would not. If the patient is on Medicare and on a fixed income, it is not crazy expensive, but it is expensive enough. When I say it is "probably covered by insurance" and then it is not, and here is what it costs, it was unpleasant enough that I stopped doing the testing. In the long run, the insurance companies are going to save money because now I am testing everyone who is suspicious. If I had this test, I would only be testing people who are at the highest risk of getting that disease.

Assemblywoman González:
My first comment is to ask if I can be added as a cosponsor. I have heard a lot about insurance and saving money. What I would like to put on the record as we are talking about these certain types of treatments is the heaviness and weight a cancer patient has to bear when going through chemotherapy. Not only are we saving people money, but we are also saving them time and the energy for their bodies that could be prevented for a treatment that might not even work.

Assemblywoman Peters:
Yes, that is accurate.

Assemblywoman Thomas:
I would also like to be added as a cosponsor on this bill.

Vice Chair Orentlicher:
There were a few others who would like to be added as cosponsors if you would like to follow up with those members. Thank you for all the questions and testimony. We can now move to testimony in support of Assembly Bill 155. Is there anyone in Carson City or Las Vegas who would like to testify?

Rapesh J. Parikh, M.D., Medical Oncologist, Comprehensive Cancer Centers of Nevada:
As Dr. Schwartzberg mentioned earlier, the importance of precision medicine in what we do every day is of the utmost importance in how we direct our treatments. On behalf of Comprehensive Cancer Centers, we are proud to support A.B. 155, which would not only ensure health plan coverage of biomarker testing, but also expedite the authorization process as it relates to plan approvals for these specific tests.

We are the largest cancer network in the state. We have over 40 physicians, 17 advanced providers, 600 health care employees, and 15 cancer centers to try to do these treatments. We participated in trials that got some of these biomarker testing and drugs available. To date, I think Comprehensive Cancer Centers has been a part of 100 new drugs over the last 40 years that have been developed to get these medicines to market.

This is what precision medicine really comes down to: targeted therapy, customized therapy, making the patients live longer; and not wasting their time with what we call broad spectrum treatments.

As more of these treatments are available, there has also been a demand for access. My colleagues and I rely heavily on these mutations to treat certain types of cancers to accurately construct a treatment plan. Let me give you a couple of examples. I will start with the ballet teacher. This lady I have known now for approximately five years. I will call her C.F. She was a ballet teacher here in Nevada and ended up with a rare cancer. She went to the University of California, Los Angeles, went through all the standard treatments, went through the clinical trials, and essentially failed. She came to me and said, can you make me comfortable? Can you help me die? In Nevada, we do not have a right to die law. She was planning a trip to go to Oregon or Washington. I ran a biomarker test on her and found a mutation. I had a drug that was available for another cancer type. Compassionate use medicine was approved. Now she is here, three years later, surviving a stable disease, healthy, and teaching her ballet students. That is what it is all about.

I will talk about the proud grandmother in example two: diagnosed initially in 1996, the cancer stayed away, but came back about two years ago. There was so much cancer, and she was in such bad shape, she was not really a good candidate for standard chemotherapy. I was able to get biomarker testing done and found an immune therapy drug that worked for her. Now she tells me, every time I meet her, another birthday has gone by. She has seen 15 birthdays go by because we have kept her alive due to biomarker testing.

Our patients should not be forced to pay out-of-pocket costs for what is readily available or have to go to major institutions for their care. This is standard of care in our field. We have the ability to do these treatments right here in Nevada; we just need access to the testing. It is also very encouraging that this bill provides health plans to expedite prior authorization requests for biomarker testing.

When treating cancer patients, as we all know, time is of the essence. Countless delays have ended up causing detrimental harm to some of our patients. Sometimes they are then unable to be treated because they have already passed away. Prior authorization treatments as a whole are notorious for causing harmful delays in care when health plans are not held to the standards of transparency. Timeliness and an expedited process for prior authorization will ensure any harm caused by administrative delay can be minimized as much as possible.

From Comprehensive Cancer Centers and all the oncologists, I am sure, in the state, we are excited to support this legislation and ask you to do the same. Thank you, Assemblywoman Peters, for sponsoring. I would be happy to answer any questions. [There were none.]

Constance McMullen, Private Citizen, Reno, Nevada:
My husband died four years ago of pancreatic cancer. He survived for two years. The first seven months he had chemotherapy and then went into remission. It then came back with a vengeance. It changed with a vengeance, way above my level of understanding. Whatever chemotherapy he used after that did not work. We tried everything to keep him alive. He had stage 4, and we knew he was not going to live long. He was terminal, but we wanted to extend his life because he had such a great life and great reasons to live. When he was ready to die, he was preparing for radiation therapy.

This is so needed, and it is so exciting. I would have loved for him to be here and able to hear this. I thank the bill sponsor and all of you. I hope you approve this.

Cari Herington, Executive Director, Nevada Cancer Coalition:
We are the state's nonprofit organization bringing together both public and private health care providers to work together on reducing the burden of cancer in our state. Our vision is simple: healthy communities across Nevada with equitable access to quality cancer care and support for every human being. However, as you know, cancer is not so simple. It is the second-leading cause of death in our state. In 2023 alone, over 17,000 of our friends, family members, neighbors, and colleagues will hear those words: You have cancer.

As you have heard, biomarker testing is an essential step in developing a personalized cancer treatment plan providing access to the latest innovations in cancer care. However, not everyone in our state is able to benefit from the latest advances in biomarker testing and precision medicine. This is inequitable access to care in our state. Improving coverage for and access to biomarker testing, as you have heard, across insurance types is key to reducing health disparities in precision medicine and providing cutting-edge care to everyone.

As such, we support A.B. 155, and we thank you for your work in helping to reduce the burden of cancer in Nevada.

Barry Cole, Private Citizen, Las Vegas, Nevada:
Perhaps Dr. Schwartzberg could help me remember what "chomp, mop, and bop" meant. When I was a medical student becoming an intern, I gave people complex regimens of multiple drugs that were not even as precise as a shotgun. It was more like a hand grenade and hoping it hit something. Outcomes were terrible, side effect burdens were god-awful, and then I got cancer. I was lucky. I could actually work myself up. I could actually find a surgeon who could remove my cancer en masse so it was completely removed. Obviously, I did not pick my family very well because both my parents had cancer, and two of my four grandparents had cancer. This is the high frontier. This is what we had hoped we would finally get to: an era of medicine where everyone is their own and of one; the treatment is unique to them. It is the difference between thinking about Hippocrates 2,500 years ago and *Star Trek's* Leonard McCoy on the Starship Enterprise; Dr. Bones with a tricorder diagnosing patients precisely and giving them exactly the medicine they needed and not one that fits anyone else.

This is going to encroach more and more into medicine. We are already looking at this in psychiatry, as weird as that may sound, because we understand many mental illnesses overlap and look very similar, but their treatments are very different. What we are trying to figure out is what medicine treats what condition.
Biomarking testing is evolving past cancer into more areas of medicine as we begin to understand what markers control what treatments and their outcomes.

Tom Clark, representing Nevada Society for Dermatologists and Dermatologic Surgery:
I have learned not to follow Dr. Cole very often because he is great. We do very much support this particular piece of legislation. At this late hour, I will leave it at that. We support the testimony that has been given to you previously.

Tom McCoy, Executive Director, State Government Affairs, Nevada Chronic Care Collaborative:
Approximately six out of ten adult Nevadans have some chronic condition. Biomarker testing and pharmaceutical research and development has brought us precision medicine, which has brought us improved outcomes and quality of life. Passage of A.B. 155 will help to expand access to more Nevadans to appreciate this very innovative development.

Vice Chair Orentlicher:
Seeing no one else in person in Carson City or Las Vegas, is there anyone waiting on the public line wishing to provide support testimony?

JoAnna Strother, Senior Director, Advocacy, American Lung Association:
The American Lung Association supports A.B. 155 to increase coverage of biomarker testing. This legislation will improve access to critical cancer care for patients in Nevada, including those with lung cancer. Comprehensive biomarker testing allows doctors to identify abnormalities in the cell's DNA, which in turn helps health care providers determine the best course of treatment for cancer patients. This is particularly important when treating lung cancer, as there are currently U.S. Food and Drug Administration lung cancer treatments for tubular abnormalities in several distinct genes.

Studies show lung cancer patients who have access to biomarker testing are able to receive targeted therapy treatments and have better overall chances of survival. Biomarker testing is a critical part of both cancer care and treatment of other chronic conditions, and has been incorporated into many clinical guidelines so doctors may make the best decisions for their patients' health. Increasing coverage of biomarker testing will also improve health equity in Nevada and make cancer and chronic disease care more affordable and accessible for patients.

With that, the American Lung Association supports A.B. 155.

Vice Chair Orentlicher:
Are there any other callers wishing to testify in support? [There were none.]

[Exhibit N, Exhibit O, Exhibit P, Exhibit Q, Exhibit R, and Exhibit S in support of A.B. 155 were submitted but not discussed and are included as exhibits of the hearing.]

We will move to opposition testimony in Carson City or Las Vegas.

Dana Sullivan Kilroy, representing Foley Public Affairs; and Nevada Association of Health Plans:
We appreciate the opportunity to provide comments on A.B. 155, which establishes provisions related to biomarker testing. The Nevada Association of Health Plans is a statewide trade association representing ten member companies who provide commercial health insurance and government programs to Nevadans. Our mission is to ensure the growth and development of a high quality and affordable health care delivery system throughout the state.

We have submitted a letter for your consideration, but wanted to bring a few issues of concern to your attention today. [No letter was received.] First, biomarker testing legislation with loose definitions of medical and scientific evidence will lead to increased costs, unnecessary testing, and worse health outcomes due to false positives and overdiagnosing. Second, health plans already cover a substantial number of evidence-based biomarker tests consistent with medically necessary clinical guidelines. There is already rapidly increasing availability of new tests as carriers review published evidence and professional guidelines to create evidence-based criteria meant to drive appropriate, safe, and effective care. Third, the use of biomarker testing must be based on peer-reviewed medical literature and be proven to materially improve net health outcomes.

We have gone into more specifics in the letter we submitted, and urge you all to read it. We appreciate the opportunity to provide comment and would also like to analyze the amendments, as we have not yet had a chance to do so. Finally, we look forward to collaborating with Assemblywoman Peters and the Committee to resolve these issues.

Vice Chair Orentlicher:
Is there anyone else in Carson City or Las Vegas who would like to provide opposition testimony? [There was no one.] Are there any callers wishing to provide opposition testimony?

Stacie Sasso, Executive Director, Health Services Coalition:
The Health Services Coalition covers 25 employer- and union-sponsored health plans, including culinary, the Las Vegas Metropolitan Police Department, Clark County, and various other groups, with a total of about 280,000 covered lives. We are in opposition to A.B. 155. We are still reviewing the newest amendment we saw today. However, this bill goes further than we were told was the intent. We would like to continue to work with the sponsor on finding something that can work.

Vice Chair Orentlicher:
Are there any other callers wishing to provide opposition testimony? [There were none.] We will move to neutral testimony for anyone here in Carson City or Las Vegas.

Sarah Watkins, Interim Executive Director, Nevada State Medical Association:
For the most part, we are in support of this bill. We appreciate working with the bill sponsor. However, we are neutral until we can see the amendment come back to make sure the scope of who can order these tests is not expanded.

Vice Chair Orentlicher:
Seeing no one else for neutral testimony in person, is there anyone waiting on the public line to testify in neutral on A.B. 155?

Wesley Falconer, Chief Operating Officer, Cancer Care Specialists, Reno, Nevada:
We are the second-largest oncology group in Nevada and the largest, privately owned oncology group in Nevada. We have clinics in Reno and in Carson City. For the most part, we are supportive of this bill, but we want to remain neutral until further details are worked out regarding the bill. Some of the details that need to be ironed out are what type of physician can order the test. We believe the test should be used to confirm the diagnosis and not for preventative measures. We would also like the State Assembly to consider the cost of care with the use of biomarker testing.

Vice Chair Orentlicher:
Are there any other callers waiting to provide neutral testimony? [There were none.] Would the sponsor like to provide closing remarks?

Assemblywoman Peters:
I would like to reiterate that we are continuing to work with stakeholders on this bill and to formalize the final amendment that will be brought to you in a work session document if we can get it that far. I appreciate your support.

Vice Chair Orentlicher:
I will close the hearing on Assembly Bill 155.

[Assemblywoman Peters reassumed the Chair.]

Chair Peters:
We will move to the last agenda item, which is public comment. Is there anyone in Carson City or Las Vegas wishing to provide public comment? [There was no one.] Is there anyone on the public line wishing to provide public comment? [There was no one.] I will close public comment. Are there any additional comments from the members before we adjourn? [There were none.]

This meeting is adjourned [at 3:34 p.m.]

RESPECTFULLY SUBMITTED:

Terry Horgan
Recording Secretary

Lori McCleary
Transcribing Secretary

APPROVED BY:

Assemblywoman Sarah Peters, Chair

DATE: ______________________________

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Assembly Bill 24, submitted and presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is the Work Session Document for Assembly Bill 40, submitted and presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Assembly Bill 138, submitted and presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is the Work Session Document for Assembly Bill 178, submitted and presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is the Work Session Document for Assembly Bill 215, submitted and presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit H is a conceptual amendment to Assembly Bill 99, submitted and presented by Assemblywoman Tracy Brown-May, Assembly District No. 42.

Exhibit I is written testimony dated March 17, 2023, submitted and presented by Constance McMullen, representing Personal Care Associates of Nevada, in support of Assembly Bill 99.

Exhibit J is a collection of letters submitted by various individuals in support of Assembly Bill 100.

Exhibit K is a proposed amendment to Assembly Bill 100, submitted and presented by Assemblywoman Tracy Brown-May, Assembly District No. 42.

Exhibit L is a proposed conceptual amendment to Assembly Bill 155, dated March 17, 2023, submitted by Assemblywoman Sarah Peters, Assembly District No. 24; and presented by Randy Johnson, Director, Government Affairs, Cancer Action Network, American Cancer Society.

Exhibit M is a copy of a PowerPoint presentation titled "Biomarker Testing and Targeted Therapies," submitted by Randy Johnson, Director, Government Affairs, Cancer Action Network, American Cancer Society.

Exhibit N is a letter dated March 16, 2023, submitted by Josie Cooper, Executive Director, Alliance for Patient Access, in support of Assembly Bill 155.

Exhibit O is a letter dated March 15, 2023, submitted by Lindsey Viscarra, Public Policy Manager, International Foundation for Autoimmune and Autoinflammatory Arthritis, in support of Assembly Bill 155.

Exhibit P is a letter dated March 15, 2023, submitted by Melissa Horn, Director of State Legislative Affairs, Arthritis Foundation, in support of Assembly Bill 155.

Exhibit Q is a letter dated March 2023, submitted by Bobby Patrick, Vice President, State Government and Regional Affairs, Advanced Medical Technology Association, in support of Assembly Bill 155.

Exhibit R is a letter dated March 14, 2023, submitted by Nicole Sheahan, President, Global Colon Cancer Association, in support of Assembly Bill 155.

Exhibit S is a letter submitted by Deidra Hamilton, Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 155.