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

**Eighty-Second Session
March 20, 2023**

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:34 p.m. on Monday, March 20, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman 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
Shuruk Ismail, Committee Manager
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

Minutes ID: 496

OTHERS PRESENT:

Stacie Weeks, Administrator, Medicaid Services, Division of Health Care Financing and Policy, Department of Health and Human Services
Brian McAnallen, representing Global Medical Response
Sarah Watkins, representing Nevada State Medical Association
Susan Fisher, representing Nevada State Society of Anesthesiologists
Susan Proffitt, Private Citizen, Las Vegas, Nevada
Connie McMullen, representing Personal Care Association of Nevada
Paula Cook, Private Citizen, Las Vegas, Nevada
Jonathan Norman, Statewide Advocacy, Outreach, and Policy Director, Nevada Coalition of Legal Service Providers
Trevor Macaluso, CEO, Eddy House, Reno, Nevada
John J. Piro, Chief Deputy Public Defender, Legislative Liaison, Clark County Public Defender's Office
Patricia Haddad, Director, Government Relations, Clark County School District
Mathilda Guerrero, representing Battle Born Progress
Joanna Jacob, Government Affairs Manager, Department of Administrative Services, Clark County
Sean Sever, Deputy Administrator, Research and Project Management Division, Department of Motor Vehicles

Chair Peters:
[Roll was taken. Committee rules and protocol were reviewed.] Just a quick notice on the agenda. We have removed Assembly Bill 237 from the agenda for today. We will have public testimony at the end of this meeting. [Public comment rules and protocol were reviewed.] If you wish to testify in person, please sign in at the table by the door and leave a business card so we get an accurate record of your name. If you do not wish to testify, you may still want to sign in so we have a record of those who are interested in our topic areas.

We will start with our bill hearings; however, we are going to take the bills out of order and begin with Assembly Bill 197.

Assembly Bill 197: Authorizes an assessment on certain health care providers for an account to fund Medicaid. (BDR 38-167)

Assemblyman David Orentlicher, Assembly District No. 20:
Thank you for the opportunity to present Assembly Bill 197 [Exhibit C]. The idea is to allow physicians, nurses, and other health care providers to request a tax to raise their Medicaid reimbursement. Medicaid reimbursement rates in Nevada have been too low for too long [page 2, Exhibit C]. If we want doctors, nurses, and other providers to take care of Medicaid patients, but we do not reimburse them well, that can make it harder for patients to find doctors. It is unfair to patients when we underpay the providers because it discourages providers from treating them. When we see survey results, doctors are less willing to see Medicaid patients than they are to see patients with private pay insurance. When I was living

in Indiana, a dermatologist colleague told me that a Medicaid patient had driven nearly two hours because she was the closest dermatologist who would take Medicaid. It is unfair to providers, too, when we undercompensate them. That is not right. They deserve to be paid a fair reimbursement rate.

The goal of this bill is to ensure providers are fairly paid for taking care of Medicaid patients. This is a provider tax, but this is how it works [page 3, Exhibit C]. Medicaid allows states to impose a tax on different health care providers to raise money, and that money can be used to reimburse them. This is voluntary. If a provider group requests the provider tax, it would apply to their net revenues. There are about 18 provider groups listed in federal statute, and the federal statute is in section 5, but provider groups could be physicians, nurses, psychologists, therapists, occupational therapists, physical therapists, respiratory therapists, dentists, chiropractors, ambulance services, et cetera.

Since around 2000, we have had a provider tax for nursing homes. Since 2017, hospitals have had the authority, along with other facilities, and have been working with the Department of Health and Human Services (DHHS) on a hospital provider tax. What is so great about this is when you take these tax dollars and spend them in the Medicaid program—and A.B. 197 would require the funds raised to be used to raise Medicaid reimbursement—you get the federal match. The federal match roughly triples the dollars, and you return all those funds to the provider group in the form of increased Medicaid reimbursement. For every dollar they put in, they get $3 back in the form of higher payments for taking care of Medicaid patients, and it is an opt-in format. For the nursing homes in 2000, the statute mandated the tax, but in 2017, the statute and this proposal allows for an opt-in, so if 67 percent of the providers in the class—physicians, nurses, psychologists, et cetera—agree to the provider fee or tax, then this tax, which is in section 6, will go into effect and can be used to increase Medicaid reimbursements.

There are guardrails in section 7 to make sure this works as intended so that any dollars raised can only be used to increase Medicaid reimbursement and cannot be diverted for other purposes [page 4]. The dollars need to be used to supplement rather than replace Medicaid dollars from the State General Fund. It would not work if we just reduced how much we spend on Medicaid from the General Fund. They have to be supplementary dollars to raise reimbursement rates. If funds remain at the end of the fiscal year, they are going to do a calculation: How much of a tax do we need to raise the money to increase reimbursement? They may overestimate or underestimate, but if there are extra dollars left for the next fiscal year, they will not go back to the State General Fund. They will carry over to be used in the following year for these provider groups to keep their reimbursement at Medicare levels. As I said, this is an opt-in; the providers have to vote for it. If there is any change in the allocation of funds, if there is some diversion of the funds away from raising Medicaid reimbursement levels, then they would automatically have to revote on whether they want to maintain the provider tax. If they opt in to this tax, we want to reassure them that the dollars will be used to raise their reimbursement and only for that purpose.

You might be wondering what the catch is. This 3-to-1 match is approximate, but it is guaranteed. There is no doubt if we use these dollars to raise Medicaid reimbursement, we will get this generous federal match. The catch is that it is an average across all of the providers, whether hospitals, physicians, or nurses. They will get one on average, but the providers who see more Medicaid patients will do better than average and those who do not see as many Medicaid patients will do less than average. The nice thing is it creates a good incentive. The way you ensure you get your money back and more is by seeing Medicaid patients, which is exactly what we want doctors to do. That has been why this kind of provider tax has not been implemented more broadly in Nevada and in other states. You tend to see them more with long-term care facilities and hospitals. I have been speaking with different provider groups, and the providers of emergency ambulance services are very interested in this and some of the others are thinking about it. I do not have an amendment today, but if there is a provider group that does not want to have this option, then I will exclude them from the bill. Right now, this would cover any of the provider groups that are not already covered in Senate Bill 509 from 2017. It is easy to carve out any provider groups that say they do not want this option.

Chair Peters:
Thank you, Vice Chair, for the presentation. We do have several questions.

Assemblywoman Thomas:
I am trying to understand the provider group makeup. You will have nurses, physicians, and psychologists, but how many people form a group?

Assemblyman Orentlicher:
Each provider group is based on their professional classification. Physicians form a group, nurses form a different group, psychologists form a group, and it would be based on that group. If it is physicians, would it be the physicians who are licensed to practice in Nevada, or would it be just physicians with an active practice in Nevada? That would be a question I would have to ask the Medicaid program, but it would be based on physicians in Nevada, or nurses in Nevada for the nursing group, or chiropractors in Nevada for the chiropractor group.

Assemblywoman Thomas:
Would that include some of our unions that have nurses in their group? Would you include the union as a provider group?

Assemblyman Orentlicher:
All nurses would be, but they would be considered separately and not as part of the larger group. In terms of polling them to decide whether they want to participate, as I understand, the nurses individually would have the ability to vote.

Chair Peters:
I have a question about the provider group and determining a threshold. I am not seeing where we get the total number for a provider group. Is that any provider of a certain service

already certified through Medicaid? It is not every provider in the state including those who take Medicaid and those who do not? Please clarify that population for us and what entity we would grab that number from.

Assemblyman Orentlicher:
We cannot just apply this to physicians or nurses or other groups that take care of Medicaid patients. One of the requirements of the Medicaid program is that the provider taxes have to be broadly based. How would we ascertain that? I have talked with DHHS about this, and the licensing boards for each of the provider groups would know who is in the state with that license. So we would probably rely on the licensing board to tell us who is out there, but it is more complicated when you are dealing with physicians or nurses than with hospitals. There is a much more limited number of hospitals, and it is easier to reach all of them.

Chair Peters:
Thank you for that clarification.

Assemblywoman Taylor:
I have a question in terms of the tax. I want to make sure I am homed in on it. So, 67 percent of a particular provider group as listed on the slide [page 3, Exhibit C] would have to vote and say, "Yes, we want to pay a provider tax." So, they basically want to tax themselves and the tax is based upon their net revenues. Who determines the percentage?

Assemblyman Orentlicher:
Under the Medicaid program, we would set the rate; the federal Department of Health and Human Services limits it. It cannot be higher than 6 percent. We would have to do a calculation: What is it going to cost to raise Medicaid reimbursement levels to Medicare levels, and what would the level of tax needed to generate those funds be—1 percent, 2 percent, 3 percent? That would be unknown until providers decided they are willing to do this, or they at least wanted to find out what it would mean for them. Then DHHS could do a rough calculation and say, here is what we project the tax to be. The providers could then say whether it sounded reasonable. If they say yes, then that would be the rate that would be adopted. It could be adjusted over time if it turns out there was an underestimate or overestimate.

Assemblywoman Taylor:
It is not set yet. It can be over 6 percent but there is a process for figuring out what that might be—probably backing into the number.

As you mentioned, there are some things that may have prohibited other states from jumping into this. Are other states currently doing this? Do they have a provider tax?

Assemblyman Orentlicher:
I think every state has a provider tax of some kind, but as I said, they tend to be more common with nursing homes and hospitals. Taxes on individual providers like physicians or nurses are much less common and have been harder to do. The problem is that physicians or

nurses or other providers who do not take care of Medicaid patients resist these kinds of taxes. There is a possibility, though it is complicated, of dividing the class. For instance, maybe pediatricians are eager to do this while some of their colleagues are not, so can the pediatricians come in by themselves? However, it is not easy to do because the federal Medicaid program does not want us to cherry pick—pick out the doctors who see the most Medicaid patients and only tax them. They want the tax to be broadly based. But if, in a particular specialty, the percentage of their patients who are Medicaid patients is similar to the state average, then you do have the option of bringing them in by themselves.

Assemblywoman Newby:
I was happy to hear that the hospital provider tax in Nevada seems to be on its way after many years. We are in a sad state when we cannot fund Medicaid and instead need to collect taxes on providers to fund it themselves. Moving on from that, my question is about administration of this tax. Who would collect it? You talked about the licensing boards. Would they collect revenue from each of these participants and then figure out what the taxes are and send a bill? How do you see that in implementation?

Assemblyman Orentlicher:
The role of the licensing boards would be to identify members of the class. I do not anticipate their having any other role in this. Our Department of Health and Human Services would have the responsibility for deciding what the provider tax would be and polling the provider class to see if they want in, just as they are doing now with the hospitals.

Assemblywoman Newby:
Who or what entity would you see being the implementer on the back end of the tax?

Chair Peters
We have Stacie Weeks here today from Medicaid Services who may be able to respond to how implementation functions, or at least explain about the discussions occurring right now with the hospitals. They are working through this provider tax issue.

Stacie Weeks, Administrator, Medicaid Services, Division of Health Care Financing and Policy, Department of Health and Human Services:
The way the bill is written today, we would be the one implementing the tax, collecting the revenue, and submitting for approval by federal Medicaid to make payments.

Chair Peters:
May I ask about the administrative burden of that and how Medicaid covers it? I did not look at the fiscal note, but I know this conversation about a provider tax is ongoing with the hospitals, although I do not know how it works with the nursing facilities. Could you tell us how that implementation burden is covered under the provider tax model?

Stacie Weeks:
Nursing facilities have their own statute, and their requirements are different. They were not polled like the hospitals. Concerning the administrative cost of this, because the way the bill

is drafted is similar to the hospital tax, we assumed that we would use a portion of the revenue to pay for administrative costs. When we looked it up, there are over 10,000 physicians licensed in Nevada, so there is quite a task ahead of us. It is doable, but we would have to definitely staff up and ramp up for this type of tax and payment structure.

Assemblyman Koenig:
From a provider's standpoint, one of the irritants in my life is dealing with Medicaid. Is this tax going to be based on dollars billed or dollars reimbursed, because those can be two different things? What is that tax going to be based off, what I should have received or what I actually got?

Assemblyman Orentlicher:
Good question, and I will start. It is important that the taxes be based on all your patients, not just Medicaid patients. There are different ways to do the tax. With facilities, it can be based on revenues or the number of beds. For individual providers, net revenue is one option, but it would be all revenue from all patients, not just Medicaid patients, as I understand it.

Stacie Weeks:
Yes, you are correct. We will use all claims and revenue and we would be relying on providers to report that to us. We would need to do some auditing because not every provider is enrolled in Medicaid, so it would be hard for us to validate the numbers they are giving us. We would have to figure out a way to do some random auditing to understand the revenue they are getting from other payers if we are taxing all payers.

Assemblyman Koenig:
Is this available to all providers of Medicaid in the state, or are we only talking about physicians, because dentists, optometrists, et cetera, take Medicaid patients. Would that tax apply to them or is it only a tax on physicians at this point?

Assemblyman Orentlicher:
The bill would allow any of the different classes of professionals you mentioned to choose to opt in. Physicians as a class would decide as would optometrists and opticians, although they may be combined. Dentists as a class would decide, chiropractors as a class, podiatrists as a class. They would all decide individually, so physicians could come in and dentists could stay out, or dentists could come in and physicians could stay out. Each group can decide for its own.

Assemblyman Koenig:
Thanks for the clarification.

Chair Peters:
I can also direct you to section 5, subsection 1, which defines provider groups under 42 C.F.R. [*Code of Federal Regulations*] 433.56(a)(1) to (18) which would include inpatient hospital services, outpatient hospital services, nursing facility services, intermediate care

facility services, physician services, home health care services, outpatient prescription drugs, services of managed care organizations, ambulatory services, surgical center services, dental services, pediatric services, chiropractic services, optometric/optician services, psychological services, therapy services, which includes several variants of that; and nursing services, laboratory and X-ray services, and emergency ambulatory services, to give you an idea of the different provider groups.

Assemblyman Hafen:
I am going to follow up on Assemblyman Koenig's, question. We are proposing a new tax, but we want to know exactly how this tax is going to be implemented. Are we going to be taxing the amount that is billed or are we going to be taxing the amount collected? Those are two substantially different numbers, especially when we start looking at Medicaid. It could be the difference between $100,000 and $20,000, so I would like that to be addressed. How is this tax going to be implemented, and what portion is going to be taxed?

Assemblyman Orentlicher:
My understanding is that it would be based on net revenues—what they collect less their operating expenses.

Assemblyman Hafen:
On a cash basis or on an accrual basis?

Stacie Weeks:
I will have to follow up with you on how we are doing that with the hospital tax.

Assemblyman Hafen:
I would appreciate that. I wanted to get clarification on that question. I live in rural Nevada, and these taxes would be applied to our community as well, but as you know, our health care struggles. We barely get by, and we struggle to get providers to come into our communities. On the hospital side, there has been a conversation about a hold harmless clause. Is such a thing envisioned in this? I did not see it in the actual language, but I was hoping you could address that.

Assemblyman Orentlicher:
I would love to include something like that; unfortunately, the federal Medicaid program disfavors hold harmless provisions. They do not like the idea of saying to the providers who are not seeing Medicaid patients, "We will at least make sure you get your tax dollars back." So, while I like the idea of a hold harmless provision, it is not something that would work with the provider tax. Because the return is so generous—a 3-to-1 return—hopefully it will be enough to persuade some provider groups that this is worth doing. It is a nice incentive especially for areas with lower-income patients and not a lot of providers, knowing that they will do well by taking care of patients on Medicaid. I think that is a very important incentive.

Assemblyman Hafen:
You mentioned there were some safeguards put into place in regard to the State General Fund. I appreciate your doing that because a big concern I have is that during a recession these funds would be swept. What I understand from reading this is that the funds from this tax would be set in its own separate account and could not be swept. However, what I am not seeing in here is protection saying what happens when we do not have the general funds, like we did during the special session, and we end up cutting Medicaid reimbursement rates. Then, all that would be left is this tax. Now, providers would be put in a position where their options would be to raise their own taxes or go out of business. I do not see those safeguards, and I am hoping you could clarify that for us or possibly add it to your language.

Assemblyman Orentlicher:
I do want that kind of safeguard in, and I would be happy to work on language with you because you are right. We do not want this to now be used as an excuse to cut Medicaid funding, so whatever safeguards would adjust that, we should include. Let us work on it and add it to the bill.

Assemblyman Gray:
Have any other states implemented this tax, the way you see it, on providers?

Assemblyman Orentlicher:
You mean has anybody done it for individual providers like physicians, nurses, and dentists?

Assemblyman Gray:
I mean, the way you want to implement this, has any other state done this?

Assemblyman Orentlicher:
Fifty states have provider taxes of some kind, and since 2000 we have for long-term care facilities; and hospitals are currently negotiating. The 2017 bill did apply to personal care services like home personal care services and other facilities. I am not aware of any other group that is negotiating or has shown interest in other states. My guess is just about every state has one for long-term care facilities, and most states do for hospitals. In terms of doctors, I think Minnesota may have a provider tax that goes beyond nursing homes and hospitals, but I have not looked recently to see if it is still in effect. The ones for individual providers are much less common, but the ones for nursing homes and hospitals are widely used, and we are a laggard overall in the extent to which we use provider taxes. I hope that helps and if not, I can do some research and give you more information.

Assemblyman Gray:
If providers can opt in at 60 to 67 percent, can they opt out if they find out they are not getting the return that was promised?

Assemblyman Orentlicher:
Let us say a provider group opts in and then decides it is not such a good deal. In the bill, there is an opportunity to revote if the rules change or if the money is diverted. I have not

considered what would happen if a group decides it is a bad deal. Can they revote? That is a good thing to think about, and I would be happy to work with you and think about whether that makes sense. I do not know if other states have this opt-in. As I said, we did not have an opt-in for the long-term care facilities; that was just imposed. It was not an opt-in the way it is for hospitals. I was not here when that design [unintelligible] rather than just implementing it, will give the providers a chance to vote on it. I do not know if that kind of option is common around the country.

Stacie Weeks:
No, I am not aware of any other state that has this opt-in polling mechanism. Usually, it is a mandate to tax providers.

Assemblyman Hibbetts:
I am looking at the fiscal impact you filed for this bill. Across the top, it says "zero" for the biennium; however, when you get down into it, it is almost $10 million for the biennium. Can you explain how we got to zero but now in the details it says $10 million?

Stacie Weeks:
In the bill there is a provision that says there are three purposes or uses for the revenue. The first two have to do with payments to providers. The third one is administrative cost to the State. While we show the cost to build up all the staff and vendors, we would need to do this work, we are assuming we would take a portion of that revenue to keep the cost to the State neutral. That is how you get to zero.

Assemblyman Hibbetts:
If you were to take a portion of that revenue, would that mean that the reimbursement rate would not go up as much as we would hope it would?

Stacie Weeks:
If you tax 10,000 physicians, it is a pretty big portion of funding. So, yes, it would go down a little bit, but I would not assume it would be that big a piece of the funds.

Chair Peters:
We do not discuss fiscal issues in this Committee, but I think implementation of this policy is important to talk about. So, with that fiscal note and the money needed to administer the tax, would that money be able to be used as the state match for Medicaid dollars? Would that money still bring in the potential 3-to-1 match?

Stacie Weeks:
Yes. For administrative spending, we can claim the federal share of it. It is usually higher than the 60 percent federal share which is nice depending on what it is for—staffing, vendors, or technology. With this number of supplemental payments, collecting taxes, calculating penalties for those who do not pay, all those things will require a lot of effort and today, a lot of our work is manual. If something like this were to pass, we were to poll

providers, and there was a 67 percent vote, we would likely need to look at software and technology to make our processes more automated and more reliable.

Assemblywoman Newby:
I have been struggling with the term "tax" in this bill because I do not know many taxes where you as a group decide that you are going to pay the tax and then potentially get back everything you paid in the tax plus 75 percent more. What is the origin of calling this a tax? Is that required, or do other states call it something else?

Assemblyman Orentlicher:
It might do well to use another term, but I am not aware if that is the commonly used term in the area. If there are other approaches, I would be interested in knowing.

Stacie Weeks:
Some people call it a fee or an assessment, but it is the same thing. It is a tax; it functions like a tax. I am not an expert on tax law, but the Department of Taxation might have other ideas. The way it is functioning is like a tax.

Chair Peters:
It could be called something like the private supplemental Medicaid State fund. These were interesting questions. We are going to go ahead and move into support testimony. Do we have anybody in support of Assembly Bill 197?

Brian McAnallen, representing Global Medical Response:
Global Medical Response is AMR - MedicWest ambulance providers in southern Nevada. We are supporting A.B. 197 as an entity and collectively as an ambulance association and as a provider class. We think this is a great opportunity to do what we have been advocating for. We also have a bill that should be dropping today as a standalone provider tax for the ambulance class. This would affect us from the private ambulance side of the house in accessing this provider assessment. As it was explained, we would assess ourselves and that money would be put into a pot to draw down those federal dollars. From a philosophical standpoint, this bill is important because we are maximizing the State's opportunities to draw down federal dollars to support and supplement in this area where Medicaid reimbursement falls short. As you can imagine, our industry has been dramatically impacted by the last decade of rising costs and reimbursement rates which do not meet our needs. With COVID-19, we have been hit hard with the challenges of providing adequate revenue from our Medicaid patients, so this would help us significantly.

I also want to point out that at least in our provider class, the public ambulance providers, your fire departments currently receive a similar program administered through State Medicaid called GEMT, which is ground emergency medical transport. That was a bill that went through the 2017 Legislative Session. It is a self-tax or assessment on the private side to draw down that additional Medicaid revenue. So, for us, this is a parity bill that would allow the private ambulance providers an avenue or opportunity to participate in this program and draw down that federal match.

Assemblyman Hafen:
I want to understand what you are referring to. When it comes to ambulatory services, in your reading of this bill, would this now include Clark County or cities in this tax that would then go into a pool, or would the private and the public stay completely separate?

Brian McAnallen:
As I understand it, this bill would provide for the class of services by ambulatory providers. The way it is written, it would allow for public and private; but in our state, we already have the public side getting the GEMT dollars that passed through the Legislature and authorized the State to work on a state plan amendment to allow the private ambulance services to access those dollars on a reimbursement increase. They already have a program that looks like this one. So, this, in our state, would allow the private ambulance providers to catch up and be on par or parity with a system that already functions for the public ambulance side of the house. Does that make sense?

Chair Peters:
I think we have an opportunity to vet your bill coming up in the future. Is there anyone else for support testimony? [There was no one.] We will move into opposition testimony. Is there anyone who would like to provide opposition testimony to Assembly Bill 197?

Sarah Watkins, representing Nevada State Medical Association:
The Nevada State Medical Association is opposed to this bill as we do not support taxing physicians to pay for Medicaid even with the understanding that payment rates might be higher. The promise of increased reimbursement is too unreliable given the winners and losers of these types of taxes. The next time a budget hole needs to be filled, reimbursement will be cut but the tax will remain. We understand and appreciate Assemblyman Orentlicher for bringing to the forefront the conversation of increasing reimbursement rates; however, at this time, the Nevada State Medical Association believes that should continue to be a State investment in our health care system specifically to the most vulnerable populations and not carried by the providers themselves.

Susan Fisher, representing Nevada State Society of Anesthesiologists:
I am speaking on behalf of the Nevada State Society of Anesthesiologists, and we oppose the bill as written for the same reasons mentioned by the Nevada State Medical Association. We opposed the bill when it was introduced last session for the same reasons. When we do hit a recession, one of the first things that gets peeled back are the Medicaid reimbursement rates. Anesthesiologists in Nevada are already reimbursed at a very low rate. If the bill does go through, we would appreciate the carveout offered by the bill sponsor.

Susan Proffitt, Private Citizen, Las Vegas, Nevada:
I am vice president of the Nevada Republican Club, and I was almost neutral on this until I heard your Carson City opposition. They have a good point; the tax always remains. I have to ask a question: Why a tax when we have a $2 billion surplus here in Nevada? And thank you to Assemblyman Hafen. I have a problem with not understanding the tax and the fact that they were not able to completely answer your questions on how they would be applied,

so I am in opposition for that reason as well. The main reason is I did not see anything in here that said the person receiving it would have to sign an affidavit. Would that be a good idea to add to this as you are updating it?

Chair Peters:
Thank you for your testimony. Seeing no one else in Las Vegas, please check the public line for opposition testimony to A.B. 197.

Connie McMullen, representing Personal Care Association of Nevada:
We are opposed to A.B. 197, or rather, we were opposed to Senate Bill 509 back in 2017, but it passed anyway and became law. State Medicaid Services did a survey, and the personal care industry resoundingly voted down the measure to tax ourselves. Not all personal care facilities accept Medicaid, and a lot of them are just mom-and-pop outfits. We are not in favor of taxing ourselves. I would like to thank the bill sponsor for excluding us from his presentation. I had a very thoughtful conversation with him, and we discussed this bill quite extensively.

Chair Peters:
Is there anyone else on the line for opposition testimony? [There was no one.] We will move on to neutral testimony. Is there anyone in Carson City or Las Vegas who would like to provide neutral testimony on Assembly Bill 197? Seeing no one approach the desks, is there anyone on the public line who would like to provide neutral testimony on A.B. 197?

Paula Cook, Private Citizen, Las Vegas, Nevada:
I am an occupational therapist in Las Vegas. I am calling in today to testify in neutral. I applaud the effort to increase incentives to see Medicaid patients and to increase the reimbursement dollars. The current rates and the system are very frustrating for the providers in town, and I appreciate the opt-in option. However, revenue is often something we do not see unless we are private practice owners, so the percentage of that revenue tax would need to be further clarified so we understand how it is structured. I am going to take these details and share them with my colleagues so that I can survey our practitioners. I will need more time to further understand the specifics.

Chair Peters:
Thank you so much. If you could provide the Committee with your contact information, we can ask Vice Chair Orentlicher to reach out as well. Are there any other callers on the public line for neutral testimony? [There were none.] Assemblyman Orentlicher, would you care to make any closing remarks?

Assemblyman Orentlicher:
Members of the Committee, as you heard, there are some provider groups like the emergency services providers who really want this bill; others who really do not want to be involved, like physicians; and some like the occupational therapists who are still thinking about it. My intent would be to carve out the provider groups who are not interested and preserve the option for those who would like this. I am happy to work with members of the Committee

on amendments to have more secure guardrails and make sure the money is used only as intended. I appreciate your consideration and I look forward to continuing the dialogue.

Chair Peters:
Thank you so much for bringing this bill. We will close the hearing on Assembly Bill 197 and open the hearing on Assembly Bill 293.

Assembly Bill 293: Revises provisions governing Medicaid. (BDR 38-972)

Assemblyman David Orentlicher, Assembly District No. 20:
I appreciate the opportunity to present Assembly Bill 293 this afternoon on the topic of medical-legal partnerships, and thanks also to Richard Whitley and Stacie Weeks of the Department of Health and Human Services for suggesting this bill. Many patients have medical problems that cannot be solved without addressing the social, economic, or environmental factors that contribute to the patient's illness. With legal assistance, health care providers can ensure that these social, economic, and environmental factors are addressed. For example, a child may be suffering from chronic asthma because of mold in the family's apartment. Legal assistance can ensure that the landlord corrects the problem. Another example, if a child or adult is being injured by domestic violence, legal assistance can secure a protective order or other interventions to prevent further abuse. Some patients may be unable to afford medications for their chronic diseases because their employer thought they could not work effectively and fired them. With legal assistance, we can ensure that the employer meets its obligation under the Americans with Disabilities Act to make accommodations in the workplace that allow the patient to resume working.

Section 1, subsection 3 on page 2 of the bill describes other ways in which legal assistance can help patients avoid eviction or obtain health care coverage, disability benefits, or other social services to which the patients are entitled. If a patient is not getting enough food or their family is not eating enough, they can have legal assistance help them get the food stamp benefits they need. In addition to providing legal assistance, staff of these medical-legal partnerships can connect the patients with lawyers who can provide representation beyond the capacity of the partnership. In Reno, for example, Northern Nevada Hopes works with Northern Nevada Legal Aid in the medical-legal partnership that we have in this state.

These partnerships tend to be based in hospitals or clinics, in health care settings where patients are getting treatment, and they can get assistance with legal problems that affect their health. Where does A.B. 293 come in? Funding to support medical-legal partnerships can be a challenge. There might be philanthropic funding. If you are partnering with a law school, the law school often helps or the health care facility may have funds for this, but funding can be a challenge. Section 1, subsection 1 of the bill, starting at the end of page 1, requires the Department of Health and Human Services (DHHS) to cover services provided by medical-legal partnerships to the extent that money and federal financial participation are available and to make Medicaid participate in funding. Section 1, subsection 2 of the bill authorizes DHHS to apply for a Medicaid waiver to create funding for medical-legal partnerships. North Carolina provides a good model for such a waiver. Other states with Medicaid funding

for medical-legal partnerships include Colorado, Indiana, Ohio, and Oregon. We have decades of experience with medical-legal partnerships, and their impact has been demonstrated and is very important in terms of making sure when there are social, economic, and environmental factors that are affecting a patient's health, that those can be dealt with to make sure that the patient has the opportunity to have their health restored.

Chair Peters:
Do we have questions on Assembly Bill 293?

Assemblywoman Taylor:
You mentioned North Carolina. Do other states participate in such a program?

Assemblyman Orentlicher:
Medical-legal partnerships in general are throughout the country. In terms of where we have Medicaid waivers to provide funding, I have seen about ten states listed, but that is based on an article that is a couple of years old, so there may be more.

Assemblyman Hibbetts:
I would refer you to section 1, subsection 1, paragraph (b) where it says, "Must be limited to providing advice and counsel to recipients of Medicaid concerning matters that have legal implications that influence the ability to secure or maintain optimal health." That seems a bit broad to me. What exactly are we looking at here? Are we talking about anything and everything that could possibly have any outcome on someone's health, or are we referring to something specific?

Assemblyman Orentlicher:
You are right; it does have some breadth to it. What we know is that these so-called social determinants of health—social, economic, and environmental factors—do cover a lot of ground: the food you eat, where you live, the air you breathe, the water you drink. There are a lot of things, as we know from Flint and Jackson and other places. The medical-legal partnerships are designed to address the fact that there are a wide range of factors that have big impacts on patients' health. If we do not address those factors, then patients are going to keep coming back, and doctors will keep putting Band-Aids on, but not adequately address the causes of the patients' medical problems. So yes, there is some breadth to it because the range of problems is pretty broad.

Assemblyman Hibbetts:
Based on that, would this law address things such as rent or a gym membership?

Assemblyman Orentlicher:
There would be some limits, and the Medicaid program would set those limits. That would be part of the waiver application, and they do not allow coverage of everything. One of the exclusions is that they do not provide the funds for legal representation. So, there are limits.

Stacie Weeks, Administrator, Medicaid Services, Division of Health Care Financing and Policy, Department of Health and Human Services:
Yes, there would be limits, and I think some examples might be helpful. For example, someone denied health care coverage would be helped with that process. Sometimes, it is seeking an appeal or letting them know where to find legal services in addition to food stamps. Some states look at helping families dealing with child welfare issues, getting a restraining order for domestic violence, things that affect someone's health, and making sure they stay on track with their appointments as well. It is working with that case management team together.

Assemblyman Gray:
Assemblyman Orentlicher, we just heard you testify on the last bill that we need to increase reimbursement rates, so we need a new tax. Yet here, you want to use Medicaid funds to pay for lawyers to provide services that, in a lot of cases are already provided through legal aid or social workers. This would create a swelling of a bureaucratic system, throwing lawyers into a mix where they should not really be. This is more of a paraprofessional world. How do you justify that?

Chair Peters:
I thought we just heard that it was not going to cover legal services; can you please clarify this?

Assemblyman Orentlicher:
In this case, the money would not be used for legal representation, but it would be used to provide legal advice and counsel. In terms of the cost, what is important about these kinds of interventions is that they save money. Using the example of the child with chronic asthma because of mold or pests in the house, if that child keeps coming back every month for medical care, that is going to be very expensive. However, if you remove the mold or the other causes of the asthma, you are saving a lot and the child does not have to keep coming back for treatment. These are cost-effective and implementing a medical-legal partnership saves Medicaid money, so I am not worried about the concern you raise.

Assemblyman Gray:
It would not be used for representation, but the example you used was an attorney to help them apply for Medicaid. To me, that is several pay grades under the level of what an attorney should be doing.

Assemblyman Orentlicher:
There are variations in how medical-legal partnerships work. Some have attorneys based in a health clinic, and they can be kept busy providing advice and referring out. Again, the Medicaid funds would not be used for legal representation. If someone's legal assistance was covered by Medicaid in Nevada, it would be to provide advice and assistance. Sometimes, you can point the patient to the forms, and they can proceed on their own. Sometimes they need to be referred to a legal aid organization, whether it is in Reno, Las Vegas, or elsewhere. They have worked very effectively, so you do not need to worry whether

medical-legal partnerships can work or whether you can find the lawyers and other staff to provide the legal guidance and make sure patients get the services they need. They have been in practice for decades and they have been very successful.

Chair Peters:
I am going to recommend we go offline with additional questions, but I want to make a point of clarification on the legal assistance for applying for other services. We have a very effective partnership between Medicaid and the Division of Welfare and Social Services. They work well together to ensure that folks are getting their needs met. I believe that is going to be where we spend most of the time and effort in this medical-legal partnership. It is important to note that many people who are on Medicaid do not have a lawyer on retainer, so this is an opportunity for folks to have access to legal advice—rather than listening to friends or colleagues who may not be attorneys—as they navigate the medical world, whether it is advocating within the medical industry or finding services, including paperwork that needs to be filled out to gain those kinds of services. We can look at it from that lens rather than from an obligatory everybody-gets-a-paid-lawyer lens. Are there any other questions from the Committee before we move on? [There were none.] We are going to begin with support testimony on Assembly Bill 293.

Jonathan Norman, Statewide Advocacy, Outreach, and Policy Director, Nevada Coalition of Legal Service Providers:
The Nevada Coalition of Legal Service Providers includes all the attorneys who take these types of cases. When I think of a medical-legal partnership, I think of another door to legal services. In Clark County, we operate the Family Law and the Civil Law Self-Help Centers. Neither one of those organizations gives legal advice. Here, you have a situation where legal advice and counsel could be given, and it is a step up from just providing a form. It is legal advice. If the situation required an attorney or legal representation, they would be able to make a referral to a legal aid provider. I view it as another door for people to access legal advice, counsel, and potentially an attorney. It just highlights that the attorney cannot be paid by this funding source. At a legal aid where I previously worked, there was a medical-legal partnership that functioned very well to provide another avenue for legal resources for people who are usually in pretty desperate situations, so thank you, and we are in support.

Chair Peters:
Is there anyone else who would like to provide support testimony on Assembly Bill 293? [There was no one.] We will move into opposition testimony. Is there anyone in Carson City or Las Vegas who would like to provide opposition testimony on Assembly Bill 293? [There was no one.] Is there anybody who would like to provide neutral testimony on Assembly Bill 293? [There was no one.] We are going to close the hearing on A.B. 293 and move on to our last bill hearing of the day, Assembly Bill 135. I want to remind the Committee that this bill came out of the Joint Interim Standing Committee on Health and Human Services. Assemblywoman González has graciously taken the lead on this bill.

Assembly Bill 135: Revises provisions relating to homelessness. (BDR 40-324)

Assemblywoman Cecelia González, Assembly District No. 16:
I want to note that there is an amendment proposed in section 6 [Exhibit D]. All of you should have that amendment on your desk, and it was not posted on NELIS [Nevada Electronic Legislative Information System], but it is a friendly amendment, and we accept it. This is a committee bill, as the Chair stated, from the Joint Interim Standing Committee on Health and Human Services (HHS) at its final meeting and work session. The HHS interim committee voted unanimously to propose the bill before you today. With me is Trevor Macaluso, Chief Executive Officer (CEO) of Eddy House, a nonprofit organization based in northern Nevada in Reno whose mission is to work with homeless and at-risk youth to help them develop the job and life skills necessary for sustainable independence. I will walk through the bill, and then I will hand it off to Mr. Macaluso for additional comments.

Sections 1 and 2 require an issuing entity of birth certificates to notify applicants about missing paperwork in their applications to obtain an official copy of their birth certificates and also notify them what kind of paperwork is missing. Additionally, if the applicant is homeless, they must be given at least 30 days to submit their missing documents. Section 1 also provides that a homeless person who obtains an official copy of their birth certificate from a government entity should submit a statement that they are homeless signed under penalty of perjury rather than a signed affidavit as currently set forth in the law. This issuing entity shall not require the signed statement be notarized. Section 3 aims to ensure that individuals experiencing homelessness are supported in their efforts to obtain a state identification card. For that purpose, the Nevada Housing Crisis Response System must collaborate with the Department of Motor Vehicles, otherwise known as the DMV, to facilitate that process.

Sections 4, 5, and 6 apply to homeless children or young adults less than 25 years of age seeking to obtain an identification (ID) card with the intent to remove common barriers for this population. Specifically, section 4 waives all fees and costs associated with the issuance of an ID card for homeless youth by removing the current limitations in law that the DMV can only waive these fees once. Section 5 removes the requirement to provide proof of a social security number to obtain a state ID card if the applicant submits a signed affidavit stating that they are a homeless youth. Section 6 allows a homeless youth to provide their legal name and age by using their school ID card as long as the ID card includes certain items listed in subsection 4 such as the school's name, the applicant's first and last name, a photo of the applicant, and his or her date of birth. In front of you is the amendment that was submitted allowing use of an unofficial transcript that includes the child or youth's date of birth [Exhibit D].

Lastly, section 7 strives to strategically address the issues of homelessness in the urban areas of our state and mandate that counties with a population of 100,000 or more—meaning Clark and Washoe Counties—develop strategic plans to address homelessness within the counties and cities and towns in those two counties. This section also addresses items that the strategic plan must include and require the plan be submitted and presented to the

Joint Interim Standing Committee on Health and Human Services on or before August 4 of the interim, which would be 2024.

Trevor Macaluso, CEO, Eddy House, Reno, Nevada:
Eddy House is the only nonprofit accepting and serving any homeless or at-risk youth without any barriers in the area. We work with organizations across the state that work with youth homelessness. This concept came about after being invited to speak at the interim committee last April. We have an issue in being able to get identification cards for our youth. This is important because we cannot get them back to work or get them housed or in leases without an ID. In the current system, we can get a birth certificate with relative ease, but then we are stuck in a loop between trying to get youth a social security card or Nevada ID because both require each other. This would help us close that loop on the Nevada ID side by using existing information that the State and school district already have that could verify that the youth are who they say they are and provide the birthdates, which would shorten the process of roughly five months to get a homeless youth an identification card to two months or less by our current estimate.

Chair Peters:
Thank you so much for the presentation. We did something similar for folks who were incarcerated or came out of systems where they do not necessarily have identification to help assist in getting those very basic things you need an ID for such as a social security card.

Assemblyman Gray:
If the government mandates you have an ID for just about everything, for instance to get a COVID-19 shot, you had to have an ID. So, if an ID is required for anything, it should be paid for. I have a brother who is chronically homeless, and he should have an ID. That is your gateway to living life. I think Assemblyman Hafen had a bill pertaining to something else that would have also provided an ID for people who could not afford it. That leads to my question: Why not just have people sign an affidavit that attests that they cannot afford it? That person may have a roof over their head, so why does it have to be somebody who is homeless?

Assemblywoman González:
I think that is part of a larger conversation when we talk about fines and fees in the DMV's budget. I do not know if anyone from the DMV is currently here to answer that, which is why we as legislators have to say, hey, what about this population; what about that population?

Assemblyman Gray:
I guess that was the reason for my question. Why not open it to people who attest that they cannot afford it?

Assemblywoman González:
Again, that is a question for the DMV and how they operate with their fines and fees, so I would defer that question to them.

Chair Peters:
I am going to take this question since it was from the interim committee. When we were talking about this issue, we were looking at ways we could assist our homeless youth—one of the largest growing populations in the state of Nevada. It also is one of the largest populations we are seeing suicide and other health issues in, so we had a focus on homeless youth, particularly this age range. We could take this conversation offline and ask what the cost would look like for the DMV and move forward from there.

Assemblyman Nguyen:
This is more about the language barrier because that has been my line of questioning. In terms of past histories and affected population, have you come across cases where there may be a language barrier to the process of filling out the affidavit? I want to make sure we are inclusive of those communities that may or may not be able to provide those testaments in English.

Trevor Macaluso:
There is a language barrier across a number of youths we serve at Eddy House. We work with strategic partners that offer interpretation and translation services as needed, so we are able to address those quickly, but I cannot speak to other organizations.

Assemblyman Nguyen:
This is a suggestion as we go along. I am not sure if this is something that we could be amenable to adding that layer. In a case where the affidavit is not accepted in any other language than English, it might provide an additional barrier even though you have services in your organization, but I am looking statewide. We can look at how we can do this for an organization that may not have that capacity and be able to serve the underserved population.

Chair Peters:
I am going to ask Mr. Sever if he could speak to this or if he wants to follow up with us on what language the DMV has documents in or what translation services are available. We will put it on our list to follow up on.

Assemblyman Hibbetts:
I have two questions, but they are both more procedural than anything else. They relate to the policy in front of us today. Why get rid of the signed affidavit and go to a statement signed under penalty of perjury? What is the reasoning behind that? That is my first question.

Trevor Macaluso:
You need an ID to get notarized, so it is really hard to have a notary sign the affidavit to verify you are homeless. The only exemption that is provided for a notary is for personally known individuals; and again, our population is not necessarily personally known by notaries.

Assemblyman Hibbetts:
If I understand correctly, an affidavit is something that is notarized. Is that correct?

Trevor Macaluso:
The current process requires a signed affidavit verified by a notary, and it is very hard to have the notary actually notarize a document when the homeless individual does not have identification.

Assemblyman Hibbetts:
Thank you. My second question concerns section 1, subsection 4, which talks about submitting their application for identification and discovering documents are missing. Is that going to be addressed right then? My concern is that two days later somebody going through these documents would say John Q Citizen is missing document X. How are you going to notify them if they are homeless?

Trevor Macaluso:
When a client or any homeless individual is trying to get their birth certificate and they have missing documents, usually the county will contact that individual, whether by phone, email, or mail. With the current situation, I believe they have 21 days to pull together the missing documents. This proposal would extend that to 30 days to give our clients a little bit of extra time. A lot of our youth at Eddy House have their mail delivered to us, and I know that is the case for other shelters as well.

Assemblyman Hibbetts:
My concern may not be best addressed by the *Nevada Revised Statutes*, so I appreciate your answering the question.

Assemblywoman Gorelow:
I did not see a definition for "homeless," and I want to put on the record exactly what we are looking at. I think of someone who is living on the streets, but there are people couch surfing, or people who may be living in a hotel or an extended stay type of thing; I want to get the definition of "homeless" and all it might encompass with this bill on the record.

Assemblywoman González:
In section 6, subsection 5, paragraph (a), the bill defines "homeless child or youth" as it currently is in the NRS.

Assemblywoman Gorelow:
That was the definition I looked up last night, but I did overlook it in the bill language, so thank you.

Chair Peters:
I believe that is a federal definition rather than the State definition. Are there any other questions from Committee members?

Assemblyman Gray:
If they are homeless, what are they going to use on the ID as their address? If they use the shelter, they frequently change shelters. Would they use the last known family residence?

Trevor Macaluso:
Most of the clients use our shelter as the address or last known residence. Once we are able to get them housed somewhere, then we are able to change that and help them with that process. But again, they cannot go to work, find a job, or find a place to live without that.

Chair Peters:
I have a vague recollection that over the last several sessions we addressed that concern for the broader homeless populations' identification. Again, I do not know if the DMV has any ideas or could follow up with how addresses for people who are homeless are dealt with. If it was not for state IDs, it was for enrollment in schools, so we have some work already in that area we can fall back on and look at.

We will move into support testimony for Assembly Bill 135 and start here in Carson City and Las Vegas and then we will go to the phones.

Jonathan Norman, Statewide Advocacy, Outreach, and Policy Director, Nevada Coalition of Legal Service Providers:
I was also a Children's Attorney Project (CAP) attorney for a while, so I represented kids in foster care. I had numerous kids who aged out and through a variety of things from being homeless, losing their ID because they were living in a park, or couch surfing, this is a real concern I would face routinely for clients who had aged out. We stayed with them often until they were 21 as their CAP attorneys. I appreciated the question from Assemblywoman Gorelow because I also had overlooked the definition and assumed it was the federal definition, but it was right in front of us.

John J. Piro, Chief Deputy Public Defender, Legislative Liaison, Clark County Public Defender's Office:
It seems very little to us, but getting an ID is a first barrier to getting yourself back into the game of life. If we can provide an easier pathway, that is a pathway that keeps people out of trouble, that keeps people from repeating bad habits, and that gets people back on the right path and we are all for that.

Patricia Haddad, Director, Government Relations, Clark County School District:
I am grateful to the presenters and to the Committee for bringing this legislation forward and for accepting the amendment in regard to student IDs that are provided [Exhibit D]. We support this legislation and want to do what we can to ensure that our homeless youth and kids are supported.

Chair Peters:
Thank you, and thank you for providing that language that will work for all of you. It is complicated when we are talking about what to provide for our kiddos.

Mathilda Guerrero, representing Battle Born Progress:
We are in support of Assembly Bill 135 as amended. This is a commonsense measure to ensure every Nevadan has access to the necessary documents they need. We are elated to see that this bill requires the Nevada Housing Crisis Response System to collaborate with the DMV to help folks who are experiencing homelessness with their ID request while also waiving fees for folks who are younger than 25. We ask this body to continue exploring creative measures such as this bill in order to provide folks the opportunity to get back on their feet and seek out new jobs, housing, and assistance programs.

Chair Peters:
Is there anyone else in our physical locations who would like to provide support testimony on Assembly Bill 135? [There was no one.] Is there anyone on the public line who would like to provide support testimony on Assembly Bill 135? [There was no one.] Is there anybody who would like to provide opposition testimony to Assembly Bill 135?

Joanna Jacob, Government Affairs Manager, Department of Administrative Services, Clark County:
Clark County is actually very supportive of most of the sections of the bill which can help reduce barriers for the youth we serve in our social services division and our Department of Family Services Division for youth aging out of foster care. We always strive to help the children we serve. We have a long-standing program called Step Up where we help the youth transitioning out of foster care, understanding that the transition can be complicated, and they may exit and come back to us. We have a lot of support built into our system. We know there are needs still out there.

I am opposed to the report and mandate in section 7, and I will tell you why. In 2018, Clark County and our community as a whole began to do a strategic plan to address homelessness. This was a very significant effort with public and private partnership and was part of our Southern Nevada Homelessness Continuum of Care, which is required by Housing and Urban Development (HUD) and a HUD-approved program updated in November 2022 with a needs assessment. My concern with that section was to be able to honor that work. And the work very importantly was youth-driven in collaboration with numerous community partners and Nevada Partnership for Homeless Youth. We had a youth advisory board involved from the beginning to help drive and illustrate this plan and has participated throughout. We are opposed to the new mandate for the report because we have

already begun a strategic plan that has been updated. We will be working with Assemblywoman González on this afterward because we are happy to report to the Legislature on the progress we have made and what we are working on in Clark County, but we did not want to duplicate that effort because it has been community-wide.

Our continuum of care is very effective. It involves Clark County, the cities, and numerous nonprofit partners. We were just awarded $15 million from HUD to address homelessness. We are one of 46 agencies awarded, and the Southern Nevada Homelessness Continuum of Care was awarded that effort. That is over three years. We are very proud of that effort in community collaboration, and that is why I am opposed to the report. We are very supportive of the rest of the bill and happy to provide that report and needs assessment to the Committee. If you would like to review it, we can certainly upload it after the hearing today.

Chair Peters:
That would be appreciated by us, and we will have staff follow up with you on those reports. Are there other folks who would like to provide opposition testimony on Assembly Bill 135? [There was no one.] We will go on to neutral testimony. Is there anyone in Carson City or Las Vegas who would like to provide neutral testimony on Assembly Bill 135?

Sean Sever, Deputy Administrator, Research and Project Management Division, Department of Motor Vehicles:
We are neutral on A.B. 135 and submitted a fiscal note on the impact. The revenue loss is minimal to the Department of Motor Vehicles (DMV) because this would affect a very small subset of our customers. Where the cost comes in is for the computer programming. The proposed effective dates are the issue. As you know, the DMV is in the middle of a transformation effort to move most of our services online; so we are between IT [information technology] systems, and this would require programming, testing, and implementation in our old system at over 900 hours, which would need to be completed by contracted programmers. The DMV is asking to move the implementation date to when the DMV transformation is complete, which would significantly lessen the impact of it.

If you want, Chair, I can address questions that were asked earlier.

Chair Peters:
Yes, that would be great.

Sean Sever:
To answer the first question, we have to assess the fiscal impact to add the other groups and we have to get back to you on that one. The second question concerned the languages. We accommodate Spanish and Tagalog in Washoe and Clark Counties. We are looking at adding Mandarin Chinese based on the last census data. The third question was about the homeless ID contact. We allow shelter addresses and once they get a permanent address, they come in to get their new card.

Chair Peters:
Thank you for those answers. Are there other questions for the DMV?

Assemblyman Nguyen:
You said you can add Chinese based on the census data. Does the census data also give you the top five languages in our state? Spanish, Tagalog, and Chinese cover a significant number of our population, but when should we be looking at adding other languages? My native language is Vietnamese, another language commonly spoken, and that population is increasing in our state. I want to make sure where Vietnamese falls on that line.

Sean Sever:
We have a language access plan I can share with you offline, but I will have to get back to you on some of your questions.

Chair Peters:
Thank you so much. Mr. Sever, do you have an anticipated implementation date for the new tech you were referring to?

Sean Sever:
That is the million-dollar question. I would just say some time in 2025.

Chair Peters:
We have had exhaustive conversations about this in the Ways and Means Committee, but that does not always translate into a policy committee, so thank you for that. Are there other questions for the DMV on this bill? [There were none.] Thank you so much for your testimony today. Are there other folks who would like to provide neutral testimony on Assembly Bill 135 either in Carson City or Las Vegas? [There was no one.] Is there anyone on the public line who would like to provide neutral testimony on Assembly Bill 135? [There was no one.] I would like to invite the bill sponsor for closing remarks.

Assemblywoman González:
I want to thank you and the Committee for the time to hear this measure, and I will be working with Clark County to address their concerns in section 7.

Chair Peters:
We will close the hearing on Assembly Bill 135 and move on to our last agenda item of public comment. We will start in our physical locations and move to the phone lines. [Public comment rules and protocol were reviewed.] Is there anyone who would like to provide public comment today? [There was no one.] We will close our public comment meeting item. Are there any additional comments from Committee members before we adjourn? [There were none.]

That concludes our meeting. With that, we are adjourned [at 3:17 p.m.].

RESPECTFULLY SUBMITTED:

____
Terry Horgan
Committee Secretary

APPROVED BY:

____
Assemblywoman Sarah Peters, Chair

DATE: ____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "AB 197 Allowing Providers to request a tax to raise Medicaid reimbursement," presented by Assemblyman David Orentlicher, Assembly District No. 20.

Exhibit D is a proposed amendment to Assembly Bill 135, presented by Patricia Haddad, Director, Government Relations, Clark County School District.