

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

**Eighty-Second Session
March 22, 2023**

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:35 p.m. on Wednesday, March 22, 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
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:

Assemblyman David Orentlicher, Vice Chair (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Brown-May, Assembly District No. 42
Assemblywoman Shonda Summers-Armstrong, Assembly District No. 6

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:

Diana Rovetti, Private Citizen, Reno, Nevada

Jack Rovetti, Private Citizen, Reno, Nevada

Catherine Nielsen, Executive Director, Nevada Governor's Council on
Developmental Disabilities

Alysa Marquez, Private Citizen, Gardnerville, Nevada

Ellen Marquez, Private Citizen, Gardnerville, Nevada

Ashlee Cooper, Manager, Advocacy and Government Affairs, Opportunity Village

Nate Boyack, Executive Director, State of Nevada Association of Providers

Lisa Holmquist, Founder, CEO, Down Syndrome Connections, Las Vegas, Nevada

Steven Cohen, Private Citizen, Las Vegas, Nevada

Dora Martinez, Private Citizen, Reno, Nevada

Travis Mills, Private Citizen, Reno, Nevada

Christina Ugalde, Executive Director, Down Syndrome Network of Northern Nevada

Sarah Watkins, representing Nevada State Medical Association

Brian K. Iriye, M.D., Managing Partner, High Risk Pregnancy Center, Las Vegas,
Nevada

Connor Cain, representing HCA Health Care

Blayne Osborn, representing Nevada Rural Hospital Partners

Jesse Wadhams, representing Pediatrix Medical Group

Alex Tanchek, representing Nevada Advanced Practice Nurses Association

Katie Roe Ryan, Director, Public Policy, Dignity Health-St. Rose Dominican

Tess Opferman, representing Nevada Women's Lobby; and Human Services Network

Elyse Monroy-Marsala, representing Children's Advocacy Alliance; and Nevada
Public Health Association

Lea Case, representing Nevada Psychiatric Association

Paula Luna, Operations Manager, Battle Born Progress

Kathleen Palmer, Private Citizen, Carson City, Nevada

Nancy Jones, Board Member, Health Freedom Nevada

Katie Banuelos, Secretary, Libertarian Party of Nevada

Farzat Kamyar, Private Citizen, Las Vegas, Nevada

Helen Foley, representing Nevada Association of Health Plans

Marc Christensen, Member, Executive Board, State of Nevada Association of
Providers

David Rovetti, Chairman of the Board, Alpha Productions Technologies Inc., Sparks,
Nevada

Emily Barney, Executive Director, Doula Co-op, Reno, Nevada

Joyce Abeng, Public Health Diversity Advisor, Larson Institute for Health Impact and
Equity, School of Public Health, University of Nevada, Reno

May Chin, Private Citizen

Jollina Simpson, Doula, Las Vegas, Nevada

Samantha D'Andrea, Doula, Reno, Nevada

Claire Murdoch, Doula, Reno, Nevada

Natalie Powell, Director, Nevada Certification Board

Angela Heinemann, Assistant Professor, School of Public Health, University of Nevada, Reno

Sue Foltz, Co-Founder and President, Doula Co-op, Reno, Nevada

Mary Kilkenny, M.D., Reno, Nevada

Jennifer Campbell, Doula, Reno, Nevada

Chair Peters:

[Roll was taken. Committee rules and protocol were reviewed.] We will move on to our first agenda item today which is a work session. We have two items on work session today. The first is Assembly Bill 45. I will ask Patrick Ashton to please go over the bill.

Assembly Bill 45: Creates a program to repay the student education loans of certain providers of health care. (BDR 18-359)

Patrick Ashton, Committee Policy Analyst:

[Read from Exhibit C.] Assembly Bill 45 was heard on March 1, 2023. It creates the Student Loan Repayment for Providers of Health Care in Underserved Communities Program administered by the State Treasurer to repay the student education loans of qualified health care providers. Further, the State Treasurer shall specify by regulation certain methodologies, procedures, and standards relating to the program including the prioritization of certain health care providers when awarding repayments of such loans. Additionally, the State Treasurer may adopt other regulations as necessary.

The bill provides a health care provider is eligible for this program if the provider:

- Is a state resident;
- Graduated on or after July 31, 2023, with a health-related degree from an institution of higher education in Nevada;
- Is actively licensed, certified, or registered in good standing to practice as a health care professional provider in the state; and
- Commits to at least 5 years of clinical practice in certain underserved communities.

Erik Jimenez, Chief Policy Deputy, Office of the State Treasurer, proposed the attached revised amendment after the hearing. In summary, the amendment:

1. Revises, in section 4, the definition of a "provider of health care";
2. Removes from section 7, the Program eligibility requirement for a provider to have graduated on or after July 31, 2023, in a health-related degree from an institution of higher education in Nevada;
3. Adds a new requirement in subsection 3 of section 6 that in administering the program, the State Treasurer shall—to the extent possible—use 15 percent of Program funds available in any year for providers who commit to practicing in a county whose population is less than 100,000;
4. Revises subsection 3, paragraph (b) of section 6 to also prioritize providers who accept patients enrolled with Medicaid or the Children's Health Insurance Program when awarding repayments of such loans;
5. Revises subsection 4 of section 6 by adding psychiatry to the definition of "primary care," which are provider professions that are prioritized for such loan repayments; and
6. Adds in subsection 3 of section 7 counties with a population less than 100,000 to the criteria of an underserved community.

Chair Peters:

Thank you, Mr. Ashton. Are there any questions from Committee members before we move into a motion? Seeing none, I will entertain a motion to amend and do pass.

ASSEMBLYWOMAN GONZÁLEZ MADE A MOTION TO AMEND AND
DO PASS ASSEMBLY BILL 45.

ASSEMBLYWOMAN TAYLOR SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblyman Hafen:

I want to thank the State Treasurer and his office for working on this amendment. I will be voting this out of Committee, but I will reserve my rights. I believe it has addressed all my concerns, but I want to dive in a bit further.

Chair Peters:

Thank you, I appreciate that. As always, you have the right to reserve your vote on the floor. I appreciate your commitment to pass the bill out of Committee today so we can continue to work on making sure the amendment language gets to the point of the bill. Are there any other discussion items?

Assemblyman Nguyen:

Thank you for the opportunity to address this on the public record. I spoke with the Treasurer's Office, and I am pleased with this bill. In my conversation with the Treasurer's Office, in terms of regulations when it does pass out of this house, I would like us to prioritize providers who have additional language abilities so we can continue to serve the underserved communities in our state. According to the census data we get, there are a lot of languages spoken in Nevada, and we would love to have the opportunity to recruit providers who speak those languages. The Treasurer's Office agreed with me that we should put this on the public record. So, I thank you, Mr. Jimenez, for working with me on this, and I am still in support of the bill as it is written.

Chair Peters:

As a reminder, the regulatory process also has a public process, and you can participate in that. It will come back to us through the Legislative Commission for final approval.

Assemblywoman Newby:

I appreciated the brilliant point my colleague made regarding the previous restriction to Nevada institutions, particularly around a practice that does not have that level of education currently in existence in Nevada. That said, the amendment removes the requirement that it be for graduates from an institution of higher education in Nevada. During the rulemaking process, I would like to see preference for graduates of Nevada institutions, but not necessarily be a requirement, understanding that there are many residencies that we do not have in our state. It would be nice to be able to lure some of our graduates back to serve their communities here after they finish with their residencies.

Chair Peters:

Thank you for the comment. It sounds as though we have quite a few people who will follow this through the regulatory process and make sure we are getting it right. Is there any other discussion on the motion? [There was none.]

THE MOTION PASSED. (ASSEMBLYMAN ORENTLICHER WAS ABSENT FOR THE VOTE.)

I will give the floor assignment to Assemblywoman Taylor. We will move on to the work session for Assembly Bill 136.

Assembly Bill 136: Requires certain facilities to be licensed as child care institutions.
(BDR 38-326)

Patrick Ashton, Committee Policy Analyst:

[Patrick Ashton presented the work session document [Exhibit D](#).] Assembly Bill 136 was heard on March 1, 2023. It requires an operator of a qualified residential treatment program that provides care and shelter for less than 16 children to obtain a license as a child care institution from the Division of Public and Behavioral Health of the Department of Health and Human Services. Any qualified residential treatment program operating on or before

January 1, 2024, may continue operating without such a license until July 1, 2024, under certain circumstances. There were no amendments proposed to this measure.

Chair Peters:

Thank you, Mr. Ashton. Are there any questions from the Committee? Seeing none, I would entertain a motion to do pass Assembly Bill 136.

ASSEMBLYMAN NGUYEN MADE A MOTION TO DO PASS
ASSEMBLY BILL 136.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

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

THE MOTION PASSED. (ASSEMBLYMAN ORENTLICHER WAS
ABSENT FOR THE VOTE.)

I am going to assign that bill to Assemblywoman Thomas. We have a bill introduction. The Bill Draft Request (BDR) is BDR 38-977, which revises provisions governing Medicaid.

BDR 38-977—Revises provisions governing Medicaid. (Later introduced as [Assembly Bill 389](#).)

ASSEMBLYMAN NGUYEN MADE A MOTION TO INTRODUCE BILL
DRAFT REQUEST 38-977.

ASSEMBLYWOMAN GONZÁLEZ SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.] As always, it is a bill introduction. This does not commit you to the bill but allows us to introduce it on the floor and have a discussion.

THE MOTION PASSED. (ASSEMBLYMAN ORENTLICHER WAS
ABSENT FOR THE VOTE.)

Now, we are going to move into our agenda bill hearings for the day. We are going to take these in order. First up is Assembly Bill 116.

Assembly Bill 116: Requires the provision of information and referrals concerning Down syndrome under certain circumstances. (BDR 40-569)

Assemblywoman Brown-May, Assembly District No. 42:

This bill requires health care providers to provide information and referral to support services related to Down syndrome to a person who has received a positive prenatal or postnatal test for Down syndrome, and/or the parents or guardians of a child with Down syndrome. I have a parent of a child—who is now an adult but will always be her child—with Down syndrome. I would like to introduce you to Diana Rovetti and her son Jack.

Diana Rovetti, Private Citizen, Reno, Nevada:

Good afternoon, Chairwoman and Committee members, and thank you so much for allowing us to be here today. I would like you to close your eyes for a moment and think about a time in your life when you had a moment you will never forget. You remember where you were, who was with you, how you felt, what the smells were, what the lights were. This might have been a happy moment or a sad moment, but it is something that sticks in your heart forever. Just hold that thought for a moment. I have a time in my life when time stood still for me. More than any other moment in my life, I remember it vividly. The sights, sounds, who was there, where I was sitting, who was in the room, the feelings. Most of all, I remember the feelings. You probably remember the feelings around your moment. My moment should have been a joyous occasion. I should have been celebrating. I should have been very happy. I had three daughters. I had been wanting a son my whole life, and I had my baby boy in my arms, but I felt sad. I remember friends stopping by, and I did not know what to say to them, so I said nothing. I remember calling my mom, and I remember the words I said to her. There were tears, and I was very, very scared. My moment was when my pediatrician told me he suspected my baby boy, the son I had been dreaming of and hoping for and waiting for, might have Down syndrome. That stopped time for me.

As you can imagine, that moment has stayed with me for 24 years. This moment happens for parents in Nevada approximately 50 times each year. A lot of times, parents are given a grim outlook when they should be offered information and hope. In 1998, if I had known what I know now, I definitely would have been celebrating, because it was this boy who made me a mom of a boy, and a very, very proud mother of a son with Down syndrome. I am a fourth-generation native of Nevada, and I am a mother of four daughters and one son, Jack. This handsome young man sitting next to me has changed the course of my life and changed it for the better. I also believe having Jack as a brother has changed the lives of my daughters for the better and has guided their careers as well.

I want to tell you about a study that was done in 2011. Dr. Brian G. Skotko, Susan P. Levine, and Richard Goldstein published a study in *The American Journal of Medical Genetics*, "Self-Perceptions from People with Down Syndrome." I do not know how much you have been around people with Down syndrome, but when I had Jack, I had hardly ever been around anybody with Down syndrome. I remember one fellow in my class who graduated with me in high school—Churchill County High School. I remember him walking around in a group with some other students. He was never included or accepted by the other kids. If you have never known what a person with Down syndrome thinks about themselves, that is why I want to tell you about this survey. Among the 284 people surveyed about their self-perception, 99 percent of the people with Down syndrome indicated they were happy

with their lives. In the general population, I do not think we can come anywhere near that number. Ninety-seven percent like who they are, and 96 percent liked how they looked. Ninety-nine percent of people with Down syndrome express love for their families.

The authors of the study said in their qualitative analysis, people with Down syndrome encourage new parents to love their babies with Down syndrome, mentioning that their own lives are good. They further encourage health care professionals to value them, emphasizing that they share similar hopes and dreams as people without Down syndrome. Overall, the overwhelming majority of people with Down syndrome surveyed indicated they live happy and fulfilling lives. I may be preaching to the choir, but I want to let you know that the lives of people with Down syndrome have value, and they enrich our lives and the lives of the people around them. With that being said, I am now turning this over to Jack.

Chair Peters:

Welcome to the Committee, Jack. Thank you for being here.

Jack Rovetti, Private Citizen, Reno, Nevada:

Did I speak? Did I speak clearly? Okay, good. I graduated from Reno High School and went to UNR [University of Nevada, Reno]. I have a lot of friends, and I love my family. I have my own business. It is called Jack's Popcorn Company. You know about my popcorn. I will be volunteering at the big school, [Marvin] Picollo School, helping kids. I work at The Eddy bar as a barback. I go to downtown Reno all by myself. I think you should have a perfect mom. I am happy I have Down syndrome and I am happy with my life. And also, tell your mama her baby is perfect.

Diana Rovetti:

For the record, we sent out a survey, and the reason this bill is needed is because I have comments from parents across the state of Nevada who shared their birth stories and diagnosis stories. Almost all of them are negative. A lot of doctors say, I am sorry that you have this baby. As parents, we think this day should be celebrated for all babies, especially babies with Down syndrome.

Assemblywoman Brown-May:

As you can hear, many times misinformation around people with Down syndrome is represented. This bill asks for factual information to be presented to parents who receive a diagnosis, prenatally and postnatally, that their child is affected with Down syndrome. They should understand that their child can be a wonderful, happy, productive, successful individual in a community. The bill says that upon receipt of positive prenatal or postnatal test results, the physician, nurse practitioner, or anyone who presents that information would be required to present information and a referral source to that family member. That is the bill, and I will be happy to take questions.

Chair Peters:

Thank you so much for the presentation and for being here. It is great to see you, Jack, and we are all familiar with your popcorn. I am going to take a moment of personal privilege

because when I was in high school, I am about the right age for you to have been in my RAVE [Respite and Volunteer Experiences] class. I volunteered with RAVE, which is a respite program for families who have children who have developmental disabilities. We took care of kiddos, and you are about the right age for a kiddo who was in my class. It brought tears to my eyes remembering those days. It was a long time ago. Are there questions from Committee members?

Assemblyman Gray:

Jack, you are perfect, Dude. This is the same experience most of us have had in our lives—never having met anybody with Down syndrome who was not happy, smiling, and made us stop and think, hey, life is good. No matter what is going on, life is good. I have a concern about this bill and want to make sure this is going in the right direction. I have a family member who had some prenatal testing done. The numbers were alarming, so they met with a geneticist. The first words out of that geneticist's mouth were, "We recommend termination." I want to make sure that is not what this bill is about.

Assemblywoman Brown-May:

I have spent 22 years supporting amazing people with intellectual and developmental disabilities. This is about enabling an enhanced conversation about the true capabilities and wonderful things people with Down syndrome can bring to our communities. I would never want to be involved in that decision-making process for any parent, but our goal is to make sure parents have as much information as possible, so they know how wonderful a person with Down syndrome is and what their true capabilities are before they make any decisions.

Chair Peters:

I would direct folks to the language of the bill. There is no obligation on anybody but the physician to provide readily available information about resources within the state of Nevada.

Assemblywoman Thomas:

Thank you for this presentation. It warms my heart. Jack almost made me cry, especially how he put his mom. I hope my kids call me that too, but they do not. My question has to do with section 1, subsection 1, paragraph (a), subparagraph (1). Why does the life expectancy for people with Down syndrome have to be in there?

Assemblywoman Brown-May:

This language is modeled after some other states that produced acts similar to this one. At one point, the life expectancy of a person with Down syndrome was not as significant as it is today, and unfortunately, many times our folks with developmental disabilities passed away early in life. That is no longer the case, and we are now living into our senior years, and so life expectancy was just identified as a way to be able to show you can have a full and wonderful life span.

Assemblywoman Gorelow:

In my other life, I work with a lot of families who have children with intellectual and developmental delays. We see a lot of children in early intervention who have Down syndrome. This is wonderful, because I hear many times from these families that they did not know they qualified for services. This would allow them the opportunity to say, this is a birth qualification. You do not need to have a developmental assessment; you automatically qualify and can get those services right away. So, thank you for bringing this bill forward.

Assemblywoman González:

Thank you so much for being here and bringing this important piece of legislation, and it is awesome to see you in Committee today, Jack.

Assemblywoman Gorelow:

May I also cosponsor?

Assemblywoman Brown-May:

I am happy to have anyone who would like to join us on this bill.

Assemblywoman Taylor:

Thank you to my colleague, and I will chase you down with a pen.

And, Jack, thank you so much for coming and sharing your story. Since I have been here in this Legislature, I have never been so impressed with a young man as I am with you right now. The poise, the confidence as you sit there—you have your jacket on and your hair is tight, and you look good. You might be looking for looks. Yes, that is what I am talking about. Get that on the record. I am so incredibly impressed with you and the way you carry yourself. I am really appreciative. I used to be on the school board in Washoe County and have spent some time at Picollo [Marvin Picollo School]. The fact that you can be there and volunteer your time with young people who aspire to live their lives like you have is just amazing. You are such a role model, such a trailblazer for them.

My question for you, sir, is what advice would you give to someone who is still in school? They have been diagnosed with Down syndrome. You have done it. You wear it so well. How can you help them? What would you tell them?

Jack Rovetti:

Well, I do not know, but that is a really good question. I graduated. Yeah, it is okay, I think it is perfect. I wanted to make it perfect. It is kind of like me, right? Like I want positive stuff, too—and I want it for you, too.

Assemblywoman Taylor:

And you know, we say it back to you, Jack. Perfect.

Chair Peters:

Thank you so much. I love that. My daughter said that to me sometimes: Perfect mom. I love the perfect baby too, though. I am going to use that with her now.

Assemblyman Hibbetts:

I would like to thank you for bringing the bill. It is wonderful. My question is for Jack. Can you tell me what your lapel pin is?

Jack Rovetti:

I do have one on my lapel. This guy just gave this to me. He was a little bit crazy—not actually too crazy.

Diana Rovetti:

Do you remember where we were when you got this?

Jack Rovetti:

I got it here in this building.

Diana Rovetti:

I think it is Las Vegas police, and he got it when we were in this building.

Assemblyman Hibbetts:

As a retired sergeant from the Las Vegas Metropolitan Police Department, I would like to commend you on your lapel pin.

Jack Rovetti:

Thank you. I like your pin, too.

Assemblyman Hibbetts:

Thank you. I will trade you.

Chair Peters:

The Assemblyman needs one of those as well.

Assemblywoman Newby:

I am not familiar with Jack's Popcorn, but I have a feeling I will be very soon. This question is for Assemblywoman Brown-May. In the literature referenced here, I am assuming there is some standard for this literature. Looking at it, it talks about evidence-based information that is provided. From testimony today, we know that the moment can be very overwhelming. I want to make sure, and not necessarily legislate this, but I would hope that the literature would be accessible and understandable and not necessarily overwhelming for the parents. Could you speak to your experience with literature in this area?

Assemblywoman Brown-May:

We went back and forth relative to this specific piece because we wanted to make sure we got it right. Subsection 2 states that the State Board of Health may adopt regulations. It would be our wish that a referral to the National Down Syndrome Organization, a local Down syndrome organization, or Nevada 211 be made so people are not left mourning a baby that could be a beautiful birth for them. We do not necessarily want pamphlets printed out or available in offices. It is not meant to be that way or to be outdated. So, it is simply the availability of technological resources for a person to find information. That is our hope through the regulatory process.

Chair Peters:

As a parent, I have had three children, and each time birth happens, you are on your own to figure out how to sleep with that child, how to change a diaper, how to do all those things. There are not a lot of resources out there for parents, so I can only imagine what it feels like when you have other factors weighing into caring for your baby. Maybe this is an opportunity to start looking at how we support parents better when they are having babies, regardless of how those babies are born. That was the last question I had on my list, and we can move into support testimony. We will move into support testimony in our physical locations starting here in Carson City and moving to Las Vegas.

Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities:

I am not providing testimony. I am providing support to Ms. Alysa today, and I will be helping her give her testimony.

Alysa Marquez, Private Citizen, Gardnerville, Nevada:

My name is Alysa Marquez, and I am her intern.

Catherine Nielsen:

Alysa and I spent some time putting this testimony together. I am going to read it on her behalf.

My name is Alysa Marquez, and I am the intern for the Nevada Governor's Council on Developmental Disabilities. I am 20 years old. I was born in Carson City, Nevada, in 2003, and I live in Gardnerville. I love to participate in the Special Olympics. My favorite sports are flag football, swimming, bowling, and bocce ball. I have also participated in beauty pageants for seven years. Last year, I was named Queen. I love to draw, play princesses, color with my crayons, markers, and paint. I am in my second semester at Western Nevada College studying general studies. My favorite classes have been pottery and sign language. I love to go shopping, spend time with my mom, dad, sister, and my service animal Girl who has joined us today. I love listening to music and singing to Taylor Swift. I love to go on trips with my family. My favorite trip so far has been to Disneyworld. I was one of the first people in Douglas County to graduate with an alternative diploma, and I have

an ABLE [Achieving a Better Life Experience] account. When I get older, I would like to work for the state of Nevada in an office. My goal is to join the 700-hour program and gain full-time employment for the State. One day, I would like to live on my own in my own apartment. I am working hard to make that happen. I was born with Down syndrome and a congenital heart defect known as atrial ventricular septal defect. Currently, 1 in 240 babies each year in the United States is born with this heart defect. Many children with and without Down syndrome are born with the same condition. When I was two-and-a-half months old, I had open heart surgery to correct my condition.

Having Down syndrome does not impact my long-term life expectancy; it is the same as a person born without Down syndrome and with the same heart condition. It is important that we talk to parents about Down syndrome and the health conditions that may accompany this diagnosis. However, it is also important that we tell them how beautiful their life will be. We must also tell them their child may be born with no medical conditions at all. They must also know their child, regardless of their Down syndrome diagnosis, will have a beautiful life. Requiring that providers tell parents all aspects of their child's condition rather than just the negatives that may be. I love my life. My life is valuable. The work I do is important. The last thing I would like you to walk away with is to remember that my name is Alysa, and I am downright awesome.

Chair Peters:

Thank you so much for the testimony and for being here today. It is not a surprise to me that you won the beauty pageant.

Ellen Marquez, Private Citizen, Gardnerville, Nevada:

I am the self-advocacy coordinator for the Nevada Governor's Council on Developmental Disabilities, but today I am here as a proud parent of a young adult with Down syndrome. I support A.B. 116 because 21 years ago when I had an amniocentesis, I was told my daughter would be born with Down syndrome. There was no explanation or information given to me. The only comment was, there are books you can read about Down syndrome and what her future will look like. Well, those books were outdated and mostly explained all the medical issues she could be born with and about institutionalization. This was disheartening, but I still looked forward to the day I would meet my precious girl.

Moving forward to when she was born, the doctor confirmed she had Down syndrome but otherwise appeared healthy. Later that day, the hospital social worker came in, and with no compassion asked, is she going home with you? My thought was where else is she going? Is someone coming to take her from me? She gave very little information or resources to contact. Supporting A.B. 116 will give parents who get the diagnosis of Down syndrome the information and support services to understand Down syndrome is not the end of their child's life. It is the beginning of a new and different adventure. Even though it may be challenging

at times—my daughter had open heart surgery at two-and-a-half months—they are now part of a diverse and supportive community.

Our children are the future of our communities and live long and prosperous lives. They go to school with their peers learning alongside their friends and can graduate with the alternative diploma, the parallel curriculum to the standard diploma. They can be employed and attend college. This is what parents need to be aware of when they receive the diagnosis of Down syndrome. My daughter Alysa is a perfect example of what can be for a person with Down syndrome.

Ashlee Cooper, Manager, Advocacy and Government Affairs, Opportunity Village:

I will be very brief as you have heard all these wonderful things. I am the manager for advocacy and government affairs for Opportunity Village, and we happily and enthusiastically support this bill.

Nate Boyack, Executive Director, State of Nevada Association of Providers:

Our member organizations provide services to thousands of people diagnosed with developmental disabilities throughout the state, and many of our agencies support individuals diagnosed with Down syndrome. We support all educational materials that may be helpful to families looking for community and medical supports related to this diagnosis.

Lisa Holmquist, Founder, CEO, Down Syndrome Connection, Las Vegas, Nevada:

I am the proud mom of Peter, who is 25 years old and has Down syndrome. I am also the founder and CEO of Down Syndrome Connections, Las Vegas. We are a 501(c)(3) corporation that helps people in the Down syndrome community, providing education, advocacy, resources, and support. We serve all ages zero or prenatal to adult, and we also promote research that helps people with Down syndrome be healthier, live longer, and be fully included in our society alongside all of us. We actively support new and expectant parents through our trained parent-mentor teams. They support people who have received a diagnosis, either prenatal or as a new parent. We highly support this bill for two reasons. The first is that physicians typically do not give a lot of Down syndrome diagnoses in their careers. The incidence of Down syndrome is between 1 in 700 or 800 live births. As a result, it is not something they are consistently delivering, but we want them to have best practices and support when they do have to deliver the diagnosis, so the people who are getting the diagnosis feel hope and not fear, and they are not afraid. Secondly, one of the things we consistently hear from our new parents is that they wish they were connected to support groups sooner in the process. This bill would provide information that is updated and in one place so health care professionals can provide a one-stop shop to give them all the support groups in Nevada. For that reason, we ask you to support the bill.

Chair Peters:

I do not see anyone else in Las Vegas. Is there anyone on the public line with support testimony on Assembly Bill 116?

Steven Cohen, Private Citizen, Las Vegas Nevada:
Ditto.

Dora Martinez, Private Citizen, Reno, Nevada:

I represent the Nevada Disability Action Coalition and want to thank you for this bill. Assemblywoman Tracy Brown-May, Jack, Ellen, and Alysa: You are the bomb. I hope you will support this bill.

Chair Peters:

Is there anyone else on the public line for support testimony? [There was no one.] We will come back to testimony in Carson City.

Travis Mills, Private Citizen, Reno, Nevada:

I am here to support this bill, and I am friends with Jack Rovetti. He does a lot of things for me. He has been an advocate for me. He has taught me a lot of things and he has been really helpful as an advocate for me. I work; I do a thing called "Tennis Buddies" [Tennis Buddies of Reno] for people with disabilities. We help tennis groups learn how to play tennis. We have Down syndrome, and we have all sorts of people with disabilities get together and socialize and have a good time. It is all fun, really fun. We also have the iCan Bike program where we help people with disabilities learn how to ride bicycles. We have Down syndrome, and all the people get together.

Christina Ugalde, Executive Director, Down Syndrome Network of Northern Nevada:

I also have a personal connection to Down syndrome. My nephew Sebastian was born with Down syndrome almost seven years ago. He is going to be seven years old later next month. When they received the diagnosis, it was a very scary time for my sister and her family. Unfortunately, they did not know about the Down Syndrome Network as I was not there at the time. It was a year, or maybe two years, before she connected with the network, and since she found them, I started volunteering. I joined the executive board, and now I have turned it into my passion, my career. This is what I do because I am so invested in making sure my nephew lives a full and happy life because everyone deserves that chance. If she could have gotten the information a little bit sooner, she could have been connected to this network that provides so many amazing resources for families. We want people to start their lives with as much hope as they can, and this bill is going to help a lot of people. I hope you pass it.

Chair Peters:

Thank you. In the support testimony, we have created a good list of resources that should be available to folks. Is there anyone else in our locations who would like to provide support testimony before we move on to opposition testimony? [There was no one.]

[[Exhibit E](#) is written testimony in support of [Assembly Bill 116](#) that was submitted but not discussed and will become part of the record.]

I will open opposition testimony in our physical locations. If you would like to provide opposition testimony to Assembly Bill 116, please come up to the desks. [There was no one.] Is there anyone on the public line who would like to provide opposition testimony on Assembly Bill 116? [There was no one.] We will move into neutral testimony in our physical locations. Is there anyone in Carson City or Las Vegas who would like to provide neutral testimony on Assembly Bill 116?

Sarah Watkins, representing Nevada State Medical Association:

We share the sponsor's goal for this bill. Children and their families should have access to any and all resource information. We are not sure the mechanism in the bill is the best way to get information to the family, and we plan to sit down with the sponsor to discuss it more.

Chair Peters:

Have you had the opportunity to meet with the sponsor?

Sarah Watkins:

Yes, we have been talking with her.

Chair Peters:

All right. Thank you so much. Is there anyone else in the physical locations for neutral testimony on A.B. 116? [There was no one.] Is there anyone on the public line for neutral testimony on A.B. 116? [There was no one.] I will invite the bill sponsor and her cosponsors to the table for final remarks.

Assemblywoman Brown-May:

We would like to offer our sincere thanks for having the opportunity to present this bill and for talking about how wonderful people with Down syndrome are. We look forward to following up later.

Chair Peters:

Jack, I would love to speak with you later and connect the dots to see if you were in my class. We will close the hearing on Assembly Bill 116 and move on to Assembly Bill 179.

**Assembly Bill 179: Establishes the Perinatal Quality Control Collaborative.
(BDR 40-98)**

Assemblywoman Michelle Gorelow, Assembly District No. 35:

I am the immediate past chair of the Southern Nevada Maternal and Child Health Coalition, also known as the MCH Coalition; past chair of the Nevada State MCH Coalition; and currently sit on the MCH coalition steering committee. I was also a member of the Governor's Association Improving Birth Outcomes and the Nevada State Collaborative Improvement and Innovative Network, also known as COIN, for three years. Maternal and child health is my thing, and I am excited to be here.

It is my pleasure to present Assembly Bill 179, which aims to establish a perinatal quality collaborative in Nevada. With me today is Dr. Brian Iriye, president of Hera Women's Health, a national collaboration of top women's health care providers. He is also the managing physician at High Risk Pregnancy Center. Dr. Iriye and I have known each other for about 15 years, and it is my honor to be working with him on this important piece of legislation to improve the health of mothers and babies. He will be providing background information on what a perinatal quality collaborative (PQC) is, and we will be doing that after I give you more background on maternal child health.

In an average week in Nevada, 647 babies are born, and of those, 72 are born preterm. That is almost 4,000 preterm births a year in Nevada, which equates to about an 11.2 percent preterm birth rate, which gets Nevada a D-minus grade on the March of Dimes report card [[Exhibit F](#)]. Las Vegas is doing even worse with a grade of F on the report card with an 11.6 percent preterm birth rate. The Nevada preterm birth rate among Black women is 39 percent higher than the rate among all other women. In 2020, 156 infants died, which translates to an infant mortality rate of 4.6 per 100,000 live births. However, I want to point out that was an abnormal decrease for Nevada in infant mortality. In 2009, it was 5.7, and in 2018, it was 6.2 per 100,000 live births. The national average is 5.4. In the exhibits, you can see that information in the Nevada report card.

Nevada ranks poorly for women's and babies' health outcomes overall. For example, between January 2020 and December 2021, there were 1,168 identified severe maternal morbidity cases in Nevada. The rate of severe maternal morbidity increased between 2016 and 2021 from 126.5 to 205.6 per 10,000 deliveries. Severe maternal morbidity is thought to be 60 times greater than mortality, and there are dramatic increased costs for that. Nevada also has one of the lowest family medicine, pediatric, and gynecological physicians per capita nationwide, as well as a high percentage of women who are uninsured during pregnancy. Research demonstrates that major costs result from subsequent neonatal care and not from pregnancy itself. This suggests we need to concentrate efforts on improvements in perinatal care to prevent unnecessary catastrophic outcomes for mothers and babies and reduce overall care costs as well.

Assembly Bill 179 is about establishing a statewide perinatal quality collaborative which typically focuses on identifying and implementing evidence-based practices that address gaps in patient care. These may include practices related to prenatal care, labor and delivery, neonatal care, and postpartum care. Collaboratives also work to establish standard protocols for care and to identify and address variations in care across different health care facilities. At this time, I would like to turn it over to Dr. Brian Iriye so he can talk more about the collaborative, and then I will go over the bill and the amendment [[Exhibit G](#)].

Brian K. Iriye, M.D., Managing Partner, High Risk Pregnancy Center, Las Vegas, Nevada:

I am here to support A.B. 179 and thank you, Madam Chair and Committee members, for letting me speak. I wanted to go over this in detail so you understand what a collaborative does and does not do and the positives of what a collaborative can create for Nevada as we

are 1 of only 2 states out of 50 in the country that do not have a collaborative. My background is varied [page 2, [Exhibit H](#)]. I am a former president of the Society for Maternal-Fetal Medicine in the United States, which is the largest high-risk pregnancy organization in the world and the most prestigious. I am the president of Hera Women's Health, which is a national integrated health care model. I have been the director of two national workshops in the United States. I am the author of over 25 research articles, and currently serve as the primary national investigator for the PRIME [premature risk assessment] trial, which is a \$20 million funded study in the U.S.

Why do we need a collaborative? We need a collaborative because of what Assemblywoman Gorelow was talking about—the U.S. maternal mortality rates. If you look at it in teal at the bottom [page 3], the maternal mortality rate in 2017-2018 was 17.4 per 100,000 births. If you compare us to other developed nations, we are at least double the average and in some cases triple that. We also have a high spend on what we do as well and that creates a big problem. Furthermore, when you look at maternal mortality in Nevada, we used to be a little bit better than other places in the country, but—we are the blue and the United States is the orange [page 4]. You can see the relative increase in maternal mortality in Nevada over the last decade. This gets even worse when you compare it to the uneven burden of U.S. maternal mortality in African-American women who have disparity of 2.9 times the maternal mortality of white non-Hispanic women and higher than that of Hispanic populations as well [page 5]. The Centers for Disease Control and Prevention (CDC) states the reasons are variations in health care, underlying chronic conditions, structural racism, and implicit bias. To bring an example to you that might hit home, everybody knows the story of Serena Williams who had a history of pulmonary emboli, was not placed on medications after delivery to prevent it from occurring. When her pulmonary embolism occurred, she had to beg and plead to be started on medications to save her life, and, thank God, she did.

In Nevada, our problems are even worse. Here is pregnancy-related mortality rate by race—63 per 100,000 in the United States [page 6]. This is the highest rate of African-American maternal mortality anywhere that records this number in the United States, so we have an immense racial disparity as well. Assemblywoman Gorelow was talking about cost and was talking about maternal morbidity. We not only have a health and equity issue, but we also have a cost issue as well. Since 50 percent of almost all births are Medicaid-related, this is a big issue for our state with severe maternal morbidity at 60 times greater [page 7, [Exhibit H](#)]. If you look at the costs—and this is 2013 data, so over a decade ago—the disparity and cost was 40 percent, and these numbers have probably doubled since that time.

What does a collaborative do [page 8]? It is a statewide team of people involved in improving quality of care for pregnancies. They look at key health care and quality processes and use evidence-based practices to push forward methods to improve and make changes. We really need this in Nevada because we have to improve quality, which will improve outcomes, which will decrease cost. Also, when you put protocols in place, you take the judgment and implicit bias out of issues, and you decrease racial disparities as well. I would recommend this eventually be considered as a mandatory participatory process for all of our hospitals in the state. As stated before, we are one of only two states that do not

have a collaborative or one that is in the formation process. I have been before the Legislature, now, for almost five years trying to push for this collaborative. Earlier, there were about 16 states without one. Now, we are in the final two. We did not move on the Maternal Mortality Review Committee until Nevada received a grant, and that put us behind in looking at this for the processes in our state.

A collaborative is a group of expert health care providers, public health people, and patient advocates working together to improve quality and safety for mothers and babies during pregnancy, childbirth, and in the postpartum period [page 9]. We need it because adoption of standards of care is slow [page 10]. The average time it takes for something to be standard of care in a research article for implementation for 50 percent of people to implement it is 17 years. What collaboratives do is take this modern information, push it forward, and get it into places where it is needed. In obstetrics and gynecology (OB-GYN), this is even more exacerbated because many of the OB-GYN groups are one, two, or three people, and you do not have teams pushing things together for women on a larger basis to get things done.

I want to go over the successes of collaboratives in other states and why 48 states have one. This is the California maternity quality care collaborative model [page 11]. They started in 2006. If you look at the slide, the U.S. rate of maternal mortality is in the red and California is in the blue—one-third the rate of maternal mortality rate in California. They have the data now up to 2016, and their maternal mortality rate is now 5.9 while the U.S. rate at that time was about 23, so this is something you can see has worked in other places.

I want to give you specific examples of what they do and what they do not do because people misunderstand what collaboratives do. They think they might get involved in processes that are more natural, and they are not; they are evidence-based and move to create care that is improved and decreases disparities. I do not think anybody is against improved care and decreasing disparities. The California maternity quality care collaborative put out a hemorrhage protocol [page 12]. Hemorrhage used to be the number one cause of death for women in the United States about 15 years ago. Now it is number four because these collaboratives put together a hemorrhage protocol. They developed a detailed means of documenting hemorrhage. It sounds silly, but people used to estimate hemorrhage. Now, they document hemorrhage, which allows earlier diagnosis and treatment, and then they have treatment protocols for it. They reduced maternal mortality from hemorrhage by 36 percent and reduced maternal morbidity, which is a cost driver, by another 21 percent.

In Ohio, they implemented an antenatal steroid protocol [page 13, [Exhibit H](#)]. Steroids are used for babies at increased risk of preterm delivery. When those babies are given just a single shot or two shots, they accelerate lung development in the fetus. If babies get them two to seven days prior to delivery, their lung development is increased. In Ohio, steroid use was increased, and respiratory distress was decreased in infants by 14 percent, which also decreases neonatal intensive care unit (NICU) rates, and NICU costs are immense and the main driver of costs.

In Texas, they had an alliance for innovation of maternal health, or AIM prenatal quality collaborative, and they put in a hypertension protocol [page 14]. About 15 or 20 years ago, a study came out that if you were treated quickly with antihypertensive agents to decrease severe blood pressure, you eliminated almost all deaths from stroke in these women. So, they developed this protocol to treat severe hypertension and hospitals that have implemented this protocol had a 34 percent lower incidence of severe maternal morbidity related to hypertensive disorders, again, decreasing costs. Illinois also had a similar result in decreasing costs.

There is a national Alliance for Innovation on Maternal Health that is under the American College of Obstetricians and Gynecologists [page 15]. They also put out some protocols for the states to use and found that hospitals that implemented an obstetric hemorrhage protocol to decrease postpartum hemorrhage had a 21 percent lower incidence of severe maternal morbidity when compared to other states and other hospitals that did not. It not only happened in California but is reproducible state-to-state. It is important for us to know if we do something like this in our state, we will get similar results. New Jersey implemented a hemorrhage protocol and hypertension protocol and had a 50 percent reduction in maternal death and a 29 percent reduction in severe maternal morbidity [page 16]. You can see that these protocols you put in place actually save lives, decrease morbidity, decrease costs, and hopefully, also decrease disparities.

We can go into other realms as well. Texas initiated a breastfeeding protocol, and they had a 5 percent increase in exclusive breastfeeding and 15 percent overall increase in breastfeeding [page 17]. The Michigan OB Safety and Improvement Program collaborative implemented a protocol to reduce early elective deliveries prior to 39 weeks and they decreased that from 27.5 percent to 4.5 percent and decreased NICU admissions by 30 percent from 9.9 percent to 6.8 percent. Again, NICU is a major driver of costs. The New York State perinatal quality collaborative implemented a neonatal safe sleep program which decreased the rate of sudden infant death syndrome.

In our state, we could develop a standardized protocol for the treatment of neonatal exposure to opioids, and we should have a dramatic savings in NICU costs. The average baby taken care of with opioid use disorder spends 16 days in the neonatal intensive care unit at an average cost of about \$10,000 a day. One of our hospitals in Las Vegas that has a great protocol decreased that to an average of 4 days which is a 12-day savings. That is something we definitely can do.

What do collaboratives do [page 18, [Exhibit H](#)]? They identify and prescribe protocols for high morbidity and mortality cases and decrease them by addressing the root causes. They look at inconsistencies in care in emergency situations that lead to poor outcomes to try to drive down disparities by helping standardize processes and increase system readiness while following evidence-based guidelines, which takes 17 years to get out to the population. They increase collaboration: when people work together and work as a team, we all do better. Perinatal care has a wide range of providers who are in smaller groups—OB-GYNs, midwives, neonatologists, nursing staffs, large and small hospitals, rural and urban centers—

quality collaboratives raise all boats by collaborating with each other and improving communication and teamwork. It will also allow us to get data, and when you get data, it allows you to drive improvement as well. There is this thing called PDSA cycles which is plan, do, study, act. That is what you do; you get the study, and then you act, and then you plan again, and then you do, so you create a constant improvement process. It would also decrease overall costs by decreasing maternal morbidity and NICU admissions. Remember, 50 percent of all births in the state are Medicaid-related.

So, what do collaboratives also do [page 19]? They get evidence-based practices based on scientific research; collaborate with providers; share resources; and promote cost effectiveness. In the United States, the Centers for Medicare and Medicaid Services is now asking two questions of all hospitals for births [page 20]. It is a two-part question: Does your hospital or health system participate in a statewide or national perinatal quality collaborative? We would be one of two states saying no to that question every time. We are late to the game, but it is time for PQC formation because it is constantly asked for now by CMS, and that will drive hospital participation as well. As I stated, Nevada was 1 of only 14 states without a perinatal quality collaborative in 2019 [page 21]. Now, we are one of only two states without a perinatal quality collaborative, so I am asking for your support because maternal mortality and morbidity is too high, and it is preventable. Health care inequities need to be addressed. Major costs to the system and from subsequent neonatal care can be lessened, and it really focuses on evidence-based medicine and not natural birth processes. We need to concentrate efforts on improvements in pregnancy care to prevent unneeded catastrophes happening within our current system.

Everybody should remember that although you spend on these things, spending on pregnancy is really the ideal preventative cost savings because it treats two patients for the price of one. It alters a lifetime of health for a baby in the future and allows that baby to have a mother in the future. I want to say that pregnancy care overall is value-based care. I not only ask for your support, but four years later, as a physician, I am begging for your support on this bill. Thank you for allowing me to have this time.

Chair Peters:

Before we go into the bill language, I think everyone on the Committee has had ample time to review the initial bill language. Would you go over the changes proposed in the amendment and then we can move into questions.

Assemblywoman Gorelow:

I want to talk about what this collaborative is not. We have received emails, and there have been misunderstandings on what it is. This does not dictate how or where a woman gives birth. This is to make sure wherever she decides to have her baby, she has the safest birth for both her health and her baby's health. This is not a special interest lobbying group. This is something I brought when I worked with the March of Dimes back in 2009 or 2011. At that time, I was doing a lot of perinatal quality work as well as working on elective deliveries before 39 weeks, so this has been around for a little bit. I want to point out that the word "control" before "collaborative" will be stricken from all of it. It is a perinatal quality

collaborative. In section 3, I have changed that the collaborative "may" consist of the following members to give a little bit of flexibility on who would be in the collaborative [page 1, [Exhibit G](#)]. Also, we added and changed a couple of things regarding who may be members. It is the Dean of the School of Medicine at the University of Nevada, Reno, and we are also adding the "University of Nevada, Las Vegas, or another accredited school of medicine within the state of Nevada." And again, it could be one, it could be three or four. This is up to the collaborative. They can decide how many members, but the one thing I do not want is to have a collaborative of 100 people. That makes it defunct. Again, it is in the regulations that they can determine these items

We want to make sure there is a representative that is a perinatologist. It mentions obstetricians and gynecologists, but it does not mention a perinatologist. I said a representative of each hospital system to take some of the burden off the hospitals, but as Dr. Iriye pointed out, we would like them all to participate. It is flexibility. We want to make sure it is flexible for them. We want a representative from at least one birthing center, so we have those voices. I did have some questions about why a mother was not on here. That is a voice that should be put on here at some point. It does not limit them; a mother can be on, but when I was speaking with Dr. Iriye, usually in the beginning stages, because this is medical, there is not that voice yet, and later on it is put on. Again, it is flexibility.

I want to point out in section 3, subsection 10, the collaborative may apply for and accept grants, gifts, and donations. That was brought to my attention by someone concerned about it. Some of this can be funded through the Centers for Disease Control and Prevention (CDC) which currently funds, I believe, 27 states, but South Dakota is in a gray area. Sometimes they are included in the funding; sometimes they are not, and I am not sure why.

Back to section 3, subsection 9, the meetings of the collaborative are closed to the public. This is in line with several other organizations, and I wanted to talk a moment about that. We are talking about sensitive information. This is medical information. It is Health Insurance Portability and Accountability Act (HIPAA)-related. The Maternal Mortality Review Committee's meetings are also closed, so I am looking at the same language that group has for their closed meetings.

To make a point, last week, I was talking about two separate people. One was a pregnant woman; one was a child I worked with in early intervention—two separate people. I did not mention their names. But based on some of the vague information I gave, they both knew who I was talking about. I do not want people to be able to figure out the sensitive information we may be talking about, whether it is a mother who passed or had a severe complication. It is a HIPAA violation, so I want to put on the record that is why this is closed. However, just like the Maternal Mortality Review Committee, we are adding in a section that they have to come back and report to the Joint Interim Standing Committee on Health and Human Services. Also, their findings need to be on the website, the same website where the Maternal Mortality Review Committee has its report, so those findings will be available for people. This is not trying to hide anything other than sensitive personal information.

We will also be adding a section 7 or section 8 concerning the effective date. This will be effective upon passage and approval of adopting any regulations and performing any other preparatory administrative tasks necessary to carry out the provisions of this act, and effective on January 1, 2024, for all other purposes. I also modeled that after the Maternal Mortality Review Committee language.

Assemblywoman González

Thank you, Dr. Iriye, for the slide show. A lot of my questions were answered in the slide presentation. We talked about the great things all these other boards have done in other states. Is there anything in the bill that talks about what happens if folks do not comply with the protocol? If anyone does not adhere to the protocol recommendation, what does that look like?

Brian Iriye:

This is something that raises all boats. You may remember from college, there is nobody worse than the premed student who wants to get ahead of you for their grade. It is the same thing for physicians, and it is same thing for people in hospitals. Their data will go out on these studies and protocols, and they will find people who are above average, and they will find people who are below average. The people who are below average always want to try to do better. The people who are above average are now in a position where they can help others and explain why something might have not been as successful in one area as another. This is not about a punishment. This is more about trying to lift all boats by putting protocols in place, education in place, and collaborating to make everybody get assistance.

Assemblywoman Gorelow:

Sometimes, if these protocols are put in place, the insurance companies will put in restrictions on payment. For example, elective deliveries prior to 39 weeks. If they were to deliver a woman because she liked the really cool birth date, which did happen in the early 2000s—there are a lot of designer birthdays—they would not pay for those births. There are ways to prohibit bad behavior.

Assemblywoman González:

This board would make a protocol and then the protocol would be mandatory. Is that correct?

Brian Iriye:

The protocol would be prescribed. There are two things about protocols. One is, they are educational. When you have a protocol in place, now the physician and the care team know the one best way of taking care of something, and they will follow that protocol. Usually what happens within hospitals if you have fallout from protocols, you will have meetings about why people fell out of the protocol and why they should not fall out of the protocol and how to prevent that in the future. When you see protocols, everybody is trying to get them to 100 percent. Can people say that they do not want to do them? Sure, they could, but usually what happens in a hospital, if something is best evidence-based and the hospital agrees it should be done a certain way, and if somebody does not follow it, it usually goes through an

internal committee process within the hospital. Then the physician or the care team needs to explain why they did not follow the protocol, and that usually ends up handling the circumstance.

Assemblywoman Taylor:

Thank you for bringing this forward. Those statistics, especially for women of color—in particular African-American women—are no surprise, but it is a wake-up call whenever I see them. Certainly, we want to protect all children, all births and mothers as well, and in particular those who are most vulnerable. Does this bill make anybody do anything other than the creation of the collaborative and hiring of the executive director?

Brian Iriye:

In all the places around the United States that have collaboratives, none of the collaboratives make anybody do anything. When you put a protocol in place, doctors follow protocols because it makes your life easier to follow a protocol because the order set is already there. It is in the computer; you do not have to order anything. You say, institute the hemorrhage protocol, and it goes step by step through it. It is also done in a way that is much more rapid. So, everybody realizes that there are improved outcomes. We have a protocol at one of our hospitals right now, and the people falling out are getting exactly what I said. They end up going to committee, being asked why they are falling out of protocol and how they can avoid falling out of protocol and why it is below the standard of care for evidence-based practice. If it continues to happen, they could be sent for remedial education or they could be taken off staff. But that is not where you want to go. You want to educate people to make them better. You want to make them understand why they are falling behind and to raise all boats. The idea of a collaborative is not to be a strong arm, but to be something that lifts all boats.

Assemblywoman Newby:

Thank you for this bill. It is long overdue. Where will the collaborative be getting the information? Is it just from the hospitals, just from the birthing centers? What about births that occur outside?

Assemblywoman Gorelow:

This is actually the working arm of other groups such as Fetal Infant Mortality Review, Maternal Mortality Review, and Child Death Review down in Las Vegas, which looks at fetal demise as well. It is going to take their findings and identify and call out problems. This is a working arm. They will be looking at the aggregate data to make those decisions on protocols.

I want to bring up a point Assemblywoman Taylor mentioned about racial disparities. In 2003 is when the March of Dimes launched the prematurity campaign. We received our first report card in 2008, which was 2006 data. At that time, Asian Americans had the lowest preterm birth rate, and it stuck in my head because I was trying to plan programs targeting certain groups. I thought to myself, oh, great they are already below the preterm birth rate goal, so I do not have to worry about them. I could spend my time targeting African-American women and Native-American women. They are now the third highest.

I would hope at some point these groups looking at morbidity and mortality might find a reason that they are now the third highest, because I have no idea. I am hoping these groups can look and then again, this collaborative will be able to go out and make those changes.

Chair Peters:

Are there other questions from the Committee? [There were none.] We will start with support testimony on Assembly Bill 179 in our physical locations and then go to the phones.

Connor Cain, representing HCA Health Care:

I am here to testify in support of Assembly Bill 179, which as you know establishes the perinatal quality control collaborative. On behalf of HCA Health Care, we take pride in caring for many of the most vulnerable babies throughout the state at Sunrise Children's Hospital's 72-bed neonatal intensive care unit, which is the largest and most comprehensive in the entire region. Many of you have had the privilege of visiting the NICU at Sunrise Children's Hospital and might remember seeing babies weighing just a few pounds who are sometimes experiencing withdrawal from illicit drugs they were exposed to in the womb. Hearing those babies cry is absolutely gut-wrenching. The team at Sunrise works miracles not only to comfort these babies but also to provide lifesaving care. We applaud the goals of this collaborative to work on issues like the one I just described by decreasing the number of infants born with neonatal abstinence syndrome and urge your support of Assembly Bill 179.

Blayne Osborn, representing Nevada Rural Hospital Partners:

I am here in support of A.B. 179. Suddenly, only three of our critical access hospitals in the state still offer routine delivery and obstetrics services. Those occur in Fallon, Winnemucca, and Ely. All three of those would be represented on this collaborative. We are happy to be participating and engaged in these important discussions.

Jesse Wadhams, representing Pediatrix Medical Group:

Pediatrix Medical Group is the largest provider of NICU services to Nevada's preterm babies, including, 12 years ago, both of my nine-week-preterm sons. We are proud to support A.B. 179. I will not reiterate the many benefits you have heard about collaboratives. Pediatrix uses collaboration across its practice units and has seen the benefits of care across its entire operations. We appreciate this bill, we appreciate your consideration of it, and thank you for your time.

Alex Tanchek, representing Nevada Advanced Practice Nurses Association:

The Nevada Advanced Practice Nurses Association wishes to support A.B. 179 and believes the work of this collaborative can help improve the care of mothers and children throughout Nevada. We also want to extend our appreciation to Assemblywoman Gorelow for the inclusion of the certified or professional nurse midwife on this collaborative.

Sarah Watkins, representing Nevada State Medical Association:

We are here in support of A.B. 179. We wanted to express our gratitude to the sponsor for meeting with our team and taking our initial concerns into consideration. We have several members who serve on the existing Maternal Mortality Review Committee and Child Death

Review Teams. The amendment tailors the focus to prenatal health, which is not currently reviewed by the existing committees, but it is certainly an important public health topic worthy of formal review. Additionally, this bill promotes dialogue among the committees, which is important in painting a full picture of the life of the individual under review. We thank you for your time and the sponsor for bringing this bill forward.

Katie Roe Ryan, Director, Public Policy, Dignity Health-St. Rose Dominican:

I am here today in support of A.B. 179. I want to echo what Dr. Iriye and my colleagues before me have said. It is time for us to pass this bill.

Tess Opferman, representing Nevada Women's Lobby; and Human Services Network:

We support this bill and urge you to pass it and join the 48 other states that already have collaboratives.

Elyse Monroy-Marsala, representing Children's Advocacy Alliance; and Nevada Public Health Association:

The PQC's are an evidence-based strategy which the Nevada Public Health Association supports. As Dr. Iriye mentioned today, these collaboratives have been shown to decrease the number of premature births and maternal mortality. Also, the Nevada Public Health Association is named as a member in the bill and looks forward to helping do this really important work to improve health outcomes for all Nevadans. [The Nevada Public Health Association provided an additional letter in support [Exhibit I](#).]

Lea Case, representing Nevada Psychiatric Association:

Several of our members are interested in working with this collaborative. They work in the High Risk Pregnancy Center. They are working with women who are pregnant and dealing with substance use issues or serious mental illness. This will be a good step. Also, Nevada should not be the only state without this collaborative.

Chair Peters:

Seeing no one else approaching the desk in Carson City and no one at the desk in Las Vegas, we will check the public line for support testimony on Assembly Bill 179.

Paula Luna, Operations Manager, Battle Born Progress:

We are in support of A.B. 179, and we thank Assemblywoman Gorelow for spearheading this critical measure. This bill establishes a perinatal quality control collaborative which will be responsible for finding measures to reduce premature birth, maternal morbidity, and infant mortality. We know that the maternal mortality rate for women of color is proportionately higher than it is for white women, and we are happy that one of the objectives of the collaborative is to reduce the disparity. Hopefully, this will lead to less maternal mortality for women of color. This measure is a necessary step to further ensure this body prioritizes maternal and infant health now and for future generations. We are committed to support A.B. 179.

Chair Peters:

We are having trouble with the phone line, so is there anyone who would like to provide opposition testimony to Assembly Bill 179?

Kathleen Palmer, Private Citizen, Carson City, Nevada:

I have several concerns about A.B. 179. It is redundant. We already have two boards that address these issues—the Maternal Health Advisory Board and the Maternal Mortality Review Committee. I am concerned about the lack of transparency this board would have. Assembly Bill 179 states that the board will meet in private. That means citizens will not be able to review the proceedings even though we, the taxpayers, would be paying travel expenses and per diem allowances for the participants. Data should be anonymous enough to be in compliance with HIPAA so the meetings can be shared with Nevadans. I am looking for transparency and accountability from my government.

Chair Peters:

Thank you for your testimony. Is there anyone else to provide opposition testimony on Assembly Bill 179? [There was no one.] We will check for opposition testimony on the line and then go back to support testimony as there are callers on the line.

Nancy Jones, Board Member, Health Freedom Nevada:

I am a parent, a resident of Nevada, and a board member of Health Freedom Nevada. We are a nonpartisan, grassroots, 100 percent volunteer organization representing approximately 5,000 Nevada families. We serve as the Nevada affiliate of both Children's Health Defense and Stand For Health Freedom—national organizations whose missions align with ours. Our founding principles include the right of every citizen and every parent or guardian—in the case of a minor child—to true and full and informed consent to any and all medical and pharmaceutical interventions, to religious freedom and parental rights in all personal health care decisions.

We oppose A.B. 179 because it increases the opportunity for regulatory interference on the private practice of medical doctors and midwives in the state of Nevada. Personalized care with the patient having a voice and acting as an informed advocate for herself or himself is essential. Health Freedom Nevada is in favor of improving health outcomes for all babies and mothers across the state, yet we oppose this being pursued by a state-endorsed collaborative that takes its cues from the pharmaceutical industry, federal bureaucracies, and the private organizations with their own agendas. In particular, we wish to make it clear we oppose having federal bureaucracies of unelected officials such as those at the CDC be given preferential influence in the affairs of practitioners in the state of Nevada.

We are also in opposition to this bill because the proposed collaborative would be devoid of representation from mothers in the state of Nevada, and the meetings would be closed to the public. The collaborative would be given private medical data and wide license to enact as an overly broad commission. We urge you to oppose this bill.

Katie Banuelos, Secretary, Libertarian Party of Nevada:

The Libertarian Party of Nevada is in opposition to [A.B. 179](#). I am also speaking as a mother of two who chose home birth and the support of a midwife rather than going to a hospital and exposing myself to a far greater risk of intervention. This proposed collaborative threatens to place an unwanted regulatory burden upon midwifery and mothers in our state. Its entire purpose is to develop and push a top-down set of standards of care. This threatens to harm alternative practitioners and mothers who choose to have their prenatal care and birth take place outside the traditional hospital setting. There is also no guarantee that the collaborative will have the right answers. With centralization of authority comes the risk that bad ideas are forced on everyone. There is not always one best way to take care of everyone, because every person and situation differs. Giving one entity the authority to dictate protocols for everyone is inherently risky. Any recommendations should be optional, and practitioners should be free to follow their consciences without penalty. Childbirth is a deeply personal experience, and every mother should have the right and opportunity to seek the care best suited to her needs. We urge you to vote against this proposal, or at a minimum, amend the bill such that governance authority applies solely to hospitals and will not impact midwives or mothers who choose alternative arrangements. [The Libertarian Party of Nevada supplied a letter in opposition [Exhibit J](#).]

Chair Peters:

Are there other callers in opposition? [There were none.]
[[Exhibit K](#) in opposition was submitted but not discussed and will become part of the record.]

I would like to open support testimony on the phone lines again.

Farzat Kamyar, Private Citizen, Las Vegas, Nevada:

I am a psychiatrist in the state of Nevada calling in support of this initiative to get the collaborative care called for by the PQC. Dr. Iriye and everyone have done a fantastic job of providing evidence and presentations. Something that specific to mental health, which is my forte, of course, all the different patient safety bundles are important, but just as a reiteration, two of them are specific to mental health that includes perinatal mental health disorders and substance use disorders. As an example of how this would play out would be collaborating and providing standards and protocols that would call for something like all practitioners in the state, regardless of the location of the birth, screen for perinatal mental health and substance use disorders. I do not find that it dictates what has to be done, it just provides best practices. At the end of the day, everyone wants to do right by their patients and wants optimal outcomes for both mother and baby. Every Nevadan deserves the right to better care, better evidence-informed care, and better outcomes.

Chair Peters:

Are there other callers in support of [Assembly Bill 179](#)? [There were none.]

[[Exhibit L](#), [Exhibit M](#), [Exhibit N](#), and [Exhibit O](#) in support were submitted but not discussed and will become part of the record.]

We will move into neutral testimony in our physical locations.

Helen Foley, representing Nevada Association of Health Plans:

The Nevada Association of Health Plans is a statewide trade organization representing ten member companies providing commercial health insurance and government programs in Nevada. We thank you for the opportunity to testify in neutral. Our members are supportive of the creation of the perinatal quality collaboration or collaborative and look forward to working alongside other stakeholders on improving care for both mothers and babies. However, we do have some questions we would like to continue to work with the sponsor to clarify, specifically in section 4, subsection 4, paragraph (d). The section notes the collaborative is entitled to information from medical facilities and providers of health insurance concerning the cost of perinatal care and other information that the collaborative requires. While we appreciate what the collaborative seeks to accomplish, the language does remain broad, and we hope to work with the sponsor to narrow the definition on what falls within the umbrella concerning the cost of perinatal care. We have connected with Assemblywoman Gorelow, and we appreciate her willingness to work with us on this important bill.

Chair Peters:

Thank you for your testimony. Is there anyone else in Carson City or Las Vegas with neutral testimony on Assembly Bill 179? [There was no one.] Is there anyone on the call line with neutral testimony on Assembly Bill 179? [There was no one.] Would the sponsor care to make any closing remarks? Assemblywoman Gorelow is waiving closing remarks. We will close the hearing on Assembly Bill 179.

We will open the hearing on Assembly Bill 259 which revises provisions governing wages for persons with disabilities.

**Assembly Bill 259: Revises provisions governing wages for persons with disabilities.
(BDR 39-13)**

Assemblywoman Tracy Brown-May, Assembly District No. 42:

This is an issue that has come before this body on multiple occasions, and I have always been in opposition, so it is interesting that I am here presenting the bill. We are working off a conceptual amendment today [[Exhibit P](#)]. In the audience is Jessica Adams, deputy administrator of the Division of Aging and Disability Services in the Department of Health and Human Services here in Nevada. We worked very closely on this bill. As I begin, it is important for you to note this bill pertains to the industry I work in. It affects all the provider organizations. I have spent a number of years working in disability services, and this bill is specific to that industry.

We are here to consider the evolution of disability services in Nevada. We are going to talk about subminimum wages. Very often when I bring up the topic of subminimum wages for people with disabilities in Nevada, I get that it does not belong in the Health and Human Services Committee because it is about wages and labor law. The peculiarity about this issue

is that it affects people with disabilities, so, in Nevada, it falls under *Nevada Revised Statutes* (NRS) Chapter 435 which governs how we support services for people with developmental disabilities, which is why it is here. I am going to give you a little bit of history. The Fair Labor Standards Act (FLSA) was considered landmark legislation back in 1938. What it did was enabled provisions regarding overtime, wages, and youth employment. It talked a lot about employment issues and was excellent and wonderful landmark legislation. Section 214(c) of the FLSA is the piece that addresses employment of people with disabilities and was designed at that time to provide employment for veterans who were returning from war. In 1938, we did not have any understanding of the capabilities of a person with a disability in competitive employment. This mechanism was meant to encourage the employment of veterans with missing limbs. That was the original section of law.

Over the years, the usage of the Fair Labor Standards Act and section 214(c) has evolved and was utilized during deinstitutionalization in the 1970s as a way for community provider organizations to engage people with developmental disabilities in a productive activity where they could receive compensation at the rate at which they were producing. It was a great tool and is still utilized by some providers here in Nevada, although those numbers continue to diminish. Over the years, there have been many efforts to lift people with developmental disabilities in competitive integrated employment as utilized by our advocates federally while working toward equity and inclusion for people with disabilities in our community. The Workforce Innovation and Opportunity Act was signed into law by President Obama and shifted how we look at employment activities and integration for people with intellectual and developmental disabilities. It stopped the pipeline of youth with disabilities aging out of high school and into sheltered workshops. Those sheltered workshops have now evolved, and they are different. They are day activities programs that provide a different level of support services, so over the years, the provider network has worked diligently to decrease its reliance on subminimum wages.

This bill continues the transition in Nevada and helps support the provider network that is working to support people with disabilities. It shores up both the nonprofit agencies that are working to support people with disabilities and the people with disabilities who are working toward employment activities. Three things are important to know. This bill eliminates subminimum wage certificates from Nevada, effective January 1, 2028, which is in two renewal cycles. There is a transition period; it is not meant to stop quickly. That is two renewal cycles for existing organizations that have certificates. It provides for time and a transition plan for jobs and day training providers serving people with disabilities, and it requires the Division of Aging and Disability Services to amend the State Home and Community Based Services waiver to include benefits planning, which is a barrier many people with developmental disabilities face when looking for employment opportunities. They do not understand how to maintain Medicaid benefits or other federal or state benefits as they pursue employment opportunities.

Who is affected by this bill? Currently, there are five organizations in Nevada with active 14(c) Department of Labor certificates. Together they serve a total of 148 people with disabilities, and two of those organizations are currently in the process of transition.

Together, they serve 125 of those people. They are in the process of transition right now, which will be done over a two-year period of time. That leaves three organizations that serve a total of 24 people. The last time this bill was presented, we were serving over 1,000 people with developmental disabilities and ten organizations.

I want to show you the amount of work that has been done to help the provider organizations successfully transition. Related to this, although not in this bill, the State has worked diligently to fund Direct Support Services under the Medicaid waiver, so there is a projected rate increase for those provider organizations to continue to enhance the levels of support they provide. The waiver rewrites requested in this bill will help increase the support services to engage people in community employment, where appropriate, and access day activities that are unpaid. This bill separates employment opportunities at or above the minimum wage from day activities and other pre-vocational rehabilitation programming that is provided.

Now, I will walk through the conceptual amendment [\[Exhibit P\]](#). Section 1 identifies the section of law we are looking at is NRS Chapter 435, which is disability services. Section 2 defines the meaning of "competitive integrated employment," which is equal to the federal identification of that language. Section 3 requires jobs day training (JDT) providers that have existing subminimum wage certificates to create a transition plan for the people they are currently serving, and it sets the transition deadline of January 1, 2028. It requires the plan to be submitted to the Division of Aging and Disability Services (ADSD) for its review. If ADSD does not determine it is an appropriate plan, the Division can ask for a resubmission from the JDT provider. Section 4 indicates that a person receiving services on a subminimum wage certificate may choose an advocate, and if they do not have an advocate who can help them through their process, one may be requested through the Division. Section 8 identifies a deadline for new entry into subminimum wages as January 1, 2025, so any new student transitioning out of high school into a center-based training program can no longer enter into a subminimum wage program as of January 1, 2025. That gives a full year to develop a new transition program.

Section 11 requires the Division to apply to the Secretary of Health and Human Services to amend the state waiver to include benefits, counseling, job coaching, and job development where it does not cross over with the Division of Vocational Rehabilitation. We have some people who would be served through rehab. Those who do not qualify for rehab services would be served under the Home and Community Based Services waiver. Section 12 eliminates subminimum wage certificates issued under section 14(c) of the Fair Labor Standards Act from Nevada in its entirety. That is the amendment.

Chair Peters:

Are there questions on the bill?

Assemblyman Gray:

With the elimination of the subminimum wage waiver and raising their wages, would this make disabled people ineligible for other benefits through social security or any other things they may be getting? Could this actually do more harm than good?

Assemblywoman Brown-May:

The answer is no, because the person is not going to work part time or full time. We are not talking about 20 hours at minimum wage. We are talking about incremental employment, but when they are productive, they should be paid at a rate that is minimum wage. That is why the benefits planning piece is written into the waiver, so the person with a disability who is considering moving into that does not jeopardize any of those other federal or state benefits. We would never want a person who has an expensive medication covered by Medicaid to go to work for \$15 an hour and not be able to afford their medication. This benefits planning piece is an important component. Currently in Nevada, the Nevada Disability Advocacy and Law Center does benefits planning. The Center cannot do benefits planning until a person has a bona fide job offer. This helps us plan on the front end by including that in their waiver plan so there is no harm done.

Chair Peters:

Are there other questions from the Committee? [There were none.] We will go ahead and move into support testimony in our physical locations.

Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities:

I am here to help Alysa provide her testimony.

Alysa Marquez, Private Citizen, Gardnerville, Nevada:

My name is Alysa Marquez, and I am an intern.

Catherine Nielsen:

Her testimony states:

I support A.B. 259 because when I worked at a day care in 2019, I did not get paid to help the younger children. I was told I was a volunteer. There was another worker who got paid regular wages that had me doing her job. My mom told the director of the day care, and that person was let go. When the pandemic closed the day care, I stayed home. When the day care opened again, my mom asked if I wanted to go work again at the day care. I said no because they do not pay me. I want to make money so that I can buy stuff and get my own apartment. I have my own checking account and savings account, and I have an ABLE [Achieving a Better Life Experience] account. I like to work, and I like going every day. I want to get paid so my mom does not have to pay for everything. It makes me feel good when I can buy my own stuff.

Chair Peters:

Thank you, and thank you, Ms. Marquez. I just want to say I like your elephant. They are my favorite animals, too. I have one on my water bottle.

Ashlee Cooper, Manager, Advocacy and Government Affairs, Opportunity Village:

We are really excited to support this bill.

Marc Christensen, Member, Executive Board, State of Nevada Association of Providers:

We represent 22 disability providers that contract with the State of Nevada to provide disability services. Our organization is in full support of A.B. 259. Thank you for allowing me to testify today.

Chair Peters:

Thank you for your testimony. Are there others in Carson City or Las Vegas who would like to provide support testimony on Assembly Bill 259? [There was no one.] Is there anyone on the phone line who would like to provide support testimony on A.B. 259?

Steven Cohen, Private Citizen, Las Vegas, Nevada:

Ditto.

Paula Luna, Operations Manager, Battle Born Progress:

We support A. B. 259 because every single Nevadan deserves to have equitable wages. We thank Assemblywoman Brown-May for championing this measure. Individuals with disabilities should not be paid less than minimum wage, and A. B. 259 rights this wrong. Pay equity includes persons with disabilities. With this body moving the needle forward on raising the minimum wage in the previous session, A.B. 259 is another step in the right direction. We cannot imagine paying an employee less than a state minimum wage. It is nearly impossible for individuals to provide for themselves, let alone a family if they are making minimum wage. Persons with disabilities should not be marginalized further by receiving inadequate pay. We urge this Committee to support A.B. 259 so we can work toward pay equity for persons with disabilities.

Dora Martinez, Private Citizen, Reno, Nevada:

I am with the Nevada Disability Action Coalition. We wholeheartedly support this bill and say thank you to the sponsors.

Chair Peters:

Next caller, please. [There were none.] We will move into opposition testimony in our physical locations. Is there anyone in Carson City or Las Vegas who would like to provide opposition testimony on Assembly Bill 259? [There was no one.] We will move into neutral testimony on A.B. 259 in our physical locations.

David Rovetti, Chairman of the Board, Alpha Productions Technologies Inc., Sparks, Nevada:

Alpha Industries is a supported work environment for people with disabilities. Currently we have 49 people with disabilities at our facility. We manufacture wire connectors, we put wire on connectors, and we have contracts with companies such as IGT and other electronic companies. Paying minimum wage, we could handle. We have an interesting business model in that we do not have any shareholders. We do not give out bonuses to the executive team. I do not really know why our executive director is working for us because he makes so little money. Yet we cannot raise our prices on the products we sell because we have competition, mostly from China, and our expenses continue to go up.

Adding minimum wage is something that needs to be done. It is something that is correct and something that we are going to do. However, I want to point out that there is one expense we have that, hopefully, will be corrected, but I want to make sure it is on everybody's mind—it is our cost for direct support staff. Currently, we augment the wages of the direct support staff, mainly because it has not increased in 19 years. It is pretty hard to find support staff for around \$10 an hour. That is a major expense of ours, and it is in our contract with Medicare that we have a certain number of support providers. It is my understanding that the Division of Aging and Disability Services will increase that, and with that in mind, we will be able to continue our business, hopefully. We have been around since 1976; that is 43 years. Hopefully, we can do another 43 years, but we will need that increase in payments to the direct support staff.

Chair Peters:

Is there anyone else in Carson City who would like to provide neutral testimony? [There was no one.] Will you check the public line for neutral testimony on Assembly Bill 259? [There was no one.] I would like to invite the bill's sponsor up for closing remarks if you would like.

Assemblywoman Brown-May:

As we close this bill hearing, I want to thank you for the opportunity to hear this bill and to point out that this is pivotal to the future of the provider organizations that are serving our community. I would be remiss if I did not acknowledge the years of dedicated effort it has taken for those organizations to transition their business models away from a subminimum wage opportunity for people with disabilities and into an enhanced day training opportunity. You have heard the testimony. It is a difficult thing to do, and the organizations that do it are doing it because they love to serve people with disabilities who are marginalized in our communities. So, thank you very much for hearing this bill today.

Chair Peters:

We will close the hearing on Assembly Bill 259 and open the hearing on Assembly Bill 283.

Assembly Bill 283: Makes changes relating to doula services. (BDR S-844)

Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6:

Today we have quite the presentation for you on Assembly Bill 283 which seeks to increase funding and payment for birth doula services. I would like to give you a bit of background. In 2021, we brought a bill, A.B. 256 of the 81st Session, which, for the first time in the history of Nevada, allowed for birth doula services to be covered by Medicaid. That bill passed through both houses and was signed into law. We went through a process of registering doulas, clarifying their roles and education requirements, and getting them onboarded. That took until April or May of last year. The issue that has arisen is the pay for these doulas, who have four to six meetings with their client plus the birth, is a grand total of \$450, and we wondered, with the amazing work doulas do, why we were unable to get doulas to sign up. We know that intervention and assistance of doulas help us have vaginal births with the least number of issues, but we cannot expect folks to do this type of work at that dollar amount.

My copresenters are the experts, and I am going to let them tell their stories. It is important you know where they are coming from, what they do, and the beautiful services they offer for the children of Nevada to be birthed with love and care.

Emily Barney, Executive Director, Doula Co-op, Reno, Nevada:

I am a birth doula, a postpartum doula, and a death doula. I am practicing privately here in Washoe County and across the state of Nevada. If someone wants to fly me out there, I will go. I am also a newborn care and parent educator. I am the executive director for the Doula Co-op of Reno, a Nevada-based nonprofit that seeks to expand access to doula services to all Nevada families, focusing our work with the underserved and marginalized communities of Nevada.

In my work as a doula, I provide nonmedical emotional, educational, and community resource support for families and birthing people throughout their prenatal, labor, and postpartum periods [page 2, [Exhibit Q](#)]. What it means is that birth doulas like me are trained to understand and recognize the physiological processes of labor. We are able to translate this knowledge to parents and empower them to experience their birth in a way that addresses their fears and centers their needs. You will soon learn why doulas are effective at what they do, but I am going to tell you why [page 3]. We provide continuity of care. We coordinate across provider disciplines to help parents understand the resources available to them. We establish a relationship and trust prenatally that lasts through until three or four weeks postpartum. We are with them through it all. That includes facilitating comfort and safety and confidence in labor and then normalizing, validating, and listening to their experiences postpartum so they feel less alone.

The work I do for my clients is deeply rewarding. I am called to serve the families, and I have a talent for this work. It is also physically demanding, emotionally impactful, and very time consuming. There was a time-use study out of San Francisco that stated the estimated time doulas spend with their client is 50 hours a month doing client care and support

[page 4]. Those are not just numbers, that is my life. Those are the hours of my life and the time that I spend every day with clients working directly and indirectly to coordinate their care. When I spend 12, 24, or 40 hours in a row supporting clients through their labor and birth, that means I have to be able to drop the responsibilities of my personal life and support my clients through what is the transformational moment of theirs. Due to demand on my time and energy, I can only take one or two birth clients a month and my fee for that is \$1,500. Under the current Medicaid legislation, the work I do is unsustainable [page 5, [Exhibit Q](#)]. To join the population of Medicaid birthing families in the past year alone, I needed to work four jobs in order to make ends meet. Considering that I am an independent contractor of the state and incur expenses and taxes as a small business owner, working with the Medicaid population is impossible for me to do with the current reimbursement rate. I would need to be taking three or four Medicaid clients for every one client I am taking privately.

What was previously unsustainable is now insurmountable. Without being paid a living wage, doulas are simply not incentivized to work with Medicaid clients, which leaves these families without support and program dollars underutilized. Doula work is my world, my livelihood, and my purpose, and passing this bill means I and other doulas can continue to do this valuable work.

Joyce Abeng, Public Health Diversity Advisor, Larson Institute for Health Impact and Equity, School of Public Health, University of Nevada, Reno:

I work at the Larson Institute at the University of Nevada, Reno in public health research. In today's presentation, I am serving as a subject matter expert and will not be advocating for or against the bill but providing information. According to the 2020 and 2021 Maternal Mortality and Severe Maternal Morbidity Report, Nevada's maternal mortality rate from 2018 to 2020 was 19.2 for 100,000 live births. That is higher than the Healthy People 2030 objective of 15.7 per 100,000 live births [page 7]. Healthy People 2030 are data-driven national objectives set by the U.S. Department of Health and Human Services to improve health and well-being over the next decade. As these statistics show, we are falling behind. From 2017 to 2018 in Nevada, Black non-Hispanic Nevadans had a mortality rate that was 4.3 times higher than rates for non-Hispanic Nevadans and 5.2 times higher than Hispanic Nevadans. There are a considerable number of well-researched studies showing that doula care is a high-value model that improves childbirth outcomes, increases care quality, and can achieve cost savings for managed care organizations in the state Medicaid program.

Cost analyses have found that doula care can reduce overall spending by avoiding unnecessary medical procedures and the potential complications and chronic conditions that may result in reducing neonatal intensive care unit (NICU) admissions and fostering health practices such as breastfeeding. In the 2017 Cochrane Review, there were 27 randomized controlled trials that studied the effects of continuous labor support, including doulas [page 8]. Overall, those who received labor support had decreases in unwanted medical intervention, which includes a 39 percent decrease in the chance of unplanned C-sections and overall anxiety and pain. Many studies have shown that doula support provided during pregnancy, birth, and the postpartum period lowers the rates of cesarean deliveries.

According to estimates in Nevada, caesarean births cost \$3,000 to \$5,000 more than vaginal deliveries [page 9]. Doula support also reduces rates of prematurity and illness in newborns and the likelihood of postpartum depression. Post-caesarean pain is a common problem with significant health and economic impacts on the individual patients as well as on society. Caesarean delivery, while we call it a birth, is major abdominal surgery, and the healing process post-caesarean is lengthy and costly.

Across the nation, Medicaid reimburses doulas for their time, providing continuous labor support during birth and prenatal and post-natal visits [page 10, [Exhibit Q](#)]. Many states are pursuing ways in which doula services can be reimbursed at a living wage. A sample of the states are Washington, D.C., Rhode Island, Michigan, California, New Jersey, and Oregon. Washington, D.C., is reimbursing \$683.22 per birth and \$97 per visit. Rhode Island is reimbursing \$900 per birth and \$100 per visit. Michigan is reimbursing \$700 per birth and \$75 per visit. California's reimbursement fee is \$1,154. New Jersey's reimbursement fee is an average of \$1,198, and Oregon's Medicaid program has been working on increasing the reimbursement rate to \$1,500. Rather than continuing with statistics, I am excited to introduce May Chin, who is not a statistic but a mom, a new mom whom, with help of a doula provided by the Medicaid program, was able to receive support for the birth of her first child just last week.

May Chin, Private Citizen:

I am a foreigner, a single mom without family support in the U.S. She is my first baby, which means I did not have any labor experience. I got emergency Medicaid assistance based on my status. By chance, when I was 37 weeks pregnant, I met with two doulas, Sue and Angela. They were willing to assist me with my labor. During the 37 hours of labor, my obstetrician/gynecologist (OB-GYN) would like to do a C-section to have my baby. However, we tried for 36 hours to avoid it. My two doulas suggested alternate options and my doctor choose to do a vacuum extraction—which worked—and my baby came into the world [page 12]. Thanks to my doula being there with me and mentally and physically supporting me during the 37 hours of labor, I avoided having a C-section.

Jollina Simpson, Doula, Las Vegas, Nevada:

Thank you, Madam Chair, and thank you, May, for sharing your birth story. This is the impact of doula work. May is the mother of a 10-day old newborn, and she was willing to join us today to share her story and advocate for more doulas supporting Medicaid clients. That is powerful. In the 81st Legislative Session, this body approved A.B. 256 of the 81st Session—doula services reimbursement by Medicaid because they saw the value of doulas for birthing families in Nevada. In the fiscal note for A.B. 256 of the 81st Session, future savings for the State were approximated at \$1.2 million. That savings was only based on the difference between vaginal births and caesarean births, but that savings will only be realized if doulas who enroll can earn a living wage while working with the Medicaid population.

I would like to offer a little more information on the savings not brought up during the 81st Session. As Ms. Abeng stated, C-sections are associated with a risk and complications

in future births. In addition, many birth parents experience physical ailments in the months following their birth such as infection and other cardiovascular conditions that can lead to death. Also, women on Medicaid who have a doula have 22 percent lower odds of delivering preterm, which can lower NICU admissions. Finally, in 2013, the Centers for Medicare and Medicaid Services (CMS) did a study that reported doula-supported births at a near universal breastfeeding initiation rate of 97.9 percent compared to 80.8 percent in the general Medicaid population. Among African-American women, that percentage was 92.7 percent of initiation of breastfeeding compared to the Medicaid population average of 70.3 percent. We looked across the nation at states actively reimbursing doulas. The average reimbursement for all of those states is \$1,224 for eight visits, which includes prenatal, postpartum, and the birth. The current Nevada reimbursement is \$450 for seven visits, which is well below the national average. The rate increase proposed takes into account Nevada's 6.2 percent increase in cost of living and the accurate calculations of the time spent with our clients delivering services. It also includes the fact that doulas are small business owners subject to all the taxes and expenditures of a business, including our enrollment fees, continuing education, child care for our children, and health care for our families.

Now, let us do a little Nevada math. We currently have 7 enrolled doulas and 11 more in the pipeline. By the time we finish this session, we are looking at 18 doulas. Those 18 doulas can take an average of 2 clients per month for the year equaling 432 births. If we follow the Nevada caesarean section rate, which is approximately 33 percent, that will equal 142 births out of the 432 of those doula-attended births. But we know from Joyce's testimony the Cochrane Review noted there is a 39 percent reduction in caesarean births when attended by a doula. If we adjust those 142 births accordingly, it will go down to 87 births. The cost difference between 87 and 142 caesarean births is approximately \$1,748 per person each year. With the doula rate increase up to \$1,500, there will be a savings of \$248. That is a pretty big drop, but in the fiscal note from the 81st Legislative Session, that savings was approximately \$900. When we look at the savings, there is a smaller savings, but there is still a savings to the State. The fiscal note for A.B. 256 of the 81st Session was only looking at vaginal and caesarean births.

There are greater savings with doula-supported births than just the numbers between vaginal and caesarean births. Doulas provide support and advocacy in ways that our medical system often cannot. We feed the humanness of our birthing persons and families; we care for them in community because we care deeply about our community. Research has shown that doula care can help mitigate some of the negative social determinants of health such as poverty and systematic racism which can impact birth outcomes in all populations, but especially in Medicaid populations. Doula care provides clients with lower medical interventions, provides them with agency, feeling of personal security, respect, and autonomy. Doulas provide knowledge transference, and connectedness to the community in communities of color, rural environments, and low income; this translates to long-term savings for the state of Nevada. We cannot and should not sacrifice the livelihood of doulas to achieve that end.

Assemblywoman Summers-Armstrong:

I think my copresenters have done a much better job than I ever could have done. We do have a conceptual amendment [[Exhibit R](#)]. We had some discussions with the folks at the Department of Health and Human Services (DHHS), and recently, the federal government has brought in the proper funding codes for doulas, and which are delineated in the proposed amendment. They also readjusted the reimbursement amounts to be more in keeping with what we are seeing on the national average. With all the visits together with pre- and post-birth visits and the birth, it still comes out to be \$1,500. We believe that is fair and equitable for what is being done. At this time, we will be happy to answer any of your questions.

Chair Peters:

You did say that the amendment addresses the \$1,200 in here and modifies that to \$1,500, or did I misunderstand that?

Assemblywoman Summers-Armstrong:

Yes, it does modify it, Madam Chair.

Emily Barney:

The conceptual amendment modifies the current procedural terminology (CPT) codes to be Healthcare Common Procedure Coding System (HCPCS) codes which are doula-specific codes that have now been approved as Medicaid codes. Those are non-medical codes as we are a non-medical profession, and that would lower the rate for the code for labor and birth, which differentiates between the codes for prenatal and post-natal visits. What we are doing in the amendment is asking for \$900 per diem for presence at the labor and birth rather than the CPT codes that have been provided in the original bill. The visits, both pre- and post-natal, would be raised to \$100 a visit with a maximum of 60 minutes per visit, and there would be six visits in the total pregnancy. The package comes to a total of \$1,500—\$900 for the birth and \$100 for each visit up to six visits.

Chair Peters:

Thank you for that clarification, and that is similar to the Rhode Island model, I believe, from your presentation.

Emily Barney:

It is exactly the same.

Assemblywoman Summers-Armstrong:

As a point of clarification, currently, the doulas are paid \$50 for their prenatal and post-partum office visits and \$150 for a birth, just to make it clear.

Chair Peters:

We have a question from a Committee member.

Assemblyman Nguyen:

I did sign on to this bill as a cosponsor. I know we are not the money committee, so I am not going to ask the money question, but since the bill on doula eligibility passed last session, what has been done in terms of outreach? Are the Medicaid populations aware of these doula services? I had to look up the definition in my native language and did not even know that it is available in these types of environments. Even as a parent going through the process, I was not aware of it. I support the fact that we need to compensate all of our professions the right way, and that is not the question here. The question is, how has the outreach been done and what have been the results?

Jollina Simpson:

Each health management organization has been handling its own outreach, and many of them are currently running pilot studies where they help enroll Medicaid recipients into those pilot studies. That is a lot of the outreach being done. On the ground with community organizations such as the Doula Co-op of Reno and in Las Vegas, we are actively recruiting doulas to fulfill the needs of the Medicaid population.

Assemblyman Nguyen:

To follow up on that in terms of what Ms. Barney said earlier about underserved communities, those come with language barriers. How has outreach been to these types of communities?

Emily Barney:

The Doula Co-op of Reno was created in response to the passing of Assembly Bill 256 of the 81st Session. We have been actively recruiting doulas to work, but it is hard to incentivize doulas to work out of private practice. We started a program with Renown Hospital in Northern Nevada called the Doula Access program. We realized that there are doulas hungry to work in this population. We also realized there is a large Hispanic Spanish-speaking population serviced by Renown. The Doula Co-op is an independent nonprofit organization, and we hired a Spanish teacher to teach our doulas Spanish and specific medical terminology that works with doulas and doula language and the clients to create some continuity between the care they are receiving and what we can provide. So, we are working on it, and we know that is a barrier. With more support and more money going towards us working with this population, we can serve a greater population and a diverse language base as well.

Assemblywoman Summers-Armstrong:

Are you asking for the doulas or the recipients, those in need of the service?

Assemblyman Nguyen:

There were two parts of my question, the first one was the recipient, and the second part was the organization itself in terms of reaching out and ensuring that the underserved communities are being served.

Assemblywoman Summers-Armstrong:

What we see in many of our underserved communities that have either cultural or language barriers is that we do not have representation. If we can encourage folks to do this work and be paid a living wage, I think we will see more participation across the board. When we do not value the work women do, we do not get them to do this type of work and be able to sustain their families. My hope is that as we are working diligently to increase the pay, to make it reasonable for folks to do this, it will spread. We will then be able to see women of every ethnicity joining in to learn and be trained and registered to do this work. As the word spreads, it will get into those communities. I do not know what process DHHS is doing for outreach. It may be a matter of coordination now that we finally have a process in place. There may be some openings for us to do some things in the languages that are commonly spoken, but we have to coordinate that and figure out where DHHS is financially with their marketing program.

Chair Peters:

Thank you for the comments and questions. Are there other questions from Committee members?

Assemblywoman Taylor:

As you presented, is it currently that doulas get for \$450 for the entire situation? This is clearer than the bill, and it is saying at least \$1,200, but we are really shooting for \$1,500. Can you walk me through those numbers, or am I just not reading section 1 correctly?

Emily Barney:

The \$1,200 was for the delivery codes specifically. The bill language is sparse, so I understand the confusion. The \$1,200 is just for the delivery codes, plus \$50 for the six visits for a total of \$1,500. With the amendment, that would be shifted to \$900 for the labor and \$100 per visit.

Assemblywoman Taylor:

You need to make that connection. The visits are important, and I think they are included in the amendment piece. Make sure the \$1,200 and the \$50 do not work against each other.

Assemblywoman Summers-Armstrong:

Thank you for the observation, and we will definitely take that suggestion.

Chair Peters:

We will open support testimony on Assembly Bill 283 in the physical locations.

Samantha D'Andrea, Doula, Reno, Nevada:

I am a mother, a doula, a midwife, and a cofounder of the co-op here in Reno. I am in support of A.B. 283. I became pregnant with my daughter in 2011. I was 19 years old, on state insurance, and suddenly needed to make massive decisions. I wanted to be informed and did much tireless research, but I found it difficult to be taken seriously in my concerns as a young mother and my desires around my pregnancy and birth. Despite conflicting

information and anxiety, I decided that I wanted to birth without medication to encourage optimal bonding and success in breastfeeding. Instead, preventable complications led me to an emergency caesarean surgery. This was traumatic and disempowering for me personally, but it helped me realize the need for birthing people to have access to personal support and more readily available information regarding their care. This lit a fire in me, and I became a birth worker in 2013. I have had the privilege of supporting many people through many aspects of their reproductive lives.

By its very nature, this work has shown me how vital the doula's role is in bridging the major health care gap we have. The unique care doulas provide is difficult to quantify because it allows for the mental, emotional, and spiritual health of the individual, the newborn, and the family to be an active part of the care plan. Better outcomes are unattainable if we only value the allopathic aspect of care. When I look back on my own experience, I see a great many ways in which a doula would have been immensely supportive. I wish for all people to have access to a doula's wide-ranging and personalized care, because doulas will continue to be key components in improving birth, birth outcomes, and experiences. Increasing the reimbursement rate for doulas working with Medicaid will help achieve this goal.

Claire Murdoch, Doula, Reno, Nevada:

I am a mom and a holistic birth and postpartum doula. I am a Nevada Board-certified doula, and I am currently in the process of becoming a Medicaid provider. I also intend to become a certified birth educator and a certified lactation educator. This year I have also practiced as a certified nurse assistant at Renown in the postpartum department. I have so much love and passion for the work I do, and I believe it is vital to the well-being of the Nevada birthing community. I want to be able to be financially able to serve the Medicaid families who deserve this care specialty that deserves fair compensation. We are not just holding clients' hands during labor, then walking away. We are changing the landscape of birth and making the maternal health care system a safer and healthier place. We invest so much of our own time and money into what we do, and we want to be able to reach a wider demographic that includes low-income families who especially need this help. So please, I urge you to vote in support of this bill so that doulas can serve those who need it most.

Natalie Powell, Director, Nevada Certification Board:

The Board strongly supports A.B. 283. The Nevada Certification Board certifies community health workers, peer recovery and support specialists, and prevention specialists. In 2021, the Nevada Certification Board was approached by Nevada Medicaid to certify doulas or develop certification for doulas as a prerequisite for enrollment in Medicaid as Medicaid providers. Birth doulas play a critical role in promoting health equity, reducing maternal and infant mortality and morbidity. It has been a privilege to be affiliated with this group of primarily women right now. I did want to address the question about representation. The Nevada Certification Board recently added a demographic section to all of our applications so we can see what type of representation we have in our certified specialists. We know there is a need for representation and outreach for all of these services. That is some data we are collecting, and we hope it will help us in outreach going forward. I want to end with the

fact that the Nevada Certification Board believes strongly in providing a living wage for doulas and all our certified specialists. Thank you very much and thank you to the sponsor.

Angela Heinemann, Assistant Professor, School of Public Health, University of Nevada, Reno:

I am also a doula in the Doula Co-op of Reno because it is not only exciting but very interesting and important work we are doing as doulas. I was at May Chin's birth and spent 30-plus hours in the hospital advocating for her and her birth, and it was really rewarding work. I can go on, but I think you have heard lots of important testimony about doulas and their importance, and I support A.B. 283.

Chair Peters:

Thank you, and thank you for your work in our community. Are there other folks in Carson City who would like to provide support testimony today? [There was no one.] Then, we will move to the phones. Is there anyone on the public line who would like to provide support testimony for Assembly Bill 283?

Paula Luna, Operations Manager, Battle Born Progress:

We are in strong support of A.B. 283. We thank Assemblywoman Summers-Armstrong for spearheading this critical measure. During pregnancy and childbirth, many individuals choose to have support from a doula or professional labor assistance. Physical and emotional support provided by doulas to a pregnant person and to their partner can help them feel supported, safe, and cared for during a critical time in their lives. Doulas play an important role in assisting with the birth of the child and support the parents. They should be paid adequately for doing such important work. Assembly Bill 283 sets in a path where doulas can be paid more fairly for the important work that they do. We urge the Committee to support A.B. 283 for doulas providing care for pregnancy and childbirth while being paid fairly.

Chair Peters:

Thank you for your testimony. Are there other callers on the public line?

Sue Foltz, Co-Founder and President, Doula Co-op, Reno, Nevada:

I am a doula. I retired from a 30-year career in laboratory diagnostic medicine. I am a mother of three and cofounder and president of the Doula Co-op. My passion for birth work started while I was a GED [general education degree] tutor at Casa de Vida. Casa de Vida is a residential nonprofit serving pregnant homeless teenagers in Reno. While I was tutoring these young women and building their trust, many of these future mamas asked me to coach them through their births. Wanting to support them, I studied and received two doula certifications. I knew after attending my first birth how vital it was to support the women in the Medicaid population, especially due to the lack of reimbursement for Medicaid services. I knew that I wanted to help start a nonprofit cooperative for doulas to support these at-risk mothers.

With the initial passing of the A.B. 256 of the 81st Session in 2021, I knew that the \$450 total Medicaid reimbursement for about 45 hours of work—equating to approximately \$7.78 per hour—was not a sustainable income for doulas in Nevada to support themselves. With the new bill, A.B. 283 presented today, and the proposed living wage from \$1,200 up to \$1,500 for Medicaid reimbursement per birth, it is significantly more motivating for birth workers to go through all of the training, extra certifications, and paperwork to become a doula Medicaid provider in the state of Nevada. This new bill will not only support a living wage for doulas but will save the state of Nevada in downstream health care costs for Medicaid-insured births.

Doula care has been researched thoroughly, and it is proven that doula care throughout a pregnancy, labor, and birth will decrease the numbers of medical interventions during birth leading to healthier outcomes for mother and baby. I strongly support A.B. 283, and I am confident and hopeful that this legislative body will see not only the health and well-being benefits for the Medicaid population and the cost savings to the State but will also respect the work of a doula and reimburse their work at a living wage. As a side note, I supported a Medicaid mother as a doula earlier this month, and her labor and delivery lasted over 37 hours. At the current Medicaid reimbursement for labor and birth, I earned less than \$4 per hour. Can a doula afford to work for under \$4 an hour? Thank you for listening, and I would appreciate your support for this bill.

Mary Kilkenny, M.D., Reno, Nevada:

I am a board-certified OB-GYN. I work at Renown Hospital on Mill Street running the level 3 labor and delivery. I am also an associate clinical professor of medicine at the University of Nevada, Reno, School of Medicine. I support A.B. 283. We oftentimes find we have psychosocial challenges in caring for our Medicaid patients. There are huge gaps in care and support that more affluent patients take for granted. We desperately need to find a way to bridge those gaps and supporting A.B. 283 is a way to help provide care that is not forthcoming for patients who are often trying to bring a child into the world on their own with no support and no help.

Chair Peters:

Thank you for your testimony and for your work in our state. Are there other callers in support?

Jennifer Campbell, Doula, Reno, Nevada:

I am testifying in support of A.B. 283. I was a doula and lactation consultant for 12 years when I moved to Reno in 2005. I went through a divorce, and due to that I have primary custody of eight children at home. As the sole bread winner, I had to give up doing what I loved. I could not earn enough to support my family, and instead worked up to four jobs in the corporate world as the schedule was consistent and I could earn more. In 2007, my certifications lapsed, and it was an emotional low in my adult life. Like many doulas, I felt like this life chose me through experiencing my own first pregnancy and birth, both positive and negative things, but I could not give up helping other women. For my three subsequent birth experiences, I had a doula, and she made a significant impact on how well things went,

how supported I felt—a supported outcome where my well-being and experience were her primary concern. I also had a doula assist me through three of my miscarriages. My final pregnancy was a loss of twins at 16 weeks’ gestation. The emotional and informational support, her physical presence, and knowing I had someone in my corner assisted me in having such successful experiences, I wanted to pass it on to other women. Over 18 months ago, and 15 years after my certifications lapsed, I remarried. My husband asked me if I was ready to go back to doing what I love. We had to make some crucial changes to our finances so we could go to a one-income family and afford the coursework necessary and the time it would take for me to build a business.

Many of us also add specialties in addition to birth doula. Mine are certified lactation educator, adoption and surrogacy doula, and bereavement doula. Now that I have been in this space again for over 18 months, I can attest to the number of hours we put in and that we have a schedule that is in part unpredictable. The cost to become a doula—all administrative costs, gas and vehicle costs, day care for our own children, and we do not have a staff to help us become providers or do our billing. We are everything. Allow me to be clear; I love what I do. Unfortunately, I talk with pregnant women frequently who want a doula but cannot access one due to lack of income and insurance that inadequately covers the amount of work put in. I am 150 percent in support of A.B. 283.

Chair Peters:

Thank you so much for your testimony. Are there other callers in support? [There were none.]

[[Exhibit S](#), letters in support, were submitted but not discussed and will become part of the record.]

We will go ahead and move on to opposition testimony. Is there anyone in Carson City who would like to provide opposition testimony today?

Sarah Watkins, representing Nevada State Medical Association:

Many of our physician members work with doulas in the delivery room, and they understand the important value of their care for the birthing person. Our concern with this bill is the rate proposed exceeds most of the physician Medicaid fee-for-service rates, and I can submit those rates to the Committee if you would like to review them. For example, the rate for a physician to provide the service of a vaginal delivery with post-delivery care is \$1,070. Also, the certification process for a doula is significantly less than for an OB-GYN or emergency room physician, and we believe education, time, and financial commitments should be considered when studying these rates.

Chair Peters:

Assemblyman Hafen has a question for you, Ms. Watkins.

Assemblyman Hafen:

I was going to ask a question about a subject you brought up—how much the OB-GYN and the nurses who are part of the delivery are paid. Could you email that information to the Committee secretary so we could have that information to review?

Sarah Watkins:

Yes, I will be sure to email that.

Assemblyman Hafen:

I appreciate it.

Chair Peters:

We appreciate the follow up. Are there other folks who would like to testify in opposition today? [There was no one.] Please check the public line for opposition testimony on Assembly Bill 283. [There was no one.] We will move into neutral testimony on A.B. 283 starting here in Carson City. Is there anybody to provide neutral testimony? [There was no one.] Is there anyone on the public line to provide neutral testimony? [There was no one.] I would invite the bill sponsor up if she has closing remarks.

Assemblywoman Summers-Armstrong:

Thank you, Madam Chair and Committee Members, for listening attentively to our presentation and giving consideration to this bill. I will reach out to the speaker from the medical association to get some clarity and hope I can understand their position. We have not had a conversation previously, and I apologize that it did not happen.

In closing, I would like to tell you a story. It is 1987. I was a young, 25-year-old mom living very far away in a little town called Fischbeck, Germany, with my then-military husband, and we were having our first child. My mother was not able to come from California to be in this small town to help me with the birth of my first child. I was lucky enough to meet a woman and her name was Frau Busse. She was exactly what her name implies. She was a stocky, brown-haired German woman who was a midwife. She did not speak very much English, but I tell you what she did. She loved on me. She helped me birth my first two sons, Braden and Dexter, at the Cloppenburg Hospital. She was my lactation specialist. She was my birthing specialist. She was everything, and I could not have done what I did without medication if it had not been for Frau Busse and the love she gave me. Love is what doulas you heard from today are offering women who are Medicaid recipients. I was a poor wife of a staff sergeant in the Air Force. We were barely making it. It cost me \$120 for each of those births, and that included every visit to the doctor and all of the love and help I got from Frau Busse.

It makes a difference how babies are born. It makes a difference how moms are treated during the prenatal portion and post-partum. It makes a difference how that child comes into this world. I ask you all to consider in Women's History Month that women's work has value and that this bill be supported. Thank you so much for your help.

Chair Peters:

We will close the hearing on Assembly Bill 283 and move to our last agenda item of public comment. Is there anybody in Carson City who would like to provide public comment today? [There was no one.] Could you check the public comment line for folks who would like to provide public comment today? [There was no one.] Are there any closing comments from the Committee before we adjourn? [There were none.] With that, we are adjourned [at 4:45 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 the Work Session Document for [Assembly Bill 45](#), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

[Exhibit D](#) is the Work Session Document for [Assembly Bill 136](#), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

[Exhibit E](#) is a collection of letters and copies of emails in support of [Assembly Bill 116](#).

[Exhibit F](#) is a document titled "2022 March of Dimes Report Card," presented by Assemblywoman Michelle Gorelow, Assembly District No. 35, in support of [Assembly Bill 179](#).

[Exhibit G](#) is a conceptual amendment to [Assembly Bill 179](#) submitted and presented by Assemblywoman Michelle Gorelow, Assembly District No. 35.

[Exhibit H](#) is a copy of a PowerPoint presentation titled "Formation of a Perinatal Quality Collaborative," submitted by Brian K. Iriye, M.D., Managing Partner, High Risk Pregnancy Center, Las Vegas, Nevada, in support of [Assembly Bill 179](#).

[Exhibit I](#) is a letter dated March 20, 2023, submitted by John Packham, Ph.D., Policy Director, Nevada Public Health Association, in support of [Assembly Bill 179](#).

[Exhibit J](#) is a letter dated March 7, 2023, submitted by Katie Banuelos, Secretary, Libertarian Party of Nevada, in opposition to [Assembly Bill 179](#).

[Exhibit K](#) is a collection of letters and copies of emails in opposition to [Assembly Bill 179](#).

[Exhibit L](#) is a fact sheet titled "Perinatal Quality Collaboratives: Working Together to Improve Maternal Outcomes," submitted by Assemblywoman Michelle Gorelow, Assembly District No. 35, in support of [Assembly Bill 179](#).

[Exhibit M](#) is a collection of letters and copies of emails in support of [Assembly Bill 179](#).

[Exhibit N](#) is a copy of an article titled "The US remains a grim leader in preterm births. Why? And can we fix it?", dated March 16, 2023; reviewed by Emily Henderson, B.Sc., and submitted by Assemblywoman Michelle Gorelow, Assembly District No. 35, in support of [Assembly Bill 179](#).

[Exhibit O](#) is a letter dated March 21, 2023, from the Society for Maternal-Fetal Medicine, signed by Anthony Sciscione, DO, et al., in support of [Assembly Bill 179](#).

[Exhibit P](#) is a conceptual amendment to [Assembly Bill 259](#), dated March 20, 2023, submitted by Assemblywoman Tracy Brown-May, Assembly District No. 42.

[Exhibit Q](#) is a copy of a PowerPoint presentation titled "AB-283 Doula Rate Increase Bill: Investing in Nevada's future families," presented by Emily Barney, Executive Director, Doula Co-op, Reno, Nevada, et al., in support of [Assembly Bill 283](#).

[Exhibit R](#) is a conceptual amendment to [Assembly Bill 283](#) submitted and presented by Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6.

[Exhibit S](#) is a collection of letters and copies of emails in support of [Assembly Bill 283](#).