MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
March 2, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:31 p.m. on Thursday, March 2, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Fabian Doñate, Chair
Senator Rochelle T. Nguyen, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Senator Marilyn Dondero Loop, Senatorial District No. 8
Senator Melanie Scheible, Senatorial District No. 9

STAFF MEMBERS PRESENT:

Destini Cooper, Policy Analyst
Mary Ashley, Committee Secretary

OTHERS PRESENT:

John Packham, Policy Director, Nevada Public Health Association
Abbey Bernhardt, National Alliance on Mental Illness
Robin Reedy, Executive Director, National Alliance on Mental Illness, Nevada Chapter
Erica Freidenburgh
Lea Case, Nevada Psychiatric Association
Shanna Alves, National Alliance on Mental Illness
Tess Opferman, Human Services Network

Alex Tanchek, Nevada Advanced Practice Nurses Association
Sarah Watkins, Interim Executive Director, Nevada State Medical Association
Jimmy Lau, Dignity Health-St. Rose Dominican
Susan Fisher, Northern Nevada HOPES
Barry Cole, M.D.
Bill Beig
Megan Comlossy, University of Nevada, Reno, School of Public Health
Shawn Gerstenberger, Dean, University of Nevada, Las Vegas, School of Public Health
Vinson Guthreau, Executive Director, Nevada Association of Counties
Joanna Jacob, Clark County
Samantha Glover
Kristina Kleist, 7 Points LLC
Nathan Noble
Liz MacMenamin, Retail Association of Nevada
Wendi Schweigart, Founder, Project Marilyn

CHAIR DOÑATE:
We will begin with Nevada Public Health Association.

JOHN PACKHAM (Policy Director, Nevada Public Health Association):
The Nevada Public Health Association (NPHA) has submitted to the Committee its advocacy and policy priorities (Exhibit C) for this Legislative Session. Improving health and achieving health equity is NPHA's mission. The top priorities can be summarized into four categories. First, increase State funding for public health infrastructure. Second, strengthen the public health workforce. Third, advance evidence-based public health policy. Fourth, strengthen and safeguard public health authority.

The first priority, increase State funding, is necessary to improve Nevada's public health. The first infrastructure improvement is the coordination of public health agencies and health districts at the State and local level. The second infrastructure improvement is to invest in a qualified and diverse public health workforce. The third infrastructure improvement is modern data and information systems to rapidly understand and assess public health threats. In previous Legislative Sessions, NPHA supported efforts to establish a Public Health Improvement Fund. This funding should be stable and long-term with per capita funding. Adequate funding will allow local health authorities to address new and emerging health threats. In summary, infrastructure funding is required for those

agencies, people and systems needed to promote and protect the public's health. Senate Bill 118 represents an important first step in that direction and the Association fully supports it.

SENATE BILL 118: Revises provisions relating to public health. (BDR 40-334)

The second priority is expanding and strengthening the Nevada public health workforce. To accomplish this priority, it will require funding and associated policy change. In a later presentation, you will hear more from my colleagues at the University of Nevada, Reno (UNR), and University of Nevada, Las Vegas (UNLV), on how the schools are educating and training the next generation of public health professionals. It is critical to support existing staff and to bring new workers into the field.

The frontline public health workers have had a difficult three years. Everyone needs to support these workers and the work of public health schools in Nevada. In addition, there are other public health workers not necessarily trained in a school of public health. The top public health occupation is community health nursing and public health nursing. I am encouraged by the numerous bills in this Legislative Session addressing healthcare workforce development. Many of these bills appear to have bipartisan support. The healthcare workforce includes clinical workers, physicians and nurses. However, it should be broadened to include public health workers, health educators, an epidemiologist and community health workers.

The third priority is advancing evidence-based policy making in Nevada. To initiate change, it could require a policy change, additional funding or both. In Nevada, NPHA has made progress, but there is still work to do. One area is tobacco and e-cigarette prevention. We have made progress on tobacco prevention. However, vaping has risen to an epidemic level in middle and high schools. The NPHA has made progress in other areas such as injury and violence prevention. In every area where NPHA has had success, there are still challenges, including immunizations and vaccines of preventable diseases. The health community has had success but is still dealing with misinformation on vaccines, causing vaccine hesitancy.

Upstream evidenced-based measures are necessary to promote and protect the health of the public. It holds the promise of considerable returns on investment in the form of reducing downstream medical costs. Think of the cost savings to

the Nevada Medicaid program. If Nevada could reduce smoking rates among the Medicaid population, then the Medicaid-eligible population could be reduced by a third or a half.

The fourth and final priority is a relatively new one. It is safeguarding public health authority, particularly in the face of political polarization. Safeguarding public health authority includes supporting and strengthening the authority and flexibility of public health officials at the local, State and national level. These officials need to issue and enforce public health emergency orders and threats to public health. Protecting the physical safety of public health officials and frontline public health workers is essential. This population has endured all kinds of abuse over the last three years. The abuse is on top of comparatively low wages, low morale and demanding workloads. Policy-making bodies, such as the Nevada State Legislature, cannot legislate social solidarity overnight or reverse the Nation's declining trust in institutions. However, safeguarding the authority of State and local public health officials is at the top of NPHA's agenda.

In conclusion, the NPHA has a vision of a healthy Nevada. This requires policy makers to support funding and evidence-based policy measures. This is tackling upstream determinants of health. Most population-focused public health measures are consistent with recent public and private efforts to advance health equity. Public health has focused on health equity for many years. Two examples are community water fluoridation and the virtual elimination of many vaccine-preventable diseases. I am reminded of the quote by Paul Wellstone. "We all do better when we all do better."

SENATOR STONE:
You discussed vaping and your desire to reduce tobacco use. You said it could decrease the cost of Medicaid and Medicare in the future. Vaping is prevalent for a whole new generation of children and young adults who are getting addicted to nicotine. What can public health do to educate the population? Tobacco use is a dangerous habit causing future morbidity and mortality. Children are experimenting with vaping devices, and there is a whole new generation of people who are addicted to cigarettes.

MR. PACKHAM:
Flexible funding for State and local health districts and public health authorities is a great start. Each one of the three health authorities: Carson City Health and

Human Services (CCHHS), Southern Nevada Health District (SNHD) and Washoe County Health District (WCHD) have very active, vibrant tobacco control programs. However, these health authorities do need additional staffing.

Nevada is below the recommended level of use of State tobacco taxes, as well as dollars from the tobacco Master Settlement Agreement of 1998. I am available to meet with or provide this Committee with additional information. The State pays a tiny fraction of the amount recommended. Additional work remains in tobacco control.

SENATOR STONE:
I am concerned about immunization hesitancy for children. I am sure you are aware of a situation in England where a doctor stated there was a nexus between the mumps, measles and rubella (MMR) vaccine and autism. The word spread across the world and made people afraid to immunize their children. How has that affected immunization rates in Nevada? What can the State do to better educate its constituencies that the MMR vaccine is a proven vaccine and has saved millions of lives? We need to restore the vaccination integrity of these immunizations to protect children.

MR. PACKHAM:
I believe you are referring to Dr. Andrew Wakefield, and Nevada is still paying the price. The NPHA has fended off claims of autism linked to the MMR vaccine. After the pandemic, the rates for childhood and adult immunizations have not increased as expected. People postponed vaccinations, and they have not returned to clinics to resume vaccinations. Local health districts and health authorities need additional staffing to remedy this issue.

CHAIR DOÑATE:
We will open with Senate Bill (S.B.) 177.

SENATE BILL 177: Imposes requirements governing Medicaid coverage of certain antipsychotic or anticonvulsant drugs. (BDR 38-82)

SENATOR MARILYN DONDERO LOOP (Senatorial District No. 8):
I am pleased to come before you to present S.B. 177. This bill codifies an existing requirement for Medicaid to cover antipsychotic and anticonvulsant drugs under certain circumstances. It extends the requirement to health maintenance organizations (HMO) and managed care organizations. Additionally,

this bill will authorize the Commissioner of Insurance to penalize those who do not comply.

I will first provide you with a brief background on mental health in Nevada. Over 20 percent of Nevada adults have reported a mental health disorder. In almost 6 percent of those adults, the disorder is so severe it causes serious functional impairments of daily living activities and the overall quality of life.

Senate Bill 177 intends to remove barriers associated with access to mental health and other health services by protecting those individuals relying on antipsychotics and anticonvulsant drugs. Antipsychotic medications are any pharmacological agent used to control the symptoms of serious mental illness, such as schizophrenia, bipolar disorder and even some severe forms of anxiety and depression. Anticonvulsants are described as drugs used to reduce the frequency, or the occurrence, of epileptic seizures or to terminate an ongoing seizure. Some anticonvulsants such as valproic acid and lamotrigine are used as mood stabilizers to treat mental illness.

There are protections written into Medicaid manuals regarding anticonvulsant and antipsychotic drugs. However, if these protections are not codified in the *Nevada Revised Statutes* (NRS), then it leaves room for additional barriers to be put in place. For example, many other states require their Medicaid patients to have more than one failure of a preferred prescription before covering another one. The gaps in treatment leave a patient to deal with withdrawal symptoms and other discomforts. Some states require the failure of two or three prescriptions, which is not something I want to see happen to Nevadans.

Section 1 of S.B. 177 codifies the existing requirement for Medicaid to provide coverage of any typical or atypical antipsychotic or anticonvulsant medication that is not on the list of preferred prescription drugs. Upon demonstrating therapeutic failure of one drug on that list, the Medicaid recipient could receive another medication to adequately treat the condition. Section 2 of this bill clarifies that this requirement will apply to an HMO. Section 3 authorizes the Commissioner of Insurance to suspend or revoke the certificate of authority of an HMO that fails to comply with this requirement. Section 4 clarifies the requirement of section 1 will apply to an HMO.

ABBEY BERNHARDT (National Alliance on Mental Illness):
At the age of three, I was diagnosed with bipolar disorder. I experienced manic episodes with rapid cycling. I had anxiety, sadness and anger all at once. By middle school, the mania turned to depression. I tried to commit suicide when I was ten years old. Years were wasted while my depression intensified. Doctors fought Medicaid while trying to manage my medications. The power of insurance controlled the approved medications. I know the importance of medication. It gave me back my life and a way to manage my mental health. If my doctors were able to choose medications based on my needs, I would not have suffered trauma for an extended time. The memories of my suicide attempt left me with recurring nightmares. When I get depressed, I fear the nightmare I once lived. I stand with those who are struggling. There can be better days ahead. I support doctors having control over medication.

ROBIN REEDY (Executive Director, National Alliance on Mental Illness, Nevada Chapter):
The National Alliance on Mental Illness (NAMI) is here to support S.B. 177 with a presentation (Exhibit D). We have been pursuing the removal of medication barriers for families. When a family receives a letter from the insurance company stating they must shift or change a medication, it is like dropping a bomb into the family environment. If the individual has been stable, changing medications is the most dangerous time. I have heard multiple stories of someone trying to complete a suicide during a medication change. Many of them are sadly successful at it.

A nonmedical change of medication is a bomb to a family and to a life. How many drugs should a patient go through before a drug that works is allowed? How much time out of a person's life should it take because the right drug is not on the preferred drug list? Senate Bill 177 is trying to minimize these situations. If the first drug from the preferred drug list does not work, then a drug the doctor and the patient know will work better should be prescribed. I have heard of people going two years trying to get on the right medicine. Two years out of a young person's life is a long time. In the mental health world, changing drugs that change the brain is the most dangerous time. This needs to be minimized.

SENATOR NGUYEN:
I have a comment not a question. I have been open about my experiences with my mother who is bipolar. When my mother was first diagnosed, I watched her

go through a process. It felt like it was a decade, but it was two years trying to figure out the right medication for her. I have witnessed the problems when she was taken off the medication. She had many attempted suicides; thankfully, none were successful. I think S.B. 177 will help change lives if we are able to pass it.

SENATOR TITUS:
I appreciate you bringing this bill forward, and I understand what it is trying to do. Unfortunately, the bill does not solve the problem I see as a practicing physician. In my practice, I will stabilize a patient on an antidepressant, antipsychotic or anticonvulsant medication. Then the formulary, whether it is Medicaid or an insurance company, changes and the prescribed drug is no longer covered. The patient must switch medication to a drug on the formulary. I would like to see S.B. 177 fix this issue. The bill needs to state that once the patient has stabilized on a drug, the patient should be allowed to continue to use the drug. This should be regardless of the formulary.

Perhaps Legal can tell us if S.B. 177 will fix this issue. There is still a void where a patient is stabilized and suddenly the formulary changes. The doctor and the patient have to go through the entire process of a new medication. I would love to see this bill expand to cover this issue. Senate Bill 177 does not go quite far enough.

MS. REEDY:
I agree with you. I also recognize an amendment would create a large fiscal note through Medicaid. In turn, it would cause a huge fight with the insurance companies. I understand your position due to my own medical issues. I do not have a thyroid and every time I change insurance, I have to justify my prescription for Synthroid. This is the only medication I can take.

I intend to return for future Sessions and make your argument. It will fix a problem for many people. This bill is the first step to codifying a regulation into legislation. It will prevent making a patient go through two or three drugs before getting to a drug that works. Senate Bill 177 will protect people.

SENATOR TITUS:
In regard to the wording in S.B. 177, a patient is on one medication. If the medication fails, then it is open-ended to allow the patient to switch to any other medication. Should there be a fiscal note on that component because the

cost of a drug can span from a dime for Benadryl to thousands of dollars for newer medications?

MS. REEDY:
The bill is attempting to mimic the existing regulation. If there is a guardrail in the regulation, then I would assume the guardrail will still be there. However, I am uncertain if it has one.

SENATOR STONE:
I am a pharmacist and I have operated 6 pharmacies over the past 42 years. As a physician, Senator Titus must make a difficult decision about a formulary change. However, I must inform the patient and tell them the medication is no longer covered by their insurance. I do not think the health plans understand they are playing Russian roulette with psychiatric drugs by forcing a patient who has been stabilized on one drug to go to another.

I will give you an example of how a patient is affected. A patient could be on an antidepressant such as Pristiq. The patient has been stabilized for five years and has not had a major depressive illness. When a new formulary does not list Pristiq, the patient has to switch to a different drug like Cymbalta. When the patient abruptly stopped taking the first drug, he or she goes through a withdrawal syndrome. It can make the patient sick for five to seven days. If the Cymbalta is not working, the patient may have to return to Pristiq. It will take another week for that drug to get back into the system where it starts working again.

You try to match the pharmacology of the drug with the symptoms and the chemistry of the patient. If a doctor tries one drug, there is no guarantee the drug will work. The doctor may need to go to a second, third or fourth choice. When psychiatrists are prescribing these medications, they have to look at a certain pharmacological class to treat a condition that they are diagnosing. When one drug does not work, then the doctor will look at a different pharmacological class. Doctors should be entitled to prescribe a drug regardless of cost. Generally, a generic alternative is available for most pharmacological classes. When you are dealing with a patient who has the potential of committing suicide, it should justify that person getting the correct medication.

When you have patients stabilized on a medication, the patient should be grandfathered into any formularies. I would like to see this put into statute,

whether it is in S.B. 177 or another bill. If you give a patient the wrong drug, he or she could go into psychosis. It could result in the patient doing things you would not want to see one do, and the patient could end up in the hospital. The insurance companies are trying to save a few dollars on a drug, but it will cost more money when the patient is admitted to the hospital. I want to support this bill. Senate Bill 177 needs a grandfather clause mandating the insurance company provide the psychiatric drug. The physician should have the choice but will use lower cost alternatives if it meets the pharmacological class. This could aid in keeping the cost affordable.

MS. REEDY:
I agree with you, but the amendment could cause the bill to fail. I want to protect the largest group of people that I can. Senate Bill 177 will legislate what is already codified. You are proposing a large fiscal note that will cause insurance companies to oppose it. This would be a hard-fought bill. I support your suggestion, but I would like to first see S.B. 177 help as many people as possible. We are working toward your suggestion.

ERICA FREIDENBURGH:
I am the mother of Abbey Bernhardt. I want to present information Abbey was not able to cover because she is looking at it from the child's view. Since she was diagnosed at three years old, medication has always been a huge part of our lives. An insurance company has a formulary with a list of approved medication. The thing I found the most terrifying is that either I could not get the medication, or it was on a list. The list would require Abbey to go through all these other medications before the right medication would be prescribed to her. I want to stress how it affected Abbey. She would be on one medication leading up to another one. The medication may not work for her, and she would have withdrawal side effects. Changing medication takes time for the new one to work. Over a period of one year, changing medication intensified. She finally reached a point that she became suicidal at ten years old. I was terrified and could do nothing to stop it. I tried to help her by hospitalization, changing doctors and writing letters. She was admitted to the hospital 13 times in 1 year. I could not afford to pay for her medication out of pocket, so I had to go with the approved medication list. The insurance company could have saved money if it gave Abbey the right medication.

When Abbey was hospitalized, the staff gave me a list to determine if she had suicidal tendencies. If she had these tendencies, was she capable of acting on

them? Yes, she was very capable of acting on them. I was terrified and felt responsible for anything that happened to her. I wanted to find her the help she needed, but I was totally helpless. I do not want this to happen to another child when it can be stopped. The power should be transitioned from formularies to doctors. The doctors should choose the medication, not the insurance company. Not only would it be a cost savings, but members in the community could be saved. I support S.B. 177.

LEA CASE (Nevada Psychiatric Association):
We submitted a letter (Exhibit E) detailing our support of this bill. This bill is a great step to protect Medicaid patients' access to medication.

SHANNA ALVES (National Alliance on Mental Illness):
I have dealt with mental health since I was 25 years old. I have been put on different medications for severe depression and anxiety. One medication I was on had me in the closet pulling my hair out. I am still trying to find the right medications. During this time, I self-medicated for years and became an addict. I am now sober for almost five years. I am a certified peer recovery support specialist through the State. I am a State-certified community health worker. I just started working the peer-run listening line for NAMI. It is difficult to switch medications. It does not make it okay to self-medicate. I work in Yerington and see people with mental health issues self-medicating. It could be different for them. I support S.B. 177.

TESS OPFERMAN (Human Services Network):
I am here on behalf of the Human Services Network (HSN) to support this bill. The HSN represents nearly 50 organizations in northern and rural Nevada which include medical and mental healthcare providers. The providers are aware how difficult it is to find the right medication to treat mental health. Senate Bill 177 can ease the burden. The bill can ensure providers are able to prescribe the medications that work for the patient rather than relying on a preapproved list determined by insurance companies.

ALEX TANCHEK (Nevada Advanced Practice Nurses Association):
We support S.B. 177.

SARA WATKINS (Interim Executive Director, Nevada State Medical Association):
We support S.B. 177. Our Association is the largest physician advocacy group in the State. This bill continues the continuity between the patient and the physician.

JIMMY LAU (Dignity Health-St. Rose Dominican):
Dignity Health-St. Rose Dominican is the largest nonprofit hospital system in the Las Vegas Valley. I want to emphasize that the risk of switching psychiatric medications can cause a mental health crisis leading to an emergency room visit. I support S.B. 177.

SUSAN FISHER (Northern Nevada HOPES):
We support S.B. 177.

BARRY COLE, M.D.:
I share Senator Titus's concern that prior authorization needs to be minimized across the board for all classes of medication. The medical community is in support of lowering the prior authorization burden. Not every medication works for every single patient. Some of the ones specific to the condition the patient has can be much more expensive than their generic alternatives. I support grandfathering medication, and I support S.B. 177.

BILL BEIG:
I am on the board of directors for the Winnemucca Ministerial Association. The Association oversees the food bank and the soup kitchen in Winnemucca. I am also a recovering alcoholic with over eight years of sobriety. Daily, I encounter people with mental illness. Winnemucca does not have a psychiatrist, and people rely on telehealth. The referrals are done through clinicians and practitioners. I support S.B. 177 because it gives the physician the opportunity to prescribe the necessary medication.

SENATOR DONDERO LOOP:
I want to thank you for your time because this is an important subject. It is time to help Nevadans who need the most help.

SENATOR DOÑATE:
Next, we will hear the presentation from the UNR and UNLV Schools of Public Health.

MEGAN COMLOSSY (University of Nevada, Reno, School of Public Health):
I am the Associate Director of the Center for Public Health Excellence within the UNR School of Public Health (SPH). Dean Gerstenberger from the UNLV SPH will virtually join me. We are here today to discuss our common interest and I have submitted a summary of our collaboration and challenges (Exhibit F) to improve the health of Nevada through education and training. The schools are focused on the current and future public health workforce, as well as community engagement and partnerships.

The UNR and UNLV Schools of Public Health are 2 of 64 schools accredited by the Council on Education for Public Health. The 2 schools have 2,000 students in the undergraduate programs and 300 students in the 5 graduate programs. Four out five of our graduates remain in Nevada. The graduates choose careers in State and local health agencies, major medical centers and community-based organizations.

The faculty and students participate in research. They are recognized nationally and internationally for work related to issues like substance abuse, environmental epidemiology and behavioral risk factor surveillance. They also serve the communities throughout the State in a variety of ways. Both UNR and UNLV serve as a major pipeline for public health practitioners in the State. The alumni are represented within all State and local public health agencies. In addition to the State's Chief Medical Officer, our alumni are in leadership positions at the Nevada Department of Health and Human Services (DHHS), the Governor's Office and local health agencies.

The two Schools of Public Health educate the next generation of public health practitioners and also provide opportunities to train the existing workforce. The majority of the public health workforce do not have traditional or formal training in public health. The Schools provide training, technical assistance, evaluation, research and services throughout the State.

At UNR, instruction is provided in four centers, expanding the reach of the Schools of Public Health beyond the campus and into the community. I have submitted a flyer (Exhibit G) on these centers. I would like to highlight two of the four.

The first one is the Center for Application of Substance Abuse Technologies and I have submitted a flyer on its highlights (Exhibit H). This Center works to

improve substance-use prevention, harm reduction, treatment and recovery. The support services, conducted by helping organizations, communities, the State and the workforce apply evidence-based practices. This Center is a leader in these areas in the State and in the Nation.

The second center I would like to highlight is the Nevada Public Health Training Center (NVPHTC). I have submitted a summary of the training (Exhibit I). The NVPHTC conducts community-engaged research, designs training programs and facilitates capacity building and workforce development. In 2022, NVPHTC developed and provided training to almost 3,500 public health practitioners. The NVPHTC is working to help build workforce capacity in State and local public health agencies. The NVPHTC is helping DHHS, Division of Public and Behavioral Health, pursue accreditation. The NVPHTC is working to help build the capacity of county health officers in rural areas.

I would like to highlight the Statewide work in responding to the COVID-19 pandemic. The UNR SPH hired, trained and managed over 100 staff members for CCHHS and WCHD. These employees were contact tracers, call center staff, testing-site staff and disease investigators. The UNR SPH developed COVID-19 trainings and webinars as well as certifications. The courses were developed for public health professionals, both for the workforce prior to the pandemic and those who joined in response to the pandemic. The UNR SPH developed and led outreach projects to fight misinformation and address vaccine hesitancy in certain communities. These projects were in partnership with community and faith-based organizations.

Finally, I would like to highlight the work for establishing academic health departments. We have strong relationships with State and local governmental public health agencies. Similar to others in the public health field, the Schools of Public Health need to be efficient with limited resources. As a result, we are establishing academic health departments. These department are like teaching hospitals. However, a teaching hospital formalizes a relationship and integrates work between the hospital and a medical school. An academic health department formalizes the affiliation and integration between a SPH and a governmental public health agency. It provides a mutual benefit of education, research service and partnership to both entities. Academia can inform public health practice, and public health practitioners can inform the academic programs. It is an opportunity to enhance work-based learning experiences, internships and fellowships to expand the public health agency's capacity. It will

enhance research collaboration among the institutions. As noted earlier, the majority of people working in public health do not have formal training. This will create a pipeline and opportunity to help people advance in public health. The UNLV SPH has an academic health department agreement with SNHD. The UNR SPH has an academic health department agreement with WCHD. A couple of weeks ago, UNR finalized an academic health department agreement with DHHS. This will be an opportunity to enhance collaboration and expand the capacity of the State and the University.

SHAWN GERSTENBERGER (Dean, University of Nevada, Las Vegas, School of Public Health):

I will not reiterate public health degrees at UNLV, since it is similar to the degrees at UNR. The one exception is that UNLV offers the only undergraduate and graduate accredited programs in healthcare administration. There are approximately 1,000 undergraduate students and 400 graduate students in UNLV's public health school. At UNLV, 80 percent of the students in the SPH degree programs self-identify as racial and ethnic minorities. We support the public health workforce to ensure the continuity and the efficacy of those workers.

The UNLV SPH does more than educate students; it is also active in research. There are roughly 170 employees with only 40 tenure-track faculty. Last year, the tenure-track faculty members brought in nearly $15 million in extramural funding from competitive sources like the National Institutes of Health, Centers for Disease Control and Prevention, Health Resources and Services Administration and many other agencies. The UNLV SPH collaborates with the community. This semester, there are 59 internship students placed with community partners.

I would like to highlight one or two other projects within the school. Continuing with the theme of COVID-19, UNLV SPH collaborated with the SNHD. The UNLV SPH received a $5.1 million grant from the State to develop and lead a contact-tracing team. The University trained 240 UNLV students and 15 experienced doctoral students from the epidemiology and biostatistics program. The contract-tracing teams were completely run by the students. The 240 students spoke over 30 different languages. The students investigated over 38,000 cases in southern Nevada, or 1 out of every 6 cases. The UNLV SPH worked closely with partners at the SNHD and DHHS to ensure the security of

the data. This is one example of how the faculty, the students and the community partners work together to solve public health problems.

A second item I would like to highlight is work the centers, laboratories, institutes and coalitions do in the community. The Nevada Institute for Children's Research and Policy (NICRP) participates in initiatives like preventing child abuse, performing a kindergarten health survey, educating parents on newborn safe sleep programs and participating in the State's child death review team. The NICRP is primarily a grant-funded group and has 38 grant-funded employees who brought in over $2.4 million last year. The NICRP is a group involved in all things related to Nevada children and their health.

The last highlight is the work performed by the Nevada Minority Health and Equity Coalition. This Statewide effort partnered with UNR and is designed to improve the health and welfare of Nevada residents. The Coalition has a particular focus on those bearing a disproportionate burden of disease. The Coalition has 80 partners with over 300 members. The members formed work groups to focus on a culturally appropriate and credible transfer of information on the COVID-19 outbreaks and COVID-19 vaccines.

The COVID-19 response became the springboard for efforts in mental health. The Coalition’s work groups are comprised of faculty, staff and partners from around the State. The Coalition focuses on diverse groups including African Americans, Asian Pacific Islanders, Native Americans, Latinx, LGBTQ, and the deaf and blind community. The Coalition wants to create credible information in a culturally appropriate manner. They provide training on community-based research, grants management, health communication and other pertinent issues Statewide.

We have a few collaborations with UNR to advance the State. What is the Behavioral Risk Factor Surveillance System survey? It is the Nation's premier system of health-related telephone surveys collecting data about Nevada residents. Both schools are coinvestigators with UNR leading the initiative. Surveys in northern Nevada are conducted by UNR while UNLV collects the surveys in the greater Las Vegas metropolitan area. Many of the metrics presented today, like the incidence and prevalence of tobacco-use diseases, exercise, and fruit and vegetable consumption, are collected from the survey. It helps us direct policy, initiatives and funding for the State.

The UNLV SPH works with UNR to create focus or work groups in the Native American and Hispanic communities in the north. The collaboration is intended to contribute to the body of knowledge and to communicate credible information to these populations.

I meet with the Dean of the UNR SPH on a regular basis. The schools have created a collaborative proposal to foster interdisciplinary research between the two universities. Work sessions have been created to introduce faculty and to organize them into breakout sessions on specific topics. Each university contributed $10,000 to create pilot projects and grants. The two schools would apply together for grants to improve the health and welfare of the State.

One of the challenges mentioned in the Nevada Public Health Association's presentation is the lack of flexible funding. Nevada is funded at $72 per person per year and is fiftieth in the Country for per capita public health funding. Increased funding will support many prevention promotions and protection activities throughout the State. The high rate of pregnancy, sexually transmitted disease, food insecurity and access to mental health care could improve with adequate funding. Public health needs additional flexible State funding for infrastructure and workforce development. Additional funding will support the two schools working on initiatives to improve health outcomes.

The State needs to improve the two schools' ability to get competitive extramural funding. Due to limited staffing and resources, the universities do not have the time to write competitive proposals to bring money into the State. Both UNR and UNLV want to partner with the State on ways to facilitate these efforts.

MS. COMLOSSY:
The workforce development is key to public health. Public health is a service-heavy field, and the workforce is the greatest asset of public health. We need to invest in strategic workforce development to meet the State's needs. The talent pipelines need to improve, and the workforce learning opportunities need to expand. The UNR SPH is working on expanding degree offerings to include a doctor of public health and a doctor of philosophy in health communication.

The State needs to provide public health leaders with tools so they can do their job to keep the State healthy. The universities need funding to support the

advancements in workforce, including support for graduate assistantships. The universities need additional funding to recruit and retain graduate assistants and postdoctoral scholarships. This will bring an expertise to the State and make the universities more competitive

CHAIR DOÑATE:
The next item is S.B. 41:

SENATE BILL 41: Revises provisions relating to child welfare. (BDR 38-392)

VINSON GUTHREAU (Executive Director, Nevada Association of Counties):
I am here on behalf of the Nevada Association of Counties board of directors to present S.B. 41. I will focus on the service delivery, collective county funding and the partnership with the State. The goal for this legislation is to bring clarity and understanding, provide solutions to child welfare funding reductions and service delivery. It will create a better understanding of legislative and regulatory changes and the impact to these services.

All counties in Nevada are involved in child welfare services. Currently, the services are delivered and funded in a hybrid format. For counties with over 100,000 in population, Clark and Washoe Counties, services are funded through a block grant from the State. This funding is comprised of State and federal funding. Clark and Washoe Counties supplement with their general fund dollars, if needed, to deliver prevention, investigation, foster care and adoption services in their communities. In the rural counties, Nevada delivers these services and assesses the counties for services provided.

Senate Bill 41 proposes to do two things. The first proposal requires a study by the Joint Interim Standing Committee on Health and Human Services to examine the funding of agencies that provide child welfare services during the 2023-2024 Interim. The study would include State and federal unfunded mandates, the impact of any funding reductions from the federal government and the ability of child welfare agencies to meet federal requirements. Additionally, the study would look at reductions under Medicaid and the Children's Health Insurance Program.

Since the submission of this bill, additional factors have risen requiring a proposed amendment (Exhibit J) to S.B. 41. These factors include the impact on

foster families for cost-of-living increases and changes to the Unified Nevada Information Technology for Youth system.

The results of the study will be submitted by January 15, 2025, to the Legislature. It will include solutions and policy recommendations to respond to any funding reductions identified in the study. The approach is to review fiscal impacts to both urban and rural counties and the State from significant policy changes since 2011.

The second proposal in S.B. 41 is to modernize terminology around the block grant funding program. The language will accurately reflect how these funds are used. My copresenter from Clark County will present the specific impact and provide an overview on it. I want to highlight the impact of unfunded mandates. The counties and the State grapple with surging assessments but experience a lack of corresponding service calls or needs. For instance, Churchill County reported its overall assessment increased in the six-figure range, but the County has had a stable or even a decrease in service calls. Lyon County reported its assessment went from just over $387,000 to over $863,000 in 2023. This County reported its youth population has not increased significantly, and the amount of service calls did not match the assessment.

For years, rural counties have been trying to understand the increased assessments. The solution to understanding the assessment should be included in the proposed study. The counties share the State's goal that public dollars and resources should be allocated to the populations needing the service. In this case, they are at-risk youth, children in foster care and victims of sexual exploitation. We understand public resources are finite and the State needs to maximize the available resources.

JOANNA JACOB (Clark County):
I want to discuss block grant funding to urban counties like Clark County. First, we need to look at the history of the policy changes the system has had to absorb and the pressure placed on it. In the interest of time, I will focus on notable bills passed without funding. There have been several bills on protecting commercially sexually exploited children. Currently, there is legislation to transition these youth from the juvenile justice system to the child welfare system. If passed, Clark County's projected cost in the upcoming biennium is $21 million per year.

In 2011, legislation was passed to extend youth support. In response to this bill, Clark County created a program called Step Up. This program helps youths transition out of foster care. It is an innovative program, developed by Legal Aid, and is in operation today. The Step Up program is fully funded from local funds. As part of the Step Up program, Clark County has extended foster care to youths up to the age of 21. Extending the time in foster care gives these youths additional support to transition out of foster care. The projected cost to Clark County is over $2.9 million for the biennium. Clark County is working on legislation this Session to address the cost.

The County implemented a specialized foster care program for children who cannot be served by traditional foster care homes. Clark County has been subsidizing the rates paid to foster parents to care for these youths. It cost Clark County $9 million over the biennium. This $9 million is after a partial offset from a federal program called the Title IV-E Prevention Services Clearinghouse (IV-E).

The County has many other programs that they have had to absorb without companion funding. These programs are State public policy and the result of past legislation. The County is currently operating at a $28 million structural budget deficit. This means the expenditures exceed the revenue coming in. The loss of revenue is due to several factors, including a loss of federal funds from the Family First Prevention Services Act.

To administer these programs, the County has had an increase in cost for staffing and workload. The County is struggling with outdated federal requirements for income levels to make services available under the IV-E program. Those income eligibility guidelines for some services are frozen at a 1996 level, meaning a family has to meet the 1996 federal poverty guidelines to qualify for the service. Clark County has bills in the Legislative Session to address some of these components.

Originally, the State's block grant program was effective. However, it was capped at 2011 funding. A portion of the funding was carved out to act as an incentive. The County could apply back to the State for a program improvement. In the beginning, the incentive funding was deemed to be flexible spending. This program no longer operates as a meaningful tool to urban child welfare agencies. As regulatory and legislative changes have been added, the

County depends on this funding. We want to make it clear that the funding is not operating as an incentive anymore.

As regulatory and legislative changes have been added, both at the federal and State level, the counties are burdened with additional costs. The urban counties—Clark and Washoe Counties—are subject to significant oversight by the State. The urban counties are also required to submit numerous reports like the biennial improvement plan. Per NRS 432B, the State is allowed to place child welfare agencies in an urban county on a corrective action plan if the county does not meet program objectives. The urban counties have a quarterly quality improvement case review process, a five-year services review and a five-year family and services plan. This last plan also requires annual progress and services updates.

Clark County has met with Washoe County and the State to align some of the reporting. The conceptual amendment in S.B. 41 combines the reporting of the incentive grant with the improvement plan. This report would be submitted on an annual basis rather than biennially. The goal is simple: maintain State oversight over county agencies but preserve the original intent of the incentive in a single report. The deadline for the report would change from a calendar year to the State fiscal year. These changes will streamline the process for county and State agencies.

Clark County has struggled not only with the structural deficit but also with an increased need from children entering the system. We had over 100 parents surrender their children to the system because they have not been able to find community mental health resources. This Committee is aware of the critical services that agencies provide in the community. This bill is not about criticizing the Legislature, past or present. Many of the policies have been in place for years, but Clark County agencies are struggling with shifting federal mandates. It is receiving significant policy changes. Therefore, it is time for a study to review funding of child welfare in the State

CHAIR DOÑATE:
We will move on to S.B. 161.

SENATE BILL 161: Provides for the use of certain federal benefits to purchase menstrual products. (BDR 38-811)

SENATOR MELANIE SCHEIBLE (Senatorial District No. 9):
I am here today to present S.B. 161. This should be easy to present since every Senator signed on to this bill. Senate Bill 161 allows for individuals receiving benefits from the Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) to use those benefits to purchase menstrual products. Menstrual products are described by the National Conference of State Legislatures (NCSL) as hygiene materials used to catch blood flow during the menstrual cycle, typically needed from puberty until menopause. Products are commonly referred to as tampons, sanitary pads, menstrual cups and other products. These products are a necessity, not a luxury.

Even though menstrual products are necessities, there are no programs in place to use public funds to purchase them. Sanitary menstrual products are increasingly unaffordable for some people. In fact, it has been reported that people will use pieces of cardboard, cloth, toilet paper, newspapers or even public bath paper towels as an alternative. These may be the only alternatives they can afford. However, they are not safe alternatives; using them can result in vaginal discomfort and life-threatening infections.

The rising cost of menstrual products continues to put people in period poverty. It creates barriers preventing them from having safe, healthy monthly cycles. The NCSL highlights a survey of low-income women in St. Louis, Missouri. The survey found 64 percent of the women have experienced difficulty affording menstrual products. In that same survey, 64 percent of female high school students reported not being able to afford these products at least once and 34 percent reported having to miss school due to the lack of menstrual supplies.

In Nevada, Governor Steve Sisolak signed A.B. No. 224 of the 81st Session. This bill broke down the barriers of period poverty. Assembly Bill No. 224 of the 81st Session codified in the NRS the requirement for charter schools, middle schools and high schools to provide menstrual products in bathrooms at no cost to students. Other states have taken steps to increase access to menstrual products, such as requiring free menstrual products in correctional facilities and homeless shelters.

In 2018, Congress passed the First Step Act, requiring all federal prisons to make sanitary napkins and tampons available free of charge. The House of Representatives Resolution 1882 of the 116th Congress, Menstrual Equity For

All Act of 2019 was introduced to expand access to menstrual hygiene products for public school students, the incarcerated, the homeless, those who use healthcare flexible spending accounts (HSA) and Medicaid recipients. However, the bill was never voted on. In 2020, the Coronavirus Aid, Relief, and Economic Securities Act was signed into law, allowing menstrual products to be paid for with pretax dollars using an HSA. Allowing people to purchase menstrual products through SNAP will reduce the barrier to access for these essential items.

I am going to walk through the sections of S.B. 161. Section 1 authorizes the recipients of SNAP or WIC to use these benefits to purchase menstrual products. The section also states that the DHHS shall take the necessary actions to get federal authorization. This includes, but is not limited to, applying for a federal waiver. Finally, the section defines menstrual products.

SAMANTHA GLOVER:
I am the advocacy director of Red Equity, a nationwide nonprofit founded in Nevada. My presentation (Exhibit K) supports S.B. 161. The focus of the program is eliminating period poverty through advocacy, distribution and education. Period poverty does include socioeconomic factors because people do not have access to menstrual products. Due to the social stigma surrounding menstruation, it impacts the accessibility of menstrual products. One in four high school students miss school because they do not have access to menstrual products. In the United States, 51 percent of women report using menstrual products for longer than the recommended time. This has significant health impacts and can cause life-threatening infections. Menstrual products are free in the women's bathrooms inside this Legislative Building. This should be normal in all public restrooms. Senate Bill 161 is leading the Country to provide menstrual product equity for everyone. Illinois is the only other state to pass this type of legislation. New Jersey has an identical bill in process in their Legislature.

KRISTINA KLEIST (7 Points LLC):
We believe feminine hygiene products should be included as a part of an individual's Medicaid coverage. This bill will help countless individuals. We hope the proposed coverage will not be limited to only the most basic or common products available today. Organic products are not only an environmentally friendly alternative, but doctors recommend them as a preferred healthcare option for certain individuals. These products should be included in the coverage

to give women and doctors a better range of choices suitable for their needs. We support S.B. 161.

NATHAN NOBLE:
I am concerned about the epidemic of period poverty. It is fundamentally one of the most inexcusable and unnecessary forms of injustice in our society. It is absolutely needed. I am proud UNR has taken steps to combat period poverty. I support S.B. 161.

LIZ MACMENAMIN (Retail Association of Nevada):
We support S.B. 161.

WENDI SCHWEIGART (Founder, Project Marilyn):
We support S.B. 161. Project Marilyn fights period poverty. The Project serves over 2,000 clients every month. Period supplies are not a luxury; they are a necessity. This bill allows everyone to have access and to make their own choices on how to spend their funds.

DR. COLE:
Menstrual products are essential necessities, and these products must be covered. I support S.B. 161.

SENATOR SCHEIBLE:
Ms. Schweigart is too modest to tell you that S.B. 161 was her idea. The bill came to us as I was driving to work one morning and listening to the radio. Ms. Schweigart was talking to the local morning disc jockeys about Project Marilyn. She mentioned in her segment that people cannot use SNAP or WIC funds to buy period products. She went on to state that this a major contributor to period poverty. I called Ms. Schweigart and told her it needed to be fixed. She has been a great partner in ensuring this legislation came to fruition. If it had not been for Wendi, none of us would be discussing this today. I am grateful to her and Project Marilyn for bringing this to my attention. I look forward to seeing this bill pass.

CHAIR DOÑATE:
As there is no other business before the Senate Committee on Health and Human Services, we are adjourned at 5:09 pm.

RESPECTFULLY SUBMITTED:

_____
Mary Ashley,
Committee Secretary

APPROVED BY:

_____
Senator Fabian Doñate, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
	C	2	John Packham/ Nevada Public Health Association	NPHA Advocacy and Policy Priorities
S.B. 177	D	7	Robin Reedy/ NAMI	Presentation
S.B. 177	E	11	Lea Case/Nevada Psychiatric Association	Letter of Support
	F	13	Megan Comlossy/ UNR, School of Public Health	UNR and UNLV Collaboration and Challenges
	G	13	Megan Comlossy/ UNR, School of Public Health	UNR Government and Community Engagement
	H	13	Megan Comlossy/ UNR, School of Public Health	UNR Presentation CASAT Highlights
	I	14	Megan Comlossy/ UNR, School of Public Health	UNR NV Public Health Training Center
S.B. 41	J	18	Vinson Guthreau/ NACO	Proposed Amendment
S.B. 161	K	23	Samantha Glover	Presentation