MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
March 9, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:37 p.m. on Thursday, March 9, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 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 Scott Hammond, Senatorial District No. 18

STAFF MEMBERS PRESENT:

Destini Cooper, Policy Analyst
Mary Ashley, Committee Secretary

OTHERS PRESENT:

Jesse Wadhams, Pediatrix Medical Group
Tess Opferman, Nevada Women's Lobby
George Ross, HCA Healthcare; Touro University
Jimmy Lau, Dignity Health-St. Rose Dominican
Elizabeth Becker
Sarah Rogers, Division of Public and Behavioral Health, Nevada Department of Health and Human Services
Anthony Anguille-Valles
Tiffany Ostovar-Kermani, M.D.

Kelvyn Garcia-Alfonso
Saideh Nia
Sara Watkins, Interim Executive Director, Nevada State Medical Association
Elliot Malin, Nevada Osteopathic Medical Association
Barry Cole, M.D.
Helen Foley, Nevada Association of Health Plans
Tom Clark, Nevada Board of Medical Examiners
Joan Hall, Nevada Rural Hospital Partners/LICON

CHAIR DOÑATE:
We will open today's hearing with Senate Bill (S.B.) 137.

SENATE BILL 137: Requires the State Plan for Medicaid to include coverage for donor breast milk and certain related products. (BDR 38-180)

SENATOR SCOTT HAMMOND (Senatorial District No. 18):
I am here to present S.B. 137 for your consideration. This bill requires the State Plan for Medicaid to include coverage for approved donor breast milk and human milk-based human milk fortifiers. The milk must be prescribed or ordered by a physician, physician assistant or advanced practice registered nurse for certain infants who required nourishment from breast milk. These infants weigh 1,500 grams or less and their mother is unable to provide breast milk.

A number of ailments can occur if these infants do not receive nourishment from breast milk. As these infants become young children, six to eight years old, they will experience more ailments and need more treatment by a physician or hospital. I am aware many on this Committee have a better understanding of this than I do. However, one of the conditions is necrotizing enterocolitis (NEC) which will affect the infant's intestines. About a third of the intestine is destroyed and the infant will have health concerns later in life.

Senate Bill 137 is a front-end bill because it is funding the problem at the beginning. This will reduce healthcare costs on the back end. This bill is trying to take care of this problem on the front end instead of the back end.

SENATOR TITUS:
Wet nurse has been around for as long as mankind. It is not unusual to have assistance with human milk by something other than the actual birth mother. I am unfamiliar with the process and if it is in other states. How does the

reimbursement work? Will it require a prescription? Can you explain the process?

SENATOR HAMMOND:
A bill like this one has passed in several other states, including Texas. Later, a doctor, who works in a Texas hospital, can elaborate on its success in her state and its cost saving.

For a variety of reasons, a mother may be unable to give the nutrients or nourishment to her baby. These babies will rely on donor breast milk or a fortifier. The enrichment put in the fortifier will allow a longer shelf life. I do not know what the prescription process is. Hopefully, another testifier will be able to respond to your question.

Nevada is not the first state to pass a bill like this. There are about six or seven states that have passed this legislation. If we invest on the front end, then we will save on the back end.

SENATOR STONE:
How does the process of donating breast milk work? What is the chain of custody? How will you ensure the milk has been refrigerated and is not spoiled? Who is responsible for overseeing the process? Is the donor compensated for the milk and is it part of the Medicaid reimbursement?

SENATOR HAMMOND:
There are two different programs. One program will compensate the donor and the other will not. The first program will pay the donor and mix the breast milk with the fortifier.

One company in Nevada had a rough start due to COVID-19 and some other factors. I reviewed this company's process. When it receives the donated milk, they document the process from beginning to end. Their records show the chain of custody and how long each person in the chain had it. Once the milk is placed on the shelf, it is labeled for how long it is good. There is a process in place prior to giving it to the baby.

JESSE WADHAMS (Pediatrix Medical Group):
Pediatrix Medical Group is the largest provider of neonatal intensive care unit (NICU) services in the State. In addition, I am a parent of two NICU babies.

One of my sons spent 102 days in a NICU. Both Pediatrix and I know the benefits of donor breast milk. We support S.B. 137.

TESS OPFERMAN (Nevada Women's Lobby):
We understand the importance of breast milk for the safety and health of our children. We support S.B. 137.

GEORGE ROSS (HCA Healthcare):
We support S.B. 137.

JIMMY LAU (Dignity Health-St. Rose Dominican):
We have submitted a letter of support (Exhibit C). Our hospital already provides donor breast milk to NICU babies. It does help with outcomes, and we support S.B. 137.

ELIZABETH BECKER:
As a certified lactation educator and counselor and a constituent of Senator Hammond, I am in full support of this bill. I have been following this legislation for several sessions. Senate Bill 137 can ensure Nevada babies will have access to the life-saving treatment that human donor milk can provide. Any family can be impacted by a preterm birth and an extended NICU stay.

Senator Hammond was my opponent during the 2020 election cycle, but he has always been a partner with the community on maternal and infant healthcare issues. I am grateful for his willingness to provide the best care for Nevada babies.

Approximately 45 percent of all babies born in Nevada are insured by Medicaid at the time of their birth. Studies have shown that infants in the NICU benefit from human milk as opposed to formula. The rates of NEC can be cut in half when using human milk and human milk fortifiers. Many women are unable to produce their own breast milk for a variety of reasons including medical trauma, preterm birth and caesarean section complications.

Donor human milk is readily available from over 30 milk banks in the Human Milk Banking Association of North America (HMBANA). No baby, regardless of their financial status, should be denied access to human milk when a doctor has deemed it necessary. Many private insurance plans and TRICARE routinely pay for donor human milk and Medicaid should as well. The cost

savings from reduced stays in NICU and invasive surgeries causing lifelong impacts cannot be overstated. Nevada should follow in the footsteps of 15 other states including Utah, California, Illinois and Texas. These states have laws directing Medicaid to cover donor human milk.

SARAH ROGERS (Division of Public and Behavioral Health, Nevada Department of Health and Human Services):
Currently, we do not have a human milk bank in the State. The HMBANA of northern Nevada did report a 20 percent increase in need to fill the gap during the formula crisis. Milk banks across the Country saw a significant increase in donations. The donors were either producing extra breast milk, experiencing loss or wanting to help parents fill the formula gap. The Massachusetts Milk Bank reported an increase from 30 to 50 donations per month to 30 per day during the formula crisis.

Nevada has three milk depots where women can go to donate their breast milk to a licensed milk bank. The closest milk bank is San Jose, California, which works with Nevada's milk depots. One milk depot is in Washoe County and two are in Clark County. Having only three milk depots in the State does create a barrier for women who may be interested in donating breast milk. The milk is shipped to San Jose for processing and will be distributed, as needed, to other locations that the San Jose milk bank serves.

SENATOR HAMMOND:
Senate Bill 137 is a milestone in my career because I am passionate about this bill. To have Ms. Becker testify on behalf of S.B. 137, shows how important it is for our community. I want to thank Ms. Becker for taking the time to come and support it.

CHAIR DOÑATE:
We will close the hearing for S.B. 137 and we can move onto S.B. 204. At this time, I will pass the gavel to Vice Chair Nguyen.

VICE CHAIR NGUYEN:
We will open the hearing for S.B. 204.

SENATE BILL 204: Provides for the limited practice of medicine by certain medical school graduates. (BDR 54-49)

SENATOR FABIAN DOÑATE (Senatorial District No. 10):
Today I come before you to speak on S.B. 204, which provides for the limited practice of medicine by certain medical school graduates. I am virtually joined by Mr. Anthony Anguille-Valles, who is a medical school graduate from Touro University and a current student enrolled at the University of Nevada, Las Vegas (UNLV), William S. Boyd School of Law. Before Mr. Anguille-Valles presents the bill, I want to document my rationale for bringing this important legislation forward. We desperately need solutions to welcome more physicians into our State.

During the Interim, I work as a health administrator. I have run medical facilities with varying levels of practitioners. I oversaw the general operations of a health center serving parts of the Las Vegas community. I understand the barriers to the frontline healthcare system. There is a severe shortage of medical workers in every profession of the healthcare sector. During my tenure as a health administrator, I faced difficulty recruiting medical professionals to work and apply for the open positions in my facility. I distinctly remember having a vacancy for a physician that was open for over a year. My goal was to find a bilingual family practice doctor that speaks and writes in Spanish. We faced difficulty finding a candidate with this qualification. To describe the impact of the severe shortage, I have to wait at least a month and a half to get an appointment with my own primary care provider.

In my early discussions with community members, it came to my attention that Nevada has residents with the knowledge and experience to practice as physicians. We have international medical graduates and students not matched into a residency who want to practice in the interim. We can do a better job to pass commonsense policies welcoming these individuals to our State. The only problem is the outdated laws stand in our way. It is our responsibility to ensure we have every tool at our disposal to attract more physicians to Nevada. This should include international medical graduates seeking to obtain a license and our own students that were not matched into a residency program. We need better tools to allow more individuals to fill the voids that we are experiencing in our community. If these individuals meet the clinical and quality metrics established for Nevada physicians and the requirements set forth through medical training, there should be pathways for them to practice medicine.

Mr. Anguille-Valles came to me with a simple proposal on how to fix the shortages that we saw from the COVID-19 pandemic. He will present his personal story and then walk us through S.B. 204 and its proposed amendment.

ANTHONY ANGUILLE-VALLES:
Senate Bill 204 is a simple idea on how to fix an issue that continues to affect all Nevadans, rural or urban. This bill has a commonsense solution and is within the bounds of the Nevada Legislature. This bill wants to influence change in a way that affects all Nevadans regardless of partisanship.

By training, I am a Doctor of Osteopathic Medicine, and I graduated in 2017. I have lived in Nevada since 2000 and am a Nevadan at heart. My medical training did require me to travel around the Country, but Nevada had a way of pulling me back in. I graduated from Coronado High School in 2005 as the valedictorian of my class. I graduated with my bachelor's degree in psychology from UNLV in 2009. While experiencing a burgeoning hospitality career in the spa industry, I went to medical school in 2013 and graduated in 2017.

I did very well in medical school. In many ways, I am the antithesis of stories you hear about why people do not match. There are a myriad of reasons behind why people do not match and why the system is currently not capable of offering or affording everyone the opportunity to practice within their training. I applied to be a urologist and went through the match with the American University of Antigua, College of Medicine. At that time, urology was the only specialty having a separate match. Unfortunately, I did not match into the very few programs to which I applied. I then scrambled into a residency program in family medicine, which was heavily inpatient focused in Chicago, Illinois. I discovered that program was simply not for me. What are your options as a fledgling medical school graduate? You can stick with your program, or you can decide this is not the future that I saw for myself.

Since this was not the right program for me and the training I was seeking, I went back to hospitality. I left my residency in good academic standing. I had no professional disciplinary measures against me, nor any concerns expressed. I eventually decided to pursue the legal field and am attending law school at UNLV. This is a second chance for me to give back to my community and provide services to people. I will be graduating from law school in May 2023.

I want to provide an overview on the background of this bill. The presentation (Exhibit D) will also include proposed amendments to S.B. 204. This bill is not only logical, but necessary given the current circumstances affecting Nevada. All 17 counties in Nevada are designated as Health Professional Shortage Areas (HPSA). Further, a subsection of the State is recognized as a Medically Underserved Area (MUA) or as housing Medically Underserved Populations (MUP). Both are federal designations, based on several different statistics, analyzing the population-to-provider ratio as well as socioeconomic factors. This means Nevada is on the precipice of a potential public health emergency. The State does not have an additional influx of medical providers to provide immediate care for situations like the COVID-19 pandemic.

The COVID-19 pandemic manifested some of the health disparities affecting both the rural and urban areas in Nevada. Specifically, COVID-19 affected those who are living with chronic illness. This population is most likely does not have access to a primary care provider. When those with chronic illness contracted COVID-19, they were more likely to suffer severe disease or death. Increasing access to care will ensure we do not leave communities at risk of a potential future pandemic.

A secondary impact from the COVID-19 pandemic is the massive influx of population into the State. We are an optimal destination for many individuals, especially with the option for people to work remotely. This is the background of "quiet quitting" in the medical profession, including doctors. Although a number of doctors still maintain a Nevada practice, they are cutting back on the number of patients. The doctors have gone through the most stressful period in their lives, trying to afford care in an unparalleled public health crisis. This has resulted in a more populous society with less access to care.

Senate Bill 204 serves to remedy the shortage by recognizing associate physicians (AP) and associate osteopathic physicians (AOP). In 2013, the Legislature granted full independent practice rights to nurse practitioners. This legislation was based on a similar healthcare shortage, but without the amplified public health crisis. The changes in 2013 did not meet the increased demand for health care.

The way the law is written, chapter 630 of the *Nevada Revised Statutes* (NRS) addresses medical doctors, physician assistants, medical assistants, perfusionist and practitioners of respiratory care. Chapter 633 addresses osteopathic

medicine. As a result, S.B. 204 will address the exact same subject matter for each chapter. Section 1 of S.B. 204 addresses sections 2 to 13 and applies to NRS 630. Section 21 addresses sections 22 to 30 and applies to NRS 633. Sections 2 and 22 define, in the exact same terminology, an MUA. The definition will include the federal designations of HPSA, MUA and MUP.

Sections 3 through 5 require the Nevada State Board of Medical Examiners (NSBME) to recognize limited licensure for certain foreign medical school graduates. It applies to those certified by the Educational Commission for Foreign Medical Graduates. In addition, they must pass the U.S. Medical Licensing Exams (USMLE): Step 1 exam and Step 2 CK exam. These exams are a way into the arena of domestic medical school graduates. The term of the limited licenses is two years and will provide a through thread for the other pieces of this legislation. The limited licenses will be under the supervision of an unrestricted licensed physician, without contingency, and I will speak to one exception to that rule very shortly. The limited licenses will be serving in a mid-level capacity. It is a collaborative arrangement, working with a supervising physician to provide care to those in need.

Sections 6 and 23 of the bill outline the authorization the NSBME and the Nevada State Board of Osteopathic Medicine (BOM) have when issuing a limited license. Whether it is an AP or AOP, the candidate will have graduated from certain medical schools in the United States or Canada. The term certain medical schools apply to those accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or those deemed equivalent by the NSBME. The candidates will agree to practice in an MUA. This is similar to foreign medical school graduates who commit to at least two years of service. This area is one of the amendments we will discuss later in the presentation. The third item is that within three years of licensure, the candidate has passed Step 1 and Step 2 CK of the USMLE or the osteopathic equivalent exams. The respective boards can accept other exams as equivalent. Finally, the candidate will need to be proficient in the Nation's primary language, English.

Sections 7 and 24 of S.B. 204 detail how the law will protect the public. The AP and AOP are mid-level providers delivering care to areas with the greatest needs. Primary care practice areas are family medicine, pediatrics, internal medicine, psychiatry, and obstetrics and gynecology. The practice in an MUA is under the supervision and control of a fully licensed physician with an

unrestricted license under Nevada law. Similar to the law for a physician assistant, during the first 30 days, the supervising physician will be required to be physically with the AP or AOP. The supervising physician will always be available while they are providing patient care.

Please note, for certain federal purposes, the associate physician working in a rural health clinic will be considered a physician assistant. Whether it is physician assistants, nurse practitioners, or other mid-level providers, we want to recognize that this is the intent of S.B. 204. It is creating a mid-level capacity to serve as part of the team. This legislation should mirror what physician assistants can do under the law.

Sections 8 and 25 are important for public health purposes. These sections require the public understands the varying levels of training that medical professionals have. The AP or AOP must inform the public the capacity in which they are serving. The AP and AOP can use the term doctor, which is consistent for resident positions when they obtain residency. To ensure the public is aware, the clinic is required to post signage stating the different levels of providers available. If the patient is going to see an associate physician, they can request to be seen by the supervising physician. The associate physician and the supervising physician will designate their position with a physical badge.

Sections 9 and 26 are specific to the supervising physician and it overlaps what we have already discussed. The supervising physician is responsible for the mid-level provider serving under their license. They are required to carry liability insurance covering malpractice for any of the services provided or rendered by the associate physician. The physician is limited to three collaborative practice agreements (CPA) with APs and AOPs. The limitation is to ensure the physician can focus on the AP or AOP and give them the experience needed. The AP and AOP will need to have a capacity to treat a large swath of ailments. Finally, both the NSBME and the BOM are prohibited from disciplining the supervising physician for any legal activity performed within the scope of the CPA.

Sections 10 and 27 detail a CPA. On page 9 of Exhibit D, it outlines the required provisions that shape the relationship between the supervising physician and the AP or AOP. There is an amendment to this section because these sections are too detailed for a statute. We are proposing to delineate the responsible party for creating a CPA. The responsibility will transfer to the respective boards. This is consistent with existing statute for a physician

assistant. The one exception is certain provisions of the CPA can be waived for up to 28 days in a year when the supervising physician is practicing in a rural health clinic. An amendment to this waiver will require a certain means of communication while the associate physician is actively providing care to patients.

Sections 11 and 28 authorize APs and AOPs to prescribe or dispense certain controlled substances. The physician assistant under the law can prescribe in the same way. The CPA will define what kinds of controlled substances the associate physician is allowed to prescribe. An amendment to S.B. 204 provides the Nevada Board of Pharmacy an additional ability to limit the prescription of controlled substances pursuant to their review and subsequent issuance of the registration certificate.

Sections 12 and 29 provide for expiration and renewal of an AP and AOP limited license. This is similar to the foreign medical graduate portion of this bill in sections 3 through 5. These licenses will expire after two years and are renewable. The AP or AOP will need to provide proof to the applicable board that they practiced pursuant to a CPA during the prior two years. The bill does not include any pathway for an unrestricted license for the AP or AOP. Later in the presentation, we will discuss an amendment for foreign medical graduates after the initial form.

In the amendments, sections 13 and 30 will require the two Boards to adopt regulations to carry out the provisions of S.B. 204. The NSBME and the BOM must work with the Nevada medical schools to develop and implement programs for the AP and AOP, respectively. Each program will enable the AP and AOP to gain knowledge and experience that count as residency credit. Each Board will maintain a website whereby the public can see who is serving as a supervising physician and who is serving in the role or capacity as an AP or AOP.

I have listed the remaining sections of S.B. 204 on page 12 of Exhibit D. These sections are mainly conforming changes to the law. The most important provisions on this page are the sections requiring insurance companies, including Medicaid, to provide coverage in Nevada for medical services provided by an AP or AOP. It will ensure services rendered will be covered. Under the law, the rate charged will be the same as a physician assistant. Finally,

section 49 will authorize the Commissioner of Insurance to take certain actions against the health insurance companies that do not comply with these sections.

I would like to present a brief overview of the proposed conceptual amendments to S.B. 204 (Exhibit E). Section 3 applies to foreign medical graduates. The initial language required the graduates to commit to three years of practice in an MUA. This section has been amended to two years, so it will line up with the duration of the limited license. In section 5, we are proposing to remove the pathway to unrestricted licenses for foreign medical graduates. This has been conceptually removed from the bill but is open to discussion in section 10.

Sections 10 and 27 include language on how frequently supervising physicians are required to review the standard of care by the associate physicians. The frequency should be determined by the respective board and placed in regulation. The respective board can determine how often the supervising physician will be required to review the standard of care provided by the AP and AOP.

In addition, the language in sections 10 and 27 was amended to add the verbiage "while in the course of providing patient care." The way the bill is written, the supervising physician can waive a provision of the CPA in rural health clinics. We did not want the supervising physician to be on call every moment of their lives. The amendment will clarify that this is while the AP or AOP is practicing and providing care.

Section 34 is specific to NRS 633 under the osteopathic section. There are a number of provisions regarding continued medical education, including osteopathic physicians and physician assistants. The amendment will include the AOP to conform with existing language.

Section 51 was formerly the section allowing the former sections to be adopted. This requirement has been moved to section 2. We have added a new section to authorize the Nevada Board of Pharmacy to further limit the prescriptions of controlled substances, poisons, et cetera. This is pursuant to their issuance of a registration certificate requiring certain medical providers, including physician assistants, APs and AOPs.

In conclusion, S.B. 204 is not a referendum on graduate medical education (GME). We are respectful of GME institutions and what they provide to medical

graduates. Graduates in residency programs have an unparalleled learning curve allowing them to practice with an independent unrestricted medical license. This bill is not requesting this capacity of care. We support investing in GME, but S.B. 204 is addressing the immediate issue before us. The lack of primary care access in Nevada is a chronic issue. This issue was amplified by the COVID-19 pandemic. Before we can address continued funding and increased access to GME programs, we must address the shortage of primary care access. Those in rural and specific urban communities need health care now. It cannot wait five to ten years for the State to work with the federal government and the Centers for Medicare & Medicaid Services to increase funding and access to these programs. Both issues need to be addressed in tandem.

Finally, we want to afford the requisite training to deliver the care that they can provide. This includes medical school graduates who have a learning curve ahead of them. The learning curve is no different from the learning curve physician assistants or nurse practitioners have when they graduate from school. However, physician assistants and nurse practitioners have less training clinically and preclinically in the substantive and experiential components of their training. When medical students graduate, they are able to practice when they leave school. Senate Bill 204 affords the same ability to the medical school graduate who, for any number of reasons, cannot complete a residency program.

SENATOR DOÑATE:
We have received letters of support (Exhibit F and Exhibit G) for S.B. 204 and have attached them on the Legislative website. One letter of support from Dr. Ostovar-Kermani, M.D. (Exhibit H) is a written testimony detailing her experience as a graduate of the Universidad Autónoma de Guadalajara School of Medicine. We have Nevada students falling into the same circumstance as Dr. Ostovar-Kermani. If they attend a school outside of the Country, they cannot practice medicine upon graduation.

We received a report from the American Immigration Council (Exhibit I) on the growing demand for physicians in Nevada. Between 2018 and 2022, Nevada had a 12.7 percent increase in job postings for physicians. General internists had a 45 percent increase in job postings. As noted earlier, I was trying to fill a position for a physician who is bilingual. The report noted from 2018 to 2022, the number of healthcare job postings requiring bilingual skills in Nevada increased by at least 28.6 percent. Brain waste is a term used to describe the

underutilization of immigrants who have the knowledge and skill set to practice. This often leads to underemployment or unemployment. In 2021, 34 percent of Nevada immigrants with professional and doctoral degrees worked in healthcare occupations that did not require those degrees.

The bottom line is, whether it is international medical school graduates or students like Mr. Anguille-Valles, who could be afforded the opportunity to fix the shortages. Senate Bill 204 will give us the opportunity to address it. This bill does not change any of the credentialing requirements or processes set forth by preexisting CPAs by our healthcare payers and providers. The goal is to fill the shortage in Nevada without circumnavigating processes in place.

The goal of S.B. 204 is to establish guidelines for the AP and AOP in the same way we approached physician assistants.

VICE CHAIR NGUYEN:
Can you expand on how other states manage this type of practice?

MR. ANGUILLE-VALLES:
Initially, legislation for APs took hold in Missouri, which was dealing with a similar healthcare shortage in rural and urban regions. Missouri adopted legislation comparable to the legislation in S.B. 204. Other states have followed suit with substantial opposition from several different networks to fill the same voids. States like Kansas, Arkansas and Arizona have a similar process. We will be in the minority of states, but it is growing in states dealing with a similar shortage. This is not only a Nevada issue, but a national issue.

VICE CHAIR NGUYEN:
Does the language emulate the program enacted in Missouri? Are we proposing something more comprehensive in S.B. 204?

MR. ANGUILLE-VALLES:
Missouri's act in some ways is broader than this bill, for example, in the requirements for an associate physician. Missouri requires the associate physician to pass the complex level exams within the three years before they apply for licensure. Missouri is not requiring both sets of boards. This is a minor difference, but it does impact who would be able to apply. Other states after Missouri were able to innovate in this area. After the initial bill was presented, the legislative process in those states reduced the requirement to a bare

minimum. For example, Arizona recently introduced a bill comparable to S.B. 204. In the end, their bill was enacted with a limited license for medical school graduates who can practice at mid-level capacity. The license is limited to one-year terms with a maximum duration of two years. The timeframe is to give them time to reapply for a residency match. Arizona narrowed the scope of who could apply and allow them to use their skills in the interim. Arizona was not addressing a primary care shortage, but an opportunity for medical school graduates to practice.

SENATOR TITUS:
I appreciate you working with me to address my concerns and making modifications on this bill. How many medical school students do we graduate a year and how many residency slots are there?

SENATOR DOÑATE:
Are you referring to Nevada or nationwide?

SENATOR TITUS:
I am referring nationwide. How many students do we graduate nationwide from medical schools? How many residency slots are available?

SENATOR DOÑATE:
I will let Mr. Anguille-Valles respond to your questions. There are statistics on how many students go unmatched.

MR. ANGUILLE-VALLES:
At the end of this month, we should see new match statistics. Therefore, I will speak in generalities to address your question. Approximately 42,000 applicants will participate in the match process. We anticipate 92 percent of domestic medical school graduates and 91 percent of osteopathic medical school graduates will match. That leaves an 8 percent to 9 percent gap, or 3,000 in each area not matching each year.

It is important to understand that the number of those not matching is building. The medical school graduate can reapply to match the next year. However, the more years a graduate goes unmatched, the less likely they will match in subsequent years. Statistics do not track where these individuals reside. I assume they are spread throughout the United States and in foreign countries.

I am certainly a product of this. There is no way of knowing how many are Nevadans or who will become a Nevadan should this bill pass.

The other group is the international medical school graduates. They only match about 51 percent to 52 percent of the time. This group is about 9,000 to 10,000 people who do not match. They are less likely to match on subsequent occasions.

SENATOR TITUS:
When I graduated from medical school, match day was a big day. In your reference to matching, we had about four students apply for programs that were highly competitive. It was common not to match in programs like ophthalmology and urology. The graduates can subsequently match, but with an 11-year internship. It is not uncommon for a graduate not to match when they chose a specific specialty. What should the graduate do for one year if they do not match anywhere, or those in a foreign medical school that cannot get back in a United States residency program?

On section 5 of the bill, you are proposing to remove the ability to have an unrestricted license. Are you striking it entirely so at no time they will have an unrestricted license?

SENATOR DOÑATE:
Yes. The proposed amendment is based on sentiment resulting in general quality metrics and the level of competency established. In five years, we may discover the international medical school graduates are doing great and are passing the exams. At that point, we can reconsider the full license process. This section applies to international medical school graduates.

SENATOR TITUS:
Under section 7, the bill is allowing them in family practices: pediatrics, internal medicine, psychiatry, and obstetrics and gynecology. My concern is some of these practices could have them doing surgical intervention. Will they have hospital privileges? Have you anticipated this will be a problem? Have other states been able to get that type of licensure and privileges to full scope?

SENATOR DOÑATE:
In the stakeholder feedback, we wanted to consider the full continuum of what primary care entails. Mr. Anguille-Valles will share what other states have done.

MR. ANGUILLE-VALLES:
Other states have not left the legislation as expansive as in this section specifically. We did address all areas for primary care because some are overlooked. This bill has expanded the scope, but the AP or AOP cannot practice beyond what the CPA allows them to do. The supervising physician has the responsibility to ensure they can do these types of services. This is comparable to the arrangement with physician assistants who can practice in all practice areas, not just in primary care. The supervising physician will determine the extent the AP or AOP has for hospital privileges.

SENATOR STONE:
I made a campaign promise to deliver more healthcare professionals to rural and urban areas in my district. Senate Bill 204 is a creative way to tap into the brain power in Nevada. By comparison, Arizona gives the applicants time to find a match and fill the gaps in the underserved areas.

The associate physician has a two-year term and NSBME and BOM can revise it. Is there a term limit or can the AP or AOP repeatedly reapply for licensure? Does either board have the ability to deny licensure for performing the job too long? Can they make a living doing this in perpetuity?

CHAIR DOÑATE:
Our goal is to use the historically underserved definition created in past legislation. We want these individuals to focus in the high-risk areas. The communities left behind, like rural areas and neighborhoods north and east of Las Vegas. We do not have enough providers in these communities.

MR. ANGUILLE-VALLES:
The answer to your question Senator Stone is yes. There is no pathway to unrestricted licensure. A medical school graduate, serving as an associate physician, can remain in the position for perpetuity in a mid-level capacity. They can make a living and provide care. Other states have placed a time limit on the terms. Missouri has not so we wanted to embody their legislation. As stated earlier, the longer an individual takes to match; the less likely they will match.

SENATOR STONE:
The amendment for section 27 proposes to strike the language on the frequency a supervising physician is required to review the standard of care. It says those procedures are going to be dictated by the applicable board. Senate Bill 204 also

limits a supervising provider to no more than three associates. What if the board comes up with a more comprehensive reporting system than what you originally proposed? Should the supervision ratio be decreased based on more reporting requirements and more collaboration with the supervising physician?

MR. ANGUILLE-VALLES:
In section 27, subsection 1, paragraph (g), the amendment has additional language to clearly state the procedures the boards may adopt. Pursuant to the review for standard of care in the CPA, it may be no more restrictive than the requirements for the physician assistants. It is my understanding, the regulation requirements for physician assistants are minimal oversight in this area. It allows the physician assistants and supervising physicians to meet the demand without burdening the supervising physician in terms of what is required to be reviewed. The language in S.B. 204 does not go beyond what is expected of a physician assistant. It should not add an additional burden to the supervising physician, which would be contradictory or counterintuitive to the purpose of this bill.

SENATOR STONE:
I am looking at the scope of services. It takes several years to be a psychiatrist. It requires intense one-on-one therapy with a psychiatric professor. I find it difficult for a mentor psychiatrist to oversee three students who have very little psychiatric training. They could be dealing with very severe psychiatric issues. How can we ensure the AP or AOP, who is delivering psychiatric services under the supervision of a psychiatrist, can truly deliver care? Psychiatry is a complicated profession.

MR. ANGUILLE-VALLES:
The amendment for section 34 has a specific provision related to your question. It has additional requirements for continuing medical education requirements specific to that area. The decision to accept an associate physician is entirely up to the psychiatrist. It is at their discretion to determine if the AP or AOP can handle it. The psychiatrist will have to determine if they can invest the time to make sure the AP or AOP is able to provide care. The psychiatrist will need to ensure they are not putting their patients at risk.

SENATOR TITUS:
Section 12 documents the AP and AOP can reapply in two years. When I reapply for my medical doctor's license, I have specific continuing medical

education (CME) requirements. Where in the bill does it mandate similar requirements for reapplying?

MR. ANGUILLE-VALLES:
The bill needs to be extended to add CME requirements. As discussed earlier, section 34 has education requirements in the osteopathic realm because NRS 633 has several CME requirements.

SENATOR DOÑATE:
We will make sure to address it.

SENATOR TITUS:
I am a residency trained family practice doctor. I have a small family practice by myself, and it is 30 miles from the nearest healthcare facility with professional emergency medical technicians. The closest pharmacy in any direction is 30 miles away. I had to know all the books and all the cases. I would go out into the field to provide care. My level of competency must be broad. In comparison, a specialist must know one book. I am concerned that an AP or AOP will be in a rural area without the extra training and have limited backup.

When I graduated, I had a three-year family practice residency. I developed rotations that provided knowledge for my rural area and the potential situations I would encounter. I chose to rotate with doctors working in rural Nevada so that I could see what they would see. Sometimes the best program is a true apprenticeship where the individual works with another doctor. My concern is the doctor physically being with the associate physician. I had many residents rotate with me and they received skills by obtaining a hands-on experience. I am not opposed to the mentorship, but we need to make sure they can learn and not be placed with minimal training unsupervised.

Before I am comfortable with this bill, we will need to have further discussion. I like the concept of this bill, but I have concerns about the training. I like the fact they can do an apprenticeship if they cannot match in a residency. We want to know they are getting mentorship and training. They need to pass the residency board. If they can show competency, then I would be comfortable.

I want to support this bill. I am concerned that we are putting citizens in rural areas with less-than-competent people because there is nobody else to be out there. In an urban area, the AP or AOP has access across the hallway to a

specialist or a colleague. I would be more comfortable using this in underserved urban areas and not in rural areas. In an underserved urban area, the AP or AOP has help five minutes away, whereas an AP or AOP in a rural area does not have immediate access to help. Urban areas have more support than rural areas.

SENATOR DOÑATE:
Based on your concerns, I can meet with you on this bill. I have some ideas on how to address the rural areas. We want to make sure that we have more physicians in rural areas. I have an idea as to how to solve it.

VICE CHAIR NGUYEN:
Thank you, Mr. Anguille-Valles for your presentation. While I am sad that we have lost you from the medical community, it sounds like you have joined an amazing legal community. It is good that you have a health policy background.

TIFFANY OSTOVAR-KERMANI, M.D.:
As discussed by Senator Doñate, I did submit my written testimony in Exhibit H to support this bill. I am a resident of Texas and have no problem relocating for an opportunity like this one. I want to address the concern regarding competency. As a medical school graduate, I had to attend an additional year of medical school in New York. I rotated specialties including surgery, psychiatry, pediatrics, family medicine, internal medicine, infectious diseases and other areas. This is more training than a medical school student in a residency specialty receives. I had an additional year of clinical experience.

I understand there are concerns that we are pushing people into rural areas with no support. However, the support is received from the supervising physician in the area. The physician in the area is a support system as well as the teacher. When a new physician applies for a rural area, they do not necessarily have as much experience as a seasoned practitioner of medicine. We are all quick learners and able to pass our exams. We are more than qualified to work in these roles.

KELVYN GARCIA-ALFONSO:
I am a Cuban doctor and am currently enrolled in the nurse practitioner program. I understand the concern with inexperienced people working with patients mainly in obstetrics and gynecology. We are already putting a nurse practitioner, without a medical doctor, in the field. As a medical assistant, I have had to

assist nurse practitioners who have misdiagnosed a patient. Even though I have 12 years of medical experience, I must stay within my scope.

SAIDEH NIA:
I support S.B. 204. I do not want anyone else to go through what I have gone through. I sacrificed to graduate from medical school. I now instruct medical assistants, nurses and pre-med students. Although I enjoy teaching, I wish I had an opportunity to give back to the community as a physician. I hope this bill passes to help medical school graduates pursue their dreams.

SARA WATKINS (Interim Executive Director, Nevada State Medical Association):
The Nevada State Medical Association opposes S.B. 204. It will create a pathway to dismiss the value of post-graduate training. In turn, it can create risks for patients and physicians. As a patient advocacy organization, we appreciate your attention to Nevada's healthcare provider shortage. We share your goal of wanting to improve the State's access to care for all Nevadans. The best path for those who have graduated medical school is to complete a residency, which is extra training. It is the foundational requirement for a doctor to be deemed clinically competent and safe to care for patients. Working to expand Nevada GME residency opportunities is a better path for trainees who are not happy with their current residency program.

We can work with you to expand Nevada's GME and residency programs. The goal should be for all doctors, who graduate from a Nevada medical school, to find immediate placement in Nevada, should they want to stay here. We want to attract the best and brightest graduates from medical schools throughout the Country. We have not fully reviewed the amendment to this bill, but are happy to work with the bill sponsors. We want to improve access to high-quality care for Nevadans.

ELLIOT MALIN (Nevada Osteopathic Medical Association):
We are neutral on S.B. 204. We appreciate the sponsor working with us on this bill and a conceptual amendment (Exhibit J). It is vital for Nevada's future to provide GME slots. As long as these doctors continue to have a limited license, we will stand in neutral and potentially in support of the bill.

BARRY COLE, M.D.:
I am neutral on S.B. 204, however I would like to see a few changes to it. Allowing an AP or AOP to be called a doctor, is no different than a doctor of

nursing practice. One of my residents informed me that last year, one-third of his graduating medical class at the University of Oklahoma did not match. It used to be a student could get a residency in anything. Psychiatry residencies fill up every year with no leftover spots. We need more residencies in psychiatry.

At first look, this bill sounds like a decentralized residency program. The concept is brilliant. I also started out in Guadalajara and then transferred to Wake Forest School of Medicine to complete my education. I would have had a similar situation as the previous caller had I stayed in Mexico. I would have had to take a fifth-year pathway. A second alternative is an internship and social service for a year in Mexico to then start over with an internship in the United States.

Emergency room doctors have no training in psychiatry. They have three years of residency with not one rotation. When I was moonlighting as an emergency room doctor, I figured out right away that every other person had a mental illness. Medicine is perishable. If you do not use your skills, you will lose them rapidly. I applaud the effort of this bill to get more people practicing. We need to figure out how to do it with all the guardrails in place, so everybody is safe.

GEORGE ROSS (Touro University):
We are neutral on S.B. 204. We support increasing the supply of physicians in Nevada. Our support is contingent on the associate physicians not taking residency positions away from graduates of Nevada medical schools or slots from public health students educated in Nevada.

HELEN FOLEY (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 to Nevadans. We are neutral on S.B. 204. We are all concerned about healthcare workforce shortages plaguing our State, but have questions about how some of the processes will work with health plans. We commit to work with the bill sponsors.

TOM CLARK (Nevada Board of Medical Examiners):
Senator Doñate has worked with our senior staff. It was Senator Doñate's work that caused the NSBME to put together a legislative subcommittee for the first time in its history. The subcommittee reviews this type of legislation. I will

present today's hearing to the subcommittee, so they can deliberate the bill. We look forward to working with Senator Doñate as we move this forward.

The shortage of providers in Nevada is real. The NSBME does not want to be a barrier to this bill. However, we want to make sure that it is thoughtful and well designed.

JOAN HALL (Nevada Rural Hospital Partners/LICON):
Rural hospitals have a need for doctors. We recognize the issues Senator Titus raised. The distance travelled to receive provider care is exactly what happens in rural Nevada. The mentorship and a good nurse beside the AP or AOP is important. We want good care for our patients. It is not excusable to lose brain power because somebody did not match with a residency. I look forward to meeting with Senator Doñate.

SENATOR DOÑATE:
I am glad you could hear the real-life stories, not just from Mr. Anguille-Valles, but others who find themselves in this situation. Supporting international medical graduates to obtain a license to practice is a very good proposal. It can help bridge the gap between health equity and the community. A diverse medical society helps all of us, especially when we can uplift physicians that not only understand the cultural barriers of a community but have lived through it. This is something that can help reduce the disparities that we see in existence.

This is not a new concept and S.B. 204 is a commonsense solution. It can attract more individuals to our State. Multiple states, as we have reiterated today, have enacted this legislation and it has been successful. I will do my part to address some of the concerns documented today. We will present the proposed amendment prior to the bill going to a work session.

We will address the fiscal note attached to this bill. We have additional work to do, but we want to thank everyone who has weighed in on this issue. We want to solve the physician shortage in Nevada, and we firmly believe that this bill will improve our communities. Thank you for letting us present this bill today.

VICE CHAIR NGUYEN:
We will close the hearing on S.B. 204. I will turn the gavel back to Chair Doñate.

CHAIR DOÑATE:
The last item on the agenda is the work session. We will begin with S.B. 4.

SENATE BILL 4: Revises provisions governing certain programs to pay for prescription drugs, pharmaceutical services and other benefits. (BDR 40-220)

DESTINI COOPER (Policy Analyst):
I have a work session document (Exhibit K) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on S.B. 4.

SENATOR NGUYEN MOVED TO DO PASS S.B. 4.

SENATOR LANGE SECONDED THE MOTION.

SENATOR TITUS:
I am going to vote no on this bill. I am concerned these monies are from the tobacco fund. If anything, these funds should be more restricted in what we are using tobacco funds for. I am worried that we are deluding what we can use the funds for and somewhat diluting the purpose of these funds initially.

THE MOTION CARRIED. (SENATORS TITUS AND STONE VOTED NO.)

* * * * *

CHAIR DOÑATE:
Let us move on to S.B. 43.

SENATE BILL 43: Makes various changes relating to services for aging persons and persons with disabilities. (BDR 38-219)

MS. COOPER:
I have a work session document (Exhibit L) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on S.B. 43.

SENATOR NGUYEN MOVED TO DO PASS S.B. 43.

SENATOR LANGE SECONDED THE MOTION.

SENATOR TITUS:
I am going to vote no on this bill. During the hearing, I expressed my concern about the number of commissions the State already has. Currently, we have over 250 boards. We have difficulty filling these boards, and I do not want to see another one. In addition, I do not want to create additional silos for all of these entities. We need one board that can encompass all of them. I am concerned we are diluting what we are trying to accomplish.

THE MOTION CARRIED. (SENATORS TITUS AND STONE VOTED NO.)

* * * * *

CHAIR DOÑATE:
Let us move on to S.B. 44.

SENATE BILL 44: Revises provisions related to dental and oral health care. (BDR 38-221)

MS. COOPER:
I have a work session document (Exhibit M) describing the bill and its amendment.

SENATOR TITUS:
I am going to support this bill. I appreciate the Nevada Department of Health and Human Services addressing my concern regarding the qualifications of the dentist.

CHAIR DOÑATE:
I will entertain a motion on S.B. 44.

SENATOR NGUYEN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 44.

SENATOR TITUS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

Remainder of page intentionally left blank; signature page to follow.

CHAIR DOÑATE:
That concludes our work session for today. As there is no other business before the Senate Committee on Health and Human Services, we are adjourned at 5:27 p.m.

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
S.B. 137	C	4	Jimmy Lau/Dignity Health-St. Rose Dominican	Letter of Support from Deepa Nagar, M.D.
S.B. 204	D	8	Anthony Anguille-Valles/Self	Presentation
S.B. 204	E	12	Anthony Anguille-Valles/Self	Conceptual Amendment Legislative Counsel Digest
S.B. 204	F	13	Senator Fabian Doñate	Letter of Support from Refugee Advocacy Lab
S.B. 204	G	13	Senator Fabian Doñate	Letter of Support from Dr. Manu Mathew
S.B. 204	H	13	Senator Fabian Doñate	Letter of Support from Dr. Tiffany Ostovar-Kermani
S.B. 204	I	13	Senator Fabian Doñate	Report from American Immigration Council
S.B. 204	J	21	Elliot Malin/ Nevada Osteopathic Medical Association	Conceptual Amendment NOMA
S.B. 4	K	24	Destini Cooper	Work Session Document
S.B. 43	L	24	Destini Cooper	Work Session Document
S.B. 44	M	25	Destini Cooper	Work Session Document