MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
March 21, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:31 p.m. on Tuesday, March 21, 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

STAFF MEMBERS PRESENT:

Destini Cooper, Policy Analyst
Norma Mallett, Committee Secretary

OTHERS PRESENT:

Jill Tolles, Executive Director, Guinn Center for Policy Priorities
Michael Stewart, Interim Research Director, Guinn Center for Policy Priorities
Jafeth E. Sanchez, Ph.D., Director, Latino Research Center, University of Nevada, Reno,
Joan Hall, President, Nevada Rural Hospital Partners
John S. Packham, Ph.D., Associate Dean, Office of Statewide Initiatives, University of Nevada, Reno, School of Medicine
Blayne Osborn, President, Nevada Rural Hospital Partners
Tom Maher, CEO, Boulder City Hospital
Jeff Prater, CEO, Carson Valley Health
Denise Ferguson, Administrator/CEO, Mt. Grant General Hospital
Jason Bleak, CEO, Battle Mountain General Hospital
Patrick Kelly, President/CEO, Nevada Hospital Association

Dan Musgrove, Valley Health System
Sarah Adler, Nevada Advanced Practice Nurses Association
Robyn Dunckhorst, CEO, Humboldt General Hospital
Brandon Chadock, Administrator/CEO, Pershing General Hospital
Toni Inserra, CEO, South Lyon Medical Center
Matt Walker, CEO, William Bee Ririe Critical Access Hospital
Melissa Rowe, CEO/Administrator, Grover C. Dils Medical Center
Robert Carnahan, CEO, Banner Churchill Community Hospital
Sandra A. Koch, M.D.
Timothy C. McFarren, M.D.
Lindsey Harmon, Executive Director, Planned Parenthood Votes Nevada
Elyse Monroy-Marsala, Nevada Public Health Association
Sarah Watkins, Interim Executive Director, Nevada State Medical Association
Caroline Mello Roberson, Southwest Regional Director, NARAL Pro-Choice Nevada
Shelbie Swartz
Fay Roepcke, M.D.

CHAIR DOÑATE:
Today we have two presentations and two bills.

JILL TOLLES (Executive Director, Guinn Center for Policy Priorities):
I am here to present an update and slide show (Exhibit C) on where the Guinn Center for Policy Priorities, is and where we have been and open the dialogue for more conversations in the future as we hope to be a resource to your Committee and the Legislative Body. I served three sessions as an advocate and then three sessions as an Assemblywoman. I am now pleased to be the Executive Director of the nonpartisan Nevada Policy Research Institute.

The Guinn Center for Policy Priorities was founded as a 501(c)(3) organization in 2014. It came together from a group of dedicated Nevadans who saw a need for independence and a nonpartisan think tank that served our entire State and the increasing needs of our ever-growing population. Our board is made up of Democrats and Republicans. We seek very intentionally to make sure that we represent all ideological backgrounds, experiences and industries and to address the pressing topics of the day in our State. We are data-driven and independent in nature. We are affiliated with the University of Nevada, Reno (UNR). We are currently housed in the Innevation Center, but we have researchers in Las Vegas and Reno, and subject matter experts across the State. We have collaborations

and research partnerships with UNR and the University of Nevada, Las Vegas (UNLV).

We are named after our namesake, Governor Kenny Guinn, Nevada's twenty-seventh Governor who was recognized for knowing the budget backward and forwards, being a champion of education and for the ability to work across party lines. So why the Guinn Center? The picture, Exhibit C, Slide 4, illustrates our experience where you might have two individuals looking at what they think are the facts. For example, one person sees there are three bars on the ground, and the other person sees four, depending on where they are standing. I experience this daily when we are given certain facts, research or information from the viewpoint of where we are standing. The most helpful way to see the whole picture is to widen the lens to see all the information to land on the best decision.

I care about this work because I have sat where you now sit, and I know how difficult it is. I know how oftentimes you are hearing from so many different constituencies and groups bringing forward information from a specific perspective. It is important to do your job based on the best facts and data that you can so that you can serve this State well.

Our team is continuing to expand after COVID-19 and has had several different directors for various good reasons. We were founded by Nancy Brune, who did an incredible amount of work in the initial years. When she stepped away to serve in public office as a Las Vegas City Councilwoman, Dale Erquiaga came on board to become Executive Director. He was soon to be the Nevada System of Higher Education Chancellor. Dr. Dana Bennett, formerly with the Legislative Counsel Bureau and the Nevada Mining Association, took over as Interim Executive Director, and then I stepped into this role in January 2023.

With a number of those changes, it has been an opportunity to come into this organization and build from the legacy of the great work done before me, but also to rebuild everything from our strategy, team and processes. Some of you have asked how we manage our team as well as our funding. In the illustration, Exhibit C, Slide 5, there are two branches in our organization. The green branch is an assistant director who will be on board in April 2023 to handle operations, outreach and fundraising. Our administrative side is separate from our research side. So, I divided the business operations and the funding side from the research side so there was an inherent separation between the two. That way,

we can ensure that the researchers are focused solely on the research, not the money.

In response to questions about where our funding comes from, in the first few years of the Guinn Center, it was primarily philanthropically funded, mostly by our board members who wanted to see a nonpartisan, independent think tank in our State. Over the last few years, we have taken on more contracts. Most of our funding today comes from State and federally-funded contracts and our philanthropic arm. We will continue to focus on broadening that to answer the questions you are asking in the sessions. We will also look at the bigger picture, questions with unrestricted funding in the areas of education, economy, health, natural resources and the tax policy budget.

One of the checks we have put in place in our strategy is to make sure the research is independent. Additional checks are to ensure that we have steering committees and a team of advisers through our advisory council that is with us from the beginning of the research project to the end. They will be coming from different perspectives and various subject matter expertise to help with the questions that we are asking to ensure that we are asking the right broad questions. At the end of a project, we are going to put our research through a rigorous peer review to ensure that even if people may not necessarily like the outcomes of the research, they can stand behind it, knowing that it has been fact-checked and thoroughly vetted. We want to ensure that when we come before you, anything we bring with a Guinn Center stamp of approval has been through a thorough process.

On the research side, we will have a new interim research director about whom we are excited. We have a current team of researchers both in Las Vegas and Reno. We contract out with faculty from UNLV and UNR and other subject matter experts. We have graduate students who work on research and soon will have an internship program. We envision building our staff and contracts with some of the smartest brain trusts in our State. We will continue to work with faculty graduate students, subject matter experts and interns while looking at fellowship programs in each of our key categories in the State.

This year, we are focused on developing strategy, rebuilding the team, and expanding our existing talented team and funding. Next year, you will see more of the production of the research we are currently working on. We are publishing some of that research, but you will see less from us in this Session as we complete those research projects. You will see more in 2024 through

research papers, policy briefs, fact sheets, ballot explainers and, when appropriate, recommendations for policy action. Then in 2025, we will promote that work to the public, the Executive Branch, the Legislature and our local entities.

On day one, we moved into the Innevation Center, and on day two, I reached out to an extremely talented former face that you would recognize as our retired Research Director for the Legislative Counsel Bureau (LCB), Mike Stewart. It took a little convincing to have him come out of retirement and come on board as our Interim Research Director. One of the important things in our initial conversation was that we are both big fans of the LCB and the work the staff does here in this building. It was important to know that we want to be a resource that LCB could turn to as they are providing their briefs to you.

MICHAEL STEWART (Interim Research Director, Guinn Center for Policy Priorities):
We are both excited to be partners with your staff, university systems, other organizations, and policy institutes Statewide. We have done some great meeting tours with our partners at UNLV and UNR, and partners at the community college system. There is great brain trust there that we can connect with as we do our work. It is a collaborative process in which we are engaging. We are enthusiastic as we move forward in this rebuilding phase. You will see more of us as we approach the 2025 Session and build out our current and future research. We are working in the economic policy space with a workforce participation study and are pleased to have partnered with the UNLV Center for Business and Economic Research.

We have a few things going on in education policy with regards to out-of-school youth, partnering with the Nevada Department of Education on some needs assessments, and looking at some per pupil funding and how that overlays with various types of school functions and Title I schools versus high socioeconomic schools, heavy Parent Teacher Association work and how the per pupil funding overlays with those inputs. We are also working with the Children's Cabinet on early childhood issues. We have a governance policy going on right now. Our Director of Economic Policy, Meredith Levine, is working on the budget explainer that should be helpful to you.

On the social policy side, we are examining housing challenges for those with intellectual and developmental disabilities. In partnership with the Grant Sawyer Center for Justice Studies and the UNR School of Social Work, we are working on a human trafficking study and looking to expand on that with some federal

funding. We are still busy doing that sort of work but will be ramping up and will have more for you in the next 12 to 18 months. The partnership opportunities are vast, and we are excited. We want to be a resource for you, your staff and the other brain trusts that we have in the State.

SENATOR NGUYEN:
I am excited about the prospects under your leadership. How are you determining what kind of policies, research and areas you are going to study? Is it possible to have policy research done in the area of health care?

MS. TOLLES:
Yes, that would be one of the key areas. We want to build out our research team to have some thorough studies for you, as well as short explanations and summary briefs. The next steps are to get input from each one of you to find out what areas you would like to see deep-dive independent and original research done. Additionally, we have an advisory council that we are continuing to build out to ask what some of the most pressing issues are in our State. We will filter those down and look at the expertise of our staff and determine what we will be able to get done before the next Session.

SENATOR NGUYEN:
I am excited about this. As legislators, we will turn to LCB because they are a great resource. There are a lot of outside organizations that we turn to, like the Council of State Governments or the National Conference of State Legislatures. The idea that we have homegrown talent and research coming from Nevada, based in Nevada, and specific to Nevada, and how it might be implemented here will be exciting to see the work that comes out of the Guinn Center.

CHAIR DOÑATE:
We will go on to our next presentation on the status of Latino health.

JAFETH E. SANCHEZ, PH.D. (Director, Latino Research Center, University of Nevada, Reno):
I was born in Mexico, grew up in Yerington and attended school in the Lyon County School District. I look forward to sharing information regarding health issues for the Latino population (Exhibit D), which I have submitted. The Latino Research Center at UNR opened its doors 20 years ago. Our mission is focused on four areas: fostering research, faculty collaborations, student achievement and advocacy and outreach, Exhibit D, Slide 2. My vision for the Research Center is to serve as a pillar of Latino research so that organizations

like yours and other entities can also use it. Our findings and discoveries will help to benefit social and cultural outcomes, whether it is Nevada or beyond.

This presentation will focus on Latino/Hispanic demographics centering more on health care which can be very exhaustive, and then narrowing in on some aspects of our Latino Research Center efforts. We are approximating one-third of our population having this identity, which is a 2.2 percent increase. It does not seem like very much, but it is 175,000 additional people that we need to serve and can help through health access. Nevada has the highest birthplace diversity among all other states. That is an important marker for thinking about how we serve this community now and in the future.

When we focus on education, we see our higher education mirroring that proportionate percentage of the population at 31.6 percent. In the Kindergarten-Grade 12 (K-12) setting, that is much larger. We will soon approach 50 percent. When we look at these population increases, it also comes with more disparities in healthcare access. Fifty percent of U.S. Hispanics have reported they have less access to quality medical care.

When we look at preventative care, they are less likely than their counterparts to receive that care. They are looking at the preventative care side. The 43 percent of students in K-12 who are already beginning at these levels need to catch up on their access to have improved quality of life. In the future, they end up with higher rates of jobs with increased risk for health problems.

A key point that focuses on the Latino aging population for those demographics is that they face greater challenges in the aging process. When we think about discrimination, they face a double jeopardy standard when it comes to their age and their racial/ethnic identity and tying it back to health care. They also live in higher poverty rates as compared to their counterparts. There is a large discrepancy in how rates differ; in turn, they have more negative influences on health outcomes.

In terms of Nevada's general population, we see the top three areas that are the leading causes of death for Latinos/Hispanics. The first one is heart disease. That is the leading cause across our racial and ethnic demographics. The second cause of death is cancer. The third cause of death, diabetes, is often linked back to obesity. So again, there are a lot of things that we can help to remedy through healthcare improvements.

Another area to highlight is self-medication for illness. There are a lot of public service announcements in our State to support this endeavor, but we still see a massive need for what we relate to self-medicating and the direct relationship that is tied to healthcare access. Many Latinos are transporting antibiotics and that is because they are not affordable or available. If we can identify remedies to prevent this, then we can help reduce what we see as resistance to drugs which later means they do not have the quality of health they deserve. Studies have reported 56 percent are accessing antibiotics without a prescription from doctors. That is a massive discrepancy from their counterparts.

In K-12, 43 percent of early diagnoses for Latino children have prevalent barriers with a diagnosis specifically to the autism spectrum disorder. As much as 3 percent to 4 percent can hinder their trajectory into those next pieces of higher education linking it back to even those challenges that we are seeing with our aging population. This is surmounted by other factors such as transportation, access to services, economic and legal status, and ongoing health insurance concerns. If they are not diagnosed and are not receiving the information and support they need, the lack of services results in different behaviors that are not valued in school systems. Therefore, they end up facing more disproportional aspects in relation to disciplinary procedures which leads to more negative consequences down that educational trajectory.

Nevada offers few services and delivery models or interventions that help support Latino students who are identified on the autism spectrum, which means that the needs of the Latino population are not being met at the same level as others. In Nevada, only two out of every three children who have this need are supported. That is coupled with a longer waitlist. Our population is often part of a low-income family background who wait longer compared to those who have private health insurance and quicker access to those things that sometimes many take advantage of.

I would be remiss if I did not mention behavioral health concerns. When we think of the U.S. population, more than half of adults with a mental illness do not receive treatment. This can be as high as 27 million individuals who are awaiting support. In Nevada, those discrepancies in identifying whether they need support is varied. That has to do with who the population is being served, who is being identified as Latino/Hispanic, or how they seek their participants.

While a lot of factors come into play, there is still a massive need when it comes to behavioral healthcare concerns for this population. They seek primary

care support, but it is often for somatic symptoms. It is often a manifestation of those depressive symptoms. A recent study in Nevada found that Latinos had lower rates of depression. Cultural norms might influence how they are identifying their symptoms. For example, a Latino who may constantly be crying could be identified as a person with depression. If they are not sleeping well, they might not associate that it is a part of depressive symptoms. That tends to influence also what our rates are for the need. It is estimated as being much higher and, in some studies, much lower. So, again, it shows there is a need to explore this more in-depth and center on the work of Latinos in Nevada.

It is important to think about this demographic under the overall vulnerability index that the Centers for Disease Control and Prevention provides, Exhibit D, Slide 10. Glancing quickly at these vulnerabilities, we can see that our population for Latinos/Hispanics hits so many of these points that, unfortunately, end up emphasizing those barriers they experience.

It is important to note that beginning with a child all the way through the aging group, how often they end up having these barriers they must overcome. It is important for our centers and organizations to bring light to this need so we can better serve our communities. Having expertise in the education field, and for me personally, we refer to that as opportunity gaps.

In health care, it is the same thing, not that Latinos/Hispanics simply have poor health by default of who they are or their gender or race identity. It is because they have not had the same opportunities for healthcare access to improve upon the health quality we all want to see, and our entire State can benefit from. That begins with healthcare access coverage and dissemination of knowledge, which means they can have more access to the resources they need. One of the largest resources is representation in the healthcare setting, whether entering an office to seek healthcare or visiting a social media page, which we see Latinos using more often now to seek information.

I will end with the increased cultural language adaptations. Sometimes it is a huge, robust endeavor. Still, it can also be when a person walks into an office to seek support that someone there resembles who they are or, if nothing else, at least understands our cultural context and gives more meaning to their experience. This, in turn, leads to more opportunities for them to seek health care and have that healing that we desire in our State.

What is the Latino Research Center doing on these endeavors? For this presentation, we are focusing on our health-centered efforts. The Community of

Bilingual English-Spanish Speakers is a grant-funded endeavor. We are in our fifth year and have 120 students we started supporting at the high school level who have been pipelined into higher education to support health, science, technology, engineering and mathematic fields. We are in the process of having another round of this grant approved within the next month, which is roughly $1.2 million. Ironically, it is in Lyon County. It will be a nice shift from supporting an urban setting to now focusing on the rural needs of our State.

The Hispanic Community Health Study of Latinos is underway in partnership with the Department of Geography at UNR, other entities, community research leaders and our Latino Research Center. The hope is that it will support community forums and the dissemination of information. It includes more than 400 families across our northern Nevada region, what they are facing during housing instability and their health needs.

In other efforts you see listed here in Exhibit D, Slide 12, we are either supporting them with evaluation needs or helping to distribute studies or surveys. We are collaborating on how we can help them reach the Latino community whether it is through advertising or through the different personal and professional connections that we have with our community members. We are helping to form community forums where they have identified findings and are using our Latino Research Center to help reach the community in an engaging manner. A lot of work is going on but lots of fun things, too. I echo my colleagues from the Guinn Center as we hope to collaborate on more endeavors together because our aims align.

CHAIR DOÑATE:
I want to go back to the slide on opportunity gaps. In talking about health equity, this is an important slide for all of us to visualize. There are efforts we can make in terms of health literacy, which is what we saw during COVID-19, but also what do cultural and linguistic resources look like, especially for certain populations that might not have the same standing as others?

My first question is about access to health care coverage, and what we have noticed, even recently. I received a report a few hours ago which laid out for me the district demographics. It showed that in my Senatorial District No. 10, of the Latinos that comprise my residents, 25 percent are uninsured. What are some of the trends you are seeing in healthcare access and why do so many Latinos in the State lack healthcare coverage?

DR. SANCHEZ:
I have not had the chance to explore that yet, but that percentage of roughly 25 percent is accurate in terms of what we are seeing across the Country. When we look at our 44 million population across the U.S., about a quarter of the immigrant population is undocumented, so that might also be a linkage. I have family members who are documented and struggle with the trust and mistrust that comes with healthcare access. Oftentimes, they are told to call a person that will help them, and they are not sure whom they are calling or if they want to share information with them. In an anecdotal way, those are some of the things that suggest exploring through focus groups and other means. However, I am unable to confirm that right now.

CHAIR DOÑATE:
I appreciate the work you are doing to collect data points on this because there are metrics we have seen, not just in Nevada but nationally, that there are segments of the population that do not have access to health care. We must discuss that with the Legislature, particularly with this population group and others. The Latino population is a sizable portion of the State, about one-third. The issues they experience are not just Latino issues, they are Nevada issues. That is something we must carry. With your presentation and the delayed care, we see that it can impact the social determinants as they move on in later life. I appreciate you detailing some of the research efforts you have been doing, and I appreciate your guidance. We look forward to collaborating with you.

I will now open the hearing on Senate Bill (S.B.) 241.

SENATE BILL 241: Revises provisions relating to Medicaid. (BDR 38-971)

SENATOR ROBIN L. TITUS (Senatorial District No. 17):
I represent Senatorial District No. 17 which includes all of Douglas, Lyon, Churchill, Mineral and Esmeralda Counties and part of Nye, specifically Tonopah. Senate Bill 241 concerns our Critical Access Hospitals (CAHs) of which there are only 13 in the State. The four in my Senatorial district are: Banner Churchill Community Hospital in Fallon; Carson Valley Health in Gardnerville; Mt. Grant General Hospital in Hawthorne and South Lyon Medical Center in Yerington, which is why it was important to me to bring forward this legislation.

This Session, we provided the Committee with the Medicare Learning Network information on what a CAH is and what swing beds are. The bill is straightforward. Section 1 requires that Nevada Medicaid pay CAHs at their

cost for providing outpatient services and swing-bed services to Medicaid beneficiaries. Currently, Nevada Medicaid does this for all critical access hospital inpatient services but not outpatient services. This will come at a cost to the State which will hopefully be discussed in the Senate Committee on Finance later in the Session, but the policy here is important to these hospitals.

Pursuant to 42 C.F.R. § 413 (2023), the Centers for Medicare and Medicaid Services (CMS) reimburse a CAH at cost for Medicare beneficiaries for both inpatient and outpatient services including swing beds and allows for state Medicaid programs to do the same. The CMS does this because they realize it is vital to small rural hospitals to keep them open and provide services to their communities.

Cost-based reimbursement does not make a profit for hospitals but acknowledges that they also should not be taking a loss for providing services to our Medicare and Medicaid recipients. They are simply being paid what it costs them to provide services in their community, and it does not include any costs of physicians or other professional services.

In any given year, about 25 percent of CAHs in Nevada have a net loss in operating revenues. This bill will go a long way in ensuring we do not have any of our CAHs in Nevada at risk of closing, and that they remain in their communities providing access to care for all our Medicaid beneficiaries.

JOAN HALL (President, Nevada Rural Hospital Partners):
I share my position as President this year with Blayne Osborn as he is replacing me when I retire at the end of the year. The Nevada Rural Hospital Partners (NRHP) were formed in 1987 with the sole purpose to maintain access to hospital-based healthcare services in rural Nevada. Senate Bill 241 is an important policy that will assist in preserving access to health care for rural Nevadans and the sustainability of our CAHs. Dr. John Packham will provide background and historical information on critical access hospital types as we have different participation and payment conditions than other hospitals. I will provide information on the types of services provided by these 13 hospitals and Blayne Osborn will finish by talking about financial information.

JOHN S. PACKHAM, PH.D. (Associate Dean, Office of Statewide Initiatives, University of Nevada, Reno, School of Medicine):
Senate Bill 241 would direct our Nevada Medicaid program to amend the State Plan for Medicaid to allow for cost-based reimbursement for outpatient and

swing-bed services received by Medicaid patients in a CAH, which is a designation given to eligible rural hospitals by the CMS in response to over 400 rural hospital closures during the 1980s and early 1990s. Since its creation, Congress has amended the CAH designation and related program requirements 11 times through additional legislation.

Currently, there are 1,358 CAHs located throughout the U.S. including 13 CAHs in Nevada. The CAH designation is designed to reduce the financial vulnerability of low-volume rural hospitals and improve access to health care in keeping essential services in rural communities. To accomplish this goal, CAHs receive certain benefits, including importantly cost-based reimbursement for Medicare inpatient and outpatient services to rural residents.

Eligible hospitals must be located in a rural area and meet the following conditions to obtain a CAH designation. They must have 25 or fewer acute inpatient beds. They must maintain an average length of stay of about 4 days or 96 hours or less for those acute care patients. All CAHs must provide 24/7 emergency medical services (EMS) to their community. They must be more than a 35-mile drive from another hospital or be more than a 15-mile drive from another hospital in an area with mountainous terrain or only secondary roads, which is the case with Incline Village Community Hospital.

In the Balanced Budget Act of 1997, Congress also created the Medicare Rural Hospital Flexibility Program or the Flex Grant Program to support new and existing CAHs in Nevada and other states. The Flex Program provides federal cooperative agreements to states to help them achieve their strategic goals and provide technical assistance and support for quality improvement in those facilities, financial and operational improvement activities and then finally, population health and rural EMS work that serves their CAH communities.

The Nevada Flex Program is our State's version of the larger federal program. It is housed in the Office of Statewide Initiatives at the UNR School of Medicine. My office has overseen the Nevada Flex Program and CAH designation process in our State since 1999. To date, the Nevada Flex Program has received $12 million to support a wide range of technical assistance to our State's 13 CAHs with about 40 percent of those dollars subcontracted to NRHP to assist my office in performance and quality improvement activities in CAHs in Nevada.

Since 2001, when Nevada designated its first CAH in Hawthorne, Nevada, Mt. Grant General Hospital, the CAH designation has been a game changer and has helped stabilize rural hospital financial performance and improve the economic viability of rural hospitals in our State. The Medicare cost-based reimbursement received by those facilities has kept the doors open in a couple of our most vulnerable rural hospitals over the past two decades.

An important piece of unfinished business is how CAHs are reimbursed by state Medicaid programs. In establishing the CAH designation and like many features of state Medicaid programs, Congress left it up to individual states to determine how Medicaid will reimburse CAHs. Several states utilize some form of cost-based reimbursement for CAHs, while other states follow a prospective payment system approach. Additionally, variation may exist between inpatient and outpatient payment policies as is the case with Nevada.

Over the past decade, every CAH in Nevada has experienced a growth in the number and proportion of patients with Medicaid coverage. What S.B. 241 would accomplish is to provide or allow those same low-volume rural hospitals to receive cost-based reimbursement for all services provided to Medicaid patients, as is currently the case with cost-based reimbursement they receive for care provided to Medicare patients.

In summary, S.B. 241 represents an important opportunity to address the financial headwinds currently faced by our State's rural hospitals and to ensure access to essential healthcare services for our State's 300,000 rural and frontier residents.

MS. HALL:
I provided you with the NRHP 2023 Consortium Map (Exhibit E), which is worth a million words. Looking at this map, you can see that the CAHs provide care in 90 percent of Nevada's land mass to only 10 percent of the population, but it is a huge area. You can also see the distances from the nearest urban Nevada hospital average over 100 miles. You can also see that Ely in White Pine County is 242 miles from Winnemucca in Humboldt County, which is 166 miles, so that is a long distance for patients.

If those hospitals were not there, it would be a long distance for patients who need transportation to a tertiary facility because we can only keep patients with an average length of stay of 96 hours. If the patients need a higher level of

care, we must have transfer agreements with all our urban hospitals to accept these patients.

The map also shows the distance of each of these rural hospitals from each other as well as the urban centers. All these hospitals must have a 24/7 EMS. These hospitals vary in size. We have two hospitals that only have four acute beds. We have six hospitals with the maximum of 25 beds, and the rest vary in between. Seven of these hospitals have distinct long-term care associated with the hospital and those are the only long-term care facilities in their communities. That is a vital role in the community. Only five of these hospitals have an intensive care unit, and only seven provide surgical services. Seven also provide the only lab and imaging in their community. There are no outpatient labs and no outpatient diagnostic centers. The hospital is the only place you can go for labs or x-rays.

Sadly, and not unlike what we see in much of rural America, we only have three CAHs that provide obstetric services. Those are in Fallon, Winnemucca and Ely. That is not unlike rural America as 60 percent of rural American communities are without services. Of the 13 hospitals, 11 operate rural health clinics. The only primary care in their communities typically is provided by these hospitals through the rural health clinics.

Eleven of our hospitals have swing-bed services as shown on the Swing-Bed Services Fact Sheet (Exhibit F). It is a special designation CMS has allowed for rural hospitals, not just critical access, but any rural hospital to use their acute bed as long-term care if a three-day hospital stay and a skilled service is required. The expectation is that you will return to your post-hospital stay health. It is for intensive intravenous, physical, speech or occupational therapy and getting people to return home. Seven of our CAHs are public hospitals and receive tax support from their counties. These public hospitals have elected governing boards, and are subject to the open meeting law, bidding and public works processes. Five are part of larger systems, and one in Boulder City is a sole non-profit hospital receiving no extra support.

BLAYNE OSBORN (President, Nevada Rural Hospital Partners):
I have a couple of additional points and have provided further information in a CAH Booklet (Exhibit G). First, outpatient service volumes are increasing in our CAHs including in EMS where our hospitals see the highest numbers of Medicaid Fee-for-Service patients. In 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act which, combined with

Nevada's decision to expand Medicaid enrollment, reduced Nevada's uninsured rate and grew Nevada's total number of Medicaid beneficiaries. The COVID-19 pandemic had a similar effect and Nevada's rural counties now total more than 69,000 Medicaid beneficiaries, which equates to Medicaid Fee-for-Service outpatient encounters as high as 30 percent in some of our CAHs.

Secondly, to offset low Medicaid rates, Nevada Medicaid offers several supplemental payment programs allowed by CMS. Unfortunately, due to eligibility requirements, three of our CAHs are not eligible to participate in any supplemental payment programs and receive no supplemental funding whatsoever. Additionally, the outpatient upper payment limit program benefits only 7 of the 13 CAHs. Although those hospitals are grateful for that benefit, it comes at a cost to them as they must provide intergovernmental transfers to participate. The total payment that they receive under that supplemental funding is less than the amount a CAH would receive for cost-based outpatient services. Though small in relation to the whole Medicaid budget, this change in reimbursement represents a significant amount to the hospitals and the communities they serve. To ensure access to health care and to keep providers serving the neediest areas in Nevada, your consideration to pass S.B. 241 is appreciated.

MS. HALL:
Nevada CAHs are the safety net providers in some of the most remote areas of the State including Battle Mountain, Caliente, Ely and Hawthorne. In any given year, a third to half of these hospitals have net operating losses. The tax support received for the seven district hospitals is what keeps them open. Net proceeds of mining for the mining communities have enabled those hospitals to build better infrastructure and have more equipment. Not all hospitals are eligible for net proceeds, so these hospitals are fortunate.

Recently, we have also been lucky that the Helmsley Charitable Trust has selected Nevada rural hospitals as an organization they want to support. They recently replaced most of our imaging equipment and we are grateful. The Pennington Foundation, also in northern Nevada, has assisted our hospitals. I tell you this because operations do not allow these rural hospitals to invest as much as these organizations have given to us.

The closure of any rural hospital has devastating effects on the community. Hospitals are usually one of the top three employers in their community. Losing emergency services would stress our already strained EMS systems which are

very fragile in rural Nevada. The hospital-based long-term care loss is horrible for those patients and their families that must travel hundreds of miles to visit, and the longer distances and travel for critical or trauma patients cannot be understated. Without these facilities, there would be no access to care in the rural community. The citizens of Tonopah have stories to tell about the closure of their hospital and the impact it has had on the lives and well-being of many. We appreciate your support and consideration of this bill for these communities and for Nevada.

CHAIR DOÑATE:
During the presentation, I pulled up a report from the U.S. Department of Health and Human Services stating that Medicare could have saved billions of CAH swing-bed services if they were reimbursed appropriately. This is a timely conversation that came out in March 2015 from the Office of the Inspector General. I looked to see if other states have similar practices and Texas was one of them. Have you researched other states that have similar practices to support our rural hospitals and what is the research behind the proposal?

MR. OSBORN:
Regarding the outpatient cost-based reimbursement side of this bill, about 18 other states have gone in this direction of providing costs. I do not know the total number of states on swing beds, but we could get that information for the Committee.

MS. HALL:
When you talk about what other states have done, Nevada only has 13 CAHs. Kansas has 84 and Texas has a substantial number as well. Montana, North Dakota, and other places with large landmasses and few people have about the same number of CAHs as Nevada.

SENATOR NGUYEN:
I know that rural hospitals have been struggling and I see this as a good solution.

SENATOR STONE:
Thank you, Senator Titus, for bringing this bill forward and for your service of being a rural physician for most of your career and dealing with these hospitals, some of which do not even have OB-GYN services. This has been an enlightening hearing for me as I look at this map and see the value of the

13 CAHs. If you just lose one, you are talking about somebody not getting the health care they need and deserve.

It is also disturbing for me to hear that a hospital only strives to break even. Perish the thought they should make a profit to try to keep the doors open, especially for uncompensated care that many of our hospitals provide. If somebody has a stroke and is hospitalized, under S.B. 241, are the CAHs entitled to get 100 percent of their costs in taking care of that stroke victim? If there are beds available in the hospital, can they get some ancillary care, physical therapy, and so forth and be reimbursed? Is there a time limit on that period before they can go home?

SENATOR TITUS:
We can only keep the patient for four days on the acute side and then we either must put them in a swing bed or transfer them to another facility.

SENATOR STONE:
If somebody is seriously ill, I assume there is a helicopter service or emergency service that transports them to a hospital that can accommodate their healthcare needs.

SENATOR TITUS:
Yes, it depends on how far away they are. Our helicopters can only fly a certain distance. We are fortunate where I practiced in Yerington to be able to have the helicopter land. I have ridden in it and know it takes 27 minutes from our back door in Yerington to Reno. My clinic in Smith Valley has a little helicopter pad and I could get the helicopter stationed in Gardnerville in 17 minutes. Locations further out, however, would require a fixed-wing plane because the helicopter cannot transport that far out and that is when you would make arrangements, depending on the weather and time of day. Sometimes nothing flies. I have done CPR on somebody for an hour and a half while being transported in an ambulance to town, so it depends on the situation.

SENATOR STONE:
Dr. Packham, can you compare the Flex Program versus the program that we are discussing today? I want to understand the differences in the funding and what they go towards.

DR. PACKHAM:
There is a CAH program that oversees the critical access designation of rural hospitals. Think of the Flex Program as a technical assistance program that has been ongoing since 1999. In the early days of that Program, we focused most of our energy on preparing rural hospitals for that survey and getting them ready for a review of their conditions of participation. Over time, we focused more on strategies and measures to help them stabilize their finances and operations. The CAH designation is part of the CAH program, and the Flex Program, operating since 1999, provides primarily technical assistance to those same facilities.

TOM MAHER (CEO, Boulder City Hospital):
We are in support of S.B. 241. Boulder City Hospital is one of the CAHs that is closer to an urban area in Clark County. Last year, were unable to accept almost 600 Medicaid referrals from the urban acute care hospitals for their patients needing sub-acute placement in our swing beds due to the incredibly low rate of Medicaid reimbursement. We can be a better partner to our Clark County urban hospitals, and increase access to lifesaving medical intervention if we can receive cost-based Medicaid reimbursement for the sub-acute transfers and free up those acute care beds for sicker patients.

Critical access hospitals are what the name implies. Healthcare facilities fill a critical need for access, especially in an emergency. Our patient volumes are low, but our presence is essential. Cost-based Medicaid reimbursement gives us a fighting chance to take care of our rural communities and that does not even begin to address the need for improvement in our facilities, equipment and infrastructure. Federal law requires that we treat and stabilize anyone who arrives in the emergency room (ER) regardless of resources. Currently, we receive about 11 cents for every dollar of cost to provide the services and this is not sustainable.

JEFF PRATER (CEO, Carson Valley Health):
In addition to our 23-bed CAH, Carson Valley Health has six outpatient clinics in Minden, Gardnerville and Topaz Ranch. We are in support of S.B. 241 to positively impact access to care within our service area. It is important this bill move forward. Our patients, like many other rural areas across the State, want access to health care close to home. In our last audited financials in 2021, Carson Valley Health incurred costs for outpatient Medicaid patients of $4.2 million of which $1.7 million was reimbursed. Included in that $4.2 million

is $500,000 to provide outpatient orthopedic services to this population of patients because we are not reimbursed for implants, which is why they are getting the surgery.

Carson Valley Health also provides swing-bed services within our 23 licensed beds. Our swing-bed costs are currently $2,825 per day, only $210 less than our acute care stay. The reason is that first, we do not employ separate nursing staff solely for swing-bed patients. Our nursing staff may have a patient load that has both acute and swing-bed patients. Second, while a swing bed is a change in patient's status and may not qualify for acute status, most swing-bed patients have a nursing acuity equal to an acute care patient. Medicaid currently pays $128 for swing-bed services, which is $2,697 less than our cost per day.

DENISE FERGUSON (Administrator/CEO, Mt. Grant General Hospital):
We support S.B. 241 for many of the same reasons that have been indicated today; if we do not exist, the land mass and people we support would be devastated. This is a significant issue for our hospital because 33 percent of our hospital ER visits are Medicaid beneficiaries, and 16 percent of all other outpatient services are currently holding Medicaid. Our hospital serves the needs of Mineral County, and for the past six years, we are also serving the needs of Tonopah since their hospital closed. The tragedy we see for these patients coming to us in critical need is staggering and sad. Our hospital serves the needs of a rural footprint. If this bill passes, it will allow us to provide continued access to services but also expand services. Our par is to be income neutral.

The biggest access to care in our community is transportation. Getting patients to come in for preventative care is difficult because they do not have transportation and getting them out of our community is even harder. If we had any income, we would first invest in transportation. Currently, there is no transportation going outside of our community or getting patients back to Tonopah. If Tonopah patients come to Mineral County to seek care in my ER or for outpatient services, we are personally paying to have them transported home.

JASON BLEAK (CEO, Battle Mountain General Hospital):
We are in favor of S.B. 241. My staff and I enjoy and love to provide care to our rural community. We have spent a lot of time learning and becoming professionals and want to be strong and healthy in our rural communities. In Battle Mountain, we serve a large land area and have 6,300 residents of which

20 percent are Medicaid patients. Of our nearest two hospitals, one is 50 miles away and the other is 70 miles away. This bill will help us maintain stability and viability. It will allow us to reinvest back into our staff, medical imaging technology and the standard of care so that we can continue advancing the level of care that we provide. It will also allow us to stabilize one of our largest cost centers, which is the emergency department. The passing of this bill will further the work that has been done by our federal government and CMS by helping stabilize Nevada rural CAHs.

PATRICK KELLEY (President/CEO, Nevada Hospital Association):
We support S.B. 241. Critical Access Hospitals are the heart of health care in rural Nevada, and we need to keep our hearts strong and healthy. Senate Bill 241 will do that, and we urge your support.

DAN MUSGROVE (Valley Health System):
We are proud to have Desert View Hospital in Pahrump as a part of our hospital group. Ditto to all that has been said. It is an important part of this community, and we support this bill.

SARAH ADLER (Nevada Advanced Practice Nurses Association):
We are in support of S.B. 241. It is our mission to create access to health care. If we lose any of our rural CAHs, we are going in the wrong direction. Advanced Practice Nurses are major healthcare providers in Nevada's rural hospitals. As the former State Director of the U.S. Department of Agriculture, Rural Development, I used to finance rural hospitals. Our hospitals cannot get low-cost, long-term loans from the federal government unless they show a revenue stream to repay that loan. If we can take this step with our Medicaid dollars, we can bring in more federal dollars to improve facilities and equipment in rural Nevada.

ROBYN DUNCKHORST (CEO, Humboldt General Hospital):
We are in support of S.B. 241. It is paramount that CAHs be paid for the cost of the delivery of outpatient care and swing-bed services. Not only do we sorely lack the resources for mental health, but primary care resources are limited in most areas and most rural counties are a primary hit spot. If you want to improve the disparity between health care and rural locations, it needs to be a priority. To ensure that access to care in these areas is supported by paying for the cost of the care that is delivered, to afford to develop services and offer rapid and effective access to primary care is critical.

With escalating inflationary costs and healthcare labor shortage issues, now is the time to offer this level of subsidy before we start to experience the possible closure of some rural organizations like the tragic recent closure of Desert Springs Hospital in Las Vegas. Unlike most industries, health care cannot pass the increased costs on to the consumer, which is not bad but does indeed cause healthcare delivery and instability in rural organizations with nothing left to give.

If this bill does not move forward, I perceive my organization will have to look at tough decisions like the closure of services of the behavioral health clinic, cardiology clinic, obstetrics services and our rural family residency program, just to ensure that we keep the heart of our life-preserving needs intact. These are just a few of the many services we offer to improve the access to adequate health care that every rural resident deserves regardless of their ability to pay. You can help ensure that grows and improves. All I am asking for today is that we are paid at the cost for the services we are already delivering. We are not looking to make money, but simply break even because it is vital to our sustainability.

BRANDON CHADOCK (Administrator/CEO, Pershing General Hospital):
Pershing General Hospital is the sole healthcare provider in Pershing County for primary and ER care, diagnostics and long-term care. We are located an hour away from other healthcare services. A decade ago, the hospital almost shut down and while much effort went into its financial turnaround, its story is not unique. Unfortunately, many CAHs face similar challenges year after year, operating on slim margins that hinder physical plant, equipment and service line reinvestment.

Rural hospital closures are increasing nationwide, but Nevada can reverse this trend by adopting innovative approaches like S.B. 241. Supporting this bill would help stabilize the Pershing General Hospital facility and reinvest in services. Over the past year, we have added certified wound care and explored a mobile rural health clinic in partnership with the county to care for the underserved and rural populations that are typically Medicaid or Medicare.

Even though the physical assets are available for a mobile clinic, the administrative burden to get through the State's application process is costly and time-consuming. We are doing the best we can with already slim margins. In 2022, our audited total margin was negative 8.3 percent, primarily due to

costs of labor and supplies. Medicaid members represent 15 percent of the patients we serve. Reimbursing those visits based on the cost to provide care would allow us to strengthen our core services, improve our aging building and equipment, and better address community health needs.

TONI INSERRA (CEO, South Lyon Medical Center):
South Lyon Medical Center (SLMC) in Yerington provides health care to the rural areas of Smith and Mason Valleys, and the surrounding communities of Mason, Schurz and Topaz Ranch Estates, a population of over 14,000 lives. With incredibly low commercial payers, SLMC relies heavily on reimbursement from Medicare and Medicaid. Our facility serves many retired individuals as well as thousands of low-income families.

We are proud to come from a rural mindset continuing to focus on farming, ranching and small business. South Lyon Medical Center is proud of its commitment to provide up-to-date diagnostic equipment to ensure these services are available regardless of a patient's ability to pay or lack of transportation. We have been committed to rural health care for more than 70 years and this bill will ensure our ability to continue to provide care in the future.

Medicaid pays our facility significantly less than our costs for outpatient services. Our costs for these services are 36 percent of the bill charges, but Medicaid only pays between 9 percent and 11 percent. In our fiscal year ending March 2022, we billed Medicaid just over $3 million for combined outpatient emergency services and were reimbursed $261,000, which was $827,000 less than our costs to provide the services. In the 11 months of our current fiscal year, ending March 2023, we billed Medicaid just over $3.4 million for combined outpatient and emergency services and were reimbursed $409,000, which is $827,000 less than our costs. I urge the Committee to support this important bill.

MATT WALKER (CEO, William Bee Ririe Critical Access Hospital):
We are in support of S.B. 241. We are a CAH in Ely with the nearest tertiary hospital 230 miles away. It is about a three-and-a-half to four-hour drive to the nearest hospital from our facility. We have the same issues and concerns that have already been stated.

In Ely, we have numerous patients who do not have adequate transportation or the means to get to a higher level of care for heart therapy they may need in the catheterization lab. We brought a catheterization lab to Ely to support that care and found we had several patients who were able to access that care and receive lifesaving procedures. Due to the low reimbursement that we see with Medicaid, which is about 20 percent of our patient population and about 8 percent uninsured, we are now trying to decide whether we can continue to keep this service because we take such a loss that it makes it difficult to continue. We need to keep our doors open for all the other services we provide. That can be extrapolated to several other services, but that is one real life example of what we have done in Ely with the catheterization lab that has made a tremendous difference to our community and our community members. We ask you to support S.B. 241.

MELISSA ROWE (CEO/Administrator, Grover C. Dils Medical Center):
We support S.B. 241. The Grover C. Dils Medical Center in Caliente is 39 percent Medicare and 25 percent Medicaid. The direct impact on our CAH receiving cost-based reimbursement for outpatient services would be significant. Access to care in rural Lincoln County is also essential to this community's aging and underserved. We provide primary care to our elderly population who cannot leave the County. We also serve a wide and diverse group of visitors to this area who come to enjoy outdoor recreation, State parks, biking, hunting, fishing and off-road enthusiasts. Additionally, we provide medical services to our Caliente Youth Center and Pioche Conservation Camp. We strongly urge you to pass S.B. 241.

ROBERT CARNAHAN (CEO, Banner Churchill Community Hospital):
We support S.B. 241. Our population is about 25,000 people and includes Fallon. We geographically serve about 10,000 more constituents besides what is in Churchill County. As far as outpatient cost-based reimbursement, this bill will allow us to provide Medicaid patients with the coverage and care they need. Currently, Medicaid reimburses us just over 20 percent. In a realm where private hospitals have a choice to provide care to Medicaid patients, CAH helps to fill the gaps to continue care for these patients, especially in rural areas.

Access to care is important. I am a nurse by trade, so when it comes to care, I want all patients to receive the best care possible and this is especially true at Banner Churchill Community Hospital. We provide ICU and ambulance services that cover over 5,000 square miles. We have one of the three OB-GYN services

in a rural facility. We provide services to the community and surrounding communities and support the Naval Air Station Fallon.

It has been a struggle to recruit providers and the cost for clinicians and providers is skyrocketing right now. The pool is limited, which makes it harder to get those providers and clinicians to the rural areas. The cost impact on hospitals because of these shortages has increased, as has the cost of supplies, pharmaceuticals and capital. Banner Churchill Community Hospital has been a great steward of our community. Over the past few years, we made a $10 million investment into a new ER department. There is a need for those increased outpatient services. We have also added a new $2.4 million magnetic resonance imaging scanner and a $1.3 million parking lot replacement. People usually do not understand the costs that go into running a hospital, even as simple as a parking lot. We must be good stewards of all these considerable costs. Having outpatient cost-based reimbursement will certainly help our efforts to provide high-quality care and continued access for all.

SENATOR TITUS:
I appreciate all of you hearing this bill as it is near and dear to my heart. You heard from all the folks that I have represented and all the passion throughout the State, from north to south and east to west. We all agree that CAHs are critical to Nevadans.

CHAIR DOÑATE:
Thank you, Senator Titus, and of course, to the healthcare executives that joined us. We know you have remarkably busy lives caring for our most vulnerable patients, so we appreciate your efforts for this bill and beyond.

I will now close the hearing on S.B. 241. We will now open the hearing on S.B. 280.

SENATE BILL 280: Revises provisions governing contraception. (BDR 40-40)

SENATOR ROCHELLE T. NGUYEN (Senatorial District No. 3):
I am bringing S.B. 280 for your consideration. Dr. Sandra Koch will be presenting this bill to the Committee.

SANDRA A. KOCH, M.D.:
I have practiced OB/GYN in Carson City since 1990. This bill could significantly improve access to long-acting reversible contraceptives (LARC) for women in a hospital setting. Access to LARCs after delivery has been hampered by the lack of these devices, both intrauterine contraceptives (IUD) and implants in hospitals. Hospitals in Nevada do not carry these devices.

Although Medicaid in Nevada reimburses for these devices, providers cannot place a device that is not available to them. The effectiveness of LARCs exceeds 99 percent. Long-acting reversible contraceptives are the most effective reversible contraceptives on the market. They have the highest continuation rate for reversible contraceptives. Seventy percent of pregnancies occurring in the first year after delivery, referred to as short-interval pregnancies, are unplanned which is very unfortunate. These short-interval pregnancies are at higher risk for premature delivery and adverse neonatal outcomes. Placing a LARC in the delivery room is more effective at reducing this rate than delayed placement of a follow-up visit following delivery, especially for those at the greatest risk for unplanned pregnancy.

Although the use of LARCs within the hospital for unrelated health concerns would be smaller unrelated to pregnancy, it is also of immense importance. Long-acting reversible contraceptives are effective tools for preventing pregnancy in women with health conditions that place them at high risk for complications if they were to get pregnant. The LARCs are also effective for reducing excessive uterine bleeding, anemia from excessive bleeding, uterine pain, hysterectomy and cancer risks. There is a role for their use in the ER, the operating room and for admitted patients. The medical community in Nevada is seeking your help to provide access to the national standard of care, LARCs within the hospital setting.

SENATOR TITUS:
I certainly support conceptually having those tools and being able to get reimbursed for them. My concern is would you expect those rural hospitals that do not have an OB-GYN to have these devices available when a woman comes in and has a premature delivery? Would you expect the person receiving that baby, who might be a physician's assistant and has never delivered a baby before, to insert one of these if that patient asked?

SENATOR NGUYEN:
That is one of the things we are talking about and how we can accomplish our goal. Even as S.B. 280 is being introduced and presented today, it is limited in the type of LARCs that are potentially required. We have already been talking about what other types of devices might be included in the bill to give some flexibility to not only doctors who are using them, but whether it is a shot or a copper IUD or a hormonal IUD. There are a lot of different opportunities and options. We are going to continue to have those conversations. We would love them to be in these rural communities where there is a lack of access to health care. This is a preventative type of birth control available when someone gives birth. Then, we can prevent unwanted or unplanned pregnancies or both.

SENATOR TITUS:
I certainly agree with that, but the expectations of IUD devices may not be reasonable in every location versus having a shot or some other birth control. It also must be within a reasonable amount. You will also hear from the rural folks.

SENATOR STONE:
This is a great bill. If you are inserting an IUD outside of delivering a baby, it is not the most pleasant experience for a woman. Usually, a woman delivering a baby has had an epidural and they may not feel the discomfort of having these proven items inserted to prevent them from getting pregnant because the minute she leaves the hospital she is still fertile. It is possible for her to become pregnant days after delivering a baby. I assume that a woman after having a baby wants to wait before having another baby and would make a request to have an IUD inserted while they are in the hospital. I assume she would have to sign a document to that effect.

DR. KOCH:
We certainly accept verbal consent, which would usually be planned in advance, but the highest risk population often has not received prenatal care. They are in the hospital, deliver a baby and decide at that point, they do not want another pregnancy. It is a perfect opportunity to give them either an Implanon in the arm or place an IUD in the uterus, which is already huge, so it does not even hurt to put it in at that time. Long-term progesterone implants or an IUD would be perfect in that setting.

SENATOR STONE:
If we focus on IUDs for just a moment, Dr. Andrea Chisholm, Director of OB-GYN at Cody Regional Rural Health Care in Wyoming, cited a statistic that said that there is a 27 percent risk of IUD expulsion if it is implanted at the time of delivery. Another warning is that because you can have uterine inflammation after birth, there is more of a chance that you could have a uterus lesion by puncturing it, which requires surgery. So I wonder, because this is not a risk-free procedure, especially after pregnancy, would it be appropriate to warn or give the patient the statistics that this could happen if she wants to get that device right after delivering a child?

DR. KOCH:
If you look at the data, there is an increased risk of expulsion of IUDs after placement following delivery. However, looking at a randomized study, the use of IUDS after six months compared the women who obtained it in the hospital versus those that received it as an outpatient. The women who still had the IUDs at six months that were implanted in the hospital were a third more than the ones who were outpatient, and this is because many of them never came in for a follow-up appointment. So when you look at the overall benefits, it is significant. I have not seen any data to say that there is an increased risk of infection or perforation.

SENATOR STONE:
I fully support this bill, but I like looking at medical data and wanted to relay that as a concern.

CHAIR DOÑATE:
Do physicians always mention the risks of a certain procedure when a patient asks for it, and is that standard practice, regardless of whether this was instituted in this bill?

DR. KOCH:
Yes, that discussion takes place. You would never do any procedure on any patient without a full discussion, all questions answered, and consent signed if necessary before the procedure.

CHAIR DOÑATE:
What is the training process if a physician or advanced practice registered nurse wanted to learn about the insertion of an IUD and they had not received that

training? Are there certain requirements or is there a certain expectation so they can understand how the process works?

DR. KOCH:
The training for OB-GYNs occurs in residency programs for IUD placement and so many IUDs are placed during that time until everyone is proficient. For the placement of the Implanon in the arm, a course must be taken and signed off before you can place them. Advanced practice registered nurses need to become comfortable with it through in-person training. They must also meet the same requirements for the implants; but for the IUDs, it is not necessary. It is something that they are trained for if they become an OB-GYN nurse practitioner and learn how to do all sorts of intrauterine procedures.

TIMOTHY C. MCFARREN, M.D.:
I have been a practicing OB-GYN for over 35 years and have also been involved with the public health sector for about 15 years. The creation of this bill is a novel idea. A woman goes to the hospital, has a baby, and comes home with a five-year contraceptive in place. I think everyone can see the benefits of this. In fact, it has been put into legislation by the Affordable Care Act and by this Nevada Legislature that long-acting contraceptives be provided to women at no cost. However, insurance companies have found a loophole. Hospitals do not carry IUDs or long-acting contraceptives because insurance companies will not reimburse hospitals as an inpatient procedure. This is denying women access after childbirth to long-acting contraceptives. I fully support S.B. 280. It closes the loophole and allows women access to LARCs in the hospital setting.

LINDSEY HARMON (Executive Director, Planned Parenthood Votes Nevada):
We are in support of S.B. 280 today and are happy that Dr. Koch has brought this forward to the Committee.

ELYSE MONROY-MARSALA (Nevada Public Health Association):
We support this bill. Ditto.

SARAH WATKINS (Interim Executive Director, Nevada State Medical Association):
We support S.B. 280 as it helps provide better access to care. This will improve the quality of care for patients who are unable to receive appropriate care after hospital discharge.

MS. ADLER:
We strongly support this bill because of what you have already discussed, the difficulty in achieving the follow-up visit for many underserved Nevadans. Being able to receive long-acting reversible contraceptives at the time of birth will benefit our most vulnerable Nevadans.

CAROLINE MELLO ROBERSON (Southwest Regional Director, NARAL Pro-Choice Nevada):
We are in support of S.B. 280. I have submitted written comments in support (Exhibit H) and thank the bill sponsor for bringing this issue forward.

MR. WALKER:
I am also in support of S.B. 280. The one concern I have is Medicaid will not pay for implants.

SHELBIE SWARTZ:
I strongly support S.B. 280 because our hospitals need to ensure they can provide IUDs to any patient requesting it, especially post-birth. I am currently pregnant and keenly aware of how necessary birth control access is in a crucial period following childbirth. The insertion of an IUD post-delivery can provide women with crucial peace of mind during the intense and confusing postpartum period. Some women are more fertile after the birth of a child and lack of access to birth control can spell disaster for new parents who need to focus on their brand-new baby. Access to reliable, effective birth control is liberating for individuals and helps them protect their bodily autonomy. I urge this Committee to support this bill.

FAY ROEPCKE, M.D.:
I am a family physician in Elko with fellowship training in obstetrics and women's health. I provide prenatal care, deliver babies, then care for both moms and children throughout their lives. I have submitted my written testimony (Exhibit I) and fully support S.B. 280.

MS. HALL:
I am in sad opposition because I believe in the premise of this bill. However, as you heard earlier, only three rural hospitals have OB units, so if we could change the words "at a hospital" to add "an OB unit of a hospital" that would work for us. For the patients delivering in our ERs and wanting this service, I am not sure that it would be safe for the patients or ER providers to do the

insertions. They are ER docs, not family practice or obstetrics. Just that slight change and I will work with the sponsor.

CHAIR DOÑATE:
At this time, I will close the hearing on S.B. 280. There being no further business in the Senate Committee on Health and Human Services, the meeting is adjourned at 5:20 p.m.

RESPECTFULLY SUBMITTED:

Norma Mallett,
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	Jill Tolles / Guinn Center	Presentation
	D	6	Dr. Jafeth E. Sanchez / Latino Research Center, UNR	Presentation
S.B. 241	E	14	Joan Hall / Nevada Rural Hospital Partners	2023 Consortium Map
S.B. 241	F	15	Joan Hall / Nevada Rural Hospital Partners	Swing-Bed Services Fact Sheet
S.B. 280	G	15	Blayne Osborn / Nevada Rural Hospital Partners	CAH Booklet
S.B. 280	H	30	Caroline Mello Roberson / NARAL Pro-Choice America	Support Letter
S.B. 280	I	30	Dr. Fay Roepcke	Support Letter