# MINUTES OF THE
# SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

## Eighty-second Session
## March 30, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:38 p.m. on Thursday, March 30, 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 Nicole J. Cannizzaro, Senatorial District No. 6
Senator Marilyn Dondero Loop, Senatorial District No. 8
Senator Melanie Scheible, Senatorial District No. 9
Assemblywoman Michelle Gorelow, Assembly District No. 35

## STAFF MEMBERS PRESENT:

Destini Cooper, Policy Analyst
Eric Robbins, Counsel
Mary Ashley, Committee Secretary

## OTHERS PRESENT:

James Humm
Regan Comis, Cleveland Clinic Lou Ruvo Center for Brain Health
Thomas Humm
Helen Foley, Nevada Association of Health Plans

Catherine Nielsen, Executive Director, Governor's Council on Developmental Disabilities, Nevada Department of Health and Human Services
Mary Pierczynski
Tim McFarren, M.D., American College of Obstetricians and Gynecologists
Caitlin Gatchalian, American Heart Association
Holly Welborn, Children's Advocacy Alliance
Annette Magnus, Battle Born Progress
Caroline Mello Roberson, NARAL Pro-Choice Nevada
Katie Ryan, Dignity Health-St. Rose Dominican
Izack Tenorio, Valley Health System; Magellan Health
George Ross, HCA Healthcare
Tess Opferman, Nevada Women’s Lobby
Joan Hall, Nevada Rural Hospital Partners/LICON
Nancy Bowen, Nevada Primary Care Association
Lea Case, Nevada Psychiatric Association; Nevada Public Health Association
Pat Kelly, Nevada Hospital Association
Jonathan Norman, Nevada Coalition of Legal Service Providers
Eric Jeng, One APIA Nevada; Asian Community Development Council
Jollina Simpson, Make It Work Nevada
Brian Iriye, M.D.
Leann McAllister, Nevada Chapter, American Academy of Pediatrics
Chris Giunchigliani
Matt Turner
Briana Escamilla, Planned Parenthood
Jessica Hollie
Jennifer Richard
Dora Martinez, Nevada Disability Peer Action Coalition
Anna Binder
Sarah Jaromin, Policy Analyst Health, National Conference of State Legislatures
Corie Nieto, Director, Telehealth Services, Nevada Health Centers
Alex Tanchek, Nevada Advanced Practice Nurses Association; Vitality Unlimited
Barry Cole, M.D.
Unidentified Testifier No. 1
Marie Coe, State Long-Term Care Ombudsman, Aging and Disability Services Division, Nevada Department of Health and Human Services
Erin Rook
Unidentified Testifier No. 2
Brett Salmon, Nevada Health Care Association

Laura Higman, Director of Quality Assurance, Mission Senior Living
Jeanne Bishop-Parise

CHAIR DOÑATE:
We will open today's hearing with Senate Bill (S.B.) 286.

**SENATE BILL 286**: Revises provisions relating to health care. (BDR 40-84)

SENATOR MARILYN DONDERO LOOP (Senatorial District No. 8):
I am pleased to present S.B. 286. This bill is on a topic near and dear to my heart. This measure seeks to bring awareness about multiple sclerosis (MS). Johns Hopkins University School of Medicine defines MS as a long-lasting disease of the nervous system. It is an autoimmune disorder causing the body to attack itself and damage the nerves. This condition disrupts the essential communication between the brain and the body affecting everyone in different ways. Symptoms can range from blurred vision to losing the ability to communicate completely. In severe cases, it can completely paralyze someone.

The Cleveland Clinic Lou Ruvo Center for Brain Health (CCCBH) in Las Vegas is the only national MS designated partner in southern Nevada. They assert that there are approximately 2,500 Nevadans suffering from this condition. There are challenges with diagnosing this disease for many reasons, such as the vagueness of symptoms and the lack of specific tests used to identify the disease. Despite these challenges, it is proven that early diagnosis yields better results and reduces disability.

Since it allows for early intervention, MS is diagnosed through a ruling-out process in which two things must be true. You must have two attacks at least one month apart and have more than one area of damage to the central nervous system, which is coding or layering of the nerve. This damage is often identified by a magnetic resonance imaging or a neurological exam. Current research shows the sooner you obtain the MS diagnosis, the sooner you can start therapy to reduce its effects.

Disease modifying therapy (DMT) is used to reduce the severity and the number of attacks one experiences. It has also been shown to be effective in reducing long term disability. David Humm received an MS diagnosis after retiring from the National Football League. When considering treatment options, he opted out of receiving a DMT. That was until he noticed his sister, Lori, who was also diagnosed with MS. Her treatment experience was different as she elected to receive a DMT and responded well to the treatment. Unfortunately, in 2018, David lost his battle with MS. If there was more information disseminated about MS, he could have been more aware of the benefits of this therapy long before Lori's diagnosis.

Our friend and longtime lobbyist, Lisa Foster, was diagnosed with MS and was told that she was 20 years into the disease. This delayed her treatment and subsequently has resulted in her now using a cane and a walker. Bringing more awareness and increasing access to information on MS could ultimately save the lives of many Nevadans. For this reason, I chose to sponsor this bill.

I will now briefly go through the sections of the bill. Section 1 amends existing law and requires the Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health to maintain a website on MS to include information and resources available. In section 2, it is a request for the Governor to proclaim the third week of March each year as Multiple Sclerosis Awareness Week. It will call on the media, educators, healthcare providers and others to bring MS to the attention of Nevadans.

I would now like to introduce David Humm's family: his brother, Tom Humm, and his nephew, James Humm. They will tell you their story and following them will be Reagan Comis, representing the Cleveland Clinic. She will provide statistics on this disease. As you can see, we are wearing orange today in honor of MS month.

JAMES HUMM:
I want to thank you for this opportunity to testify on the merits of S.B. 286. This bill means a great deal to my family. Unfortunately, MS has been a big part of our lives and, in many cases, it has revolved around it. As I sit here with my father, I cannot remember a day that MS has not impacted our lives.

I still recall seeing my cousin, Courtney, at age ten pushing her dad in his wheelchair. Watching a young person learn how to push, collapse and lift a wheelchair into the back of a car was truly a sight to see. My aunt, Lori, who many people may not know, also has been afflicted with this disease. She had to navigate raising young children while her body slowly betrayed her. It was no easy task to attend school and sporting events and try to tackle the bleachers with the use of a cane. She continues to this day to fight this disease. Although

Uncle David lost his battle, there are many others out there like Lori. They continue their fight and struggle daily with what we would consider to be mundane tasks.

Although I have shared their struggles, please know they have had several uplifting and incredibly positive experiences. My uncle has received many acknowledgments and accolades denoting his battle. My aunt has gotten the health care and medicine when she has needed it. We have met people like Dr. Hua, at the CCCBH, and Regan Comis. They are doing terrific work.

We are honored to be here with Senator Dondero Loop. The action she is taking will help raise awareness and educate people on early detection, proper diagnoses, treatment and long-term care. This will also help in the continued research to battle this silent killer. I ask this Committee to pass this bill without delay. It is the first step on our journey to raise awareness, prolong lives and beat this disease. As Dr. Le Hua said, "time equals brain."

REGAN COMIS (Cleveland Clinic Lou Ruvo Center for Brain Health):
It is estimated nearly one million individuals in the U.S. are living with MS. It is sometimes referred to as the invisible disease because many people are living with MS without outwardly exhibiting symptoms. This can create a unique set of issues and some people assume that the patients do not have the disease. It can discourage people from seeking treatment or getting help for their problems. We know the earlier you obtain a proper diagnosis and start the appropriate therapy, it can reduce the risk of future disability.

One of the early diagnoses includes general awareness about this disease. The onset of MS often occurs between the ages of 20 and 40 years old. The warning signs include blurry vision, numbness and tingling, weakness, balance issues, cognitive impairment and bladder and bowel dysfunction. There can be additional red flags including joint pain and a rash. The CCCBH's Mellen Center for Multiple Sclerosis Treatment and Research is the only comprehensive MS center in Nevada. We currently serve around 2,000 lives and see over 3,500 patients a year. We have conducted 26 clinical trials and have tested 5 newly approved FDA drugs. We continue to return to early detection and diagnosis as providing the best outcome for our patients. We are in support of S.B. 286 to increase awareness around MS, provide tools for families to find the assistance and support they need and emphasize the importance of seeing a doctor if you or a loved one exhibit any of the signs or symptoms of the disease.

THOMAS HUMM:
I am David and Lori's brother. I am here today to put a human side to MS. My brother and I played football together. We shared the same bedroom growing up and the same dorm room at the University of Nebraska, Lincoln. My brother took care of his body, but I watched him wither away. In the 1970s, if you played football, you were never hurt. He thought he could overcome everything. When our sister was diagnosed with MS, she saw what happened to her big brother and she had two young babies. She sought out immediate treatment because she wanted to see her children grow up. So, on behalf of the Humm family, we want to thank you for your kindness. It is a terrible disease, and it affects many people. It is a slow and painful disease.

SENATOR STONE:
Besides treating MS, are you doing any research? You mentioned you are using some investigational drugs. They have not been able to conclude there are any genetics involved. Although there is some hypothesis that possibly 200 to 300 genes are responsible for MS, there has been no gene discovered. What research is the CCCBH doing on MS?

MS. COMIS:
We are doing extensive research on MS. We do research on additional diseases as well. We are trying to find ways to increase treatment and lessen the disability. I cannot tell you the exact number of studies but am happy to follow up with you afterwards.

SENATOR STONE:
It is not necessary to submit the information. I am pleased to hear you are doing research and trying to prevent the morbidity and mortality associated with this devastating disease.

SENATOR TITUS:
As a provider, I have had too many patients present symptoms of MS. In turn, I need to refer them, because I know almost immediately on physical exam what it could be. I appreciate the ability to have a place where these families could turn to without delay. It prepares them for the next step. We are always

happy for the patient to see a neurologist, but it is delayed when a family does not know what else to do.

HELEN FOLEY:
I am testifying on behalf of myself. I grew up with the Humm family. David and Tom's sister, Lori, has been a dynamic member of our lobbying team for many years. It is tragic to think she could have been diagnosed earlier and received better care if she had known about her MS. I actively support S.B. 286.

CATHERINE NIELSEN:
I am testifying on behalf of myself. When I was 23, I showed the first signs of MS and when I was 27, I was diagnosed with it. I knew of the disease because my aunt has MS. My aunt is now completely bedbound and depends on others to help her with every aspect of her life. My aunt was a part of the first round of testing DMT drugs. Because of people like her, we have treatments available much sooner. I received my treatment at the CCCBH, and I applaud their hard work. I am hopeful that I will watch my daughters walk down the aisle. It is vital for this bill to pass to allow earlier access to information. Hopefully, this will also prolong the life of those who receive this devastating diagnosis.

MARY PIERCZYNSKI:
I am representing myself today. I want to thank Senator Dondero Loop for the proclamation she presented on the Senate Floor today. I have worked with Lisa Foster for the last 14 years. Early awareness would have helped her journey with MS. Although it is a struggle, Lori is doing fine, because she is strong. This bill brings more awareness to people. I appreciate the Committee hearing it today and hope that there is full support.

SENATOR NGUYEN MOVED TO DO PASS S.B. 286.

SENATOR TITUS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

SENATOR DOÑATE:
We will close the hearing on S.B. 286 and open the hearing on S.B. 232.

**SENATE BILL 232**: Requires the State Plan for Medicaid to include coverage for postpartum care services. (BDR 38-45)

SENATOR NICOLE J. CANNIZZARO (Senatorial District No. 6):
I am pleased to present to you S.B. 232. This bill has never been discussed during the Legislative Session. It is great to be here to have this conversation. This bill extends a recipient's Medicaid coverage for postpartum care services from a 60-day period to 12 months. Assemblywoman Michelle Gorelow is joining me today.

Currently, about one in three pregnancy-related deaths occurs between one week and one year after childbirth. This makes postpartum a vital intervention point for healthcare providers. A disruption of healthcare coverage, particularly among those covered under Medicaid, is a common cause of death during this period, contributing to stark ethnic and racial disparities and maternal health outcomes. Nevada has about 22.5 deaths compared to a nationwide average of 15.7 deaths per 100,000 live births. African Americans have a four times higher chance of death while pregnant or within one year of giving birth. Within six months of giving birth, research shows over 20 percent of women covered under pregnancy-related Medicaid become uninsured. This is a crucial intervention point due to income and the ability to find insurance coverage. During this time, sometimes referred to as the fourth trimester, it allows healthcare providers to address delivery complications, identify postpartum depression and transition obstetric care to primary care.

In 2021, approximately 55 percent of births in Nevada were covered by the Medicaid program, making it the largest payer of prenatal care. Existing law allows Medicaid to continue postpartum coverage for up to 60 days after childbirth. However, it leaves potentially 305 additional days of high risk and vulnerability for a person who gave birth. According to the National Conference of State Legislatures, at least 25 states have made strides to extend postpartum Medicaid coverage.

On the federal level, the House of Representatives Resolution 1319 of the 117th Congress, American Rescue Plan Act of 2021, allowed states to extend Medicaid coverage from 60 days up to 1 year. However, that coverage will expire after five years. Extending Medicaid coverage for the postpartum period would provide Nevadans with access to health care that may decrease pregnancy-related fatalities and morbidity. Additionally, it would promote more consistent care for chronic conditions like depression, diabetes, heart issues, high blood pressure and substance use.

I recently had a child and am in the process of making another one. For anyone who experienced the birth of a child, you are aware of the adjustments for the mother and her family. Not only do you have to care for a new baby, but also the mother. She carried that child, and the mother could have a whole host of potentially life-threatening and physical issues. Even in the best of instances, her body has spent close to ten months creating another human being. She also helped to bring that life into the world one way or another. This does not happen without some serious changes. If you have ever talked to a new mother, you will find there are a whole range of challenges accompanying the pregnancy and birth.

Some of the challenges appear while you are in the hospital getting ready for discharge, but others do not appear until after you are home. A new baby will require frequent feedings, diaper changes and overall care to ensure the environment is safe and warm. This creates a struggle between figuring out how to care for this new life and how to care for yourself. It is critical for the mother to have medical coverage and the ability to seek a medical professional, even after that 60-day period.

It would be difficult to find someone, 60 days after giving birth, to tell you she is back to normal. New mothers typically have questions about changes in their body when transitioning from pregnancy to postnatal. Extending coverage is something we should do for Nevadans, because there are many things to address in the postpartum period. It is an indicator of maternal health to provide access to care.

Senate Bill 232 is short and straightforward. It requires the director of DHHS to include postpartum care services for 12 months after childbirth in the State Plan for Medicaid coverage. The bill also defines the term postpartum care services and the kind of medical care provided following the end of pregnancy. It includes, but is not limited to, the development of a plan for postpartum care, contact with the person within three weeks after giving birth or loss of a pregnancy and a comprehensive postpartum visit. That visit would include a full assessment of the physical, social and psychological well-being of the person; treatment of any complications from pregnancy and childbirth, such as pelvic floor disorders and postpartum depression; and the assessment of risk factors for cardiovascular disease and care related to the loss of a pregnancy.

The American College of Obstetricians and Gynecologists submitted a proposed conceptual amendment (Exhibit C). The amendment conforms some of the language in the bill to allow the standard of care the providers will use for their patients.

Senate Bill 232 includes a comprehensive postpartum visit to make sure the provider is looking for risk factors of postpartum depression. It is a simple examination, but sometimes it is not covered by Medicaid and the patient does not have additional coverage. This is medical care for someone who has undergone a significant medical process. Although this is a policy committee, there is a fiscal note attached to this bill. I am hopeful, as this bill moves along, we will be able to continue the conversation on the fiscal note. Since this is a Medicaid piece, there would be substantial federal funds to match any State funds for providing continued coverage.

ASSEMBLYWOMAN MICHELLE GORELOW (Assembly District No. 35):
I am honored to be here today with the majority leader, Senator Cannizzaro. I want to echo her statement that everyone's pregnancies are different. I had cesarean-section births and, due to the pain, I was barely able to get out of bed for eight weeks. My sister had twins and, unfortunately, they let her labor go too long. By the time she got to the hospital, she was already crowning, and the second baby was feet first. The doctors wrapped a towel and yanked the baby out, which caused my sister to have fourth degree tears. She ended up having back surgery several years later, but she was sore for more than eight weeks.

There can be complications during the pregnancy, whether it is preeclampsia, which during postpartum could turn into eclampsia. This complication causes high blood pressure, and the pregnant mom can have strokes, seizures or even die. Gestational diabetes is another complication. We want to make sure the mother’s blood sugar levels are back to a normal range. It is important to have coverage longer than 60 days. Given that 60 percent of deaths happen in the first year of the baby’s life, we need to prevent it by expanding postpartum care. We could save moms and families and make life better for everybody.

SENATOR TITUS:
When I was a medical student, my sister-in-law committed suicide six months after having a baby. My brother-in-law raised this child to become a wonderful young woman. None of us saw the postpartum depression coming. Doctor's visits and follow-up care is critical. I love the policy and do have a copy of the fiscal note. I know I will have a chance to discuss the fiscal note at another committee, so I will just go on record to say I love the policy.

SENATOR STONE:
As a pharmacist, I saw many people with postpartum depression. I also had new mothers with lactation issues, and many were unaware there are drugs to help promote lactation. Women who have had a cesarean section can have complications with infection and even potential sepsis. There is no doubt in my mind that this bill is going to pass. It is going to save lives. I applaud you both for bringing it forward.

SENATOR NGUYEN:
It is shocking when you said this is the first time it has been brought into this Legislative Body. People often ask what kind of policies you see brought forward that are different. When we have a female majority Legislature, we have women who have children and have gone through postpartum depression. To see these experiences come to fruition in policies is heartwarming.

SENATOR CANNIZZARO:
My colleague, Assemblywoman Gorelow, has done a great job to advocate for additional coverage during this and past sessions. She has led the way to ask for additional coverage.

The postpartum piece is unspoken. When we were preparing for this bill hearing, we all had different experiences with our pregnancies and the issues that arose. We are multifaceted, but we can have that conversation. I must thank Senator Stone for pointing out other issues like lactation problems. I personally had issues and needed a medical intervention to help me feed my baby. The issues women face postpartum vary between pregnancies and it varies between women.

We have been able to have conversations about our experiences. Not having access to the care that allows a mother to address her issues sounds frightening. We are providing additional services to women and their children.

I am grateful we can have that conversation in a real way. We will need to discuss the fiscal piece, but to be able to give some coverage is important. This is why we are passionate about this bill.

TIM MCFARREN, M.D. (American College of Obstetricians and Gynecologists):
My organization represents about 300 obstetricians and gynecologists who practice throughout the State. We want to express our unwavering support for S.B. 232 to provide pregnant women eligible for Medicaid services coverage for 12 months after the end of the pregnancy. This legislation could be the difference between life and death for many women. Medicaid coverage runs out 60 days after the pregnancy. A lack of coverage and disruptions in coverage contributes to preventable maternal deaths. More than half of the deaths occur after 60 days when Medicaid coverage runs out. Providing pregnant women with continuous Medicaid coverage for at least one year postpartum will help reduce preventable maternal deaths and improve outcomes for mothers and babies.

The postpartum period is simultaneously a time of vulnerability and maternal health risk. It is a transitional period with often unmet maternal health needs. Due to an arbitrary 60-day Medicaid cutoff postdelivery, many new moms become uninsured during the vulnerable weeks and months after childbirth. Those new moms with high blood pressure, gestational diabetes and postpartum depression lose their insurance access to important medical and mental health care. Our national and State rate of maternal mortality is rising. Evidence confirms postpartum insurance disruptions are a major contributing factor into this maternal health crisis.

About 50 percent of Nevada births are covered by Medicaid. As a result, Medicaid has a critical role to play. It is more important than ever to ensure postpartum women in Nevada have continuous coverage for 12 months after the pregnancy ends. Nationally, this is bipartisan legislation. Forty states have either passed, or are in the process of passing, extensions to a 12-month postpartum Medicaid coverage. Our neighboring states, Utah and Arizona, have already signed this into law. Let us be the forty-first state.

CAITLIN GATCHALIAN (American Heart Association):
We support S.B. 232, which extends postpartum Medicaid coverage from 60 days to 12 months. Health insurance status is an important dimension of access to care. Studies have documented disparities in health insurance

coverage among low-income, young and minority populations, as well as adverse maternal and infant outcomes among uninsured and those covered by Medicaid.

Women, diagnosed with hypertensive disorders or pregnancies, are at risk for future cardiovascular disease and events. More than one in three maternal deaths occur after birth. Heart disease and strokes are at their highest in the six weeks to a year after giving birth.

We all want babies to have the best possible start in life. Ensuring the expectant parent has access to care during pregnancy and the first year after giving birth is essential to provide a healthy and successful start. Extending Medicaid coverage from 60 days to 12 months following birth, is important to address health issues discovered during pregnancy or resulting from pregnancy. It will allow lower income pregnant women to obtain comprehensive care coverage so they can get healthcare services.

Mothers need to be healthy during and following pregnancy to have better birth outcomes, reduce instances of costly medical complications during pregnancy and lower the risk of health problems for the baby during infancy. Benefits of continuous coverage will result in a higher rate of women more likely to seek well-child visits and immunizations for their children. It will assist in early identification and treatment of postpartum depression, encourage women to quit smoking, prevent violence and treat substance use disorders. Caring for women and birthing parents in their reproductive years, while ensuring maternal health, is equitable across populations. It begins long before pregnancy and lasts well beyond childbirth. Saving a mother’s life requires a policy road map to better health.

We support S.B. 232. As a mother, this is an important bill. I have watched many friends struggle to get care after the Medicaid 60-day period. It is important to support this bill.

HOLLY WELBORN (Children's Advocacy Alliance):
We support S.B. 232. Access to postpartum health care impacts the entire family. The first year of a child's life is crucial for long-term health and stability. This bill will ensure new parents can access care and focus on the responsibilities of getting their baby off to a strong start in life. As noted by the cosponsor, over 60 percent of total maternal deaths after pregnancy are

preventable. The loss of a parent places a child at risk for detrimental health outcomes and poor development.

Implementing this bill will save lives and ensure adequate health coverage during a vulnerable period. We encourage your support.

ANNETTE MAGNUS (Battle Born Progress):
We are here today in strong support of S.B. 232. Extending postpartum Medicaid coverage to 12 months will help ensure Nevada parents and babies can thrive together. Pregnant people with Medicaid health insurance lose their coverage after only 60 days postpartum. It leaves new moms without access to contraceptives, follow-up visits with the doctor and mental health support, if needed.

Stable yearlong postpartum coverage, a long-standing recommendation by the American College of Obstetricians and Gynecologists, will help new parents deal with any postpartum health issues they may face. It will fulfill their responsibility of getting their baby off to a healthy start in life. We urge this body to support S.B. 232.

CAROLINE MELLO ROBERSON (NARAL Pro-Choice Nevada):
We support S.B. 232, and I have submitted my written comments (Exhibit D) to this Committee. Reproductive freedom means the ability to plan your family and your future.

In 2017, I was pregnant myself. Although I had resources and support at my disposal, I still needed help from qualified medical providers. I had the ability to obtain this help and every Nevadan should have the same opportunity.

KATIE RYAN (Dignity Health-St. Rose Dominican):
We support S.B. 232. I want to echo everything that has been said. As someone whose blood pressure did not come back to normal for a year after my pregnancy, I cannot imagine going through it without insurance. I hope you will support this bill today.

IZACK TENORIO (Valley Health System; Magellan Health):
We support S.B. 232. Postpartum care will lead to healthy babies and healthy moms. I want to echo the statements already made.

GEORGE ROSS (HCA Healthcare):
We strongly support this bill and urge you to pass it. The previous testimonies made it very clear we need the bill in our State. My wife delivered 7 children and my daughters and daughters-in-law have delivered 16 children. I have seen quite a few postdelivery psychological and physical situations. Every Nevada lady deserves exactly the same kind of insurance coverage that my family had.

TESS OPFERMAN (Nevada Women's Lobby):
We support S.B. 232. The U.S. has the highest maternal mortality rate of any high-income country in the world. Nevada is no exception and 60 percent of those deaths can be prevented. Please pass this bill.

JOAN HALL (Nevada Rural Hospital Partners/LICON):
I urge your support of this bill.

NANCY BOWEN (Nevada Primary Care Association):
We support S.B. 232.

LEA CASE (Nevada Psychiatric Association; Nevada Public Health Association):
We support S.B. 232.

PAT KELLY (Nevada Hospital Association):
We support S.B. 232.

JONATHAN NORMAN (Nevada Coalition of Legal Service Providers):
Our organization represents children in foster care, both babies and teenage mothers. We support S.B. 232.

ERIC JENG (One APIA Nevada; Asian Community Development Council):
We support S.B. 232.

JOLLINA SIMPSON (Make It Work Nevada):
We support S.B. 232. Providing appropriate postpartum medical coverage is a social, civil and human rights movement to address the unprecedented loss of life, legacy and family financial stability. We strongly support this medical expansion for postpartum support for up to one year.

As a postpartum mom, I did lose my coverage. I had high blood pressure issues and was unable to get mental health support for over a year. There were days during that year I thought I was going to need to leave my babies behind. I justified it as it would leave them with a better life because what I was experiencing was not worth it. The only help I received was sporadic or not at all.

The free clinics gave me three visits and then I had to wait six months to get another three visits. This kind of care is too much for any family to navigate. A postpartum parent dealing with the physical rigors from just having a baby and then raising that baby is compounded with the emotional, psychological and societal rigors of trying to support and care for oneself. New parents do not need barriers. They need ease and support. Again, we fully support this bill and hope you will support it too.

BRIAN IRIYE, M.D.:
I am a maternal-fetal medicine specialist in northern and southern Nevada. It is crucial to extend postpartum coverage for a year. Thousands of women in Nevada rely solely on Medicaid for prenatal care, labor, delivery and postpartum care. Unfortunately, under the current system, it leaves countless new mothers without essential health care during the critical care period of recovery and adjustment. New parents are challenged with financial stress to feed another person, securing additional space for the baby, increased pediatric and postpartum appointments and managing life with reduced sleep and medical challenges. Extending postpartum coverage for Medicaid for one year is not only a matter of compassion, but also a matter of public health. Maternal morbidity and mortality rates in the U.S. are alarmingly high when compared to other developed countries. Almost 20 percent of these deaths in some states occur in the postpartum period and they peak at approximately nine months postpartum. Extending this coverage beyond 60 days is critical for women to get the necessary care. It can identify and address issues early and prevent avoidable tragedies for the families.

To illustrate the impact of this policy change, I had a patient give birth to her first child and was receiving care from our office for opioid use. She faced several health challenges in the months following her delivery, including treatment for opioid use disorder and postpartum depression. After delivery, she had to be transitioned into care with another provider due to the lapse in coverage. She was placed in a nonpregnancy-based facility. Her new provider wanted her to arrive at six in the morning and wait in line. This would require her to bring the new baby while already fatigued, sleep deprived, with many other demands. Her care was now incompatible with her circumstances. She eventually began using illicit drugs again, her depression increased, she stopped breastfeeding and did not attend her postpartum visits. This was all due to her Medicaid coverage expiring after 60 days. She could not get convenient, timely or adequate medical care.

Her father was heartbroken and showed up at our office. He wanted to be hopeful for his grandchild and the life his daughter had when she received medical care. His pleading made us reinitiate care for people one year postpartum without insurance. However, this is not a long-term or a sustainable solution. My example is not unique and countless mothers in Nevada face similar challenges when lacking the healthcare support they desperately need during this vulnerable time. Extending postpartum Medicare coverage for one year after delivery significantly addresses the public health crisis of maternal morbidity and mortality. It will improve healthcare outcomes for women in Nevada and their families. It will reduce preventable complications.

LEANN MCALLISTER (Nevada Chapter, American Academy of Pediatrics):
We support S.B. 232, and I have submitted my written comments (Exhibit E) to this Committee.

CHRIS GIUNCHIGLIANI:
I am in support of S.B. 232. It is a commonsense bill and a great equalizer for all women, especially women of color. I had a friend that was pregnant at age 38. She went undiagnosed and after she had her baby, she had postpartum depression. Her coverage was cut off 60 days after the birth of her baby. It is imperative coverage is maintained. In the U.S., Black women are three times more likely to have a maternal health issue than a White woman. Awareness of the risk, heightened stress and anxiety during pregnancy, can potentially place women of color at risk for postpartum depression which affects one in eight new mothers.

The risk of postpartum depression is significantly higher for new mothers of color. Notably, while Black women are more likely to have it, they are less likely to receive help. Identifying and understanding these factors may be a lifesaving measure. A key part of this legislation is to make sure people are screened for any issues they are having. Unfortunately, most of the research and screening tools have focused on White women. It may have better results if it also looked at women of color. I urge your support for this bill.

MATT TURNER:
I am calling in support of this bill because I am the father of three children. My partner is an advocate for birth equity and access. Through my own parenting experiences, I have learned about the toll birth has on the physical and mental well-being of the mother. We were fortunate to have an uncomplicated, unmedicated out-of-hospital birth. We had the privilege of a postpartum doula, as well as medical insurance covering postpartum care.

I cannot imagine what it would have been like to recover from a complicated birth. Even in a best-case scenario, it took my partner at least a year to fully recover from the childbirth experience. As a psychologist and a Nevadan, I support extending Medicaid coverage. It is an investment to make sure children have parents who are healthy mentally and physically. They need parents who are present and able to build vital attachments during the first year of life.

BRIANA ESCAMILLA (Planned Parenthood):
We support S.B. 232. True reproductive freedom and justice includes access to all aspects of reproductive health care, including postpartum services. All new mothers deserve medical coverage to maintain healthy lives and care for their child. This is especially true for communities that historically lack access to health care. Maternal mortality for Black mothers is a health crisis in this Country.

Increasing access to all forms of reproductive health care, especially postpartum follow-up care, is essential to address these issues of deep-seated racial inequities in our healthcare system. We are proud to support this Legislation and urge your support of S.B. 232.

JESSICA HOLLIE:
As a mother who suffered from postpartum depression, these services need to be offered. This is a bipartisan bill regardless of political affiliation or beliefs on other issues. We all want healthy babies and want their mothers to take care of them.

Las Vegas social services continues to fall short of actual support for low-income families or Nevada families in general. This is one step toward a positive future where we are not continually stressing out every other day. It is a support system for families because the State is dropping the ball. If you do not give these additional benefits, you are going to continue to overwhelm our other systems. There is not enough help. There is not enough redirection of the wealth, and it is circling around the matter and not trickling down to the people who need the help. If you want mothers to care for their children, then we need them to be mentally and physically healthy enough to do so. This is a commonsense medical coverage.

JENNIFER RICHARD:
I am two weeks postpartum with my son and I have had so many appointments with him. I did not realize until months later that I had dislocated my hip and my ribcage was out of place. It required months of physical therapy to learn to walk again and to heal from my injuries. If I had been a Medicaid recipient, I would not have received this care. I was told I was lucky that I did receive care, because a delay would have required hip replacement surgery and additional care. Every mom should be able to receive care. I urge your support of this bill.

DORA MARTINEZ (Nevada Disability Peer Action Coalition):
We support S.B. 232.

ANNA BINDER:
As a mother to five children, I did not have insurance when I had my first three babies. I had corporate insurance for my fourth and State insurance for my fifth baby. I, too, suffered a hip injury. I cannot begin to tell you how terrible it was to get care. There is a huge gap in the community between those who qualify for Medicaid and those who do not. The latter still cannot afford care even with the plans they have.

I am so glad this bill is coming forward. Not having coverage, or not enough coverage, left mothers like me in a bad spot financially and emotionally. I was never able to rest for years after childbirth. We need to alleviate women's healthcare issues because it is important.

CHAIR DOÑATE:
I have five documents in support of S.B. 232 (Exhibit F) to put into the record. We will close the hearing on S.B. 232.

SENATOR NGUYEN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 232.

SENATOR STONE SECONDED THE MOTION.

SENATOR TITUS:
As stated earlier, I love this policy but will need to analyze the fiscal note. I am not sure if they considered the potential savings from this bill. I want to put on the record, I will pass this bill out of this Committee with the understanding it may have to change if we cannot resolve the fiscal note. This bill makes good sense because it will not only save money but lives.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

CHAIR DOÑATE:
We will open a presentation (Exhibit G) from the National Conference of State Legislatures (NCSL).

SARAH JAROMIN (Policy Analyst Health, National Conference of State Legislatures):
I work on our healthcare team covering access cost and coverage issues. My specific portfolio covers telehealth, scope of practice and healthcare workforce issues. I am going to provide a brief level setting on telehealth and highlight State trends. Next, I will present telehealth parity and private payer laws before concluding with recent changes and a few in-depth State samples.

We are your national bipartisan membership organization. On page 4 of Exhibit G, I have listed a few of the services we provide. Any policy or state examples referenced in the presentation are for informational purposes and do not indicate NCSL support. Telehealth remains a relevant topic for state legislatures.

Currently, there are 482 telehealth-related bills introduced in state legislatures. Of these bills, 295 are rule changes related to Medicaid reimbursement and 114 are related to private pay or reimbursement. Not all bills are explicitly related to parity, but a number of the bills are.

There have been over 500 proposed rule changes at the executive level. These changes will be made through state Medicaid programs or state boards. The major topic areas are summarized into seven major categories as outlined on page 4 of Exhibit G. In 2023, the Center for Connected Health Policy (CCHP) is expecting many changes to telehealth. The changes will be nuanced and specific rather than the broader all-encompassing telehealth laws that categorized the COVID-19 pandemic.

On page 6 of Exhibit G are the four primary modalities used for telehealth. As a result of the public health emergency, there are a variety of telehealth flexibilities related to Medicare at the federal level. It includes eliminating some state restrictions, expanding reimbursable services modalities and providers and requiring the same rate of reimbursement for telehealth as in-person care, otherwise known as payment parity.

The federal public health emergency will expire on May 11, 2023. The CCHP released guidance on what it will mean for patients, providers and states. The Centers for Medicare & Medicaid Services (CMS) has announced it will include Medicare reimbursement for eligible telehealth services for patients located in both a geographically rural area and at an eligible originating site. However, in most cases, it does not include the home as an originating sight. Medicare may reimburse for mental health telehealth services, including audio-only in some cases. To be reimbursed, it requires an in-person visit within the first 6 months of an initial telehealth visit and then every 12 months thereafter. Finally, Medicare reimbursement will continue to cover federally qualified health centers (FQHC) and rural health clinics for mental health services delivered via audio-only or live video.

CHAIR DOÑATE:
Is the legislation introduced in other states primarily supporting what Medicare is aligning towards?

MS. JAROMIN:
Legislation varies from state to state. Many states are trying to clarify what will be expiring. They are also trying to determine the differences between the Medicare and Medicaid populations, including how they will overlap. Later in the presentation, I will present national trends in terms of the flexibilities. In general, we have not seen a lot of legislation going through. The primary concern is determining what is going away and how each state can close the gap.

There are a few different dates when certain flexibilities will expire. The three dates are May 11, 2023; December 31, 2023; and December 31, 2024. Two flexibilities are expiring in May 2023: the use of HIPAA-noncompliant remote communication products by providers and tele-prescribing. The latter, tele-prescribing, is prescribing controlled substances over telehealth without an in-person examination. The Drug Enforcement Agency and U.S. Department of Health and Human Services are proposing new rules, but they have yet to be approved.

Two flexibilities are scheduled to expire in December 2023. The first one is a virtual presence for direct supervision. It is primarily relevant to teaching settings where residents are overseen by teaching physicians. The second flexibility is reimbursement codes for Medicare's category III list. Some items may be added to categories I or II, allowing permanent reimbursement, but no decision has been made.

Two more flexibilities are scheduled to expire December 2024. The first one is made up of three components. Medicare will no longer reimburse telehealth services provided to patients at home or to an expanded list of providers, including occupational therapists, physical therapists, speech and language pathologists and audiologists. The third noneligible reimbursement is to a FQHC and a rural health center as distant site provider for nonmental health services. The second flexibility expiring is Medicare coverage of audio-only telehealth for nonmental health visits.

On page 10 of Exhibit G are some of the state telehealth policy levers that legislators may choose to pursue. Medicaid states have flexibility and authority in determining Medicaid reimbursement for healthcare services provided by telehealth. Some Medicaid policies are enabled or mandated through state law. As discussed earlier, a significant number are made by the state's executive branch through Medicaid rules and regulations. The policy actions determine the option for telehealth, including the type of services provided, the area it can be used, how it is implemented, what Medicaid can reimburse for and the types of qualified practitioners who can deliver services to Medicaid enrollees.

Similar to private insurance coverage, Medicaid reimbursement for all telehealth modalities has increased significantly over the past decade. Seventeen states currently stipulate Medicaid coverage and reimbursement for all four common telehealth modalities summarized on page 6 of Exhibit G. All state Medicaid programs include policies providing some type of reimbursement for live video telehealth consultations, but the scope of these policies vary. Moving beyond live video, 25 states allow for reimbursement of asynchronous telehealth. Thirty-four states cover remote patient monitoring, and 34 states plus the District of Columbia (DC) reimburse for audio-only telehealth. Finally, some states have recently added the Place of Service Code 10, including Louisiana and Rhode Island. It allows the home to serve as an acceptable originating site for telehealth services. They joined the other 32 states and DC that explicitly allow for reimbursement of telehealth services originating within the home. Thirty-six states and DC reimburse for telehealth services taking place within the home.

Audio-only telehealth represents the biggest change in telehealth policy since the pandemic. According to the Commonwealth Fund, prior to 2020 only three states explicitly require reimbursement of audio only. This number has grown to 34 states, including Nevada and DC, having their Medicaid programs reimburse for audio-only telehealth. The most common limitation for reimbursing audio-only is if it is for tele behavioral health services. Since the spring of 2022, five states have added audio-only reimbursement. It remains the most common modality added by states. It has been helpful for rural or underserved patients who do not have access to broadband or are unable to access video services.

On page 13 of Exhibit G are cross state licensing compacts. Adoption of provider compacts, and telehealth-specific licensing, is one of the biggest trends. Currently, 25 states have active telehealth-specific licensing. There are eight active provider compacts with varying participation. I did not include the ninth, the advanced practice registered nurse compact, because not enough states have enacted it for it to become active.

Next, I would like to discuss coverage or service parity and payment parity. A state-managed coverage or service parity means the insurer must cover telemedicine services if it is covering the same service delivered face-to-face. In other words, if a service is covered in-person, it must be covered when delivered by telemedicine. Coverage or service parity does not guarantee the same rate of reimbursement or payment. Currently, it only relates to coverage of services. Coverage parity is more common than payment parity.

Payment parity requires an insurer to reimburse at the same payment rate for telehealth services as in-person care. The specific wording in bills can range from not less than, not more than or the same as in-person services. Some states have payment parity for specific types of providers or services, such as mental health providers or physical therapists. It is not always a blanket payment parity of all health providers. Finally, the Medicare policy reimbursing for telehealth at the same rate of payment as in-person care is scheduled to expire at the end of 2023.

On page 15 of Exhibit G are the trends within private payer laws and parity. In 2012, 16 states enacted private insurance laws. However, each state's laws tend to vary greatly such as variants between coverage or payment parity requirements. In 2021, CCHP analyzed private payer telehealth coverage before and during the COVID-19 pandemic. They did it by focusing on the seven largest U.S.-based health insurers with a particular interest on changes from March 2020 through January 2021. The report notes in 2019, prior to the pandemic, nearly all of these insurers had offered some type of coverage for telehealth services. This is due to market trends and an increase in private payer laws requiring service parity. Most covered services before the pandemic were live video telehealth.

At the onset of COVID-19 and the public health emergency, CCHP found that the major insurers voluntarily expanded their telehealth coverage to encompass additional modalities and eligibility. In some cases, this included coverage of audio only, pay parity and reimbursement for services from out-of-network providers. Six of the seven major insurers agreed to temporarily establish pay parity during the public health emergency, including for audio-only services. At the time, only seven states explicitly required they had payment parity. Since their inception and up until today, many private payer laws give insurers leeway in setting reimbursement rates. Per the study, many of them do already reimburse at in-person rates for telehealth. Example language of this leeway would be "services shall be reimbursed at the negotiated commercially reasonable rate."

In 2012, 16 states had private insurance laws for telehealth. This number has grown to 43 states, including Nevada and DC. As discussed previously, state laws vary greatly in coverage requirements for private insurers, including reimbursement for telehealth services. Forty-one states and DC require coverage parity, which ensures private insurers cover services delivered through telehealth if they cover them as in-person services. Twenty-four states require that private insurance reimbursement for telehealth is on the same basis as in-person care. This is not necessarily a blanket payment parity, but the private insurer has at least one profession. They currently have coverage parity and payment parity. Some states have no private insurance laws, and others have them, but they have no explicit parity within the law.

According to the CCHP, three states have made changes to their private payer laws. By spring of 2022, Louisiana passed a bill adding the requirement for payment parity for physical therapy services. All other telehealth services provided by physicians must be reimbursed at least 75 percent of the reimbursement rate for in-person care. However, it does not require explicit payment parity unless it is physical therapy.

Utah passed a bill to include payment parity provisions only for mental health providers. However, all other services will be reimbursed at a negotiated rate. A third state, New Jersey, passed a bill to clarify that their private insurance law applies to the Medicaid program and private insurers. It does limit the ability of insurers to restrict by modality. However, this stipulation is scheduled to expire at the end of the federal public health emergency.

In the fall of 2022, New York amended their laws to include a requirement for payment parity for both private insurers and Medicaid. These laws will expire on April 1, 2024. During this same timeframe, Connecticut passed laws to add payment parity provisions. These laws changed its expiration from June 2023 to June 2024. The expiration date applies to payment parity; the coverage parity does not have an expiration date. Most states are not passing new private payer laws. The trends are expanding payment parity to specific professions, types of services or prolonging the temporary provisions.

Oregon has laws stipulating coverage of telehealth service for four categories. The first is a plan must provide coverage if the service is covered for in-person care. The second is the service is medically necessary. The third is the service can be provided safely and effectively using telemedicine. The fourth category is the service is HIPAA-compliant. Oregon also established a plan not allowing to distinguish between rural or originating sites when establishing coverage. Finally, Oregon requires plans to have explicit payment parity; however, plans are not barred from the use of value-based payment methods.

Arizona has language requiring explicit coverage parity, but only for telehealth services that their Telehealth Advisory Committee on Telehealth Best Practice has assured are safe, effective and can be properly conducted. Any telehealth service that does not have this evidence may be limited or denied in terms of coverage by insurers. As of January 1, 2023, it also includes a stipulation that audio-only telehealth must be covered, if the research supports it can be appropriately and effectively provided. Arizona requires payment parity for audiovisual services. Audio-only services require payment parity when used for behavioral health or substance use disorder services.

CHAIR DOÑATE:
There are trends of states looking at audio-only for mental health services. Are there other cases of audio-only? In addition, you presented Arizona allows mental health and substance use services.

MS. JAROMIN:
Mental health and substance use services are the primary examples, especially when states are doing payment parity. Payment parity is tied to behavioral health services. We have heard some discussion of rural areas. However, we have not seen a lot of legislation on it. Research has shown audio-only access is essential to rural areas. For now, parity for audio only is usually tied to mental health or substance use services.

CHAIR DOÑATE:
Looking at Oregon legislation, does parity conflict with what we have done towards value-based care? Are you seeing trends in other states looking at that as well or how have they responded?

MS. JAROMIN:
I am not familiar with other bills that explicitly talk about value-based payment methods in their parity bills. If I can find any other bills that do explicitly talk about it, I will submit the information to you.

CHAIR DOÑATE:
We will close the presentation and open the hearing on S.B. 119.

**SENATE BILL 119**: Provides for the continuation of certain requirements governing insurance coverage of telehealth services. (BDR S-336)

CORIE NIETO (Director, Telehealth Services, Nevada Health Centers):
I am here today to present S.B. 119. To begin my presentation (Exhibit H), I want to establish clarifying definitions of telehealth. The originating site is where the patient is receiving the service. A distant site is where the provider is located. Telehealth is the delivery of healthcare services from a patient to provider in different locations. This service is delivered using audio or video communications.

At Nevada Health Centers, a patient can walk into any of our 18 clinics and be seen by a medical assistant. The visit would begin with checking the ears and listening to the heart and lungs. Although the patient is in one clinic, the service can be performed by a provider at a different health center. The remote health center can perform these initial checks through the use of technology.

The other branch of telehealth we use is direct to consumer. A patient can use a personal device and the provider is at a different location. This program requires the patient to have Internet access with some type of self-monitoring, analysis, and report technology, commonly called SMART.

The history of parity in Nevada was given by the previous presenter. I will expand on how it has affected the growth of the telehealth field. Prior to 2015, patients had to be from a rural area and had to be at an approved originating site, like a clinic or a hospital. It did not allow urban patients, patients from home, telephone calls or a FQHC providing a service to their own patients. Telehealth was launched to create a relationship with patients in rural communities. It meant to help patients in rural communities and reduce healthcare costs. For example, it could cost $1,000 for a patient to travel from Elko to Reno.

Assembly Bill No. 292 of the 78th Session addressed parity, the shortage of providers and lowering the cost. This bill declared it is public policy for the State to encourage telehealth services and require Medicaid, or any health or industrial insurance policy, to cover telehealth services to the same extent as services provided in person. In 2015, all of the patients living in urban Nevada could seek care through telehealth services. It allowed our 18 health centers across Nevada to interact with each other. For example, we have a clinic in Jackpot on the border of Idaho. The provider in this clinic sees a handful of patients each day. He can connect to an urban clinic, which has maximum capacity for patients. It allows walk-in patients to receive service at the urban clinic. This increases access to care and keeps the rural provider busy.

The previous legislation also allowed us to place an endpoint in schools. It avoids a child waiting until the evening to seek health care at an urgent care or an emergency room (ER). It is also less costly to the child's family. An endpoint in a school provides some medical and behavioral health services.

In 2019, we were working toward direct-to-consumer telehealth. We had not launched the program and had been struggling with adoption due to culture and a patient using their own device at home. Once COVID-19 began, restrictions for payment and coverage parity were removed and we were able to launch our direct-to-consumer program. We had a little girl diagnosed with cancer through the use of a direct-to-consumer technology. We also had a patient who was seen in a clinic who had a heart murmur and ended up having an aortic valve replacement within a month.

In December 2022, U.S. President Joe Biden signed the House of Representatives Resolution 2617 of the 117th Congress, the Consolidated Appropriations Act, 2023. This Act removed the geographical location, expanded the originating sites, allowed a FQHC to be a distant site provider and continued audio-only visits. For the first time, we were aligned with CMS.

Senate Bill No. 5 of the 81st Session is scheduled to expire, so we need to pass this bill. Without passage, we will no longer be aligned or have parity. Medicaid cannot pay for children obtaining services in schools or for people receiving care from home. In 2020, when we opened the regulations and had payment parity, care increased. Patient and provider adoption was successful. We exposed patients and providers to this form of care. Our numbers are still high because patients have a choice without the fear of being exposed to COVID-19. They can choose to receive care in person or virtually.

At the Nevada Health Centers, 17 percent of our patients choose to use telehealth. We do have exclusions for things that can be done via telehealth. A patient cannot have an excluded condition and they have to choose to receive telehealth care. We have hired two providers who exclusively provide telehealth services for our patients. These providers previously saw patients in person and were ready to leave our clinics. We offered them the option to be telehealth providers and they stayed with the organization. As part of our recruiting efforts, we advertised that providers can choose to be part-time or full-time telehealth providers.

Without the assurance that healthcare providers will be reimbursed for telehealth services and the resolution of other legal barriers, the full benefits of telehealth cannot be realized. During the COVID-19 pandemic, legal reimbursement restrictions were lifted. Patient and provider adoption of telehealth skyrocketed. Even today with less fear of contracting COVID-19, we have a large percentage of people of all ages, in both rural and urban locations, who are choosing telehealth to receive care. Unfortunately, the law has a sunset date and without S.B. 119, the State will no longer have telehealth parity.

Passing this bill takes us back to 2015 and aligns us with 2022 CMS guidelines for telehealth. Allowing this bill to pass will promote better outcomes for our patients. The CMS guidelines allow audio-only telehealth and I would support the Committee approving a proposed conceptual amendment (Exhibit I) to allow audio-only. We have used this for our behavioral health patients but have also used it for medical patients.

We try to do video for every patient but have had negative experiences with usage. Bandwidth, access to a SMART phone, and other social determinants of health have caused issues. We are dealing with the underserved, who sometimes do not understand how to use the technology. We work with every patient, before a provider sees them, to make sure they have the proper technology but sometimes the patient cannot connect. The provider can help the patient by telephone, so we would need this amendment to allow it. We do not want to leave a patient with emotional issues, who is unable to connect virtually causing us not to see them. A telephone call can be important.

CHAIR DOÑATE:
From your perspective, what is the most negative effect we will see if we do not continue telehealth?

MS. NIETO:
We would return to 2015, where CMS has the only mandate for telehealth parity in Nevada. The risk is the State does not have to follow CMS regulations. Medicaid or private payers could opt not to follow CMS guidelines and access to telehealth could discontinue.

CHAIR DOÑATE:
Can you submit the actual numbers for the data on page 11 of Exhibit H? Since the parity enacted from COVID-19, have you had an increase of telehealth companies or startups approach you?

MS. NIETO:
Are you asking about telehealth company providers or technology?

CHAIR DOÑATE:
Both. Since the 2015 legislation until today, have you been approached because Nevada has this enacted?

MS. NIETO:
Yes. I am on committees with others involved with telehealth, and they are trying to push telemedicine services. We share information on technology like videoconferencing platforms and ways to deliver the best services to our patients. We collaborate on optimal methods to perform remote patient monitoring. We share information on technology, but also how to connect our providers with our patients in Nevada.

SENATOR TITUS:
Are all of your telehealth providers licensed Nevada providers?

MS. NIETO:
Yes. They are all employed by Nevada Health Centers and are all licensed by the State.

SENATOR TITUS:
One of my concerns about this bill is the risk if we allow telehealth for everybody or if we require them to be a Nevada provider. We required a Nevada license for our brick-and-mortar doctors. We need to avoid an insurance company from contracting with foreign providers. The insurance company would see it as no risk, overhead, cost or accountability. Are you aware of any programs that may hire foreign providers?

MS. NIETO:
We had that situation in 2015 and still have it today. There are national companies providing video visits to our patients. If a patient wanted to use this service, he or she would have to pay cash. Even if we have restrictions, these

companies will still do it for a nominal amount of cash. I can tell you our patients are happy to use our telehealth service because of the continuity of care from the provider.

SENATOR TITUS:
The audio component is a good thing for rural Nevada. Frequently people will have to sign off the video equipment because of the bandwidth. The patient will have to call in to get care, because he or she cannot have both the video and the audio. For the rural or underserved patient, talking to your provider on the phone may be the only option. I am not opposed to the audio-only component because of access to care.

SENATOR STONE:
I share Senator Titus's position on the audio-only but would hope clinics will use every opportunity to do audio and visual. Since 2015, have you seen any increase in your liability issues as a result of using modern day technology in lieu of seeing patients in person?

MS. NIETO:
I am not aware of any issue. If a patient has an issue and cannot get in to see the primary care provider, we provide a telehealth service today. We have dedicated telehealth providers available when a patient calls. Rather than focusing on liability, we can see the benefits like hearing a murmur or diagnosing cancer. We are able to offer same-day or next-day visits.

SENATOR LANGE:
Will you still continue to have a co-pay?

MS. NIETO:
It depends on parity. Currently, the co-pay is paid the same for an in-person visit as it is for telehealth. In short, if the payer has a co-pay, then it is required for telehealth. We have not had complaints from patients because they are getting access to care.

SENATOR LANGE:
There are no fiscal notes on this. Does this mean it is going take care of itself?

ERIC ROBBINS (Counsel):
If there have been no fiscal notes, it means the State agencies have viewed the original version of the bill and determined it is not going to have a fiscal impact. It does not apply to any amendments suggested today.

CHAIR DOÑATE:
I am trying to think through the ramifications if we do not continue this. We had NCSL present to this Committee, so they could explain what is happening around us in other states. We also need to be informed how we align with CMS guidelines, including what is permanent and what is going to expire. We should align ourselves to what CMS is going to do. At the end of the day, we need to consider what is beneficial for our State and the economic development lens.

To use an example, let us presume I am a rural patient and I have been fainting for the last few days. When I see my urban doctor, he could have me do a blood panel and schedule me to have a follow-up visit in three weeks. Perhaps he can prescribe me some level of medication. As an alternative, he may want to wait until after the panels get back before he decides what the next steps are. After three weeks, something comes up and I cannot make the appointment. Rather than cancelling the appointment, I ask if I could switch to a telehealth appointment. If he has the capability, which most providers do, we can switch it and it should be considered the same visit. This should be considered as part of the conversation we are having today.

Medication adherence is another conversation. As an example, a diabetic's blood test results could be handled in a telehealth environment. The physician wants to look at the test to see whether your medication amount is correct. Should this visit be billed the same way as a regular visit? We need a conversation as to what a visit entails. There are multiple visits and multiple things getting done within 15- to 30-minute slots. Perhaps we should treat some visits differently and others the same.

There is feedback on the idea of value-based care and how it contradicts what we are talking about today. Do you have any response to that?

MS. NIETO:
I would like to go back to your previous comments and then I will talk about value-based care. We are billing evaluation management codes now. You have to have that level of care in a telehealth visit to bill appropriately. You may not

get the biometric data. Although we ask patients if they have blood pressure cuffs, thermometers and scales at home. However, you can bill certain codes appropriately through telehealth. It is sometimes seen as a lesser service, but that is not always true. You are correct, who wants to tell a patient the labs or imaging are abnormal? Why do you need a patient to drive an hour and a half to see how the change in their medication went. If the patient drove to your clinic, you get paid for the visit. You could review the change in medication virtually.

I came from a population health management organization, and it was all about quality. The reason we did telehealth was to reach patients in rural Nevada. This population would go without care because they did not want to drive to an urban area. I am uncertain about value-based care reimbursement.

CHAIR DOÑATE:
Have you done any research on telehealth quality metrics? Do you know if other states have? Is that something you have had in any of the meetings when you are brainstorming on care? Do you discuss how to make sure the patients are receiving the quality of care? Do you discuss a comparison of in-person care versus telehealth care?

MS. NIETO:
We constantly discuss this. We are going to make sure patients are taking their preventative medicine. They will receive an opportunity for services whether it is an in-person or a telehealth visit. Watching a patient take their blood pressure on a monitor counts as we view the process. A lab result is different. You send the patient to the lab and then see them virtually to discuss the results. Quality is part of telehealth visits for organizations like ours. We are reporting measures on quality, and we want it to be counted.

SENATOR STONE:
I am a strong proponent of telehealth and I want to make sure the providers are Nevada physicians. We do not want to open the floodgates where we have competitors coming in. We have a primary care shortage in Nevada and certainly a shortage in the rural areas.

I would like for you to expand on the limitations of telehealth. What percentage of patients using telehealth have a condition beyond the scope of this service? For example, the patient is from a rural area and calls in with a terrible pain in his or her left arm paired with shortness of breath. This description would raise flags that the patient may be having a heart attack or on the verge of having one. I would presume this situation would not be managed with a prescription for nitroglycerin.

Tell me how you react to acute situations having significant healthcare ramifications since the patient is not getting seen physically.

MS. NIETO:
Everybody handles it differently, but we have an exclusion list. We have a clinical body that meets monthly and develops what can and cannot be seen through telehealth. When the patient calls in for an appointment and gives symptoms on the exclusion list, he or she are instructed to go to an ER or an urgent care. These situations do not end up with telehealth providers.

Another example is the clinical telehealth team meets and determines they are struggling over rashes, which are difficult to see from a smartphone. We encourage patients, especially new patients, to follow up with a primary care provider. We let the telehealth provider determine if the visit requires an in-person follow-up appointment with the primary care provider. Some of the visits could be just a sore throat and it can be treated one time. We can check the patient virtually in and out. We will schedule the patient at the initial visit for an in-person, follow-up appointment.

SENATOR STONE:
Do you track patients that exceed your ability to treat them and are referred to urgent care or the hospital? Do you track the percentage of your patients who did not get his or her problem solved through telehealth? I would assume the majority do get the issues solved, but a certain percentage has more serious anomalies needing acute attention in person.

MS. NIETO:
It is the responsibility of who does the follow up, whether that is the primary care provider or the ER. We do not have the ability to track that information. We have had discussions, but I do not have an exact number.

CHAIR DOÑATE:
You may want to consider the Hospital Consumer Assessment of Healthcare Providers and Systems or the HCAHPS. It is a survey on a patients' perspective

of hospital care. It would provide feedback for a patient who was dissatisfied with the service received.

MS. BOWEN:
Our members serve the most vulnerable Nevadans. The majority of our patients, or 91 percent, have an income 200 percent below the federal poverty level. Telehealth is important to our patients because they rely on public transportation and cannot afford time away from work and family. In 2021, our Nevada health centers had nearly 113,000 virtual visits. These visits are 28 percent of the total visits for that year. It is critical for the State to continue to reimburse for these services. Our patients cannot lose this effective and convenient way to access health care. We support this bill.

MS. HALL:
Since the passage of the law in 2015, telehealth utilization for our rural hospitals and clinics has not been as robust as anticipated. The issue is beyond our control, like bandwidth, telehealth providers and a patient's ability to use a SMART device. However, it is still vital to rural Nevada care. We use it in ER, acute care and in some intensive care units as well as primary care.

During the COVID-19 pandemic, we saw the benefit when the rules were changed. It allowed providers in the rural health clinics to become a distant site. During the pandemic, audio-only for behavioral health patients was vital. We are in support of S.B. 119.

In response to Senator Titus's question, not all of our providers are local, but they are licensed in Nevada. We found many specialists who do not provide specialty care via telehealth that are based out of state.

MR. ROSS:
We are in support of S.B. 119 and urge its passage. It will maintain and increase access to quality of care. In particular, the certainty of future coverage will encourage future investment.

ALEX TANCHEK (Nevada Advanced Practice Nurses Association; Vitality Unlimited):
We are in support of S.B. 119 and have submitted letters of support. One letter (Exhibit J) is from Dr. Cameron Duncan of the Nevada Advanced Practice Nurses Association and the other letter (Exhibit K) is from Ester Quilici of

Vitality Unlimited. This bill will give providers the necessary support to care for patients Statewide.

MR. TENORIO:
Telehealth helps address mental health and behavior health services in the State. We urge your support of this bill, and it should continue to be reimbursed by the State.

MS. RYAN:
Dignity Health-St. Rose Dominican supports S.B. 119.

BARRY COLE, M.D.:
As a reminder, 95 percent of a diagnosis comes from the interview and taking the history. The remaining 5 percent comes from doing the physical examination to assess if your hypothesis on what could be happening is correct. In psychiatry, the clinical interview is key. The only time a psychiatrist does a physical examination is in a hospital setting and the service does not come with a provider. Typically, a psychiatrist does not perform a physical examination.

The proposed amendment includes a referral to have a provider perform an annual physical examination. I have worked for both a large hospital system and a mental health center. The visual component rarely worked consistently. Even in a hospital setting, the system could fail, but I could talk with the patient. When I needed to use translation, I would turn off the audio of the audio-visual system and rely on the translation from my cell phone. At this point, I am watching a patient while talking to them through the telephone.

I do not see that this is going to be a threat to brick-and-mortar practitioners. As a testimonial, I recently received telemedicine services from my endocrinologist. It does work.

MR. KELLY:
One of the good things coming out of the pandemic is the adoption of telehealth. We should not lose that momentum. It is a very important key to access to health care. We support S.B. 119.

MS. BINDER:
Telehealth has saved our family of eight. We have children with multiple medical needs, and it allows me to have more time with them. For example, about a

week ago, we used telehealth when I had three sick children. It saved me from spending half a day to take them into the pediatrician's office.

I receive long-term pain management as well as psychological sessions. Most of my providers do require in-person visits. I need to see some providers every three months and others every six months. Having a practice with telehealth is invaluable.

UNIDENTIFIED TESTIFIER NO. 1:
I am one of the Nevadans who relies on telehealth and my landline telephone to speak to my doctors. Since the COVID-19 pandemic, I mainly use telehealth. I am disabled and it permits me to no longer have to travel to the provider's office.

What are the benefits and drawbacks of telehealth? In addition to the items pointed out by Dr. Cole, the onset of COVID-19 taught us many things. My Internet and cell phone coverage are spotty at best, and it causes me to rely on a landline phone for audio-only visits. Many times, video calls on my cell phone were dropped at least three or four times in a matter of five minutes. Switching cell phone service did not help. There have been other times when I was running around outside in a bathrobe in the rain with my phone in the air trying to find enough bars so I could talk to my doctor.

My main concern for this bill is the big change to the health care of Nevada's senior citizens who rely on landlines for medical care. Many do not like technology or cannot afford a cell phone and Internet service. I like my landline phone and it costs less than a cell phone. My doctors are watching this bill because of the parity situation. If it goes away, then they will not get paid equally for a phone conversation as an in-person visit. The doctor is going to lose the patient and I am going to lose the doctor. I hope you consider the senior citizens.

MS. NIELSEN:
I am testifying on my behalf, and I support S.B. 119. My husband has severe epilepsy and had major brain surgery in August 2022. He received a lot of his care from telehealth services with doctors as far away as Minnesota. Unfortunately, Nevada did not have an epileptologist able to assist him with his care. Telehealth was vital in keeping him alive.

Our nine-year-old daughter has type 1 diabetes, and telehealth has been vital for her treatment. Telehealth keeps us out of the hospital because we are able to connect with her doctors to make the necessary adjustments to her insulin regimen. She can quickly go from being perfectly okay to diabetic ketoacidosis in the blink of an eye.

I also rely on telehealth services with CCCBH. It allows me to stay with my family in Carson City while working with providers in Las Vegas. Telehealth has helped keep my family alive. Please consider passing this bill.

HELEN FOLEY (Nevada Association of Health Plans):
We oppose S.B. 119, and I have submitted a letter (Exhibit L) to this Committee. Our organization supports patients receiving the services and modality that is the best fit for them. This support remains if the regular environment and reimbursement is appropriately recognized for the quality and cost differences of the services. Members have experienced a high level of quality care and improved health outcomes in using telehealth for certain services and specialties. However, there is still not enough quality or safety data to suggest all telehealth encounters are alike.

CHAIR DOÑATE:
What is the feedback from your organization to align this bill toward what CMS has made permanent? Have they had any pushback?

MS. FOLEY:
I polled some of our members and there was great interest. They thought CMS had come out with a fair system. Based on other states, we are all grappling with this issue. Even CMS has extensive changes with the addition of 54 different codes in 3 categories on the telehealth list. This is not an easy thing, but we do not like to continue as if we are in the COVID-19 mode.

I would like to add that I also represent a FQHC that has permanent services. We want to make sure we have mental health services in the rural areas. We understand the connectivity problems with rural areas. We want to work with you to find a good solution.

MS. CASE:
Although Nevada Psychiatric Association and Nevada Public Health Association are in neutral on S.B. 119, we support its inclusion of the parity component for

audio-only telehealth. We did submit an amendment, Exhibit I. It does not include any conceptual language because the bill makes changes to the *Nevada Revised Statutes* (NRS) and eliminates the sunset. Since I am not a lawyer, I will defer to Legislative Counsel for the amended language.

Telehealth pay parity is imperative for our providers. There are many professions, like attorneys, who bill by the quarter hour regardless of the means of communication. This should be extended to health providers who practice their skill via audio only or telemedicine. They have worked hard to get to this point in their career to practice medicine. They are licensed in Nevada, and they should be fairly compensated. This includes payment parity regardless of the means of communication.

CHAIR DOÑATE:
I have two documents (Exhibit M) in support of S.B. 119 to put into the record. I have three documents (Exhibit N, Exhibit O and Exhibit P) from Comagine Health in support of S.B. 119 to put into the record. We will close the hearing on S.B. 119 and open the hearing on S.B. 298.

**SENATE BILL 298**: Revises provisions governing the involuntary discharge of a resident from a residential facility for groups. (BDR 40-301)

SENATOR MELANIE SCHEIBLE (Senatorial District No. 9):
Senate Bill 298 came from a recommendation made by the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs. During the 2021-2022 Interim, a presentation to the Committee on June 28, 2022, revealed there are 7,610 residents in licensed residential facilities for groups and assisted-living facilities in Nevada. Federal regulations require the State to have a written agreement for each of these residents. The agreements must provide protections addressing eviction processes and appeals comparable to those provided under a jurisdiction's landlord-tenant law.

Nevada law does not offer eviction protections for these individuals and residential facilities for groups. When an eviction takes place, it is often initiated because of the resident's behavioral challenges or financial issues. Residents in lower levels of care, such as residential facilities for groups or assisted living facilities, do not have protections from evictions by providers regardless of the payer source.

A formal discharge process with appeal rights does not exist for these individuals. They are often evicted to homeless shelters or hospitals where they may not receive the appropriate level of care. Senate Bill 298 would make changes to chapter 449A of NRS. It will bring Nevada into compliance with Centers for Medicare & Medicaid Services, setting rules providing increased protections for individuals living in non-skilled nursing locations. The bill proposes to establish a baseline of eviction protections for all individuals and group residential facilities. It will mirror federal regulations and create compliance with the requirements of CMS setting rules.

This bill will incorporate a notification process to alert the Long-Term Care Ombudsman Program with the Aging and Disability Services Division (ADSD) within 30 days of a proposed eviction. The bill also includes penalties for facilities that do not follow the process with enforcement mechanisms. This bill will designate a forum to adjudicate eviction disputes.

Sections 2 through 7 of S.B. 298 provide definitions for the terms related to residential facilities for groups. Unless the provider is a relative, section 8 prohibits them from acting as a representative of a resident in the process of an involuntary discharge. Section 9 outlines the specific information and details required to be included in the contract between the resident and the provider.

Section 10 requires a provider to give additional notice before involuntarily discharging a resident for failure to pay the contracted charges. It will require an attempt to first resolve any issues resulting in the involuntary discharge of a resident before the eviction. This section also provides for five exceptions when an involuntary discharge is allowed. The first exception is a resident's health has improved to the point where they no longer need the services of a residential facility for groups. The second exception is if the health or safety of any person in the facility is endangered. The third one is, after sufficient notice has been provided, the resident has failed to pay for contracted charges. The fourth exception is the services provided by the residential facility for groups are no longer adequate to meet the needs of the resident. The fifth one is the residential facility for groups is no longer in operation.

Section 11 provides the required content of a written notice of intent to discharge a resident. Section 12 of the bill requires a residential facility for groups to provide certain assistance in the discharge and relocation of a resident. This section also requires the provider to make sure a representative of the resident is involved in the planning for the discharge, except in emergency situations. Section 12 requires emergency placement situations must be temporary.

Section 13 allows a residential facility for groups to request the Nevada Department of Administration to make a determination for an immediate transfer or discharge of a resident in an emergency. This section requires the Department to order a transfer or discharge if allowing the resident to remain at the facility would endanger the health, safety or welfare of the resident or other residents. The Department would also be required to hold a hearing no later than seven days after issuing an order. Section 16 provides that advance notice of an emergency order by the Department is not required.

Before an involuntary discharge takes place, section 14 authorizes a resident or their representative to request a hearing before the Hearings Division of the Nevada Department of Administration. Sections 14 and 17 provide for the confidentiality of the hearing. Sections 1 and 19 authorize the disciplinary action against a residential facility for groups that violate the provisions of sections 4 through 14. Section 18 authorizes the State Long-Term Care Ombudsman to help a facility, a resident and the representative in planning for the discharge and relocation of the resident from the facility.

MARIE COE (State Long-Term Care Ombudsman, Aging and Disability Services Division, Nevada Department of Health and Human Services):
I am the State Long-Term Care Ombudsman and my office has the privilege of advocating for residents in these residential facilities for groups.

SENATOR TITUS:
I was concerned about section 11, subsection 1, paragraph (d) which is contacting the State Ombudsman. I worked in long-term care and there are not enough ombudsmen. How will you manage the workload, because frequently a patient's family has difficulty getting in touch with an ombudsman. When the families have concerns or needs, it takes a long time to receive help.

I am aware your capacity has been expanded with additional positions. What is the vacancy rate for these positions and how will this bill impact your ability to respond?

MS. COE:
We support S.B. 298 because it gives these residents protections. During the last year, we have seen a 38 percent increase in complaints regarding discharges. Currently, the ombudsman has limited ability to advocate for discharged residents. We are usually limited to helping them find another place to live. If somebody has been discharged from these settings, they currently do not have the right to return from a hospital if their acute needs have been met. If they have care needs and they are going to a homeless shelter or to another setting, their needs cannot be met.

We would encourage and advocate for the discharged residents in the appeal settings. They will have the opportunity to share if they have care needs and should remain in a setting. If it is a payment issue, we can help advocate and get the provider the payment source. We do not have enough of us, but this process will help residents. This bill will allow us to meet our goal to provide assistance to them.

Senate Bill 298 gives residents the ability to have legal representation. Currently, if a resident contacted us on a disputed discharge, we can contact legal services. However, there is nothing to support the process or its legal defense.

SENATOR TITUS:
Does it expand your role because technically you are a long-term care spokesman? This is a resident facility, not necessarily a long-term care facility. These are residential housing facilities. Do we need to make a change in definition?

MS. COE:
We cover the advocacy in these settings. It is within our jurisdiction to meet with all the residents in these settings.

MR. NORMAN:
The Nevada Coalition of Legal Service Providers supports S.B. 298. We represent a lot of people under guardianship. Based on discussions with ADSD, this problem is happening to others. This type of completely nonjudicial eviction is extremely harsh for people who find themselves in need of a level of care that is not available. We have residents with medical needs discharged to homeless shelters and it creates tragic circumstances.

ERIN ROOK:
I am in support of S.B. 298. People living in a residential facility for groups have a right to eviction protections comparable to those provided under standard landlord laws. People, who are more vulnerable due to mobility, cognitive or financial limitations, should be given a greater degree of protection. While there are scenarios for evictions, such as a facility can no longer provide care for a particular resident, exemptions will address these concerns. We are trusting these places to care for our loved ones and want to ensure they will not be put at risk. I urge your support of S.B. 298 to make sure vulnerable Nevadans are never left behind.

UNIDENTIFIED TESTIFIER NO. 2:
I am in full support of S.B. 298.

BRETT SALMON (Nevada Health Care Association):
We oppose S.B. 298, and I have submitted my written comments (Exhibit Q) to this Committee.

I want to highlight one area from the letter. The bill grants hearing rights in every single case of a transfer and discharge. This item created a fiscal note by the Nevada Department of Administration, Hearings Division. The most recent data I found is the Division's fiscal year 2021-2022 report. It documented only 33.6 percent of all cases are resolved at the hearing officer level in less than 90 days. This caused us to pause because it means 60 percent of those cases take longer than 90 days for resolution. We are concerned about potential delays in a hearing process that appears already overwhelmed even with the additional staff included in the fiscal note.

A delayed hearings process is not healthy for a resident. He or she needs to be transferred to a higher level care setting because of the health concerns we have for them. If they have to wait four to six months to go through a process, then they are not in the best place for them. On the other hand, it is not financially healthy for an assisted living community to have to carry out an appeal process in the same time frame.

Senator Scheible mentioned the CMS settings rule and the mandate on assisted living. This is only a mandate for those assisted living facilities accepting Medicaid. Many facilities in Nevada, because of the lower Medicaid rates, do not accept Medicaid. I wanted to put it on the record and clarify, it only applies to those who accept Medicaid.

CHAIR DOÑATE:
What is the greatest concern you have with this bill?

MR. SALMON:
We have a few areas of concern. The first concern is the additional items in the admission agreement. It could be handled in a different way. I met with ADSD earlier this week to discuss the agreement. A second concern is the hearing process. There should be definite timelines put in the process. I am not concerned with the hearing process but am concerned with the timelines. Both the resident and the facility would benefit from a defined timeline.

CHAIR DOÑATE:
In terms of the section on the written notice, is there any pushback on providing the resident or their family members with a written notice or is it the timeline?

MR. SALMON:
We already provide a written notice and work with the ombudsman and Adult Protective Services (APS). An extensive process is already in place. The hearing would be the newest part of the process.

LAURA HIGMAN (Director of Quality Assurance, Mission Senior Living):
I have been in the senior living industry since 2011 and have a passion for supporting residents and quality care. I am here today to voice my opposition on portions of S.B. 298. Prohibiting the involuntary discharge or transfer of a resident except for the reasons listed on the bill would remove our ability as an operator to uphold and enforce the complete extent of the signed rental agreement.

Some topics may not fall within the categories of the proposed bill. For example, NRS requires we uphold nondiscrimination within our community. I cannot support that culture if I have a resident who makes a discriminatory statement towards staff and other residents. After multiple discussions, if I cannot act on those types of situations, which goes against our rental agreement, then I have no choice but to continue that behavior inside of my community.

In addition, prohibiting the involuntary discharge of a resident after emergency placement leaves the possibility of a resident returning to a facility where care and services cannot be met. The proposed bill states the Nevada Department of Administration will have the ability to transfer a resident if deemed necessary. However, in this market, there are no fundamental resources to transfer to. It would be another privately owned facility willing and able to accept the resident.

To conclude, my organization operates ethically to the best of our ability. Similar to Mr. Salmon, if we have an involuntary discharge, we include APS and the ombudsman. Placing barriers in diverse situations forces the facilities to make decisions outside of the best interest of the business and the residents we serve.

JEANNE BISHOP-PARISE:
I am a Health Services Executive for the State and was originally licensed in 1984. I oppose S.B. 298, and have submitted my written comments (Exhibit R) to this Committee.

MS. HALL:
Nevada Rural Hospital Partners is neutral on S.B. 298. We do not have a lot of residential care providers in rural Nevada. Half of our hospitals have distinct long-term care. Ms. Bishop has stated real issues. We are seeing more elderly patients who do not have family involvement. They do not have control over their finances or behavioral health issues. They are in residential care because it is the only place they can live. In rural areas, when the patients become a problem or cannot pay, we find them in our ER. They have a medical condition, but after care, we have no place to discharge them. We have many hospitals that house these individuals for over a year with no payment.

SENATOR TITUS:
I have a comment that I did not think to ask earlier. We are doing long-term care, and we may have to keep foreign nationals for over a year. We had a gentleman from Canada with no payer source. Since he was a citizen in Canada, we could not bill. We could not do anything about it. It is a real issue.

CATHERINE NIELSEN (Executive Director, Governor's Council on Developmental Disabilities, Nevada Department of Health and Human Services):
We are testifying in neutral on S.B. 298. I would like to personally echo the many positive comments stated here today.

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

CHAIR DOÑATE:
Hearing no public testimony, we are adjourned at 6:30 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. 232 | C | 10 | Senator Nicole J. Cannizzaro | Proposed Conceptual Amendment |
| S.B. 232 | D | 14 | Caroline Mello Roberson/NARAL Pro-Choice Nevada | Letter of Support |
| S.B. 232 | E | 17 | Leann McAllister/ Nevada Chapter, American Academy of Pediatrics | Letter of Support |
| S.B. 232 | F | 19 | Senator Fabian Doñate | Five Letters of Support |
| | G | 20 | National Conference of State Legislators | Presentation |
| S.B. 119 | H | 27 | Corie Nieto/ Telehealth Services, Nevada Health Centers | Presentation |
| S.B. 119 | I | 29 | Corie Nieto/ Telehealth Services, Nevada Health Centers | Proposed Conceptual Amendment from the Nevada Psychiatric Association; Nevada Primary Care Association |
| S.B. 119 | J | 35 | Alex Tanchek/ Nevada Advanced Practice Nurses Association | Letter of Support |
| S.B. 119 | K | 35 | Alex Tanchek/ Vitality Unlimited | Letter of Support |
| S.B. 119 | L | 38 | Helen Foley/ Nevada Assoc. of Health Plans | Letter of Opposition |

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|---|---|---|---|---|
| S.B. 119 | M | 39 | Senator Fabian Doñate | Two Letters of Support |
| S.B. 119 | N | 39 | Senator Fabian Doñate | Comagine Letter of Support |
| S.B. 119 | O | 39 | Senator Fabian Doñate | Comagine Appendix A Nevada Telehealth Summary |
| S.B. 119 | P | 39 | Senator Fabian Doñate | Comagine Appendix B Critical Access Hospital Telehealth Guide |
| S.B. 298 | Q | 43 | Brett Salmon/ Nevada Health Care Association | Letter of Opposition |
| S.B. 298 | R | 45 | Jeanne Bishop-Parise | Letter of Opposition |