MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
April 6, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 12:41 p.m. on Thursday, April 6, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

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

GUEST LEGISLATORS PRESENT:

Senator Marilyn Dondero Loop, Senatorial District No. 8
Senator Julie Pazina, Senatorial District No. 12

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

James Rosenthal, CEO, Caring.com
Brett Salmon, Nevada Health Care Association
Joanna Jacob, Clark County
Jonathan Norman, Nevada Coalition of Legal Service Providers
DaShun Jackson, Director, Children's Safety and Welfare Policy, Children's Advocacy Alliance of Nevada
Cara Paoli, Human Services, Washoe County

Timothy Baker, M.D., Senior Associate Dean for Academic Affairs, School of Medicine, University of Nevada, Reno
Angelina Rodriguez, M.D., Sunrise Health Graduate Medical Education Consortium, HCA Healthcare
Connor Cain, Touro University, Nevada; HCA Healthcare
Trevor Parrish, Vegas Chamber
Katie Ryan, Dignity Health-St. Rose Dominican
Sheila Bray, University of Nevada, Reno
Susan Martinez, Nevada State AFL-CIO
Kate Martin, M.D., Associate Dean, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas
Sarah Watkins, Nevada State Medical Association
Chris Bosse, Renown Health
Elyse Monroy-Marsala, Nevada Public Health Association; Nevada Primary Care Association
Dan Musgrove, Valley Health System of Hospitals
Kent Ervin, Nevada Faculty Alliance
Constance Brooks, University of Nevada, Las Vegas
Blayne Osborn, Nevada Rural Hospital Partners
Samantha Sato, Roseman University of Health Sciences
Marc Ellis, Communications Workers of America
Alejandro Rodriquez, Nevada System of Higher Education
Patrick Kelly, Nevada Hospital Association
Barry Cole, M.D.
Maya Holmes, Culinary Health Fund
Stacie Sasso, Health Services Coalition
Todd Ingalsbee, Professional Firefighters of Nevada
Satoria Partridge
Paul Catha, Culinary Workers Union Local 226
John Abel, Las Vegas Police Protective Association
Troyce Krumme, Las Vegas Police Managers & Supervisors Association

CHAIR DOÑATE:
We will open the hearing with Senate Bill (S.B.) 260.

SENATE BILL 260: Revises provisions relating to certain persons providing referrals to group housing for persons who are aged. (BDR 40-675)

SENATOR MARILYN DONDERO LOOP (Senatorial District No. 8):
I am pleased to present S.B. 260. I will begin the presentation by walking the Committee through the sections of this bill. Section 2 defines the term, senior living community, to refer to certain facilities or other living arrangements for people who are aged, including residential facilities. Section 3 of this bill defines the term, senior living community referral (SLCR) agency, as a person who refers individuals to a senior living community.

Section 4 requires all unlicensed SLCR agencies to disclose certain information to a person who is aged or the representative of the individual to obtain consent before a referral can be made. This section also requires the SLCR agency to maintain a record of disclosure or consent for at least three years and provide a copy of this record to certain entities.

Under certain provisions, section 5 prohibits an unlicensed SLCR agency from referring a senior living community to a person who is aged or to their representative. This section also requires an unlicensed SLCR agency to establish a policy that protects the privacy of the aged person and their representative, including prevention of selling their personal information. Additionally, this section requires an unlicensed SLCR agency to stop contacting or referring an aged person or their representative upon request.

JAMES ROSENTHAL (CEO, Caring.com):
Nevada is currently the only state that operates exclusively on a subscription fee structure. The State requires senior living communities to subscribe to referral agencies like ours and to pay a subscription fee, whether a senior is placed in a community or not. Charging a subscription harms many of the communities caring for senior citizens. The current law creates instances where a community pays for a service that is rarely or never used. It can price some of the smaller communities out of the market. Some of the smaller communities choose not to use our services, which makes it difficult for us to help families find the best community for their loved ones.

The goal of S.B. 260 is to align the interests of the three parties involved: the senior and family, the referral agency and the senior living community. It will ensure the senior moves into the community that is the best fit for the senior's needs and wants. We are convinced that optimization happens when we are able to charge communities on a move-in basis. All of our services are free to the seniors and families. This pricing change, along with many of the consumer

protection provisions outlined in S.B. 260, protects some of our most vulnerable population along with the communities they are joining.

SENATOR TITUS:
Having been a long-term care medical director, I have had contact nationwide from families trying to place a senior parent. Can you explain what your organization does? I am assuming you do not administer any care to patients.

MR. ROSENTHAL:
We are a referral agency and do not provide care to the senior citizen. We refer senior citizens after discussing his or her needs and preferences. Based on this discussion, we research communities that could be a good fit. Once we have the senior's consent, we share his or her information with the community. We continue to nurture both sides to find the best fit for the senior citizen.

SENATOR TITUS:
To clarify, you are serving the senior citizen and the family to find the location. You are searching for the correct match in housing. Does the senior or family make the final decision on selecting a location?

MR. ROSENTHAL:
You are correct. Most people will tour the community prior to moving in. Therefore, the next step is to schedule a tour of the facility. We will work together to ensure it is a good fit for the senior citizen and the community. We stay involved to nurture both sides.

SENATOR TITUS:
Are you reimbursed by the facility if the senior moves in?

MR. ROSENTHAL:
The communities pay us on a subscription basis rather than a move-in basis. This is unique to Nevada because the remaining 49 states are not exclusively subscription.

SENATOR DONDERO LOOP:
Unbeknownst to me when I started this bill, my sister-in-law had used this service for her father. His cognitive abilities and medical needs changed. As a result, she needed to find a different place for him. This process helped her find a match for her father.

SENATOR TITUS:
Are there other referral agencies?

MR. ROSENTHAL:
There are national and local referral agencies. The national agencies tend to have an Internet model. The local agencies are similar to a local real estate agency.

SENATOR STONE:
What happens if the match does not go well, and the patient does not like living in the new environment? What is the cancellation provision?

What happens if a patient has a deteriorating medical condition requiring additional medical help? How would a family transfer the patient to a medically serving facility?

MR. ROSENTHAL:
These situations occur frequently. Seniors may change their needs and wants, especially their care needs. Typically, the senior living community is aware and is helpful in finding a new place. We will get involved if asked. We do not know what is going on in the community. We are always available to help, but the communities take the lead for these situations.

SENATOR STONE:
Does the patient or the patient's family sign a rental agreement with the facility? Can the agreement be broken if the patient subjectively does not like the care they are receiving? How easy is it for the patient or family to cancel because the preference has changed? How do you deal with situations like that?

MR. ROSENTHAL:
The senior and the family do not sign a contractual agreement with us. However, they do sign a residential agreement with the community. The situations we are familiar with, and the partners that we are aligned with, make it relatively easy to move out. This happens all the time.

SENATOR STONE:
I wanted to make sure there is recourse for a patient who has not had their needs met. I wanted to verify the fee you received is not passed onto the patient because they want to move out prior to the end of the lease.

MR. ROSENTHAL:
The other 49 states allow a fee on a move-in basis. When a patient moves out prior to the end of the lease, our fee is significantly reduced. It is called a respite fee.

BRETT SALMON (Nevada Health Care Association):
We oppose S.B. 260. We represent the assisted living and nursing facilities discussed previously. As we understand the bill, it would allow a referral agency to operate without a license in Nevada. It does add several requirements to these companies, but it appears there would be no statutory or regulatory oversight by the State. This type of model does not protect consumers who ultimately become our residents. However, we had two productive conversations with the proponents of the bill and look forward to future conversations with them.

CHAIR DOÑATE:
We will close the hearing on S.B. 260.

SENATOR NGUYEN MOVED TO DO PASS S.B. 260.

SENATOR STONE SECONDED THE MOTION.

SENATOR TITUS:
Per the expression about documentation and licensure to have a business in Nevada, I would like to have the Legal Division confirm they would have to have a license to do business in Nevada.

ERIC ROBBINS (Counsel):
Yes, to the same extent as any other business.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
We will open the hearing on S.B. 380.

SENATE BILL 380: Revises provisions relating to the Extended Young Adult Support Services Program. (BDR S-991)

SENATOR ROCHELLE T. NGUYEN (Senatorial District No. 3):
It is my pleasure to present S.B. 380, which pertains to extended foster care programs throughout Nevada. The extended foster care programs allow youth to retain or reenter care beyond their eighteenth birthday. This critical resource allows young people to gain time to develop critical life skills, relationships and resources that can help them thrive as adults.

Pursuant to the House of Representatives Resolution 6893 of the 110th Congress, the Fostering Connections to Success and Increasing Adoptions Act of 2008, the State explored the extension of foster care. In response, the Legislature passed S.B. No. 397 of the 81st Session to allow agencies providing child welfare services to establish extended foster care programs. This extension enabled the continuance of a legacy State program called "Step Up." The goal is to transition to full funding from federal money should the program prove to be beneficial. At the request of the stakeholders, including the State, Clark and Washoe Counties, I have sponsored this bill.

Fundamentally and on a high level, this legislation extends the effective date of the extended foster care program to July 1, 2025, to give those stakeholders more time to implement this program. The stakeholders will make several changes to implement the program originally contemplated in S.B. No. 397 of the 81st Session.

Clark County has filed a proposed amendment (Exhibit C) to include language on an extension of the effective date and a new reporting requirement. Since the passage of S.B. No. 397 of the 81st Session, it has been difficult to fully implement the program; hence the extension and accountability will ensure some legislative oversight.

JOANNA JACOB (Clark County):
We have been partnering with the State and Washoe County on accessing federal funds to support some of the child welfare programs. The intent of the amendment reflects Nevada's communication with the federal government. We cannot partially implement programs and need to work in collaboration. Our extended foster care program, Step Up, has been in existence for many years. This bill is not ending Step Up; it is changing the funding to federal reimbursement.

We need to change other key items including kinship, guardianship, assistance payments to age 21 and adoption subsidy payments. In short, wherever the child is at the age of 18, it needs to extend to the age of 21. These changes are based on discussions the State has had with the federal government.

The proposed amendment removes the stipulation that this bill only applies to populations over 100,000. This change will extend the program to children served by the State in rural regions. The reporting is going to make sure we can keep the Legislature informed. This is a policy shift, and it is important to stay in communication with the Interim Finance Committee (IFC).

SENATOR NGUYEN:
I wanted to expand on the removal of the population cap. The initial legislation contemplated the cap, but subsequent conversations determined we could use federal funds for the rural communities.

SENATOR TITUS:
I had asked about the population cap, and I appreciate you heard my concerns. However, I still have a few additional questions. I agree with some of the services extending past the age of 18. This population suddenly finds themselves without support. I want to make sure the child signs an agreement since they are legally an adult. There has to be a component of the extension to ensure the funds are given to the child and not the foster parent. I just want to make sure that any extension follows the person.

MS. JACOB:
When a child enters the Step Up program, he or she agrees to oversight by the court. A child in Clark County transfers from the Family Services Division to Social Service. I believe Washoe County has the same process. The Step Up program has been in place for a long time and predates some of the conversations at the federal level about extending foster care.

The decision the State needs to make, and will be reported to the IFC, is the foster care payments. We have a child in a foster home receiving payments to help support the foster parents. The extended program will make these payments up to age 21. The money is wherever the child is and how they are being served. There is federal money available to help defray some of the costs for all of those programs.

SENATOR NGUYEN:
This is a perfect example of where the Legislative Body had the foresight to establish a program. The federal government realized the success of the program and now we are trying to catch up to the federal money.

SENATOR STONE:
I am aware of what happens when a foster child reaches 18 and has nowhere to go. Unfortunately, in many cases, they end up in the criminal justice system. They are not prepared for a job or have any independent life skills. I am in support of what you are trying to do.

We should leverage federal funds, not only here, but through Medicaid. If you receive the funding in 2025, how many additional children in Clark County would you be able to help?

MS. JACOB:
I will get you the requested information since I do not have it with me today. Clark County youths are fortunate because they are supported. Due to the foresight of former Assemblywoman Barbara Buckley, we have a program where this population is receiving support to attend college or obtain job skills. Clark County has approximately 287 participants in this program. We have started other programs to support youths who have aged out.

I will get you the number, but I am uncertain how we can forecast it. The shift we will experience over the Interim will require additional resources at our County level. This is one of the items we will report to IFC. We project additional staffing as we move to serve these children. It will be everyone in foster care up to the age of 21.

SENATOR STONE:
Do not spend a lot of time on it. I was just wondering about the amount of funding we will receive from the federal government. Is it going to be fully funded or will it still include a portion from the County?

MS. JACOB:
It will not be fully funded by the federal government. The information I am presenting today is an estimate, and I will follow up with more detailed information. However, it will average 30 percent of the costs, meaning we will defray the General Fund costs. We will try to bill what we can to the federal

government. As federal policy develops, we may see a percentage change, but currently it averages 30 percent to 35 percent of the cost.

JONATHAN NORMAN (Nevada Coalition of Legal Service Providers):
At any time, we represent 3,000 to 4,000 youths in foster care. I have worked with youths who are 18 to 21 years old. They have been with me for so long, and the extended foster care program is vital. We look forward to the effort to tap into federal funds to further serve foster children. Whether through adoption subsidies, kinship gap subsidies or the kids who age out. We support S.B. 380.

DASHUN JACKSON (Director, Children's Safety and Welfare Policy, Children's Advocacy Alliance of Nevada):
As a former foster child, I understand the importance of extending foster care to the age of 21. We stand in support of S.B. 380.

CARA PAOLI (Human Services, Washoe County):
We are in support of S.B. 380 and the proposed amendment. We appreciate Senator Nguyen's willingness to make changes so there can be a unanimous child welfare voice across Nevada.

CHAIR DOÑATE:
We will close the hearing on S.B. 380.

SENATOR TITUS MOVED TO AMEND AND DO PASS AS AMENDED S.B. 380.

SENATOR STONE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
We will open the hearing on S.B. 350.

SENATE BILL 350: Revises provisions relating to graduate medical education. (BDR 18-553)

SENATOR JULIE PAZINA (Senatorial District No. 12):
I am proud to present S.B. 350. We are facing a shortage of medical professionals in Nevada. This bill aims to expand graduate medical education opportunities including residencies and fellowship programs in the State. It will ensure Nevada medical school graduates and physicians will stay in Nevada to practice medicine after their residency or fellowship.

When I have met with Nevada citizens, it is a common story of how many times the citizen or family member was unable to get into a doctor. The delay for a doctor visit can be weeks or even months. For a visit with a specialty physician, it can be even longer. This is the genesis of S.B. 350.

I will go over each section of the bill. Section 1 amends chapter 223 of the *Nevada Revised Statutes* to include sections 2 through 6 of this bill. Section 2 creates the Account for the Graduate Medical Education (GME) Grant Program in the General Fund. This section requires the Director of the Office of Science, Innovation and Technology (OSIT) in the Office of the Governor to administer this Account. In addition, section 2 requires the money in the Account to be used to award competitive grants to institutions in the State.

Section 3 creates the Advisory Council on GME. This section outlines who will make up the Advisory Council, compensation, the term of an appointment and other guidelines. Section 4 requires the Advisory Council to evaluate applications for competitive grants for the Program and make recommendations to OSIT for approval, as established in section 5. Additionally, sections 4 and 5 require the Advisory Council and OSIT to give priority to applications for grants made for the purpose of the creation, expansion and retention of residency training and fellowship programs.

Section 6 requires OSIT to submit an annual report to the Governor and the Director of the Legislative Counsel Bureau with any recommendations for measures to create, expand and retain the Program. Sections 7 and 8 require the Director of OSIT to provide the necessary support to the Advisory Council and to implement the Program. Additionally, these sections clarify that funding for the Program is required to be deposited into the account.

Section 9 makes an appropriation from the General Fund to the Program. Finally, section 11 makes S.B. 350 effective upon passage and approval.

I have submitted to this Committee a proposed amendment (Exhibit D). In section 3, subsection 6, language has been added regarding the frequency of the Advisory Council's meetings on grant recommendations. In section 4, subsection 2, paragraph (b), emphasis is placed on the healthcare needs for the State. Finally, in section 9, subsection 2, the grant money is to be reverted to the Program for additional GME grant expenditures.

Senator Titus and I have been working together on funding and policymaking for GME. We desire to combine elements from S.B. 350 and S.B. 369 to ensure sustainable funding for graduate medical education in Nevada.

SENATE BILL 369: Revises provisions relating to health care. (BDR 32-528)

TIMOTHY BAKER, M.D. (Senior Associate Dean for Academic Affairs, School of Medicine, University of Nevada, Reno):
I oversee the Office of GME, which manages all residency and fellowship programs sponsored by the University of Nevada, Reno (UNR), School of Medicine. I am also a primary care physician of internal medicine.

As Senator Pazina mentioned, any patient who waits months for an appointment, realizes Nevada needs more doctors. Having public medical schools in Reno and Las Vegas, as well as residency and fellowship programs, has proven to be successful for keeping homegrown physicians in Nevada. Nearly 40 percent of students who attended one of our public medical schools stay in Nevada to practice. Fifty-five percent of those who complete residency and fellowship in Nevada will practice in our State. More than three out of every four physicians who complete both medical school and residency in Nevada stay here to practice. This data clearly demonstrates the powerful additive effect of having both public medical schools as well as residency and fellowship programs within the State.

We work closely with the University of Nevada, Las Vegas (UNLV) School of Medicine on these initiatives. To train more doctors requires a long-term commitment. Sustainable funding for these programs is a requirement of the Accreditation Council for Graduate Medical Education (ACGME). If sustainably resourced, a training program will last indefinitely and continue to create doctors who can care for future generations of Nevadans.

I graduated from the UNR School of Medicine and had an opportunity to stay here for my training in internal medicine. My wife, however, was pursuing pediatric training and Nevada did not have a pediatric residency program. We were forced to leave the community to ensure we both received the training needed. We are the exception because we returned after our training was complete.

We do much better when we teach doctors in Nevada at our State medical schools. Each residency program or fellowship program that we do not have is a missed opportunity to keep our own students here. They are our homegrown doctors. Senate Bill 350, with its emphasis on the growth of residency and fellowship programs, is an excellent and positive first step toward achieving this goal.

ANGELINA RODRIGUEZ, M.D. (Sunrise Health Graduate Medical Education Consortium, HCA Healthcare):
I am speaking on behalf of Jesus Medrano, Vice President of GME at HCA, Far West Division. I oversee the accreditation of all the resident and fellowship programs at Mountain View Hospital and Sunrise Hospital and Medical Center in Las Vegas. Sunrise Hospital is also part of our GME consortium. We are in support of S.B. 350.

Match Day was March 17, 2023, or the day graduating medical students learn where they will spend the next several years as residents or fellows. We matched 109 new residents who joined 279 current residents based at Mountain View Hospital and Southern Hills Hospital and Medical Center. This is good news for Nevada because statistically 54.6 percent of these residents will stay in Nevada.

There is tremendous opportunity to do more. Our programs received many applications for a limited number of positions. For example, our anesthesiology residency program received more than 1,000 applications for 8 positions. Diagnostic radiology received more than 400 applications for 5 positions. Physical medicine and rehabilitation, the only program in Nevada, received more than 400 applications for 6 positions.

For a July 2023 start, we have received ACGME accreditation for pain medicine in coordination with the U.S. Department of Veteran Affairs and an infectious

disease fellowship. Both are the first in the State and neither are funded by the Centers for Medicare & Medicaid Services (CMS).

If we build the slots, the residents and fellows will come and stay. Unfortunately, our facilities are now past the five-year period CMS allows for building resident cap slots. Creating new programs is challenging. Grants, such as those contemplated in S.B. 350, can help get subspecialties implemented. It costs up to $150,000 per resident to cover costs, including salaries, benefits, training and administrative support for an accredited program. Senate Bill 350 invests in GME with a focus on Nevada's most needed specialties. In addition, the funding will allow investment into start-up fellowship programs in subspecialty training.

Thank you for considering S.B. 350. We look forward to continuing to work with Senator Pazina and this Committee. This bill is an investment in the development of our healthcare workforce.

SENATOR TITUS:
Moving forward is the key here. Not to give a plug to S.B. 369, but I am concerned about the set fund of $17 million. I am on the money committee and will see this bill again. How far will this funding take you and how many residency slots will it achieve?

SENATOR PAZINA:
Sustainability and funding are some of the reasons we have been working together. Joining forces with S.B. 369 and establishing a credit against the modified business tax can ensure this money is a lot more sustainable.

One of our concerns is it takes three to four years to develop a fellowship program. It is important to have sustainable money that can move forward. In the proposed amendment, we added language for the money to revert back to the fund as opposed to the General Fund. It will create a number of programs. The challenge will be fellowship programs; that is why melding our bills and working together is important.

SENATOR TITUS:
Dr. Rodriguez testified it costs approximately $150,000 per resident. Is that cost per year or the total cost for the three years of residency training?

DR. RODRIGUEZ:
It is $150,000 per year, per resident.

SENATOR TITUS:
If I did simple math, I could figure out how far this funding will go. What happens if the residency program starts, and it does not get the accreditation?

DR. RODRIGUEZ:
We cannot move forward with the programs if they are not ACGME accredited.

SENATOR TITUS:
Do you have a defined timeline like five years? I am worried it may take longer than five years. I am just looking forward on this bill and ensuring it is sustainable.

SENATOR STONE:
I am aware of the shortage of primary care providers and specialists in Nevada. Dr. Rodriguez, you stated that 54.6 percent of those trained here are going to stay here. I am not sure if this is a question for the Advisory Council, but I am going to ask you. What is the strategy, other than Nevada residencies, to have doctors stay here? I want to make the referenced percentage go higher.

DR. RODRIGUEZ:
I agree with your goal to increase the percentage. My organization's goal, as well as my GME colleagues, is to train and retain these graduates. Efforts and strategic plans are in place to continue to improve the retention in Nevada. We can all agree that number needs to increase.

SENATOR PAZINA:
It is my understanding that more than three out of four doctors who graduate and complete their residency in Nevada will stay here. We need to have an emphasis on doctors who graduate in Nevada are placed into these programs.

SENATOR STONE:
Nationally, about 70 percent of residents who move to a particular area usually end up staying there. I appreciate the fact that Nevada has an infectious disease residency program and a pain medication program on the way.

When the program is formed, will specialties be given a priority that we do not have in Nevada? We do not need to duplicate residencies for specialties that we do have, like pediatrics and oncology.

SENATOR PAZINA:
The reason we emphasized four years rather than the biennium funding is to prioritize specialty physician fellowships. When we spoke to the deans of UNR, UNLV, Roseman University and Touro University Nevada, we discovered the importance of having them on the Advisory Council. The deans, along with doctors working at hospitals, can share some of the State's needs. We are also working with rural communities in an attempt to engage specialties in those areas as well.

CONNOR CAIN (Touro University, Nevada):
We support S.B. 350. Touro University Nevada is a private nonprofit medical school that graduates 180 future doctors every year. Investing in GME is essential to keep medical school graduates in Nevada where they are desperately needed. All of Nevada's medical schools are graduating excellent physicians and we urge your support of S.B. 350 to help keep them in Nevada.

TREVOR PARRISH (Vegas Chamber):
We support S.B. 350 because it places importance on GME. Las Vegas currently ranks at the bottom of the list of physicians per capita and healthcare delivery systems. It is important to increase the State's focus and investment in GME. We support these efforts and the creation of the Graduate Medical Education Grant Program. This Program will award grants to Nevada's institutions of higher education that are expanding or creating residency programs.

Having additional medical residencies in Nevada will motivate more doctors to stay here to practice medicine. The Advisory Council on GME will help improve Nevada's efforts to increase physician capacity. Their expertise and knowledge will be essential to our success in these endeavors. It is important to leverage State funds and efforts to expand our capacity for medical students at the private and public medical schools. Our goal is to have a stronger healthcare system for our employers, employees and families. Thank you for consideration and support of S.B. 350.

KATIE RYAN (Dignity Health-St. Rose Dominican):
We support S.B. 350. We thank the bill sponsor for this great piece of legislation and for working with Senator Titus to combine the bills. We have two GME programs, one is in internal medicine and the other is family medicine. We are looking to grow it into fellowships, and we are excited this legislation is going to create the infrastructure.

SHEILA BRAY (University of Nevada, Reno):
We urge your support for S.B. 350. We want to thank the bill sponsor for including us as well as other institutions into this discussion. This bill will go far in terms of the expansive efforts to increase our healthcare workforce.

SUSAN MARTINEZ (Nevada State AFL-CIO):
On behalf of over 150,000 members and 120 unions, we are in full support of S.B. 350.

KATE MARTIN, M.D. (Associate Dean, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas):
I am a lifelong Nevadan, a graduate of the UNR School of Medicine and a primary care physician. I am here today to support S.B. 350. Nevada remains at or near the bottom of national rankings for active physicians per capita, whether specialists or primary care doctors. We have made progress by starting new programs and GME and expanding existing residency programs, which will address the physician shortage issue. Funding new programs and expansion efforts have largely come from grants awarded by OSIT. This bill would provide the Statewide infrastructure and sustained financial support to meet the healthcare needs of our growing communities. Half of our residents are leaving the State when they graduate to pursue advanced training or fellowship programs not offered in Nevada. Senate Bill 350 can help solve this problem.

SARAH WATKINS (Nevada State Medical Association):
We are in full support of S.B. 350. I have submitted my written comments (Exhibit E) to this Committee.

CHRIS BOSSE (Renown Health):
As the academic affiliate partner with UNR School of Medicine, we are here today in support of S.B. 350. This bill will create opportunities to grow our GME programs. Therefore, we are in support of this bill.

ELYSE MONROY-MARSALA (Nevada Public Health Association; Nevada Primary Care Association):
We support any initiatives to support the healthcare workforce. Earlier this Session, we were proud to support Senator Titus's bill, S.B. 369. These two bills together will grow the workforce for physicians in Nevada.

DAN MUSGROVE (Valley Health System of Hospitals):
Our organization is Statewide, and we have an incredible relationship with Touro University. We have approximately 160 residents and hope to grow another 80 more. We do residencies in internal medicine, family practice, general surgery, psychiatry, pulmonary, neurology and emergency medicine. We hope to go into obstetrics in the future. We support S.B. 350.

KENT ERVIN (Nevada Faculty Alliance):
We are an independent Statewide association of professional employees at Nevada's public colleges and universities. We work to empower our members to be fully engaged in our mission to help students succeed. Senate Bill 350 will provide more opportunities for our medical graduates. It will reduce the provider shortage in Nevada and make it easier for our members to get health care.

CONSTANCE BROOKS (University of Nevada, Las Vegas):
I want to echo the sentiments of Dr. Martin and applaud the efforts of Senator Pazina. Not only did you listen to your constituents, but you were inclusive on the development of this bill. We support S.B. 350.

BLAYNE OSBORN (Nevada Rural Hospital Partners):
We are here to support S.B. 350, particularly for the only rural residency program scheduled to be at Humboldt General Hospital in Winnemucca.

SAMANTHA SATO (Roseman University of Health Sciences):
We appreciate the bill sponsor for bringing this legislation forward and are in full support of S.B. 350.

MARC ELLIS (Communications Workers of America):
We support S.B. 350.

ALEJANDRO RODRIQUEZ (Nevada System of Higher Education):
We support S.B. 350.

PATRICK KELLY (Nevada Hospital Association):
I support S.B. 350.

BARRY COLE, M.D.:
I support S.B. 350.

CHAIR DOÑATE:
We will close the hearing on S.B. 350.

SENATOR NGUYEN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 350.

SENATOR TITUS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
I will present S.B. 348 and will pass the gavel to Senator Lange.

VICE CHAIR LANGE:
We will open the hearing on S.B. 348.

SENATE BILL 348: Revises provisions relating to health facilities. (BDR 40-51)

SENATOR FABIAN DOÑATE (Senatorial District No. 10):
I come before you to speak on S.B. 348. I have submitted my written comments (Exhibit F) to this Committee. Having grown up in east Las Vegas, I have been frustrated with the delivery of care for this area. We need to do a better job with support services. As a healthcare administrator, I have been in conversations with other facilities and colleagues. We always end up with east Las Vegas deserving a healthcare system like every other part of the city. It is not fair to those of us who live on the east side to travel across town to see our specialists. It is also not fair that our hospitals are farther away.

This bill addresses when a hospital closes, the public deserves to know what happened. We had a hospital close on the east side of Las Vegas. We now have limited resources to another hospital, which is unfortunate. We have spent time

in this Committee discussing the strain on resources and how it relates to the delivery of care. When a hospital closes, it is an institutional change that can dramatically reduce healthcare services for the community.

Nevadans deserve to know when their hospital is closing. They should know where to receive the services once the hospital closes. As policymakers, we need to ensure our residents and clinicians are informed of major healthcare decisions that may negatively impact or reduce the institutional quality of care.

I have submitted a proposed amendment (Exhibit G) and would like to walk you through the changes. Section 2, subsection 1 is divided into two paragraphs. If a hospital is closing, it would require a notification be sent to the Division of Public and Behavioral Health (DPBH), Nevada Department of Health and Human Services (DHHS). It does not have set time requirements only an intent to close.

If the facility is transitioning to a freestanding emergency room (ER) or other type of facility, then they would have to go through an application process within a 30-day time period. The bill currently has in section 2 certain requirements the hospital will need to submit. The application will include the following information on the hospital: location, ownership structure, the reason for the conversion, impact to local institutions and an explanation for the closure. It will also require data on how the population will be impacted within the 24-month window.

This bill is not intended to have the government tell a facility whether they can close. However, if a hospital closes, like the one on the east side of Las Vegas, then three major groups should be made aware of the closure. Those groups are DHHS, the patient population relying on that hospital system and other providers who will have to pick up services no longer covered.

The proposed amendment also removes section 3, which addressed independent centers for emergency medical care.

SENATOR NGUYEN:
I have some concerns about a freestanding ER. A lot of people think it is a true emergency room. If someone is at one of these facilities and it is determined they cannot treat the emergency, is the patient transported by an ambulance to another facility? If they are transported by an ambulance, is it to a hospital associated with the freestanding ER? If it is not the closest facility for the

emergency, how does it work when time is of the utmost concern? What do you do when you have someone presenting an emergency that cannot be handled by a freestanding ER? The patient would have to be transported to another facility that is farther away. How does it work in practice?

SENATOR DOÑATE:
We are seeing freestanding ERs all over town. We need to educate the consumer or the patient. If you do not know how the healthcare system operates, then you could assume a facility with the ER sign has a full range of services attached to a hospital. This is a common reality for those who do not interact the same way that we do with the healthcare system.

There are structures in place like urgent cares. Now we have freestanding ERs and ERs attached to acute hospital systems. A patient could go to a freestanding ER and the medical issue is more catastrophic than the facility can handle. It would require a delay of care and a transfer to an acute facility. There are some levels of services the freestanding ER may not be able to take care of. It is important for the consumer to understand this.

MAYA HOLMES (Culinary Health Fund):
One issue is the lack of transparency because freestanding ERs often are not licensed separately. We cannot always track utilization and the spending is separate. We have worked it through with the Health Services Coalition in our contracts, so our patients will not get double billed. It will happen occasionally, but it is an issue we have worked on. I cannot speak for the uninsured or other health plans, but it is a concern we have.

I believe there is a misconception on freestanding ERs. People do not always understand when they are going into these facilities that it is not an urgent care. It is an emergency room with emergency room rates.

SENATOR NGUYEN:
Do you know what percentage of patients who start at a freestanding ER are later transported to a different facility? If someone has an emergency and enters a freestanding ER, then is taken to the closest hospital, would this be considered two emergency room visits because it would be at two different hospitals?

STACIE SASSO (Health Services Coalition):
The Health Services Coalition represents 25 union and employer-sponsored health plans in southern Nevada with an estimated 280,000 employees. It is our understanding that if the patient is stable but requires a transfer to a higher level of care, often those freestanding ERs will transfer them within their system. It is possible the patient could be transferred to a location farther away from his or her home. I can only speak for the groups we represent or negotiate contracts for. If the patient is transferred within the system, he or she usually will not be charged a second time. However, if a patient is experiencing an emergency and needs the closest facility that is not within the freestanding ER system, then he or she could have a second ER charge.

The percent of transfers is not tracked, because we do not have any way to track it. Everything rolls up to the mother hospital of the freestanding ER.

SENATOR NGUYEN:
Based on discussions with first responders, it is my understanding they will not transport people to freestanding ERs when they need certain qualities of care. Are first responders trained on who to bring to freestanding ERs?

TODD INGALSBEE (Professional Firefighters of Nevada):
I have spent the last 18 years as a firefighter, paramedic and a captain in downtown Las Vegas. We do have destination protocols through the Southern Nevada Health District. The protocols dictate criteria on where we can go, whether it be stroke hospitals, burn centers, a university medical center, etc.

There is a protocol to educate our members within the emergency management system (EMS) on when we can transport to a freestanding ER. What it boils down to is anybody without a normal range of vital signs should not be taken to a freestanding ER because the facility cannot provide the care needed.

SENATOR NGUYEN:
Can you provide an example of someone who would be transported to a freestanding ER as opposed to a hospital ER?

MR. INGALSBEE:
Anyone who meets trauma criteria would not go to the freestanding ER.

SENATOR NGUYEN:
Who would go there?

MR. INGALSBEE:
From my experience, I have never transported anyone to a freestanding ER. I have picked up plenty of patients from there and transported them. I classify it as similar to an urgent care. We have been educated in our protocols within the EMS. I do not know if the public has that same education regarding services provided at freestanding ERs.

SENATOR STONE:
The emergency rooms not affiliated with a major hospital in Nevada can cherry pick the patient populations they will accept. Running a hospital today is not an inexpensive endeavor. The hospital depends on the emergency room, which is probably a major profit center, and housing patients in its facility.

I am looking at section 6 of the bill and it requires that an independent center for emergency medical care be licensed separately from any other licensed facility. We have a number of independent ERs that are part of a larger hospital system. These ERs can get technical medical advice for more serious cases in their facilities. If the patient is at an ER and needs to be transferred to an affiliated hospital, then I would agree they probably would not be charged. However, if the patient needs to be transferred to the nearest hospital and it is not affiliated, then I understand it could be a separate charge.

It seems to me we are charging an existing medical provider for two licenses when they really have an extension within the community. I wanted to hear your rationale for those emergency centers that are a part of a major hospital.

SENATOR DOÑATE:
During development of the bill, I questioned the difference between an urgent care, an independent emergency medical care facility and an ER in an acute hospital. We should be treating it separately. There are likely services a freestanding ER can provide that an urgent care cannot. There is a level of difference of care in an acute facility.

Institutions in this State have multiple facilities under different types of licenses. That is the norm if you have different types of facilities under your jurisdiction.

This bill is attempting to repair that issue. I am willing to work with stakeholders to see how it plays out.

MS. HOLMES:
For Nevada, a freestanding ER is a newer medical model. By next year it is projected that Las Vegas will have 15, including micro-hospitals. To Senator Doñate's point, the health system world has various types of facilities that are licensed differently. This is a new model that needs to be addressed within the licensing and regulatory structure. It is also a transparency issue. The State is doing more with all-payer claims databases and other things to understand healthcare spending and growth. When you consider utilization, cost and quality, it is helpful to have these facilities separated.

SENATOR STONE:
We would love to have more hospitals in place of these independent ERs in urban and rural areas. However, financing for opening a hospital is a challenging endeavor. I am trying to compare an independent ER to an ER satellite facility. The independent ER has a finite number of staff and multidisciplinary help in an acute emergency. They should be treated differently than an ER satellite facility, which is part of a larger system.

We have to make sure our hospitals remain profitable. Uncompensated care from the ER is a big issue for traditional hospitals. Closure would be alarming, and I understand your concerns.

SENATOR TITUS:
This is a misguided bill and could have unintended consequences. We already have different levels of hospitals. I see this bill doing the opposite of its intention. In your opening statement, you stated you did not want hospitals to close and leave a community empty. However, establishing a satellite system is less expensive than establishing a full facility.

I am a provider in rural Nevada at a hospital with a level 1 ER. We frequently stabilize a patient in the ER and then transfer him or her to the nearest facility. With some exceptions, if it is a life-threatening situation, you take the patient to a rural hospital. Once they are stabilized, then you transfer the patient to the receiving facility. We cannot afford to have a tertiary hospital everywhere in our State. Now you are asking the facilities not to have satellite systems and you object because it is too far to the next facility.

SENATOR DOÑATE:
I think you may have misunderstood the intention of this bill. As you can see, all of the Legislators from east Las Vegas have signed on to this bill. Many of us share the frustration with the level of care delivered in this part of the city.

When a facility closes, a patient is impacted. A healthcare executive who works in a nearby facility will have to manage the increased patient load and deserves some level of coordination. Imagine a situation where your hospital suddenly closes. As a patient, you do not know what happened to your records. You also do not have any information on where to go for healthcare services. This is an important conversation.

I do not have any argument with freestanding ERs. They have a place in a community and can provide a level of service. Other states have incorporated the rationale for licensure differentiation. We need to start looking at the levels of tertiary care and how the services are different from one another. It will help to coordinate and plan. It can avoid the consequences of reimbursements for the receiving facility for a first responder.

We have seen gaps; these facilities have served to address those gaps. We have acknowledged the service they have filled. However, it is important for the consumer to understand the different levels of care and how it relates to his or her needs.

SENATOR TITUS:
Rural hospitals have closed by the thousands throughout our Nation because of the cost to stay open. Freestanding ERs are an option to replace these closures. In rural Nevada, we have a satellite clinic away from the hospital. I am the only healthcare provider for 30 miles in any direction.

The average consumer does not understand that my office is not an ER. I have had people bring a patient with an emergency medical need into my office. I have a satellite helicopter pad behind my office and would stabilize the patient prior to transferring them to the nearest center. The reality is a patient will go to the nearest facility for care. I do not expect patients to have a level of knowledge on services.

Truth in advertising is important and I share your concern. If a facility is advertising as an ER, then how are they different than an urgent care? I do hear your concerns on the component of truth in advertising.

Freestanding ERs, associated with a larger facility, will typically not charge for transporting the patient to their main hub. If the main hub cannot care for the patient, then he or she may be transferred to a different hospital. This is not the fault of the hospital associated with the freestanding ER. The hospital has the right to survive. If they do not get reimbursed, the facility cannot stay open.

This bill is well intended, but it appears to have unintended consequences to those of us in the healthcare world.

SENATOR DOÑATE:
There are certain aspects of this bill that could provide stabilization of services. One example is the coordination of care. This bill would have been helpful when the hospital closed in east Las Vegas.

It is not a criticism of freestanding ERs in east Las Vegas. These facilities have a place in the community, especially if they provide access to additional care. In the long term, we need to solve the underserved areas that have a higher share of Medicaid patients. As part of the patient population, how do we support them for the long term? We need to have a serious conversation about the types of facilities and the different levels of service.

SENATOR LANGE:
The hospital that closed is in my district and our community was devastated. It served the community's needs for many years. It is now a freestanding ER. Is there different licensing for a freestanding ER as compared to a hospital?

MS. HOLMES:
There is a gap in the licensing, and nothing can prevent a freestanding ER from existing. It is recognized as a new type of medical facility and there is no specific licensing for it.

SENATOR LANGE:
If you are trying to decide where an ambulance is transporting a patient, then the first responder would need to know the services a facility has available. Under current laws, does it limit the services a freestanding ER can perform?

MR. ROBBINS:
I am uncertain how to answer your question. The level of service is often up to the regulations the State Board of Health adopts and the way DPBH interprets those regulations.

MS. SASSO:
There are services that can be performed at a freestanding ER as well as a large acute care hospital. I am unaware of any service performed at a freestanding ER that cannot be performed at the main hospital.

SATORIA PARTRIDGE:
I am here today in support of S.B. 348. I have submitted my written comments (Exhibit H) to this Committee.

In 2017, I lived in Henderson, and my child was a victim of a hit-and-run. We had to drive over 15 minutes to University Medical Center because the hospitals in our area did not have trauma care.

Nevada needs to treat freestanding ERs differently and license them separately from hospitals.

PAUL CATHA (Culinary Workers Union Local 226):
The Culinary Health Fund (CHF) is one of the largest healthcare consumers in the State. It is sponsored by the Culinary Union and provides health insurance coverage for over 130,000 Culinary Union members and their dependents. As a leader in Nevada healthcare policy, we continue to advocate for patient protections, lowering healthcare costs and increasing transparency.

The majority of Culinary Union membership lives on the east side of the Las Vegas Valley and in North Las Vegas, which are healthcare deserts. The CHF intentionally located the first health center within a 5-mile radius of approximately 40,000 culinary member homes. Culinary union members have noticed a disturbing pattern in the proliferation of freestanding ERs in their neighborhoods. In addition, their neighborhood hospitals, like Desert Springs Hospital, have been converted into emergency-only facilities.

Some Culinary Union members believe they are going to an urgent care, but end up paying emergency room rates. Nevada needs to step in and create a separate licensing process for freestanding ERs. The State needs to require notification

when hospitals are going to be removed from working-class communities and replaced with these sorts of facilities. Passing this bill will benefit all Nevadans. We support S.B. 348 and encourage the Nevada Legislature to support and pass this bill.

MS. MARTINEZ:
The Nevada State AFL-CIO is in full support of S.B. 348. I live on the east side of Las Vegas and understand the struggles patients experience. I have an elderly mother and want nothing but the best for her and our community.

MR. ELLIS:
The Communications Workers of America support S.B. 348.

JOHN ABEL (Las Vegas Police Protective Association):
We support S.B. 348. On a personal note, I had appendicitis and live two minutes from a freestanding ER. I knew better and went to an actual hospital for surgery. I worry our members do not know this information and may go to a freestanding ER. An appendix could burst, and the member could possibly die. This could be because they did not realize they should have gone to a hospital for care.

MR. INGALSBEE:
The Professional Firefighters of Nevada support S.B. 348. I am not sure how it works in rural Nevada, but Las Vegas has protocols with criteria dictating which hospital we can take a patient to. I have never taken a patient to a freestanding ER, because I try not to transport patients who do not need to be transported. If the patient falls within normal vital signs, we do not transport because it is a huge cost to the patient.

MS. JACOB:
Clark County is in support of S.B. 348.

TROYCE KRUMME (Las Vegas Police Managers & Supervisors Association):
We support S.B. 348.

CONNOR CAIN (HCA Healthcare):
We are in opposition to S.B. 348. I want to acknowledge the sponsor for his open-door policy and willingness to work with us on this bill. We take immense pride in caring for patients on the east side of Las Vegas. We know the sponsor

shares our desire to ensure this population has access to and receives the best possible health care.

Due to our concerns with section 6, subsection 2, we are here in opposition to S.B. 348. Freestanding ERs improve access to care by creating additional places for patients with emergent needs. These facilities provide emergency department level care for these patients at a reduced wait time. Our freestanding ERs are an extension of our emergency departments with the same staff and capabilities to treat emergencies such as heart attacks.

There are many reasons why a patient may transfer to a different department when they are already in the emergency room of a hospital. For example, a patient might need to get a magnetic resonance imaging commonly called an MRI. If a patient was in a freestanding ER, instead of taking an elevator, he or she would take an emergency transport. The patient would not pay for the transfer nor incur a co-pay for insurance. The visit is treated as the same event.

If the patient meets trauma criteria, then the patient would be transferred to a trauma center. If a private ambulance drops a patient off at a freestanding ER, we can accept the patient. Freestanding ERs have the same capabilities as a hospital ER with physicians and the call panels.

The facility has clinical capabilities, like equipment, staff and services, that an urgent care does not have. Freestanding ERs offer services like an imaging lab, pharmacy and respiratory care. They operate 24 hours a day, 7 days a week, but an urgent care does not. When you think of an urgent care, it is typically a place to get a vaccine or seek medical care for a cold or stitches.

When you think of a freestanding ER, you should think chest pain, difficulty breathing or head trauma. If it was one of my loved ones having a heart attack, I would want them to get emergency care as quickly as possible. They could receive that care at a freestanding ER.

Less than 1 percent of the patients who visit our freestanding ER went there erroneously. We appreciate the sponsor for working with us and look forward to continuing discussions.

MR. KELLY:
The Nevada Hospital Association opposes S.B. 348, primarily due to section 6. We are going to work with the sponsor of the bill to address our concerns, like a freestanding ER's affiliation with a hospital. Several years ago, the Legislature passed a law requiring all freestanding ERs to have an affiliation agreement with a hospital. Currently, they all have an agreement and we do not have any independent ERs.

Freestanding ERs are recognized by CMS and The Joint Commission. They are treated as a department of the hospital. It is an important distinction between this level of care and an urgent care.

Prior testimony stated separate licensing for freestanding ERs will make it different. Consumers will never know whether the facility has a separate license, because both facility types will still have an applicable sign that states either emergency department or urgent care. The licensing is not going to inform the consumer. We need to study the policy reason for having different licensing.

MR. MUSGROVE:
Valley Health System of Hospitals (VHSH) opposes this bill. Tragically, the likely genesis of this bill was our facility, Desert Springs Hospital. It was a great facility, and it was a tragic circumstance for VHSH to contemplate closing it. It was an important part of our health system.

It continues today as an ER and, in the future, we will build a freestanding ER next to it. There has been a lot of discussion today about the differences between a freestanding ER, an urgent care and a hospital. We all have a responsibility to make sure patients know the difference. We do not want anyone to pay for unnecessary costs. I applaud Mr. Ingalsbee, in his role as a first responder, who makes sure it is a last resort to transport anybody. We all ought to try to emulate him in accessing primary care. Telehealth is an option to avoid going into a facility and is a cost-saving measure for the patient.

I want to thank Senator Doñate for his willingness to work with us. We want to continue discussions on section 6 of the bill. We only transfer 8 percent to 10 percent from our freestanding ER to our acute care facility. This is a very small percentage, and we try to incorporate a front door that allows people access to services needed. Desert Springs ER will continue and will provide a

front door for the community. Hopefully, our small percentage of transfers will continue.

We have a facility close to Desert Springs. I checked the mileage between Las Vegas High School and Desert Springs and agree with Senator Doñate that it is 7.2 miles apart. I also checked the mileage from Las Vegas High School to the Henderson Hospital and it is 7.3 miles apart. Although Senator Doñate used the school distance as an example, this bill is meant to increase healthcare access for all areas of the community. We do support that intent.

The previous bill was an attempt to bring providers into the State. As Senator Titus discussed, we need to make sure our healthcare providers can survive in Nevada. That means reimbursement rates, whether private insurance or government-run healthcare programs.

MS. RYAN:
Dignity Health-St. Rose Dominican is neutral on S.B. 348. I do want to clarify a miscommunication about our neighborhood hospital model. We are just a smaller version of a hospital with a full ER. It has ten beds and a number of ancillary services. It is similar to a rural hospital.

We have a level 3 trauma center in Henderson, the Sienna Campus. This facility has been in the community for over a decade. We have built these neighborhood hospitals specifically in places of need.

VICE CHAIR LANGE:
We will close the hearing on S.B. 348.

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CHAIR DOÑATE:
Hearing no public comment, we are adjourned at 2:35 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. 380	C	7	Senator Rochelle Nguyen	Clark County Proposed Amendment
S.B. 350	D	12	Senator Julie Pazina	Proposed Amendment
S.B. 350	E	17	Sarah Watkins/ Nevada State Medical Association	Written Comments
S.B. 348	F	19	Senator Fabian Doñate	Written Comments
S.B. 348	G	20	Senator Fabian Doñate	Proposed Amendment
S.B. 348	H	27	Satoria Partridge	Written Comments