MINUTES OF THE
SENATE COMMITTEE ON REVENUE AND ECONOMIC DEVELOPMENT

Eighty-second Session
March 28, 2023

The Senate Committee on Revenue and Economic Development was called to order by Chair Dina Neal at 1:05 p.m. on Tuesday, March 28, 2023, in Room 2149 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 Dina Neal, Chair
Senator Fabian Doñate, Vice Chair
Senator Heidi Seevers Gansert
Senator Carrie A. Buck

COMMITTEE MEMBERS ABSENT:

Senator Pat Spearman (Excused)

GUEST LEGISLATORS PRESENT:

Senator Robin Titus, Senatorial District No. 17

STAFF MEMBERS PRESENT:

Michael Nakamoto, Chief Principal Deputy Fiscal Analyst
Christian Thauer, Deputy Fiscal Analyst
Connie Summers, Committee Secretary

OTHERS PRESENT:

Stephen Lencioni
Daniel Spogen, M.D., Site Director, Elko Family Medicine Residency Program; Professor and Faculty, University of Nevada, Reno, School of Medicine
Joan Hall, Nevada Rural Hospital Partners
Sarah Watkins, Nevada State Medical Association

Aamira Aziz
Elyse Monroy-Marsala, Nevada Public Health Association; Nevada Primary Care Association
Katie Ryan, Dignity Health-St. Rose Dominican

CHAIR NEAL:
We will open the hearing for Senate Bill (S.B.) 369.

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

SENATOR ROBIN TITUS (Senatorial District No. 17):
Senate Bill 369 is an act relating to taxation and establishing a credit against the Modified Business Tax (MBT) for taxpayers who donate money to an organization providing grants to public or private institutions for the establishment of certain programs of residency training and postdoctoral fellowships for physicians. It sets forth certain requirements for an organization providing such grants and for an institution that is a recipient of such grants.

We do not have enough providers in this State for the population growth. Even though we have expanded the medical school in Reno, have started a medical school in Las Vegas and have two private medical schools in the State, the students we graduate will frequently go out of State for their graduate medical education (GME). Statistically, where students complete their final education is where they will stay. We do not want to continue educating our finest students only to have them move to other states.

There are many suggestions for funding GME in association with our hospitals. Most require budget allocations dependent on each administration. Senate Bill 369 presents a unique approach for sustainable funding. The bill offers the option of expanding programs beyond primary care so Nevada may someday become a mecca for advanced care and recognized as serving our population's needs. The program offers an opportunity for private medical groups to apply for these funds if they want to start a residency or fellowship.

The idea for S.B. 369 was brought to me in 2022 by Stephen Lencioni, a second-year medical student at the University of Nevada, Reno, School of Medicine. The original suggestion had several components, but after many meetings with our fiscal staff and others, it was decided we would take small steps to begin the process.

I want to clarify that discussions have been held as to who will monitor and control the funds. It was suggested that either the Nevada Health Service Corps or the Nevada State Office of Rural Health would take on this role. However, these two agencies may want to apply for grants. Therefore, we are considering amending the bill to have the Office of Science, Innovation and Technology monitor the funds.

This bill would complement S.B. 350 which establishes an advisory council on graduate medical education. I have discussed this proposal with the sponsor of that bill, Senator Julie Panzina.

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

STEPHEN LENCIONI:
I am a second-year medical student at the University of Nevada, Reno, Medical School. A synopsis of my testimony (Exhibit C) supports S.B. 369 which would provide grant funding to public or private institutions to accelerate the process of establishing new graduate medical education programs in Nevada.

The expansion of the physician workforce is an urgent need in Nevada. This bill will accelerate the building of Nevada's GME pipeline to serve the needs of our diverse and growing State.

As background, upon completion of four years of undergraduate medical education, new physicians are required to complete mandatory residency known as graduate medical education which lasts three to seven years before they can enter independent practice. This is followed by an optional one to three years of subspecialty fellowship training. The Centers for Medicare and Medicaid Services (CMS) typically provides most GME funding through direct payments to hospitals as well as indirect medical payments that cover the additional cost of having a teaching environment. The scale of government support for this phase is unlike that of any other profession in the Nation.

In fiscal year 2017-2018, the Congressional Budget Office estimated federal GME spending exceeded $15 billion; however, federal financing for hospital-based GME does not evenly address the needs of all Americans and leaves rural areas in persistent shortage. Moreover, undergraduate medical education training programs are outpacing residency training positions. This is

primarily due to the Balanced Budget Act of 1997 which limited the number and locations of training programs. As a result, states must create GME initiatives to address the health and physician workforce needs of their constituents.

Other states have engineered and introduced successful methods of increasing their physician workforce through grant programs. In 2012, Georgia prioritized the expansion of GME, expecting to spend $22 million with the goal of adding 400 new positions. When the startup program ended in 2018, nearly $19 million had been awarded toward generating an expected 613 new residency positions when programs reach full capacity in 2025. Georgia Department of Audits and Accounts reported 75 percent of the new residencies were in primary care. In 2013, Texas created the Planning and Partnership Grants Program to increase the number of GME positions. As a result, 19 new residency programs received national accreditation and enrolled their first residents, creating 154 new first-year positions.

The Consolidated Appropriations Act, 2021, included 1,000 new Medicare-funded GME positions with 10 percent designated to rural hospitals, teaching hospitals, hospitals that serve areas designated as health professional shortage areas and hospitals in states with new medical schools. This was followed by the Consolidated Appropriations Act, 2023, which included an additional 200 slots with respect to Nevada.

Although we have been adding undergraduate and graduate medical education positions, we have not kept pace with the needs of our growing State. Workforce studies suggest Nevada needs an additional 2,450 physicians to meet national per capita rates per 100,000 population. Moreover, 67.3 percent of the State's population resides in a federally designated primary care shortage area; 94.5 percent, in a federally designated mental health shortage area. In 2008, Nevada ranked forty-fifth for active physicians and forty-sixth for primary care physicians. Fifteen years later, we still rank forty-fifth for active physicians and are now ranked forty-eighth for primary care, forty-ninth for general surgeons. In 2008, we ranked forty-sixth for the number of residents and fellows per 100,000 population. Fifteen years later, we ranked forty-first. Approximately one in four physicians completing graduate medical education are leaving Nevada for additional subspecialty training that does not exist or is in short supply in the State. Although we have been steadily adding medical school positions and GME, Nevada has not kept pace with its growing needs and does not adequately support subspecialty training here.

Despite the physician shortage, we have a unique opportunity in GME with a strong record of physician retention following medical education. Nevada retained 39.8 percent of physicians who completed their undergraduate medical education (UME) in Nevada; 55.2 percent GME, which is sixth in the Nation; and 76.9 percent which is eighth in the Nation of physicians who completed both UME and GME in Nevada. With a strong track record of physician retention, innovative Legislators supporting GME growth is an upstream evidence-based mechanism to have a meaningful impact on the physician shortage.

An investment into GME is not a zero-sum game. If we actively invest, Nevadans can benefit from improved access to care, a dynamic physician workforce pipeline and economic stimulus. Data demonstrates GME increases access to care and reduces cost of care for both patients and health systems. Moreover, GME elevates the profile of the system through research, innovation and quality improvement activities. Additionally, physicians have greater training, and teaching physicians have greater overall job satisfaction and lower rates of burnout as compared to their nonteaching physician counterparts. Economically, physicians are meaningful direct and indirect contributors to job creation and economic stimulus. In Nevada, on average, physicians support 12.08 jobs, over $1 million in total wages and benefits, and over $75,000 in local and State tax revenues annually.

High start-up costs are one of the major hurdles with GME expansion. These costs vary significantly among hospitals, and the variance can be attributed to factors such as the number of new residency programs, program types and existing physical infrastructure of the facility. Other costs include recruiting and preparing faculty, obtaining accreditations, developing curriculum and establishing policies and procedures. In Nevada, the estimated start-up costs for a new program range from $1 million to $2 million with a typical lead time of 2 to 3 years.

This bill seeks to provide grant funding to financially support the efforts to develop a residency or fellowship program after a program director has been hired and before the first resident or fellow begins, since hospitals are not eligible for federal GME reimbursement until the first resident or fellow begins training.

This grant program would make a meaningful impact, increasing the number of GME positions in this State by 30 percent by 2030, 50 percent by 2034 and 83 percent by 2040. The expansion of the physician workforce is an urgent need in Nevada. We do not want to be a net exporter of physicians. We want to grow our own Battle Born physician workforce to serve the needs of our diverse and growing State. This will move the needle in accelerating funding for GME expansion, increasing access to care for Nevadans, creating a sustainable funding mechanism, providing tax credits to encourage investment into the physician workforce and stimulating future physician leaders who will contribute to the State.

DANIEL SPOGEN, M.D. (Site Director, Elko Family Medicine Residency Program; Professor and Faculty, University of Nevada, Reno, School of Medicine):
As site director, I have been in charge of developing and maintaining a residency program in Elko, a rural medically underserved community of Nevada. We are closing our program due to inadequate funding. Most resident physician salaries come from GME support through local hospitals. Northeastern Nevada Regional Hospital is withdrawing that support at the end of June. Northeastern is managed by a hospital corporation out of Tennessee. Faculty support primarily comes from clinical revenue. Even though the family medicine program has been successful as an educational entity and provider of primary care, there has been an inadequate transfer of funds to support faculty salaries. Neither the hospital nor the clinic are locally managed.

In Elko, S.B. 369 allows for local community support to augment those start-up funds. The cost of educating one resident physician per year is approximately $180,000. In addition, normal start-up costs for a residency Mr. Lencioni just mentioned are approximately $2 million—exactly our start-up costs for Elko. It is my hope this bill will allow community support for the development of new programs. With a community supporting the start-up of new training programs, it will be tougher for other entities to withdraw their financial support in the future. In addition, this would allow a more sustainable program than we experienced in Elko. Our State and local communities should be responsible for rectifying the physician workforce shortages, not outside entities. Closing the residency program in Elko hurts the community and hurts patient care. Local businesses could help us in avoiding that problem. Please support S.B. 369.

SENATOR TITUS:
I would be happy to walk the Committee through the bill as presented with the caveat that there will be changes.

CHAIR NEAL:
How many sections will have changes?

SENATOR TITUS:
It is section 8 on who will manage the funds. Under statute, financial institutions, mining businesses and other employers are already required to pay an excise tax, the Modified Business Tax on wages they pay. Sections 1 through 4 establish a credit against the MBT. While these businesses are still paying taxes, they will be able to direct where they want payments to go in this fund. The cap on what can be donated to the fund is $4 million. The fund must be approved by the Nevada Department of Taxation (DOT). This must be monitored to ensure taxes are paid and monies are in the fund. The Department would recognize where the funds are and the potential impacts. A requirement in section 7 requires DOT to do this for 36 months. Section 8 is where the changes would be on who would monitor the organizations, and the tax credit would be through a cooperative agreement with the Office of Science, Innovation and Technology.

SENATOR SEEVERS GANSERT:
Some bills coming out not only have an MBT but also an Insurance Premium Tax. Did you consider both taxes for credit purposes?

SENATOR TITUS:
As we were putting this bill forward, we looked at the MBT as the option most businesses would be willing to undertake. We are not closed to other suggestions. We are still looking at a $4 million maximum cap.

CHAIR NEAL:
It was stated it takes one to three years to prepare for a residency. My question pertains to section 7, subsection 4, where you have language stipulating if a new residency program is not established within 36 months, the grant must be repaid. My concern is that 36 months is not enough time given an individual or entity may still be working on financing for the program.

DR. SPOGEN:
That is a wonderful thought because it does take time to develop a program. It took us three years to develop our program in Elko. There are a number of things to do to get GME approval for a program, including a site visit—if it is an independent program—which often extends the program approval process from three to five years. Provisional approval may be all that is needed to justify using the funds because it indicates the program is moving forward.

CHAIR NEAL:
Once the program is established, does student recruitment begin in Year Three?

DR. SPOGEN:
We formed our residency in Elko as an additional site that was part of the Reno program, so we did invest time to get the program established as is the case with independent programs. At the end of the second year, we were able to start recruiting for residents.

Most rural programs are 1 + 2 models where the first year of training is completed in a big city so the students can experience big hospital medicine. The student's second and third years of postgraduate training would be at the rural site. Even though we were recruiting at the end of the second year and got residents at the third year, it was the fourth year when those residents were able to come to Elko.

CHAIR NEAL:
My next question pertains to section 3, subsection 6, which states the balance of the credit cannot be carried forward for more than five years. It is likely the program will run longer than five years. How long is a residency?

DR. SPOGEN:
It depends on the residency. It is a three-year program for family medicine.

CHAIR NEAL:
What about residency for a specialties program, which is noted in the bill?

SENATOR TITUS:
The bill offers flexibility, allowing funds to potentially be used for a one- to three-year fellowship. If the program offers a cardiology residency, for example, a cardiologist will do an internal medicine residency rotation for three years and

then a cardiac fellowship with postgraduate training afterward. We want to avoid putting taxpayer money into programs that will not succeed, and we want to hold the programs accountable. Perhaps, we were naive thinking three to five years would be enough time. We will be taking money out of the General Fund to invest in these programs, so we want to reassure those dedicating the funds that we recognize an obligation to use the money in a certain manner. We are committed to making the program successful. We are open to extending the program to four or six years, recognizing the challenges.

SENATOR NEAL:
If the credit must be used within five years and because a specialized residency takes longer, that might not be enough time to complete the specialized residency training program and require additional funding.

MICHAEL NAKAMOTO (Chief Principal Deputy Fiscal Analyst):
As nonpartisan Legislative Counsel Bureau staff, I do not support or oppose any legislation, but I am asked occasionally to provide clarification. I will do so on how the credit process would work on S.B. 369.

I used as an example the Nevada Educational Choice Scholarship Program approved by the Legislature in A.B. No. 165 of the 78th Session. Senate Bill 369 provides a similar mechanism for funding. A business liable for the MBT may make a donation to an organization for a specific purpose. In this case, it would be for these residency programs.

Before an organization accepts the donation, it would contact DOT to determine the remaining tax credit on the allocation. Senate Bill 369 specifies that in fiscal year 2023-2024, no more than $4 million of credits against the MBT may be allocated with a 3 percent escalator in each fiscal year beyond that.

Once the Department has determined there are credits remaining, it will notify the organization. When DOT receives notification that a donation has been made, it will issue a Certificate of Tax Credits to the business making the donation which the business can then use against its MBT liability for a period not to exceed five years. When a business receives the credit, it has five years to use it. In a way, it is independent of the funding because the funding is realized upfront. It is the amount of time for the taxpayer that makes the donation to receive the benefit from the donation.

SENATOR BUCK:
This bill is an innovative way to reinvest a community. Would the passage of the bill be timely for Elko?

DR. SPOGEN:
It is too late for the Elko program. We went through our residency match to select residents for next year but had to pull out of the match because we did not have the financial support.

CHAIR NEAL:
The bill would allow public and private hospitals and nonprofit organizations to stand up programs. How many for-profit and nonprofit organizations are now participating in residency programs in Nevada?

SENATOR TITUS:
That is what makes this program unique—it will allow for funding and the potential start-up of these programs. Several large, private medical groups, such as radiology, internal medicine or orthopedic groups, would potentially be interested in this program. Getting these community partners interested in the program is a key factor for fellowships.

We are dependent on our Nevada hospital partners to fund these programs, but they are running out of program instructors. This bill would expand our options.

CHAIR NEAL:
How do we ensure the students who come into the program funded by public tax dollars stay in the program? There should be standards on how the program functions, how it treats students, what the student expectations are and what they receive from engaging in a residency or fellowship program. In addition to the data reporting, would you be requiring the Office of Science, Innovation and Technology to standardize the program?

SENATOR TITUS:
When we start up our GME programs in public hospitals, residents have no obligation to stay in Nevada. We know a higher percent of residents stay in Nevada if they do their residencies in the State. This is not like the U.S. Public Health Service Commissioned Corps funding programs that reimburse residents for returning to Nevada.

The established program specifies why these folks are in Nevada for their training. These individuals are already physicians who can see patients and expand the access to health care. The bill would increase the potential for more residency slots with a greater percent of residents who stay in Nevada.

CHAIR NEAL:
When students are trying to get into medical school, shadowing hours are required but not always easy to obtain. Would this program allow students to participate in shadowing programs?

MR. LENCIONI:
Applying to medical school is a singular process. An individual completes medical school in four years and becomes a physician with an M.D. degree. He or she is then required to complete a residency ranging from three to seven years at an accredited institution. Senate Bill 369 would help to establish GME-accredited programs for certification.

CHAIR NEAL:
Would it apply to shadowing hours for premedical students wishing to apply to medical school?

SENATOR TITUS:
As a doctor for more than 40 years, I was one of those preceptors. From the day I opened my practice, I had medical students, including high school and premed students, rotate and shadow with me. I eventually transitioned to resident rural rotations and had residents rotate with me. I never received any reimbursement for shadowing.

To shadow does not require the same accreditation. When someone applies to medical school, the school's admissions committee is looking at whether a student has any healthcare experience to understand the healthcare world he or she would be entering. Shadowing is important for students, but that is usually offered at no expense, and accreditation is not required. This bill would require accreditation, and funding is the key component.

SENATOR SEEVERS GANSERT:
What is unique about this bill and potential programs is they can be in the private sector. Today, many programs are government-based with Centers for Medicare and Medicaid Services reimbursement. Large organizations in northern

Nevada such as the Reno Orthopedic Center or Urology Nevada almost run their own minihospitals for the type of care they provide. The way I am reading the bill, those types of organizations would be open to recipients of grants to establish residency programs outside of what we traditionally see in hospital-based programs. Is that correct?

SENATOR TITUS:
That is one of the unique points in this bill. There is no mandate now for private groups because they are focusing on how to survive financially in the healthcare world. There is no way they could expand their programs to allow for residencies. With this bill, training programs could be expanded so students would be inclined to stay in Nevada with their training groups.

SENATOR SEEVERS GANSERT:
I used the previously mentioned medical groups as examples because I know them. I do not know if they have an interest in training programs, but they do have the scale to potentially grow and train individuals who may likely stay with those types of organizations. If they trained with those organizations, they would potentially be offered a job with them.

JOAN HALL (Nevada Rural Hospital Partners):
Rural residencies are important to rural health care. The closure of the Elko center is sad. The only other center we have is in Winnemucca. Other communities have considered residency programs, but the financial burden is too great, and CMS reimbursement does not cover the expense. We are, therefore, in support of S.B. 369.

SARAH WATKINS (Nevada State Medical Association):
My members fully support S.B. 369 as an avenue to help fund more residency and postdoctoral programs in the State. This will in turn help the physician shortage in Nevada and increase access to care for Nevadans.

AAMIRA AZIZ:
I am a second-year medical student at the University of Nevada, Reno, Medical School. I am speaking on behalf of myself in support of S.B. 369.

I have lived in Reno for the last 23 years where I completed my entire education from kindergarten to medical school. I am passionate about the field of ophthalmology, specifically retinal surgery, where I have worked during the past

six years. Over 500,000 of Nevada's 3 million population are over the age of 65 and plagued with a host of eye diseases that come naturally with age. In Reno specifically, there are only four retinal surgeons capable of providing the care these patients need. They serve patients as far as Truckee, Susanville, Fallon, Gardnerville and Hawthorne.

There is no home program in Reno or even in Nevada for ophthalmology, meaning I will certainly leave the State if I decide to pursue my passion. It is a fact that nearly 60 percent of doctors over the last ten years stay in the state where they complete their residency. This is an obvious indication as to why there is a physician shortage in Nevada because the State offers few residency spots and only four or five for different specialties. Nevada has managed to make do during the last few decades, but the front lines of our health care are overburdened. There are six physicians at our clinic, and the physician for whom I work sees almost 100 patients every day.

I urge the Committee to consider the financial support of measures such as S.B. 369 to mitigate the burden on our citizens, our neighbors and our healthcare providers and support Nevada's health for decades to come.

ELYSE MONROY-MARSALA (Nevada Public Health Association; Nevada Primary Care Association):
Nevada Primary Care Association (NPCA) members, staff, 60 clinics and mobile units across the State serve 100,000 Nevadans every day. Members discuss challenges they have related to hiring. The NPCA would like the Legislature to do anything it can to increase the supply of physicians and healthcare workforce in Nevada. The Association believes S.B. 369 would accomplish that.

KATIE RYAN (Dignity Health-St. Rose Dominican):
We support of S.B. 369. We are growing our graduate medical education programs and have internal medicine and family medicine programs. We just completed our first match and would like to expand into fellowships and other specialty areas. Senate Bill 369 would assist with that.

SENATOR TITUS:
I thank the Committee for hearing S.B. 369. It is time for Nevada to take innovative steps to ensure the future of the State's health care. Listening to what our next generation of doctors and providers have to say is a good start. I would be happy to continue to work with the Committee on this bill.

CHAIR NEAL:
The meeting is adjourned at 1:48 p.m.

RESPECTFULLY SUBMITTED:

_____
Connie Summers,
Committee Secretary

APPROVED BY:

_____
Senator Dina Neal, 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. 369	C	3	Stephen Lencioni	Testimony