MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-third Session
March 11, 2025

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:36 p.m. on Tuesday, March 11, 2025, in Room 2134 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4 of the Nevada Legislature Hearing Rooms, 7120 Amigo Street, 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 Angela D. Taylor, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Senator Nicole J. Cannizzaro, Senatorial District No. 6

STAFF MEMBERS PRESENT:

Destini Cooper, Committee Policy Analyst
Eric Robbins, Committee Counsel
Norma Mallett, Committee Secretary

OTHERS PRESENT:

Jennifer Atlas
Beau Tucker
Stacie Weeks, Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services
Crissa S. Markow
Anthony J. Markow
Robert Haynes

Lindsey Harmon, President, Nevadans for Reproductive Freedom; Executive Director, Planned Parenthood Votes, Nevada
Drianna Dimatulac, Brownstein Hyatt Farber Schreck, NeuroRestorative Nevada
Jacqueline L. Nguyen, Nevada State Medical Association
Wendy Colborne, Chief of Staff, Building and Construction Trades Council of Northern Nevada
Terrence R. McAllister, President, Nevada Chapter of the American Academy of Pediatrics
Paul Larson, Advocacy Director, Lutheran Engagement and Advocacy in Nevada
Chip Carter, Children's Advocacy Alliance of Nevada
Regan Comis, University Medical Center of Southern Nevada
Alejandra Sataray-Rodriguez, Nevada American Academy of Pediatrics
Jorge Monge
Dora Martinez, Advocate, Nevada Disability Peer Action Coalition
Joanne Wittie
Rebeka Acosta, Executive Director, A + J Patient Advocacy
Catherine Nielsen, Executive Director, Governor's Council on Developmental Disabilities, Nevada Department of Health and Human Services
Patrick D. Kelly, President and CEO, Nevada Hospital Association
Oscar Delgado, CEO, Community Health Alliance
Josh Kurtzig, CEO, Valir PACE and Valir Health
Robert List, President, List Company
Nancy J. Bowen, CEO, Nevada Primary Care Association
Kelsey Avery, Director, State Government Affairs, SCAN Health Plan
Peter Fitzgerald, Executive Vice President, Policy and Strategy, National PACE Association
Marie Baxter, CEO, Catholic Charities of Northern Nevada
Barry Johnson

CHAIR DOÑATE:
I will open the meeting with a hearing on Senate Bill (S.B.) 138.

SENATE BILL 138: Makes revisions governing Medicaid eligibility and enrollment for certain infants. (BDR 38-580)

SENATOR NICOLE J. CANNIZZARO (Senatorial District No. 6):
I am proud to present to you S.B. 138 for your consideration alongside my co-presenters, Jennifer Atlas and her son, Beau Tucker. I would like to bring the committee's attention to a proposed conceptual amendment (Exhibit C) for

S.B. 138. This conceptual amendment does show the new language that will be coming for this bill. The bill now focuses on ensuring that hospitals providing birthing services are enrolled with Medicaid as a provider of presumptive eligibility services and ensuring they are screening pregnant women who may be eligible. The amendment also enshrines the rights of parent(s) with children in the Neonatal Intensive Care Unit (NICU)—the right to know, the right to be involved and the right to be set up to succeed as a parent leaving the hospital for the first time.

This bill seeks to strengthen healthcare access for pregnant individuals and newborns in Nevada by ensuring that all hospitals providing birthing services enroll with Medicaid as a provider of presumptive eligibility services. Under federal law, hospitals have the option to screen patients for presumptive eligibility for Medicaid. However, not all hospitals currently participate in this process. By requiring participation as a condition of licensure, we ensure that all eligible pregnant patients receive timely healthcare coverage, reducing barriers to essential maternal and infant care.

Under this amendment, hospitals will be required to have qualified hospital staff and screen all pregnant patients for presumptive eligibility coverage in accordance with Title 42 CFR section 435.1110 (a). If a patient is determined to be eligible, they will receive written notification outlining their benefits, coverage period and instructions for applying for full Medicaid benefits in Nevada. If a patient is determined ineligible, they will receive a written notice explaining the denial and guidance on submitting a full Medicaid application.

Additionally, this amendment includes provisions to support families of newborns with special medical needs. If a newborn is born prematurely with low birth weight or with any condition qualifying them for Supplemental Security Income (SSI), hospital staff must provide written notice to the parents or caregivers that the newborn may be eligible for SSI and, by extension, Medicaid presumptive eligibility coverage.

Finally, this amendment establishes a NICU Parents' Bill of Rights to provide critical protections and assurances for families who are navigating neonatal intensive care. This bill of rights affirms that parents have the right to receive clear, timely medical updates, to be involved in decision-making, to provide things like skin-to-skin contact, access breastfeeding support and receive mental health resources, among other important protections. By enshrining these rights,

we promote transparency, family-centered care and improved health outcomes for vulnerable infants.

With that, I want to note that there are some very real reasons why this bill is coming before you today. This bill is designed to ensure that babies and parents are receiving adequate health care within our healthcare systems, especially when those babies become part of our little team that ends up in the NICU. I have some very important presenters with me who I am going to pass the presentation over to in just a moment, but I do want to make just a couple of remarks before doing so.

There was a fiscal note in the original language of this bill, and while this is not a money committee, it is an important thing that we have been trying to figure out how to navigate that language. That fiscal note from the Division of Welfare and Supportive Services of the Nevada Department of Health and Human Services (DHHS) should now be removed once the amendment is adopted. Again, we are talking about the conceptual amendment that has been provided to the committee and has been posted for everyone else to view as well.

JENNIFER ATLAS:
As most of you are aware, I work for the American Cancer Society Cancer Action Network, but today I sit before you as a mother who was granted a miracle. My son, Beau, was born after 56 hours of labor through an emergency cesarean section delivery. I barely remember his birth. I was septic and struggling to stay awake, but I remember the silence—there was no cry from my baby.

In that instant, Beau was taken away to the NICU—and the world as I knew it, turned into a living nightmare. The NICU is a place of paradox, a sanctuary where fragile lives are saved, but also a battleground where parents stand powerless and unarmed. There I watched my son, his tiny body entwined with tubes, surrounded by machines, the rhythmic beeping, a haunting reminder of how fragile his existence was. For five agonizing days, Beau lay in an induced coma suspended between hope and uncertainty.

After 20 days in the NICU, we finally brought Beau home, though not without a constant reminder of how fragile he still was. He came home on oxygen, a constant reminder of a tether to the battle he had fought so early in life. It is both inconceivable and heroic that so many families endure this journey even

longer. As we crossed the threshold back home, leaving the uncertainty of the NICU behind us, what came next was nearly as cruel—a hospital bill so staggering it seemed beyond comprehension, totaling nearly $500,000. While our insurance covered the majority, we were still left with overwhelming out-of-pocket costs that only grew as Beau required ongoing medical care in his early years.

During those exhausting days in the hospital, I was handed a Medicaid application. Overwhelmed, emotionally drained and naive to the complexities of the system, I pushed it aside assuming we wouldn't qualify. I didn't understand that Beau qualified for Medicaid because of the circumstances of his birth. I had insurance through my employer and assumed we would not be eligible because expenses would be covered. I was wrong.

I remember holding Beau in my arms, finally home, while on the phone with the insurance company desperately trying to prove that he was sick enough to deserve coverage, as if surviving a stroke, spending weeks in the NICU and coming home tethered to oxygen weren't proof enough. I had survived. My baby had survived. But my financial stability was destroyed.

I share this with you because I know my story is not unique. You'll hear from parents today whose babies fought for their lives while medical bills stacked higher than they could ever afford. They sat in NICU rooms just like I did—helpless, terrified—and then were handed a stack of paperwork alongside their grief. Some were forced into debt they'll never escape. And some lost their babies and still had to pay the bill.

Right now, in Nevada when a baby is born into crisis, when they are taken from their mother's arms and rushed to the NICU, their parents are expected to navigate an insurance system that was not designed for them. Paperwork, approvals and delays, all while their child is fighting for life. One missed signature, one processing error, one bureaucratic delay could mean a lapse in coverage—when coverage is needed the most.

Senate Bill 138 does something so simple and obvious that it should have been done already. It automatically enrolls NICU babies in Medicaid if they already qualify. This bill is not expanding the universe of children who qualify, but rather a promise that no family will be left to navigate a financial crisis while their baby is fighting to live. It is a fiscally responsible approach that ensures hospitals and

providers receive payment while preventing families from falling into medical bankruptcy.

I was granted a miracle. My NICU warrior, Beau, is here today. He's ten years old, strong, smart and full of life because of the doctors and nurses who fought for him, because of modern medicine and because, in the end, sheer stubborn luck was on our side. That miracle will always outweigh the burden of medical bills, but no family should have to carry that weight in the first place. There is no reason to allow others to endure such unnecessary hardship when we have the power to change it.

I am asking you to pass this bill for the parents who, at this very moment, are sitting beside an incubator, watching over their fragile newborn, praying that their NICU warrior will survive. Pass this bill for the infants who cannot speak for themselves, whose futures depend on the care they receive today. Pass it so that no family in Nevada has to endure the fear and financial devastation that mine did. This is our chance to ensure that when a child's life hangs in the balance, their family's financial stability does not have to.

BEAU TUCKER:
When I was born, I was very sick and had to stay in the NICU. My mom had health insurance, but she was still left with huge medical bills. That's not fair. Parents should be able to focus on their baby's health, not on fighting through paperwork or worrying about costs. My mom calls this "Beau's Bill—Babies Enrolled Automatically." Beau's Bill will make sure all NICU babies are automatically covered by Medicaid, so families can focus on the baby's health instead of worrying about paying. I hope you'll support it.

SENATOR CANNIZZARO:
This is just one story out of countless others. Some may share today, and so many others are not sharing. For babies who are born in precarious situations, there are families who are praying and hoping that their baby is going to come home. I have to apologize, because I should have started this hearing with noting that this bill is what we are calling Beau's Bill.

It is important to hear why this bill is important from real people who this has affected. Just so that we are clear, this bill is not seeking to add folks to the Medicaid rolls who are not already eligible. It is not seeking to have undue burdens put on families or anyone else. This bill is saying that if you are going

to be in a hospital giving birth to a baby and you are a birthing hospital, that you need to [inform] these families about coverage because they just do not know that they will qualify for coverage. Their focus then can be on their baby and not on whether they are going to be able to financially sustain the impact from all this medical intervention. It is scary enough to be having a baby. It is even more frightening beyond my comprehension to be in the position of Jennifer or certainly baby Beau. What we are asking for here is so that people know that they can qualify for this coverage so they can focus on their babies.

SENATOR TITUS:
I certainly support the bill in concept, but I have concerns about the amendment. Addressing the first paragraph on the proposed amendment, Exhibit C, "As a condition of licensure, hospitals operating in the State that provide birthing services must enroll with Medicaid as a provider of presumptive eligibility … ". Is this saying that existing birthing centers, existing hospitals that already deliver and possibly have NICUs are going to lose their licensure if they do not do this?

SENATOR CANNIZZARO:
We are not intending to remove or revoke licensure from hospitals. We would be happy to work on any language that might be appropriate to ensure that any currently licensed birthing hospitals are able to enroll as such and able to provide this information to their patients. But certainly, the bill is not a backdoor way to remove licensure from a hospital that is currently licensed.

What we are trying to do, though, is say that as part of having that license—because that is where we can tie it to—that is where the State has some sort of oversight and ability to have a say-so. That is that; the hospitals have to enroll as a presumptive provider, which they will qualify as; and that they have to provide this information to their patients who would qualify. Obviously, if there's a patient that does not qualify, just to be clear, this does not somehow automatically entitle them or enroll them to some sort of eligibility. If there's language we need in the first paragraph to ensure that this gives hospitals the requisite amount of time to complete all those steps, become an enrolled provider and put into place the things they need to make sure that they are giving these families this information, we'd be happy to talk about it and do that.

SENATOR TITUS:
I just want to make sure that if a hospital chooses not to enroll in Medicaid, they will not lose their ability to be in this State, because Medicaid has pros and cons. Certainly, we have many babies on Medicaid, and we need that backstop for cost. However, knowing what Medicaid does not cover, mandating that they enroll in Medicaid has me concerned.

SENATOR CANNIZZARO:
What we are asking is that these hospitals which provide birthing services would need to, at some point, become an enrollee to provide these services. Because otherwise, if you have babies who are going to be placed into the NICU, the parents should be aware that they would qualify for this coverage. If there are logistical questions or concerns about how that would take place, we can work that out in the bill language and are certainly amenable to do so. The purpose of passing this bill is not so that suddenly, the day after this bill goes into effect, a bunch of hospitals are unlicensed. We can certainly provide a runway to do that.

SENATOR STONE:
I had the pleasure of meeting Ms. Atlas and Beau in my office and heard of this frightening story. Ms. Atlas, when you were in the hospital, you were obviously concerned about your child in the NICU. They shoved this piece of paper at you and said, you want to sign here for Medicaid? You thought that you had appropriate insurance and did not need State aid, and that it was all going to be taken care of. Tell us more about your story and how you found out that you had these horrific bills.

MS. ATLAS:
This is something that I honestly did not know was an option for me: that Beau, until he was 7 or 8 years old, should have been enrolled in SSI and Medicaid. I did not have the knowledge that I do now. I was a professional ballroom dancer, and I worked in hospitality. I did not know that there were people I could go to, that I had representation in my State Legislature and that I could say I do not know why I am getting these costs. Coming through this new career path and learning about advocacy, I did realize that if I had just filled out that paperwork, the bills might not have come quite as large and that my son could have been covered.

SENATOR CANNIZZARO:
One of the things you are getting at is trying to be addressed in this bill, making sure that families and people who are having a baby have that information, are getting that information ahead of time and these benefits are explained to them. One of the issues that exist for a lot of these families is they do not know. Ms. Atlas did not know that her baby would have qualified.

There wasn't anyone there to come to her and say, listen, you are about to have a baby and something may go wrong. When you go in to have a baby, there's a ton of things that they go over with you, like, do you want to have an epidural? Do you want to have skin-to-skin contact when your baby is born? Are you planning to breastfeed or bottle feed? You must consent and sign off on all these things before you actually have the baby for folks who are going in and registering. Obviously, there are situations where people are showing up and having a baby at a hospital. But like a lot of these things, all these different touch points are discussed with those individuals. This should be one of them. If something goes wrong, if your baby qualifies for SSI, if you fall under this eligibility for Medicaid, can we go ahead and get that process going? Or once you have a child and your baby is in the NICU that there's somebody there to explain all this to you. That's part of what this bill is seeking to address.

SENATOR STONE:
It would seem to me that if you have private insurance and your child qualifies under SSI to get Medicaid, I am looking forward to hearing from the hospitals as to why they would not embrace the program? I mean, would they rather have uncompensated care or have reimbursement? This would certainly require the (DHHS) director to administer changes in the existing Medicaid State Plan should this get passed. Correct?

SENATOR CANNIZZARO:
I am glad that you brought up the point about uncompensated care. Because what we are talking about is a family who, even if they have other insurance, that baby qualifies for this Medicaid coverage to be in the NICU. So, they do not have to have that hospital bill at the end. But the problem with this is that when you have a baby who is in the NICU and who is not being covered by that private insurance, that is uncompensated care in as much as it pertains to the hospitals. I have for a long time been an advocate of finding ways to have less uncompensated care that might be paid for through Medicaid. We should be doing that. There are others who can answer this question better than I can, but

I do not think that this will require too much of a change with respect to the State Plan. Our hospitals in Nevada, and I should have noted this ahead of time, are already enrolled with Medicaid. A significant number of births here in the State are covered under Medicaid already, about one in two. I think where we can find these pieces are where there is less uncompensated care, and where a lot of these hospitals are providing NICU services.

We talk about this a lot in our finance committees and have in previous sessions with respect to increasing reimbursement rates for hospitals who provide NICU services. That is something that we would want to make sure is being covered so they can continue to provide those services. This is certainly one piece of that. With respect to the more technical questions on the State Plan for Medicaid, I would leave that to either our very competent and able Legislative Counsel Bureau staff or certainly to our DHHS. We may have someone in the audience, and I do not know if she can answer that question or is willing to answer that question, but if she is not, I will certainly get that information and give it the committee.

STACIE WEEKS (Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services):
We currently do presumptive eligibility. We should not have to do a State Plan amendment. This is just making sure that hospitals are participating in helping pregnant women access Medicaid when they need to for their infants.

SENATOR STONE:
If a hospital takes Medicaid presently and they have not done this presumptive eligibility before, are they able to bill after? And what about when they find out that somebody does not have insurance, or they received high medical bills because of a NICU incident?

MS. WEEKS:
No. The only way they can do that is through presumptive eligibility. We can backdate through an abbreviated application that the individual would fill out and sign that they are presumed eligible. Anything that occurs during that time is covered by Medicaid. They do have to fill out the full application within, I think it is 60 days, and at that point they may not be determined eligible for Medicaid beyond that time, but those services during that time are presumed eligible and covered.

SENATOR TAYLOR:
My question is, let's say there's a hospital that does not share this information with the mother. And then half a million dollars worth of debt shows up. Is there an appeals process? What if the mother was not aware; is there any backstop for them?

SENATOR CANNIZZARO:
The language of the bill does not contemplate an appeals process. Obviously, the mechanism for enforcement for this is tied to hospital licensure to make sure that they are enrolled and are providing this sort of information. But certainly, we can provide any other guard rails that might be appropriate. The tough part for the families is if a hospital is not doing this; Ms. Weeks spoke to that. If you are not enrolled in this program, you can't come back and backdate it. That is why we want to make sure that they—before someone is showing up in the hospital and having that baby—are filling out this information ahead of time. We want them to be aware that, if their baby does then find its way into the NICU, they could be deemed presumptively eligible, and those services would then be covered.

Unfortunately, if it does not happen, you leave a family with a significant amount of debt that they have to figure out how to pay, which is what we are trying to solve here. So hopefully, we will have good actors who will come forward, implement this, follow the law and do what they are supposed to do to make sure that families are getting that information and are getting enrolled when it is appropriate.

CRISSA S. MARKOW:
I am here in support of S.B. 138 and submitted a support letter (Exhibit D) of my testimony.

ANTHONY J. MARKOW:
My full remarks and testimony have been submitted in a support letter (Exhibit E).

ROBERT HAYNES:
My wife Cheryl and I submitted our testimony in a support letter (Exhibit F) for S.B. 138. We urge you to support this bill as well.

LINDSEY HARMON (President, Nevadans for Reproductive Freedom; Executive Director, Planned Parenthood Votes, Nevada):
We are here to urge you to support S.B. 138.

DRIANNA DIMATULAC (Brownstein Hyatt Farber Schreck; NeuroRestorative Nevada):
On behalf of NeuroRestorative, we stand in strong support of S.B. 138, Beau's Bill. NeuroRestorative is a pediatric skilled nursing facility with three locations, two in Las Vegas and one in Reno. Our dedicated and highly trained team provides care to children with complex medical, nursing and therapy needs, including those with brain and spinal cord injuries. Many of the children that we assist come to us directly after being discharged from the NICU, which is a time filled with high-end anxiety for parents who are already facing overwhelming circumstances.

We support this bill because although leaving the NICU is a significant milestone for these children, it also marks the beginning of a challenging recovery period, especially for children who rely on Medicaid. Senate Bill 138 is a compassionate and practical measure that will protect the health and well-being of our most vulnerable infants. I urge you to support this bill and to ensure that all NICU infants receive the timely and comprehensive care they deserve while supporting their journey toward recovery.

JACQUELINE L. NGUYEN (Nevada State Medical Association):
The Nevada State Medical Association is the oldest and largest organization representing physicians in our State. Medicaid coverage is essential for babies in the NICU. We support this bill because we understand the high cost of medical care, the need for access to specialized care and the importance of ensuring that everyone, particularly this vulnerable population, has access to equitable health care. As a mother of twin NICU babies myself, and on behalf of our National State Medical Association President, Dr. Joseph Adashek, and all our physician members, we fully support this bill.

WENDY COLBORNE (Chief of Staff, Building and Construction Trades Council of Northern Nevada):
We fight every day for Nevada's working families, many of whom have faced situations like this one, and we are here in solidarity today to support S.B. 138. Beau's Bill is not just policy. It is an opportunity to nurture our State's future. It

is about shielding parents from the crushing weight of catastrophic debt so they can hold their infants close without fear shadowing those first tender moments.

As the Battle Born State, Nevada knows that every fire starts small by investing in the tiniest Nevadans. You're helping to build a future where every child has a fighting chance. This bill helps build a stronger Nevada for working families, one tiny heartbeat at a time. We urge you to support it.

TERRENCE R. MCALLISTER (President, Nevada Chapter of the American Academy of Pediatrics):
I am the president of the Nevada Chapter of the American Academy of Pediatrics as well as a practicing pediatrician in Las Vegas. I am here to speak in favor of Beau's Bill. When a child is admitted to the NICU, it is never a planned event. It is chaos and the parents of that child can rely on the medical team to make thousands of decisions every day to support that child. They're not asked how much or what the dose of antibiotics could be or what the pressure settings on the vent have to be. They're able to trust the medical professionals and the medical team to make those decisions.

The ability to get Medicaid coverage should be just as simple for the parents. There needs to be other specialists that they can trust to make that decision or to guide them in that decision. It needs to be a simple process because there is so much else on their minds at that moment. That is why we, the American Academy of Pediatrics, Nevada Chapter, support Beau's Bill.

PAUL LARSON (Advocacy Director, Lutheran Engagement and Advocacy in Nevada):
I rise to support this bill on behalf of Lutherans across Nevada. It is important that we consider medical inequities in our infants.

CHIP CARTER (Children's Advocacy Alliance of Nevada):
The Children's Advocacy Alliance of Nevada (CAA) is the independent voice for Nevada's children, advancing systemic change in the areas of early childhood, children's health and child welfare to ensure that every child in Nevada thrives. I am here to strongly support S.B. 138, Beau's Bill, to provide presumptive Medicaid coverage for newborns who require NICU care.

As everyone has said, just like Beau's family and Bennett's family, Exhibit D, Exhibit E and Exhibit F, no family should face the devastating reality of financial

ruin simply because their child was born premature and with medical complications. When a newborn is admitted to the NICU, parents are immediately confronted with overwhelming stress, medical costs, lost income from time off work and uncertainty about insurance coverage. A single day in the NICU can cost thousands of dollars. For many families, as we have heard, waiting for Medicaid approval means delayed care, mountains of medical debt and financial insecurity at an already stressful time.

Presumptive Medicaid coverage ensures that babies get the care they need immediately without forcing parents into impossible situations. Without Medicaid coverage in place from birth, families may face denied claims, delays in care or forced decisions based on cost rather than medical need. The long-term financial impact of NICU stays can be devastating, particularly for middle-class families who do not qualify for immediate Medicaid but cannot afford the astronomical costs of neonatal care. Even for insured families, NICU bills often come with high deductibles and out-of-network charges as a surprise, and uncovered services leaving them tens of thousands of dollars in debt before their child ever gets home. Presumptive Medicaid helps ensure every baby gets equal access to care regardless of their family's financial situation.

We know that early medical intervention leads to better long-term outcomes, reducing disability rates, future hospitalizations and long-term healthcare costs. Ensuring this Medicaid coverage for NICU babies is not only the right thing to do, but also a smart investment in the future of our healthcare system. Therefore, we at CAA urge you to support presumptive Medicaid coverage for NICU babies and ensure that no other family has to choose between their child's health and financial survival. Every newborn deserves the best possible start in life.

REGAN COMIS (University Medical Center of Southern Nevada):
On behalf of UMC, we are here in support of S.B. 138.

ALEJANDRA SATARAY-RODRIGUEZ (Nevada American Academy of Pediatrics):
I will also keep it short and simple. I am a third-year medical student, and I am currently seeing how important this bill is as I go through my clerkship rotations. I am fully in support of this bill, and I urge you to do the same.

JORGE MONGE:
I am a fourth-year medical student at the University of Nevada, Reno, School of Medicine, soon to be graduating and becoming a practicing physician in the community. I am here in support of this bill. I have rotated through the NICU maternity and delivery wards at Renown Regional Medical Center and have seen firsthand the difficulties that mothers and patients face after the birth of their children. I fully believe this bill will help to support those families, ensuring that their full attention and care is committed towards the well-being of their children, and ensuring they do not have to deal with the financial difficulties that often come with giving birth and the challenges that come afterward.

DORA MARTINEZ (Advocate, Nevada Disability Peer Action Coalition):
We wholeheartedly support S.B. 138. Just make sure that when given the written Medicaid application, it is in a language the mom can understand, whether English or another language. If the mom is blind, please make sure it is in an electronic format that is fillable, so she can do it at her home. If the mom is an American Sign Language user, hopefully there's an interpreter that can help her with that process.

JOANNE WITTIE:
I, too, am a parent of twin NICU babies, and it is difficult to say that I consider myself one of the lucky ones, because I am a healthcare professional. I am a pharmacist by trade and, when I was in the NICU, I had an amazing colleague who highly encouraged me to fill out the Medicaid paperwork. When I completed it, I too thought about setting it aside and not filling it out. She had a social worker come speak with me. We were double covered. We also did not think that we needed to fill out this paperwork. We were like, that is ridiculous. We would never qualify.

When my colleague encouraged the social worker to speak with me, she said no, you should fill it out. You have two babies, and it does not matter that you are double covered. Your income does not matter. You had a baby that was born at 2 pounds, 8 ounces, and the other, born at 1 pound, 15 ounces. I can tell you that we are ever so grateful that we completed the paperwork. We did not receive a single bill from our children's stay; one stayed six weeks, and our second baby stayed 109 days. I highly support this bill, and I urge you to do so as well.

REBEKA ACOSTA (A + J Patient Advocacy):
I am in support of S.B. 138 as both a pediatric health advocate and the mom of two teenagers with lifelong medical conditions, one having spent time in the NICU. I am keenly aware of the financial burden. My written testimony has been submitted in a support letter (Exhibit G).

CATHERINE NIELSEN (Executive Director, Governor's Council on Developmental Disabilities, Nevada Department of Health and Human Services):
To save you all time, we ditto all comments in support of S.B. 138.

PATRICK D. KELLY (President and CEO, Nevada Hospital Association):
I planned to come here today to support this bill, but at the last minute, I received a very extensive conceptual amendment that I just saw this afternoon. I have not had a chance to talk to any of the hospitals about it, except a couple. So technically at this point, we are in opposition, but I think we can move towards connecting with the sponsor and work things out.

I do want to answer a couple of questions that were asked. One is that we have always been advocates of allowing hospital personnel to do presumption eligibility and that has really picked up in the last couple of years. There's now a course that is offered quarterly, a three-day training, that we can send people to. It gets them all set up to do presumptive eligibility. I did have a chance to talk to a couple of hospitals that had NICUs, and they said they do presumptive eligibility.

I did not have the chance to talk to hospitals that did not have a NICU, because this bill covers those hospitals as well. I just want to know where they are in terms of what they are doing and if there are any issues with it. As you know, the smaller hospitals tend to have some of the bigger issues—they do not deliver a lot of babies, and they have personnel changes. I want to check on all that before we say okay because I know that if I do not object now, I cannot object later. So, I am just trying to preserve that right at this point.

CHAIR DOÑATE:
Hearing no further testimony in opposition or neutral, Senator Cannizzaro, do you have any closing remarks?

SENATOR CANNIZZARO:
Thank you to all the families who came and shared their experiences. In case anybody is not saying it often or enough, I certainly will. It is hard to be pregnant and have a baby. I cannot imagine adding on top of that, watching your baby in the NICU. Those families should be focused on those complications, not on whether they are going to be able to afford to take their baby home and continue to provide a life that baby deserves. Or, in the very heartbreaking cases, when that baby does not return home. What I will say about any opposition that we have heard today for this bill is that no one has come to talk to me about opposition to this bill or concerns with the language. If there are concerns, they should find their way to my office.

What I heard was a lot of this is already happening. Making sure that this happens across the board so that there is not a family that is left behind is the very least that we can do, and the very least that we can require. There is no reason not to when you go to a hospital to have a baby. If you end up in labor and delivery triage, they are going to ask you a litany of questions. You're going to fill out a litany of paperwork to so many questions. What is your insurance? How many babies have you had and have those babies come to term? Were there any complications? What are your allergies? What sort of medication are you on? What does your prenatal care look like? What doctors do you see? How often are you seeing them? Have there been any complications as a result of any of those appointments? When you have this baby, what do you want to happen? And so on, and so on and so on.

If we add to that, we want to talk to you about Medicaid coverage. Yes, you might have medical insurance. Yes, it might cover some portions of this should your baby end up in the NICU, but we want you to fill this out so that that your baby can be covered, and you can focus on your baby and not on whether you are going to be able to afford this. That's all this bill is about. Hospitals that already provide this sort of care, a birthing hospital, are covered under Medicaid. Let's make sure people get that presumptive eligibility. It sounds to me that at the next hearing on this bill, we should hear a lot more support. I hope to earn all your support for Beau's Bill.

CHAIR DOÑATE:
In addition to hearing testimony on this bill today, our committee secretary received three letters in support (Exhibit H) and one letter in neutral (Exhibit I). We will now close the hearing on S.B. 138 and open the hearing on S.B. 207.

SENATE BILL 207: Requires the establishment of a program of all-inclusive care for the elderly. (BDR 38-763)

SENATOR ANGELA D. TAYLOR (Senatorial District No. 15):
Senate Bill 207 requires the establishment of a Program for All-Inclusive Care for the Elderly (PACE). This program is a community-based healthcare program that allows seniors to get medical and social services in their home and in a one-stop shop. Presenting with me is Oscar Delgado, CEO of Community Health Alliance, a very large Federally Qualified Health Center (FQHC) in Northern Nevada. He will go over exactly what the PACE program is and how it has impacted the lives of seniors all over the country. Josh Kurtzig, CEO of Valir PACE and Valir Health, will introduce you to a PACE program in action. You'll get to see what it really is. And then I am honored to present former Nevada Governor Bob List. He will share his experiences with the PACE program, and why he believes we need PACE in Nevada.

For a little background information, this journey for me began when I became the caregiver for my mother. I had no idea how much of a void we have when it comes to caring for our seniors, especially those with additional challenges and financial barriers as well as memory issues—being low income, lacking support for day-to-day care and, of course, finances. The PACE program addresses every one of those challenges.

This bill was originally brought in the 2009 Legislative Session by Assemblymember Sheila Leslie with the intention to allow seniors more choices and staying out of nursing homes. The original bill placed the PACE program within the Aging and Disability Services Division (ADSD) of DHHS. This bill ultimately shifts the authority responsible for establishing and administering the PACE Program from ADSD to any division of DHHS. However, should the bill that establishes a health authority pass this session, it will ultimately transfer to that division and not remain in ADSD.

Section 1 of the bill requires that DHHS establish and carry out a PACE program. The program may be carried out solely by DHHS or the health authority and any division thereof, or in cooperation with another entity such as state agencies, local governments, the federal government, a FQHC or a third party. Section 1 also requires a program to comply with federal regulations. After discussions with several stakeholders, the part that required the use of an FQHC was removed with the amendment (Exhibit J) that was distributed to you

today. Section 1 further authorizes DHHS to use personnel from within the Department or to contract with any appropriate public or private agency, organization or institution to provide the services necessary to carry out the provisions of this section. The requirements for a contract entered with a public or private agency, organization or institution are also listed in section 1.

Lastly, subsections 5 and 6 of section 1 require DHHS to apply for any waiver of federal law to establish the PACE program and authorizes the Department to apply for, accept and expend any federal or private grant of money or assistance to carry out the provisions of establishing the PACE program. There's also a little bit of cleanup. Sections 2 and 8 eliminate the authority of a ADSD to establish a PACE program, as I mentioned earlier. And sections 2 through 4 remove the references in existing law to such a PACE program, replacing it with section 1 of this bill.

OSCAR DELGADO (CEO, Community Health Alliance):
The PACE program is all-inclusive care of the elderly. I am now going to read the presentation (Exhibit K contains copyrighted material. Original is available upon request from the Research Library.). This program is for individuals ages 55 and older who, otherwise, would need a nursing home level of care. There's going to be a focus on patient-centered care, using a community-based integrated model. What you have here are 11 members of an interdisciplinary team to sit with the patient and make sure they have all the care needed from professionals. It is care that they would probably otherwise see in the community through transportation issues or having a caregiver take them all over town to see their therapists, dieticians or other medical professionals.

This will all take place under one roof under the care of either an FQHC or another provider that would come in to apply for such services. The PACE model philosophy is really to make sure that we are honoring the wants and needs of frail elders and their families. We all can understand, just from within our own families and communities, the needs and stresses on families of reassuring their loved ones, making sure they have the care they need without having to take time off work, take time away from their families and the other stressors involved by having all that surrounding support within a PACE program.

Who does PACE serve? Currently across the nation there are over 80,000 older adults who receive PACE care daily. Picture in your mind a grocery store and

about two-thirds of that space would be an active living space, with individuals, nurses, physical therapists and social workers. Other individuals would work with each other and make sure that they have socialization. The other third of that facility would be a clinic, so those individuals that are currently in a PACE program would have a provider, pharmacy, nurse practitioners and medical assistants on site. They'd have all the support needed for the individuals who have those needs.

At the moment, 97 [*sic*] percent of those individuals that will go to a PACE program live in their own homes. The whole idea is that they are not going to a nursing home. It is providing proactive, preventative care, reassuring those who have chronic issues and meeting all those needs. Individuals going to nursing homes would be about 5 percent, but they could also be served by having PACE support. Again, the whole idea is to keep them out of nursing homes, keep them at home, keep them with their loved ones, while also supporting and giving caregiver support.

We've talked about the providers who are providing patient-centered support. Those services again are meals, primary specialty care, medications, rehabilitation (rehab), home care, transportation and social activities. People ask, "How do we get there as required by PACE?" As Josh Kurtzig will tell us later, you are required to provide transportation to all those. What you would do is have that provider pick up individuals and bring them to the PACE program. They spend time there throughout the entire day, where they receive meals, primary care if needed, some general case-management support, dressing if needed, haircuts, et cetera. At the end of the day, they would then be transported back to their own homes where they would be able to then come back the following day.

Transportation and meals are provided by PACE; across the nation, they provide night shifts. Not all PACE individuals go to a PACE center. Some people think the centers are always full and only go when needed. Some individuals only use the clinic or to see a provider. They only receive the pharmacy, and then they go back home if needed. This is only for those that need that extra additional care.

As you can see, the PACE program is not new. It would be new to Nevada, of course, but there's a growing need across the nation. They're seeing the care and the return on investment in terms of supporting PACE programs. Just a few

years ago, that growth was at 84 percent and now we are over 180 percent and growing. It just makes all the sense in the world to be similar to an FQHC. We have all these services under one roof. You'll have the same services for the frail elderly and the community at large.

Unfortunately, as you see in Exhibit K, Nevada is not one of those states. What's different is that Illinois is colored in dark blue and is now providing PACE programs. So, it is really a matter of time and for us to know our community's growing needs, especially in Washoe County. Through your support, we could start PACE programs as soon as possible.

What are some highlights and outcomes? Through all the information and data that is gathered across the nation, it is less than one emergency room (ER) visit per year, which is extraordinary, especially for limiting our patients to go on and take those extraordinary costs that we see at the ER visits. It is decreased rehospitalization and fewer nursing home admissions. Again, I think many can speak to the cost savings and the return on investment for supporting such a program like this one.

JOSH KURTZIG (CEO, Valir PACE and Valir Health):
We are based in Oklahoma City and have been running PACE for ten years. We are also expanding to other states later this year and other parts of Oklahoma. We also run a hospice business, nursing homes and so forth and so on. During those 20 years at Valir Health, we realized that nursing homes are not places people want to be. The goal of PACE is to keep people out of nursing homes, keep them in the community, keep them in their homes, surrounded by their families with wraparound services that only PACE organizations provide. We can talk about numbers all day. In a moment, I think former Governor List is going to tell you about some of the numbers from Nevada. But I can tell you that, from my experience in working with PACE, this is the best healthcare program, and it is the future of health care in this country. It not only saves money for the states, but it also provides better care for participants.

So, what am I talking about specifically? People come to the PACE center to increase their social determinants of health. This is an expression that healthcare people throw around. The idea is when you are among community members and friends, you do better than if you are sitting at home by yourself. You do better than if you are isolated in a nursing home. They come, they play bingo, mahjong and canasta. They play whatever they play, get meals and

healthcare services. We drive them to appointments with doctors, cardiologists, urologists and we make sure that they have rehab, medicine and all that care. We provide all their medication and hospitalizations if it comes to it. We also provide all their ER visits. We even provide transplants if it is deemed necessary.

The risk is on us. That's the best part; it's in our interest to keep them healthy and out of the hospital. It is in our financial interest to do that. That's good for the State and good for the participants. Last quarter, we ran a survey and asked people in our programs if their life was better off having joined PACE. The response from 92 percent said yes. We have tremendous satisfaction among our participants and their families. We talk about cost savings and what Nevada would look like. But in my mind, this is the best thing that has happened to many of our participants. We deal with the most clinically vulnerable, most food-insecure and most housing-insecure populations in our country. They are the vulnerable people who are Medicare- and Medicaid-eligible, low-income and elderly who need our support. At Valir and the other 180 PACE programs around the country, we make it our mission to make sure that these people live healthier lives in their homes instead of going to an institution.

I will give you one quick anecdote. We are ten years into PACE. One of our first participants who is celebrating his tenth anniversary at our program had a stroke ten years ago and was paralyzed on one side of his body. Governor List—you actually met this man—he considered taking his own life and was prepared to do so when he joined the PACE program and gave it a month. Since then, we have rehabilitated him to walk and join the community. He's ten years on. We can do that for America's most vulnerable population. We hope you will consider bringing this to Nevada. It would be a great benefit to everyone in this State.

ROBERT LIST (President, List Company):
I remember well the days when I was Governor and the folks that I met in the nursing homes, who I often visited, and family members of mine who had been in nursing homes. When asked how they felt about it and how difficult it was for them, they felt isolated, felt as if no one loved them, often with no opportunities for recreation or interaction or socialization with others. Five years ago, I was on the board of directors of a financial institution and our chair was a man from Oklahoma City. His name is John Giles and as I got to know him, found out that his primary business was in health care and that he and his three partners owned PACE programs in Atlanta and Oklahoma City. His family

had owned nursing homes across the Midwest for many years. His story was that he came to the point where he learned how difficult it was for the patients who were in nursing homes. Nobody wanted to be there. People oftentimes felt like it was the last stop in their lives, and it was very difficult to hire staff. It was an unpleasant place to work.

He said they started branching out into the PACE program and learned that people loved it and it allowed them to stay in their own homes, often with loved ones. They could take advantage of the same benefits that they had, only it was delivered to them by the staff of a PACE operation. They delivered; they took them to buy their groceries. They had transportation, took them to their doctor's and dentist offices, brought them to the hub or the center where they could socialize and have medical care right there. They could keep their own doctors also. It allowed them to continue the socialization with others while still maintaining the family surroundings of their comfortable home.

I told John that I needed to know more about that and that we needed that in Nevada. I went back to Oklahoma City, and I got introduced to the program there. I met the participants and the people who operated it, and I was really moved by how effective it was for these folks. They told me their stories and I asked, "Why do we not have that in Nevada?" They said, "Well we have it in 33 or 34 other states, but why not in Nevada?" So, I got interested in it and came and talked to the [current] Governor about it. I got to meet with Stacie Weeks, and she said we need this in Nevada. I hope that she will tell you about it today.

In any event, I want to say that Nevada has 3.2 million people. In Nevada, 811,000 of those residents are Medicaid-enrolled. 95,000 of those residents are dual-eligible; that is, they are on Medicaid and over age 65, and the benefits that they can get through PACE are incredible. Medicaid criteria in Nevada is that it is for adults ages 19 to 64, and their income is less than $20,000 per year. So, we have a lot of people in Nevada that can take advantage of this that do not even know about it at this point because we do not have it.

One of the things I like about the program is that it is run by a private enterprise. A company like Valir comes in and makes the investment of millions of dollars to create a facility, a center or a hub or whatever you call it. They put their money at risk to set this up and then they get reimbursed for the services from Medicaid. Each state has a given formula that is dependent upon the local

economy and financial circumstances of each state. They get reimbursed for each patient or each participant.

In Nevada, we ran the numbers. If 2,000 people signed up for this program in Nevada, it would save the State and federal government $14 million because PACE is cheaper to operate than a nursing home. The money that comes back to the PACE program is about $7,000 less per person than the cost of a nursing home. If we had 5,000 of our people enrolled in PACE, it would save us $35 million. We all know what the costs are with operating government and the amount of taxes, and how valuable those tax dollars are to you as members of this committee, and to members of the Legislature making appropriations. I want to say that Nevada needs this program. It ought to have bipartisan support. It is good for Nevada. It is good for the patients. It is privately run, and it is good for the federal government. I am hopeful that we do not see a cut in Medicaid in Washington. We're being assured that we will not, and I can tell you that Governor Lombardo has been in touch with the White House urging them to not to cut into this money. I encourage you all to support this program and this bill.

SENATOR TAYLOR:
I am the only one at this table who has not seen a PACE program, but they have convinced me that this is something that is really important for our residents here and, hopefully, we will convince you as well.

SENATOR LANGE:
There was a program in Las Vegas that sounds similar to what this is, and it did not make it. I am wondering if you know what was it called?

CHAIR DOÑATE:
There are Medicare Advantage plans that offer a similar program for senior daycare, which were not successful, financially insolvent.

SENATOR LANGE:
I am wondering how this program could be implemented, so we can learn from the lessons that happened in Las Vegas, so it can continue because it is a great idea.

SENATOR TAYLOR:
I am not familiar with the program in Las Vegas, but if it was a Medicare Advantage program, I am certainly familiar with those. This is not that. This is more of a comprehensive care—one-stop shop, picking people up, it is really the wraparound. That is the best way to put it is the wraparound. The Medicare Advantage program is a way to get your health care, but they do not do all the other wraparound pieces that the PACE program does.

MR. LIST:
This program deals with Medicaid primarily, and if an individual is over 65 and also in the Medicare program, they are doubly eligible. The reimbursement to the PACE program is slightly more for the people who are over 65. But it is primarily geared toward Medicaid, the poorer folks that cannot afford to take care of themselves except to go to a nursing home. They have to be nursing home-qualified Medicaid patients to participate in the program.

SENATOR STONE:
I am excited about this program, and I want to understand a little bit more. Originally it would have been heard through ADSD, but now it could be licensed by DHHS to one of these private providers? What is the nexus to the FQHCs? How does that all intertwine?

SENATOR TAYLOR:
An FQHC, as well as an organization or a company like Valir, would contract with our agency, which hopefully would be the health authority. Our agency will be in charge of it, but they contract to another partner to put the program together and to run it. Did that answer your question?

SENATOR STONE:
So, an FQHC can be a PACE?

SENATOR TAYLOR:
Yes.

SENATOR STONE:
And the bill mandates the use of a FQHC to provide these services? Are there any concerns about the capacity for these centers to meet the needs of the program?

SENATOR TAYLOR:
The amendment took that part out to leave it open so that it can be a FQHC. It could also be an organization such as Valir. It does not require it to be a FQHC; it can be, but it can also be another organization.

SENATOR STONE:
Medicaid is not one of the better payors, right? Our friends that are here that have opened these programs up in other states, have you examined Medicaid rates here? And is it a profitable model for you? Is it something that we can actively promote and expand? I think it'd be a great service for our senior citizens.

MR. KURTZIG:
The answer is that the healthcare authority and Ms. Weeks will have to do an actuarial before this happens. But I can tell you what the rates are in Oklahoma and other states. For example, in Oklahoma, Medicaid is not a great payor. About 13 percent of our participants are Medicaid-only, another 87 percent are dual-eligible, meaning also over 65. And so, you get a Medicaid payment, and you get a Medicare supplement on top of it. Medicare is paid directly from the Centers for Medicare and Medicaid Services (CMS) and the Medicaid portion is paid from the State. Obviously, we want the latter, we want the dual-eligibles.

I should add there is a risk score adjustment for people who are particularly ill, let us say end-stage renal failure, renal disease. We get a risk adjustment from CMS to compensate us for that risk. But let us be clear, we are at risk. Our money is at risk, our capital in terms of investing $10 or $20 million in building a center, hiring the staff, making sure we have the providers, the trucks, the cars, all that stuff; we are at risk. It is in our interest to keep people healthy. That's how we make our margin, and it is in our interest to expand to as many people as we can. An FHQC entity can do that, a private for profit, private nonprofit, anyone can do it. That is what this bill is about. It has far better outcomes for the participants and for the community than other programs I have seen.

Senator Lange, I think you are talking about a Dual-Special Needs Plan (D-SNP)? If you are, Nevada has nine D-SNPs. I think Ms. Weeks could talk about that more. That certainly is part of the solution, but our solution has care coordination that these D-SNPs do not have. This holistic interdisciplinary team (IDT) is at the core of what we do every day. The IDT meets every single day to

discuss every patient and what their needs are to make sure they have what they need like—walkers, medicine, diapers, transportation, dentists, vision, absolutely everything—and that is what sets this program apart.

SENATOR STONE:
Do you believe that we have enough FQHCs to get this program off the ground statewide? I am concerned about the rural areas; could the rural areas participate in this as well?

SENATOR TAYLOR:
It does not have to be an FQHC, it can be but doesn't have to be. For example, it could be the Community Health Alliance in one part of the State and Valir in another part of the State. So, one organization would not have to do that. Certainly, there are economies of scale, but it would not have to be an FQHC that has to have the reach all around. Does that answer your question?

SENATOR STONE:
I think it does and then you mentioned that the DHHS would do an actuarial and it would be a capitated model? Is that the way I am understanding how this is?

SENATOR TAYLOR:
Again, it would hopefully be the health authority, which is what we are looking at and the Governor wants to make that shift.

CHAIR DOÑATE:
Just for my understanding, and I think this is what Senator Lange was mentioning, this program would allow private industry, FQHCs, nonprofits, everyone, to establish a PACE program, which pays a capitated model to provide primary care, dental services, social work and so on. The senior daycare is the way that you get them in with the activities. But the reason you bring them in is in case they complain of chest pain or other issues, you can monitor them and see them quickly to prevent them from going to catastrophic cases where it becomes more expensive. That's the prevention model, correct?

MR. KURTZIG:
Yes, that's exactly correct. We provide not only the primary care, but we also cover the hospitalizations. If they do need to end up at a nursing care facility, we cover that, everything is on us. We use the daycare center to keep them socially engaged. We provide meals, of course; transportation has been

mentioned several times. But we also make sure that we are monitoring their social, physical, nutritional and health, all the wraparound services to keep them healthy.

CHAIR DOÑATE:
This is just a recommendation, more so with the implementation of the bill, not really the language. One of the critical aspects of making sure such a program is effective is making sure that adequate transportation is being provided to the participants. I want to make sure that if there's an agreement to receive a capitated payment, that you are upholding the services you promise to deliver.

What we saw with the Medicare Advantage plans was that they offered it as a service, saying if you enroll in our Medicare Advantage plan, the provider will receive the capitated payment. They would offer the senior daycare centers or facilities who provided them social work, et cetera, but the transportation was always a headache in Las Vegas because the vans and transportation were not equipped and did not have the ability to transport seniors with disabilities. If you are going to agree to get the capitated payment, there should be some level of security that you are actually delivering on that, and that you are not avoiding picking people up and shifting them to the insurance carriers simply because you just do not have the means to do.

So, that is more of an implementation thing—that is not really on the policy lens. I just want to make sure we are clear that there are requirements that are going to have to come forth with you being on the hook for the contract, right? It is not just a free-for-all, and you doing bingo with patients, right?

MR. KURTZIG:
Yes, I completely agree. We are subject to state and CMS audits constantly to ensure that we provide the very services that you are mentioning. We have something called a state authorization agreement, which is basically a tri-party agreement between the provider—us or anybody else—the state and CMS, where we contractually agree to all the services that you just mentioned, including vans that can transport wheelchair-bound people, non-ambulatory people and so forth.

If you do not mind, may I answer the Senator's question about rural areas? Obviously, Nevada is a rural state; Oklahoma is too, with just a few population centers. One of the things we pride ourselves on is being able to deal with rural

populations through telehealth and other sort of workarounds. We make sure that we provide transportation when they need to be in the center, but also contract with local providers and local hospitals in these towns and communities to make sure that they do not have to drive into Reno or into Las Vegas for services they can provide; we still pay for it.

More importantly, we coordinate it to make sure that we track their health throughout the whole entire process. We try to keep them in their home and as close to their home as possible. We also work, in some cases, with local senior centers and other communities that are already established to be the daycare-centers there. A lot of the rules that you are talking about will come in the rules-setting part of how we set the rules for this in Nevada. But yes, I agree that's an important consideration.

CHAIR DOÑATE:
The reason I mentioned this was because I was a part of the program that did it for Medicare Advantage. I saw the downfalls of the complaints that many patients are going to give you. So, in terms of making sure that the services are just, and that people actually get the care that they need, we have to take that into consideration as we are doing the rulemaking process. It is not a no; we should not do this; it is a yes, 100 percent, we should do this. We want to make sure that if we are going to do this, then you are going to do the services that you are entrusted to do and deliver on. I just want to make sure that we are on the same page for that.

SENATOR TITUS:
I appreciate the questions about the rural area. One of the things you mentioned just now was the telehealth component of this. Frequently, out in the rural areas, we do not have good Internet service. Our patients may not even have a computer. So how will that be part of the set up and part of the overall coverage for that access?

MR. KURTZIG:
The answer to your question is, I do not know. I am happy to tell you what I know and happy to tell you when I do not know. For telehealth, we do not really need a Zoom or screen; a telephone call is okay in some cases, and I assume most people have access to that kind of technology. So, I do not know. I can tell you what we do in Oklahoma. We do a combination of regular

visits, telephone calls, Zoom, FaceTime, those type of things. I do not know how it would work here to be honest.

SENATOR TITUS:
Thank you for that because out in rural Nevada, my cell phone does not work most of the time. If you are looking at going out to rural Nevada to see some of my patients when I go out, I have Starlink for my Internet service. I have that satellite with me so I can have cell service, emergency contacts and whatever. I just would want to make sure that that would be part of the coverage to say we will cover everybody with telehealth. It is a lot easier said than the reality of it. A lot of my rural folks are not going to use the cell phone because it is just not available. To fully grasp this concept, I want to make sure that the coverage promised for rural health is aligned with the actual deliverables. There is a recurring pattern of discrepancies between what is promised and what is delivered, and this must be addressed.

I appreciate you saying you just do not know because that is the best answer when you do not know. It is a unique bird out here with our mountains. Oklahoma is a different setting; the mountains are not the same and the cell service just does not get through. So, I would just caution you about making sure about that accessibility. Per our Chair's comment regarding transports and making sure that there are ride services, which is a big issue in getting the patients. I would always see a patient who walks through my door but getting them to that specialist in another area is a huge concern. Making sure that transfer is included and not only yes, it is included, but if there's nobody that does that transportation there, I mean, that is also a concern. You promise the moon, but then there are no satellites and there are no lunar landings. I really have concerns about that.

MR. LIST:
I, too, have family in rural Nevada and I know exactly what you are talking about when you talk about those challenges. We've had that discussion with Stacie Weeks and her staff, I know that that is a big concern on her part. We were asked about it. Valir does have a territory that they are expanding into, including Native American communities in Oklahoma. They are having some new experiences with that. It is fair for me to say that Valir or any other provider that you would deal with as a State will try to be creative and look for ways. The law of PACE allows a lot of flexibility to be creative and work out ways to reach rural Nevada. I certainly want to see that; I know they do too.

CHAIR DOÑATE:
I understand there's going to be a procurement process that we can probably amend into the bill and talk more specifics about that. In the other states where you have seen this, is there a minimum standard of what types of services are offered in the PACE program? For example, if we wanted to say every facility that is open under the PACE program, in exchange for you getting a capitated payment, you have to offer primary care, behavioral health care, dental, diabetes care and cardiovascular health, right? Those are the top issues that we know seniors suffer from and every center must have that as a base minimum. Have other states considered that as part of opening these centers? I know there's a differentiation of whether you want to have physical therapy, wellness, et cetera, but is there at least a standard of what you have to offer?

MR. KURTZIG:
There is a body of at least 17 services that by federal law we must provide, including everything that you mentioned. I think someone from the National Pace Association (NPA) can provide the details. But as we go through the process, you'll see that we provide more than the 17 minimum requirements. Everything you have mentioned, diabetes care, primary care therapy, everything else, there's no choice. We must do that as part of our contract.

CHAIR DOÑATE:
I do not think we need to go into detail right now. But if you could just send me the follow-up for it, I would like to read more about it.

MR. DELGADO:
Slide 7 in Exhibit K was provided to us by the NPA. Like an FQHC, we are required by the federal government to provide services to cover our patients. To answer your question, we will get you an updated list of services, but this is the required list that was provided to us as of last week. Every state may add additional services, but transportation is one of those, as part of this whole entire algorithm, in terms of what the capitated rate looks like. Again, like an FQHC, it is very heavily audited, regulated by the federal government and provides patient-centered care. You have to provide all these services under one roof. If the patients do not receive that under that one roof, the services are provided to them one way or another and is covered by the entity that is providing the PACE program.

NANCY J. BOWEN (CEO, Nevada Primary Care Association):
We represent the State's Community Health Centers, otherwise known as FHQCs, which provide comprehensive primary, dental and behavioral health care to over 116,000 Nevadans. Our members have been interested in participating in the PACE program for about the last eight years. Although the conceptual amendment expands eligibility for participating in the program, we are grateful for recognizing the value of health centers in delivering these services. We are in strong support of S.B. 207.

KELSEY AVERY (Director, State Government Affairs, SCAN Health Plan):
I am here to testify in support of S.B. 207, which requires the establishment of a PACE program in Nevada. The SCAN Group is a leading not-for-profit healthcare organization dedicated to keeping seniors healthy and independent. Nearly 50 years ago, SCAN, which is short for Senior Care Action Network, was founded by a group of fiercely independent seniors who knew there had to be a better way to get the medical and social services they needed to live safely at home as they got older. Today, SCAN serves over 300,000 individuals through Medicare Advantage, and we are proud to be a growing plan option for Nevada seniors since 2021.

Our dedication to our mission of keeping seniors healthy and independent led SCAN to co-launch myPlace Health, which provides comprehensive personalized care through the PACE model. Today, myPlace Health offers health coverage and services at no or low cost to PACE-eligible seniors within the Los Angeles service area. Under the PACE model, myPlace Health provides and coordinates the entire continuum of health care and supportive services for which a participant is eligible under both Medicaid and Medicare. From preventive care to hospitalizations to long-term care to nutritious meals and social activities, myPlace Health helps high-functioning interdisciplinary teams of physicians and other healthcare professionals to develop customized care plans that reflect each PACE participant's life goals so the care they receive is customized to their individual preferences.

You've already heard a fair bit about the PACE model during this hearing today, so I will not repeat what other presenters have already shared. I will simply reiterate that PACE promotes independence and the highest levels of functioning for vulnerable older adults, while allowing choice and dignity for both enrollees and their families. I also emphasize that PACE has earned wide recognition as a top-performing and cost-saving model for seniors with complex health and social

needs. For example, one study found that PACE enrollees cost the state's Medicaid program about 40 percent less than the average amount that would have been paid for a similar Medicaid member who is not enrolled in PACE.

As a mission-driven organization dedicated to keeping seniors healthy and independent, the SCAN Group strongly supports the PACE model and S.B. 207. We look forward to Nevada joining 33 states and the District of Columbia in making this highly effective program available to older adults in our communities. We urge the committee to vote yes on S.B. 207.

MS. NGUYEN:
We are supportive of comprehensive care. Many times, wraparound services are critical to successful care, especially preventative care; therefore, we are supportive of S.B. 207.

PETER FITZGERALD (Executive Vice President, Policy and Strategy, National PACE Association):
I speak in support of S.B. 207. Given that individuals aged 65 and older are the largest age group in Nevada, the NPA has long supported and advocated for PACE in Nevada. PACE is a program, as you have already heard, that helps older adults who need long-term care, live at home with a higher quality of life and at a lower cost through PACE. Older adults continue living in their own home rather than in a nursing home. The comprehensive and integrated services of PACE simplify access to needed care. Older adults in PACE have better health outcomes and a higher quality of life and PACE lowers the cost of care for individuals, families and taxpayers.

It is notable that PACE programs are serving a population that is entirely at a nursing home level of care. Yet, 95 percent of the people in our care can continue living at home. Within that percent, 50 percent of the people that we are taking care of have Alzheimer's. The PACE program has proven it is successful, really helping some of the most difficult to care for and most vulnerable individuals, live at home and offering their family caregivers the support they need so that they can remain a part of their loved ones' lives while also carrying on with their own lives.

There's been some discussion about PACE in rural areas. We have a significant number of PACE organizations operating in rural areas across the country and they've been extremely successful there. We see in rural areas, a higher uptake

of the PACE program as a percentage of the population in that community that need care than we see in urban areas. That largely reflects the fact that many rural areas lack access to care and that problem is only getting worse as we see some of the financial strains that are leading many rural long-term care facilities to close.

A recent report by the National Advisory Commission on Rural Health and Human Services highlighted PACE as a solution for offering better care to older adults living in rural areas. You can find that report on the U.S. Department of Health and Human Resources website and the study that underlined it was led by former Governor Jeff Collier of Kansas, underscoring support of the federal government for PACE in rural areas.

The Health Resources and Services Administration's Office of Rural Health Policy recently issued an opportunity for funding notice to support the development of PACE in rural areas. That opportunity is currently live with the due date of April 17. So, we are seeing a lot of success in rural areas. I want to also stress the integrated care nature of PACE, unlike some of the other programs that we have heard about with Medicare Advantage special-needs plans. Program of All-Inclusive Care for the Elderly is actually a provider, not only a health plan. The PACE organizations have learned to integrate the care of the people that are in their care along with the responsibilities of receiving and operating as a small specialized health plan for a particularly challenging population. Given the higher outcomes and saving dollars, NPA urges the Legislature to move forward with this bill and bring PACE to Nevada.

MARIE BAXTER (CEO, Catholic Charities of Northern Nevada):
As one of the largest providers, not only in the metropolitan Reno-Sparks area, but in rural Nevada and working with our tribal communities, I want to offer my support for S.B. 207. There is so much need for seniors and those populations that we see daily. I think PACE programming would make a tremendous difference in the lives of seniors.

BARRY JOHNSON:
We need the Nevada ADSD to protect families, not tear them apart. Your actions to lower pay for doctors and use residency students instead destroyed many families' lives. We have lost almost everything taking care of my mom. My 89-year-old dad almost died helping her because I had to work.

Dementia patients are in danger because the government cuts doctor pay. Metro [*sic*] has no way of helping families get elderly parents to the hospital when they need help. When my mother stopped taking her dementia medication because it made her urinate more, Metro [*sic*] had to help us convince her to go to Southern Hills saying that we were all going with her but had no legal way to force her to go. And what did we find at Southern Hills? A horrible psychiatric attendant … [unintelligible statement] … who left on vacation leaving a student doctor illegally in charge for the weekend. My mom was left in a hospital bed, dementia spiraling out of control. We brought her home. She was worse.

The big beg … [unintelligible statement] … to multiple doctors, they psychiatric, not social workers, whether they do. Social workers told my mother we are trying to put her in a home; that reckless statement turned her against us and made her become convinced that we were her enemies instead of ADSD helping us. They started a protective order against my dad, and this was laughable and then … [unintelligible] … angry to take the dementia patient off her medication. If we had not tracked down the social worker and went to the ADSD office for intervention, they might have taken my mother away from us entirely. The family court failed to understand the reality of dementia … [unintelligible] … attempted to and attorneys and social workers instead of medical professionals who could help, which we had to stop to keep her from thinking we were trying to put her in a home.

Now the most painful part, my mother died on February 18th, almost a month ago due to … [unintelligible] … Spring Valley doctors. And just three hours ago, Spring Valley contacted me to set up an institutional Medicaid appointment weeks after her death in two extra weeks before we try to make that happen. To make matters worse the undereducated doctors at Spring Valley still have not signed her death certificate leaving the official cause of death unknown so she is still at the funeral home. This is not just scary; it is a disgrace. Her good doctors left because … [unintelligible] … wants more resident doctors to help her stock portfolio instead of restoring doctor pay rates, so we have good doctors. For years we have been told that our system will protect the elderly, the hospitals, the agencies and reports to support families in crisis.

But, I experienced the failures and the difference and the … [unintelligible] … was proof that the vets [*sic*] medical system is just not feeling the elders, instead of getting of care, we got bureaucratic red tape; instead of doctors, we got social workers that are unqualified to handle dementia; instead of

compassion, we got legal threats against the very people who are trying to help. It is not my tragedy; it is a warning if this system is not held accountable, this will happen to countless other families.

SENATOR TAYLOR:
I want to say that because of the work of Assemblymember Sheila Leslie in 2009, the State can have a PACE program. This is going beyond saying we can have one. It is saying we will have one, and today, we have more seniors in need of this program than we did back in 2009. I urge you to vote to support S.B. 207.

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CHAIR DOÑATE:
In addition to the testimony we heard today, our committee secretary received one letter in support (Exhibit L) for S.B. 207. The hearing on S.B. 207 is now closed and that concludes our presentations today. Hearing no public comment, the meeting is adjourned at 5:32 p.m.

RESPECTFULLY SUBMITTED:

Norma Mallett,
Committee Secretary

APPROVED BY:

Senator Fabian Doñate, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
S.B. 138	C	2	Senator Nicole J. Cannizzaro	Conceptual Amendment
S.B. 138	D	11	Crissa S. Markow	Support Letter
S.B. 138	E	11	Anthony J. Markow	Support Letter
S.B. 138	F	11	Robert Haynes	Support Letter
S.B. 138	G	16	Rebeka Acosta / A +J Patient Advocacy	Support Letter
S.B. 138	H	17	Senator Fabian Doñate	Three Letters in Support
S.B. 138	I	17	Senator Fabian Doñate	One Letter in Neutral
S.B. 207	J	18	Senator Angela D. Taylor	Proposed Amendment
S.B. 207	K	19	Oscar Delgado / Community Health Alliance	Presentation – Bringing the Program of All-Inclusive Care for the Elderly to Nevada
S.B. 207	L	37	Senator Fabian Doñate	One Letter in Support