MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-third Session
March 13, 2025

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:30 p.m. on Thursday, March 13, 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 Ira Hansen, Senatorial District No. 14
Senator Julie Pazina, Senatorial District No. 12
Senator Melanie Scheible, Senatorial District No. 9

STAFF MEMBERS PRESENT:

Destini Cooper, Committee Policy Analyst
Eric Robbins, Committee Counsel
McKenna Melvin, Committee Secretary

OTHERS PRESENT:

Steven A. Shane, Renown Children's Pediatric Specialty Care, Healthy Lifestyles Clinic, Renown Children's Hospital
Carissa Pearce, Children's Advocacy Alliance
Terence R. McAllister, President, Nevada Chapter of the American Academy of Pediatrics
Bradley Mayer, Southern Nevada Health District

Jacqueline L. Nguyen, Nevada State Medical Association; American College of Obstetrics and Gynecologists
Kristina Deeter, Chair of Pediatrics, School of Medicine, University of Nevada, Reno
Schauntelle Puliti, Metabolic and Bariatric Surgical Program Manager, Renown Health
Barry Johnson
Amy Shogren, Novo Nordisk
Paul J. Hauptman, Dean, University of Nevada, Reno, School of Medicine
Chris Nicholas, CEO, Renown Regional Medical Center
Marc J. Kahn, Vice President, Health Affairs; Dean, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas
Jeff Murawsky, Chief Medical Officer, HCA Far West Division
Claudia Watkins, Medical Student, University of Nevada, Reno
Maureen Scott, Medical, Student, University of Nevada, Reno
Jacob LaMay, Medical Student, University of Nevada, Reno
Wolfgang G. Gilliar, Dean, College of Osteopathic Medicine, Touro University Nevada
Kelsie Little, Medical Student, Touro University Nevada
Raul Marquez, Medical Student, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas
Trevor Parrish, Vegas Chamber
Nancy Bowen, CEO, Nevada Primary Care Association
Damon Schilling, Intermountain Health
Natalie Osborn, Medical Student, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas
Mary Patricia Ann McDonough, Medical Resident, Family Medicine Clinic, University of Nevada, Las Vegas
Regan Comis, University Medical Center of Southern Nevada
Allison Herzik, Dignity Health–St. Rose Dominican
Alejandro Rodriguez, Nevada System of Higher Education
Patrick D. Kelly, President and CEO, Nevada Hospital Association
Blayne Osborn, Nevada Rural Hospital Partners Foundation
Salvatore Robert Aiello, Medical Resident, University Medical Center of Southern Nevada
Emily Oberlies, Medical Student, Touro University Nevada
A'Esha Goins
Dylan Keith, Southwest Gas
Jesse Wadhams, Vegas Chamber

Kanani Espinoza, AT&T
Misty Grimmer, Cox Communications
Kurt Berner, Las Vegas Chapter, National Utility Contractors Association
Paige Barnes, Lumen
Shelly Capurro, Charter Communications
Brian Reeder, Verizon
Garrett Weir, Commission General Counsel, Public Utilities Commission of Nevada
Paul Maguire, Engineering Manager, Public Utilities Commission of Nevada
Rhonda Martines
Heather Richardson
Carlos Hernandez, Nevada State AFL-CIO
Ross Kinson, Northern Nevada Central Labor Council
Robin Franklin, Division of Child Protective Services, Clark County Department of Family Services
Shalonda Adams, Clark County Department of Family Services
Casey Stimpson, Clark County Department of Family Services
Andrew Rivas, Teamsters Local 533
Alexis Esparza, SEIU Local 1107
Sarah Evans, Clark County Department of Family Services
Michelle Maese, President, SEIU Local 1107; Clark County Department of Family Services
Ashley Dodson, NAACP Las Vegas #1111
Richman Warnke, SEIU
Joanna Jacob, Clark County
Cadence Matijevich, Washoe County
Christal Sanders, Clark County Department of Family Services; SEIU Local 1107

CHAIR DOÑATE:
We will open the hearing on Senate Bill (S.B.) 244.

SENATE BILL 244: Requires Medicaid to provide coverage of certain treatments for obesity. (BDR 38-206)

SENATOR ROBERTA LANGE (Senatorial District No. 7):
Obesity continues to be one of the most challenging health problems we face both as a State and as a nation. According to the National Library of Medicine, more than 32 percent of American adults are obese and roughly 17 percent of adolescents are overweight. Additionally, Medicaid enrollees have the highest

prevalence of obesity compared to those who are uninsured, privately insured or covered under Medicare. As obesity rates continue to increase, so does the prevalence of chronic diseases such as hypertension, diabetes or stroke which as we know, further strains the healthcare system.

Currently, eight states have expanded Medicaid programs to cover all recommended obesity treatments for adults and ten states reimburse for obesity-related treatments for children. I have Dr. Steven Shane with me, and he will go through the sections of the bill.

STEVEN A. SHANE (Renown Children's Pediatric Specialty Care, Healthy Lifestyles Clinic, Renown Children's Hospital):
I am a pediatrician who practices pediatric obesity medicine. In Reno, I run the Healthy Lifestyles Clinic at Renown Children's Hospital. Every day I see multiple children and adolescents with chronic disease of obesity which is not their choice. This is a complicated multifactorial disease with many associated comorbid conditions. Every day I am severely limited in the care that I can provide my patients, particularly those with Medicaid coverage. I typically cannot offer the best evidence-based therapies because Medicaid does not cover these options. It is no different than not having the best therapies for other diseases such as asthma, diabetes or even cancer which are all associated with obesity.

My patients suffer with a lower quality of life and with many other associated conditions like depression, low self-esteem, diabetes, liver disease, high blood pressure and high cholesterol, just to name a few. Those will continue to escalate and affect their lives and productivity as they become adults. Today, I am asking you to look at the long run regarding healthcare outcomes and costs, and do the right thing for individuals suffering with obesity and let us stop treating those with obesity as second-tier citizens. I have submitted a presentation (Exhibit C contains copyrighted material. Original is available upon request from the Research Library.).

The language for the digest of this bill in section 1 says Medicaid will cover intensive health, behavior and lifestyle treatment for obesity. Medicaid will cover at least one FDA-approved anti-obesity medication. Medicaid will cover any surgical intervention for obesity included in the most current guidelines of the American Society of Metabolic and Bariatric Surgery (ASMBS) and the International Federation for Surgery of Obesity and Metabolic Disorders (IFSO).

Medicaid will cover the Diabetes Prevention Program for those meeting eligibility requirements. In section 2, Medicaid must include a list of preferred prescription drugs approved by the FDA with an indication for chronic weight management in patients who have been diagnosed with obesity.

Section 3 requires the director to administer the provisions of section 1 in the same manner as other provisions governing Medicaid. Section 4 requires the Department of Health and Human Services (DHHS) to notify the recipients of Medicaid when such coverage becomes available. Just a reminder, obesity is a chronic disease. It is not a choice, and it is very complicated. It is a behavioral, progressive, relapsing disease that causes much metabolic dysfunction in our bodies. It can affect all organ systems from head to toe. It can even be associated with Alzheimer's disease. It is associated with 13 cancers. It is second to tobacco as a leading cause for cancer.

Looking at Nevada for obesity, when adults are asked if they are obese, a third will answer yes. If you measure these adults for body mass index (BMI), it would probably be more likely at 40 percent. Another third of our adult population is overweight. Then certain ethnicities have much higher proportions of obesity such as Native Americans, Black people, Pacific Islanders and Hispanics. Approximately $1.7 trillion is the cost our country will spend every year on obesity. Indirect healthcare costs are at least a third higher, if not more, for people with obesity.

Looking at data from 2019–2023, our Washoe County children in Grades 4, 7 and 10 who have had BMI measurements—a little over a quarter of those measured in 2023—have obesity and another 16.5 percent were overweight. So, approaching half of these kids have an unhealthy weight. Things are even worse in Clark County. In the 2021-2022 school year, a third of the kids were measured to have obesity and another 17 percent overweight. So, half of these kids, and that is a lot of kids in Clark County, were either overweight or obese.

Let's get to the bill itself as far as what it is asking for and that is intensive health, behavior and lifestyle treatment, which is the foundation of obesity treatment and can provide anywhere from 3 percent to 7 percent reduction in BMI. Currently, Medicaid provides nutritional therapy for just 4 hours over 12 months. This kind of therapy really calls for not only nutrition counseling, but physical activity and mental health counseling as well as other factors including sleep and everything that goes into wellness. The American Academy of

Pediatrics (AAP) and the U.S. Preventive Services Task Force have recommended children get 26 hours or more of contact time over 3 to 12 months to be effective. For adults, the Obesity Society and the American Heart Association recommends adults get 14 visits or more over 6 months to get the same benefit.

We have some good medications available now and sometimes these can provide up to 25 percent reduction in BMI. Medicaid in Nevada recently started covering Wegovy in adults who are overweight or obese, but with established cardiovascular disease only. This means that you must have had a myocardial infarction or heart failure, or some sort of other cardiovascular disease documented. The AAP and the FDA approve and recommend these medications for children 12 years of age and older with obesity. The American College of Endocrinology and the FDA recommend adults with overweight- and weight-related complications or with obesity with or without complications, be offered these medications. Bariatric surgery, our most durable and sustaining therapy for obesity, we typically see 25 percent to 30 percent reduction in BMI; it is very significant. Currently, Nevada Medicaid covers those 21 years and older with severe obesity and a complication such as diabetes. The ASMBS and IFSO guidelines for children with severe obesity with complications recommend they be considered for surgery. That applies to those with the most severe form Class 3 obesity with or without complications. For adults, it is just obesity alone—a BMI of 30 or greater with complications and severe obesity at Class 2 and Class 3 with or without complications.

Lastly, the Diabetes Prevention Program can provide up to 5 percent to 7 percent BMI reduction. Currently, Nevada Medicaid does not cover this. This is a Centers for Disease Control and Prevention-approved 12-month lifestyle change program. Basically, it is an intensive health, behavior and lifestyle treatment for adults to prevent or delay the onset of Type 2 diabetes and those with high risk. This is typically provided in group sessions by health organizations, educational institutions or community organizations such as YMCAs. The benefits are tremendous: diabetes risk reduction of 58 percent at 3 years, 34 percent at 10 years and 27 percent at 15 years. Medicare currently reimburses $550 for 22 sessions per 12 months. So, it is a cheap type of treatment to provide a lot of return on investment.

The benefits of obesity treatment are a lot of healthcare cost savings down the road, reduced hospitalizations and medications for comorbid conditions like

diabetes, high blood pressure, high cholesterol and heart disease. In 2021, Nevada Medicaid spent $313 million alone for cardiovascular disease, diabetes and cancer. There are also workplace and disability savings. One trillion dollars was spent or lost to decreased productivity in the U.S. alone in 2018. Treating obesity reduces absenteeism, increases productivity and reduces disability and workers' compensation claims. For insurers and employers, it is a potential 2:1 to 3:1 return on investment in treating obesity.

Some real numbers are shown in Exhibit C: 2018 numbers on the top and then on the left are the 2024 adjusted numbers. We have normal weight individuals and then, moving from Class 1 to Class 2 to Class 3 obesity, you can see how not only medical costs but also indirect costs go up. Absenteeism, disability claims and decreased productivity more than double when you go from normal weight to Class 3 obesity.

Another study in 2024, in the *Journal of the American Medical Association*, shows annual healthcare savings varied from hundreds of dollars to thousands with a 5 percent weight loss going up to 25 percent weight loss. The greater the baseline BMI, the greater the savings that were realized at each percentage of weight loss. The comorbid conditions realizing the greatest savings were diabetes, arthritis and back problems.

Looking at some specific numbers on the top part of the graph in Exhibit C, slide 17, individuals with more comorbidities have greater annual direct medical costs. So, moving from someone with obesity, annual medical costs of approximately $5,000 to $6,000 and moving across to those who have three or more obesity-related complications, you can see the cost more than triples. At the bottom part of the graph, we have a group of 100,000 individuals with a theoretical 15 percent weight loss and this shows us what would happen over a five-year period with direct medical costs. You can see a cumulative total of almost $85million saved if these 100,000 individuals with obesity and complications lost 15 percent weight. This is something easily obtainable with current medications and bariatric surgery.

Here are some real numbers from the Nevada Public Employees Benefit Program. This is an obesity care management program offered to participants. It is a voluntary program. On the graph, Exhibit C, slide 18 you can see participants in the left column and nonparticipants in the right column. Moving all the way down to the bottom, you can see annualized individual cost per member per

year. This is data from the latter half of 2023, and you can see a cost of approximately $5,000 for an individual in the obesity care management program per year. The cost is almost $11,000 for an individual with obesity who did not participate in the program. This is mostly savings through fewer visits and lower amounts of hospitalization.

Looking at medications, we all know these medications are extremely expensive. Exhibit C, slide 19 shows real-life utilization from 12 states that cover GLP-1 medications such as Wegovy and Zepbound, and these are utilization rates based on eligible Medicaid participants. We can see the range is small. California, for instance, is 0.13 percent GLP-1 utilization and Minnesota has the highest utilization rate at 3.16 percent. Many people do not take advantage when they are eligible. Slide 20 in Exhibit C shows a study being conducted to look at state Medicaid liability over a five-year period, if a Medicaid program added anti-obesity medications to their preferred drug list. I have highlighted cost offsets for improved outcomes when treating obesity. This is the state portion with the current formulation of state and federal funding, and it estimates it would cost anywhere from 4 cents to 7 cents per member per month for this additional coverage. They used a higher utilization rate in this study than we saw in that last slide of 3 percent to almost 6 percent utilization. This potentially could be covered by the offsets in the healthcare savings that I just demonstrated in the previous slide. It offset what we are potentially anticipating from decreased Medicaid dollars from the federal government.

Lastly, on slide 21 of Exhibit C, is bariatric surgery utilization. Since we are looking at providing the service for individuals under 21 years of age, I am looking at 12- to 19-year-olds. Only about 1,700 procedures are performed annually on adolescents in the U.S. Many are eligible, and just like the medications not many actually get the procedure done. Only about 4.5 procedures per 100,000 adolescents are performed nationally and only about a third are Medicaid patients. If we look at the 12 percent of Nevada's 3.26 million individuals 10 to 19 years of age, that is only about 400,000 individuals. You will see this is a pretty low number of procedures that would be done in individuals under 21 years of age. Vertical sleeve gastrectomy costs about $15,000 to $25,000 nationally. In Reno, it is about a $15,000 to $18,000 per procedure. Insurers can easily recover costs within two to four years after the procedure because of the healthcare savings from reversal of complications such as diabetes, hypertension, hypercholesterolemia and

obstructive sleep apnea, just to name a few. Cost effectiveness has been demonstrated in adolescents in the United Kingdom, as well as the U.S. In summary, comprehensive obesity treatment improves healthcare outcomes, quality of life and has been shown to be cost-effective. I am asking this committee to strongly consider giving my patients a chance in this State, and the tools needed to become healthier, happier and more productive citizens.

SENATOR TITUS:
You mentioned pediatric bariatric surgery. Do we have any providers who do that in Reno because I was not aware of that?

MR. SHANE:
We do have two providers who are qualified to provide that service.

SENATOR TITUS:
In Clark County, do they have the services available there?

MR. SHANE:
I am pretty sure there are surgeons available who are qualified to provide that surgery.

SENATOR TITUS:
I just want to make sure some of these treatments are indeed available in Nevada. We hear all the time that, especially in the pediatric world, we are sending people over to Stanford [University Medical Center] or Oakland Children's Hospital [UCSF Benioff Children's Hospital Oakland]. In Clark County, we hear about parents having to take their children out of State and I just want to make sure that these services are indeed available to our Nevadans. During your testimony, you stated that several states have already applied for this Medicaid waiver. Are they getting approved?

MR. SHANE:
Yes, they are getting approved.

SENATOR TITUS:
So, it's been standardized now—the federal government has approved this already?

SENATOR TAYLOR:
This is a really important issue. How many people in our State now are participating in these kinds of programs, adults or children? Do you have any numbers, not related to Medicaid, but just in general?

MR. SHANE:
I do not think we have any data. I am not sure if anyone has any data as far as numbers participating in all these programs.

SENATOR TAYLOR:
Do you have any data relating to the medications that we are talking about adding from a Medicaid standpoint?

MR. SHANE:
I am sorry, I do not have any numbers.

SENATOR TAYLOR:
Okay. I was just wondering how many people are already involved in this that are not on Medicaid.

MR. SHANE:
I do have patients who are on some of these medications, but I could not give you statewide data.

SENATOR STONE:
Obviously, these services are dramatically needed here. You mentioned GLP-1 drug utilization in Nevada. My understanding is that this is now Medicaid payable in the 12 states you had in your chart that have been approved. As a part of this legislation, you are recommending that just one drug of this class be approved, or can a doctor prescribe any of these particular drugs? I can give you the list of all the GLP-1s, but I am sure you know them all.

MR. SHANE:
We are asking for at least one FDA-approved drug be approved.

SENATOR STONE:
So, this will be on a Medicaid formulary then where one drug will be chosen out of the roughly seven?

MR. SHANE:
Yes, at least one.

SENATOR STONE:
Will there be any criteria if somebody has an allergic reaction to one? Will they be able to get on another one? These are pretty important drugs and have had quite a success rate. I was wondering if you entertain the thought of anybody having an adverse reaction to one that they might be able to go to another one. Of these GLP-1 drugs, how would you recommend the one be chosen? Do you have any advice as to which one should be on the formulary or not on the formulary?

MR. SHANE:
The verbiage is at least one. I hope there would be more than one chosen to be on the formulary by the state committee which oversees the state formulary.

SENATOR STONE:
I would hope that there would be a choice. From a pharmacy benefit manager standpoint, it's possible to negotiate deals for these expensive drugs to minimize the financial burden on taxpayers. And then, once the program gets approved, how are we going to reach out to these Medicaid recipients and let them know about the 30-day notification period to get them acquainted with the program?

MR. SHANE:
I am not sure what the typical procedure is for that when Medicaid approves new services.

SENATOR STONE:
I assume the doctors will reach out to these patients and let them know they have a new drug. Getting back to bariatric surgery, is that now covered in any way under Medicaid in Nevada?

MR. SHANE:
It is covered for 21 years of age and up with severe obesity and a complication from that obesity.

SENATOR STONE:
Will this legislation change that?

MR. SHANE:
This is to cover it for not only adults, but also adolescents, based on the guidelines from those two surgical societies which I mentioned in the presentation.

SENATOR STONE:
Okay, and other states have been successful in getting this approved?

MR. SHANE:
Correct.

CHAIR DOÑATE:
The program that you administer here in Nevada is specifically focused on pediatrics. Is that correct?

MR. SHANE:
That is correct.

CHAIR DOÑATE:
But the bill does not reference that. In the bill, there is no age limit from my understanding.

MR. SHANE:
Correct, this would cover all ages.

CHAIR DOÑATE:
Let's say I am a patient whom you have determined to be prediabetic. So, explain to me the diagnoses in terms of how you prescribe my treatment under this bill. Is the preference to first go towards intensive health behavior and lifestyle treatments? How do you determine the acuity of whether someone should get bariatric surgery from the outset that you meet them?

MR. SHANE:
I follow the AAP Clinical Practice Guidelines that goes through the recommendations based on age and severity of a disease. Obviously, it depends on those variables, and it is well delineated in that document that came out two years ago.

CHAIR DOÑATE:
In terms of the guidelines, for you to determine whether a patient is going to go through bariatric surgery and so forth, as a recommendation based on the treatment, there could be a wide variety of factors including age, BMI, glucose levels, et cetera. There's a variety of factors that contribute to it, correct?

MR. SHANE:
Correct.

CHAIR DOÑATE:
From my understanding, to reach the bariatric surgery level or say semaglutide being prescribed as a potential mechanism, the goal usually is to provide at least the lifestyle changes or the recommendations first before escalating. Is that correct in terms of practice?

MR. SHANE:
Currently, that particular guideline that I was just mentioning is from the AAP. Their current recommendation, if a child is 12 years of age and older and they have obesity, is to provide intensive health, behavior and lifestyle treatment and also to offer anti-obesity medications simultaneously. If that same patient would happen to have severe obesity with a complication or the most severe form of Class 3 obesity with or without a complication, the recommendation is to consider a surgical consultation also.

CHAIR DOÑATE:
Now let us think of the semantics of when you apply the bill. What's stopping the provider from prescribing or recommending treatment of say Ozempic or bariatric surgery for every patient who walks through their door instead of doing the interventions?

MR. SHANE:
That's an excellent question. That is something I would have to rely upon people practicing good medicine like we do for a lot of different situations as far as doing what is considered current and evidence-based to provide that kind of care in the correct fashion.

CHAIR DOÑATE:
The reason I am asking that question is because I am familiar with the structure of what other states have gone through. This is an expensive program in

general, and the public health concern is if doctors are now empowered to get reimbursement for a specific procedure, what is stopping you from recommending the procedure that is going to pay you the most? We are missing the critical piece—which is that obesity is a complex issue and a lot of it can be influenced by dietary and behavioral health aspects. The preference has been to focus on that.

Now in terms of prediabetes and so forth and managing folks who have been diagnosed with Type 2 diabetes, you hinted that there is a level of acuity that could be prescribed for say the patients with the highest critical need—the ones that are most pressing. The difficulty that I am trying to accept is what is stopping a physician from just recommending—I know the standards are there, and that we all try to adhere to the same standards—but we miss the critical piece of teaching kids what lifestyle changes they need to make. That is not to say that all physicians are going to apply the same standards. They all have different mechanisms of how they interact with patients.

The last thing that is more concerning is mandated coverage. Right now, there's a sensationalizing of obesity medications. If I am a pharmaceutical company and a state were to pass this requirement, the first thing I would do would be to send as many representatives as possible. If the mandate is on the coverage of it, there's nothing stopping me from doubling or tripling the cost of the prescription medication because now it is mandated via state law.

I am trying to understand how we can ensure there are guardrails stating that the prescriptive treatments are medically necessary versus saying that any doctor can recommend. Now we have to prescribe it via medication or whatever the treatment is, considering how costly it is already because of the sensationalizing that has occurred in the media for patients to ask their doctor for this prescription or treatment. I do not know if you have any commentary on that, but that is my concern more on the public health aspect of it.

MR. SHANE:
As far as the medications are concerned, and other treatments being asked for coverage in this bill, maybe we should add some additional verbiage that would provide more delineated criteria or reference the clinical practice guidelines. Guidelines are referenced for the surgical end of the bill and those are very well delineated. But as far as the intensive health behavior, lifestyle treatment and

the medication part, perhaps adding guidelines that need to be followed in accordance with the prescribing practices.

CHAIR DOÑATE:
Just to make sure that we are on the same page, the question is not what services to provide. The difficulty is how costly they are to maintain as part of our state Medicaid program, on top of the other needs that we have. Are we missing the public health piece, which we need to ensure that people are educated in terms of lifestyles? In terms of healthcare delivery, we always look at the invasive stuff last and we look at the prevention stuff first because there are a lot of things that we can do that are very low cost or minimal effort that can go a long way. I just wanted to make sure, and maybe we could just talk offline, about what the guardrails are before you can come in and just say boom, there you go, here's your prescription. That is more of the concern that I wanted to make sure we were on the same page. If there are any recommendations you may have in terms of standardizing the level of acuity of what constitutes certain treatments, that is something we can talk about offline. I do not know if you have any other recommendations.

MR. SHANE:
I do not have any other recommendations at this time.

CARISSA PEARCE (Children's Advocacy Alliance):
The Children's Advocacy Alliance is an independent voice for Nevada's children with a mission to ensure that every child in Nevada thrives. I am here in strong support of S.B. 244, which provides Medicaid coverage for the treatment of obesity for children and all ages, but I am focusing on children. This bill is a crucial step towards improving the health and well-being of children in Nevada, particularly for those in low-income families who rely on Medicaid. Nearly half of the children and families in Nevada who are enrolled in Medicaid are more likely to face challenges affording nutritious foods which can contribute to higher outcomes of obesity for children.

This coverage will ensure that children under Medicaid receive comprehensive care to address and prevent comorbidities including Type 2 diabetes and heart disease, which will lead to better long-term health outcomes. The stigma associated with obesity can have profound effects on a child's mental health. Children who are overweight or obese often face bullying and discrimination which can lead to low self-esteem, anxiety and depression. Providing coverage

for obesity treatment will reduce the stigma associated with obesity and help children improve their mental health. In conclusion, S.B. 244 is a vital piece of legislation that will significantly benefit children in Nevada by addressing challenges associated with obesity. We ask for your support in passing this important legislation.

TERENCE R. MCALLISTER (President, Nevada Chapter of American Academy of Pediatrics):
In full disclosure here, there is a member of our AAP Chapter who'd be a better person to give this testimony and that is Dr. Steven Shane. He is our Chapter's obesity prevention advocate. We know that obesity is a serious chronic illness. There are more than 14 million children in this country who have been diagnosed as obese, making it one of the most common chronic diseases in childhood. We know as pediatricians that our goal is to promote good health and that making good health decisions and having good health early in life means being healthier later in life. Addressing obesity in children in the pediatric population is critical to the long-term health and welfare of this country. We support this bill knowing that obesity is a complicated medical problem. There is no one simple solution and the multifaceted approach that is taken by the AAP and by Dr. Shane in his clinic is what is needed to address this issue.

BRADLEY MAYER (Southern Nevada Health District):
We are here in support of S.B. 244. Of course, there's been a lot of focus on the obesity piece of this, but it also contains the diabetes prevention component, and the need to make good decisions as well. Obesity is a chronic disease that significantly increases the risk for many other chronic diseases—heart disease, diabetes and, in some cases, cancer. You have heard a lot of the statistics in Nevada. Adults at 34 percent and high schoolers at 16 percent have obesity and even over a third of kindergartners are found to have some form of obesity or overweight.

While obesity does impact every community, the data does indicate that it impacts communities of color and low-income communities disproportionately. Despite all these statistics, you have heard a lot about the lack of access due to the lack of coverage. Providing this coverage would not only improve health outcomes but is a cost-effective strategy because of what it costs in our healthcare system. Obesity and excess weight are estimated to cost the U.S. about $116 billion in additional costs. Much of that is borne by Medicare and Medicaid. I will conclude with a study by the National Institutes of Health that

found that relative to the status quo, expanding coverage for obesity treatments would result in an estimated cost savings of about $231 billion for Medicare and $188 billion for Medicaid over the course of 75 years.

JACQUELINE L. NGUYEN (Nevada State Medical Association):
The Nevada State Medical Association supports comprehensive and preventative health care for our patients. Obesity is a major risk factor for numerous chronic diseases. It also impacts both physical and mental health. Offering obesity treatments, including medications and lifestyle interventions, can reduce the associated long-term healthcare costs. While initial treatment may require investment, coverage of obesity, drugs and behavioral treatments can lead to significant savings in the long term by managing or preventing chronic diseases, hospitalizations and expensive interventions in the future. Therefore, we are in support.

KRISTINA DEETER (Chair of Pediatrics, School of Medicine, University of Nevada, Reno):
I am here to speak as a pediatric intensive care physician. After COVID-19, my patients in the pediatric unit were not the same as we were seeing in the adult unit. We saw a drop in our volume on the pediatric side. All the patients I admitted into my unit were 300- and 400-pound teenagers from Northern Nevada, and it was shocking to me. We have continued to work with our providers to provide additional care, to decrease the rate of obesity in Northern and Southern Nevada. What we see is children who have tried the jump ropes and the diets. We all, as pediatricians, provide that advice as much as we can.

These medications have evidence-based research to show that they help drop weight and help these kids get a second chance at life so that they can go into adulthood as healthy adults and not obese adults with diabetes. We are in full support of this bill. As pediatricians, when we refer, we do not get paid for that referral or medications for the surgery. The surgeons that we have in our hospital meet criteria and make sure those patients meet criteria and are very strict in what they do. They are the ones who would perform the surgery on those patients. We do have two very qualified surgeons in Northern Nevada and two in Southern Nevada.

SCHAUNTELLE PULITI (Metabolic and Bariatric Surgical Program Manager, Renown Health):
We are trying to establish a pediatric program for adolescents as well. I do not have anything prepared for you today other than I am on the receiving end, where I host the support groups for these people with these life-changing procedures. In addition to my husband being one of those patients as well, I can speak to that it is life-changing in so many ways. To see them evolve and come into who they truly are, other than this obese person who's labeled as such in society and seen as such, is such an amazing process. I have gotten support group members going in for three years who were going to their weddings, and all these people going to their weddings and supporting them. Without these surgeries, they may have never seen this day or have had the confidence or ability to go out and go back to school and find that one loving person.

From more of a personal standpoint, I know there's a lot of numbers thrown around, but we are missing a critical piece which is these are people. In this bill, these are adolescents who are bullied, get fingers pointed at them and are laughed at. There are pictures taken of them posted online and labeled with memes. It goes so much farther than just the financial piece, and I understand all of that you are pointing out. But gosh, they are people, and they've got this life that they want to live and bloom into and become who they really are meant to be. So, I am supporting that aspect.

BARRY JOHNSON:
I struggle with my weight when I do not exercise and drink sodas and energy drinks. Many presenters are struggling with their weight. These medications alone could balloon healthcare costs dramatically, potentially costing Medicaid upwards of $13,600 per person annually and have serious side effects like destroying the bones of patients. The idea that this expansion will have no significant financial potential impact is laughable. Who are we kidding? We are talking about money from the taxpayers' pockets. We can't continue funding treatment endlessly for individuals who do not take responsibility for their own health.

When does this cycle end? Are we notifying the schools of these kids to make sure that they are exercising and eating a specific diet? Are the parents held liable so that they have to reimburse us for their kids? What about the parents of obese [children], feeding them Ho Hos and Ding Dongs? Should we have to pay for that? Is the evidence he is using from the federal government going to

change now that their focus is on nutrition, and we are taking Fruit Loops off the food pyramid.

Have we looked at how much these guys are making from big pharma companies? Novo Nordisk spent $177 million on paying off doctors; I just looked it up on the open payment portal. Every dollar spent covering the expenses of surgeries and medication for obesity under Medicaid is one dollar less available for critical care to the most vulnerable among us. Children, seniors and individuals with diabetes desperately rely on Medicaid for essential services. But you want to abuse Medicaid for able-bodied, irresponsible people?

If you can't cover kids who are nonverbal and need constant care, what kind of animal would present this waste of money that should be used for disabled people? This is reckless spending strategy that not only threatens the fiscal health of our State, but jeopardizes the very futures of those people really in need. Instead of perpetuating dependency on the pharmaceuticals with known side effects that could lead to even more expensive health complications, let's invest in wise prevention. Medicaid resources should be redirected toward incentivizing people, if you can. The financial impact is laughable. Ask yourself honestly, if obesity medications could cost up to $13,000 a year, how can we argue that there is no impact?

AMY SHOGREN (Novo Nordisk):
I wanted to speak about the proposed amendment (Exhibit D) that is before you. The amendment seeks to provide patients with an option in their treatment plan. In addition to health behavior and lifestyle treatment, they have at least one FDA-approved anti-obesity medication. It does not need to be a GLP-1, and those should be available to patients prior to surgical intervention.

MR. SHANE:
Obesity is not a choice. It is a chronic multifactorial disease process that is out of the control of most people who have it. The best service that we can provide to our Nevada citizens is providing them with care for this very significant disease process that is associated with many complications and will continue to escalate if it starts in childhood. I hope you seriously consider moving this important piece of legislation out of committee.

CHAIR DOÑATE:
In addition to the testimony we heard today, our committee secretary received five letters in support of S.B. 244 (Exhibit E). We will close this hearing on S.B. 244 and will now open the hearing on S.B. 262.

SENATE BILL 262: Revises provisions relating to graduate medical education. (BDR 18-120)

SENATOR JULIE PAZINA (Senatorial District No. 12):
Before we start, I hope you have an opportunity to access the proposed conceptual amendment (Exhibit F) so that I can share why this bill is so important to me, to many of those in this room and around the State. I had the opportunity to knock on doors to meet with my neighbors and ask them, "How can we make your lives better here in Carson City? What can we do to help you improve your daily lives for you and for your family?" I had multiple people on their doorsteps, my neighbors in tears, telling me stories about how their children, their partners and their parents were unable to get into see a doctor, sometimes for months and even longer. The concern over having a sick child or a partner whose condition may deteriorate over time was heartbreaking, not just for them but for me. That is why S.B. 262 is before you today.

Nevada ranks last in the nation when it comes to the ratio of physicians to patients with about 218 physicians for every 100,000 people. Dr. Marc Khan will be speaking with us shortly, and we do have a couple of presenters in Las Vegas as well. The dean of the Kirk Kerkorian School of Medicine at the University of Nevada, Las Vegas, (UNLV) noted in the *Las Vegas Weekly*, "We're short in everything." There's some urgency because if we are going to provide the level of health care that we should provide, we are going to need more healthcare practitioners, and the only way is to grow your own or to import. Dr. Khan also stated that students who complete their residency in Nevada have an increased chance of staying and practicing in the State, which would really help with our healthcare shortage. Currently, Nevada has about 403 federally funded residency positions based on a formula from 1997. Both U.S. Senator Catherine Cortez Masto and U.S. Senator Jacky Rosen made efforts and urged the U.S. Department of Health and Human Services to take the necessary steps to award Nevada more residency slots. However, in the meantime, an effort could and should be made on the State level for passage and approval of S.B. 262.

I will now walk you through the bill. Existing law requires the Office of Science, Innovation and Technology (OSIT) in the Office of the Governor, to establish and administer the Graduate Medical Education (GME) Grant Program to award grants to institutions in the State seeking to create, expand or retain programs for residency. Sections 1 and 2 move the program and the account for the program from OSIT to DHHS. Sections 3 and 6 authorize the money in the account to be used for operating programs for residency training approved by the Accreditation Council for GME or its successor organization. It will be used if the training of residents exceeds the maximum number of full-time equivalent resident positions for which the institution receives direct or indirect GME payments from Medicare.

Sections 3 through 7 transfer the Advisory Council and its duties to administer the program and the account from OSIT to DHHS. Section 8 makes an appropriation of $4.5 million for fiscal years (FY) 2025-2026 and FY 2026-2027. I would also be remiss if I did not thank the many stakeholders who've helped for over two and a half years. I will hand this presentation over to some of the people who critically understand why we are here today.

PAUL J. HAUPTMAN (Dean, School of Medicine, University of Nevada, Reno):
I am here in support of S.B. 262. As committee members know, we have a healthcare crisis in the State related to our workforce. State support for accredited GME programs is the smartest mechanism by which we can count on a growth in the number of physicians. We cannot count on new and expanded federal funding. Despite multiple efforts, there has not been a demonstrable increase in funding in almost 30 years. The 40-60-80 rule applies here: 40 percent of medical students in Nevada ultimately practice in Nevada; 60 percent of residents ultimately practice in Nevada; but importantly, 80 percent of individuals who've received both undergraduate and GME in the State will practice in the State. This ranks us in the top ten in the U.S.

I highlight, as well, that some states have taken the lead here. For example, Texas spends more than $300 million during their biennium to support new and existing GME programs. So, the bottom line here is the growth of GME is pivotal to Nevada's future growth. At the University of Nevada, Reno, School of Medicine (UNR Med), we have an ambitious plan to meet the needs of the State along with Dr. Marc Kahn, Dean at the UNLV Med School. We call it the 5-by-30 plan, or including UNLV, 10-by-30. We are planning to develop five new programs by 2030 at UNR Med and Renown: an OB-GYN residency; an

addiction medicine fellowship, in 2026; a rural track in family medicine; a surgery residency; and a fellowship in cardiovascular medicine. All these training programs will include a component of research and will meet the rigorous standards set by the Accreditation Council for GME.

Expansion of GME and loan repayment programs can help solve the physician shortage. Other novel approaches include additional training programs in other disciplines like medical lab science. In summary, UNR Med supports S.B. 262 and appreciates the engagement of the bill's sponsors. I am also joined today by three third-year UNR Med students, Jacob LaMay, Claudia Watkins and Maureen Scott, who are here to provide personal testimony as to the importance of this legislation.

CHRIS NICHOLAS (CEO, Renown Regional Medical Center):
Renown has participated in GME since the 1970s and, like all GME programs that existed back then, our Medicare funding was capped in the late 1990s so that Medicare could manage its budget. This made future growth of those capped programs difficult since, on average, it costs between $180,000 and $200,000 per resident, per year for three to five years for residents and one to three years for fellows. Today, we fund over 78 residents and fellows and receive Medicare funding for 56. We also receive limited funding from Medicaid. We are funding the training of 22 residents and fellows over our cap. Prior to opening the UNLV School of Medicine and UNR School of Medicine, medical students, residents and fellows received key components of their training in Clark County—for instance, in surgery, OB-GYN and pediatrics.

So, it was not as significant that those GME programs did not exist in Northern Nevada. However, now with our affiliation with UNR Med and the focus of their training being in Northern Nevada, it is important for the medical students, residents and fellows to have exposure to a broad learning environment as they select their specialty and train.

At Renown, we've been working with our academic affiliation partner, UNR Med, to identify the key programs needed to round out the GME learning environment and meet the future healthcare needs of the communities that we serve. Our near-term list includes pediatric residency, which we started three years ago; an OB-GYN residency; rural family medicine track; an addiction medicine fellowship; general surgery residency; and cardiology fellowship. These programs will take a significant investment to start up and to operate. The

resources and much-needed funding for the GME programs, such as the GME expansion needed at Renown, will be provided in S.B. 262.

MARC J. KAHN (Vice President, Health Affairs; Dean, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas):
A lot of what I was going to say has already been said, but a couple of things bear repeating. We have a significant physician shortage in our State. Access to care is a huge problem. Not a day goes by that I do not get an outreach for a connection to a healthcare practitioner. The two ways to get more physicians in our State are either to import more or to grow our own. Dean Hauptman and I have been aligned on this and have been working to show how GME can directly affect our State. As Dean Hauptman stated, but it deserves to be restated, about 40 percent of graduates of a medical school in our State practice here. About 60 percent of residents practice here. But if you do both, that number goes to 80 percent and that is critical for providing the healthcare future for our State. We're, therefore, strongly in support of S.B. 262.

We are in the process of creating a couple of new programs and, as Dr. Hauptman said, we are trying to work together to match State needs. We are in the process of starting a HemOnc [Hematology/Oncology] Fellowship Training Program, the only one in a State, with an aging population where cancer becomes a major problem. We're also well underway in establishing the State's only ophthalmology training program. Again, ophthalmologic services are needed by our communities and certainly needed in an aging community. Other specialties that we are working on include dermatology, urology, anesthesia, and even neurosurgery. We feel that we were woefully underserved vis-à-vis federal support for GME. Those positions, as mentioned, were capped in 1997. We have 403 positions in our State compared to California with over 9,000 and in New York over 18,000. We also brought some students and residents who want to testify about the importance of this bill.

Again, our mission is the same as Dr. Hauptman's mission—to train physicians for the State. Without GME, it is going to be very hard to keep our graduates here. It is absolutely critical for us and our affiliate hospitals—Renown, UNR Med and us. We have residents at both, predominantly the University Medical Center of Southern Nevada Hospital, but also at Sunrise Hospital and Medical Center, and you are about to hear from their chief medical officer. This is critical for the health of our State.

JEFF MURAWSKY (Chief Medical Officer, HCA Far West Division):
We proudly take care of over a million Nevadans every year in our hospitals, including vulnerable pediatric, Medicare and Medicaid populations. An important and critical component of the services we provide in our hospitals is GME. We are part of HCA Healthcare with over 5,400 residents in training at 79 hospitals in 16 different states. We see how different states approach this. We have seen Texas approach this, and in Nevada, we have 284 residents at Sunrise Children's Mountainview Hospital and 18 residents at Southern Hills Hospital. We support the pediatric residency program with UNLV School of Medicine at Sunrise Children's Hospital with 19 positions that are part of that 1997 cap that was mentioned before. Sunrise Hospital has over 800 patients and a residency cap of 19. That means we are limited to the number of trainees we can bring in without support based on that number. That number is also geographically disparate, as Dean Kahn mentioned.

In Nevada, we have 28 residents per 100,000 capita, where in Arizona they have 30, California has 36, Illinois has 55 and New York has 97. So, there are things we need to do to proactively raise that number. This cap establishment has lowered our ability to recruit and these shortages that we talked about are significant. We have taken the position to develop programs to meet many of these [shortages] and you have heard about them. We hear about them regularly in programs like primary care related, family practice, internal medicine, obstetrics and gynecology, and psychiatry. But also, in hospital-based programs, there is also a shortage of physicians [in fields] such as anesthesia and radiology. We also have shortages in fellowship training. We've added addiction, medicine and infectious disease as well as gastroenterology. All these services are short, as was mentioned; we are at the bottom of the physician ranking.

It would take 1,589 new doctors, with none of us retiring, to get to just the average for access. The best way to close this gap, as Dean Kahn mentioned, is to grow our own. We've been able to keep our graduates at the same rates that were mentioned before in the State, and we think that is why this bill is such a great commitment to raise that number of trainees. It also helps us to retain our current faculty that we have in our hospitals and on the medical staffs. Teaching is a rewarding experience; it is for me as well as many of my peers, and the ability to be involved in teaching both the medical student and at the resident level helps to maintain practitioners and makes them happy, healthy and [able to] practice longer, which also can help solve our problem. All these issues are important to help us achieve the goal of serving Nevadans.

SENATOR PAZINA:
The bottom line is that we have an extreme doctor shortage here in Nevada. This bill will help solve that. It will keep our students and doctors who are graduating from our medical schools here in the State for their GME and give them the opportunity to stay and practice here. When we knocked on doors and we talked to our neighbors, my goal is always to make their life better and that is what this bill does. It helps with our doctor shortage and provides accessible health care.

CHAIR DOÑATE:
You have put a lot of thought and effort into what we are looking at.

SENATOR LANGE:
Please correct me if I am wrong, but in the last session of the Legislature, didn't you pass GME legislation? If so, could you tell us what that was?

SENATOR PAZINA:
Yes, last session I worked on S.B No. 350 of the 82nd Session, which was co-sponsored by several of my colleagues. I also worked closely with Senator Titus on that bill. What we did was create a GME Advisory Council, which is so critical. It is something that was in place under former Governor Brian Sandoval. When he left office, because it had been an executive order and not in statute, it unfortunately went away. What that does is allows the deans of our medical schools, our doctors in large, medium and rural counties to have the opportunity to have a voice when it comes to selecting what those residencies or fellowships are and where this money is going. It is State money, and it is important that people who have the most knowledge of what the critical needs in the State are, have a voice in where that money goes. So, we were able to get S.B. No. 350 of the 82nd Session passed.

We had hoped to look at a more sustainable funding option as well as some money to go behind that bill. Unfortunately, last session the funding went to some other very important legislation, but this is so critical. So, we are back again and looking to make a few more policy tweaks. We look forward to having that money allocated and I will say that for a four-year fellowship program for an OB-GYN program, two years ago when I brought this bill, it was $2.8 million per year. Now, it might be a little less in the first year and a little more in progressing years. But that gives you an idea when asking for $9 million, why that's so important. In the conceptual amendment Exhibit F that

I provided you'll see that the money, [this is] something else we did last session, stays in this fund for GME and does not revert to the General Fund. That is because when we are looking at a fellowship that is longer than the two-year program, which is the four-year program, it can't just be funded through the biennium. We must commit to all years of that particular fellowship.

SENATOR LANGE:
It is important for all of us to know that the legwork for this bill started long before this session and that you have been working with many people from both universities. I appreciate both universities working together for the good of our whole State.

SENATOR TITUS:
I need clarification because as Senator Lange mentioned, you brought and worked hard on that bill last session, putting it in OSIT. But the Advisory Council was not, to my knowledge, really created—that council was never actually stood up.

SENATOR PAZINA:
Correct. So, you are exactly right. I checked in with the Governor's Office and OSIT more than I checked in with my family sometimes, asking what the progress was on that. And I know that you did, and that Senator Doñate did as chair of the Interim Health and Human Services Joint Committee, as well. Several people checked in on that and, unfortunately, it did not get off the ground. The appointments to the council were made, but the position had not been hired. The position finally has been hired now with a full-time employee. So, the plan is to move them from OSIT to DHHS. But you are exactly right. Part of what is so important is getting that to move forward.

SENATOR TITUS:
All right, I just want to make sure that it was clear we spent lots of hours with the Governor's Office trying to get the right person in that seat. With lots of changes having to happen, it finally happened. There were a lot of applicants for that position and, hopefully, it is now filled. We do know DHHS welcomes this and that they have the capacity to do this. The Advisory Council will now be stood up and there will be an administrator for that. So that is a good thing that this bill does and that changes from the last bill. The money that you are asking for needs to go on record for what it costs to start a program. We know, and good for you to make sure that this money is rolled over. Because of delay, we

lost a family practice program in Elko because the local hospital there was not going to support it. It was a tragedy that we had a rural family practice rotation that closed—that should never happen again.

So, in this bill, it clarifies that this money is to be rolled over and not absorbed back into the General Fund. If indeed this bill passes, the funding is there and that is a critical piece to this component. I worry that $4.5 million is not going to create the volume that we need. You mentioned there are 78 residency programs in Northern Nevada at this time, is that correct?

MR. NICHOLAS:
At Renown, yes, that is correct.

SENATOR TITUS:
It is my understanding that it is about $5 million to start a residency program. I was one of those folks in the 1970s so I can testify that is accurate because I was there. I graduated from medical school, the second four-year class at UNR in 1981. And we did it all. We did not rotate in Las Vegas at all. We did all our rotations at Renown, St. Mary's Regional Medical Center and at the Reno VA Medical Center. Then I did my family practice residency in Reno—the whole program. Having said that, we also had a surgery rotation residency and a pediatrics residency, and they all cost money and we lost those. Now we are looking at reinventing the wheel. Now we need this, and it just takes money to hold on to this. Hopefully, we can look at other funding to make sure these are sustainable programs. Suddenly, like what happened last session, does not happen again—where you and I were both looking at each other and not believing this is happening when the money was stripped out. So, I just want to make sure, on the record, that these funds need to be in there. It needs to be funded, and you are on the absolute right track. I applaud you for moving forward and correcting what were big flaws on that bill last session and hopefully this helps solve some of that.

SENATOR PAZINA:
I did confirm with Wayne Thorley, Senate Fiscal Analyst, about drafting language so that the money does indeed stay in the account. That has been confirmed and the amendment Exhibit F that is provided on NELIS [Nevada Electronic Legislative Information System] will show that as well.

MR. HAUPTMAN:
If I may for the record: if you do a back-of-the-envelope calculation, if we are going to succeed with our 5 by 30 plan you are talking about $12 million per year to sustain those five new programs to give you some context. Obviously, it takes time for those programs to mature. If you have a four-year program, it takes four years for you to have a full contingent. But that gives you some idea about the magnitude of the financial challenge in building GME.

CLAUDIA WATKINS (Medical Student, University of Nevada, Reno):
I am a third-year medical student at UNR. I am here to testify in support of S.B. 262. The saying "Home Means Nevada" rings true for me as I grew up in Las Vegas and completed my undergraduate studies at UNR. I then chose to continue my medical education at UNR in hopes of one day practicing in our rapidly expanding Northern Nevada community as an OB-GYN. I am delighted to say that I may have the opportunity to continue my education in Northern Nevada with the opening of an OB-GYN residency. I have no doubt that the residency will be a robust training program, but I can acknowledge the lack of funding is a massive hurdle in the residency's ability to reach its full potential. Senate Bill 262 is a piece of legislation that will help train the well-rounded OB-GYNs that Nevada urgently needs.

MAUREEN SCOTT (Medical Student, University of Nevada, Reno):
I support S.B. 262. I am a third-year medical student and a first-generation college student at UNR. I was born and raised near downtown Reno, and my experience with our underserved healthcare system is what inspired me to go to medical school and make a difference in our community. While I would love to continue my training and become an OB-GYN in Nevada, this potential program is dependent on the funding of S.B. 262 as physicians often stay in the state where they do residency. This bill will directly address the physician shortage within Nevada and provide opportunities for learners who enrich and empower their local communities through healthcare access. Please support the expansion of medical training through S.B. 262.

JACOB LAMAY (Medical Student, University of Nevada, Reno):
I present before you as a third-year medical student at UNR and [I am] invested in the health of our State. I was born and raised in Nevada and was drawn to medicine after witnessing firsthand the challenges faced by patients needing specialized surgical care. Too often, I hear of patients requiring care in nearby states who are better equipped to meet the needs of our residents or patients

having to then travel hours from our State to reach the care they need. These experiences solidified my commitment to becoming a surgeon and serving our community. However, the reality is that without a surgical residency program here, my path and the path of many aspiring surgeons like me will lead us out of State.

This summer and fall, I will be traveling to different states to showcase my skills as a fourth-year medical student to hospitals that train doctors in my surgical field of choice. I hope that they choose me when I apply for residency this September, but I would have preferred to stay here in Nevada if this were possible. Although I want to return to the State when I finish my surgical residency, I may end up staying where I complete my five-year residency because I will develop relationships and possible partnerships with the doctors who trained me. This is why I am in support of this bill.

WOLFGANG G. GILLIAR (Dean, College of Osteopathic Medicine, Touro University Nevada):

I am speaking in favor of S.B. 262. Right after me, I would like to have one of our wonderful students from Elko speak who is graduating and going through the Match Day next week. We are about one week away from Match Day, in which approximately 40,000 medical students in the U.S. learn where they will go for their residency after graduation and which specialty at which hospital. It is the most unique day that I, as an educator, can see because that is the most emotionally laden day when these students find out after all these years where they will be going and doing this residency. I am the Dean of Touro Nevada and somehow, we always fall through the crack somewhere. There are three medical schools in the State. I really need to underscore that all three deans, Dean Hauptman, Dean Khan and I, worked on this together because this is the same mission that we espoused when we became medical students. We want to assure you that we have had enough of the pipeline going on and the travesty that we have here.

We have about 300 medical students graduating in the State, and we do not have enough residency spots. We are neither deep nor, as Senator Pazina pointed out, one of the worst in the country. I was doing my residency in New York before it was a totally different environment and including the investment that went into residency, sustenance, maintenance and creation, and we are failing it. I will tell you it is pittance for what is being asked. I am sorry if I am that direct, that $15 million, $20 million, $30 million is not enough.

We need to talk about $50 million to $100 million. But I also have a saying and that is, with little we can do a lot, with nothing we can do nothing. So, I am urging you to really keep that impetus going.

I would like Kelsie Little to speak because she is from Nevada and wants to do her residency in Nevada. Her voice is exactly what we need to hear because I can assure you, that for this generation of medical students, it does not matter at which medical school. They rock, they are so good. These are the best medical students I have had in all my life, and I stand up for our medical students because they are dedicated and motivated.

KELSIE LITTLE (Medical Student, Touro University Nevada):
I am a fourth-year medical student at Touro University of Nevada. I am from Elko, Nevada, and a gold miner's daughter. I did my undergraduate at UNR and now I am here in Henderson doing my doctorate of Osteopathic Medicine at the College, hopefully matching next week. My number one choice is Nevada, so fingers crossed. However, my numbers two, three and four were not able to be. I am trying to go into family medicine and in Nevada, there are only about five programs with multiple positions in that specialty. So, looking at the different specialties, the different places, I had to reply to other states. As stated before, the other states have multiple resources for us as graduating physicians to go out and become the physicians that we want to be. I would like to be a physician for the community that served me, but I may not have the chance. So, I am for S.B. 262, and I hope that everyone here in this room as well as everybody in Carson City is also for continuing the positions of Nevada. We would like to be number one, one of these days.

RAUL MARQUEZ (Medical Student, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas):
This May, I will graduate and God willing pursue a family medicine residency here in Las Vegas. As a future primary care physician, my highest professional goal is to provide culturally sensitive medical care to anyone in the Southern Nevada community, where I have lived for all my 28 years of life. Standing before you as a future physician, I place immense trust in the integrity and the success of Las Vegas family medicine residencies to help me grow as a physician and ultimately fulfill my mission of serving the healthcare needs of our community. I chose family medicine in Las Vegas because of my deep commitment to addressing the significant barriers to basic healthcare access caused by this ongoing physician shortage.

As a medical student, I have seen firsthand how the lack of residency opportunities forces many talented future doctors to leave the State for training. Senate Bill 262 makes critical changes to address this issue and strengthen physician residency programs. To retain more physicians in Nevada, we must ensure that they have residency opportunities right here. Other similarly driven medical students and I are deeply committed to remaining in Nevada to serve our community and enhance healthcare accessibility for everyone. However, this is only possible if we continue to expand and adequately fund residency programs. Supporting S.B. 262 is not just an investment in medical education, it is an investment in the future of health care in Nevada.

TREVOR PARRISH (Vegas Chamber):
I am here today in strong support of S.B. 262. Graduate medical education funding is a Southern Nevada Forum priority, which this year was organized by our director, Nicholas Schneider. The Southern Nevada Forum was originally created in 2013 as a partnership between the [Nevada Assembly] Office of the Speaker, the Vegas Chamber and the City of Las Vegas to find policy priorities for the public at large in Southern Nevada. We appreciate that this bill would call for a greater attention to graduate medical funding by placing GME in it is own office. As many of you have heard in this committee, we continue to be in desperate need of healthcare workers in this State and GME is essential to developing a talent pipeline to address this need within our State. We ask for your support on this bill.

JACQUELINE L. NGUYEN (Nevada State Medical Association; American College of Obstetrics and Gynecologists):
I am representing the Nevada State Medical Association (NSMA). Also, the American College of Obstetrics and Gynecologists are joining in my comments to save time today. A long-standing priority for NSMA has been the expansion of GME in Nevada. Our State is facing significant physician shortages which are only compounded by an aging physician population, physician burnout and ongoing challenges physicians face in operating private practice here.

Expanding GME is critical to addressing these issues and ensuring that Nevada has a well-trained sustainable healthcare workforce. Residencies provide invaluable hands-on experience in a chosen specialty and allow for subspecialty training as well. Medical schools teach the fundamentals. Hands-on training and clinical exposure cultivate the true passion for the practice of medicine is provided by GME. Also, the accreditation and certification of our GME programs

guarantee that residency programs meet high-quality standards and produce competent physicians. Expanding GME is not just an ideal, it is a necessary solution to our workforce shortages, and it requires our priority and investment.

The foundation of exceptional medical care in our nation is built upon a system of competitive world-class institutions of higher learning, as represented today by our wonderful deans and incredible students who I am so proud to say that they are our members. We take great pride in our GME training programs which are highly competitive and standardized across the country, ensuring that physicians receive the highest caliber of training, whether they are in Boston, Houston or Reno. This caliber of training ensures that our physicians are prepared to deliver outstanding care wherever they practice. But we know that physicians who train in a state through GME are more likely to stay and practice there as they develop strong professional and personal ties to our community during their residency. By investing in GME in Nevada we have one of the most effective and reliable methods to increase our physician workforce.

NANCY BOWEN (CEO, Nevada Primary Care Association):
Thank you for the opportunity to give our support for S.B. 262. Nevada Primary Care Association represents the State's community health centers, and we spend a lot of time looking for ways to expand the health workforce to increase access to care. The difficulty in hiring and retaining primary care providers is always one of our members' chief concerns in our work. We are fortunate to have excellent relationships with the designated primary care associations in many states. Last year, we learned that our neighbors in Arizona and New Mexico have built impressive primary care residency programs in their community health centers. We are determined to position Nevada for a similar program.

We strongly support S.B. 262 for three key reasons. First, it maximizes resources. We were surprised to learn that Nevada was not receiving matching Medicaid funds for the State's GME investment. This bill is the first step toward drawing in federal funding that would allow the program to more than double, even if the State funding were kept level. Second, the eligibility language keeps open the possibility for our vision of Nevada as a place that is known for excellent primary care residency experience. And finally, we appreciate that the bill retains the advisory council so that there is a forum to hear new ideas to address Nevada's unique healthcare needs.

DAMON SCHILLING (Intermountain Health):
We stand in strong in support of S.B. 262 which aims to enhance GME within our State. By investing in the training of new physicians, this legislation addresses the critical need for healthcare professionals in Nevada, ensuring that our communities have access to quality care now and in the future. The establishment of our children's hospital not only expands access to essential pediatric services, but also creates new opportunities for medical education and training. By serving as a hub for pediatric residency and fellowship programs, the hospital will attract and retain talented healthcare professionals in Nevada directly supporting the objectives of S.B. 262.

Beyond the hospital, Intermountain Health is deeply rooted in Nevada's communities through an extensive network of clinical and primary care offices. These facilities serve as the front line of care for thousands of Nevadans offering critical services that support preventative health and early intervention. Our commitment extends to building pathways for medical education with these facilities creating hands-on training opportunities that will help cultivate the next generation of healthcare providers. Together, S.B. 262 and Intermountain Health and our investment in pediatric care as well as adult, make significant strides towards a healthier future for Nevada's children and families. We are committed to collaborating with legislators, educators and healthcare providers to ensure that our State remains at the forefront of medical excellence.

NATALIE OSBORN (Medical Student, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas):
I am a fourth-year medical student at UNLV School of Medicine and soon to be a pediatrician. Next Friday I, along with every medical school graduate in the country, will be finding out where I will be doing my residency training. I hope I am fortunate enough to match at a Nevada Institution. I grew up here. I am a Coronado High School graduate, a UNLV alumnus and soon to be Kirk Kerkorian School of Medicine at UNLV alumnus. My home is here, and I want to start a family here. I want to practice medicine alongside the amazing physicians who have mentored me throughout my journey. I want to be an advocate for Nevada's children and help address our physician shortage in the State.

Despite similar Nevada ties and desires to practice here, there's no guarantee that I or my colleagues will match here, especially because there are more graduating medical students than available residency slots. Senate Bill 262 puts more resources into developing residencies and fellowship programs in our State

and streamlines the implementation of workforce solutions within DHHS. Where resident and fellow physicians train, correlates to where they choose to practice as you have heard numerous times today. This is why I am in support of this legislation, so we can increase access to training opportunities in our State. Instead of hoping that our students come back to practice in Nevada, I would love to see more opportunities for students to train where their roots are so we can give back to the community that grew us.

MARY PATRICIA ANN MCDONOUGH (Medical Resident, Family Medicine Clinic, University of Nevada, Las Vegas):
I am a second-year family medicine resident at the UNLV School of Medicine. I was born and raised in Las Vegas, and I have had the immense privilege of completing my undergraduate degree in medical school and now my residency at UNLV. I am incredibly passionate about serving this community that I have always called home. Growing up in Las Vegas, I have witnessed firsthand the challenges our State faces due to the ongoing physician shortage. As a physician now myself, I am committed to staying here to practice and to continue giving back to the community that has given so much to me. I believe S.B. 262 is a crucial step toward improving healthcare access for Nevadans and allowing others like me the opportunity to stay in Nevada and provide the health care our community deserves. I urge you to support this bill.

REGAN COMIS (University Medical Center of Southern Nevada):
We are in strong support.

ALLISON HERZIK (Dignity Health–St. Rose Dominican):
We are in support.

ALEJANDRO RODRIGUEZ (Nevada System of Higher Education):
We are in strong support of this bill.

PATRICK D. KELLY (President & CEO, Nevada Hospital Association):
We are in support.

BLAYNE OSBORN (President, Nevada Rural Hospital Partners):
We're in support.

SALVATORE ROBERT AIELLO (Medical Resident, University Medical Center of Southern Nevada):
I am a first-year emergency medicine resident at UNLV, and I am in support of S.B. 262.

EMILY OBERLIES (Medical Student, Touro University Nevada):
I am a Touro University Nevada fourth-year medical student and in strong support of S.B. 262.

SENATOR PAZINA:
We've heard from deans from three of our amazing medical schools in the State. We've heard from hospitals and associations. But one of the most important things we did today was hear from some of the students who want so badly to be able to stay here in the State to do their graduate education and to practice here in the State from the North to the South to the rural communities.

CHAIR DOÑATE:
The hearing on S.B. 262 is now closed, and we will open the hearing on S.B. 214.

SENATE BILL 214: Revises provisions relating to excavations. (BDR 40-749)

SENATOR IRA HANSEN (Senatorial District No. 14):
I am here today to introduce S.B. 214. I have learned so much in the last 24 hours about this whole issue. I doubled your normal population in [this committee room] today because to my surprise every utility company on the planet is against this bill. I will explain the background of this bill. First, I am a plumbing contractor for 39 years and have been a plumber since 1979. During that time, I worked in the field as a plumber, a fact I bring up because one of the issues that is going to be brought up is safety. This is my hard hat that I wore from about 2000 to 2008. There's a sticker inside that states you can wear this one up until 2008; that's why I know the date because you have to get a new one if you go past that date. Anyway, you'll notice I have safety stickers and all that on it. I only brought that to show this is a very practical issue here. Now, what happened?

Well, the rule was for contractors—and only contractors—if you are going to use mechanical devices, you had to contact 811. What we would do is go out,

and let’s say we are coming to Senator Lange's house, and she has a water main that needs to be replaced. We would paint it with white paint and call 811. They would come out and double-check to make sure there were no utilities in the way, and if there were, they would mark them. We would be extra careful in that spot and then we would do our work and dig it up.

Well, last session in 2023, we passed a new law. This is an interesting law because I voted for it, and I did not catch this. I have heard it was and might have even been in the committee I was on. We changed that totally. Originally, it was for contractors only using mechanical equipment, in other words back hoes or something that could possibly damage the utility. We changed the law the last time though to where every single person in Nevada, if you use a shovel, if you go out in your yard to plant a tree, you have to now mark the location and call 811 and wait 48 hours to have it all laid out. Now, also if you are going to drive a stake in the ground more than 12 inches, you have to do the same thing. You have to mark it and do all these steps, then the 811 people can come out and double-check to make sure there is not some type of public utility there. Now that shifts the burden to every single person in the State, not just contractors using mechanical equipment. Everybody who takes a shovel and digs a hole or takes a hammer and pounds a stake in the ground is now liable if they do not follow this procedure.

Nobody knows about the procedure. I did not even know until I just met with the Public Utilities Commission of Nevada (PUCN). I thought it was still only if you are using mechanical stuff. I read the bill and for hell's sake, every person in Nevada that digs a hole in their yard for any reason up to 12 inches is now liable if they have not marked it, called 811 and gotten it properly laid out where the utilities might be. Here is the reality. Let’s say Senator Taylor calls Ira Hansen's plumbing company to come out to her house. She has a puddle in the yard, and she says this puddle is not going away and wants to know what is going on. What would happen? Ira Hansen in his younger days would come out to her house and take a shovel and start digging where that puddle is. Sure enough, she had a broken valve or something in the ground, and then I would repair it and give her a bill and leave. That would be it.

Now, what happens? I come out to Angie Taylor's house, and I have to diagnose the problem, then paint it with white paint. We have to wait 48 hours and then after the utility company has come out to her home and double-checked everything, I will now come back to actually do the work that

I could have done already. Now, who pays for that? Angie Taylor gets to pay Ira Hansen twice for what could have been done once. I do not know if you have hired a plumber lately, but we're not cheap. Plumbers are fairly expensive and if you want a good plumber, you pay him well, especially in this day and age.

So, we just doubled your bill by forcing every consumer in Nevada to pay, not just plumbers or landscapers—anybody that is going to do any work in your yard—that much more every single time. We are talking legally now here. Just like there's real politics in the world, there's also real economics in the world. Nobody knows about this bill. Right now, if Angie Taylor called my company and we send a plumber out there and they find a puddle of water, they are going to do the work that I described to begin with. Until today, I literally did not know that was the new law.

The guy that gives the lowest price to Angie Taylor is going to be the one that gets the job. If I come in and say, "Hey, Angie, I'm sorry, I've got to come back in a couple of days to do the work." And Angie says, "Okay, can you give me an estimate on the cost of this?" And I tell her that adds about $300, then she calls some other company, and they tell her they'll do it right now and save her that $300. So that there's an economic reality to this as well.

There's another question that comes up and it is the law now. Do I have the right to force you to not dig a hole in your yard on your private property without a penalty? And the issue about having easements on your property came up. Obviously, I am guessing there are over a million homes in Nevada that have natural or propane gas to them. I talked to the PUCN, and they said it is roughly that amount. Every single one of the homes could theoretically have some sort of problem if somebody dug and hit that gas line. People are digging in yards all the time. How many cases do they actually have? It is exceptionally low, yet, to have this hypersensitive standard of safety we have now has dramatically increased the cost for every single consumer in Nevada that is going to have any landscaping done in their yard.

I got involved in this in the first place when a landscaping contractor called me. He said, "Ira, did you guys actually pass a law that we can't dig a hole more than 12 inches deep without calling 811?" I said, "Hell no, what are you talking about?" And he said, you better double-check. I got back to him and confirmed it was 12 inches. Guess what? I was wrong. As a contractor, if we dig one inch

in the ground, we have to call and paint it out. So, if I go in the yard and rake the yard with something trying to find a clean out on the sewer pipe or where your utilities are buried, like half of them are in Nevada, I have to call 811 and mark it as a contractor. So, I was wrong. I told the guy he could go up to 12 inches deep. No, he can't go one inch deep without waiting, going and painting. So he goes out to the house to plant the trees that the customer wants. First, he gives him the bid and then he goes out. Now instead of just planting the trees, he has to spray paint every single spot where he is going to plant the tree. He also has to figure out, if you ever watch them plant trees, they run wires to stakes to stabilize the tree. Now he has to mark every single spot in advance where he is going to put the stakes. If he does not do that and somehow, he drives the stake in and he hits some underground utility, he is liable.

They told me no fines. Well, technically no fines now, but the minimum fine is $1,000. And they say, we do not do that to homeowners unless they've done it several times. I said the whole thing is crazy. My bill started out so simple. Well, this is crazy. Let's just go from 12 to 18 inches. Okay, why not? No problem. You know, almost all utilities are under 12 inches. They'll point out that code is 12 in Northern Nevada; everything's at least 18 inches deep. So, at the very minimum that was that. I thought that law only applied to contractors. It applies to every one of you. If you do any yard work at all, like rototill your yard or something, and if it is going to go more than 12 inches deep, for a homeowner you have to mark where you are going to do it, call 811 and they have to come out to their yard and snoop around and find it.

Now, there is a question of easements. This is an interesting one because if there is an actual easement on your property where they buried the electric lines, and gas lines and so forth, then okay, I could see maybe there would be something where you do not dig in that spot. But is there an actual physical easement on a piece of property? Turns out there's not; there is what they call a prescriptive easement because when they are going to do this stuff, they do not know where it is going to run. You could have utilities all over your yard. What I am getting at is there is no safe way for you to do anything in your yard legally anymore. This is the funny part—for contractors, I can't dig an inch deep. But the PUCN said, we have actually been generous, we go to 12 inches.

The federal law is you as a homeowner have to be at one inch. Now, federal law—I learned this today just a little bit ago from PUCN. And by the way, the

people are going to oppose my bill. I do not hold them for it, that there's a legitimate reason for them to, as you will hear for some of the concerns and here is what it is. The federal government in 2015 came up with a brand-new code. Now remember, as a plumber, I am governed under their Uniform Plumbing Code. They have a new federal law that is put out by the National Transportation Safety Board which requires all these standards that I just mentioned. Those are federal laws that you as a homeowner can't even dig an inch deep. Nevada's kind of pushed back and said, well can our homeowners at least dig 12 inches deep?

Now, why are we allowing the federal government to tell us what to do? I have been a contractor since 1986 and a plumber since 1979, and the laws were if you are using mechanical equipment as a contractor, not a homeowner, you needed to call 811. Now, they've changed it to where you and I, and everybody in this room now has a liability if you dare dig a hole in your yard and under federal standards it is one inch. In Nevada, the PUCN has given us some flexibility, it is 12 inches. So, why is the PUCN so worried about that? There's a million dollars involved. If we have complied with the federal laws, they get a million dollars to do all their underground inspections. And undoubtedly whether it is the Southern Nevada Water Authority, and I am a little surprised about this, I heard the Vegas Chamber is against me on this, but it's like, why do they care? Well, because these liability issues and the loss of federal dollars essentially blackmailed everyone. The federal government has blackmailed Nevada, and we now force every single homeowner or any property owner or anybody, a landscaper, anybody digging a hole anywhere in Nevada now faces possible liability.

Here is the interesting part. Nobody knows this. As a contractor, I thought the rules were exactly like it was in 2023. I have three backhoes. If I was going to be digging with backhoes, I knew to always mark it and call 811. And I am fine with that. It's a good smart thing. Mechanically, it is much easier to damage stuff because you do not feel it. If you are out there though with a shovel, and I've done lots and lots of that in my lifetime, you notice right away if you are hitting something weird. At first you wonder if there is a root here, what is this? And then you are like, oh, it is the underground telephone line. Oh, good grief. I did not know it was here. But because you are doing it slow and steady with a shovel, you very rarely damage those things.

In the old days, I was doing work like that up until 2023. For every 1,000 calls that they got from a guy like me, there were 2.7 that actually ended up being in some kind of damage situation. Now, they are going to tell you for every 1,000 now, it has dropped down to 1.1. But they've dramatically increased the number of calls because everybody's going to dig a hole more than 12 inches deep. If they understand, and there's enough of them in the landscaping world that especially do, they are making those calls. So, anyway, some real interesting questions on the whole idea that can hold you liable on your own property if you dig a hole in your yard.

I thought this would be a two-second presentation because I was going to come in here and tell you I think we goofed last time. Why don't we just go six inches deeper and kind of solve the problem. Boy, have I gotten an education in the last day or so. I am telling you right now, this is a consumer protection bill because if everybody follows this, your cost for every single thing in your yard just went through the roof. Electrical guys, if they are going to drive a ground rod in your yard, they are liable if they do not mark it in advance. If the landscapers come out to plant trees, they are liable for that. If the plumber shows up, he is liable. If you as a homeowner just want to do something totally by yourself like dig a hole and put in a little kids' pool or something like that, you are now liable for any potential damage. Up until 2023, no homeowner, no private anybody had any liability whatsoever—only contractors like me. Now, contractors and you are liable for any kind of work like that done in your home.

SENATOR STONE:
I appreciate the knowledge that we have this little inconsistency in the law, if you want to call it that. But how do you think your bill is going to impact the safety protocols for excavation for subsurface installations? We're going to hear some opposition, and I think you are expecting it.

SENATOR HANSEN:
Oh, yeah. They've come to talk and there's no hostility. I understand completely where they are coming from. If we eliminate this bill completely, I recommend that we go back to pre-2023, when it only applied to contractors using mechanical equipment. The only reason we can't is because these guys are being blackmailed by the federal government and they are going to lose a million bucks. That is why you guys are probably not going to support my bill. I really believed it was that simple though. We're just going to change the depth a little bit. Why did we change that?

But in the meantime, every consumer in Nevada that has anybody come to your property and follow this law, your bill is going to go up substantially. So just consider that there are hundreds of thousands of people that use all these services. I am glad these guys will save a little money because now there should be a higher level of safety. Because they are going to mark every damn thing you can possibly do. The amount of money that the average person in Nevada is going to be forced to pay to help these guys out is going to go up. They are going to have to follow all those rules and regulations, and the costs are always passed to the consumer. Any normal person wants a plumber to get in and out as quick as possible, landscapers, electricians—whoever. Every minute that they are there, the clock is going ding, ding, ding and you are paying for it. While I am glad these guys do not want to pick up the bill anymore for some damage, it really sucks that every single person in the State now has a liability that did not exist prior to 2023.

A'ESHA GOINS:
I am just testifying as a constituent. I did not even have this bill on my radar, but I too, would like to dig six more inches if I needed to. If my father wants to plant a tree, I do not want the drama of him wanting to plant a tree, that just is common sense. I urge you all to support the constituents and the consumers that did not know that they could not drive a stake in their yard for marking a dog space or building a fence, so I support this bill.

DYLAN KEITH (Southwest Gas):
After speaking with Senator Hansen about this bill, we do understand why he is bringing the legislation forward. However, we are in strong opposition to this language. Nevada's implementation of 811 Call Before You Dig, is reducing damages, saving ratepayer dollars and increasing public safety. The PUCN just recently passed the updated hand digging legislation. Senate Bill No. 27 of the 82nd Session passed by a unanimous vote across both houses.

Our lines are buried at least from 18 to 24 inches when it starts. As the ground continues to settle and erosion occurs over decades, we cannot guarantee our lines are deeper than 18 inches. Safety is the most important aspect to Southwest Gas for our customers, our staff and the communities we serve. And safety is our company culture above all else. In 2023, Southwest Gas was second in the nation for damages per 10,000 services. The 811 number works to protect Nevadans. Southwest Gas really wants to prevent the rapid disassembly of human anatomy. This is very serious. It is flammable. We love

our product, but safety is our number one priority for a reason. We ask for your opposition to S.B. 214 and to always call before you dig.

JESSE WADHAMS (Vegas Chamber):
As drafted, we do have significant safety concerns for many of the items that Mr. Keith just mentioned. The subsurface lines being buried between 18 and 24 inches below the surface line and ground settling clearly creates damages and a risk to utilities and people. The Vegas Chamber stands in opposition.

KANANI ESPINOZA (AT&T):
We are in opposition to this bill. As we explained to the bill proponent, telecommunication infrastructure is typically buried at a depth of 18 inches. Causing a proposed change to 12 inches is a concern. The proposed changes in S.B. 214 would significantly increase the likelihood of fiber cuts resulting in more Internet and wireless outages across the State.

MISTY GRIMMER (Cox Communications):
I will just say ditto to all the previous statements that were made. It is the same situation for us and our facilities. They're all in the same trenches. I am one of those people who dug a hole in my yard, and I put a pick through my water main.

KURT BERNER (Las Vegas Chapter, National Utility Contractors Association):
I serve as a volunteer board member on the National Utility Contractors Association (NUCA). We request further discussions related to S.B. 214 with the affected stakeholders, as well as to oppose the bill as written. Senator Hansen was saying from 1991 to 2023 the definition of excavation in the *Nevada Revised Statutes* (NRS), Chapter 455 essentially limited excavation to the movement or removal of earth by use of mechanical equipment. Last legislative session, the definition was amended to include both mechanical and non-mechanical methods for contractors, contractors being defined by NRS 624.020. In essence, it requires contractors to follow safe digging practices, whether they are using a shovel, driving a stake into the ground or using a 40-ton excavator.

The impetus behind this was that a lot of utility damage and resulting injuries were caused by non-mechanical excavation methods. For example, a concrete contractor driving a stake into the ground to set form boards or a landscaper. This happens all the time and I bet you, Southwest Gas, would attest to this. A

landscaper could be driving a pickaxe through a gas line while digging a shallow trench for irrigation lines. It further states that the definition of excavation does not include a person who does not fall under the definition of a contractor, a person that removes earth less than 12 inches from the surface. This provides an exception to an individual looking to plant some vegetables in the backyard. The definition of excavation is a triggering mechanism to assure that anyone digging below the surface follows safe excavation practices.

One of the most important requirements is a duty to notify utility operators of one's intent to excavate. This allows the utility operators two business days to mark the area with paint that one intends to excavate to identify these subsurface installations that have the potential to cause severe harm and damage by the excavation. This is facilitated by an 811 Call Before You Dig, and I would like to point out that the service is complimentary. It is a phone call. It does not take that long. Marking out white paint is the cost of a can of white paint.

It is also important to mention like some others have, that Nevada leads the nation in utility damage prevention. National Utility Contractors Association is unaware of any reason, nor can imagine one, for increasing the depth of excavation for a noncontracted person from 12 inches to 18 inches, eliminating the need to follow safe excavation practices within this space.

Nonetheless, NUCA is more than willing to discuss any reasons supporting the change. The reality is that safe excavation saves lives. More of the impetus behind the change in 2023 was that many utility damages were caused using digging methods that were non-mechanical such as the examples previously mentioned. Granting an increased exception to people that are not skilled tradesmen will unnecessarily lead to avoidable injuries, property damage and death. Again, NUCA and its members are available as a resource and more than willing to provide our expertise and engage in discussions related to this bill. However, NUCA opposes S.B. 214 as written.

PAIGE BARNES (Lumen):
We are in opposition to S.B. 214 and echo the comments of our colleagues regarding the public safety concerns.

SHELLY CAPURRO (Charter Communications):
We say ditto on the safety concerns of the bill.

BRIAN REEDER (Verizon):
Depending on the location, we bury infrastructure at 18 or 36 inches, so this could put our network at risk. We are opposed to this bill.

GARRETT WEIR (Commission General Counsel, Public Utilities Commission of Nevada):
We are in the neutral position today. To provide some background on this proposal, it undoes one of the provisions that was included in S.B. No. 27 of the 82nd Session, which was sponsored by the Commission and ultimately adopted by the Legislature.

PAUL MAGUIRE (Engineering Manager, Public Utilities Commission of Nevada):
Although our utilities do go above and beyond, a lot of them, like Nevada Energy and Southwest Gas do bury at 18 inches. The federal code minimum is 12 inches. A lot of times we see erosion grade changes, people build retaining walls, or they want to pour recreational vehicle pads, and they cut the grade and that is why the lines can be shallow. The whole 12-inch thing came for common sense. We do not want a realtor to have to wait two days to put up a for-sale sign; they're not a contractor. They're going to hammer in the stake. You want to put up a lawn sign, go for it; they do not go 12 inches. But the whole thing on the 12 inches was gas lines can be buried there; other facilities can be buried there. A lot of the fiber being installed to homes are microtrenched. They're only in there three or four inches, so there are a lot of facilities that are in that area and that is where the 12 inches came. It allowed for some flexibility for homeowners. Say a Boy Scout Troop wants to put a tent in the backyard, go ahead. The stakes are four or six inches deep, go for it. We're not saying you have to call in, but that is where the 12 inches came from.

SENATOR HANSEN:
The idea of people being blown up, just so you know, there's never been a single incident. Remember with the old law that existed prior to 2023, I wore a hard hat because I was worried about my own safety, I could be the one that supposedly got blown up. Guess how many people were blown up Nevada in the last century under the old law? Not one single person was killed by a gas line blowing up in their yard. So, that is a ridiculous thing. It is not just the cost of the paint; it is the hours going to your house and then coming back two days later. You are getting charged for two trips to do one thing and that is it. So anyway, I got public safety, they did not mention the million dollars on the

federal side, which is a little disingenuous because that is one of the main motives. But we should make sure that we look at this from the side of the average homeowner as a consumer. I am glad these guys are going to save money, and they have less problems by forcing everybody in the entire State who wants to dig with a shovel to call 811. But I do not think that we, as Legislators, should be getting down to that micro-level of hyper management of everybody on their own property.

CHAIR DOÑATE:
In addition to the testimony we heard today, our committee secretary received one letter in opposition (Exhibit G). We will now close the hearing on S.B. 214 and open the hearing on S.B. 183.

SENATE BILL 183: Revises provisions relating to caseworkers of agencies which provide child welfare services. (BDR 38-710)

SENATOR MELANIE SCHEIBLE (Senatorial District No. 9):
I am joined by two everyday superheroes from Las Vegas. They are foster parents in Clark County. I know that you all will give them your full attention and listen to what they have to say because it is incredibly important. They had to rearrange some childcare to stay in the committee room today and give you this testimony because that is how much they believe in the policy behind S.B. 183.

The purpose of S.B. 183 is to ensure that caseworkers, who are employed by a county or by the State to oversee foster kids or oversee cases, are not burnt out and overwhelmed from the start. It is to ensure that they have a small enough caseload that they can give each child the attention that he or she needs and be able to communicate with the foster parents in a meaningful way.

I submitted an amendment (Exhibit H) that I think will be further amended, so stay tuned for that. I did want to point out in the amendment that the goal of the language in section 1, subsection 2, paragraphs (a) through (e) have this kind of gradual process where caseworkers take on more responsibility or take on more cases as they become more experienced. The overall goal of the bill is to cap the number of cases that a particular caseworker can handle. I know, because I was there, we have been talking to the counties about this and we've been talking to the agencies who provide permanency services, and we are

open to developing this language more so that we can come to a place of agreement on it.

We will be speaking to this version of the bill today, but I want you to really think about the overall policy proposal here and the goal. While we are speaking of amendments, this is only intended to cover those caseworkers who are in charge of foster kids' cases. We're not talking about anybody else. I understand that the term caseworker may also apply in other areas of the law, including other areas within the Division of Child and Family Services in DHHS, but this is not supposed to include them. This only includes the caseworkers who are assigned to the cases of foster kids.

The last thing that I will mention about the amendment is that it still currently indicates an implementation date is January 1 of next year. I think that would be awfully ambitious to reassign and reduce those cases by January of next year, and so, we will be looking at extending that. We also do not want to disrupt kids who are already placed with a caseworker, who maybe has more than 30 kids on their caseload. We want to give the agencies the flexibility to meet that 30-cap goal in the future and going forward. But we do not want that to come at the expense of kids and tell them they are assigned to this caseworker today, but not tomorrow, even though they may get along with their caseworker. They may like their caseworker, or they may have siblings who are assigned to the same caseworker. So, the amendment in paragraph (e) is also intended to maintain that value of keeping siblings together and ensure that caseworkers who already have someone in their caseload can also take on that person's sibling if they also come into care, which sadly happens. One caseworker told me that often, once they have a kid in their care, another sibling also comes into care. With those technicalities out of the way, I am going to hand it over to the true experts who are in Las Vegas, and who will explain to you the importance of this policy and really the strength of the bill.

RHONDA MARTINES:
I have been a foster parent for over two years. I was a previous Clark County Department of Family Services (CCFS) caseworker for six-and-a-half years and hold a master's degree in family and human development. As a result, I have had the opportunity to observe firsthand the challenges around child welfare. I am here to express my strong support for S.B. 183 and its potential to improve outcomes for children in foster care, our family and other foster families. As a Clark County worker, I have held the positions of a caseworker in

permanency as well as the kinship. I have had the opportunity to be a part of true successes of reunification and I have also seen the unfortunate side of casework where reunification is unsuccessful.

Personally, I have been a foster parent of two amazing boys who have gone through challenging child welfare cases that involved reunification attempts, special needs referrals and criminal justice involvement. I have firsthand witnessed overloaded caseworkers and the negative impact that it presents to both the child, biological parents and foster parents involved. When caseworkers are stretched too thin, human error increases which in turn leads to failures in the true safety of children in care. If caseworkers are unable to receive extra support for their cases, caregivers like me and biological parents struggle to receive the true needed full support that is required for successful outcomes. Routine child-foster family contacts are rushed, and communication can be minimal. Furthermore, high caseloads limit the time caseworkers must connect with the children, foster parents and their biological families.

After leaving the CCFS in 2024, I knew that I wanted to improve on the challenges that I saw where caseworkers were overloaded. Too many failed reunification attempts and too much caseworker turnover were the results. The great thing about my experience as a caseworker was seeing the people I have worked with have the same passion, love and care for vulnerable children. By no means was my time as a caseworker mostly bad experiences. It involved many successes with CCFS. With that being said, I stand before you today remembering the most impactful cases and knowing that there is always something we could have done better for that child.

Last year, I reached out to many foster parents in the community to ask about their experiences and how they think we could improve on child welfare safety. I was shocked at the amount of feedback I received, but it also validated my own concerns and experiences. After several meetings and sessions, I knew we could make a difference. So, I took it upon myself to reach out to Senator Melanie Scheible for the insight in making a change. I was honored that she listened to the community voice and dedicated herself to help with this topic that so many foster parents and I are truly passionate about.

Our Rowan is a two-and-a-half-year-old boy who's the coolest kid in his class. He wears Vans shoes and loves having his hood up on his hoodie. He is not shy about singing his ABC’s, watching Paddington Bear or expressing his love for

mac and cheese. Rowan will hug you so tight and melt your heart with his please and thank you. Rowan was one of my foster boys. Rowan was physically abused after only five weeks of an in-home safety plan with his biological parents. During this time, he sustained bruising over the majority of his body to include down his spine, both sides of his head and his cheeks from someone squeezing his mouth so tightly. These injuries were documented as multiple stages of bruising with some up to ten days old. These injuries were done by people who will face the criminal justice system. But Rowan deserved better from us who are in front of you today, and I can't help but think that Rowan's case could have gone differently.

I think that, even if we do everything right, we could have done something better to stop him from having to go through that. It is a guarantee that a decreased caseload and an increased casework experience and training will help in the goal to eliminate Rowan's situation from happening again to a child in our care. Rowan is home safe with his family today—that's us. But there are many who are not. Human errors decrease and detailed work product increase by stress reduction. Human error is reduced by training and experience in child welfare. And if you reduce a little human error and add experience and training, I don't think Rowan would have to go through what he did. So again, I stand here in front of you as a foster parent, a previous caseworker and a loving mother in our Battle Born State of Nevada with our children's safety, permanency and well-being in mind. With all our hearts, I urge you to support S.B. 183 and follow national best practice recommendations. This is so our most vulnerable children receive the time and attention they deserve to ensure their safety.

HEATHER RICHARDSON:
Thank you for the opportunity to speak today on a matter of critical importance—the urgent need to reduce child welfare caseloads in Nevada's foster care system. The safety, permanency and well-being of our most vulnerable children depend on it. I have submitted a letter of support (Exhibit I). I have dedicated 20 years to working in foster care in Nevada. In 2021, I left CCFS foster care after 16 years as a dedicated caseworker and supervisor, including five years doing child fatalities and legislation. I left CCFS due to the crushing caseload demand in Nevada and its impact on children and families.

Unfortunately, my story is not unique. There is a crisis in child welfare caseloads. Nevada's child welfare system is overwhelmed. Caseworkers are

burdened with unmanageable caseloads far exceeding national averages and recommendations. The Child Welfare America recommends no more than 12 to 15 children per worker for ongoing services. Yet, Nevada's caseworkers routinely handle double or even triple that number. This is not just a problem of capacity; it is a crisis of safety.

This bill recommends a cap of 30 children per caseworker, bringing Nevada in line with national averages. Research shows that high caseloads correlate directly with negative outcomes for children, including increased placement instability, longer stays in foster care and a higher likelihood of recidivism. When caseworkers are stretched too thin, children suffer; they do not receive timely and adequate visits. Necessary services for children and parents are delayed and critical warning signs of abuse or neglect can be missed. In states that have reduced caseloads, child safety improves. For example, in Illinois after implementing caseload reform, the state saw a 20 percent decrease in child fatalities and maltreatment recurrence. This is a life-and-death issue, and Nevada cannot afford to wait. Reducing caseloads saves money beyond the moral imperative, it is also a fiscally responsible decision. High caseloads lead to high turnover, which is one of the costliest inefficiencies in child welfare. The national average annual turnover rate for caseworkers is 30 percent to 40 percent.

Nevada is losing millions of dollars each year due to turnover. The cost for replacing a single caseworker including recruitment, training and loss of productivity can be as high as $70,000 to $200,000 per worker. Turnover leads to case delays, more children languishing in foster care and higher rates of reinjury, which cost the State millions of dollars annually. A stable well-supported workforce reduces these costs when workers stay and children move quickly towards permanency, whether through reunification or adoption. This ultimately reduces the financial burden on the State. For example, Missouri saw a 50 percent reduction in turnover after lowering caseloads, leading to millions of dollars in savings and improved child outcomes. Nevada can and must follow suit.

Foster parents also leave the system due to caseload sizes. The costs of losing quality foster parents can be substantial to a state. It costs $6,000 to recruit and train a new foster parent for each one that leaves. In addition, there is the expense of congregate care for a child to be placed at a facility like Child Haven in Las Vegas. In another bill before this committee, Clark County indicates that

the cost of congregate care exceeds the cost of placing a child in a private foster home. Children who are placed with better matched foster families due to proper caseworker attention, experience fewer placement disruptions.

Iowa experienced a 50 percent reduction in placement disruptions when caseloads were capped at recommended levels. Fewer placement moves result in better emotional and behavioral stability, making permanent reunification or adoption more successful. Lower caseloads allow caseworkers to connect families to therapy, parenting classes and substance abuse treatment faster, preventing crises that lead to reentry. For each child in foster care, it costs taxpayers between $25,000 to $50,000 annually. Studies show that reducing time in care by just one month per child could save states millions of dollars annually. Further, just a 1 percent decrease in recidivism has been shown to save millions. States like Illinois and Alabama saw recidivism rates drop by 15 percent to 20 percent when they invested in lower caseloads. Missouri reduced caseloads and saw 40 percent drop over five years. New Jersey reported a significant decrease in foster care reentries within 12 months of reunification when they reduced the number of children assigned to a caseworker.

This is commonsense legislation for a stronger Nevada. This is not just about compliance, it is about protecting children and making smart financial choices. Reducing caseloads will: ensure child safety by allowing caseworkers to provide the attention each child deserves; lower caseworker turnover; reduce costly recruitment, hiring and training cycles; improve permanency outcomes; decrease the time children spend in costly foster placements; improve retention of seasoned foster parents; save taxpayer dollars by preventing crises; and reduce legal costs. Increasing system efficiency improves access to service for families, lower recidivism of children being retraumatized by subsequent removal.

I urge this Legislature to invest in the future of Nevada's children. Reducing caseloads allows caseworkers to move children toward permanency faster, saving the State millions in unnecessary costs while improving child outcomes. We cannot continue to ask caseworkers to do the impossible while expecting better outcomes. Reducing caseloads is not just commonsense, it is lifesaving legislation that will ensure the safety and success of our children.

SENATOR TITUS:
I am curious if you have done a study on all the counties and what the current caseload is per county, especially looking at rural areas.

SENATOR SCHEIBLE:
We did meet with the administrator from the Division of Child and Family Service at the state level. The 15 counties, not including Washoe and Clark Counties, are all served by the same office and that office is already meeting these caseload requirements.

SENATOR TITUS:
That is what I thought just based on what I know. So, the counties that are going to be affected by this are Washoe and Clark. It was mentioned briefly in the testimony in Las Vegas that the current national recommendation is 15 cases. Is that the current national recommendation? Fortunately, you have given them enough time to find these people. I worry that throughout our State, there's a shortage in everything, especially in occupational licenses and mental health providers, et cetera. How long does it take to train somebody if we are going to pass this bill? I think it is well intended. Do they need a special certification to be in child welfare services and what does that look like?

SENATOR SCHEIBLE:
I can give a general answer, but I think the caseworkers in the South could tell you more. But generally, you do have to have some kind of degree in child development or social work or something like that. Every caseworker goes through a training academy with their agency. I know that Clark County is also here. They would probably confirm that the academy is about four months that a caseworker goes through to become a part of the team and get assigned cases.

SENATOR TITUS:
I appreciate your amendment. As somebody becomes more immersed in this and more skilled at it, they perhaps could supervise more children and certainly have more if they have family members. But what about the difficulty of the cases? I mean, some cases are much more dramatic than other cases. Is that taken into consideration by numbers that are not necessarily arbitrary? The cases can be so different, so dramatic on what is happening to that child. I am wondering if the types of cases that are assigned are taken into consideration at all?

SENATOR SCHEIBLE:
Great question. One of the reasons that we are looking at amending the bill is that it does not take that into consideration. My understanding is that some of the agencies do have their own process for essentially weighting cases that are more complex or that are more difficult, and they have an internal process to ensure that they are distributing those cases appropriately. We would not want to undo those efforts with these efforts. Your point is well taken, and I am open to additional amendments and language, if there is a way to put that into statute. I think that it is an excellent point.

SENATOR TITUS:
So, along that same line, have you reached out to Washoe County to get that information? I think that would be important to include in this as we move forward.

SENATOR SCHEIBLE:
I am not sure if Ms. Richardson or Ms. Martines want to respond to that.

MS. RICHARDSON:
Each academy is approximately six to eight weeks for a newly hired employee that goes through CCFS. As a former supervisor myself, I can tell you that the difficulty of cases is definitely taken into consideration in trying to distribute them. While I appreciate that concern, there's really no way to objectively quantify that. But that's where we hope to aim to start with this bill. The national recommendations by the Child Welfare League of America is saying 12 to 15 children and we understand that some of the caseworkers right now are north of 30 and pushing 40. I think there is a way and we don't necessarily need to legislate cases. But we could at least control the number of children being assigned to caseworkers; that's a great start for Nevada.

MS. PEARCE:
We see this bill as supportive for both families and caseworkers. Particularly for caseworkers, this bill is addressing concerns for burnout, and we know that burnout is more than just about numbers. Caseworkers are witnessing significant trauma and without proper support are experiencing secondary traumatic stress impacting their own well-being and their effectiveness in supporting children.

Senate Bill 183 is an opportunity to begin preventing and alleviating that burnout. We also hope that this policy would prompt exploring other mechanisms to uplift caseworkers, including mental health supports, reflective supervision and trauma-informed workplace policies. By investing in caseworker well-being, we ensure stronger, more stable relationships for children navigating the foster care system. It will increase support for permanence, housing and placement of children facing foster care. It will also support caseworkers, so they can spend adequate time with the families, making sure that those children are receiving the resources that they need to thrive and continue growing and developing.

CARLOS HERNANDEZ (Nevada State AFL-CIO):
We are in full support of this bill.

ROSS KINSON (Northern Nevada Central Labor Council):
We support this bill for all the reasons previously stated from the child's advocacy group. This is from a worker's perspective. This is a way to keep our workers continuing to work and not burn out, and not go and try to find other fields to be in. So, we support this bill.

ROBIN FRANKLIN (Division of Child Protective Services, Clark County Department of Family Services):
I am a supervisor with child protective services and have been a warrior and champion for 20 years. I am speaking in support of this bill because I have seen the struggle that workers go through every day when they can't do all the tasks asked of them. I've seen how it impacts the children and how they are not able to get to permanency quickly because of the structure of not being able to do all the tasks. I know that you have heard that it is 15 children per caseload. That's a manageable thing; 30 is manageable. But when we get unmanageable caseloads, we see people burn out. I have seen caseworkers leave with no job. They just walk off the job; it has happened. So, we want to make sure that our children are in a safe environment with the activities for permanency. We want to make sure that we support them, so I am asking you to support this bill.

SHALONDA ADAMS (Clark County Department of Family Services):
I stand in support of S.B. 183 because of the burnout that I have witnessed and experienced myself. I have been in child welfare now for 11 years and I just wanted to state that society looks at parents with large families with a judgmental eye—why does she have so many children? How does she manage

her home and take care of housing, food, medical, dental, vision, education, special needs, and the emotional, social and physical well-being needs of her children? And this family that society deems as large consists of 5 to 6, maybe even up to 12 children. But when these children come into the care and under the supervision of case managers in the CCFS system, that lone case manager then becomes responsible for all the responsibilities that I just outlined of the parent.

Additionally, they are responsible for meeting with the children every single month, plus meeting with foster parents and with each and every parent every month. They develop case plans for the parents and well-being needs of each child. They submit referrals for therapy and any special needs. They attend individual education plan meetings, autistic assessments, and do out-of-state travel monthly in person for each child placed in out-of-state acute hospitalization. They attend Juvenile Justice Services hearings, respond to runaway's courtroom assistance attorneys, moms' attorneys and dads' attorneys. They submit referrals for service providers on each parent's behalf—drug testing, alcohol testing, and are responsible for writing court reports in a timely manner. They report on all the efforts on everyone's behalf in your court report but are only allowed to speak on behalf of you as the individual in the courtroom. Each party salivates over that report that you are writing, only to rip it up and tear it apart for your lack of not doing whatever they thought you should have been doing. Are you tired of listening or are case managers tired of doing? Because this does not even begin to scratch the surface of the administrative tasks that go along with each of those actions that I have just outlined. The results do not equal best case management, which each caseworker that I know comes into this field to do. The results equal stress, burnout, declining health, minimal self-care and that is why I am in support of S.B. 183.

CASEY STIMPSON (Clark County Department of Family Services):
I am a 19-year member of Service Employees International Union (SEIU) Local 1107, a supervisor in specialized permanency and I am in support of S.B. 183. We serve the children and families impacted by sexual abuse, child fatalities, near-fatalities, at-risk youth and physical abuse to children aged four and under. Children on these caseloads have extensive medical, emotional and behavioral needs. Over the last three years, we have seen a drastic reduction in staff and an increase in caseloads. In 2022, specialized workers averaged 15 new kids assigned to their caseload. In 2024, that average increased to

30 new kids. This alone has resulted in multiple specialized workers managing caseloads well over 30 kids.

This bill will help ensure your workers are better able to serve the children in our communities. Workers need to have quality interactions with children, caregivers and service providers to ensure the safety and well-being of these children. Each case deserves thorough evaluation, engagement and service provisions. Caseloads over 30 children do not allow for this. Caseloads over 30 are stuck in crisis management. Caseloads over 30 delay reunification and [unintelligible] outcomes. Managing large caseloads is overly taxing on workers resulting in increased time, illness, exhaustion and a lack of time for themselves and their families. The specialized team is made up of some of the most hardworking and dedicated people I have had the pleasure of working with, and S.B. 183 will help them do this difficult work even more effectively. Children and families deserve the best from their caseworkers.

ANDREW RIVAS (Teamsters Local 533):
I echo the comments that all my colleagues and everyone else has already said.

ALEXIS ESPARZA (SEIU Local 1107):
I am in support of S.B. 183.

SARAH EVANS (Clark County Department of Family Services):
I am a 16-year SEIU member who works at CCFS, and I am in support of S.B. 183. In January 2023, the agency had a new training academy, and we had 27 people; 13 people left the academy. Nine of those were voluntary. That's a 51 percent survival rate. I was a supervisor of permanency at that time. I lost eight people all within a two-and-a-half-year span. Mind you, I only had six people in my unit assigned to me at any given time. A great quote from a former foster youth was, "My worker was always late, disheveled and really quite strange, but he loved me, and that made all the difference."

These workers who I lost genuinely loved their kids and their kids loved them. When workers leave, it creates one more traumatic event for a child who already had to endure challenges most of us could not even comprehend. These children will grow up without the ability to form attachments or thinking they do not have a place in this world. We can do better for our children and, by making sure that children come first, we all create a better future. The agency has the capability to ensure there are reasonable caseload sizes; what they do not want

is accountability. Caseloads can be equally distributed fairly amongst our zones. We need a law in place to hold leadership accountable to reach these staffing ratios. I leave you with this data: A child with a single caseworker achieves permanency at a 74 percent rate. Whereas, if you have a child who had two caseworkers, permanency achievement falls to 17 percent.

MICHELLE MAESE (President, SEIU Local 1107; Clark County Department of Family Services):
Yesterday was my 17th anniversary at CCFS. I am so grateful to all the caseworkers and the foster parents who do this job tirelessly every day. It is a thankless job and a lot of times the workers are not thanked enough. So, I definitely want to thank them first. When I started at CCFS, the lifetime of a caseworker was 11 years; today, it is one year and three months. No one can prepare you for what you are going to see—abused and neglected children, beaten and dead children. It is a very taxing job, and we sign up for it and do it because we really want to help families.

Today I have reports that there are 151 permanency workers. We are not asking for the department to make this drastic change. Right now, there are only about 25 workers over 30 kids. We are asking them to reallocate those cases so that kids and families can be served better. I am fortunate to be with SEIU and in our collective bargaining agreement, we have Articles 10 and 42 that speak to the labor management committee. For the last ten years, we have been talking about these issues in our labor management committee about our plan and solution to make sure that children and families are served properly and that kids have quality of care from their workers. Thank you, Heather Richardson and Senators, for bringing forward this solution because we have not heard from Clark County. We are eager to support S.B. 183.

I want to tell you that 45 years ago, a 12-year-old child had a daughter, and she put her in foster care because she could not care for her. I am that daughter who she put up for adoption and put in foster care. So, I am grateful for foster parents and caseworkers. I had one caseworker, and I was adopted. I was that 74 percent my coworker, Sarah Evans, was talking about. I believe this is very doable for Clark County, and I cannot wait to hear the opposition.

ASHLEY DODSON (NAACP Las Vegas Branch #1111):
On behalf of the NAACP Las Vegas Branch #1111 and in support of SEIU, we are here to express our strong support for S.B. 183, a necessary step toward

ensuring the well-being and protection of children in the child welfare system. The child welfare system is a cornerstone of public service, yet it is one that has been overburdened and under resourced for far too long. The dedicated caseworkers who serve our most vulnerable children face unsustainable caseloads leading to burnout, high turnover and diminished quality of care. The current system not only places an undue burden on these professionals, but also jeopardizes the safety, stability and long-term success of the children in their care. We are in support of this bill as it will reduce caseloads, meaning better outcomes for children.

Research consistently shows that lower caseloads lead to better permanency outcomes, fewer placements and improved well-being for children in foster care. Overburdened caseworkers struggle to provide the individualized attention and services that children need to heal from trauma and transition to stable permanent homes. High turnover harms the system and the children. Nevada, like many states, experiences high turnover rates among child welfare professionals largely due to stress and unmanageable caseloads. When caseworkers leave children lose trusted advocates and agencies must expand resources, recruiting and training replacements, further straining the system.

Equity and fairness for Black and Brown children in foster care is a must. Studies indicate that Black children are disproportionately represented in the foster care system and experience longer stays before achieving permanency. Ensuring that caseworkers have manageable caseloads will allow them to devote more time to each child addressing racial disparities in service delivery and case outcomes. The NAACP Las Vegas urges this committee to support S.B. 183. We recognize that implementing this bill may require additional resources, but the cost of inaction far outweighs the cost of investment. A well-supported, well-resourced child welfare workforce saves lives, strengthens families and builds a healthier and more just Nevada.

RICHMAN WARNKE (SEIU):
For the sake of workers, foster parents and children, I stand in support of S.B. 183.

JOANNA JACOB (Clark County):
For the record, we are here today in opposition to the conceptual amendment on NELIS that we received a copy of today. We are just trying to work with Senator Scheible and the proponents on something that will work. We

wholeheartedly believe in the stated intent of this bill to keep our kids safe and to support our workers. You just heard a lot of testimony about the challenges that our system has and that the workers face in trying to administer the system; and that those are real challenges. In fact, in a bill that we had before this committee last year, sponsored by the National Association of Counties, we asked for a structural study of these challenges and the increased unfunded mandate that we get every session respectively from the Legislature.

You heard some of the workers talk about the increased requirements that are put onto our system and that is something that we know we need resources to sustain. The legislation that we worked on last session would have asked for a study on unfunded mandates, on Medicaid policy, and on some of the challenges we face. Included in there was a study on workload and caseload challenges. We appreciate Senator Scheible continuing to work with us on implementation and will continue to work with her on this bill.

Year after year, we have asked for our block grant that funds child welfare to be adjusted. I understand that system is not one that can be adjusted easily. However, we know that with increased pressures from the Legislature, from federal policy, from caseload, from the cost-of-living and from all the things that we have faced in the last ten years … so we are asking for your help. We understand why this bill is being proposed and we want you to know that we would like your help in getting us there. We will work with the proponents on this measure and hopefully come back to you with an amendment.

CADENCE MATIJEVICH (Washoe County):
Ms. Jacob stated a lot of things on behalf of Clark County that are also true for Washoe County. I do want to say that Washoe County is already in compliance with the original version of the bill. While we understand that may not be the case for our sister county, from Washoe County's perspective, we are able to meet that. We appreciate Senator Scheible's willingness to hear our concerns about the proposed amendment. We are just concerned that it is overly prescriptive. The question Senator Titus asked about the ability of a child welfare agency to work within our existing caseworkers and appropriate caseloads is not just about the number of a single case. We are concerned about that, and I would echo Ms. Jacob's comments, and we stand behind the policy.

We understand that this is incredibly difficult work that these people do, and we value them tremendously. But without the resources to pay for this—and I recognize this is not a fiscal committee—but in this case, the money is the policy. Section 2 of this bill says that if the Legislature places a new requirement on local governments that they give us the revenue. That does not apply to us. So, we have been given the mandate but have not been given the resources. We look forward to continuing the discussion about how to meet the intent of this bill within our limited resources, and we look forward to the partnership.

CHAIR DOÑATE:
In addition to hearing testimony today on S.B. 183, our committee secretary received four letters in support (Exhibit J). The hearing on S.B. 183 is now closed, and we will open it up to public comment.

CHRISTAL SANDERS (Clark County Department of Family Services; SEIU Local 1107):
I am a 16-year member of the SEIU Local 1107 and work as a family services supervisor. I was waiting for you to let us know that we can volunteer to be put on in support of the bill, but that did not come across. So, I hope that this is okay. I am in support of S.B. 183. I have been with the agency almost 17 years and have been newly promoted to supervisor in November 2024. I am not too far removed from the field so I can speak from personal experience as one of those front-line workers. I am not sure how many individuals in the room are familiar with what we do or how hard our job is. Just over the last two weeks, I lost my senior worker because she was overwhelmed and did not feel supported. I am now down to four people. One of those four individuals is letting me know she is seeking other employment because she is overwhelmed and feeling not supported. One of my other workers two weeks ago was up to 45 kids—today she is down to 40. She is not able to adequately assess safety like that. She is not able to adequately spend the time with her parents to find out what it is that they need and how she can better serve them.

We all have to remember that these individuals that we service in our community are not separate from us. They are our neighbors. These kids go to school with our children; they work beside us in some of our jobs. So, when you have these workers who come to work every day to do the job that they love, we cannot control how many calls come into our hotline from day to day. We can't control how many calls get screened out that need someone to come

out and investigate from day to day. What we need is support on our front line so that we do not lose these workers who are dedicated to our families, child safety and well-being. That is our overall objective here, child safety and well-being. We would be doing our community a disservice by not considering the caseload sizes of our workers and their inability to properly service the families and children within our communities.

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CHAIR DOÑATE:
I made an exception to allow your testimony in favor of S.B. 183 because I did make an oversight of not calling for support testimony online for that bill. However, for any further public comment callers, I reiterate that we have concluded the bill hearing. Therefore, your comments can be general, but they cannot refer back to the bill. You can always send your testimony in writing to us. We will now continue with public comment.

Hearing no public comment, I would like to remind any additional testifiers on any of the bills that they can still send in their written testimony. Having no further business, this meeting is now adjourned at 6:32 p.m.

RESPECTFULLY SUBMITTED:

_____
Donna Crawford Kennedy
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. 244	C	4	Steven Shane / Renown Children's Pediatric Specialty Care, Healthy Lifestyles Clinic, Renown Children's Hospital	Presentation
S.B. 244	D	19	Amy Shogren / Novo Nordisk	Proposed Amendment
S.B. 244	E	20	Senator Fabian Doñate	Five Letters in Support
S.B. 262	F	20	Senator Julie Pazina	Conceptual Amendment
S.B. 214	G	45	Senator Fabian Doñate	One Letter in Opposition
S.B. 183	H	45	Senator Melanie Scheible	Proposed Amendment
S.B. 183	I	48	Heather Richardson	Letter of Support
S.B. 183	J	59	Senator Fabian Doñate	Four Letters in Support