MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
February 14, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:31 p.m. on Tuesday, February 14, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

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

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Patrick D. Kelly, President and CEO, Nevada Hospital Association
Fran Almaraz, President, Nevada Silver Haired Legislative Forum, District 10
Marie Coe, State Long-Term Care Ombudsman, Aging and Disability Services Division, Nevada Department of Health and Human Services
Tom Morley, Laborer's Union Local 872 and Local 169
Marc Ellis, President, Communication Workers of America Local 9413
Dora Martinez, Nevada Disability to Action Coalition; Nevada Council of the Blind
Lisa Bogard, President and CEO, Anthem Blue Cross and Blue Shield
Emily Paulsen, Housing Program Manager, Anthem Blue Cross and Blue Shield
Kelly Simonson, President, Health Plan of Nevada
Rob Baughman, Plan President, Molina Healthcare Of Nevada, Inc.

Eric Schmacker, CEO, SilverSummit Healthplan
Niki Atcheson King, Vice President of Community Solutions, SilverSummit Healthplan

CHAIR DOÑATE:
I will open the meeting with the Nevada Hospital Association.

PATRICK D. KELLY (President and CEO, Nevada Hospital Association):
I will go over my presentation, which is an overview of our healthcare delivery system in Nevada (Exhibit C). The Nevada Hospital Association (NHA) has 68 hospitals in the State. Three of the 68 are federal facilities with one hospital at Nellis Air Force Base and a veteran facility in the north and the south. The 68 hospitals are acute care, behavioral health, critical access, long-term acute care and rehabilitation hospitals. The NHA has over 34,000 employees with a $4.3 billion payroll. We have 360,000 patients and over 1 million emergency department visits each year.

Since NHA does not track community benefits, we rely on the annual reports submitted by the hospitals to Nevada. However, this information is limited to hospitals with 100 or more beds. As a result, we can only provide information on 19 acute care hospitals. Under reimbursed health care, NHA provided $1.3 billion in care for patients on Medicare, Medicaid, uninsured and underinsured. These are patients in our hospitals who cannot pay the total cost of the services they received. Medicaid pays about 53 percent of the cost of care. Medicare pays approximately 87 percent of the cost. This has resulted in many patients not covering the total cost of their care.

The NHA provides professional health education in our hospitals for medical and nursing students. Any medical technician or student receiving certification needs some training within a facility. The NHA will provide this service. In addition, it provides services to the community through health education, clinical support services and other health-related needs. In 2021, NHA contributed $524 million in capital improvements to enhance access to medical care.

Half of the acute care hospitals in the State had a negative operating margin for the first three quarters of 2022. We do not have the fourth quarter data, but I do not expect it to improve. Half of the hospitals are having some economic struggle. In 2022, we experienced inflation and shortages of goods. We also had a surge in cases of COVID-19 and of respiratory illness. We saw many

cases of children with Respiratory Syncytial Virus (RSV). We also had many adults with respiratory illnesses.

I would like to discuss the cost drivers. The first component is drug costs. For example, there was a shortage of gadolinium dye. This contrast dye is used for Computed Tomography and Magnetic Resonance Imaging, commonly called CT/MRI. When available, the price for the dye increased from $700 to $7,000. A second component is the increased cost of supplies like baby formula and goods made from petroleum. Supplies such as nitrile gloves, plastic syringes with the needle in it, plastic IV bags and tubes all increased due to petroleum prices. The final component is labor cost. Payroll is 60 percent or more of our total cost.

We did a survey of our hospitals and requested the number of vacancies on July 1, 2022. The hospitals reported over 2,300 vacancies in registered nurse (RN) positions, 188 licensed practical nurse (LPN) positions and 616 certified nursing assistant positions. This data does not include the rest of the healthcare delivery system. The vacancies in the hospitals caused us to hire traveling nurses. We had to pay a traveling nurse two to four times the normal rate of pay for a staff nurse. The salary for the average RN is $89,700 and for an LPN is $60,000. As of October 31, 2022, Nevada is ranked by *Becker's Hospital Review* as having the sixth highest RN wages when adjusted for the cost of living. Nevada's salaries are competitive with New York, Massachusetts and California.

Since the COVID-19 surge, we have not discharged patients in a timely manner due to the shortage of nurses. In December 2022, we averaged 517 patients medically cleared for discharge, but we were unable to timely discharge them. The nursing shortage is one of the biggest problems plaguing the Nevada healthcare delivery system. There is no solution on the horizon, and projected retirements, based on the age of our nurses, is a concern. We also need policies and laws encouraging physicians to practice in Nevada. We are in desperate need of physicians.

Finally, I would ask for no additional costs or burdens be placed on hospitals. Many hospitals are having financial issues and need help to get through this period. When COVID-19 first started, the federal government provided financial support, but this funding dried up quickly. In the past year, we have not received federal money needed to sustain our operations.

SENATOR TITUS:
One thing we experienced at my hospital is a staff nurse leaving employment to become a traveling nurse. Do you have any information on the number of nurses who opted to do this?

MR. KELLY:
We do not have that information. As noted in my presentation, Nevada wages are competitive, but we cannot compete with the wages for traveling nurses.

SENATOR TITUS:
During COVID-19, healthcare employees near retirement age would choose to retire. It is not anticipated that these employees will return to the workforce. We are considering bills that include a nursing licensure compact allowing nurses from other states to work in Nevada. This may accelerate licensure in Nevada. Would NHA support this legislation?

MR. KELLY:
We would support this legislation. It will help when we experience a surge, but it may not solve the nursing shortage. During the RSV surge, the east coast started to experience RSV cases before we did. In response, east coast hospitals contracted pediatric nurses. The pool of these nurses is not large, and the east coast hospital would contract them for three to six months. When Nevada began to experience the RSV surge, it was difficult to recruit nurses. In addition to the shortage, some of the traveling nurse companies had moved Nevada down on the priority list. The time frame to place a nurse is a deterrent for prioritizing Nevada. If Nevada became a compact state, the nurses could start working in a Nevada hospital immediately.

SENATOR TITUS:
A solution to healthcare providers is ensuring partnerships with the hospitals. Is NHA ready to partner with and continue to partner with the university system's nursing schools? We need to make sure slots are available whether it is a social worker, a nurse or a laboratory technician.

MR. KELLY:
We do want to help, but the problem we encounter is scheduling. The students want to come into the hospital during the exact same hours. We need educators to work with us on a schedule with staggered times. This will eliminate the

congestion. With the tight nurse supply in the hospital, it is difficult to have nursing students on the floor to train.

CHAIR DOÑATE:
On page 5 of Exhibit C, you discussed the under-reimbursed healthcare cost is $1.3 billion. Is this figure from 2022?

MR. KELLY:
The figure is from 2021.

SENATOR NGUYEN:
During the COVID-19 pandemic, Nevada had a nursing compact to permit flexibility in staffing. Is this protocol still in place and are we able to bring in nurses without the compact right now?

MR. KELLY:
It is no longer in place. During the COVID-19 pandemic, Nevada Declaration of Emergency Directive 011 allowed us to bring in nurses very quickly. The emergency directives related to COVID-19 have since been terminated.

SENATOR STONE:
What is the impact of the low Medicaid fee on Nevada hospitals?

MR. KELLY:
It has led to cost shifting and it needs to be addressed. We have been working on the Medicaid provider fee program for hospitals. We are getting close to finalizing it. It should help some of the hospitals in financial trouble.

SENATOR STONE:
I am concerned about hospitals operating in the negative. The cost shift will have a positive impact and allow greater access by physicians willing to take it.

What do you think is the largest hindrance to attract nurses to Nevada? You mentioned Nevada is one of the highest payers of nurses in the Country. What is the obstacle for recruiting?

MR. KELLY:
Our issue is we are not graduating enough nurses. Based on my research, the State has experienced a low number of graduating nurses for 15 years. The

problem is cumulative, and COVID-19 caused it to snap. We need to graduate more nurses. We are looking at different ways to increase the number of nursing students. We could look at a two-year RN program or recruiting foreign nurses.

SENATOR STONE:
We support expanding the number of nursing students in Nevada. However, if we are going to have an immediate solution for the nursing shortage, then we need to be more innovative.

Our neighboring state had a major problem with homeless populations occupying emergency rooms. How has the homeless situation affected hospitals in Nevada?

MR. KELLY:
At times, we do have homeless people using the emergency room as shelter or an opportunity to receive meals. I would welcome a meeting regarding the homeless population and how we can best serve them.

CHAIR DOÑATE:
What has been the response from the hospitals regarding the recent so-called patient dumping? Has there been a further discussion on the transition of care between different hospital systems? Have you had an internal conversation? Can you provide some insight on this?

MR. KELLY:
I did see the patient dumping video and was concerned about it. We have had discussions on this topic.

CHAIR DOÑATE:
On page 10 of Exhibit C, you discussed hospitals operating in the negative. Do you have the same information prior to COVID-19?

MR. KELLY:
I did create a chart the year before COVID-19 and about one-third of the hospitals had a negative operating margin of 1 percent or less. One percent does not make a material difference, but it is increasing. The whole healthcare delivery system has been struggling the last couple of years.

SENATOR LANGE:
Nevada is paying staff nurses a competitive wage, yet we are still hiring traveling nurses who are making more money. Does this reduce the opportunity to hire more full-time nurses?

MR. KELLY:
At this point, we will hire any qualified nurse. A traveling nurse is not ideal since their earnings will benefit another state. If we can increase the number of staff nurses, then it will have a greater economic impact in the State.

SENATOR LANGE:
Do you think people prefer to be traveling nurses due to the compensation? Is this the reason it is difficult to attract full-time staff nurses?

MR. KELLY:
We are beginning to see a slowdown of people wanting to be traveling nurses. The traveling rates have decreased since the surge. We were paying four times the normal rate and are now paying twice the normal rate. People are also tired of traveling.

SENATOR LANGE:
Have you seen more nurses transitioning from traveling into full-time staff positions?

MR. KELLY:
There has been a slight increase but nothing overwhelming.

CHAIR DOÑATE:
I will open the hearing on Senate Bill (S.B.) 45.

SENATE BILL 45: Establishes the amount for the personal needs allowance provided to certain recipients of Medicaid. (BDR 38-295)

FRAN ALMARAZ (President, Nevada Silver Haired Legislative Forum, District 10):
I am here to present S.B. 45. This legislation would increase the monthly personal needs allowance (PNA) for certain Medicaid recipients residing in skilled nursing facilities. This bill is proposing the PNA will equal the amount received by Medicaid waiver recipients living in group homes.

The Nevada Silver Haired Legislative Forum was created in 1997 to identify and act upon issues of importance to aging persons. The Forum strives to promote inclusive government by directly involving seniors in the legislative process. It is comprised of up to 21 members, 60 years of age or older, nominated by State Senators for appointment by the Legislative Commission. Forum members participate at public meetings, ask questions of the presenters and discuss agenda items for future consideration. In the past, the Forum studied senior issues such as respite care for caregivers, improvements in the provision of long-term care services, protection of seniors from abuse and neglect and homelessness among aging seniors in Nevada. The Forum may submit one bill draft request for each regular Legislative Session.

During the last Interim, Forum members met five times and considered topics related to climate change awareness and resilience planning for senior citizens, potential increased penalties for scams and fraud targeting seniors, long-term care challenges and opportunities, assistance for seniors with dementia and their caregivers and families, and community services and assistance for seniors in need in Nevada.

At the June 2022 Forum meeting, during a Nevada Department of Health and Human Services (DHHS) presentation, members learned that there are two care options for long-term services and support for certain Medicaid recipients: institutional care and home- or community-based services. Institutional care is an individual residing and receiving care in a skilled nursing facility due to a high-level need for care. Home- and community-based services allow individuals to continue living in their homes or in home-like settings such as group homes. These individuals have significant physical or cognitive limitations and are at risk of being admitted to a nursing facility. These services allow the individual to remain integrated with the community.

We also learned that the Supplemental Security Income Restoration Act provides Medicaid recipients, residing in nursing facilities and group home settings, to have PNA. This Act requires the PNA to be deducted from their monthly income to reserve funds for costs of care not reimbursed by Medicaid. The rest of their monthly income goes to the nursing facility or group home for room and board. These Medicaid recipients depend on PNA for items like clothing, grooming needs, snacks, writing utensils, stationary, essential personal items and other incidentals. Federal statute sets a $30 minimum monthly PNA. States can allow a higher monthly PNA than the required federal minimum.

In Nevada, Medicaid recipients living in nursing facilities receive a $35 PNA but those living in group homes receive $149. This has created a disparity of $114 a month. A senior living in a group home receives an allowance over four times higher than a senior residing in a nursing facility.

Based on information provided by DHHS, the Division of Welfare and Supportive Services (DWSS), the PNA rate for residents of nursing facilities has not changed since 1991. Nevada is one of seven states maintaining a PNA rate of less than $40. Seniors residing in a nursing home must save their PNA for several months to replace basic items. Inflation has only exacerbated the problem of affording everyday items.

In contrast, seniors living in a group home and receiving Medicaid home- and community-based waiver services have their PNA increased annually. The rate is derived from the Social Security Administration's cost-of-living adjustment (COLA). Effective January 2023, these recipients received a total Supplemental Security Income (SSI) of $1,305 per month. The split is $914 from a federal payment and $391 from a supplemental State payment. Waiver recipients may keep an allowance of $149. The remaining $1,156 is used to cover room and board costs. The PNA is increased proportionately to the SSI COLA adjustment. For example, the 2023 COLA increased the PNA approximately 8.7 percent from $137 per month to $149.

I will give you two examples of other states tying the allowance increases of nursing home residents on Medicaid to the COLA by the Social Security Administration. Minnesota established a monthly minimum amount of $45 for PNAs and requires COLA increases by the same percentage increase as the federal benefit rate. Washington set the PNA at $72.05 for clients being served in nursing homes in residential settings. They are increasing the allowance by the COLA percentage. In 2022, Washington passed a bill allowing Medicaid recipients in long-term care settings to keep up to 300 percent of the federal benefit rate to cover personal and household expenses.

Senate Bill 45 will fix the discrepancy in PNA regardless of the long-term care facility a person resides in.

The core policy of S.B. 45 is provided in section 1 of the bill, which requires the monthly PNA for Medicaid recipients in a skilled nursing facility to be equal to the PNA received by Medicaid waiver recipients living in a group home setting.

Section 2 makes certain conforming changes. Section 3 makes the bill effective upon passage and approval, for the purpose of performing administrative tasks. For all other purposes, the effective date is January 1, 2024.

Increasing the PNA from $35 to $149 for Medicaid recipients residing in skilled nursing facilities would also impact the recipient's share to the nursing facility. If the PNA increases, the recipient's share decreases. This means the cost covered by Nevada Medicaid would increase by $114 per recipient.

I would also like to highlight the actual costs for State and county funds are less than $1 million each for the upcoming biennium. The Federal Medical Assistance Percentage will cover the majority of the increased cost.

This concludes my presentation of S.B. 45. This bill will improve the quality of life for seniors and others dependent on long-term care services and support. Supporting this bill is an acknowledgement of our responsibility to care for vulnerable senior citizens in Nevada.

CHAIR DOÑATE:
I just want to remind the Committee members, this is a policy committee and not a finance committee.

SENATOR NGUYEN:
My question is a money issue, but it is related to a policy question. What is the monetary amount to an individual seeking this increase?

MS. ALMARAZ:
In the nursing home facilities, it would be an increase from $35 to $114.

SENATOR TITUS:
I need clarification. In your testimony, you used the term nursing home and skilled facility interchangeably. There is a significant distinction between these terms. For my clarity, are long-term care patients already receiving PNA and skilled facility patients are not receiving the PNA?

MARIE COE (State Long-Term Care Ombudsman, Aging and Disability Services Division, Nevada Department of Health and Human Services):
Skilled nursing facilities do have residents who are there for rehabilitation and residents who are there for long-term care. Senate Bill 45 would only affect residents who are in the skilled nursing facilities for long-term care.

SENATOR TITUS:
Thank you for the clarity. It is about parity for patients at the same locations but receiving different levels of care. The patients should receive the same amount of funds for their personal use. What percent of our patients in long-term care facilities are on Medicaid?

MS. COE:
Any patient resident who is in a facility has the potential to be there long term.

SENATOR TITUS:
Are you aware of a plan to increase the number of ombudsmen?

MS. COE:
We have had a significant increase in our ombudsmen throughout the State. This has allowed increased visitation in rural areas. We can visit residents in long-term care on a monthly basis. The increased frequency has brought many issues to our attention and has allowed us to properly advocate for the residents. We are continuing to grow with the needs of our residents in long-term care.

SENATOR STONE:
I want to make sure I understand it correctly. At a group home, they receive $35, and at a skilled nursing facility, they receive $114.

MS. COE:
Residents in community care group homes are receiving a higher amount of spending money than residents in a skilled nursing facility.

SENATOR STONE:
Is the amount paid to each of those facilities the same?

MS. COE:
The amount paid to the facilities is not the same. A significantly higher amount is paid to skilled nursing facilities. Typically, a resident in a skilled nursing facility has a higher need than somebody in a community care group home. This is based on their daily living activities and care required. A community setting would have a caregiver not specifically trained. We also see people with disabilities and people who do not qualify for services in the lower levels of care due to age. In addition, it could be an individual who has a medical need that may be able to be met in the community. However, the programs of support may not be available in the community, and they may be a resident at a skilled nursing facility.

SENATOR STONE:
This award, whether it is $35 or $114, reduces the gross amount paid on behalf of the senior citizen. If you have a higher amount paid out, does it mean the home is going to get less? Will it have an impact on the beds available at some of these facilities?

MS. COE:
It would not have an impact on availability of beds or licensure within the facility. I will defer to DHHS, the Division of Health Care Financing and Policy (DHCFP), regarding the financial impact to the facility.

SENATOR LANGE:
To clarify, the $114 difference is the amount between the two groups. Is the goal to give parity with everyone receiving $149?

MS. COE:
Yes. Since 1991, residents at a skilled nursing facility with a higher level of care are receiving $35 a month. There is not a process to review and increase the amount. It has been a flat rate since 1991 and has not been looked at since then. The residents in a lower level of care are receiving a higher amount and have a different process for determining the amount.

SENATOR TITUS:
I want to clarify that this monthly amount is not about reimbursement for the facility. This is for the resident to use the money on personal items. This is not intended to cover the cost of the resident living in a facility.

TOM MORLEY (Laborer's Union Local 872 and Local 169)
We are in support of S.B. 45.

MARC ELLIS (President, Communication Workers of America Local 9413)
We are in support of S.B. 45.

DORA MARTINEZ (Nevada Disability to Action Coalition; Nevada Council of the Blind):
We are in support of S.B. 45.

SENATOR NGUYEN MOVED TO DO PASS S.B. 45.

SENATOR TITUS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
We will have each Nevada Medicaid Managed Care Organization (MCO) present its plans and the work it has done in the community.

LISA BOGARD (President and CEO, Anthem Blue Cross and Blue Shield):
I will provide an overview of our healthcare delivery system in Nevada (Exhibit D contains copyrighted material. Original is available upon request of the Research Library.) Elevance Health is one of the largest health benefit companies in the United States. One in eight Americans receive coverage from an Elevance-affiliated plan. We support health at every life stage. We offer health plans, clinical behavioral health, pharmacy and complex care solutions. Our approach to health really begins with redefining health and reimagining the system to strengthen communities.

Anthem Blue Cross Blue Shield is a part of Elevance and has been providing care to Nevadans for over 50 years. One in five Nevadans carry an Anthem card. Anthem employs more than 1,800 Nevadans. We have been a trusted State partner serving the Medicaid population for over 13 years and have over 212,000 members. We are unwavering in our commitment to improve the health of Nevadans.

Our whole health approach is an integrated care model. It is designed to improve health outcomes in advancing health equity. We have six different domains: maternal and child health, chronic disease management, access to behavioral health, social determinants of health, prevention and vaccinations, and rural health and network. It is important to address the disparities in rural health. Strengthening all communities has a positive effect on health. Building those partnerships and creating connections with our community partners supports overall health.

In 2022, Anthem partnered with over 115 local community organizations. Each year, we bring a mammogram van into specific zip codes. We are bringing a service to women who do not always have access to this care. We also have a rural diaper bank, and I was excited to give out the two millionth diaper. In support of workforce development for medical students, we have created grants and sponsorships at the University of Nevada, Las Vegas (UNLV) and the University of Nevada, Reno (UNR). We are working towards ensuring Nevadans will have access to sufficient care.

Since 2017, we have focused on a program called Anthem Pathways. Each year we provide support, including housing, for inmates exiting parole and probation from our justice system. This program is aimed at reducing the recidivism rates. Our current recidivism rate for these programs is 5 percent. We are pleased to continue this program every year and view housing as health.

EMILY PAULSEN (Housing Program Manager, Anthem Blue Cross and Blue Shield):
I would like to present a program to provide stable housing as a healthcare benefit. Anthem has launched a strategy offering an array of housing interventions for its members. Housing interventions include housing problem-solving, homeless prevention and diversion, emergency housing, transitional housing and permanent supportive housing. Each of these housing programs integrates physical and behavioral healthcare management. As a result, members benefit from interdisciplinary support and care. We know housing members who are experiencing homelessness transform their lives. It provides safety, stability and wraparound support. It will give them access to physical and behavioral healthcare services. Housing will reduce emergency room visits and inpatient stays. In Anthem's supportive housing programs, which serve higher needs members, cost studies have shown up to $2,300 in savings per member per month from reductions in emergency room and inpatient utilization.

Providing housing as healthcare is not a new endeavor for Anthem Nevada Medicaid, which is the first MCO in the State to offer value-added housing benefits. In 2022, Anthem significantly increased community reinvestment into the housing continuum by launching new programs. By investing approximately $4.5 million into housing programs, Anthem exceeded the 3 percent contractual requirement. These efforts provided housing support to over 1,800 Anthem Nevada Medicaid members experiencing homelessness or housing insecurity.

Supportive housing works and is an investment as a healthcare resource. One member visited the emergency room 353 times in the year before he received housing through the permanent supportive housing program. After six months in his new home, the member stopped utilizing the emergency room for services. The individual spent an entire year without visiting the emergency room because he was able to get connected to the right providers for the right care.

MS. BOGARD:
In closing, Anthem is the first Nevada MCO to achieve the National Committee for Quality Assurance (NCQA) Health Equity accreditation. It is important to consider community needs.

SENATOR NGUYEN:
Can you provide additional information and the actual amount you dedicated to the community investment funds in Nevada?

MS. BOGARD:
Anthem spent approximately $4.5 million in 2022 on community investment. In addition, there were value-added services and benefits provided to members.

SENATOR NGUYEN:
Can you provide an example of the value-added benefit unique to your program?

MS. BOGARD:
During the COVID-19 timeframe, a benefit was a $100 member incentive program to promote vaccines. This year, Anthem is providing postpartum incentive meals for mothers. Another pregnancy benefit is incentive items like car seats.

CHAIR DOÑATE:
We will proceed with a presentation from Health Plan of Nevada (Exhibit E).

KELLY SIMONSON (President, Health Plan of Nevada):
Health Plan of Nevada (HPN) recently celebrated its fortieth year of serving its members in Nevada. For the last 26 years, HPN has been serving Nevada Medicaid recipients and is the only insurance company contracted with DHCFP since the inception of Medicaid managed care in 1997. Starting with only one member, HPN brought mainstream medical services and healthcare services to individuals in the Medicaid arena like our commercial members.

Health Plan of Nevada has gained a lot of information and knowledge about these Medicaid members over the last 26 years by listening and understanding their healthcare service needs. As a result, HPN has built a program and a network around those needs to serve the members' health care. When given a choice, a member often chooses this health plan. Today, HPN enrolls about 232,000 members in Clark and Washoe Counties, representing the largest market share in the State or about 32 percent.

Health Plan of Nevada is part of United Healthcare and under the overarching umbrella of UnitedHealth Group. Approximately 6,600 Nevadans are employed and volunteer about 83,000 hours per year. Health Plan of Nevada makes significant investments in this community and has focused on the provider network, offering more than 10,000 unique providers to serve Medicaid members in Clark and Washoe Counties.

Health Plan of Nevada has a comprehensive clinical program overseen by chief medical officers and a behavioral health chief medical officer. They manage 350 clinical employees in Nevada. Staff follows the members through their healthcare journey from the inpatient setting to the outpatient setting. Health Plan of Nevada ensure the members receive the right care at the right time in the right setting. Complimentary to the clinical programs are the social determinants of health programs. Research shows 85 percent of the factors impacting health have been completely outside the healthcare setting. Social determinants of health are food, housing, transportation and employment insecurity. Health Plan of Nevada has built programs to address these needs for members. The housing program, originally launched in 2015, has continued to grow by providing transitional housing, long-term and supportive housing, sober living housing and medical respite housing.

In 2015, HPN also launched a complement of community health workers. It is a group of field-based workers in the communities to meet with members and close the gaps in social determinants of health. Individuals can focus on their healthcare needs and not be burdened by issues such as insecure housing and food.

A part of social determinants of health are health equity programs. Health Plan of Nevada has several programs available to members to address disparities in health care. For example, a "doula" program was begun a couple of years ago. Looking at the birth outcomes for African-American women in the program, 92 percent of the babies are born at a full-term birth gestation. A vaccine navigator program focuses on minority communities and childhood immunization rates. The vaccine rate is increasing, particularly in the Latino community.

Health Plan of Nevada is the highest rated NCQA Medicaid managed care plan available in Nevada. The rating is based on consumer assessment of health plan service scores and Healthcare Effectiveness Data and Information Set.

Health Plan of Nevada is focused on four areas to improve these member healthcare services. The first area is access to care. Additional programs were launched to serve members where they live, including a mobile clinic and partnering with other mobile clinics in the community. Home-care programs send practitioners to the home, and telehealth is an option for members. Another focus is on integrated care sites where members can receive behavioral and medical services in the same setting.

Another plan is to partner with provider groups to help them engage in recruiting efforts to bring more physicians to the State and develop additional programs for primary care. This service will be available to Medicaid recipients.

The second area is behavioral health care. Since 2020, HPN has focused on expanding this network by 170 percent. Recently, a provider group in southern Nevada transitioned from a fixed fee per patient or capitation agreement to a fee-for-service program. Further plans are to build out a peer support specialist program, a recovery and resiliency program and a crisis continuum of care model with internal and external partners. In addition, DHCFP has submitted a substance use disorder waiver program, which is waiting for approval from the Centers for Medicare & Medicaid Services (CMS). It will allow for residential care for those afflicted with addiction issues.

The third area is social determinants of health. Besides housing, members need support and wraparound services. An "in lieu of tenancy support" program has been submitted by DHCFP and is waiting for approval from CMS. Once approved, it will help further build out tenancy support services. The goal is to give the member self-sufficiency and to potentially move off Medicaid. Transportation to medical appointments, social service appointments and behavioral health appointments is another benefit, as are a variety of food insecurity programs.

The fourth area is Medicaid redeterminations. Health Plan of Nevada is focused on partnering with the State to mitigate the uninsured rate from potentially increasing. One way is updating demographic information with the State on members. Educating community-based organizations and providers on Medicaid redetermination will aid them in passing this knowledge onto Medicaid recipients.

Health Plan of Nevada has a legacy of giving back to the community by making an investment in Nevada community-based organizations. This investment comes from the parent organization, UnitedHealth Group, and ranges from $250,000 to $25 million. To increase the healthcare workforce, grants were made to the UNLV School of Medicine and Touro University. For affordable housing, over $2 million was given to community-based organizations in 2022.

To bring budget predictability to Medicaid managed care, the State can transfer cost risk of claims to the health plans for a fixed payment. There are guardrails around profits and losses for managed care plans. The federal medical loss ratio (MLR) is set at 85 percent. If less than 85 cents is spent for every dollar of revenue received, the money goes back to the State. Failure to reach the targeted MLR means not enough money was spent to care for members. In compliance with *Nevada Revised Statutes* 680B.025, HPN pays a premium tax to the State. This tax is based on 3.5 percent of the premiums written on policies.

To improve health care, the State measures HPN in several ways. One example is the Healthcare Effectiveness Data and Information Set. It is a common tool, provided by NCQA, to measure performance care and service. There is also "a pay for performance," where the State withholds a certain percentage of the insurance premium. Health Plan of Nevada has an opportunity to win the money

back by meeting the targeted goal. Member satisfaction is another measurement through an annual cap survey and member services case management.

Over 350 clinicians assist members and the community health workers in the field by promoting value-added benefits, such as housing, food programs, transportation programs and gasoline purchases at a discounted rate. These benefits are offered outside of Medicaid managed care capitation rates.

The State monitors the contractual access and availability requirements to members. Through value-based contracts with providers, it opens more appointments for members. Also, by scheduling appointments directly into some provider scheduling systems, it takes the burden away from members.

SENATOR NGUYEN:
Do you coordinate with other MCOs to reinvest funds into the community? You referenced a couple of organizations and nonprofits around housing. How do you select an organization for reinvestment?

MS. SIMONSON:
Health Plan of Nevada meets regularly with community-based organizations. The requesting organization completes a form and describes the program. Once received, the request is vetted to determine if it would meet the needs of members.

Health Plan of Nevada coordinates with other MCOs on projects like Northern Nevada Food Bank. The MCOs have coordinated to bring people in and educate them about Medicaid, on how to obtain the benefits and what services are available.

SENATOR TITUS:
You mentioned Clark and Washoe Counties. Do you offer your programs throughout the State?

MS. SIMONSON:
We do not. Our service area for Medicaid is Clark and Washoe Counties.

SENATOR TITUS:
You mentioned increased telehealth flexibilities. You also mentioned providers not licensed in Nevada are able to provide this service. Can you clarify?

MS. SIMONSON:
Providers who are licensed in another state can provide telehealth services to Medicaid recipients. For example, pediatric subspecialties are limited in Nevada. It would be helpful to have those providers who are licensed in another state to conduct a telehealth visit.

SENATOR TITUS:
I am concerned about telehealth for non-licensed Nevada providers. It could undermine Nevada brick-and-mortar providers who have established patient relationships. I would like additional information on your plan. If it is a unique specialty, not available here, then the provider needs to consult with the out-of-state specialist.

CHAIR DOÑATE:
On page 5 of Exhibit E, in terms of the 2022 primary care investments, you mentioned value-based contracting. What feedback have you received from the community?

MS. SIMONSON:
Overall, the feedback has been positive from providers. They are concerned about the Medicaid fee schedule and their ability to meet their costs. So they welcome additional reimbursement. Sometimes they are providing the services. The additional income is helpful for them to close the gap.

CHAIR DOÑATE:
We will proceed with the presentation from Molina Healthcare Of Nevada, Inc.

ROB BAUGHMAN (Plan President, Molina Healthcare Of Nevada, Inc.):
Molina Healthcare of Nevada has been in business for over 40 years driven by a mission to improve the health and lives of members. I am here to present Molina's overview (Exhibit F contains copyrighted material. Original is available upon request of the Research Library.) With physical locations in the north and the south, there are approximately 250 employees throughout the State serving over 118,000 Nevadans on Medicaid. At the beginning of this year, Molina launched a Medicare program with a rollout to the marketplace in 2024. Our mobile help unit launched this past month. The mobile unit will provide service in the communities where members live. It will address challenges in transportation and access to care. Over 25 value-added benefits are offered to members through these programs.

To focus on the Medicaid redetermination effort, Molina is updating contact information and preparing to renew Medicaid once the public health emergency ends. This is an opportunity to make sure members can successfully re-enroll in the program. Molina collaborates with providers, community-based organizations, and within our own organization and has recently added a call center. Members are directed to the State to update their contact information proactively. This avoids a crisis mode and gets them back enrolled for coverage on Medicaid.

Value-based arrangements are another big area. Over 80 percent of the membership is enrolled with primary care physicians who are part of our value-based arrangements. This goes beyond just participating in a fee-for-service environment to incentivize the providers to be focused on the outcomes.

Molina is committing $1.2 million in community-based reinvestment programs. These programs are intended to serve the greater population rather than be specific to our membership. They focus on population mental health programs, like UNR's Extension for Community Healthcare Outcomes known as Project ECHO. To support one of our partners in the Las Vegas area, the Nevada Department of Veterans Services Share Village for homeless veterans, a sizable grant was provided to them. Molina is approaching things from the social determinants of health, like homelessness and behavioral health, and looking at programs that can be impactful in the coming year. It is a continued investment with these programs.

CHAIR DOÑATE:
Can you provide some details on how your organization is addressing the homeless issue and housing?

MR. BAUGHMAN:
Molina has a housing program in the north and the south, contracting with providers to supply beds for our specific membership population and the community in general.

SENATOR STONE:
Could you elaborate on your mental health program including the professionals delivering the mental health services. Are you employing psychiatrists, psychologists or marriage and family therapists?

MR. BAUGHMAN:
Molina has a psychologist on staff. I will follow up with the Committee on the behavioral health staff.

SENATOR TITUS:
Are your services offered throughout the State?

MR. BAUGHMAN:
The service area for the Medicaid program is Clark and Washoe Counties, but the Medicare program will expand in 2023 to Nye County and Carson City.

CHAIR DOÑATE:
We will proceed with a presentation (Exhibit G) from SilverSummit Healthplan.

ERIC SCHMACKER (CEO, SilverSummit Healthplan):
SilverSummit Healthplan is a wholly-owned subsidiary of Centene Corporation, headquartered in Saint Louis, Missouri, and is the Country's largest provider of government-sponsored health insurance with over 26 million insured. SilverSummit is one of four MCOs serving Nevada with the Medicaid program in Clark and Washoe Counties. A health insurance marketplace product called Ambetter is available Statewide, as well as a Medicare Advantage program. There are 180 plus employees in Las Vegas and Reno who receive support from over 70,000 employees nationwide in a mission to transform the health of the community one member at a time. Recent accreditation from NCQA for Health Equity is woven through the fabric of every single department within this organization and is a foundational piece of what is done every day.

Everything at SilverSummit focuses on the members, including the whole health of members through integrated behavioral health providers and community networks. When building a network, there is not just a focus on time, distance or provider type, but on other factors such as ethnicity, race and gender. Members can see providers they are aligned with and feel comfortable with. Continual management ensures standards are being met and members have access to high-quality providers. Finally, to sustain and mature our network, there is collaboration with providers in value-based agreements to expand their services.

The focus is on providing access to quality care for members. SilverSummit has immediate same-day appointments seven days a week and guaranteed crisis talk

therapy and appointments for any crisis or urgent needs in our provider network. An accelerated breast cancer treatment program was developed by SilverSummit to improve survival for women diagnosed with breast cancer to eliminate delays between diagnosis and treatment.

To expand access, for example, Cure 4 The Kids Foundation is assisting in recruiting and funding a pediatric rheumatologist. Southern Nevada Infectious Disease Society is helping to fund an Infectious Disease Fellowship program. A $500,000 grant to Racial and Ethnic Approaches to Community Health is helping fund a clinic. They are a nonprofit focused on access to care in Nevada. The funding for the clinic will help reduce health disparities in the Hispanic community by providing them an access point to providers they trust.

A $500,000 grant to Nevada Health Centers is allowing them to expand into Washoe County, where they have never had a clinic and $200,000 in funding to Northern Nevada, the HIV Outpatient Programs Education and Services, better known as HOPES, is helping to fund another clinic location in Reno. Lastly, SilverSummit is working with Project ECHO to fund continuing education for some providers. One of the two Project ECHO programs this year is the Transgender ECHO Project.

NIKI ATCHESON KING (Vice President of Community Solutions, SilverSummit Healthplan):
Another focus is to increase access points within the community network by working with agencies that offer services to members, like food banks and housing. An investment of $500,000 to Baby's Bounty expanded their program to Washoe County and the northern rural counties. Access to healthy food was increased through an investment in The Just One Project. The funding was used to serve twice as many people in Las Vegas and offer evening hours for the first time. Catholic Charities of Northern Nevada received $600,000 to open a new community market in Reno and, for the first time, offer Saturday hours.

A huge gap in homeless services in Washoe County was addressed by investing $1 million in our Life Changes Healing Home. This program provides nonmedical respite care. It offers members experiencing homelessness a safe place to discharge from the hospital and receive home health care after an illness or injury.

The most ambitious project to date is the permanent supportive housing complex in Las Vegas, which will develop approximately 150 studio, one-, two- and three-bedroom options. Within the facility will be workforce development, childcare, a community market, case management and Nevada health centers with full-service clinics.

Because how we give is just as important as how much we give, SilverSummit has set up a mini foundation with an open application process. The review committee is comprised of community members and our members who score and select the awardees. In 2022, SilverSummit invested over $9 million, far exceeding the 3 percent requirement. This funding aligns with the priorities of State partners and our members.

MR. SCHMACKER:
I would like to share some outcomes SIlverSummit has achieved over the past several years. There are significant improvements in quality of care and in the behavioral health network, achieved through a comprehensive integrated approach focused on the whole health of members including social determinants of health needs. The focus is on improving maternal and child outcomes with an initiative to improve communication with providers. SilverSummit improved the notification of a pregnancy process. The care management team reviews these notifications, identifies medium- and high-risk pregnancies, and enrolls them in our nationally recognized "Start Smart for Your Baby Program." SilverSummit initiated a remote patient-monitoring program providing members with technology to monitor various vital statistics. The results are automatically sent to a clinical team who can immediately address routine, urgent and critical care needs. A 20 percent increase in survival rates is anticipated through the accelerated breast cancer treatment program.

MS. ATCHESON KING:
SilverSummit's housing program is delivering results in partnership with Clark County and Help of Southern Nevada. This program provides housing support and wrap-around services for up to two years for qualified members. Through this approach, members have reduced their emergency room visits by 96 percent while increasing their use of primary and specialty care services.

Funding $1.5 million to the public health campaign to prevent teen suicide was a partnership with Hope Means Nevada and the Nevada Office of Suicide Prevention. Both groups target teens and their parents earning less than

$50,000 a year in Clark and Washoe Counties. This investment will drive awareness about the free and low-cost mental health resources available. The data shows this campaign performed equally well among teens and parents and English and Spanish audiences. The 4,000 interventions included a 30 percent increase to the anonymous phone line with the primary users being Hispanic parents. In addition, the Trevor Project, which is the dedicated crisis line for the LGBTQ community, received 300 calls and 106 texts at SilverSummit. Primary behavioral health providers saw a 32 percent increase in new therapy appointments. Why does this matter? Because studies indicate if people are seeking mental health care, they are less likely to attempt suicide.

Finally, funding was provided to six female members to receive scholarships from the Nevada Women's Fund. The average amount of the scholarship will pay for an entire year of tuition for these recipients. The women are each pursuing degrees allowing them to give back to the community. This investment not only impacts the members but their entire family. These investments enable SilverSummit to meet our mission of transforming the health of the community one member at a time.

CHAIR DOÑATE:
Do your selection committee members have a timeline for how long they serve on this committee? Is there a diversity requirement when selecting a member?

MS. ATCHESON KING:
The selection committee is made up of five SilverSummit employees, two community members and two SilverSummit members. For the community members, Sheila Leslie and Kim Riggs were selected. As you will recall, Ms. Leslie was a State Senator for many years and is experienced in grant funding. The other community member is Ms. Riggs from DWSS. Both members understand the nonprofit world and the services provided.

The process to apply is on our website and is transparent. We built the foundation similar to submitting a grant. We read all 62 applications totaling $22 million. We score the applications based on SilverSummit priorities and the track record of the applicant.

CHAIR DOÑATE:
Do you track the applications as they go through the application process? Do you help applicants reapplying to improve the application?

MS. ATCHESON KING:
Yes. Applicants can receive help on our website or can call our office. I have received many phone calls and have walked applicants through the application. This includes guiding them on what we are looking for. Health equity is important to the foundation.

SENATOR TITUS:
What counties do you cover?

MR. SCHMACKER:
For the Medicaid side, the managed care organizations only have coverage in Clark and Washoe Counties. The Ambetter product is available Statewide. The Medicare Advantage is available in Clark County, Washoe County and several surrounding counties.

SENATOR TITUS:
On page 7 of Exhibit G, you show a 53 percent reduction in days in neonatal intensive care (ICU) in the provider network for maternal and child health. How was this figure calculated? Is it across all patients you saw a reduction? What is the reason for the improvement?

MR. SCHMACKER:
Improving notification of the pregnancy process has aided in the reduction. The earlier we know our member is pregnant, the earlier an assessment can be made. Those members at medium- and high-risk are placed into the "Start Smart for Your Baby Program." This Program has nurses trained in obstetrics, postpartum care and neonatal intensive care. The nurses navigate the members through various services and work with the obstetricians to ensure access to care. Over time, this Program has achieved the reduction in neonatal ICU days.

SENATOR TITUS:
One of the largest costs is the neonatal ICU days. Improving the outcome will give the child a better start.

SENATOR STONE:
Please explain how your program accelerates breast cancer detection and treatment.

MR. SCHMACKER:
The chief medical officer is very passionate about breast cancer treatment. The longer the delay between diagnosis and treatment, the worse the survivability of the patient. Every single day is spent reviewing mammography screenings and identifying those potentially positive. If questionable or positive, the process is streamlined to get the member into a provider. A navigator is guiding them through the process including further testing or scheduling a surgeon. We are communicating with their primary care physician to ensure their office is aware of the process. The goal is to reduce the timeline and increase the survivability for the patient.

SENATOR STONE:
Your stated you are offering psychiatric appointments within 24 hours. Is the service offered through telehealth or is it an in-person therapy session?

MR. SCHMACKER:
We collaborate with our behavioral provider network and pre-purchase appointments with in-person providers to ensure our members are getting access to care.

SENATOR STONE:
Is the provider a psychiatrist or a psychologist?

MR. SCHMACKER:
In most cases a psychiatrist. It would depend on the needs of the patient.

SENATOR STONE:
Is this telehealth network a Nevada provider or is it a national network of physicians?

MR. SCHMACKER:
We partner with two contractors to provide telehealth services. Most of the providers are in the State, but we do have some out of state.

SENATOR STONE:
Are the providers selected due to financial savings to the plan or a lack of specialties in Nevada?

MR. SCHMACKER:
It is a combination of both reasons. To ensure daily access to telehealth services 24 hours a day, both Nevada providers and out-of-state providers are needed.

SENATOR STONE:
We need to make sure our Nevada physicians are given the opportunities to participate in the health plans. We are trying to nurture a growth of Nevada physicians and not relegate service to other states.

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

CHAIR DOÑATE:
Hearing no public testimony, we are adjourned at 4:29 p.m.

RESPECTFULLY SUBMITTED:

Mary Ashley,
Committee Secretary

APPROVED BY:

Senator Fabian Doñate, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
	C	2	Patrick D. Kelly/ Nevada Hospital Association	Nevada Hospital Association Presentation
	D	13	Lisa Bogard/Anthem Blue Cross	Anthem Blue Cross and Blue Shield Healthcare Solutions Presentation
	E	15	Kelly Simonson/ Health Plan of Nevada	Health Plan of Nevada Presentation
	F	20	Rob Baughman/ Molina	Molina Healthcare of Nevada Presentation
	G	22	Eric Schmacker/ SilverSummit Healthplan	SilverSummit Healthplan Presentation