December 18, 2024

The Honorable Joe Lombardo
Office of the Governor
101 North Carson Street
Caron City, NV 89701

RE: Patient Protection Commission January 1 Report

Dear Governor Lombardo:

In accordance with Nevada Revised Statutes (NRS) 439.918, the Patient Protection Commission (PPC) is respectfully submitting its twice-yearly report to provide updates regarding the meetings and activities of this Commission. As directed by Executive Order 2024-002, the Commission has focused their attention on reviewing available data and national best practices to provide recommendations within this report aimed at addressing the state's health care workforce shortage, to allow all Nevadans access to quality health care. If further information is required, please contact me at your convenience.

Respectfully,

Joseph Filippi
Executive Director
Patient Protection Commission
jfilippi@dhhs.nv.gov
(775) 634-5420

cc: Richard Whitley, Director, Nevada Department of Health and Human Services

Enclosures:

1. PPC January 1, 2025 Report
2. Summary Minutes for PPC Meetings (June-December 2024)
3. Solicitation of Health Care Workforce Recommendations (June 2024)
4. Solicitation of Health Care Provider Recommendations Relating to Nevada Medicaid (June 2024)

Semi-Annual Report of the Patient Protection Commission

January 2025

Department of Health and Human Services

Patient Protection Commission

(NRS 439.908)

Joe Lombardo
Governor
State of Nevada

Richard Whitley, MS
Director
Department of Health and Human Services

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I. Patient Protection Commission

Commissioners

Dr. Ikram Khan, Chair
One member who is a provider of health care who operates a for-profit business to provide health care.

Marilyn Kirkpatrick, Vice Chair
One member who represents a nonprofit public hospital that is located in the county of this State that spends the largest amount of money on hospital care for indigent persons pursuant to chapter 428 of NRS.

Dr. Andria Peterson
One member who has expertise and experience in advocating for persons with special health care needs and has education and experience in health care.

Dr. Bayo Curry-Winchell and Wendy Simons
Two members who are persons with expertise and experience in advocating on behalf of patients.

Bethany Sexton
One member who represents the private nonprofit health insurer with the highest percentage of insureds in this State who are adversely impacted by social determinants of health.

Floriene Kahn
Representative of the General Public

Jalyn Behunin
One member who is a registered nurse who practices primarily at a nonprofit hospital.

Walter Davis
One member who has expertise and experience in advocating for persons who are not covered by a policy of health insurance.

Ex-Officio (Nonvoting) Commissioners

Richard Whitley, Director, Nevada Department of Health and Human Services

Celestena Glover, Executive Officer, Public Employees Benefits Program

Scott Kipper, Insurance Commissioner, Nevada Division of Insurance

Russell Cook, Executive Director, Silver State Health Insurance Exchange

Commission Staff

Joseph Filippi, Executive Director

Madison Lopey, Policy Analyst (July – September 2024)

Dylan Malmlov, Policy Analyst (December 2024)

Meybelin Rodriguez, Executive Assistant

II. Introduction

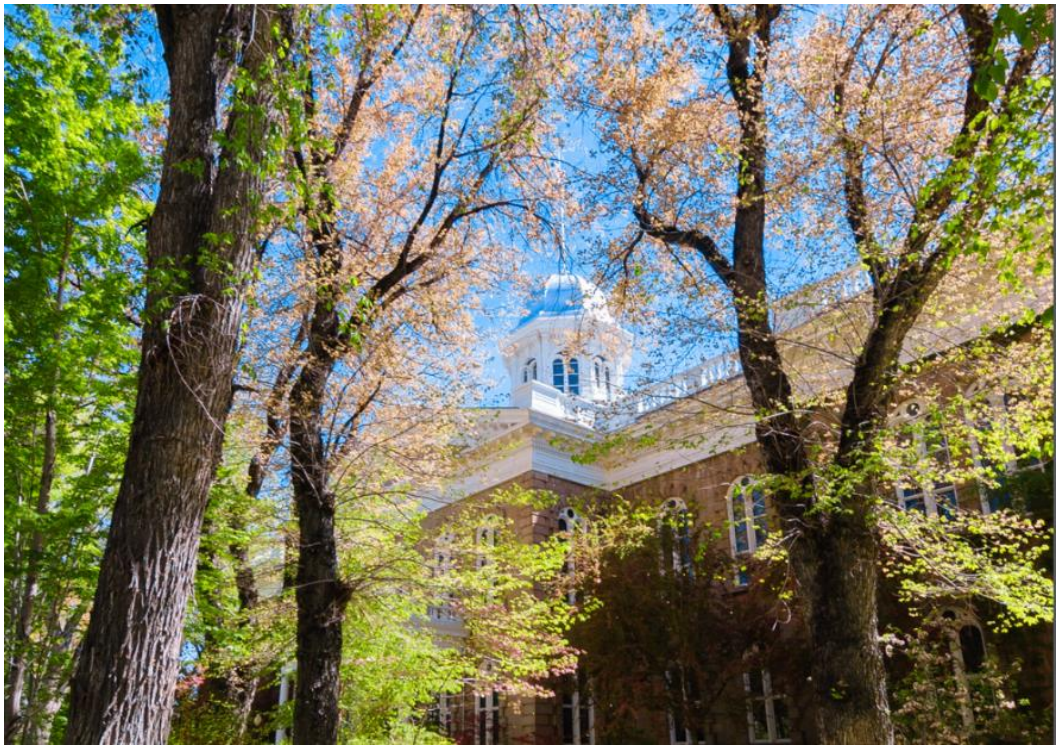
The Nevada Patient Protection Commission (PPC; Commission) is a public body located within the Nevada Department of Health and Human Services (DHHS). The PPC is comprised of 12 voting members and 4 nonvoting members appointed by the Governor with representation from across the health care spectrum, including advocates, providers, and industry professionals who are dedicated to improving health care in Nevada. Nevada Revised Statutes (NRS) 439.902-918 provides the PPC with statutory authority to systematically review issues related to the health care needs of residents of Nevada and the quality, accessibility, and affordability of health care in the state. This report is being submitted in accordance with NRS 439.918.2.(a), which requires the PPC to submit a semi-annual report describing the meetings and activities of the Commission during the immediately preceding six months. The report must include, without limitation, a description of any issues identified as negatively impacting the quality, accessibility or affordability of health care in this state and any recommendations for legislation, regulations or other changes to policy or budgets to address those issues.

As directed by Governor Joe Lombardo's Executive Order 2024-002, the Commission has focused their attention on reviewing available data and national best practices to provide recommendations within this report aimed at addressing the state's health care workforce shortage, to allow all Nevadans access to quality health care. The longstanding shortage of health care providers statewide has direct negative implications on health care access, quality and affordability for Nevada residents. Each recommendation included in this report aims to address the statewide health care workforce challenges and provide an opportunity to address the health care needs of Nevadans. This report is meant to reflect the Commission's activities over the past six months and includes several recommendations for the Governor and the Nevada Legislature to consider as the state approaches the upcoming 83rd (2025) Legislative Session and beyond.

III. Executive Order 2024-002

On April 11, 2024, Governor Joe Lombardo signed Executive Order 2024-002, directing the PPC to make recommendations aimed at addressing the state's health care workforce shortage and improving patient access to quality health care statewide. The Executive Order directs the PPC to review available data and national best practices to provide recommendations for the following:

- Attracting and retaining talent to address health-care workforce challenges in urban and rural communities;
- Improving access to primary care and public health services;
- Removing unnecessary state administrative hurdles to recruiting and retaining health-care workers;
- Identifying sustainable funding strategies for strengthening the state's health-care workforce, which includes supporting competitive Medicaid reimbursements;
- Ensuring recommended strategies for increasing provider reimbursement are based on payment methodologies that incentivize and reward for better quality and value for the taxpayer dollar; and
- Identifying strategies for evaluating new and existing state investments in efforts to improve the capacity and size of the state's health-care workforce.



(Photo of Nevada State Capitol Building, https://www.canva.com/)

Over the past six months, the Commission held five public meetings and reviewed available health care workforce data and national best practices through various presentations from external parties and other means. For more information about these meetings and materials, please go to: https://ppc.nv.gov/. Additionally, the Commission issued a public solicitation to seek health care workforce policy recommendations. Nearly 50 recommendations were submitted through the solicitation from various organizations and individuals throughout the state. Among these recommendations, a handful of themes were present with a large number focusing on increasing insurance reimbursement rates, expanding

education and training programs, improving access to care, implementing interstate licensure compacts and reciprocity, and reducing administrative barriers for providers. The Commission used the solicitation responses and other information received through public comment, Commission meeting presentations, available data, and national best practices to guide their work over the past six months. The legislative measures and formal recommendations included in this report are meant to address the health care workforce shortage in Nevada.

IV. Bill Draft Requests

Pursuant to NRS 218D.213, the Commission may submit up to three bill draft requests (BDRs) to the Nevada Legislature on or before September 1st preceding each regular session. In alignment with the Commission's efforts to address Governor Lombardo's Executive Order, the Commission developed three BDRs for consideration during the 83rd (2025) Legislative Session that are intended to address the health care workforce needs of the state. Each proposed legislative measure was developed based upon recommendations received by the public and stakeholders, input from subject matter experts and available national and state data. It should also be noted that each BDR is anticipated to have a fiscal impact. Any potential fiscal impacts will be determined during the course of the legislative process in 2025.

A. Senate Bill 40: Medicaid Health Care Workforce Account (BDR 38-451)

The Commission's first legislative measure, Senate Bill 40 (BDR 38-451), seeks to improve the capacity and size of the state's health care workforce, while increasing access to care for Medicaid recipients.[1] The legislative measure would establish a Medicaid Health Care Workforce Account and would authorize the Division of Health Care Financing and Policy (DHCFP, Nevada Medicaid) within the Department of Health and Human Services (DHHS) to administer the account. The account would provide sustainable funding to support and expand Graduate Medical Education (GME) programs, fellowship programs, apprenticeship programs and loan repayment programs. Funding allocated to the account would be matched with federal Medicaid funds, which would provide a higher return on any state investment for provider workforce initiatives.

Graduate Medical Education (GME) refers to the formal residency and fellowship training and education medical students receive upon graduation from medical school. According to the Association of American Medical Colleges (AAMC), 57.1% of physicians in the United States continue practicing in the state where they completed their residency, and Nevada aligns closely at 57.2%.[2] Of the physicians practicing in Nevada, 70.9% are in Clark County, 22.4% in Washoe County, 2.9% in Carson City, and 3.8% in the remainder of the state. In 2023, the rate of licensed physicians per 100K population in Nevada was lower than the national rate at 328.8 compared to 449.2 per 100K population and all counties except Carson City and Washoe County were below the national rate.[3] Investing in providers and programs that enhance GME will encourage current residents entering the medical field to stay in the state to complete their training as well as attract new talent from other states to practice in Nevada.

Currently, Nevada has existing GME residency programs for family medicine, internal medicine, pediatrics, anesthesiology, psychiatry and behavioral sciences, emergency medicine, general surgery, obstetrics and gynecology, orthopedic surgery,

[1] Nevada State Legislature. (2024, November 15). SB 40 (BDR 38-451). Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/11814/Overview

[2] Boyle, P. (2021, December 1). *America's medical residents, by the numbers*. Retrieved from AAMC: https://www.aamc.org/news/america-s-medical-residents-numbers-0

[3] Packham, J., Griswold, T., Mwalili, N., Brown, A., & Etchegoyhen, L. (2023, October). *Physician Workforce in Nevada: A Chartbook*. Retrieved from https://www.nvhealthforce.org/wp-content/uploads/2024/03/23-Physician-Workforce-in-Nevada-a-Chartbook.pdf#:~:text=John%20Packham,%20PhD.%20Tabor%20Griswold,%20PhD

plastic surgery, otolaryngology, and neurology.[4] Each year roughly half of the students among these programs graduated from a Nevada medical school. This is likely due to the limited residency programs available in the state which forces students to move elsewhere for additional training.[5] Expanding access to these existing GME programs will provide more opportunity for Nevada students to learn and practice in the state upon graduation.

Along with retaining talent in Nevada, GME programs can be utilized to provide medical services to rural and underserved areas by sending residents to meet with patients who typically have limited access to care. This supplies an opportunity for residents to be exposed to a variety of medical conditions while providing services to individuals and communities that otherwise may not have a chance to receive them. However, Nevada historically has had difficulty not only getting these programs stood up but also ensuring that they are financially stable as well. As an example, in October 2018, the University of Nevada, Reno, School of Medicine and Nevada Health Centers partnered to open a rural residency program for family medicine in Elko, Nevada. The program was successful in providing services to patients and education to residents for nearly five years until it ended in the summer of 2023. Although there were a variety of reasons the program didn't survive, unsustainable funding was a key factor. GME programs come with many costs for the host provider, which includes hiring a program director and physicians to supervise the residents, among other operating costs.[6] In fact, the cost per resident per year is roughly $209,000 and growing and many facilities struggle to maintain sufficient long-term funding.[7]

The Commission discussed the need to establish sustainable funding opportunities to support and expand existing GME programs that are not reliant on state or federal grants, which are short-term in nature. After presentations and discussion with subject matter experts, on August 16th, the Commission voted to use one of their BDRs to create the Medicaid Health Care Workforce Account to leverage Medicaid federal funds to support the expansion of GME programs through increased reimbursement for training sites that will improve the capacity and size of the state's health care workforce and increase access to care. This proposed change would give Nevada Medicaid the ability to expand its partnership efforts with local universities, teaching hospitals and other teaching entities to support GME programs by providing the necessary funding through increased reimbursement for services provided at these facilities in support of the staffing and infrastructure already in place, while leveraging federal Medicaid matching dollars. As the state's Medicaid program, DHCFP can leverage, on average, $6 additional dollars in federal funds under Title XIX of the Social Security Act for every $4 in state dollars spent on these efforts. This will ensure a higher return on investment for the state taxpayer's dollar.

According to a return-on-investment study conducted in Indiana, by 2026, for every $1.00 invested into GME programs, the return is estimated to be $12.56. This total is up 48% from $8.46 in 2022.[8] This return on investment is seen by the state through many avenues, including but not limited to, direct impact due to the program, indirect impact such as related

[4] *Medical Residency in Nevada*. (2024). Retrieved from Residency Programs List: https://www.residencyprogramslist.com/in-nevada#:~:text=Search%20residency%20programs%20by%20criteria%20to

[5] Do, K., Do, J., Kawana, E., & Zhang, R. (2023, July 11). *Nevada's Healthcare Crisis: A Severe Shortage of Physicians and Residency Positions*. Retrieved from National Library of Medicine: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10414134/#:~:text=As%20of%20now%2C%20there%20are%20around%20404%20residency,and%20UNLV%20medical%20students%2C%20respectively%20%5B%206%20%5D

[6] Mercer. (2024, July 19). *Graduate Medical Education in Nevada*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/6.0_Final%20ADA%207-19-24%20NV%20GME%20PPC.pdf

[7] American Academy of Family Physicians. (2023, October). *Graduate Medical Education Financing Policy*. Retrieved from https://www.aafp.org/about/policies/all/graduate-medical-education-financing.html#:~:text=According%20to%20a%202018%20study%2C%20the%20median%20cost,2022-2023%2C%20given%20inflation%2C%20has%20been%20updated%20to%20%24209%2C000.

[8] Tripp Umbach. (2022, October 25). *The Economic Impact of Graduate Medical Education Expansion in Indiana*. Retrieved from https://www.in.gov/che/files/FINAL_Economic-Impact-of-Graduate-Medical-Education-in-Indiana.pdf

purchases, and induced impacts such as household spending. As the number of GME positions in a state increase, the demand for goods and services and spending in the community increases and drives the economy overall. For every dollar Nevada invests in expanding GME programs in the state, Nevadans will be positively impacted, regardless of their interaction with the health care system.

B. Senate Bill 29: Increase Medicaid Rates and Establish Accountable Care Payment Models (BDR 38-450)

The Commission's second legislative measure, Senate Bill 29 (BDR 38-450), focuses on increasing provider reimbursements that incentivize and reward providers that deliver higher quality care and bring greater value to the taxpayer dollar.[9] The Commission received feedback through public solicitation, meeting presentations and public comment that Nevada Medicaid reimbursement rates are too low for many provider types and services. Nevada Medicaid is a taxpayer-funded health insurance program that serves 1 in 4 Nevadans and covers 1 in 2 births in Nevada. Low reimbursement rates can discourage providers from accepting Medicaid recipients and in turn decrease access to care for those individuals. To address these issues, the Commission voted to submit a legislative measure (BDR 38-450) that would request Nevada Medicaid to increase its reimbursement rates by 5% for services provided by a physician or advanced practice registered nurse (APRN) to eligible recipients. The BDR requests that Nevada Medicaid also add a 3% bonus payment for services provided to Nevadans in rural communities by a physician or an APRN and a separate 3% bonus payment for these providers who participate in value-based payment models.

Additionally, the BDR requests that Nevada Medicaid seek federal authority to establish accountable care payment models, also known as value-based payment models, that rewards providers for delivering high quality and coordinated care in a manner that drives greater efficiencies and improved health outcomes. Unlike traditional fee-for-service where providers are paid a certain amount for each service that is delivered, under an accountable care payment model, payments are dependent on the outcome of the care and the quality of the services provided, all with a goal to focus on improving health care while reducing costs. The Centers for Medicare and Medicaid Services (CMS) Innovation Center previously awarded several grants to states to implement these new types of payment models, which focus on paying providers for quality of services rather than quantity of services. These models have proven successful by states who have implemented the changes and experienced significant cost savings that can be better allocated to areas in need.

Depending on the model selected, providers can opt in to a shared risk program, where if the quality of services exceeds the benchmark, they receive a portion of the savings. If quality does not meet the benchmark, then the provider owes money to cover the additional costs. One of the goals of these models is to drive the provider focus on removing a lot of the barriers for patients and unnecessary cost drivers by reducing inefficiencies in the system such as reducing the number of duplicate tests, increasing preventive tests and screenings, and increasing wellness visits rather than emergency room visits for routine care.

Colorado, Maine, Minnesota, Oregon, and Vermont were among the first states to implement an ACO model and saw significant savings in the initial years. Colorado saved $77 million in the first four years, Vermont saved $14.6 million in the first year, and emergency department visits decreased by 23% in Oregon.[10] Minnesota's accountable care model, Integrated Health Partnerships , saved $14.8 million in year one with a reduction in emergency room visits by 7% and

[9] Nevada State Legislature. (2024, November 13). *SB29 (BDR 38-450).* Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/11796/Overview

[10] Houston, R., & McGinnis, T. (2016, February). *Program Design Considerations for Medicaid Accountable Care Organizations*. Retrieved from https://www.chcs.org/media/Program-Design-Considerations-for-Medicaid-Accountable-Care-Organizations.pdf

hospital stays by 14%.[11] Today this savings is closer to $401 million in health care spending. These trends are expected to continue over time with increased savings seen each year as states have higher participation in the program.
This initiative, if passed by the legislature, would provide Nevada Medicaid with the necessary authority and resources to establish the infrastructure needed to implement and operate an ACO model for providers and hospitals. Currently, the use of value-based payment models in Nevada is minimal compared to other states. By aligning with national best practices through an ACO model, Nevada Medicaid can better contain health care costs while improving health outcomes in the state.

Lastly, the BDR requests Nevada Medicaid to issue a biennial survey to enrolled providers requesting recommendations on how to improve the provider's billing experience and increasing provider participation in Nevada Medicaid.

C. Senate Bill 34: Interstate Licensure Compacts (BDR 54-449)

The Commission's third legislative measure, Senate Bill 34 (BDR 54-449), requires Nevada to enact multiple interstate licensure compacts.[12] The purpose of this BDR is to address the ongoing challenges with building an adequate health care workforce to care for residents by removing any unnecessary licensing barriers for recruiting and retaining health care providers. One of these barriers is the lengthy administrative process for obtaining a license to practice in the state. According to public feedback received through written and oral comments made to the Commission, in some instances, it can take applicants months to complete the process from time the application is submitted to time the license is issued.

Unnecessary delays for processing a state license to practice in Nevada can lead to frustration for potential providers and result in providers choosing to practice elsewhere – in states where the process is less burdensome. Interstate licensure compacts have been established for several occupations to address these types of barriers and support the portability of provider licensure across state lines. Through licensure compacts, states establish uniform standards to lower barriers to multi-state practice while preserving a state's practice act and initial licensure process. Licensure compacts also enhance public protection through a data system that allows member states to efficiently communicate licensure data, including disciplinary actions against licenses. Enacting licensure portability policies such as licensure compacts support recruitment of health care professionals and reduce administrative burdens associated with licensure for qualified health care professionals. A state might desire portability policies to:

- Support gainful employment of military personnel who move frequently;
- Expedite the deployment of healthcare professionals in the instance of a public health emergency;
- Create an accessible regulatory environment that supports health professions recruitment; and
- Enhance access to health care services[13]

Currently, Nevada is a member of interstate licensure compacts for the following professions: emergency medical services, massage therapists, physicians, teachers, and psychologists. These compacts have proven to be beneficial to Nevadans by not only expediting the process for licensed professionals but also attracting new talent to the state. As of July 2024, the number of physician medical licenses issued in Nevada had increased 63% from the previous year and the Nevada State Board of Medical Examiners attributes this in part to the Interstate Medical Licensure Compact along

[11] Minnesota Department of Health and Department of Human Services. (2015, August). *Integrated Health Partnerships*. Retrieved from https://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_196131.pdf

[12] Nevada State Legislature. (2024, November 15). *SB34 (BDR 54-449).* Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/11805/Overview

[13] National Governors Association. (n.d.). *Common State Policy Solutions to Support Health Professions Portability*. Retrieved from https://www.nga.org/wp-content/uploads/2022/10/State-Policy-Options-to-Support-Portability.pdf

with improvements to internal processes.[14] The Board also stated that approximately 50% of new medical licenses are issued through the Interstate Medical Licensure Compact.[15]

The following table summarizes the compacts Nevada is not currently participating in. The Social Work Licensure Compact and the Counseling Compact were excluded from the list due to the PPC receiving information regarding other entities pursuing these through separate bill draft requests. The table also includes the number of states who have passed legislation to join each compact.

Compact	States/Territories in Compact	Provider Type
Advanced Practice Registered Nurse (APRN) Compact	4 states	Nurse Practitioners (NPs)
Audiology and Speech Language Pathology Interstate Compact	33 states	Audiologists
		Speech Language Pathologists
Dentist and Dental Hygienist Compact	9 states	Dentists
		Dental Hygienists
Dietitian Licensure Compact	3 states	Dietitians and Nutritionists
Interstate Compact for School Psychologists	2 states	School Psychologists
Nurse Licensure Compact	40 states and 2 territories	Registered Nurses (RNs)
Occupational Therapy Licensure Compact	31 states	Occupational Therapists
Physical Therapy Licensure Compact	38 states and 1 territory	Physical Therapists
PA Licensure Compact	13 states	Physician Assistants

Source: National Center for Interstate Compacts[16]

During the August 16th meeting, the Commission voted to use a BDR to require Nevada to join the five interstate licensure compacts outlined in the table below. These compacts include the:

- Audiology and Speech Language Pathology Interstate Compact
- Nurse Licensure Compact
- Occupational Therapy Licensure Compact
- Physical Therapy Licensure Compact
- Physician Assistant (PA) Compact

Compact	Provider Type	National Rate (per 100,000 Residents)	Nevada Rate (per 100,000 Residents)	Nevada Ranking
Audiology and Speech Language Pathology Interstate Compact	Audiologists	4.2	2.5	49
	Speech Language Pathologists	59.3	30.2	50
Nurse Licensure Compact	Registered Nurses (RNs)	948.1	810.5	45

[14] Mueller, T. (2024, August 20). *Nevada Medical License Counts Surge*. Retrieved from The Nevada Independent: https://thenevadaindependent.com/field-notes/tabitha-mueller/nevada-medical-license-counts-surge

[15] Nevada State Board of Medical Examiners. (2024, March 11). *Presentation Before the Joint Interim Standing Committee on Health and Human Services*. Retrieved from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/29897

[16] National Center for Interstate Compacts. (2024). Compact Database. Retrieved from https://compacts.csg.org/

Occupational Therapy Licensure Compact	Occupational Therapists	43.2	38.2	35
Physical Therapy Licensure Compact	Physical Therapists	71.9	58.9	46
PA Licensure Compact	Physician Assistants	37.7	27.9	36

Sources: U.S. Bureau of Labor Statistics,[17] American Speech-Language-Hearing Association,[18] Kaiser Family Foundation,[19] Population estimates are from the US Census[20]

Currently, Nevada ranks well below the national average in all the health care provider types listed above. The threshold number of states required to activate a licensure compact is usually between seven and ten states. Once the threshold is reached, a commission is formed to govern the compact and ensure coordination between the participating states. All five compacts being proposed have met the state threshold and are considered activated. The PA Compact is the newest compact included in the recommended list and is not currently operational. There is a seven-state threshold to activate the PA compact, which was met in May 2024. Currently 13 states including Delaware, Utah, Washington, Wisconsin, West Virginia, Nebraska, Virginia, Oklahoma, Ohio, Maine, Colorado, Tennessee, and Minnesota have enacted the PA Compact model legislation. Those states are working through creating the interstate commission and setting up the compact to be fully operational, which is expected to take 18-24 months. The Occupational Therapy Compact and the Audiology and Speech Language Pathology Compact are also not currently operational but are establishing the necessary systems and will begin issuing compact privileges in 2025.

By joining these interstate licensure compacts, Nevada could support increased mobility for essential health care providers and expedite the process for licensure. This would allow providers the opportunity to establish themselves as a practitioner in the state with greater ease and expediency.

V. Recommendations to Address Nevada's Health Care Workforce Shortage

Along with the proposed solutions identified in the Commission's BDRs, the following recommendations reflect opportunities for the state to address the chronic health care workforce shortage and increase access to quality health care. Any potential fiscal impacts will be determined by the legislative process if they are addressed in future legislation.

A. Health Care Cross-Government Collaboration & Prioritization of Workforce Initiatives

The following recommendations by the Commission center on the need to support greater collaboration across state agencies, localities, and private entities with respect to the funding of health care workforce initiatives. Such efforts are critical to reducing unnecessary duplication of activities and maximizing the use of limited resources.

[17] U.S. Bureau of Labor Statistics. (2023, May). Occupational Employment and Wage Statistics (OEWS) Tables. Retrieved from https://www.bls.gov/oes/tables.htm

[18] American Speech-Language-Hearing Association (ASHA). (2024, August). Annual Workforce Data: 2023 ASHA-Certified Audiologist- and Speech-Language Pathologist-to-Population Ratios. Retrieved from https://www.asha.org/siteassets/surveys/audiologist-and-slp-to-population-ratios-report.pdf

[19] Kaiser Family Foundation (KFF). (2024, September). State Health Facts: Total Number of Physician Assistants. Retrieved from https://www.kff.org/other/state-indicator/total-number-of-physician-assistants/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[20] United States Census Bureau. (2021, April 27). 2020 Census: Percent Change in Resident Population for the 50 States, the District of Columbia, and Puerto Rico: 2010 to 2020. Retrieved from https://www.census.gov/library/visualizations/2021/dec/2020-percent-change-map.html

1. Recommendation: Health care workforce initiatives should be coordinated across state and local governments and assessed for their effectiveness to ensure the strategic deployment of limited state resources. This includes:

- ***Establishing or designating an agency or taskforce to lead statewide health care workforce efforts, conduct statewide assessments of health care workforce gaps, and convene state leaders and other health care industry stakeholders to develop and implement a health care workforce strategic plan.***
- ***Assessing existing State programs and whether they are effective in enhancing the state's health care workforce.***
- ***Ensuring state investments in workforce initiatives have a high return on investment for the state.***

To meet the health care needs of Nevadans, the state should coordinate across agencies and with localities when deploying limited state resources in support of the expansion of initiatives to develop the state's health care workforce. Currently, the state lacks a coordinated statewide strategy for addressing workforce challenges; instead, these initiatives appear, for the most part, to be developed and conducted in a fragmented manner with limited agency and government collaboration.

In response to this challenge, other states have tasked certain committees or state entities with the responsibility of assessing the workforce needs and developing a strategic plan for the deployment of state resources for these initiatives. For example, the Virginia Health Care Workforce Development Authority (VHWDA) was established by the legislature to identify and address health care workforce issues in Virginia.[21] The VHDWA used an assessment to conduct a statewide study of the health care needs and workforce gaps.[22] The final report from this study identified available funding streams, including state, federal and private funding, for enhancing the state's health care workforce, along with existing state regulatory barriers for providers seeking to enter the state's health care workforce. Using this information, the VHDWA created a strategic plan for addressing the workforce with statewide goals, objectives with measurable outcomes. This plan also included a matrix, detailing the roles and responsibilities of agency partners and other parties. Virginia uses this plan as the basis for funding and operationalizing its workforce initiatives.

Like Virginia, Vermont has also taken steps to improve coordination amongst state entities with respect to workforce development initiatives. This included requiring a state agency to consult with an advisory group to develop and maintain a health care workforce strategic plan for the state.[23] This plan identified issues and provided recommendations for solutions.[24] These recommendations identified the entities responsible for future implementation and coordination of these efforts in support of enhancing the workforce, reducing duplication of efforts, and maximizing limited resources.

Nevada could benefit from a similar approach to its workforce initiatives in health care. This includes identifying a state entity or body responsible for ensuring statewide collaboration regarding the use of resources for workforce initiatives and conducting a comprehensive, statewide assessment of the current gaps in the state's health care workforce by

[21] Virginia Health Workforce Development Authority (n.d.). *Purpose*. Retrieved from https://www.vhwda.org/about/purpose
[22] Virginia Health Workforce Development Authority (2023, January). *Initiatives: Health Workforce Study*. Retrieved from https://www.vhwda.org/initiatives/health-workforce-study
[23] Vermont Legislature (2020). *AB155 An act relating to increasing the supply of nurses and primary care providers in Vermont*. Retrieved from https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT155/ACT155%20As%20Enacted.pdf
[24] Vermont Legislature (2021, October 15). *Health Care Workforce Development Strategic Plan*. Retrieved from https://legislature.vermont.gov/Documents/2022/WorkGroups/House%20Health%20Care/Health%20Care%20Workforce/W~Ena%20Backus~Vermont%20Health%20Care%20Workforce%20Development%20Strategic%20Plan%2011-11-2021%20Revised~1-6-2022.pdf

provider type and service array. Using this assessment, Nevada could develop a statewide strategic plan for addressing these gaps similar to Virginia and Vermont. Additionally, the PPC found that statewide workforce development efforts should be assessed regularly as to their effectiveness in recruiting and retaining providers to serve Nevadans. This includes studying the return on investment for the state with respect to these initiatives currently funded by state programs.

2. ***Recommendation: The state should establish and fund one state webpage to serve as the state's single resource for health care employers, employees, stakeholders, providers and students on health care workforce resources and workforce development initiatives, like the Nevada Health Force website at the Division of Public and Behavioral Health.***

During the Commission's review of Nevada's current efforts, it became clear that the state has multiple initiatives aimed at improving the health care workforce pipeline and increasing provider recruitment and retention. Unfortunately, as stated earlier, the state lacks one designated party or entity that is responsible for consolidating this information, monitoring the effectiveness of existing programs, and ensuring that these efforts are coordinated in a strategic manner.

To improve transparency, the state should establish a comprehensive public resource about these efforts. A recent successful state example is the website developed by the Division of Public and Behavioral Health (DPBH).[25] The website provides information on health care career opportunities, provides educational and training resources, and connects people to partners. During a Commission meeting in September, DPBH shared plans for future website enhancements, including content expansions and information on career pathways related to public health, behavioral health and primary care careers. DPBH stated the website will also eventually include a user self-assessment, where a user can review career position requirements and determine what may be needed to qualify for certain positions. The assessment tool will also include the average salary of various positions, and the training and education required.

The Commission discussed the need for Nevada to provide sustainable funding for the Nevada Health Force website, which is a great example of state agency innovation and provides future opportunities to serve as a resource for statewide health care career workforce resources and information.

3. ***Recommendation: Developing the health care workforce should not be sole responsibility of state agencies that interact with the state's health care system; other agencies that are designed to promote the development of the labor workforce should also prioritize the enhancement of the state's health care workforce. This includes:***

    - ***The Office of Workforce Innovation (OWINN) and the Governor's Workforce Development Board (GWDB) prioritizing these efforts through available funding, including federal funding reserved for statewide workforce investment activities from the Workforce Innovation and Opportunity Act (WIOA), on health care workforce training, education initiatives and apprenticeships to increase health care provider supply.***

Some states have aligned health care workforce policy activities with broader state workforce development activities. According to the National Governor's Association, states play an important role in workforce development activities, including directing federal pass-through funding to support these activities and developing a state workforce plan.[26] In Nevada, the Governor's Workforce Development Board (GWDB) is viewed as the primary leader of workforce policy in the state through the examination of the statewide workforce development system, creating the Workforce Innovation and

[25] Nevada Division of Public and Behavioral Health (n.d.). *Building Nevada's Health Workforce*. Retrieved from https://www.nvhealthforce.org/

[26] National Governors Association. (n.d.). *State Health Workforce Toolkit: Data and Planning*. Retrieved from https://www.nga.org/state-health-workforce-toolkit/data-and-planning/#dataPolicy

Opportunity Act (WIOA) State Plan, and recommending policy improvements of the workforce development system to the Office of Workforce Innovation (OWINN).[27]

The Commission recognizes that, while the state's workforce needs are diverse, the GWDB and OWINN have an opportunity to prioritize workforce development for the health care industry. By including the health care industry needs in the WIOA State Plan, Nevada could receive sustainable federal funding to strengthen and improve the capacity of the state's health care workforce.

B. Establish Pathways from Education to Health Care Workforce

The Commission identified the state's education system as another area where the state may find additional opportunities to increase the number of health care providers in the state. This includes the following recommendations:

1. ***Recommendation: The state should explore ways to increase youth exposure to health care careers early in high school and incentivize youth to complete health-related courses prior to college or professional training school, including requiring the Nevada System of Higher Education (NSHE) to offer credits tied to such courses or certifications before high school graduation.***

Existing health care education and training programs must be enhanced to meet the needs of both students and the community. Health care workforce development efforts should expose students to career opportunities as early as elementary school and include opportunities for high school students to take courses focused on health care. Additionally, certain certification programs should be offered to high school students who may be inclined to enter the workforce upon graduation. For example, legislation recently passed in the State of Hawaii established a High School Health Care Workforce Certificate Program.[28] This program is intended to allow public high school students the opportunity to receive certification to fill entry-level health care positions that pay a living wage and offer opportunities for advancement. Hawaii lawmakers recognized that over a thousand entry-level health care positions could be filled by certified high school students upon their graduation.

The Commission recognizes the need for Nevada to create more opportunities for high school students to receive exposure to health care careers. By exposing more students to health care career opportunities and offering education and training during high school, the state will be able to recruit and retain the next generation and fill more entry-level positions. Additionally, the Commission recommends the Nevada System of Higher Education (NSHE) medical schools, nursing schools or other health care related programs offer potential college credit for students who have completed health related courses or certifications during high school. By offering college credit to high school students who show interest in health-related courses, more students will qualify for entry-level health care occupations and may be inclined to pursue additional higher education in health-related programs, which in turn promotes upward mobility of workers.

2. ***Recommendation: The OWINN should ensure collaboration with the Department of Health and Human Services (DHHS), Nevada Area Health Education Centers (AHECs) and representatives of the health care industry during implementation of AB 428 (2023) to ensure health care career pathways are developed to interest a person to enter or advance in health occupations in high need areas.***

[27] Office of Workforce Innovation (OWINN). (n.d.). *Governor's Workforce Development Board (GWDB)*. Retrieved from https://gowinn.nv.gov/boards-commissions/gwdb/

[28] Hawai'i State Legislature. (2024, June 28). *HB1827 HD2 SD1 CD1*. Retrieved from https://www.capitol.hawaii.gov/session/measure_indiv.aspx?billtype=HB&billnumber=1827&year=2024

During the 2023 Legislative Session, Nevada passed Assembly Bill (AB) 428 which mandates the creation of career pathways that engage students from kindergarten through post-secondary education and/or certification programs, aimed at fostering economic growth and workforce diversification. A recent Request for Proposals (RFP) was distributed by the OWINN, asking applicants to create a structured career pathway demonstration program tasked with targeting students as early as kindergarten and continuing through high school and on to employment.[29] According to OWINN, the pathway will enable students to acquire the skills, certifications and experiences necessary for sustainable careers that address the long-term needs of their communities and the state of Nevada in teaching, healthcare, and clean energy and manufacturing.

The Commission received presentations from various agencies such as the Nevada Area Education Centers (AHEC) and DPBH—both of which are actively involved in establishing career pathways for the health care industry. The Commission recognized the need for OWINN to collaborate with the DHHS, AHEC and other representatives of the health care industry during implementation of AB 428 (2023). This will reduce duplication of efforts and align statewide efforts to establish health care career pathways to interest a person to enter or advance in health occupations in high need areas.

3. Recommendation: State funding in support of Nevada AHECs should be increased to enhance health care workforce development pipeline efforts statewide.

Nationally, AHECs are organizations dedicated to enhancing quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through strategic partnerships with academic programs, communities and professional organizations. Congress established the AHEC program in 1971 to strengthen and diversify the healthcare workforce in rural and medically underserved communities. In Nevada, there are three regional AHECs – High Sierra, Desert Meadows, and Frontier. High Sierra AHEC serves Washoe, Carson City, Churchill, Douglas, Lyon and Storey County. Desert Meadows AHEC serves Clark, Nye and Esmeralda County. Frontier AHEC serves Elko, Eureka, Humboldt, Lander and Mineral County. In September, the Commission received a presentation regarding Nevada AHEC workforce development activities and information regarding each regional AHEC's programs and existing operating budget.

Nevada AHEC programs focus on recruiting, training, and retaining health care professionals, especially in underserved and rural areas. Starting as early as 5th grade, they offer early career exploration, continuing education, technical assistance, and student programs to enhance practice opportunities for health care providers. Additionally, AHECs build strong relationships with community organizations, academic institutions, and employers. These partnerships address local healthcare needs, ensure educational programs are relevant and impactful, and improve the coordination of efforts across the state. As an example, High Sierra AHEC coordinated the efforts of the Nevada Health Care Workforce Pipeline and Development Workgroup and led the Primary Care Workgroup Subcommittee.

According to the AHEC presentation to the Commission, during fiscal year 2023-2024, the three Nevada AHECs received a combined total of $432,750 federal HRSA funds and $51,000 state general funds.[30] Two of the three AHECs (Frontier and Desert Meadows) currently operate with less than two full-time employees (FTE). In contrast, High Sierra AHEC operates with 9 FTE and 3 interns. With additional staff and resources, High Sierra AHEC is better prepared to actively seek additional federal and state grant funding opportunities to expand their program operations. High Sierra AHEC is also the

[29] Office of Workforce Innovation (OWINN). (2024, October 31). *AB428 Career Pathways Demonstration Program (CPDP)*. Retrieved from https://gowinn.nv.gov/wp-content/uploads/2024/11/AB428-NV-CPDP-.pdf

[30] Nevada Patient Protection Commission. (n.d.). *Nevada Area Health Education Centers (AHEC)*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%209.20.24%20Patient%20Protection%20Commission.pdf

only Nevada AHEC that is not hosted and operates as a 501(c)3 nonprofit organization. AHECs have proven to be successful partners in Nevada and other states in collaborating and implementing health care workforce development planning and pipeline initiatives. Other states have invested in their AHECs to sustain and expand health careers promotional programming. In 2023, Kentucky allocated state funding to expand existing programs that included a statewide nursing pipeline for high school and college students; enhancement of school-based presentations and longitudinal programs, including expansion into middle schools; and development of new pre-med prep programs.[31]

To support Nevada AHECs to perform the duties assigned to them in NRS 396.907 and increase the number of primary care providers, the PPC recommends Nevada increase the amount of state funding provided to each regional AHEC.[32] Additional funding will allow Nevada AHECs to enhance school-based (K-12) presentations, longitudinal pathway programs, provide educational programs to health care professional students, provide continuing education to practicing health care professionals, strengthen the workforce development pipeline, and enhance community health initiatives. Without an increase in state funding, Nevada AHECs will have limited ability to inspire the next generation to enter the health care workforce. By providing more state funding to each regional AHEC, Nevada will be able to improve health care workforce pipeline efforts and "grow our own" skilled and compassionate future health care providers.

C. Enhance Provider Recruitment and Retention

The Commission made additional recommendations as outlined below that focus on expanding resources and programs in the areas of provider recruitment and retention to ensure that upfront investments in education and training results in the retainment of providers to serve Nevadans, with acute attention to Nevada's hard to serve communities in frontier or rural regions of the state.

1. ***Recommendation: The state should focus a portion of its development of workforce initiatives on establishing incentives for recruiting health care occupations in areas, where providers are in significant undersupply or in historically underserved rural and frontier areas of the state communities.***

Nevada should continue to develop workforce incentives focused on recruiting occupations in undersupply and target rural or underserved communities to improve access to care. Offering financial incentives to providers who decide to live and work in rural or underserved communities, through stipends, loan repayment options and higher reimbursement rates have proven effective and could be enhanced with additional funding.

Loan repayment has been a successful tool used to recruit and retain more health care providers in Nevada. The Nevada Health Service Corps (NHSC) loan repayment program is administered by the Nevada State Office of Rural Health in the Office of Statewide Initiatives based at the University of Nevada, Reno School of Medicine and was established by the Nevada State Legislature in 1989.[33] The purpose of the program is to encourage health practitioners to practice in areas of Nevada in which a shortage of that type of practitioner exists. A practitioner may enter into the NHSC by engaging in full-time clinical practice in an assigned medically underserved community in exchange for loan repayment funds. According to Dr. John Packham, Associate Dean of the Office of Statewide Initiatives, since the inception of the state and

[31] Northeast AHEC. (2024, June 11). *Kentucky AHEC Program Receives $5 Million in State Funding*. Retrieved from https://www.neahec.org/news/kentucky-ahec-program-receives-5-million-in-state-funding

[32] Nevada State Legislature. (n.d.). *NRS 396.907 Area Health Education Center Program; Establishment; duties; use of gifts and other money.* Retrieved from https://www.leg.state.nv.us/nrs/nrs-396.html#NRS396Sec907

[33] University of Nevada, Reno School of Medicine. (n.d.). *Nevada State Office of Rural Health: Office of Statewide Initiatives*. Retrieved from https://med.unr.edu/statewide/programs/nevada-state-office-of-rural-health/nevada-health-service-corps

federally funded program in 1989, 70 physicians have been supported through loan repayment in Nevada. Currently 45 physicians are actively practicing and 44 of them remain in Nevada.

During the Commission's meeting in October, the Nevada State Treasurer's Office provided a presentation regarding the implementation of the Student Loan Repayment Program for Providers of Health Care in Underserved Communities, which was established by AB 45 from the 2023 Legislative Session.[34] The program is anticipated to launch in January 2025 and will likely build upon the success of the Nevada Health Service Corps program. The Program will receive $2.5 million each fiscal year as an automatic statutory trigger from the Abandoned Property Trust Account. Eligible providers such as physicians, physician assistants, licensed nurses, optometrists, psychologists, and social workers, etc., who are successfully approved for this program can receive up to $120,000 in exchange for practicing in an underserved community in Nevada. Funds will be disbursed to approved applicants over a 5-year period.

The Commission agreed Nevada should continue to focus additional new funding for workforce incentives towards recruiting occupations in undersupply and target rural or underserved communities to improve access to care.

2. ***Recommendation: The state should expand loan repayment options and consider creating housing assistance programs for new providers who agree to practice in rural and underserved areas of the State.***

In addition to expanding loan repayment options for health care providers with an emphasis on underserved areas of the state, the Commission agreed the State should consider creating a housing assistance program for providers who may be relocating or working for extended periods of time in rural areas underserved areas. Housing assistance programs have been successful in other states in retaining and recruiting health care providers. For instance, St. Luke's Wood River in Idaho partnered with local community organizations to develop a 12-unit single family home project for their employees. Bozeman Health in Montana invested in securing 100 units in future workforce housing in partnership with capital groups, ensuring affordable rental options for their staff. Additionally, the Cleveland Clinic offers forgivable loans of $20,000 for down payment and closing costs, which are completely forgiven if the employee remains with the clinic and occupies the home.[35] The Nevada Housing Division has a similar program for teachers called "Home Is Possible for Teachers", which provides down payment assistance to help recruit and retain educators in the state.[36]

3. ***Recommendation: Develop public-private partnerships to fund health care workforce initiatives, leveraging resources from both sectors to maximize impact.***

The Commission recognizes that investments in the state's health-care workforce must be sustainable to ensure the most efficient use of limited taxpayer dollars. The Commission discussed the need to expand federal, state, public, and private funding investments into Graduate Medical Education (GME) residency and fellowship programs and other workforce initiatives. For example, SB 369 (2023) failed to pass, but would have established tax credits for certain businesses who donate money to assist in establishing graduate medical education residency or fellowship programs. As mentioned

[34] Nevada Patient Protection Commission. (2024, October 18). *Student Loan Repayment Program for Providers of Health Care in Underserved Communities' Program*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20Healthcare%20provider%20loan%20repayment%2010.18.24_AB45_Updated.pdf

[35] American Hospital Association. (2022, June). *Workforce Solutions: Recruitment and Retention Strategies in the Wake of the COVID 19 Pandemic*. Retrieved from https://www.aha.org/guidesreports/2022-06-29-workforce-solutions-recruitment-and-retention-strategies-wake-covid-19

[36] Nevada Housing Division. (n.d.). *Home is Possible for Teachers*. Retrieved from https://www.homeispossiblenv.org/home-possible-teachers

earlier, the Medicaid Health Care Workforce Fund proposed by SB 40 (BDR 38-451) will assist the State in leveraging more federal funding to match any state investments allocated to the account. Nevada can benefit from developing future opportunities for government and non-governmental organizations to invest in health care workforce initiatives.

Pursuant to NRS 422.175 to 422.205, the Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP) must establish an advisory committee to provide advisory recommendations to DHCFP and Medicaid managed care organizations (MCOs) regarding the investment of profits by MCOs in the communities they serve. Specifically, this advisory committee must be established in any county where the population is 700,000 or more. Currently, only Clark County satisfies this requirement. The State's current contract with MCOs includes a requirement that each MCO must reinvest at least 3 percent of its pretax profits in the community being served by the MCO. Annually, MCOs are required to submit a written plan to DHCFP detailing the anticipated community reinvestment activities. During the 82nd legislative session, the Division received state approval in its budget to finance the expansion of the Medicaid Managed Care Program to all counties in the State pursuant to NRS 422.273. The statewide expansion will begin on January 1, 2026, with the implementation of the next Managed Care Contract Period, resulting in about a 10 percent increase in Medicaid recipients served by the State's Medicaid Managed Care Program.[37] With the expansion of statewide managed care, MCOs will be serving all Nevada Counties. The DHCFP has an opportunity to include language in the State's contract with MCOs requesting a percentage of their profits be reinvested to support the recruitment and retainment of health care providers. This will ensure each Nevada County receives a sustainable allotment of Medicaid reinvestment dollars. By reinvesting in the health care workforce, more patients, including Medicaid recipients will have greater access to care.

4. Recommendation: The state should explore ways to reduce or defer the amount of interest students owe on medical education loans.

According to the American Medical Association (AMA), reducing medical student indebtedness may contribute to a reduction in the shortage of physicians.[38] The AMA also stated that the enormous debt load medical students face is further compounded during low paying residency and fellowship training. Even if graduates qualify to have their payments suspended during training, their loans continue to accrue interest, which increases their overall debt. Identifying ways to reduce or cap the amount of interest borrowers must pay will incentivize more students to pursue medical education. The high cost and interest rates on educations loans is often a barrier to attracting and retaining providers, especially for students from rural or underserved communities. Legislation has been introduced by Congress at the federal level HR 4122 (2021-2022) that if implemented would have allowed borrowers to qualify for interest-free deferment on their student loans while serving in medical or dental internships or residency programs.[39]

The PPC discussed the need for Nevada to identify ways to incentivize providers to practice in Nevada through loan interest reduction or deferment. By reducing or deferring medical education loan debt issued to health care providers, Nevada can incentivize more providers to practice and complete their graduate medical education in the State.

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[37] Nevada Division of Health Care Financing and Policy. (n.d.). *Statewide Managed Care Program*. Retrieved from https://dhcfp.nv.gov/Providers/Statewide_Managed_Care/

[38] James L. Madara, M. (2021, July 1). *AMA: American Medical Association Support for HR 4122, "Residential Education Deferred Interest (REDI) Act"*. Retrieved from https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-7-1-Letter-to-Babin-and-Houlahan-re-Resident-Education-Deferred-Interest-Act-(Final).pdf

[39] 117th House of Representatives. (2021, July 24). *H.R. 4122 - REDI Act*. Retrieved from https://www.congress.gov/bill/117th-congress/house-bill/4122?q=%7B%22search%22%3A%22hr+4122%22%7D&s=3&r=1

D. Nursing Workforce

According to a report developed by the UNR Nevada Health Care Workforce Research Center, Nevada needs an additional 3,162 registered nurses (RNs), 3,284 licensed practical nurses (LPNs), 5,055 certified nursing assistants (CNAs), 626 nurse practitioners (NPs/APRNs) and 307 certified registered nurse anesthetists (CRNAs) to meet national population-provider averages.[40] The COVID-19 pandemic has exacerbated a national shortage of registered nurses, making it critical that policymakers invest in all segments of the nursing workforce, from education and training to retention. Therefore, in addition to the BDR recommendation to authorize the state to participate in the interstate nurse licensure compact, the PPC made the following recommendations to address this shortage:

1. Recommendation: The state should fund and support a Nevada Nurse Workforce Center to serve as a hub to advance nursing education, practice, leadership, workforce development, and policy.

According to the National Forum of State Nursing Workforce Centers, State Nursing Workforce Centers serve as hubs that support nursing workforce research, nursing education, practice, leadership, and workforce development at the state and local levels focused on the utilization of evidence.[41] Services of nursing workforce centers typically include: conducting localized research; publishing reports related to supply, demand, and educational capacity of the nursing workforce; and implementing other activities to improve the nursing workforce in their states. They utilize data-driven insights and expert consultation at community, regional, and state levels to foster meaningful discussions about the real challenges facing the nursing workforce and practical solutions to address them.

A December 2022 report from UNR's Nevada Health Workforce Research Center laid out several ways to alleviate the nursing shortage, one of which included a proposal to establish a statewide Nevada Nurse Workforce Center.[42] A Nevada Nurse Workforce Center would address the nursing shortage by studying the unique characteristics of the nursing workforce in Nevada; developing strategies to increase the number of new nurses in the state; recruiting nurses to the profession; implementing strategies to retain nurses in the workforce; and advocating for changes in policy to improve the stability of the nursing workforce in Nevada.

Other states who have enacted legislation to establish a statewide Nursing Workforce Center including: Washington, Florida, Hawaii, Illinois, Tennessee, and Texas.[43] Nevada recently passed legislation through AB 37 (2023),

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[40] Nevada Health Force. (2023, May). *Health Workforce in Nevada: A Chartbook*. Retrieved from https://www.nvhealthforce.org/wp-content/uploads/2024/03/Health-Workforce-in-Nevada-a-Chartbook.pdf

[41] National Forum of State Nursing Workforce Centers. (n.d.). *National Nursing Workforce Center Act*. Retrieved from https://nursingworkforcecenters.org/national-nursing-workforce-center-bill/

[42] Nevada State Legislature. (2022, December). *Addressing Nevada's Nursing Workforce Shortages: A Call to Action*. Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/82nd2023/ExhibitDocument/OpenExhibitDocument?exhibitId=69305&fileDownloadName=SB375_NevadaNursingCalltoActionDEC2022_PreparedbyJohnPackhamUNR.pdf

[43] Washington State Legislature. (2005). *RCW 18.79.202 License fee surcharge - Use of Proceeds - Nursing resource center account – Report to the legislature - Review - Rules*. Retrieved from https://app.leg.wa.gov/rcw/default.aspx?cite=18.79.202; The Florida Senate. (2021). *464.0195 Florida Center for Nursing; goals*. Retrieved from https://www.flsenate.gov/laws/statutes/2021/464.0195;
State of Hawaii. (2003). *H.B. 422 UH; Nursing; Center for Nursing, Center for Nursing Special Fund, and Center for Nursing Fee; Established*. Retrieved from https://www.capitol.hawaii.gov/sessions/session2003/bills/HB422_cd1_.htm;
Illinois General Assembly. (2023, July 28). *Public Act 103-0285*. Retrieved from https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=103-0285&GA=103 ;

which established a Behavioral Health Workforce Development Center within the Nevada System of Higher Education (NSHE).[44] Establishing a similar Center devoted to nursing would allow the state to address the nursing shortage at the state and local level by conducting localized research, publishing reports related to supply, demand, and educational capacity of the nursing workforce, and then developing and implementing strategies to improve the nursing workforce in Nevada.

The Commission received several letters of support regarding this proposal from the Nevada Action Coalition, UNLV School of Nursing, UNR Orvis School of Nursing, UNR School of Medicine and Nevada Rural Hospital Partners.[45]

2. Recommendation: The state should provide additional funding to the DPBH and DHHS to continue the Nurse Apprenticeship Program over the 2026-2027 biennium.

In February 2022, the Nevada Legislature's Interim Finance Committee (IFC) approved federal American Rescue Plan Act (ARPA) funding to support existing Nurse Apprentice Programs (NAP) and to encourage the creation of new programs in Nevada hospitals and skilled nursing facilities. This funding aims to address the existing nursing workforce shortage and support Nevada health care facilities experiencing sever staffing shortages. The Nevada State Board of Nursing adopted regulation LCB File No. R018-22AP in 2022 to allow apprentice nurses to work in all medical facilities licensed pursuant to NRS 449.[46] This expanded the types of facilities which can employ apprentice nurses. A nurse apprentice is an employee of an agency who is currently enrolled in a pre-licensure registered nurse (RN) or licensed practical nurse (LPN) nursing program. Under supervision of registered nurses, nurse apprentices work at a health care facility providing nursing care following the Nevada State Board of Nursing approved skills list.[47] The Nevada Nurse Apprentice Program has proven to be a successful tool for Nevada health care facilities to produce graduate nurses with clinical experience and retain licensed nurses, thus increasing the nursing workforce in Nevada.

Since March 2022, the Nevada Rural Hospital Partners (NRHP) has executed the grant program on behalf of the Nevada Division of Public and Behavioral Health (DPBH). NRHP has worked closely with all eligible facilities, nursing schools and

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Tennessee General Assembly Fiscal Review Committee. (2022, February 9). *Fiscal Note HB 2148 - SB 2401*. Retrieved from https://www.capitol.tn.gov/Bills/112/Fiscal/HB2148.pdf
State of Texas. (2007, September 1). *Sec 105.002 Establishment of Center*. Retrieved from https://statutes.capitol.texas.gov/Docs/HS/htm/HS.105.htm#105.002

[44] Nevada State Legislature. (2023). *AB37*. Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/82nd2023/Bill/9566/Text

[45] Nevada Action Coalition. (2024, August 15). *Nevada Nurse Workforce Center Sustainability Request*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20Nevada%20Workforce%20Center%20Sustainability%20Request.pdf;
University of Nevada, Reno Orvis School of Nursing. (2024, October 15). *Support the Establishment of Sustainable Nevada Nursing Workforce Center (NNWC)*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20-%20OSN%20LOS%20-%20Nevada%20Nursing%20Workforce%20Center.pdf ;
University of Nevada, Reno School of Medicine Office of Statewide Initiatives. (2024, October 16). *Support for the Nevada Nursing Workforce Center (NNWC)*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%2024%20Support%20Letter%20-%20NNWC%20to%20NV%20PPC%2010-17-24.pdf;
Nevada Rural Hospital Partners. (2024, October 17). *Support for Nevada Nurse Workforce Center (NNWC)*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20NRHP%20PPC%20LOS%2010-17-24.pdf

[46] Nevada State Legislature. (2022, June 13). *Approved Regulation of the State Board of Nursing*. Retrieved from https://www.leg.state.nv.us/Register/2022Register/R018-22AP.pdf

[47] Nevada State Board of Nursing. (2023, February 1). *Nurse Apprentice Skills List*. Retrieved from https://nevadanursingboard.org/wp-content/uploads/2023/03/NSBN-Apprentice-Nurse-Skills-List-updated-02012023.pdf

nursing students to increase awareness and utilization of the Nevada Nurse Apprentice Program Grant opportunity.[48] Through the grant opportunity, health facilities receive funding to pay for nurse apprentice salaries. The funding is also used to pay a stipend to supervising RNs and to offer graduating nurses a retention payment if they agree to work for the facility for a number of years. Nursing students also receive travel reimbursement if they travel 50 miles or more (one way) to work as nurse apprentices. This has incentivized nursing students to seek apprenticeship experience and work in rural and underserved areas. According to the NAP ARPA Grant state fiscal year (SFY) report for 2023 and 2024, a total of 242 nurses (58 in SFY23 and 184 in SFY24) have been retained since March 2022. Additionally, the number of programs statewide has increased and the number of nursing students working as nurse apprentices has tripled since the program's inception with 250-300 nursing students working in Nevada health care facilities each month. On July 16th, the IFC approved additional ARPA funding to extend the NAP ARPA Grant through the current SFY25, which ends June 30, 2025. The Nevada Nurse Apprenticeship Program has proven to be a successful and innovative 'earn while you learn' model for Nevada to recruit and retain nursing students and address the nursing shortage.

The Commission recommends the State appropriate additional funding during the next Legislative Session to ensure the Nevada Nurse Apprentice Program continues through the 2026-2027 biennium.

E. Increase Access to Care for Medicaid Recipients

The Medicaid program provides health care coverage to one in four Nevadans; many of the workforce challenges for health care have disproportionately affected this population given its size and the historical challenges with provider participation in Nevada. Therefore, the Commission recommended the following:

1. ***Recommendation: Nevada Medicaid should be authorized and funded by the legislature to pilot a virtual "Hospital at Home" program to increase access to care in rural and frontier areas. This includes:***

    - ***Ensuring the development of the pilot program will not negatively impact existing medical services and workforce supply in rural and underserved communities; and***
    - ***Prior to launching the Nevada pilot program, engaging with the Commission to solicit feedback on proposed pilot program models.***

Nevadans living in rural areas of the state face unique challenges in finding an available health-care provider and require creative solutions for addressing these challenges. In September, the Commission received a presentation regarding an innovative care model that other states have implemented to increase access to care and treat patients within their own home.[49] Federally, CMS has authorized innovative care models such as the Emergency Department in Home (EDiH) and Hospital at Home (HaH) to provide in-home care for patients who qualify and would normally receive services in an emergency department or inpatient setting. Hospital at Home models seek to increase access to emergency, outpatient and inpatient care options in rural areas; support the emergency medical services (EMS) system by reducing avoidable emergency department transports; decrease hospital overcrowding in urban settings; and better allocate available health care workforce resources.

[48] Nevada Rural Hospital Partners Foundation. (n.d.). *Nevada Nurse Apprentice Program*. Retrieved from https://nap.nrhp.org/

[49] Tripp | Hollander Advisors. (2024, September 20). *Hospital At Home and Other Virtual-Forward Innovations: Improving Patient Access to Care and Workforce Retention*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20Nevada%20Patient%20Protection%20Commission_EDiH-HaH_9.20.24.pdf

These models rely on a combination of in-person clinicians (EMS/paramedics) with remote physicians and nurses, to provide emergency level, in-patient and primary care for patients who can safely be treated at home in rural areas. Rather than removing patients from their own communities to access care, eligible patients would be able to opt-in to receiving necessary care at home.

To increase access to care for rural and frontier communities, the Commission recommends Nevada Medicaid secure necessary funding and authority to establish a pilot program based on Hospital at Home care models. The Commission had robust discussion regarding the development of the pilot program and emphasized the importance of ensuring the pilot program remains safe, affordable and does not negatively impact existing medical services and workforce supply in rural and underserved communities. The pilot will allow an innovative opportunity for Nevada to share key learnings about safety, quality, and cost to inform future health care regulatory and payment policy.

2. ***Recommendation: Nevada Medicaid should review prior authorization (PA) data and requirements to simplify and streamline the process for health care providers as applicable. Recommend Nevada Medicaid establish a data dashboard to support the transparency and review of PA data. Following the establishment of such a data dashboard, Nevada Medicaid should review which PAs should and can be removed without undue risk of increasing fraud, waste and abuse. In addition, Nevada Medicaid should report to the Legislature each biennium regarding the Division's findings related to PA data and activities made to reduce provider administrative burden.***

The PA process in Nevada Medicaid is a payment review mechanism conducted by physicians and other clinicians on behalf of the state or health carrier that is designed to ensure certain services are medically necessary, appropriate, and meet program requirements before they are deemed reimbursable. Medicaid policies outline which services require a PA. Requests from providers are submitted electronically to Medicaid (state or health carrier), including all necessary documentation, and are reviewed by a physician or other appropriate clinician to determine whether the definition of medical necessity and service requirements have been met. Once approved, an authorization number is issued for claims, and denied requests can be appealed through established procedures. While this process helps protect the state from payment fraud and inappropriate, unauthorized payments to providers, it can be time-consuming and administratively burdensome for providers.

In June, the Commission issued a solicitation, asking providers of health care to provide feedback on how to improve the Nevada Medicaid billing experience and increase provider utilization to increase access to care for Medicaid recipients. Although most providers responded noting that low Medicaid reimbursement rates were often the cause for low provider utilization, another common response included the recommendation to reduce prior authorization challenges. During a PPC meeting in July, the Nevada State Medical Association (NSMA), the State's oldest and largest physician advocacy organization, shared that PA reform is the single most requested administrative fix according to their members.[50] NSMA claims the Medicaid PA authorization process can be cumbersome, complex and distinct variations exist amount Medicaid Fee-for-service and the four Medicaid Managed Care Organizations (MCOs).

The PPC recommends that Nevada Medicaid review and streamline the PA process to address inefficiencies and unnecessary barriers to care. Specifically, it suggests identifying and removing PAs for services that are routinely approved and pose minimal risk of fraud, waste, and abuse. These requirements often add unnecessary administrative burdens for

[50] Nevada State Medical Association. (2024, July 2024). *Nevada Medicaid: Physician Perspectives*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/5.1_Final%20ADA%20NSMA%20and%20NV%20Medicaid-%20PPC%20Presentation%2007192024-%20Final(1).pdf

providers while delaying timely access to care for patients. By simplifying and reducing the scope of PAs, Nevada Medicaid can improve efficiency, enhance patient outcomes, and lower provider workloads, all while maintaining program integrity and oversight.

F. Increase Access to Primary Care

The Governor's Executive Order 2024-002 requests the PPC provide recommendations for increasing access to primary care and public health services. The Commission explored this issue and made the following recommendation:

1. ***Recommendation: Prioritize health care workforce investments on those that will support the expansion of primary care providers.***

According to 2023 data provided by the UNR Nevada Health Workforce Research Center, Nevada ranks 48th in the U.S. for primary care physicians per 100,000 people.[51] Approximately half of the osteopathic physicians (565) are licensed in primary care specialties (45.3%), as compared to only 1,943 of allopathic physicians (26.0%) in primary care specialties. An estimated 2,282,125 Nevadans or 69.7% of the state's population reside in a federally designated primary care health care provider shortage area (HPSA). Additionally, 12 of 17 counties in Nevada are single-county primary care HPSAs including 11 of 14 rural and frontier counties. Increasing the number of primary care providers will increase access to more affordable preventative health care services for Nevada patients. Current research has shown that there is a higher probability of a healthy community when there are more primary care physicians available for the general population.

An increase in the number of primary care physicians has also been shown to lower the frequency of patients presenting to the emergency department or hospital, which helps reduce health care costs while improving long-term health outcomes.[52] Training programs should be expanded to grow and retain more primary care providers such as physicians, advanced practice registered nurses and physician assistants. Consumers often perceive overall access to care based on the availability and affordability of primary care services. For patients in Nevada, many may wait up to or even longer than one month to see their primary care physicians. For specialty care, the wait time may even be extended, and this is assuming that the specialty exists in the state.

While this recommendation seeks to prioritize investments into primary care, the Commission acknowledges there is a need to increase access to health care generally, which includes primary care, public health and behavioral health services. The State of Nevada has made significant investments to improve public health and behavioral health services in recent years. Examples include the passing of SB 118 (2023), which allocated millions of dollars toward public health infrastructure and service improvement.[53] Additionally, Nevada recently announced that over $200 million in Medicaid funds will be invested in children's community behavioral health services over the next three years with the use of a portion of the state's hospital provider tax revenue.

[51] Nevada Health Force. (2023, October). *Physician Workforce in Nevada: A Chartbook*. Retrieved from https://www.nvhealthforce.org/wp-content/uploads/2024/03/23-Physician-Workforce-in-Nevada-a-Chartbook.pdf

[52] Kenny Do, J. D. (2023, July 11). *Nevada's Healthcare Crisis: A Severe Shortage of Physicians and Residency Positions*. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC10414134/#REF4

[53] Nevada State Legislature. (2023, February 8). *SB118*. Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/82nd2023/Bill/9765/Overview

The Commission supports any state investment directed at improving health care access, quality and affordability, and recommends future investments in programs aim at increasing primary care services statewide, especially for rural and underserved communities.[54]

G. Direct Care Workforce

Another topic the Commission discussed as needed increased attention by lawmakers is the direct care workforce that serve seniors and people with disabilities in Nevada.

1. Recommendation: Support direct care workers by strengthening career pipelines, expanding training and educational opportunities throughout the state, and increasing wages and benefits for the existing workforce.

According to the U.S. Bureau of Labor Statistics, direct care workers are categorized as Certified Nursing Assistants, Home Health Aides, and Personal Care Aides. Direct care workers assist older adults and people with disabilities with essential daily tasks and activities across a range of long-term care settings.[55] Direct care workers provide essential services in a variety of settings, including home and community-based settings, residential care settings and nursing facilities. Nevada is considered to have one of the fastest growing populations. This population is becoming older and more diverse as well, with 1 in 6 Nevadans aged 65 and older.[56]

With the increase in the size of the state's aging population and the lack of a sufficient number of health care providers in the state to care for this population, Nevada should begin to address these gaps now to mitigate the negative effects of the workforce gaps on this population especially as the size of this population is not expected to decrease any time soon. This includes strengthening recruitment and retention efforts to increase the state's direct care workforce. Nevada ranks 50th out of 51 states including D.C. in terms of the number of direct care workers per 100,000 residents, indicating a significant shortage.[57] Recruitment and retention efforts are often difficult, when direct care workers in Nevada face low wages, which can lead to financial instability and high turnover rates.

Nevada currently has a $16 an hour minimum wage for Home Care Workers and a proposal has been discussed to further increase the minimum wage to $20/hour.[58] Increasing wages and benefits for direct care workers will help reduce turnover, improve worker satisfaction and reduce reliance on public assistance, such as Medicaid and SNAP. According to the Nevada Health Care Career Manual, employers often train home health aides and personal care aides on the job and only require a high school diploma to start.[59] These careers offer an opportunity for upward mobility into other health care professions. These positions offer high school graduates and others without prior health care experience an entry point into the health care workforce pipeline. By increasing wages, offering essential benefits, and

[54] Nevada Governor Joe Lombardo. (2024, March 21). *Governor Lombardo Announces Plans for Behavioral Health Care Services for Nevada Children*. Retrieved from https://gov.nv.gov/Newsroom/PRs/2024/2024-03-22_behavioral_health_care/

[55] PHI. (2021, September 7). *Direct Care Workers in the United States*. Retrieved from https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2/

[56] Davidson, M. S. (2019, June 19). *Nevada growing older, more diverse, Census data shows*. Retrieved from https://www.reviewjournal.com/local/local-nevada/nevada-growing-older-more-diverse-census-data-shows-1691182/

[57] PHI. (n.d.). *Direct Care Workforce State Index State Profile*. Retrieved from https://www.phinational.org/state/nevada/

[58] Alvarez, C. (2024, May 31). *Nevada homecare workers call on officials for higher pay, better working conditions*. Retrieved from https://www.knpr.org/news-88-9-knpr/2024-05-31/nevada-homecare-workers-call-on-state-lawmakers-for-higher-pay-better-working-conditions

[59] Nevada Health Force. (2024-2025). *Health Care Careers in Nevada*. Retrieved from https://www.nvhealthforce.org/wp-content/uploads/2024/03/2024-2025_HCCM_Interactive-Careers-Manual-1.pdf

expanding training and educational opportunities provided to this workforce, the State will be able to ensure older and vulnerable Nevadans have access to the assistance they need for daily tasks.

H. Physician Retention and Wellness

Burnout and fatigue among providers have historically been a challenge when trying to retain a health care workforce. These issues were compounded by the COVID-19 pandemic, leading to what many referred to as "The Great Resignation."[60] High demand and stressful working conditions during the pandemic combined with staffing shortages caused many health care professionals to leave the industry.

1. ***Recommendation: To aid in workforce retention and provider wellness, the state should establish a Physician Wellness Program in Nevada to allow physicians to access a confidential wellness program. This program should:***
   - ***Be offered as a grant opportunity by DHHS to an eligible 501 (c)(3) nonprofit that primarily represents physicians to administer the Program statewide; and***
   - ***Support physicians through evidence-based wellbeing initiatives with a statewide physician and physician family resource line, online wellness resources and training.***

Nevada ranks well below the national average, at 48th for active physicians per 100,000 population. In addition, Nevada had the fifth highest population increase between 2010 and 2020 according to initial results of the 2020 Census.[61] According to data provided by the Nevada Health Workforce Research Center, 2 million Nevadans, nearly 70% of the state's population, reside in a federally designated primary care health provider shortage area (HPSA). Additionally, 2.8 million Nevadans, nearly 88% of the state's population, reside in a federally designated mental health provider shortage area. Every County in Nevada has a physician shortage of varying degrees, and 11 of 14 rural and frontier areas of Nevada are single-county primary care HPSAs.

With such a severe shortage of physicians in Nevada, the Commission recognizes the importance of retaining the existing physician workforce to ensure access to care, patient safety and quality outcomes. To address these barriers and support the retention of employees, the Commission recommends that the state invest in programs that create a supportive environment for providers including incentives to practice and remain in the state of Nevada. This includes investing in a statewide Physician Wellness Program operated by an independent 501(c)(3) nonprofit and that the legislature provide DHHS with funding for this program that can be provided as a grant funding opportunity.

The Commission also recommends that the organization selected to operate such a program be independent from (without affiliation with) any health system, health facility, or health care regulatory body. The selected organization should also not be mandated by certain state reporting requirements regarding any patient specific data. Otherwise, providers may be hesitant to use available resources due to potential implications to their licensure. Similar health care professional well-being grant programs have been developed through legislation in Arizona and Minnesota.[62, 63]

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[60] *The Great Resignation in Healthcare & What To Do About It*. (2022). Retrieved from Mend: https://mend.com/resource/great-resignation-in-healthcare-what-to-do-about-it/#burnout

[61] United States Census Bureau. (2021, April 27). *2020 Census: Percent Change in Resident Population for the 50 States, the District of Columbia, and Puerto Rico: 2010 to 2020*. Retrieved from https://www.census.gov/library/visualizations/2021/dec/2020-percent-change-map.html

[62] Arizona State Legislature. (2022). *HB 2429*. Retrieved from https://www.azleg.gov/legtext/55leg/2r/bills/hb2429s.pdf

[63] Minnesota Legislature. (2023-2024). *SF 3531*. Retrieved from https://www.revisor.mn.gov/bills/text.php?number=SF3531&version=latest&session_year=2024&session_number=0

2. ***Recommendation: State licensure boards, hospitals, health systems and the Nevada Division of Insurance should remove intrusive mental health questions from physician and other health care provider licensure and credentialing applications.***

Currently in Nevada, certain entities, including Division of Insurance, state licensure boards, and health systems, require physicians and other health care practitioners to answer questions about their mental health history and current treatment information when filling out applications for credentialing and/or licensure. Overly invasive questions in licensing and credentialing applications have been found to prevent health workers from seeking support and increasing the risk of suicide.[64] Such questioning tends to be unnecessarily broad or stigmatizing. Examples include asking about past mental health disorders and treatment, neither of which has any bearing on a health worker's ability to provide care and runs afoul of the protections of the Americans with Disabilities Act. For example, one study found that 4 in 10 physicians report not seeking help for burnout or depression because of concern that their employer or state medical board would be notified.[65,]

More than 40 professional medical organizations, including the American Academy of Family Physicians and the American Psychiatric Association, signed a joint statement in 2020 calling for changes in disclosure rules about mental health.[66] California recently passed legislation aimed at prohibiting licensure boards from requiring applicants to disclose specific information that does not impair the applicants ability to provide safe patient care.[67] As of September 2024, 34 licensure boards and 375 hospitals have verified their licensing or credentialing applications are free of intrusive mental health questions.[68]

Destigmatizing mental health care for physicians and other providers can create an environment that encourages voluntary self-disclosure and help-seeking behavior. Rather than requiring a provider to disclose past mental health challenges or current mental health conditions, providers could be asked to simply disclose any health condition that would affect the provider's ability to practice medicine in a competent, safe and ethical manner. Therefore, the Commission recommends Nevada join other states in recognizing the importance of removing intrusive mental questions from licensure and credentialing applications, to remove any barriers that prevent health care providers from seeking care when necessary.

I. Occupational Licensure

In response to the COVID-19 pandemic, the State of Nevada temporarily waived certain licensure requirements to bolster the health care workforce and combat the public health emergency. Emergency Directive 011 allowed health care

[64] Dr. Lorna Breen Heroes' Foundation. (n.d.). *Remove Barriers to Mental Health Care for Health Workers*. Retrieved from https://drlornabreen.org/removebarriers/

[65] Leslie Kane, M. (2023). *US Physician Burnout and Depression Report*. Retrieved from https://www.medscape.com/slideshow/2023-lifestyle-burnout-6016058?reg=1; Jerry L Halverson, M. (2024, May 21). *Depression*. Retrieved from https://emedicine.medscape.com/article/286759-overview?form=fpf

[66] Joint Commission. (n.d.). *Joint Statement Supporting Clinician Health in the Post-COVID Pandemic Era*. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/covid19/joint-statement-supporting-clinician-health.pdf

[67] Digital Democracy. (2023-2024). *AB 2164: Physicians and surgeons: licensure requirements: disclosure*. Retrieved from https://digitaldemocracy.calmatters.org/bills/ca_202320240ab2164

[68] Dr. Lorna Breen Heroes' Foundation. (2024, September 1). *Record Number of Licensure Boards and Hospitals Take Action to Prevent Suicide for the Healthcare Workforce*. Retrieved from https://drlornabreen.org/record-number-of-licensure-boards-and-hospitals-take-action-to-prevent-suicide-for-the-healthcare-workforce/

professionals who held a valid license in good standing in another state to practice in Nevada during the declared emergency.[69] The waivers and exemptions did not apply to providers with licenses that had been revoked or surrendered as a result of disciplinary proceedings. At a national level, the Centers for Medicare and Medicaid Services (CMS) temporarily waived these requirements that out-of-state Medicare practitioners be licensed in the state where they are providing services.[70] CMS also released guidance stating that state Medicaid agencies could use Section 1135 waiver authority to permit providers located out of state to provide care to another state's Medicaid enrollee impacted by the COVID-19 emergency. These changes were particularly helpful in enabling providers to meet increasing demand for services throughout the pandemic.

While the public health emergency has officially ended, the need for Nevada to reduce barriers and increase flexibility to maintain the capacity of providers has not. In order to tackle the ongoing challenges with building an adequate health care workforce to care for residents, Nevada must remove any unnecessary barriers for recruiting and retaining health care providers. In addition to enacting interstate licensure compacts, the Commission discussed several recommendations for Nevada to expedite and streamline the occupational licensure process for providers of health care.

1. ***Recommendation: Each health care occupational licensing board should offer temporary or provisional licenses for providers already licensed in another state during the time they are fulfilling the requirements needed to qualify for endorsement in this state, or while awaiting verification of documentation supporting such an endorsement, including obtaining background checks.***

This recommendation seeks to establish administrative uniformity among all state health care occupational licensing boards and expedite the licensure process for health care professionals. In Nevada, the duration of time varies from the time of application submission to when a license is issued. Much of this variation depends on the Board's internal processes and whether they issue a provisional or temporary license while background checks or other verifications are pending. For example, the Nevada State Board of Nursing issues a temporary license to all applicants who meet certain criteria while background checks and other documentation are being processed. This process ensures that nurses applying for a Nevada license can begin practicing in the state within a few days, instead of a few weeks or even months.

Other occupational licensing boards who do not currently offer a temporary or provisional license delay issuance of licenses until a background check or other application review has been completed. In Nevada, all occupational licensing boards rely on the Nevada Department of Public Safety to conduct applicant background checks – a process that can often take several weeks or several months depending on various circumstances.

The Commission recommends each occupational licensing board issue temporary or provisional licenses based on an affidavit from the applicant that the information provided on the application is true and that the verifying documentation has been requested.

2. ***Recommendation: Each health care occupational licensing board, including the Board of Medical Examiners and Board of Osteopathic Medicine, should provide licensure reciprocity for out-of-state licensed health care providers seeking the same licensure in this state.***

[69] Nevada Governor Joe Lombardo. (2020, March 12). *Declaration of Emergency Directive 011*. Retrieved from https://gov.nv.gov/layouts/full_page.aspx?id=302852

[70] CMS. (2022, October 13). *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*. Retrieved from https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

Licensure reciprocity enables a health professional with a license or certification from another state to become licensed or certified in a new state without going through the initial license application process. Endorsement is essentially a "stamp of approval" that validates the process of initial licensure that was completed by an external state's licensing authority, but still requires the individual to become licensed within the state in order to practice within the state. Without active endorsement policies, health care professionals licensed in an external state have to undergo the process of initial licensure, which generally includes submitting transcripts, validating completion of all training requirements (including educational programs, examinations, and experience if applicable). Typically, certain activities such as background checks and finger printing are still required.

In 2012, Nevada Governor Brian Sandoval issued Executive Order 2012-11 providing licensure reciprocity for military spouses seeking licensure in this state.[71] The Executive Order requested each occupational licensing board facilitate endorsement of a current license from another state as long as the requirements for licensure were equivalent to the Nevada requirements; and required each board to issue a provisional or temporary license to expedite application procedures for a military spouse. In 2015, the Nevada Legislature passed AB 89, which authorized certain providers of health care and professionals to obtain an expedited license by endorsement to practice their respective professions in this State if the provider: (1) holds a valid and unrestricted license to practice in the District of Columbia or another state or territory of the United States; (2) is an active member or veteran of, the spouse of an active member or veteran of, or the surviving spouse of a veteran of, the Armed Forces of the United States; and (3) meets certain other requirements.[72]

The Commission recommends Nevada consider expanding the current licensure reciprocity laws and expedited application processes currently offered to active military, veterans and military spouses to all health care providers applying for Nevada licensure. This process could be expanded more broadly to streamline the licensure process and avoid unnecessary delays that prevent or delay health care professionals from practicing in Nevada.

3. ***Recommendation: The state should establish a single state authority over all health care occupational licensing boards to ensure uniform standards to reduce the unnecessary duplication in requirements that lead to unintended administrative barriers and delays to entering the workforce.***

Nevada's occupational licensing boards operate independently from the legislative and executive branch of state government. As a result, each individual board has established their own methods of operating, which in turn leads to variation and inconsistencies among the various occupational licensing boards. In 2023, the Nevada Legislature adopted SB 481, now codified as NRS 232.8415, which establishes the Nevada Office of Boards and Commissions and Councils Standards within the Department of Business and Industry. The new office has purview over 37 professional and occupational licensing boards and is required to establish centralized administration, uniform standards, uphold transparency and consumer protection, and ensure efficacy and efficiency. It is currently unclear how the office intends to hold licensing boards accountable to certain metrics or establish uniform standards.

At the direction of the Governor, the Department of Business and Industry has undertaken a process to develop a framework for reform and modernization of Nevada's boards and commissions.[73] The Commission recommends the office

[71] State of Nevada Executive Department. (2012, May). *Executive Order 2012-11*. Retrieved from https://medboard.nv.gov/uploadedFiles/medboardnvgov/content/Forms/EO_2012-11.pdf
[72] Nevada State Legislature. (2015). *AB89*. Retrieved from https://www.leg.state.nv.us/Session/78th2015/Bills/AB/AB89_EN.pdf
[73] Boards and Commissions. (n.d.). *Reforming Nevada's Boards and Commissions*. Retrieved from https://business.nv.gov/Boards_and_Commissions/Boards_and_Commissions/

use their authority to ensure all health care occupational licensing boards operate uniformly and be held accountable for certain metrics. An example of how the State could create uniformity among the various licensing boards would be to establish a universal application for all health care professionals to submit their applications through a single online portal. This would streamline the licensure process for healthcare professionals and create a "one-stop shop" for licensure application submission.

In addition to establishing a uniform application process, the Commission recommends each occupation licensing board be held accountable for certain metrics, such as regularly reporting the length of time from application to licensure. By increasing transparency of licensure issuance delays, the State can direct necessary resources to resolve any barriers that may prevent or delay the issuance of licenses to health care professionals.

4. ***Recommendation: The state should align occupational licensure training requirements and facility training requirements to remove duplication or unnecessary requirements.***

This recommendation seeks to remove any redundant requirements from the provider onboarding process and align facility training and licensure or CME requirements. The Commission received information through a public solicitation stating that facilities may have training requirements that are duplicative of occupational licensing training requirements. By recognizing similar training courses and aligning facility and licensing board training requirements, the health care provider onboarding process will be streamlined, and providers can spend less time taking unnecessary training and have more time for patient care.

J. Increase Health Workforce Diversity

Recommendation: Identify ways to recruit and retain a more diverse health care workforce.

Diversity in the health care workforce is critical as it improves communication, decision-making, and adherence to care plans among patients when there is commonality between patients and their providers.[74] The Fitzhugh Mullan Institute for Health Workforce Equity maintains a Health Workforce Diversity Tracker that displays a labor force Diversity Index that can be used to evaluate diversity for the selected state, profession, and race.[75] A Diversity Index less than 1 indicates underrepresentation for the selected race in that profession.

As shown in the table below, in Nevada, among physicians, Hispanics have the lowest index at 0.2620 while all other races have a Diversity Index greater than 1. Similarly, among physician assistants and registered nurses, Black and Hispanic Nevadans have indices lower than 1 whereas Asian and White Nevadans have indices greater than 1. On the other hand, Hispanics have an index greater than 1 among medical assistants and all other races have indices less than 1.

[74] Rosenkranz, K., Arora, T., Termuhlen, P., Stain, S., Misra, S., Dent, D., & Nfonsam, V. (2021, July). *Diversity, Equity and Inclusion in Medicine: Why It Matters and How do We Achieve It?* . Retrieved from Journal of Surgical Education: https://gme.dartmouth-hitchcock.org/sites/default/files/2021-10/diversity-equity-inclusion-in-medicine.pdf#:~:text=Commonality%20between%20patients%20and%20their%20providers%20results%20in,all%20benefit%20from%20diversity%20in%20the%20healthcare%20workplace

[75] Fitzhugh Mullan Institute for Health Workforce Equity. (2023). Health Workforce Diversity Tracker. Retrieved from https://www.gwhwi.org/diversitytracker.html

Race	Physician	Physician Assistant	Registered Nurse	Medical Assistant
Asian	2.905	1.840	3.553	0.682
Black	1.188	0.078	0.681	0.832
Hispanic	0.262	0.551	0.310	1.785
White	1.166	1.388	1.093	0.706

The PPC discussed how lack of diversity in the Nevada's existing health care workforce and in Nevada's medical schools may deter prospective medical graduates from completing their graduate medical education (GME) in Nevada. Results from a recent JAMA study suggest that additional efforts are needed to increase the representation of Black, Hispanic, and Native American people in the health care profession and measuring and reporting on representation of these groups in the health care workforce and educational pipeline may encourage these efforts.[76]

Several states including Indiana, Minnesota and Virginia have created interactive dashboards to monitor trends in diversity of the health care workforce.[77] These states collect demographic information from health care professionals during their licensure renewal process. In 2021, Nevada passed similar legislation that is now codified in NRS 439A.116, which requires the Nevada Department of Health and Human Services (DHHS) to establish a database that collects information such as the race and ethnicity of the applicant, the primary language spoken, the geographic location and setting where the provider practices[78]

As of writing this report, DHHS is still in the process of establishing the database and is working with the Health Care Workforce Working Group to establish a process of collecting the provider information from each health care occupational licensing board. Once the database is operational, the Health Care Workforce Working Group established by NRS 439A.121 will be able to analyze information and provide recommendations on how to attract more persons and increase diversity among various types of providers. According to a publication from the American Public Health Association, numerous studies have demonstrated that the quality of health care in the United States varies according to patients' race and ethnicity.[79] By diversifying the health care workforce, the patient-physician relationship will have less racial differences and in turn can reduce racial disparities in the patient care provided to Nevadans.

VI. Commission Collaboration

NRS 439.918.1, paragraphs (a) and (b) requires the Commission to attempt to identify and facilitate collaboration between existing state governmental entities that study or address issues related to the quality, accessibility, and affordability of health care in this State. The Commission is willing to collaborate with any public, private or state governmental entity that studies or addresses issues related to the quality, accessibility, and affordability of health care in this State; and looks

[76] Edward Salsberg, M., Chelsea Richwine, P., Sara Westergaard, M. M., & al, e. (2021, March 31). *Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce*. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777977?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=033121#google_vignette

[77] Bowen Portal. (n.d.). *Indiana Physician Workforce Dashboards*. Retrieved from https://bowenportal.org/indiana-physician-workforce/;
Minnesota Department of Health. (2024). *Minnesota's Licensed Health Care Workforce Data*. Retrieved from https://www.health.state.mn.us/data/workforce/hcwdash/index.html?url_var=sexraceethnicity#NaN;
Virginia Department of Health Professionals. (n.d.). *Virginia Healthcare Workforce: Gender and Racial/Ethnic Diversity*. Retrieved From https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/Dashboards/GenderandRacialEthnicDiversity/

[78] Nevada State Legislature. (n.d.). *NRS 439A.116*. Retrieved from https://www.leg.state.nv.us/nrs/nrs-439a.html#NRS439ASec116

[79] Somnath Saha, M. M., Jose J. Arbelaez, M. M., & Lisa A. Cooper MD, M. (2003, May). *Patient-Physician Relationships and Racial Disparities in the Quality of Healthcare*. Retrieved from https://ajph.aphapublications.org/doi/full/10.2105/AJPH.93.10.1713

forward to continuing this practice through open communication with the Commission and offering direct collaboration from the Executive Director. During the reporting period, the Executive Director met with various health care and workforce development stakeholders, governmental entities and institutions of higher education to build relationships and collaborate on statewide efforts related to the scope of the Commission. Additionally, the Executive Director was appointed to serve on various committees which relate to the scope of the Commission:

Nevada Division of Insurance Commissioner's Life & Health Advisory Subcommittee
Per NRS 629.095, the Commissioner of Insurance is required to develop a standardized form for use by insurers and other entities to obtain information related to the credentials of certain providers of health care. The Subcommittee discussed the need to revise the current NDOI-901 Universal Credentialing Form, which had not been updated since 2016. The Subcommittee discussed the need to remove intrusive and stigmatizing mental health questions, identify opportunities to shorten the form and develop a shorter form for provider re-credentialing. Following feedback from the Subcommittee, the Division is currently revising the form and implemented an addendum form to allow providers to re-certify by simply attesting there had been no changes since the last credentialing form submission. The Executive Director is grateful for the opportunity to collaborate with the Division of Insurance and the Subcommittee to reduce the administrative burden for insurers and health care providers by streamlining the universal credentialing form and re-credentialing process.

Health Care Workforce Working Group
The Health Care Workforce Working Group (HCWWG) was established by SB379 (2021) and is codified in NRS 439A.111-122. The HCWWG is responsible for making recommendations to the Director of the Department of Health and Human Services (DHHS) concerning the information collected from applicants for the renewal of a license, certificate, or registration as a provider of health care. The PPC Executive Director was appointed to the board by the DHHS Director in July 2024 and will serve a two-year term. The HCWWG held its first meeting on October 17th and is discussing how to establish a health care provider database as required per NRS 439A.116.

VII. Reduce Duplication of Efforts

The Commission is committed to coordinating with any state governmental entity to reduce any duplication of efforts among and between those entities and the Commission. Commission staff monitor public meeting notices and attend meetings that relate to health care access, quality and affordability. Additionally, Commission staff monitor available data, reports and other publications relating to the scope of the Commission. The Executive Director will continue to identify opportunities for the Commission to reduce duplication and coordinate with partners statewide.

VIII. Next Steps

The Commission is scheduled to meet on January 17, 2025, and is expected to receive information from the Nevada Division of Insurance related to the Health Insurance Market in Nevada. In addition to reviewing information related to health care access, quality and affordability, the Commission will continue reviewing available data and national best practices related to addressing the health care workforce shortage in the State. The Executive Director will be supporting the Commission during the upcoming 83rd Legislative Session. In addition to monitoring their own bills, the Commission will be monitoring legislation introduced that pertains to the scope of the Commission.

Enclosures:
1. PPC Meeting Minutes (June – December 2024)
2. Solicitation of Health Care Workforce Recommendations (June 2024)
3. Solicitation of Health Care Provider Recommendations Relating to Nevada Medicaid (June 2024)

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
JUNE 21, 2024

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, June 21, 2024, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2024/PPC2024/.

1. Call to order: Roll call
By: Dr. Ikram Khan, Chairman

The meeting was called to order at 9:00 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

Commission Members Present
Dr. Ikram Khan, Chair
Jalyn Behunin
Dr. Bayo Curry-Winchell
Walter Davis
Marilyn Kirkpatrick, Vice Chair
Dr. Andria Peterson
Bethany Sexton
Wendy Simons

Commission Members Absent
Flo Kahn - Excused

Advisory Commission Members Present
Scott Kipper, Insurance Commissioner; Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP); Russell Cook, Executive Director, Silver State Health Insurance Exchange

Staff Present
Joseph Filippi, Executive Director, PPC; Madison Lopey, Policy Analyst, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Others Present
Gabriel D. Lither, Senior Deputy Attorney General, HHS; Maria Tello Magana, Executive Assistant, DHHS; Kareen

Filippi, Management Analyst III, WIC; Vance Farrow, Healthcare Industry Specialist, GOED; Lindsey Miller, Constituent Services, Governor's Office; Casey Angres, Social Services Chief 1, DHCFP; Malinda Southard, Deputy Administrator, DHCFP; Jennifer Quihuis, Management Analyst II, DHCFP; Andrea Gregg, CEO, High Sierra Area Health Education Center (AHEC); Kelsie George, Senior Policy Specialist, National Council of State Legislators (NCSL); Amanda Brazeau; Areli Alarcon; Brian Evans; Belz and Case Government Affairs; Carissa Pearce; Cassidy Wilson; Blayne Osborn; Caroline Bergner; Daniel Logsdon, Danny Thompson; David Coldwater; Edward Ableser; Elissa Secrist; Elyse Monroy-Marsala; Esther Badiata; Maya Holmes; Jeny Zendejas; Jimmy Lau; James Wadhams; Dr. John Packham; Kenneth Kunke; Linda Anderson; Mark Funkhouser; Mary Staples; Michael Willden; Misty Grimmer; Natalie Gautereaux; Sabrina Schnur; Samantha Barnes; Shawna Ross; Tess Opferman; Tina Gerber-Winn; Trey Delap; Dan Musgrove; Stacie Sasso

2. Opening Remarks

Dr. Ikram Khan, Chairman, thanked Commissioner Marilyn Kirkpatrick for Chairing the last PPC meeting. Dr. Khan also noted that he has requested Commissioner Kirkpatrick serve as Vice Chair of the Patient Protection Commission to which she graciously accepted. Dr. Khan then handed it off to Joseph Filippi, Executive Director to introduce the next agenda item.

3. Public Comment *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Shawna Ross, a Speech Language Pathologist and Private Practice Owner, thanked the commission for the opportunity to make a public comment. Ms. Ross serves as a state advocate on reimbursements for Medicaid and private insurance for the Nevada Speech Language Hearing Association (NSHA). She stated that NSHA is actively working with legislators on a bill to allow Nevada to join the Interstate Compact for Licensure for Speech Language Pathologists and Audiologists. More importantly, Ms. Ross stressed the need for reimbursement for CPT Codes 92612 (Flexible Fiber Optic Endoscopic Evaluation of Swallowing), 92511 (Nasopharyngoscopy with Endoscope), and 31579 (Diagnostic Laryngoscopy with Stroboscopy), as the reimbursement rate is currently $0 for speech pathologists. Ms. Ross stated that although physicians can be reimbursed for these codes, reports in Southern and Northern Nevada show that they are not completing these procedures, creating barriers to care and adversity in the recruitment and employment workforce when this highly skilled work receives zero payments. She argued that these CPT Codes are within the scope of practice for Speech Language Pathologists and are reimbursed under other insurance plans. Public comments submitted by Ms. Ross can be found here or on the PPC webpage, and she is asking that legislators support these requests in the budget and policy changes needed for FY25.

Carissa Pearce, Health Policy Manager for the Children's Advocacy Alliance (CAA), spoke about the organization's mission and current challenges. CAA is a non-profit, independent, and nonpartisan organization dedicated to cultivating public policy that allows every child in Nevada to thrive by supporting actions to increase the delivery and access to health resources while maintaining the medical integrity of patients. Ms. Pearce stated that Nevada is experiencing a severe health provider shortage, and it is imperative to address these issues as health disparities are increasing. Currently, there are very few postdoctoral fellowships in Nevada that are not related to emergency medicine. As a result, residents are leaving the state to find fellowships elsewhere. Ms. Pearce stressed that expanding the accreditation program to allow more graduate medical education opportunities would enable more residents to stay in Nevada for fellowship and practice. She also mentioned that CCA is in a research phase to better understand how Nevada might expand the scope of practice for advanced practice clinicians to reduce the provider shortage. Supporting agenda item five, Ms. Pearce noted that many families with medically involved children are leaving the state due to a lack of pediatric specialists, with many of these

treatments being medically necessary. She stressed that there is an opportunity to help these families by allowing for flexibility and coordination between states.

4. For Possible Action: Review and Approve Meeting Minutes from May 15, 2024
By: Dr. Ikram Khan, Chairman

Chairman Khan motioned for the approval of the May 15, 2024, meeting minutes. Commissioner Walter Davis motioned to approve the minutes as presented, and Commissioner Wendy Simons seconded the motion. The motion carried, and the May 15, 2024, meeting minutes were approved unanimously.

5. Presentation on Opportunities Identified to Address Health care Workforce Shortages from Other States
By: Kelsie George, Senior Policy Specialist, National Council of State Legislators (NCSL)

Kelsie George presented on Opportunities to Address Health Care Workforce Shortages from Other States. The presentation is available on the PPC webpage or by clicking here. The National Conference of State Legislators (NCSL) is a bipartisan organization serving legislators and legislative staff by providing services such as policy research, connections, training, state representation in D.C., and meetings. Currently, NCSL is developing a health workforce database to track enacted legislation across the 50 states and U.S. territories. Strategies for addressing workforce shortages include data collection and analysis, recruitment and retention, licensure portability, and telehealth flexibilities. Ms. George emphasized that data collection and analysis are foundational for understanding health workforce dynamics. States like Colorado, Florida, Georgia, Illinois, Indiana, and Utah are leading efforts to comprehensively track who provides services and to whom. Recruitment and retention follow, with states such as Colorado, Indiana, and Nebraska implementing career pathways and pipeline initiatives to attract new professionals. Graduate medical education is crucial, as physicians often practice where they complete their residency. States like Georgia, Idaho, New York, Louisiana, and Oregon offer financial incentives, such as loan forgiveness, repayment programs, and tax credits, to reduce turnover rates. Regarding licensure portability, Ms. George briefly discussed interstate compacts, noting that they are not all equal. This topic will be explored further in the following agenda item. Some states waive certain licensure requirements for episodic care consultations or other specific circumstances. Unlike Nevada, states such as Georgia, Hawaii, Idaho, and Utah have established limited licenses or other exceptions to expedite the licensure process, thereby increasing access to care.

Commissioner Davis thanked Ms. George for her presentation and inquired about her thoughts on expediting licensure. He also wondered if there is a correlation between expedited licensure and faster enrollment of providers in payer plans. Ms. George responded that while these initiatives focus on the legislative angle specifically addressing licensure requirements, they do not directly address the payer side. However, she acknowledged that there are specific requirements and processes for individual payers, such as Medicaid and private insurers. She expressed her willingness to investigate this further and follow up with the commission.

Commissioner Sexton asked about additional insights regarding states with these compacts and reciprocity and how they often don't find that there is a net increase in overall providers. Ms. George stated that interstate licensure compacts, reciprocity, and endorsement allow providers to shift from state to state and practice across state lines while still operating with the same baseline number of providers across the nation.

6. Presentation on National Trends in Occupational Licensing Policy
By: Daniel Logsdon, National Center for Interstate Compacts, Council of State Governments

Daniel Logsdon shared a presentation on National Trends in Occupational Licensing Policy. The presentation is available on the PPC webpage or by clicking here. The Council of State Governments (CSG) aims to provide technical assistance to states on a wide range of issues, including interstate compacts. CSG serves all three

branches of government and was founded at the University of Chicago in 1933. CSG creates and evaluates interstate compacts, facilitating states in coming together to cooperatively address problems that are bilateral, regional, or national. Mr. Logsdon stated that interstate compacts protect state sovereignty by allowing states to internally deal with issues rather than relying on a federal mandate. Active occupational licensing interstate compacts include nurse licensure, counseling, interstate teacher mobility, physician assistant (PA) licensure, medical licensure, audiology and speech-language pathology, dentistry and dental hygiene, among others highlighted in the presentation. One of the key benefits to practitioners of occupational licensure compacts is increased mobility, which supports the relocation of military members and their families. A benefit to licensing boards of occupational licensure compacts is the increased ability to bring in high-quality practitioners.

Commissioner Andria Peterson thanked Mr. Logsdon for his presentation. She mentioned some concerns that unions might currently be facing and asked if he could speak more on this, specifically why some of these concerns might be around those who have not adopted these compacts. Mr. Logsdon stated that the Nurse Licensure Compact could speak more freely about this and encouraged Commissioner Peterson to reach out to them for a more detailed answer. However, Mr. Logsdon did mention that the overall concern is over standards but noted that it is different for each compact.

7. Submitted Policy Recommendations to be Reviewed by the PPC
By: Joseph Filippi, Executive Director, Patient Protection Commission

Mr. Filippi provided a summary of policy recommendations the PPC had received since releasing the solicitation for workforce recommendations on June 3, 2024. The summary document is available on the PPC website here. As of June 14th, the PPC had received 26 submissions, most of which focus on insurance issues and increasing Medicaid reimbursement rates. Mr. Filippi then introduced Natalie Gautereaux, who discussed recommendations concerning social workers and workforce development for social workers in the state.

Natalie Gautereaux, Executive Director of the Nevada Public Health Foundation (NPHF), presented an overview of social work workforce development recommendations. The presentation is available on the PPC webpage or by clicking here. Currently, NPHF is working on several initiatives to address the significant shortage of social workers in Nevada, which has only one social worker per 1,420 people. Ms. Gautereaux explained that social workers play a critical role in serving high-need populations such as children and families, individuals with mental health and substance abuse disorders, those receiving healthcare, and people who are seriously ill and need assistance with daily living. Despite their crucial role in addressing mental, behavioral, and social health, social workers are often overlooked as key providers. Ms. Gautereaux emphasized the importance of including social workers as part of a multidisciplinary team, noting that 80%-90% of health outcomes are influenced by environmental factors such as housing, transportation, economic stability, and family and social support. However, social work students in bachelor's and master's programs are required to complete unpaid practicums of up to 15 hours per week, which, combined with their academic workload, often leads to high college debt and lower pay compared to other health care professionals. Tina Gerber-Winn, Community Engagement Specialist for NPHF and a social worker with over 30 years of experience, then discussed potential policy ideas to impact policy development. She highlighted the critical need for paid internship opportunities to help retain students, allowing them to focus on their education and careers. She also stressed the importance of providing support for recent graduates entering fields like child welfare and adult protective services. Many new social workers lack specialized training and understanding of these complex fields, leading to overwhelming experiences and contributing to the social worker shortage. Ms. Gerber-Winn suggested developing stronger educational pathways, such as establishing a workforce center or entity for social workers in specialty areas, to offer more guidance and training once they enter the field. She also recommended the creation of occupational wellness training, support, mentorship, and awareness programs separate from the employer, which are crucial due to the secondary trauma social workers often face. Additionally, Ms. Gerber-Winn proposed expanding the loan repayment program to include bachelor's and master's level social workers, who are currently not covered

under the recent legislative bill that was just approved last week.

Executive Director Filippi thanked both Ms. Gautereaux and Ms. Gerber-Winn for the very informative overview of social work recommendations. He then gave everyone the opportunity to ask any follow up questions or request for additional information regarding any of the received recommendations.

Commissioner Peterson asked several specific questions regarding Medicaid reimbursement rates. She inquired about how Medicaid conducts its rate review process every four years, the decision-making process based on these reviews, and how these rate reviews translate into increased rates for providers participating in managed care. She also asked about the policy levers Nevada needs to consider increasing these rates and improve access to care. Commissioner Peterson requested that the most recent review analysis be presented at the next PPC meeting to understand the reasons behind the low provider participation, despite Medicaid's active efforts to engage providers. She questioned whether some of the low provider rates might be caused by different underlying problems. Lastly, she inquired about how do rate reviews translate to increased rate for providers participating in managed Medicaid.

Chairman Khan acknowledged that these were excellent questions but suggested waiting until the next PPC meeting when Medicaid would be presenting, as that would be the perfect time for these inquiries. He explained that reimbursement rates are part of the Governor's executive order to be reviewed, which could potentially lead to a Bill Draft Request (BDR).

Commissioner Sexton followed up with an additional question for Medicaid about the evaluation of providers, specifically inquiring about the differences between providers participating in Medicaid versus those participating only in Medicare and commercial insurance.

8. For Possible Action: Review and Discussion of Possible Bill Draft Request (BDR) and Recommendations that align with Governor's Executive Order 2024-002
By: Joseph Filippi, Executive Director, Patient Protection Commission

Mr. Filippi provided a presentation on the discussion of possible Bill Draft Requests (BDRs) and recommendations that align with the Governor's Executive Order 2024-002. This presentation is available on the PPC website or by clicking here. Mr. Filippi explained the PPC BDR timeline, starting with the initial BDR discussion at this meeting. The next step is the review and ranking of BDR ideas by the commission in July. In August, the commission will vote on the top three BDRs to submit to the Legislative Counsel Bureau (LCB) by September 1st.

Commissioner Peterson inquired whether the commission could receive information on why providers are not participating in Medicaid. She then asked Mr. Filippi if this issue had been addressed previously to avoid duplicating recommendations. Chairman Khan partially answered, noting that past PPC meetings identified Medicaid reimbursement rates as a primary reason for low provider participation. However, he also mentioned that when this issue was presented to the Legislature, it was regarded more as a budgetary concern, with the budget priorities not necessarily focused on this aspect of the health care problem.

Commissioner Jalyn Behunin asked about the Nurse Apprenticeship Program and whether the commission could obtain a release of information (ROI) to review how many nurses in the program continued to work in Nevada. Mr. Filippi responded that he personally helped facilitate this program and mentioned that they are required to provide an annual report to the legislature, which includes all the information requested by Commissioner Behunin. He noted that this report is due in August and will follow-up to inquire if the PPC can obtain a copy of the annual report.

9. For Possible Action: Review and Approve Semi-Annual PPC Report required per NRS 439.918
By: Joseph Filippi, Executive Director, Patient Protection Commission

Mr. Filippi discussed the next agenda item which is to review and approve the Semi-Annual Report required per NRS 439.918. This report is available on the PPC website or by clicking here. He reiterated that the commission is required to submit a report every six months to the Governor and Legislature. This report must include a description of the meetings held and issues identified that negatively impact the quality, accessibility, or affordability of health care in the state.

Chairman Khan, Commissioner Simons, and Commissioner Curry-Winchell all complimented Mr. Filippi on his initiative efforts, noting that everything discussed, proposed, and presented had been executed smoothly. Chairman Khan then suggested a topic for the next PPC meeting when Medicaid presents. He would like to see a comparison of Nevada's Medicaid Fee-for-Service (FFS) reimbursement rates with those of other states. Additionally, he requested an analysis of how reimbursements are managed through Medicaid to providers and how these compare with Managed Care Organization (MCO) reimbursement rates in other states. Chairman Khan also expressed interest in hearing firsthand provider opinions from Medicaid, particularly regarding the challenges faced in both medical and hospital settings.

In response to Chairman Khan's request, Mr. Filippi mentioned that numerous provider groups have already expressed concerns about Medicaid reimbursement rates. He proposed that obtaining written feedback from these groups would be beneficial and indicated that this request will be made aiming to ensure that all groups are included and that their voices are heard.

Commissioner Curry-Winchell commented on the importance of having a mix of both verbal and written presentations from providers. She emphasized that hearing firsthand how low reimbursement rates have affected their practices and their ability to accept Medicaid patients can provide a more vivid understanding of the ongoing issue that the commission is addressing.

Commissioner Simons revisited the Semi-Annual Report and proposed adding language to extend the Commission's invitation to collaborate not only with the government but also with the private and public sector. Mr. Filippi confirmed his intention to incorporate this edit. Attorney General Gabriel Lither emphasized that since this discussion is categorized as an agenda item, formal motions or combined formal motions are encouraged. These formal votes ensure that changes made to the report are officially endorsed.

Commissioner Behunin inquired about the Bill Draft Requests (BDRs) and asked if the commission could receive a sample or proposed language of the bills to better understand the ongoing discussions. Mr. Filippi explained that typically, once the draft is finalized, the commission provides initial language to the Legislative Counsel Bureau (LCB), who then reviews and refines the language with their lawyers. It's only after this process that the commission reviews and approves the actual draft language that will be used in the bill.

Commissioner Sexton asked about the next steps after the submission of the BDRs and whether the Commission would continue with meetings. Chairman Khan explained that after submission, the BDRs would proceed to discussion in the next legislative session. Mr. Filippi emphasized his intention to maintain scheduled meetings even after BDR submission, as the Commission's role involves reviewing various issues relating to health care on an ongoing basis. Commissioner Sexton agreed, noting that due to the complexity and multitude of issues, more time is needed to address all these domains. She then asked if, during the next PPC meeting, Medicaid could also discuss how the dollars allocated for patient care reimbursement are distributed as a percentage of the total pool of Medicaid funds.

Commissioner Peterson inquired about the interest in having a presentation detailing how the licensing boards can be held accountable and the time it takes to receive a license. Chairman Khan mentioned that the PPC had already received a similar presentation in the past and asked Mr. Filippi to bring this information forward to avoid duplicating requests. Mr. Filippi acknowledged the request and added that a bill had been passed creating an office of boards and commissions under the Department of Business and Industry. However, they are currently experiencing staffing issues. He assured that he would continue to communicate and collaborate with them to provide Commissioner Peterson and the Commission with additional information.

Mr. Filippi then proceeded to ask the commission for a formal motion to add new language that includes public and private sector relations within the collaboration section of the report. Commissioner Simons initiated the motion, and Commissioner Sexton seconded it. All Commissioners approved, and the motion carried.

10. Public Comment *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made. Mr. Filippi reiterated that the next meeting is scheduled for July 19, 2024, the third Friday of the month.

11. Adjournment
By: Dr. Ikram Khan, Chairman

Chairman Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 10:49 AM.

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
JULY 19, 2024

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, July 19, 2024, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2024/PPC2024/.

1. Call to order: Roll call
By: Dr. Ikram Khan, Chairman

The meeting was called to order at 9:00 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

Commission Members Present
Dr. Ikram Khan, Chair
Jalyn Behunin
Dr. Bayo Curry-Winchell
Walter Davis
Marilyn Kirkpatrick, Vice Chair
Dr. Andria Peterson
Bethany Sexton
Wendy Simons
Flo Khan

Commission Members Absent

Advisory Commission Members Present
Scott Kipper, Insurance Commissioner; Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP); Russell Cook, Executive Director, Silver State Health Insurance Exchange

Staff Present
Joseph Filippi, Executive Director, PPC; Madison Lopey, Policy Analyst, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Others Present
Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Lauren M. Driscoll, Deputy Attorney

General, Attorney General; Maria Tello Magana, Executive Assistant, DHHS; Lindsey Miller, Constituent Services, Governor's Office; Stacie Weeks, Administrator, DHCFP; Jennifer Krupp, Deputy Administrator, DHCFP; Ann Jensen, Agency Manager, DHCFP; Jeremey Hays, Management Analyst IV, DHCFP; Kimberly Adams, Admin Services Officer III, DHCFP; Jack Childress, Insurance Actuarial Analyst III, DOI; Janel Davis, Chief Operations Officer, Silver State Health Insurance Exchange; Kareen Filippi, Management Analyst III, WIC; Andrea Gregg, CEO, High Sierra Area Health Education Center (AHEC); Aaron William; Allison Genco; Amy Shogren; Amanda Brazeau; Annette Logan; April Corbin Girnus; Areli Alarcon; Brian Evans; Belz and Case Government Affairs; Charles Greenberg; Chris Bosse; Dan Musgrove; David L Carlson; Donna Laffey; Elissa Secrist; Elyse Monroy-Marsala; Eric R. Schmacker; Esther Badiata; Fred Olmstead; Gabriele McGregor; Galina Tole; Irene Bustamante Adams; Jacqueline L. Nguyen; James Wadhams; Jason Flynn; Jesse Wadhams; Dr. John Packham; Kelsey Avery; Kenneth Kunke; Linda Anderson; Luiza Benisano; Mari Nakashima Nielsen; Marissa Brown; Mark Funkhouser; Michael Hillerby; Michael Willden; Miranda Hoover; Misty Grimmer; Nancy Bowen; Natalie Powell; Nicole M. King; Dr. Nilesh Gokal; Patrick Kelly; Paul Young; Ricardo Elle, Sam Anastassatos; Sarah E. Fox; Sarah Watkins; Shannon Sullivan; Shawna Ross; Shelia A. Bray; Shirish S. Limaye; Stacie Sasso**;** Stephanie A. Woodard; Steve Messinger; Tess Opferman; Tucker Desmond; Duane Young

2. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Dr. Nilesh Gokal, a Family Physician based in Southern Nevada, is the President of the Nevada Physician Wellness Coalition (NPWC), an autonomous, independent nonprofit formed in 2018 in Northern Nevada by a group of physicians following the suicides of two colleagues. The NPWC, along with the Nevada Chapter of the American College of Physicians, submitted a proposal aligning with PPC objectives to address healthcare workforce shortages. They aim to receive support for removing invasive mental health questions from physician licensure and credentialing applications, enhancing recruitment and retention of a healthy workforce to better serve the growing population. Dr. Gokal pointed out that Nevada currently ranks 48th for board-certified primary care physicians per capita, burdening the healthcare system and correlating with high rates of physician suicide. One in five physicians plans to leave their current practice, and one in three plans to reduce their hours, given that 62.8% of physicians experienced burnout in 2021, up from what was 30% in 2020. Their proposed changes also align with those of the American Medical Association (AMA) and the Lorna Breen Foundation, adopted by 23 states so far, directly addressing the stigma surrounding mental health and improving access to care. Dr. Gokal notes that these 23 states received direct funding, proposing a line item in the Nevada State Budget to support the NPWC. He emphasizes that these changes will help achieve the statewide goal of retention and as a result, positively impact patient safety, health outcomes, and access to care.

Kenneth Kunke, a practicing pharmacist since 2003, is a representative advocating for lower out-of-pocket costs and improved patient access in Nevada, a workgroup consisting of healthcare professionals, healthcare and patient associations, and businesses. Mr. Kunke submitted a PDF highlighting concerns about Pharmacy Benefit Managers (PBMs), available on the PPC webpage or by clicking here. He states that the lack of transparency with PBMs can increase patient out-of-pocket costs and limit access to medications. Mr. Kunke argues that the high prices are driven by price points set by PBMs, who control nationwide data. While other states have taken steps to legislate transparency in this part of the drug supply chain, Nevada lags behind. PBMs are identified as the primary cause of these issues, and Mr. Kunke recommends two proposed bill draft requests to address these concerns.

3. **For Possible Action: Review and Approve Meeting Minutes from June 21, 2024**
By: Dr. Ikram Khan, Chairman

Chairman Khan motioned for the approval of the June 21, 2024, meeting minutes. Commissioner Marilyn Kirkpatrick motioned to approve the minutes as presented, and Commissioner Wendy Simons seconded the motion. The motion carried, and the June 21, 2024, meeting minutes were approved unanimously.

4. Nevada Medicaid Overview and Policy Opportunities to Address Provider Workforce Shortages
By: Stacie Weeks, Administrator, Nevada Division of Health Care Financing and Policy (DHCFP)

Stacie Weeks, Administrator of Nevada's Division of Health Care Financing and Policy, gave a presentation on Nevada Medicaid Opportunities to Address Health Workforce Shortages. This presentation is available on the PPC webpage or by clicking here. It sheds light on Nevada Medicaid as a program funded jointly by state and federal sources. She emphasized the distinction between Medicare, managed at the federal level, and Medicaid, which involves joint management by the state and the Centers for Medicare & Medicaid Services (CMS). In discussing Nevada's Medicaid financing, Administrator Weeks highlighted that the program operates with an average federal funding share of 60%, while the state contributes 40%. This funding structure supports a total approved spending of $15.7 billion for the 2023-2025 biennium. Notably, only 3% of this budget is allocated to administrative expenses, with most of the program's focus on provider reimbursement and coverage for Nevadans. She then went on detailing the base rates—which represent typical fee schedules per service based on funding levels or provider cost reports. She explained that supplemental payments, commonly seen in hospitals, supplement these base rates and are influenced by funding availability, often disbursed annually or quarterly. Additionally, bonus payments serve as incentives tied to funding levels and provider performance outcomes. Administrator Weeks addressed the Quadrennial Rate Review (QRR) occurs every four years, currently finalizing its Behavioral Health report, which will be released soon. It's crucial to note that the QRR is advisory and does not automatically lead to rate increases. State budget authority for funding adjustments occurs biennially, posing challenges when providers advocate for reimbursement increases. She pointed out that the QRR often doesn't get enough data from providers about notices and costs. This makes it hard to compare the actual costs of services with the reimbursement rates, and they often end up with a small sample size. Nevada ranks 7th nationally in Medicaid reimbursement rates, which are higher compared to Medicare rates. However, despite these rates, providers may feel differently due to variations in healthcare costs and commercial reimbursement rates in the state. To raise Medicaid provider reimbursement rates, we must boost the state's general fund allocation for Medicaid medical expenses. This involves submitting a CMS 64 for every claim showing Medicaid paid 40 cents for every dollar, which complicates the process. She noted that there are only three levers: rates, cutting eligibility, or reducing services, none of which are beneficial. Finally, she emphasized that increasing Medicaid rates alone won't solve access to care issues and attracting more providers should not compromise system quality.

Chairman Khan commented on Nevada's low ranking in healthcare quality and highlighted a longstanding issue: most extended care facilities, like nursing homes and long-term acute rehab centers, do not accept Fee for Service (FFS) Medicaid patients due to low provider reimbursement rates. This issue has been debated in the legislature for years. He emphasized that hospitals are reluctant to accommodate Medicaid patients, often reserving only three to four beds for them. Chairman Khan stressed the ongoing need to address these multiple challenges in ongoing discussions. He later asked about the availability of providers to care for these patients due to low reimbursement rates affecting Pediatric Intensive Care Unit physicians. Administrator Weeks stated that data shows no need to send children out of state due to a shortage of pediatric physicians.

Commissioner Walter Davis thanked Administrator Weeks for her comprehensive overview. He asked whether the 60%/40% funding split is consistent across all states or specific to Nevada, and whether the 3% allocation for administrative costs on average is typical. Administrator Weeks clarified that funding structures vary by state based on per capita income, with the federal government always contributing at least 50%. She noted that Nevada's administrative cost allocation is lower compared other states but emphasized the need for increased

funding to better serve the people they support.

Commissioner Flo Kahn asked Administrator Weeks about improving data access through an all-claims database to inform rate decisions, given challenges with data from commercial plans and providers. She also inquired whether streamlining prior authorization processes requires legislative changes or can be managed internally. Administrator Weeks mentioned the upcoming system to enhance data access, which will take about a year to implement, improving insights into healthcare access and dynamics in Nevada. She confirmed that streamlining prior authorization can be achieved internally but highlighted the need for better vendor support to effectively reduce unnecessary prior authorizations.

Commissioner Bethany Sexton asked Administrator Weeks whether the 3% allocated for administrative costs includes expenses incurred by Managed Care Organizations (MCOs). Administrator Weeks clarified that it does not, as it is part of the 97% focused on provider reimbursement. Commissioner Sexton then inquired about Graduate Medical Education (GME). Administrator Weeks indicated they would cover GME in more detail later in the meeting but briefly mentioned the potential to secure funds annually to invest in state dollars, which could reduce costs and support medical residents to serve as staff for providers.

Commissioner Marilyn Kirkpatrick thanked Administrator Weeks for her presentation, stating that it was one of the most comprehensive Medicaid presentations she had seen in 20 years. She mentioned that behavioral health was not covered and asked if it was addressed separately. Administrator Weeks explained that due to finalizing the QRR report, not all information was yet available. However, she did mention that some information had already been presented to the Interim Finance Committee regarding the increase in rates for residential treatment centers to $800 a day, with bonus payments tied to value.

Commissioner Andria Peterson inquired about any additional needs regarding loan repayment options. Administrator Weeks acknowledged that it would be beneficial to track where these loan repayment receipts are going, stating that tying loan repayments to people staying in the state is necessary.

5. Nevada Medicaid Considerations from Provider Perspective
By: Nevada Hospital Association, Nevada Rural Hospital Partners, Nevada State Medical Association

Patrick Kelly, President of the Nevada Hospital Association, shared a presentation on Nevada Medicaid considerations from the provider perspective. The presentation is available on the PPC webpage or by clicking here. Mr. Kelly began by explaining the historical perspective of Medicaid reimbursement to hospitals, noting a 5% increase in reimbursements over the past 21 years. However, he highlighted a significant disparity, with hospital costs per adjusted inpatient day rising by 57% during the same period. Mr. Kelly then discussed the Private Hospital Medicaid Provider Fee Program, where 42 private Nevada hospitals agreed to self-tax, with the funds sent to the federal government and matched by the federal medical assistance percentage assigned to Nevada Medicaid. He noted that this initiative generated a net benefit of $362 million in SFY 2024 for these hospitals. Despite this, he emphasized that it has not sufficiently addressed the issue of unreimbursed care, which remains substantial due to the earlier 5% and 57% gap. In SFY 2022, larger hospitals in Nevada provided over $1.2 billion in unreimbursed health care costs, leaving $838 million in unreimbursed care after deducting the net benefit. Blayne Osborn, President of the Nevada Rural Hospital Partners, then addressed rural hospitals. He mentioned Senate Bill (SB) 241, passed in 2023, which mandates Medicaid payments to public Critical Access Hospitals at cost-based rates for outpatient services. He emphasized that increasing Medicaid reimbursement rates is crucial for ensuring adequate patient access to care.

Commissioner Kirkpatrick thanked them and asked about the 5% and 57% disparity, particularly regarding factors driving hospital costs. She stressed the importance of addressing primary care to prevent emergency rooms from becoming primary care providers. Mr. Kelly mentioned statistical factors contributing to the disparity and stated hospital wages and drug costs as significant cost increases.

Commissioner Khan asked whether the costs of unreimbursed care have been rising or have stabilized now that more Nevadans have insurance under the Affordable Care Act. Mr. Kelly responded that with more insured individuals, the costs tend to decrease. However, he noted that there is still unreimbursed care due to people with high-deductible plans who cannot afford to pay or meet their deductibles, thereby increasing unreimbursed costs.

Jacqueline Nguyen, policy director for the Nevada State Medical Association (NSMA), presented on Nevada Medicaid: Physician Perspectives. The presentation is available on the PPC webpage or by clicking here. Established in 1875, NSMA's mission is to advocate for high-quality healthcare for all Nevadans. Physicians are the only Medicare providers not receiving an annual inflationary update; from 2001 to 2024, Medicare physician payments have lagged 20% behind inflation rates. Ms. Nguyen highlighted the impact of Nevada Medicaid payments on access to care. For CPT code 99213 (established patient office visit), commercial insurance pays $127.36, Medicare non-facility pays $91.15, NV Medicaid pays $35.79, and Utah Medicaid pays $66.08. This significant difference is a key reason why physicians hesitate to accept Medicaid patients, as it is unsustainable for practices to incur losses on each 99213 visits if patients are on Medicaid. Closing the gap between Medicaid and Medicare reimbursements can reduce disparities in access to care for everyone. Ms. Nguyen also addressed administrative challenges, noting that prior authorizations are burdensome and billing Medicaid involves more obstacles compared to commercial insurance. She cited national average losses on Medicaid claims due to processing costs and risks of claim abandonment, amounting to about 18%, compared to 4.7% for Medicare and 2.4% for commercial insurance. She emphasized that fixing prior authorization processes is a priority. A survey revealed additional challenges faced by physicians when accepting Medicaid clients, including delayed payments, difficulties in obtaining patient resources like medications, and higher rates of patient no-shows. Ms. Nguyen warned that Nevada physician practices may close if reimbursement rates remain low, exacerbating physician shortages and causing economic impacts. In conclusion, Ms. Nguyen called for a dual approach: increasing Medicaid reimbursement rates and simplifying administrative burdens.

Chairman Khan thanked Ms. Nguyen for her presentation. He commented on the low reimbursement rates, stating that it is unacceptable for NV Medicaid to reimburse only $37.79 to a medical professional. He emphasized that the state needs to take these low reimbursement rates more seriously, considering that physicians spend over 10 years receiving education and attending residency. He also commented on the burden that prior authorizations cause, noting specifically that patients in acute rehab in long-term care facilities or nursing homes often stay at these facilities while waiting for prior authorizations to be reviewed. He mentioned that the turnaround time is usually 48-72 hours. When denied, the turnaround time extends to 8-10 days, by which time patients have often improved and are ready to be released. Chairman Khan stated that these statistics are something that should be addressed by the insurance commissioner.

Commissioner Bayo Curry-Winchell also commented on the effects of low reimbursement rates, noting that as a physician, she often cannot refer her patients to necessary care because providers are not participating with Medicaid. This stopped care leads to delays in diagnosis and patient complications, ultimately contributing to the unreimbursed healthcare costs.

Commissioner Kirkpatrick asked a couple of questions: whether one of her slides displayed national data, and if she had reached out to Administrator Weeks or sat down with them to discuss the administrative burden of prior authorizations. Ms. Nguyen clarified that Slide 3 on Medicare data was sourced from the AMA, while Slide

4 on Medicaid reimbursable rates for CPT codes was specific to Nevada data. She also mentioned they recently met and plan to collaborate to streamline prior authorizations effectively. They intend to hold quarterly meetings with NSMA providers to focus on various specialists and their interactions with Medicaid.

Commissioner Kirkpatrick also inquired of the insurance commissioner, Scott Kipper, about ongoing studies or separate dialogues concerning insurance rates. Commissioner Kipper agreed, emphasizing the necessity of a separate dialogue to thoroughly explore this issue, which is crucial for the overall health of the insurance marketplace. Mr. Filippi added that if the commission unanimously supports further discussions on this matter, a future meeting with the Division of Insurance could be scheduled.

Commissioner Peterson brought up the topic of loan repayment programs, wondering if they're effective or if there's more that's needed. She's hesitant to recommend what's already in place. Ms. Nguyen said she'd like to be part of this discussion and plans to ask her members who've used these repayment options how it has affected their decisions to stay in Nevada.

Commissioner Davis mentioned that Federally Qualified Health Centers (FQHCs) rely on loan repayments, acknowledging they provide some help. However, he emphasized that these repayments alone aren't sufficient to retain providers in the state. Once providers receive forgiveness for their loans, they often leave, highlighting the need for further efforts to address this issue.

6. Policy Considerations for Expanding Graduate Medical Education (GME) in Nevada
By: Mercer Government Human Services Consulting

William Aaron from Mercer Government Human Services Consulting provided an overview of Policy Considerations for Expanding Graduate Medical Education (GME) in Nevada. The presentation is available on the PPC webpage or by clicking here. Mr. Aaron explained that GME is a vital component of formal medical education, primarily sponsored by hospitals. It includes internships, residencies, subspecialty, and fellowship programs essential for state licensure and board certification. He noted that funding for GME is divided into two categories: startup costs, which are not reimbursable by Medicaid, and ongoing costs such as salaries, which Medicaid can reimburse. This underscores Medicaid's potential role in supporting and fostering GME growth in Nevada. Mr. Aaron highlighted an increase in physicians completing primary care GME in Nevada over the past 12 years. Charles Greenberg then discussed their multi-state review and GME roles in Nevada. Mercer examined Medicaid-focused GME programs across seven states, identifying commonalities and differences. Examples included New Mexico, Florida, and Massachusetts, each implementing unique innovations like new state boards, grant programs, Medicaid-funded startup bonuses, and Medicaid support for GME resident loan repayments. Mr. Greenberg discussed challenges Nevada faces in expanding GME programs, particularly the costs of hiring program directors and coordinators, especially in rural areas where providers are hesitant to practice. He emphasized the importance of aligning initiatives with the state's priorities for success. Looking ahead, he suggested exploring Florida's approved startup bonuses and addressing complexities in Medicaid funding for student loan repayments but notes that it requires careful cost-saving strategies to maintain sustainability.

Chairman Khan asked Mercer if they have data on how many doctors and residents graduate from UNLV and UNR and stay in Nevada after their residency. Mr. Aaron stated that they do have some data, but it varies year to year, averaging slightly less than half. Chairman Khan expressed concern that if fewer than half stay, expanding GME might not be such a priority if many providers leave the state. Mr. Aaron agreed but mentioned that this retention issue is common nationwide. Mr. Filippi added that Administrator Weeks talked about possibly requiring residents to stay in Nevada after their training, with loan forgiveness as an incentive.

Commissioner Peterson asked about the initiatives seen in Florida and whether they were driven by legislation or initiated through Medicaid. Mr. Greenberg indicated that he believed these initiatives originated from

legislation or budget allocations. He assured the commission that they would investigate further and provide more information.

Commissioner Flo Khan asked if there is a possibility of utilizing the Federal Department of Education or if they have ever funded GME programs. Mr. Aaron mentioned they had explored this possibility but wasn't entirely certain if there was any involvement from them. He will further be investigating this matter. Commissioner Khan also suggested considering the Labor Department as another potential department to explore.

Administrator Weeks added that if Medicaid funds were to play a role in the residency program, it could address challenges providers often face, such as salaries. She suggested exploring a potential five-year obligation to stay in Nevada as a solution. Chairman Khan also mentioned that the Military healthcare program requires a 12-year service obligation after education or residency completion and agreed with Administrator Weeks that it could lead to better provider retention.

Commissioner Curry-Winchell emphasized the significance of provider satisfaction and feeling represented at their workplaces, highlighting Nevada's need to address diversity. She noted that the state should explore ways to diversify its population. From her interactions with medical students, residents, and physicians, she found that many consider Nevada's cultural and diversity offerings when deciding to stay. She then asked Mercer to investigate the Elko residency program, which failed to sustain itself. Understanding the reasons behind this could help develop solutions to prevent similar issues in the future. Mr. Aaron did state that the closure in Elko was ultimately a financial decision.

Commissioner Davis mentioned his deep involvement in the failed Elko residency program, attributing its closure primarily to infrastructure challenges. Faculty and medical residents faced a four-hour commute to reach Elko, which posed a significant obstacle. He also highlighted housing issues, noting that ultimately, lack of resources led to the program's discontinuation.

Commissioner Kirkpatrick highlighted her recent meeting with the Director of Labor, who emphasized that Nevada shouldn't continue building hospitals without ensuring an adequate workforce to support them. She then asked Mercer if they had looked into Rhode Island's initiatives, particularly their efforts to attract healthcare providers. Mr. Aaron responded that he wasn't familiar with Rhode Island's specific initiatives but expressed willingness to research them further.

Commissioner Peterson asked Administrator Weeks if funding support comes from legislation or Medicaid. Administrator Weeks explained that it depends on legislation focused on workforce development and whether the state invests in that fund, which Medicaid might match. She also mentioned using local funds or private donations as options. Director Richard Whitley added that a legislative bill is needed to include funding in Medicaid's budget, allowing them to leverage federal matching funds effectively. He emphasized that matching funds with federal resources is essential for expanding funding opportunities.

Commissioner Khan followed up on Administrator Weeks' and Director Whitley's comments, asking specifically how much funding is required. Director Whitley explained that the bill needs to direct them to leverage funding, including other available funds. He emphasized that he didn't want to restrict the amount of funding, as discussions with Medicaid on how to maximize federal matching funds were still ongoing and depended on the funding's allocation.

Commissioner Sexton asked if they have national data on the percentage of providers who stay in the state where they trained, especially with programs like medical school training, residency, and fellowship, as this information could help determine the best way to use funds. Mr. Aaron noted that reasons for providers staying or leaving are often not well-documented. However, he did highlight that in Nevada, family considerations play a

significant role in provider retention. He expressed his willingness to further explore this data.

Commissioner Kirkpatrick emphasized the importance of Bill Draft Requests (BDR) topics being broad and autonomous to effectively guide agencies and prevent obstacles or setbacks. Allowing Medicaid, the freedom to innovate and be creative, rather than restricting their actions, could expedite significant progress.

Commissioner Simons complimented Administrator Weeks and Director Whitley, highlighting Administrator Weeks' proactive efforts as particularly encouraging in government.

7. Submitted Policy Recommendations to be Reviewed by the PPC
By: Joseph Filippi, Executive Director, Patient Protection Commission

Mr. Filippi presented the submitted policy recommendations for review by the PPC. The presentation can be accessed on the PPC webpage or by clicking here. He emphasized the two public solicitations for recommendations: one concerning the healthcare workforce and the other focused on improving provider experience with Medicaid. Mr. Filippi mentioned that there were few changes from the last PPC meeting but noted an increase in responses related to provider wellness and mental health issues.

Commissioner Kirkpatrick emphasized her priorities: first, examining Medicaid reimbursement; second, addressing GME; and third, breaking down barriers for workforce development. She suggested that by approaching these recommendations with a broader perspective, more goals could be achieved simultaneously.

8. For Possible Action: Review and Discussion of Bill Draft Request (BDR) Topics
By: Joseph Filippi, Executive Director, Patient Protection Commission

Mr. Filippi presented on the review and discussion of BDR topics. The presentation is available on the PPC webpage or by clicking here. He highlighted that the PPC submitted a total of 13 BDR topics for potential consideration. The top three topics include joining the Interstate Nurse Licensure Compact to study its impact on the nursing workforce, increasing Medicaid reimbursement rates for physicians and other medical providers in critical areas, and investing in Graduate Medical Education (GME) to expand primary care residency and fellowship programs statewide. Regarding the top three topics, Mr. Filippi noted that GME and provider rate increases are potentially high-cost areas but could have long-term impacts on both rural and urban healthcare access. In contrast, joining the nurse licensure compact is seen as a lower-cost initiative, with an annual fee of approximately $6,000 to remain in the compact. While it facilitates easier onboarding of nurses, it may not directly increase nurse production or retention. He discussed the pros and cons of each topic. GME could bolster the healthcare workforce and potentially attract federal grant funding for rural residency programs, but it poses fiscal challenges. The nurse licensure compact offers streamlined processes and improved access to care but faces opposition from unions, which has failed in past legislative sessions.

Commissioner Behunin really wants to figure out how to do things differently because of the strong opposition from unions that the nurse licensure compact is up against. She hopes things might move forward if they change how they present things. Commissioner Sexton agreed with Commissioner Behunin, saying they need to figure out if joining a compact has to be done through a law or if licensing boards could handle it internally. Mr. Filippi chimed in, saying that joining a compact does require a law. He wasn't sure if a board could propose a compact or if it has to be done individually. Michael Hillerby, the government affairs representative for the State Board of Nursing, said he's willing to look at different ways on how it can be presented.

Commissioner Kirkpatrick commented on her experience in legislation, she expressed concerns about the difficulty in passing this compact, emphasizing the need to first build support from external stakeholders for a more favorable outcome. She argued that delaying the decision would allow for the establishment of a solid foundation and long-term nursing support. Mr. Hillerby agreed with Commissioner Kirkpatrick, highlighting the

serious nursing shortage faced not only by Nevada but also across the country. He emphasized the importance of engaging middle school students in discussions about pursuing STEM-related education in science and healthcare to bolster and enhance the workforce.

Commissioner Behunin asked Mr. Hillerby if states with strong union opposition, like California, Massachusetts, or New York, have managed to pass similar legislation that includes clauses about strikes. Mr. Hillerby mentioned that there is an updated map on this topic, which will be provided to Mr. Filippi to share with the commissioners. He noted that historically, the East Coast has faced more strong union opposition. Additionally, Mr. Hillerby pointed out that one concern unions have raised is whether such legislation could be used to make it easier to hire strike breakers during a labor shortage.

Chairman Khan suggested that all commissioners draft language to address the ongoing issue with the Nurse Licensure Compact if it is not submitted as a BDR. He proposed that by doing so, it could be pushed as a recommendation for other legislators to consider. Commissioner Peterson then asked if it would be possible to review what has historically been proposed in past legislative sessions. Mr. Filippi noted that this information has been shared with the commission before but is happy to provide it again to everyone.

Commissioner Kirkpatrick suggested that, given the ongoing discussions about Medicaid reimbursement rates, the commission should draft language for a BDR to move forward. She recommended voting on this draft to address future discussions with Administrator Weeks about potential costs, as this might be a concern for the Governor or the legislature. Mr. Filippi noted that another meeting is scheduled before the BDR topics are due. He offered to request additional information from Nevada Medicaid, focusing on potential increases that could address access gaps. This information could then be presented to the commission as a list of provider types to consider for discussion and finalization. Chairman Khan agreed that the topic should be finalized and voted on today, recognizing it as an ongoing issue. He suggested that if the BDR is approved, the commission could vote at the next meeting to adjust the proposed language for final submission. Lauren Driscoll, Deputy Attorney General, asked for clarification on the topic to ensure it is properly recorded before the vote. Commissioner Kirkpatrick stated that the topic is "Medicaid Reimbursements with a Targeted Approach." Chairman Khan then motioned for the final approval of the BDR topic titled "Medicaid Reimbursements with a Targeted Approach." Commissioner Kirkpatrick motioned to approve the topic as presented, and Commissioner Davis seconded the motion. The motion carried, and the BDR topic was approved.

Commissioner Simons highlighted Medicaid's request for flexibility in utilizing federal funds to support GME. She and Commissioner Sexton suggested that this should be included in the BDR proposed language, allowing Medicaid to use its funding for various purposes. Director Whitley agreed, noting that including this in the Medicaid budget would enable leveraging of federal funds. Chairman Khan then motioned for a second BDR topic: providing Medicaid with authorization for budget authority to leverage a variety of funds to expand Graduate Medical Education (GME) in the state. Commissioner Flo Khan second. The motion carried, and the second BDR topic was approved.

Chairman Khan reiterated that the Commission can approve up to three BDRs. He then asked if the third BDR topic, which involves joining the Interstate Nurse Licensure Compact to study its impact on the nursing workforce, should be voted on as the final BDR topic. Commissioner Kirkpatrick disagreed, arguing that it should not be a BDR topic. She suggested that a more general BDR focused on reducing workforce barriers would better align with the PPC's mission. Chairman Khan agreed, proposing that if the topic is not suitable for a BDR, it could be considered as a recommendation from the commission at a later time.

Commissioner Flo Khan shifted back to the second BDR topic and supported Commissioner Simons and Sexton's point, emphasizing that addressing administrative burdens, such as credentialing and prior authorization could

be effectively handled through a BDR. She argued that eliminating these hurdles might be quicker than other recommendations and would align with the PPC's objective of increasing the availability of healthcare providers. She felt that this is precisely the type of issue that a BDR should address. Chairman Khan noted that many of these administrative burdens are managed by the Insurance Commission and suggested collaborating with them to develop a plan to reduce these burdens. Commissioner Kirkpatrick agreed with Chairman Flo Khan, stating that this aligns with her concern about modernizing the billing process. She proposed that this issue could potentially be included under the Medicaid Reimbursement BDR topic, depending on how the proposed language is framed and presented.

Commissioner Sexton agreed with the discussion but noted that Administrator Weeks has mentioned efforts to actively reduce these administrative burdens. She suggested that the topic might be better framed as a recommendation for both Medicaid and the Department of Insurance. Commissioner Khan agreed with the idea but expressed concern about combining too many subtopics into a single BDR, which could complicate the process and potentially conflict with state legal standards. Mr. Filippi proposed that this issue be discussed between now and the next meeting. The commission could then provide specific feedback on which administrative burdens they want to address and determine if these issues can be resolved through regulation or legislation. Commissioner Kirkpatrick agreed with Mr. Filippi's suggestion, adding that this approach should be applied to all three final BDR topics.

Chairman Khan then introduced the topic of unfunded mandates by Medicaid. Mr. Filippi provided additional context based on information received from Nevada Medicaid and Public Employee Benefits Program (PEBP), explaining that the recommendation is to ensure that any state-mandated benefits are included in state-controlled insurance products, such as Medicaid Managed Care Organizations (MCOs) or UMR PEBP. He noted that if a state mandates coverage for a specific benefit, it does not guarantee that the Centers for Medicare & Medicaid Services (CMS) will approve federal funding for this benefit. Consequently, the state would need to cover the costs through general funds, which could lead to increased premium costs for consumers.

Commissioner Kirkpatrick shifted the discussion back to the BDR topic of the Nurse Licensure Compact. While she agreed that the BDR should proceed, she sought clarification on whether her earlier issue regarding a bill to reduce barriers in the workforce was no longer considered a proposed topic. Mr. Filippi acknowledged that there is some hesitation about the Nurse Licensure Compact as a final BDR topic, but he noted that it does address workforce barriers, which is why it was identified as a relevant topic. He assured that the commission could still explore other areas for potential BDRs. Commissioner Kirkpatrick expressed her belief that the bill regarding the Nurse Licensure Compact should be postponed for now, emphasizing the need for a bill focused on modernizing the billing process.

9. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

David Carlson, Associate Dean for Graduate Medical Education at the University of Nevada, Reno, expressed gratitude for the advocacy aimed at potentially including GME in Medicaid’s budget. He emphasized that without GME, the state struggles to retain graduating medical students. Currently, 312 students graduate from various medical schools each year, with about 39.8% remaining to practice in the state. However, with GME, retention increases to 55.2%, highlighting the critical role of GME in retaining medical professionals. Mr. Carlson mentioned that UNR is expanding its GME footprint with a new pediatric program but requires additional operating costs to sustain this and other programs. They are also considering starting an addiction medicine fellowship, which would also need operating costs to be successful and to develop more GME programs.

Chairman Khan thanked Mr. Carlson for his public comment and requested that he submit these comments to Mr. Filippi so they can be presented to the Commission.

10. Adjournment
By: Dr. Ikram Khan, Chairman

Chairman Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 12:23PM.

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
August 16, 2024

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, August 16, 2024, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2024/PPC2024/.

1. Call to order: Roll call
By: Dr. Ikram Khan, Chairman

The meeting was called to order at 9:00 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

Commission Members Present
Dr. Ikram Khan, Chair
Dr. Andria Peterson
Dr. Bayo Curry-Winchell
Bethany Sexton
Walter Davis
Wendy Simons

Commission Members Absent
Marilyn Kirkpatrick, Vice Chair – Excused
Flo Kahn - Excused
Jalyn Behunin - Excused

Advisory Commission Members Present
Scott Kipper, Insurance Commissioner; Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP); Russell Cook, Executive Director, Silver State Health Insurance Exchange

Staff Present
Joseph Filippi, Executive Director, PPC; Madison Lopey, Policy Analyst, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Others Present

Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Lindsey Miller, Constituent Services, Governor's Office; Stacie Weeks, Administrator, DHCFP; Jennifer Krupp, Deputy Administrator, DHCFP; Ann Jensen, Agency Manager, DHCFP; LaTanya Cash-Calhoun, Social Services Program Specialist III, DHCFP; Brooke Maylath, Health Facility Inspector, DPBH; Kareen Filippi, Management Analyst III, WIC; Vance Farrow, Health Industry Specialist, GOED; Andrea Gregg, CEO, High Sierra Area Health Education Center (AHEC); Allison Genco; Amanda Brazeau; Areli Alarcon; Belz & Case Government Affairs; Brain Evans; Brian Lauf; Cathy Dinauer; Cheri Glockner; Cheryl Ledward; Cherylyn Rahr-Wood; Chris Boose; Dan Musgrove; Dorthy Edwards; Eric Schmacker; Esther Badiata; Farzad Kamyar; Jamelle Nance; Jay Cafferata; Jessica Longstreth; Kelsey Avery; Kendra Edwards; Kerrie Kramer; Kimberly Arguello; Kristina Kovacs; Lea Case; Linda Anderson; Lisa Pacheco; Maya Holmes; Marcia Turner; Marisa Sandoval; Michael Willden; Nadine Kienhoefer; Nancy Bowen; Patrick Kelly; Regan Comis; Sabrina Schnur; Shawna Ross; Sheryl Bennett; Stephanie Woodard; Steve Messinger; Tamara Pachak; Tom Clark; Tom McCoy; Tucker Desmond.

2. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Dr. Kristina Kovacs, Chief Clinical Officer for Behavioral Health Solutions, commented on a recent recommendation submitted to the Patient Protection Commission (PPC) regarding the Behavioral Complex Care Program (BCCP), a state program that provides additional reimbursements for complex behavioral patients in nursing homes. Dr. Kovacs noted that the recommendation had inaccurate data. While the recommendation claimed that BCCP did not provide adequate services, Dr. Kovacs argued that the program offers extensive services, including psychiatric medication management, one-on-one patient interactions, care planning with caregivers, and person-centered interventions. Stating that these services have enabled the successful transition of previously difficult patients out of hospitals and into low-cost transition settings. Dr. Kovacs highlighted that data shows patients enrolled in BCCP are hospitalized 72% less frequently than those with similar psychiatric diagnoses not enrolled in the program, demonstrating the program's effectiveness in improving patient quality of life.

Dr. Lisa Marie Pacheco, a member of the Executive Board of the Nevada Action Coalition for the Future of Nursing, commented on the national nursing crisis, highlighting that the shortage of bedside nurses leads to patient safety concerns and needs to be addressed. She noted that one of the most effective practices in improving nursing conditions has been the establishment of State Nurse Workforce Centers. These centers have, for over a decade, worked on professional education, coaching, and retention through resilience and recovery efforts. In 2023, the Nevada nursing workforce center joined 40 other states in developing a state nurse workforce initiative. In 2022, Dr. John Packham and his team released a report titled "Addressing Nevada's Nursing Workforce Shortage: A Call to Action," which recommends funding and supporting a statewide Nevada Nurse Workforce Center. Dr. Pacheco emphasized that now is the time to invest in nursing and establish a sustainable nurse workforce center for Nevada.

Kim McFarland, a Physician Assistant licensed in Utah and Idaho and working for the virtual practice ConnectCare, noted that he was able to practice virtually in Nevada during the COVID-19 pandemic. However, this option was eliminated when the emergency proclamation ended. While Nurse Practitioners can provide care in Nevada, Physician Assistants cannot, due to restrictive regulations that do not align with those in neighboring states. States like Utah, Idaho, Arizona, Wyoming, Oregon, and Montana all have less restrictive practice environments for PA's compared to Nevada. Mr. McFarland suggested that Nevada consider similar legislation to expand PA practice, which could enhance patient care and address the national healthcare shortage.

Steve Messinger, Policy Director for the Nevada Primary Care Association (NVPCA), represents the State Federally Qualified Health Centers (FQHCs) that provide high-quality primary care integrated with behavioral and dental services in medically underserved areas and populations. Mr. Messinger provided several policy recommendations to the commission, stating that investments should prioritize the production of primary care providers, as Nevada is ranked at the bottom for population-to-provider ratios. He argued that poor access to chronic disease management, cancer screening, and vaccination rates are direct causes of this issue. Primary care providers need support to alleviate the compounding burden of working in such a profound shortage. Mr. Messinger recommended an investment in health workforce training needs to be directed to facilities that serve Nevadans with existing barriers to access, such as insurance type, income, language, or geography, including FQHCs. Mr. Messinger argued that FQHCs are mission-driven and focused on integrated primary care, making them ideal candidates for this investment. He also mentioned that training programs should be established in primary care practices in Nevada and that investments should extend beyond the production of physicians to include other primary care providers, such as advanced practice nurses and physician assistants, who are crucial to Nevada's primary care workforce. Mr. Messinger's final recommendation is to propose a program developed by existing stakeholders, including schools of medicine and public health, nursing programs, education centers, and facility representatives such as NVPCA, Nevada rural hospital partners, and Nevada Medicaid. He suggested that stakeholders and the Commission work together to maximize funding opportunities, including federal matching funds, and propose an investment package for the 2027 legislature.

3. **For Possible Action: Review and Approve Meeting Minutes from July 19, 2024**
   By: Dr. Ikram Khan, Chairman

Chairman Khan motioned for the approval of the July 19, 2024, meeting minutes. Commissioner Wendy Simons motioned to approve the minutes as presented, and Commissioner Andria Peterson seconded the motion. The motion carried, and the July 19, 2024, meeting minutes were approved unanimously.

4. **For Possible Action: Review, Discuss and Approve BDR Topics for Submission to Nevada Legislature**
   The Executive Director will provide and update on the Commission's currently selected bill draft requests (BDR) topics. The Commission will have the opportunity to review drafted language and vote to approve, modify or pursue a different topic in preparation for submitting its BDRs, due to the Nevada Legislative Counsel Bureau by September 1, 2024.
   By: Dr. Ikram Khan, Chairman

Mr. Filippi provided a presentation that is available on the PPC website or by clicking here. He gave the commission the opportunity to review, discuss, and approve three Bill Draft Request (BDRs) topics to submit to the 2025 legislative session. The first BDR topic was discussed and approved during the previous PPC meeting and would establish a Medicaid Health Care Workforce Development Fund with an intent to establish funding for Graduate Medical Education (GME) programs that could leverage Medicaid federal funds to support the expansion of these programs in support of access to care for Medicaid recipients. Mr. Filippi notedthe draft language was developed in coordination with the Division of Health Care Financing and Policy (DHCFP).

Commissioner Andria Peterson commented on the draft language, suggesting that verbiage to ensure adequate staffing within Medicaid be added and inquiring if this had been previously discussed. Mr. Filippi mentioned that the collaboration with DHCFP had not included this but noted that it could be added by DHCFP to the fiscal note during the 2025 legislative session to highlight the need for additional staffing funding.

Commissioner Simons expressed support for the proposed recommendation but suggested that adding fiscal notes to a bill might lead to a veto. She recommended incorporating the need for additional staffing funding directly into the language to show the Commission's serious consideration of the issue. Mr. Filippi thanked Commissioner Simons for her input and noted that perhaps an additional sentence or verbiage could be

included to highlight this concern. Attorney General Gabriel Lither clarified that once a motion is presented for the added language, it could be included even if it doesn't have the exact verbiage. He also mentioned that, as a representative of Nevada Medicaid, he appreciates this added motion or language, as Medicaid duties have expanded significantly over the years, putting stress on staff.

Commissioner Walter Davis asked for confirmation on whether the topic of eligibility for GME also includes a teaching healthcare center program for additional funding to support the establishment of such programs for healthcare center organizations. Mr. Filippi stated that the intention behind this BDR topic is to keep it broad but mentioned that there could be funding allocated if the programs are accredited teaching healthcare center programs. He reiterated that this BDR is meant to establish funds for the state to invest in various types of GME programs.

Mr. Filippi then made a motion to approve the language as drafted, with the condition that he work with DHCFP to ensure any necessary staffing funding is incorporated into the BDR before its submission to the legislature on September 1st. Commissioner Simons moved to approve the motion. Commissioner Davis seconded the motion, and the motion was approved unanimously.

Mr. Filippi then discussed the second BDR topic, which is to increase Medicaid reimbursement rates with a targeted approach. There are several intents within this BDR topic. First, to increase Medicaid reimbursement rates for physicians and Advanced Practice Registered Nurses (APRN) by 5%, including an additional 3% increase for rural services and an added 3% for physicians and APRNs who participate in value-based payment models. The BDR also requires DHCFP to seek federal authority to establish accountable care payment models that promote high-quality and coordinated primary care. Lastly, this BDR mandates that DHCFP issue a survey every biennium to all providers of health care, requesting recommendations on how to improve the provider billing experience and increase provider utilization with Nevada Medicaid.

Commissioner Peterson pointed out that one significant aspect not being addressed is the impact on managed care. Mr. Filippi noted that, to his understanding, managed care organizations could be included in the value-based payment models as long as they enroll to receive these benefits. Commissioner Peterson emphasized the need for further clarification in the draft language regarding this impact and followed up with additional questions. She pointed out that the BDR draft language is focused on physicians and APRNs and inquired whether other provider types are being considered. She also asked if there has been any discussion on the potential impact on the budget. Mr. Filippi responded that this BDR would involve a substantial investment from the state, up to $100 million, as a similar increase for physicians of around 5% was implemented in the previous session. He noted that while several provider types would benefit from increased reimbursement rates, physicians and APRNs are currently the most in need.

Chairman Khan noted that Medicaid has outsourced a significant portion of its services to managed care organizations (MCOs). He emphasized that this BDR should support MCOs, as the majority of the Medicaid population is insured through these organizations. He highlighted that the intent of this BDR seems to lean more towards MCOs, while the Medicaid fee-for-service (FFS) population is comparatively smaller. Commissioner Bethany Sexton added that incorporating MCO providers could be challenging. She explained that the funds allocated to MCOs are capitated actuarial amounts on a per member per month (PMPM) basis, which means MCO providers must negotiate rates with individual providers.

Stacie Weeks, Administrator for DHCFP, clarified that the majority of the funds will be directed towards the provider fee schedule, requiring Medicaid MCOs to pay the negotiated fees outlined in that schedule. Commissioner Peterson inquired whether the intent to impact MCOs is covered by the current language or if additional verbiage is needed. Administrator Weeks indicated that additional verbiage will be added for clarity

and to address future needs. Commissioner Sexton then asked if the fee schedule rates would be adjusted actuarially to ensure that the funds are also appropriately allocated to the MCOs and that providers are not reluctant to accept the minimum payments. Administrator Weeks confirmed that implementing a fee schedule would affect the cap rate and reiterated that this would need to be addressed in the budget bill.

Chairman Khan agreed that additional verbiage should be included but emphasized the importance of ensuring the BDR covers all types of physician providers in Nevada. Mr. Filippi responded that there is a detailed list of all physician and APRN providers covered by this BDR, and he will share this document with the Commission. Administrator Weeks noted that during the last legislative session, a 5% increase in physician reimbursement rates was implemented, which amounted to $37 million in state general funds. She emphasized that while 5% might seem low, it represents a significant investment. Chairman Khan agreed, stating that healthcare should be a state priority, especially in underserved areas where providers are reluctant to accept Medicaid patients due to low reimbursement rates.

Commissioner Bayo Curry-Winchell referenced the rural community highlighted in the BDR draft language and suggested that the commission should take a more historical view of the offerings for APRNs and other clinicians when considering improvements or increased access. Commissioner Curry-Winchell pointed out that past increases in access did not focus on primary care or the Medicaid population. She emphasized that the increased reimbursement rates should target providers and APRNs who are in primary care and serve the Medicaid population. She noted that historically, improvements in access have been directed towards different provider specialties, rather than focusing on the provider population that needs it the most.

Administrator Weeks stated that Medicaid is seeing significant increases in the utilization of services from physicians, dentists, and APRNs. She noted that the previous 5% increase implemented by the Governor's budget is showing positive results and expressed enthusiasm about seeing the impact of these past efforts.

Chairman Khan thanked and recognized Administrator Weeks, stating that, as someone who has been working with the state legislature for over 40 years, Administrator Weeks is one of the most knowledgeable state representatives.

Chairman Khan entertained a motion to approve the BDR topic proposal, with the draft language to be modified to include the impact on Managed Care Organizations. Commissioner Sexton moved to approve the motion, and Commissioner Davis seconded. The motion carried and was approved unanimously.

Mr. Filippi then addressed the final BDR topic which relates to health care occupational licensure. The intent of this BDR is to reduce barriers for licensed providers to practice in Nevada by authorizing the state to enter into multiple licensure compacts with other states. The goal is to remove unnecessary obstacles to recruiting and retaining health care providers, support relocating military members and their families, improve licensure portability, streamline the onboarding process for essential health providers, enhance access to care, and address health care workforce challenges. Mr. Filippi stated there are several interstate licensure compacts that the Commission could consider including in this BDR, which are the Audiology and Speech-Language Pathology Interstate Compact, Nurse Licensure Compact, Occupational Therapy Licensure Compact, Physical Therapy Licensure Compact, and Physician Assistant Licensure Compact. Mr. Filippi noted that it might be possible to combine multiple state licensure compacts into a single BDR, as they all relate to a common topic.

Chairman Khan noted that to be part of the Interstate Medical Licensure Compact (IMLC), physicians must pay a $700 fee to join the compact, in addition to the state fees required for a Nevada license. He questioned the additional costs, asking why providers have to pay extra if they are already contributing to the compact. He also inquired about the timeframe for providers to receive their license through the compact, noting that it typically takes an average of three to six months to obtain a license for physicians in the state. Mr. Filippi clarified that

the IMLC allows physicians to be issued a Nevada license within one to three business days. He explained that physician compacts operate differently, as physicians must enroll in the compact and select the states in which they wish to practice. While there is a $700 joining fee and a separate fee for each state they wish to practice in, these fees might be reduced when applying through the compact. Mr. Filippi added that the Nurse Licensure Compact operates differently. Once a nurse obtains a compact license, they can practice in any compact state without needing to contact the licensing board in each state.

Commissioner Walter Davis emphasized the importance of the credentialing process, noting that while he supports focusing the BDR topic on licensure compacts, the credentialing process remains a significant challenge that should be addressed. Chairman Khan stated that the challenge with direct applicants is that the medical board requires them to ensure all required information is submitted before applying, which often delays the process. Commissioner Davis acknowledged Chairman Khan's response and noted that a common scenario he encounters daily is that once a provider obtains their licensure, they must then wait for their credentials to be approved before they can see patients with different payor sources. He argued that with the current provider shortage, health centers like Federally Qualified Health Centers (FQHCs) cannot afford to lose providers and that there is no time to wait for credentials. This situation leads to providers being able to see only a small number of uninsured patients while still needing to be paid their respective salaries. Commissioner Davis argued that the credentialing process needs to be reworked, as it is very slow and places a significant burden on health care centers. Commissioner Curry-Winchell agreed with Commissioner Davis, adding that once a provider is licensed, it takes 90 to 120 days, and sometimes up to six months, for them to start seeing a variety of insured patients. Commissioner Sexton provided additional clarification from the payor perspective, stating that there are certain requirements providers must meet before being credentialed, which often delays the process.

Chairman Khan added that if the state licensing boards and credentialing payors could reduce the time it takes to receive a license and be credentialed, the process could be expedited. However, he noted that this could only be achieved if reciprocity is allowed. Chairman Khan then asked the Commission for their thoughts on allowing reciprocity. Mr. Filippi suggested that if licensure reciprocity is discussed more and favored over the licensure compact, a motion to focus on reciprocity might be necessary. Commissioner Simons expressed her support for pursuing the licensure compacts as the third and final BDR topic, emphasizing that approximately 40 states have adopted these licensure compacts and urging the Commission to proceed with this topic as presented. Commissioner Sexton agreed with Commissioner Simons, noting that significant thought and effort have already gone into the licensure compact BDR and suggesting that licensure reciprocity could be considered in future discussions. Commissioner Davis agreed, stating that Nevada is currently facing a critical provider shortage and that the Commission must do everything possible to ensure appropriate patient access to care. Commissioner Curry-Winchell supported approving the final BDR topic while also voicing support for licensure reciprocity, suggesting it could help Nevada move forward. Commissioner Peterson expressed hesitation about pursuing this BDR as presented, mentioning the possibility that the BDR might not pass due to previous barriers and noting her concern about the potential for another unsuccessful BDR passing.

Chairman Khan acknowledged that the majority is in favor of pursuing the licensure compact as the final BDR topic. He emphasized that licensure compacts and licensure reciprocity cannot be included in the same BDR, as it would make the proposal redundant. He recognized the concerns some Commissioners might have regarding the licensure compact, given its previous lack of success, and suggested that the Commission should narrow the BDR topic to focus only on the most impactful licensing compacts. He noted that including multiple types of licensing compacts in one BDR might lead to multiple opinions among stakeholders and could jeopardize the BDR's chances of passing. Mr. Filippi mentioned that the five different types of licensure compacts included in the BDR are included to address several provider shortages currently faced in Nevada. He then asked the Commission whether they support moving forward with five compacts earlier presented. Commissioner Simons

expressed support for this BDR as presented, noting that these compacts have more state participation compared to others. Commissioner Sexton inquired whether the BDR will be modified if it goes to the legislature, suggesting that the BDR should garner support to avoid modifications once it reaches legislation. Chairman Khan acknowledged that this is a possibility and a challenge the Commission might face. He stated that while the proposed BDR may be tweaked, modified, or adjusted during the legislative process, the Commission must start somewhere.

Chairman Khan then asked Mr. Filippi for more information regarding the opposition to the nurse licensure compact. Mr. Filippi explained that the nurse licensure compact has previously failed to pass in prior legislative sessions. Ms. Cathy Dinauer, Executive Director of the State Board of Nursing, mentioned that they have tried for over 10 years to get the nurse licensure compact passed, noting that most of the opposition comes from nursing unions. Ms. Dinauer also shared that a 2022 survey of nurses in the state revealed that approximately 92% of state nurses support the nurse licensure compact.

Chairman Khan entertained a motion to approve the final BDR topic regarding health care occupational licensure as presented. Mr. Filippi reiterated that the five compacts included in the BDR are the Audiology and Speech-Language Pathology Interstate Compact, Nurse Licensure Compact, Occupational Therapy Licensure Compact, Physical Therapy Licensure Compact, and Physician Assistant Licensure Compact. He then opened the floor for a motion to approve, modify, or reject the drafted language as presented. Commissioner Simons motioned to approve the BDR topic and draft language as presented. Commissioner Sexton seconded the motion. The motion carried and was approved unanimously.

5. For Possible Action: Discuss the Governor's Executive Order 2024-002 and Proposed Next Steps
By: Joseph Filippi, Executive Director, Patient Protection Commission

Mr. Filippi provided a presentation to discuss the Governor's Executive Order 2024-002 and proposed next steps. The presentation is available on the PPC webpage or by clicking here. Mr. Filippi reiterated his intention to continue pursuing monthly PPC meetings after the three approved BDRs are submitted by September 1st for the 2025 legislative session. He proposed holding meetings monthly until November or December to review different recommendations to address the state's workforce challenges. Mr. Filippi explained his plan for the Commission to conduct a work session in October to review and approve a final list of workforce recommendations to include in their semi-annual final report, for submission on January 1st, 2025. He then noted that the legislative sessions would begin on February 1st, 2025, and asked the Commission if they would prefer to reduce the number of meetings to every other month or hold quarterly meetings. Additionally, Mr. Filippi proposed the idea of developing a sub-committee to focus specifically on workforce issues, while the full Commission could address other areas related to health care, access, quality, and affordability.

Chairman Khan asked Mr. Filippi to reiterate the deadline for the submission of the three BDRs. Mr. Filippi stated that the final draft language and BDR topics are due by September 1st. The Legislative Council Bureau (LCB) will then take about a month to review and return the official draft language. He informed the Commission that November 20th, 2024, is another critical deadline for any bill that needs to be prefiled, which involves confirming with the LCB that the Commission wishes to proceed with the official draft language for the 2025 legislative session.

6. Public Comment *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made. Mr. Filippi thanked and acknowledged the Commission for their outstanding work in finalizing the three BDRs prior to the submission deadline.

7. Adjournment
By: Dr. Ikram Khan, Chairman

Chairman Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 10:29AM.

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
September 20, 2024

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, September 20, 2024, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2024/PPC2024/.

1. Call to order: Roll call
By: Dr. Ikram Khan, Chairman

The meeting was called to order at 9:00 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

Commission Members Present
Dr. Ikram Khan, Chair
Marilyn Kirkpatrick, Vice Chair
Bethany Sexton
Flo Kahn
Jalyn Behunin
Walter Davis
Wendy Simons

Commission Members Absent
Dr. Andria Peterson – Excused
Dr. Bayo Curry-Winchell – Excused

Advisory Commission Members Present
Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP)

Advisory Commission Members Absent Excused
Scott Kipper, Insurance Commissioner, Division of Insurance (DOI)
Russell Cook, Executive Director, Silver State Health Insurance Exchange

Staff Present
Joseph Filippi, Executive Director, PPC; Madison Lopey, Policy Analyst, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Guests Present

Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Lindsey Miller, Constituent Services, Governor's Office; Ann Jensen, Agency Manager, DHCFP; Maria Tello Magana, Executive Assistant, DHHS; Kayla Hammond, Family Services Specialist 1; DHHS; Danacamile Roscom, Health Program Manager, DPBH; Todd Rich, Deputy Commissioner; DOI; Thomas Sargent; Insurance Actuarial Analyst II, DOI; Jack Childress, Insurance Actuarial Analyst, DOI; Kareen Filippi, Management Analyst III, WIC; Vance Farrow, Health Industry Specialist, GOED; Bobbie Sullivan, Emergency Medical Services Rep III; Mitch DeValliere, Agency Manager; Andrea Gregg, CEO, High Sierra Area Health Education Center (AHEC); Areli Alarcon; Belz & Case Government Affairs; Dan Musgrove; Elissa Secrist; Gerald Ackerman; Lea Case; Lisa Tripp; Michael Willden; Nadine Kienhoefer; Natalie Gillis; Reagan Hart; Ronald Hall; Stacie Sasso; Sabrina Schnur; Shannon Miller; Shira Hollander; Steve Messinger; Tray Abney.

2. Public Comment *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made.

3. For Possible Action: Review and Approve Meeting Minutes from August 16, 2024
By: Dr. Ikram Khan, Chairman

Chairman Khan motioned for the approval of the August 16, 2024, meeting minutes. Commissioner Wendy Simons motioned to approve the minutes as presented, and Commissioner Walter Davis seconded the motion. The motion carried, and the August 16, 2024, meeting minutes were approved unanimously.

4. Overview of Nevada Area Health Education Centers (AHEC) and Related Policy Considerations
By: Andrea Gregg, Chief Executive Officer, High Sierra AHEC and Gerald Ackerman, Director, Nevada AHEC Program, School of Medicine, University of Nevada Reno (UNR)

Andrea Greg, Chief Executive Officer, High Sierra AHEC and Gerald Ackerman, Director of Nevada AHEC Program, provided a presentation related to Nevada Area Health Education Centers (AHEC) and related policy considerations. The presentation is available on the PPC webpage or by clicking here. The national AHEC organization represents more than 300 AHEC program offices and centers that serve over 85% of United States counties and is funded through the federal Health Resources and Services Administration (HRSA). The AHEC program was established by Congress in 1971 to recruit, train, and retain a health professions workforce dedicated to serving underserved populations. Since then, it has advanced its mission through three designated centers in Nevada, providing services statewide. Mr. Ackerman explained that the FY23-24 state funds allocated were evenly distributed, with $17,000 for each of the three AHEC centers. He noted the importance of equal shares to support healthcare, workforce development, and community health initiatives. Ms. Gregg then provided a more in-depth overview of the current projects of AHEC by connecting communities, advancing workforce development, cultivating inclusivity, and transforming care. She stated that their vision is to empower the next generation of Nevada healthcare leaders, starting as early as 5th grade. AHEC is dedicated to growing future leaders, emphasizing mentorship and skill development, promoting health equity, and forging strong statewide partnerships. Ms. Gregg explained the workforce pipeline, stating that K-12 initiatives offer a variety of hands-on education, virtual reality, and active learning in health and STEM fields, targeting Title I schools and rural communities. At the undergraduate level, they begin to engage community leaders who support the AHEC mission and contribute to healthcare education. Moving along the workforce pipeline to the graduate and doctorate levels, healthcare professionals are equipped with a variety of skills to serve their communities and

improve healthcare access in underserved and rural areas, resulting in 91% of K-12 AHEC participants expressing interest in pursuing higher education after completing the program. Mr. Ackerman then discussed other state initiatives, including those in North Carolina, Virginia, Georgia, and Kentucky. Focusing on Virginia, he stated that they are committed to advancing their healthcare workforce through a broad and integrated approach to establish a statewide infrastructure for assessing and planning workforce needs, engaging health professionals, training programs, and decision-making. Their authority supports policy development, provides evidence-based strategies for workforce development, and addresses healthcare needs in underserved areas. Virginia's Area Health Education Centers aids community recruitment and retention efforts, evaluates graduate medical education programs, and advocates for debt reduction for new professionals. Mr. Ackerman briefly touched on North Carolina, Kentucky, and Georgia's Area Health Education Centers, noting that while each operates differently to establish and meet its workforce needs, all share a common goal of linking academic medical health programs with community partnerships, collaborations, the needs of individual students, and training programs.

Vice Chair Marilyn Kirkpatrick thanked Ms. Gregg and Mr. Ackerman for their presentation. She shared her recent experiences with high school students across the state and noted that they are very interested in a healthcare workforce app. Vice Chair Kirkpatrick expressed her willingness to sponsor this with economic development dollars, emphasizing that the next generation is the future of healthcare leaders, and we must meet them where they are.

Commissioner Flo Kahn inquired about the private funding received in addition to federal and state funding, asking how they engage corporations to provide private grant funding. Ms. Gregg explained that High Sierra AHEC is a 501(c)(3), which requires a focus on long-term sustainability that includes both public and private foundational support.

5. Overview of the Health Care Workforce Website Developed by the Division of Public and Behavioral Health (DPBH)
By: Danacamile Roscom, Health Program Manager II, Public Health Infrastructure and Improvement, DPBH

Danacamile Roscom, Health Program Manager II, shared a presentation regarding an overview of the Health Care Workforce Website developed by the Division of Public and Behavioral Health (DPBH). The presentation is available on the webpage or by clicking here. Ms. Roscom provided an overview of the Public Health Infrastructure & Improvement (PHII) Section and outlined their current priorities, which include workforce development, infrastructure initiatives, quality improvement, and data modernization initiatives. She explained their current projects and programs, include the ARPA Nevada Health Workforce Pipeline Grant, which was disseminated to communities and partners for educational and financial assistance opportunities. She went on to further explain other programs and projects, including the CDC Public Health Infrastructure Grant (PHIG), which focuses on workforce development, foundational capacity, and data modernization; the DPBH Public Service Internship Program, which aims to strengthen partnerships with universities and colleges; the Nursing Apprenticeship Program, currently supporting 220 nurse apprentices statewide; and SB 118, which funds efforts across the state to help address public health priorities. Ms. Roscom then discussed and gave a virtual tour of the NV Health Force website, stating that its purpose is to provide a detailed overview from a workforce development perspective to entice those who are not familiar with healthcare. Upcoming developments include phase two: website reorganization and content expansion, breaking down health into three career categories: public health, behavioral and mental health, and primary care careers; and phase three: user self-assessment. Ms. Roscom stated that the next phase of the website will launch in January 2025 and will include a variety of website exposure, marketing, and collaboration. She concluded the presentation by sharing some final thoughts for the commission to consider regarding the sustainability of workforce development efforts, building a

cohesive and comprehensive pipeline beginning at the early exposure stages, and reconvening the health care workforce development pipeline working groups.

Commissioner Davis thanked Ms. Roscom for her presentation. He inquired about additional information regarding the training for Medical Assistants (MAs), wondering if there are existing dual-track training programs that focus on ancillary services and support teams for individuals interested in the training. Ms. Roscom stated that the MA training program takes place within Federally Qualified Health Centers (FQHCs) to best prepare individuals for working in an FQHC setting.

Commissioner Flo Kahn commented on the NV Health Force website, stating how impressed she is and looks forward to the continued development of the website.

Mr. Filippi thanked Ms. Roscom for her presentation and commented that he wanted to highlight the last two presentations for the Commission to emphasize the various healthcare workforce initiatives ongoing from different stakeholders throughout the state. He suggested that the Commission continue to investigate these different types of initiatives to finalize their formal recommendations on how to best address the shortage of the healthcare workforce in Nevada.

6. Overview of the Emergency Department in Home (EDiH) and Hospital at Home (HaH) Care Delivery Models and Opportunities to Increase Access to Care in Nevada
By: Lisa Tripp, Partner and Shira Hollander, Partner of Tripp Hollander Advisors

Lisa Tripp and Shira Hollander, partners at Tripp Hollander Advisors, presented on the Emergency Department in Home (EDiH) and Hospital at Home (HaH) care delivery models and opportunities to increase access to care in Nevada. The presentation is available on the PPC webpage or by clicking here. Ms. Tripp explained that their ultimate goal is to provide care at home that is typically delivered in a hospital setting. Viewing it from a paradigmatic perspective, she noted that the nation has built many brick and mortar hospital facilities over the past hundred years; however, now in 2024, this facility-building paradigm is failing to deliver the access and quality needed, resulting in workforce burnout. Ms. Tripp presented their proposal to combine in-person clinicians (paramedics) with remote physicians and nurses to provide care from emergency levels to inpatient and primary care for patients who can safely be treated at home. She pointed out that Nevada is at risk of rural hospital closures, which leads to overcrowding in urban and suburban hospitals, causing some to operate at more than 110% capacity and resulting in care being provided in hallways. She explained that while Nevada has shown forward thinking in innovating and using resources differently, we still face hospital closures, such as the Carson Tahoe Continuing Care Hospital closure in July 2023, due to the changing landscape of healthcare. This creates a lack of access to hospital care in Nevada. Ms. Tripp argued that when focusing on rural areas in Nevada, the economy does not support the creation of new hospital buildings, proposing a shift in the paradigm to bring care to rural communities. This approach will benefit patients and the state's EMS system by sharing key insights about safety, quality, and cost to inform regulatory and payment policy. Ms. Tripp stated that the process would begin with a call to 911. Cases deemed non-life-threatening will result in the simultaneous dispatch of a 911 ambulance and the pilot team's community paramedics to the caller's home. When both arrive, they will assess the situation based on pre-established protocols (e.g., obvious emergencies, chest pain, abdominal pain, stroke symptoms, etc.) to determine whether the patient needs to be transported to a hospital or can be treated at home. If a patient is eligible for home treatment, they will receive inpatient-level care at home, placed on the equivalent of observation status or treated and released. Ms. Tripp stated that by taking these ideas and integrating into the healthcare system, it could strengthen the communities for different healthcare providers to work together.

Vice Chair Kirkpatrick inquired about a more detailed process, noting that there are franchise agreements in place and expressed concern about this care model potentially not reaching underserved communities. She also asked if any states are currently utilizing this model. Ms. Tripp acknowledged that she initially felt nervous about implementing this model. However, after learning about the long history of hospital care at home in countries like Australia, the United Kingdom, France, Israel, Spain, and others, she became more confident. Ms. Tripp explained that they conducted a bibliography of approximately 350 studies showing substantial benefits of hospital-at-home care, including lower readmission rates, decreased mortality, and reduced infection rates. Vice Chair Kirkpatrick stated that she would reach out offline for more information.

Commissioner Davis inquired about the payment system and reimbursements, stating that this model could potentially help reduce hospitalization costs and issues with insurance companies. He asked if there is any information regarding the billing process. Ms. Tripp explained that currently, most hospitals bill for hospital-at-home care in the same way they bill for traditional brick-and-mortar hospitalizations. She reiterated that piloting this model is critical, as it will help clarify the actual costs of providing this care. Commissioner Davis thanked Ms. Tripp and expressed his interest in learning more from a Federally Qualified Health Center (FQHC) standpoint, as the presentation mentioned that this model could result in patients being transported to FQHCs. He would like to discuss this further offline.

Commissioner Sexton inquired whether this model includes collaboration with nearby hospitals in rural areas or with hospitals in metropolitan areas. Ms. Tripp stated that this collaboration depends on who is interested and willing to participate.

Commissioner Flo Kahn stated that she is intrigued by the hospital-at-home care model but shares the same concerns expressed by previous commissioners regarding potential trade-offs. She asked how this model measures quality of care and patient outcomes, noting that in a hospital setting, there are specific requirements that need to be reported to ensure quality. She also questioned what will be covered by insurance, the out-of-pocket costs for patients, and what changes in law are necessary to facilitate this model. Ms. Tripp explained that this will be part of the CMS hospital-to-home program, and the requirements will remain the same. She also shared that a 2023 CMS study concluded that unanticipated mortality rates in hospital-at-home settings were lower than those in traditional hospitals. Ms. Tripp then reiterated that when it comes to insurance billing and out-of-pocket costs, there is no difference in billing; it will be billed in the same way as hospital care.

Commissioner Behunin thanked Ms. Tripp for the presentation. She expressed concerns regarding the healthcare workforce and its current shortage, inquiring about the plan to backfill all necessary positions, as the workforce pipeline is not yet strong enough. Ms. Tripp argued that this model aids in workforce retention, noting that they have seen nurses who were considering leaving the profession or who are nearing retirement transition to the hospital-at-home model. Ms. Tripp then outlined the plan to have nursing, physician, and paramedic schools incorporate this model into their curriculum, ultimately improving the healthcare workforce.

Commissioner Simons thanked Ms. Tripp for the presentation. She shared that she has personally experienced the benefits of a house call model from Geriatric Specialty Groups. She inquired about regulatory oversight, noting that hospitals are heavily regulated and monitored. Additionally, she asked about the plan if something goes wrong within the first 12 hours after home discharge. Ms. Tripp explained that the plan has been carefully developed by clinicians over the years. She added that there have been no complaints regarding hospital-at-home programs from either agencies or patients. She reiterated that piloting this program is critical and that establishing new and appropriate regulations will contribute to positive workforce outcomes.

Chair Khan thanked Ms. Tripp for the presentation and the diverse perspectives she shared. He expressed several concerns regarding this care model. First, he raised issues related to liability, noting that in some cases

the nearest hospital may be out of state, which could complicate licensing, as Nevada regulations state that practitioners must be licensed within the state. Second, he pointed out the CMS observation guidelines, explaining that CMS allows for one day or less than two days in a hospital setting. If patients are cleared and discharged but later require hospitalization due to test results, the inpatient system would then need to transition to a DRG payment system, which could create complications if this occurs at home. Chair Khan acknowledged that while these services may be offered in rural areas, he is concerned about the effectiveness of this care, suggesting that some patients might receive second-class treatment compared to what is provided in traditional hospitals. He noted that although other countries may already be implementing hospital-at-home care, many of their hospitals have a history of not delivering the appropriate care needed. Ms. Tripp responded that the characterization of second-class care would be contested by many physicians, nurses, and paramedics currently practicing this model at institutions such as Mount Sinai, Vanderbilt, the University of Chicago, the Mayo Clinic, Cleveland Clinic, and community systems throughout the nation.

Ms. Tripp stated that CMS will be submitting an exhaustive report to Congress at the end of this month and invited any interested members of the Commission to review it. She also expressed her willingness to share the bibliography that includes recent studies conducted across different geographic areas in the nation. Mr. Filippi agreed, noting that this report would be very helpful for the Commission and asked Ms. Tripp for the reports when available.

Commissioner Sexton suggested that while there are many questions and concerns, it would still be beneficial for the Commission to continue reviewing and evaluating the data, as technology has drastically improved and can now support many services being provided remotely, virtually, and digitally. She thanked Ms. Tripp for the presentation and for bringing this important topic forward, and she expressed her eagerness to review the CMS report.

7. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made. Mr. Filippi announced that the PPC Policy Analyst, Madison Lopey, was recently offered a promotional opportunity within the department and acknowledged all her hard work over the last few months.

8. **Adjournment**
By: Dr. Ikram Khan, Chairman

Chairman Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 11:15 AM.

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
October 18, 2024

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, October 18, 2024, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2024/PPC2024/.

1. Call to order: Roll call
By: Dr. Ikram Khan, Chairman

The meeting was called to order at 9:08 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

Commission Members Present
Dr. Ikram Khan, Chair
Marilyn Kirkpatrick, Vice Chair
Dr. Andria Peterson
Dr. Bayo Curry-Winchell
Flo Kahn
Jalyn Behunin
Walter Davis
Wendy Simons

Commission Members Absent
Bethany Sexton – Excused

Advisory Commission Members Present
Scott Kipper, Insurance Commissioner, Division of Insurance (DOI); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP); Shannon Litz, Deputy Director on behalf of Richard Whitley, Director, Department of Health and Human Services; Janel Davis, Operations Manager on behalf of Russell Cook, Executive Director, Silver State Health Insurance Exchange

Staff Present
Joseph Filippi, Executive Director, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Guests Present
Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Lindsey Miller, Constituent Services,

Governor's Office; Stacie Weeks, Administrator, DHCFP; Sandie Ruybalid, Deputy Administrator, DHCFP; Ann Jensen, Agency Manager, DHCFP; Dylan Malmlov, Intern Contractor, DHCFP; Kayla Hammond, Family Services Specialist 1; DHHS; Adam Plain, Insurance Regulation Liaison, DOI; Erik Jimenez, Senior Deputy, Office of the State Treasurer; Ahmad Brooks, Office of the State Treasurer; J; Meagan Ranson, Silver Sage Health Insurance Exchange; Kareen Filippi, Management Analyst III, WIC; Vance Farrow, Health Industry Specialist, GOED; Cathy Dinauer, NSBN; Andrea Gregg, CEO, High Sierra Area Health Education Center (AHEC); Alberto Quintero; Alexandria Cannito; Areli Alarcon; Barry Cole; Belz & Case Government Affairs; Brian Evans; Cherylyn Rahr-Wood; Courtney Canova; Dan Musgrove; Davis Florence; Dave Wuest; Debra Collins; Eileen Colen; Elissa Secrist; Elyse Monroy-Marsala; Fred Olmstead; Jackie Lheureux; Jacob Keeperman, Jacqueline Nguyen; Jay Cafferata; Jerry Reeves; Jimmy Lau; Kamyar Farzad; Kenneth Kunke; Lea Case; Lisa Marie Pacheco; Lisa Tripp; Mari Nakashima Nielsen; Maya Holmes; Nancy Kuhles; Natalie Emerson; Natalie Powell; Nicholas Chiang; Nilesh Gokal; Reagan Hart; Ricardo Rubalcaba Paredes; Sabrina Schnur; Sabrina Elvrum; Sam Anastassatos; Sarah Daniel; Spencer Gabe; Tave Kuckhoff; Tori Supple; Tray Abney; Valerie Cauhape.

2. Public Comment *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Valerie Cauhape, a rural regional Behavioral Health Coordinator, wanted to point out that whenever funding or resources are allocated toward Nevada AHECs, it has been extremely successful in rural Nevada. Ms. Cauhape also stated that Assembly Bill 37, which was passed during the last legislative session, created the Behavioral Health Education, Retention, and Expansion Network of Nevada (BeHERE). She noted that this success was achieved by utilizing existing resources provided by Nevada AHEC. The work of AHECs is heavily influenced by many other items listed in the PPC Recommendations Work Session Document, and she emphasized that any opportunity to advocate for funds and resources is very beneficial to rural Nevada.

Natalie Powell, the Director of the Nevada Certification Board (NCB), established in 2016, provides peer prevention certifications through International Certification (IC) and Reciprocity Consortium (RC). She made a public comment stating that since 2020, NCB has collaborated with High Sierra AHEC to offer Nevada Cultural Competency Training for all of their certifications, as well as other AHEC educational opportunities that aim to address and reduce health disparities in Nevada. Ms. Powell noted that NCB is also working to address the underrepresentation in the healthcare workforce at every level, given Nevada's healthcare shortages. She mentioned that hundreds of students have gone through the program created with High Sierra AHEC and emphasized that it would be a shame to lose that opportunity. Ms. Powell also credited Nevada AHEC for proactively seeking improvements in their curriculum and programming.

3. For Possible Action: Review and Approve Meeting Minutes from September 20, 2024
By: Dr. Ikram Khan, Chairman

Chairman Khan motioned for the approval of the September 20, 2024, meeting minutes. Commissioner Wendy Simons motioned to approve the minutes as presented, and Vice Chair Marilyn Kirkpatrick seconded the motion. The motion carried, and the September 20, 2024, meeting minutes were approved unanimously.

4. Update on the Establishment of the Student Loan Repayment for Providers of Health Care in Underserved Communities Program created by Assembly Bill 45 (2023) and codified in NRS 226.458
By: Erik Jimenez, Chief Policy Deputy, Nevada State Treasurer's Office

Erick Jimenez, Chief Policy Deputy Director at the Nevada State Treasurer's Office presented on the Student Loan Repayment Program for Providers of Health Care in Underserved Communities' Program. The presentation is available on the PPC webpage or by clicking here. He explained that this program was made possible through the passage of Assembly Bill 45 (2023) receiving $2.5 million each fiscal year as an automatic statutory trigger

from the Abandoned Property Trust Account. Eligible providers such as physicians, physician assistants, licensed nurses, optometrists, psychologists, and social workers, etc., who are successfully approved for this program can receive up to $120,000 in exchange for practicing in an underserved community in Nevada. To be considered, eligible providers must be current Nevada residents, actively licensed in good standing, committed to practicing in an underserved community, and must commit to clinical practice for a period of five years. The goal of this program is to attract new providers to work in underserved areas and to retain those currently practicing there. Providers are eligible to change their residence or location of practice and may work at multiple locations. Mr. Jimenez then explained what constitutes underserved communities, including low-income census tracts, those scoring higher on the CDC Social Vulnerability Index, communities with over 20% of households that are non-English proficient, tribal communities, rural counties with fewer than 100,000 residents, and areas subjected to redlining, segregation, and other discriminatory practices. This program is expected to launch in January 2025 and a request for applications will be open for 30 days. 30 days prior to the program launch, the State Treasurer's Office will release a copy of the application and scoring rubric. Mr. Jimenez stated that they are prioritizing two specific types of providers: those offering primary care for sexual and reproductive health services and behavioral health care providers, though other provider types are still encouraged to apply. Once a provider submits their application, they will receive an automated letter confirming that their application has been received and is under review. A final determination will be communicated via email notification no later than 30 days after the application window closes.

Commissioner Walter Davis thanked Mr. Jimenez for his presentation and inquired about the risks for a provider who does not complete their five-year commitment, as well as the process if they are later found to be a poor fit for the organization and program. Mr. Jimenez explained that they expect the approved provider to sign a student loan repayment contract, which outlines the corrective actions the state could take for recoupment. He mentioned that the state is actively working on a provision that accounts for unforeseen hardships, which would allow a provider to be exempt from their five-year obligation. Depending on the circumstances, providers may have the option to relocate if the organization is not a good fit, before any grounds for termination are determined. Commissioner Davis followed up with a question regarding whether there are requirements for the employer of the provider to give notice to the organization prior to termination. Mr. Jimenez acknowledged that this is still being developed, but stated that ultimately, it is the recipient who must notify the organization of any changes and added that the employer will need to complete an employment verification form for the provider, outlining relevant factors, which must be submitted annually.

Commissioner Flo Kahn asked if they plan to conduct any systematic measures to identify the retention rate of providers after their 5-year obligation is up. She also inquired about the limitations of funds and whether that will continue to prohibit underserved individuals from being eligible to enter the program, given the restrictions on how much can actually be repaid. Mr. Jimenez reiterated that the program has not yet launched but assured that they do plan to collect data during and after the process, noting that one method will be regular surveys or exit surveys. Mr. Jimenez acknowledged the structural barriers and stated that the state has had multiple discussions regarding either a lump sum payment or spreading payments over time, emphasizing their expectation of running out of funds and the need to preserve them. He also mentioned that they have implemented a language proficiency scoring system, where providers practicing in a certain demographic area who also speak that language will receive a higher score. He noted that while there is still much work to be done, they will use the first year as a metric to adjust plans as needed.

Chairman Khan commented on the historical challenge of retaining physicians after they complete their residency and inquired about the incentives this program can provide to ensure that providers do not leave after their 5-year obligation. Mr. Jimenez acknowledged these concerns and stated that the state has limited tools in place to ensure retention. However, he noted that adding special clauses to the regulations could help retain

providers. While he acknowledged that there may not be a definitive right or wrong answer at this moment, he expressed hope that they will learn more as they progress through the first cohort.

5. Possible Action: Work Session – Discussion and Possible Action on Recommendations to Address the Health Care Workforce Shortage in the State of Nevada
By: Joseph Filippi, Executive Director, PPC

Mr. Filippi prepared and presented a work session document to assist the Commission in determining recommendations to include in the next statutorily required report, whether by accepting, rejecting, modifying, or taking no action on the recommendations. The presentation is available on the PPC webpage or by clicking here. He noted that any potential recommendations with fiscal impacts have not been determined at this time. This work session document included 23 recommendations and five letters of support for the Commission to consider, which will be presented in the following slides. Mr. Filippi then proceeded to read each recommendation, depicting the member survey results that ranged from support to indifferent, opposed, or unsure/additional information needed.

In no particular order, recommendation one seeks to identify ways to recruit and retain a more diverse health care workforce. This recommendation focuses on how the lack of diversity may deter prospective medical graduates from completing GME in Nevada. Results from a recent JAMA study suggest that additional efforts are needed to increase the representation of Black, Hispanic, and Native American people in the health care professions; measuring and reporting on representation of these groups in the health care workforce and educational pipeline may encourage these efforts. This recommendation received unanimous support, and no discussion occurred.

Commissioner Flo Kahn questioned all 23 recommendations and asked whether they are part of the Bill Draft Requests (BDRs) that were recently approved by the Commission. Mr. Filippi clarified that these are not BDRs and that the Commission has already voted on the three allowed to be submitted to the legislature. If approved, these recommendations would be included in the report due to the Legislature and the Governor in January 2025. He reiterated that the Commission is responsible for providing recommendations every six months to address issues related to healthcare access, quality, and affordability.

Chairman Khan expressed concern about reviewing all 23 recommendations at once and suggested that, in the interest of time, it might be beneficial to compile those that received unanimous support. Deputy Attorney General Gabriel Lither appreciated the idea of compiling these but emphasized the importance of reading each recommendation individually to facilitate discussion among the commissioners. Mr. Lither advised moving through all the recommendations slide by slide, allowing for consensus or discussion, and then opening it up for a final vote at the end.

Recommendation two requests that the state continue to develop workforce incentives aimed at recruiting occupations in undersupply and targeting rural or underserved communities to improve access to care. This would offer financial incentives to providers, such as stipends, loan repayment options, and higher reimbursement rates, which have been proven effective. This recommendation received unanimous support, and no discussion took place.

Recommendation three requests that the state reduce or cap the amount of interest charged by insurers on medical education loans. High costs and interest rates on education loans can be barriers to attracting and retaining providers, especially in rural and underserved areas. The significant debt that medical students face is further compounded during low-paying residency and fellowship training. According to the survey, there were 7 commissioners in support, 1 indifferent, and 1 unsure, with additional information needed. Mr. Lither asked if the commissioner who was unsure had received the necessary information for this recommendation. Vice Chair

Kirkpatrick indicated that she had and now feels comfortable with it. Mr. Filippi assured that he made efforts to ensure that all commissioners who voted as unsure received additional information regarding the respective recommendation.

Recommendation four seeks to establish a Physician Wellness Program in Nevada, allowing physicians and other healthcare providers to access a confidential wellness program. It recommends that DHHS offer grant funding to an eligible 501(c)(3) nonprofit, such as the Nevada Physician Wellness Coalition, to administer the program statewide. The program must support physicians and other healthcare providers through evidence-based wellbeing initiatives and provide a statewide resource line for physicians and their families, as well as online wellness resources and training. The commission showed a majority of support for this recommendation, and no discussion was made.

Recommendation five would recommend aligning licensure and facility training requirements to remove duplication, reduce administrative burdens and expedite onboarding. This recommendation received unanimous support, and no discussion was made.

Recommendation six would request licensure boards, hospitals, health systems and the Nevada Division of Insurance to remove intrusive mental health questions from physician and other health care provider licensure and credentialing applications. This recommendation would support physician well-being and in turn support patient well-being and safety by destigmatizing mental health care for providers. Commissioner Flo Kahn pointed out that while it's important not to stigmatize mental health issues, we also need to know if a provider is capable of practicing, especially if they need help. She questioned how to balance those concerns and what really counts as an intrusive mental health question. Chairman Khan added that if someone discloses mental health issues, it might lead the licensing board to ask for medical records, which raises HIPAA concerns and could create more problems. Dr. Nilesh Gokal, President of the Nevada Physician Wellness Coalition, noted that burnout is linked to negative outcomes, mentioning that over 40% of physicians in a national survey said they wouldn't answer truthfully because of existing culture of silence and fear of repercussions. He also pointed out that sharing history of basic psychotherapy needs can become invasive, leading to a lot of paperwork if applicants answer 'yes' to certain questions during the licensing process. Dr. Gokal stated the Nevada Physician Wellness Coalition's proposal would be to emphasize the importance of patient safety and quality outcomes, while also ensuring the physician is well. Dr. Gokal stated asking invasive questions about a provider's mental health issues should be removed as a barrier to physicians having the ability to seek necessary care. The recommendation would be to include questions about current active conditions that may impact an individual's ability to practice. The Commission indicated they had no further questions regarding the recommendation.

Recommendation seven would require each healthcare occupational licensing board to offer a temporary or provisional license to health professionals who meet certain criteria while documentation and background checks are pending. Some licensing boards in the state are currently offering this, and the Nevada State Board of Nursing issues a temporary license to all applicants who meet certain criteria while their background checks and other documentation are processed. The commission showed a majority of support for this recommendation, and no discussion was held.

Recommendation eight would recommend establishing a single state authority over all health care occupational licensing boards. The recommendation would request licensing boards report and be held accountable for certain metrics (i.e. duration of time from application to licensure). A single authority will help establish uniform standards, metric reporting and reduce unnecessary duplication in requirements that can create barriers and delays to entering the workforce. The commission showed a majority of support for this recommendation, and no discussion was held.

Recommendation nine would develop public-private partnerships to fund health care workforce initiatives by leveraging resources from both sectors to maximize impact. This includes expanding federal, state, public, and private funding investments into Graduate Medical Education (GME) residency and fellowship programs. The commission showed a majority of support for this recommendation, and no discussion was held.

Recommendation ten would make an appropriation of funding to the Division of Public and Behavioral Health (DPBH) within the Department of Health and Human Services (DHHS) to continue the Nurse Apprenticeship Program over the 2026-2027 biennium. The Commission showed a majority of support for this recommendation, and no discussion was held.

Recommendation eleven would recommend the Governor's Office of Workforce Innovation (GOWINN) and Governor's Workforce Development Board (GWDB) prioritize workforce development for the health care industry. Prioritize available funding, including federal funds reserved for statewide workforce investment activities under the Workforce Innovation and Opportunity Act (WIOA) State Plan, on health care workforce training, education and apprenticeships to increase health care provider supply. Additionally, it would recommend GOWINN collaborate with the Department of Health and Human Services (DHHS), Nevada Area Health Education Centers (AHECs) and representatives of the health care industry during implementation of AB 428 (2023) to ensure health care career pathways are developed to interest a person to enter or advance in health occupations in high need areas. The Commission showed a majority of support for this recommendation, and no discussion was held.

Recommendation twelve requests Nevada to create more opportunities for high school students to gain exposure to health care careers. One example would be allowing Nevada students to earn college credits while in high school by taking health-related classes. Chairman Khan emphasized the importance of recognizing this credit for students. The Commission requested to modify the language to include a call for Nevada medical schools, nursing schools, and other health care-related programs to offer potential credit to students who participate in health care classes or certifications.

Recommendation thirteen would request to establish a health care workforce development resource center. The State has many health care workforce initiatives and resources aimed at addressing workforce development and would be helpful to have a single resource for public and stakeholders to refer. A great example is the health care workforce website being developed by the Division of Public and Behavioral Health which exposes visitors to career opportunities, provides educational and training resources, and connects visitors to partners. Commissioner Flo Kahn pointed out that this recommendation overlaps with some others discussed and suggested combining them into one clear point, especially since organizations like the Nevada Health Education Centers are already tackling similar issues. Vice Chair Kirkpatrick highlighted the need to focus on these initiatives, especially with a third of the legislature turning over. She proposed changing the language to include 'maintaining' a Healthcare Workforce Development Resource Center and stressed the importance of ongoing funding.

Recommendation fourteen suggests that Nevada Medicaid review prior authorization (PA) data and requirements to simplify and streamline the process for healthcare providers where applicable. It recommends that Nevada Medicaid establish a data dashboard to support transparency and review of PA data. Following the establishment of such a dashboard, Nevada Medicaid should assess which PAs can be removed without unduly increasing the risk of fraud, waste, and abuse. Additionally, Nevada Medicaid should report to the Legislature every biennium regarding the Division's findings related to PA data and efforts made to reduce the administrative burden on providers. Chairman Khan commented on this recommendation and asked whether it would apply to both Managed Care Organizations (MCOs) and Fee-for-Service (FFS). Stacie Weeks, Administrator at the Division of Healthcare Financing and Policy, confirmed that it would apply to both. She mentioned her

intention to create a quality "gold card" similar to what the private market offers for high-quality providers engaged in certain program integrity activities. Given the challenges of fraud in Medicaid, she hopes to balance these concerns, believing that implementation could improve the process by aligning timelines and requirements for providers across FFS and MCO plans. No further discussion was held.

Recommendation fifteen would conduct regular assessments of the effectiveness of existing State programs to determine where changes can be made to improve the capacity of the healthcare workforce. Ensure investments in State programs have high return on investment and provide the most value for the taxpayer dollar. The commission showed a majority of support for this recommendation, and no discussion was held.

Recommendation sixteen would prioritize health care workforce investments on producing more primary care providers (physicians, APRNS, PAs, nurses). Consumers often perceive overall access to care based on availability and affordability of primary care services. Increasing the number of primary care providers will increase access to more affordable primary care services for Nevada patients. The commission showed a majority of support for this recommendation, and no discussion was held.

Recommendation seventeen would increase state funding to support Nevada Area Health Education Centers (AHEC) to enhance health care workforce development pipeline efforts statewide. Nationally, AHECs are organizations dedicated to serving underserved and rural populations across the nation. In Nevada, there are three AHECs – High Sierra, Desert Meadows, and Frontier. AHECs have proven to be successful partners in Nevada and other states in implementing health care workforce development planning and other initiatives. Nevada AHECs provides education and training for students studying to become health professionals and engage with K-12 schools. Current funding constraints hinder opportunities for service expansion and innovation to meet the needs of each regional AHEC. Commissioner Jalyn Behunin asked if this is related to Recommendation 12, which focuses on creating more opportunities for high school students. Mr. Filippi noted that this recommendation specifically supports the Nevada AHECs, building on the previous one since they already offer many opportunities for high school students to explore different health care careers. While the recommendations are related, they are also distinct because there are various ways to introduce high school students to healthcare careers. No further discussion was held.

Recommendation eighteen would request the state to recommend Nevada Medicaid pilot a virtual “Hospital at Home” program to increase access to care in rural and frontier areas. Care models such as the Emergency Department in Home (EDiH) and Hospital at Home (HaH) provide in home care for patients who qualify and would normally receive services in an emergency department (ED) or inpatient settings. The pilot program would seek to increase access to emergency, outpatient and inpatient care options in rural areas, support the EMS system by reducing avoidable ED transports, decrease hospital overcrowding in urban settings, and better allocate available health care workforce resources. The pilot program will include the combination of in-person clinicians, such as paramedics, with remote physicians and nurses, to provide emergency level, in-patient and primary care for patients who can safely be treated at home in rural areas. Rather than removing patients from their own communities to access care, eligible patients would be able to opt-in to receiving necessary care at their home. The pilot will allow an innovative opportunity for Nevada to share key learnings about safety, quality, and cost to inform future health care regulatory and payment policy.

Vice Chair Kirkpatrick stressed the importance of ensuring patients are not billed as if they had a hospital emergency room (ER) visit, aiming to provide care without turning it into a money grab and notes that high activation fees and excessive charges can be avoided. Chairman Khan agreed with Vice Chair Kirkpatrick and shared the same concerns. Administrator Weeks agreed that ER billing is not the solution and stated that if a new model is developed it will include public input and innovative approaches to health care. Vice Chair Kirkpatrick suggested to modify the recommendation language to include regulations for financial and clinical

standards to ensure comprehensive care.

Dr. Jacob Keeperman, an emergency physician and practitioner of a hospital-at-home, provided public input stating he believes this initiative can be implemented safely and financially responsibly. In other EDiH home programs, patients are seen by a board-certified emergency medicine physician using high-quality audio-visual technology and all evaluations and treatments are properly prescribed. Vice Chair Kirkpatrick stated that if emergency medical technicians (EMT)s are paid through this pilot in rural areas, they would need to be compensated similarly to urban EMTs, making it hard to address these challenges given the difficulty in recruiting volunteers. Dr. Keeperman stated that a key aspect of the program's development is ensuring critical access hospitals remain open and optimize their services, as these hospitals are essential partners in the local rural workforce. This initiative could provide funding to better support EMTs, allowing them to respond to time-critical emergencies and assist with EDiH home visits and he will continue working with the state for this pilot.

Commissioner Flo Kahn stated in rural areas, funding is a major issue. We need to provide more access to providers without creating a program that ends up costing more than what already exists, as that would further limit access. While there might be some short-term benefits for individuals, it could ultimately depress resources and take money away from others in those regions. As we make this recommendation, ensure there's a clear benefit to the community and should include protections against increasing costs and focus on maintaining affordability. Commissioner Davis states that resources in rural areas are extremely scarce, and as we explore these models, we need to consider the overall workforce situation, including how to support or employ volunteers. He states that it's difficult to address the cost aspect over time but that can't let concerns about costs prevent us from moving forward.

Administrator Weeks recommended to include language stating that Medicaid will bring back models and ideas regarding the benefit structure for the PPC to review. This way, the Commission can provide feedback and have a more engaging discussion as it could help everyone feel more comfortable and involved in the process.

Chairman Khan inquired about the additional training that paramedics would be expected to undergo. Dr. Keeperman confirmed that there will be additional training, often referred to as mobile integrated health care, which typically requires individuals to have a few years of paramedic experience before entering these programs. The duration of this training can vary from 3 months to a year. Chairman Khan then asked whether they have documentation of the quality metrics illustrating the required training standards. Dr. Keeperman noted that this is typically developed when the program starts and emphasized that it is part of the implementation stage of the program.

Recommendation nineteen would recommend each health care occupational licensing board, including the Board of Medical Examiners and Board of Osteopathic Medicine, provide licensure reciprocity for health care providers seeking licensure in this state. The recommendation would also, require the licensing boards to provide for a temporary or provisional license allowing a provider to practice while fulfilling requirements needed to qualify for endorsement in this state, or while awaiting verification of documentation supporting such an endorsement. Additionally, the recommendation seeks to require the licensing boards to issue temporary or provisional license based on an affidavit from the applicant that the information provided on the application is true and that the verifying documentation has been requested. This recommendation received unanimous support, and no discussion was held.

Recommendation twenty would recommend establishing an agency or taskforce to lead statewide health care workforce efforts, conduct a comprehensive needs assessment, and be responsible for convening state leaders and other health care industry stakeholders to develop and maintain a health care workforce strategic plan. Several states have taken steps to more holistically assess their healthcare workforce. For example, as part of its

annual budget, Virginia policymakers directed the Virginia Health Care Workforce Development Authority to conduct a study of primary care, behavioral, and nursing health care workforce issues. In Vermont, legislation was passed which created an advisory group to develop and maintain a current health care workforce development plan. The survey showed three commission in support and six were indifferent. No discussion was held.

Recommendation twenty-one seeks to create a funding source to provide incentives for health care workers such as expanding existing loan repayment programs or creating a housing assistance program. Investing in these incentive programs will encourage healthcare professionals to practice in Nevada. The Commission showed a majority of support for this recommendation, and no discussion was held.

Recommendation twenty-two would recommend funding and sustainably supporting a Nevada Nurse Workforce Center to serve as a hub to advance nursing education, practice, leadership, workforce development, and policy. Nationally, State Nursing Workforce Centers use an evidence-based strategy for nursing workforce planning. They utilize data-driven insights and expert consultation at community, regional, and state levels to foster meaningful discussions about the real challenges facing the nursing workforce and practical solutions to address them. The survey showed that four Commissioners were in support and five were indifferent. No discussion was held.

The final recommendation would request the state to support direct care workers by strengthening career pipelines, expanding training and educational opportunities throughout the state, and increasing wages and benefits for the existing workforce. Direct care workers, categorized as Certified Nursing Assistants, Home Health Aides, and Personal Care Aides, provide essential services in a variety of settings including home and community-based settings. With an increase in demand paired with high turnover rates, strengthening this workforce will ensure Nevadans have access to the assistance they need for daily tasks. The commission showed a majority of support for this recommendation, and no discussion was held.

Mr. Filippi then discussed the following letters of support for the Commission to consider sending. The first letter supports the prompt payment law (BDR 57-367) developed by the Nevada Commission on Minority Affairs (NCMA). These measures aim to establish a reliable and prompt reimbursement system for health care providers, fostering an environment conducive to the growth of medical practices and improving health care access for Nevada residents, with a specific focus on reducing disparities in minority communities. The majority of the Commission was in support of sending a letter regarding this BDR, and no discussion was held.

The second letter of support would allow for the Commission to support BDR-352 developed by the Joint Interim Standing Committee on Health and Human Services, which establishes the Social Work Apprentice Program. The program is modeled from the successful nurse apprentice program and will create a long-term social work development pipeline that will aid the state in recruiting and retaining social work professionals. The majority of the Commission was in support of sending a letter regarding this BDR, and no discussion was held.

The third letter of support would allow for the Commission to support BDR-354 developed by the Joint Interim Standing Committee on Health and Human Services that requires all entities that license or certify health care professions in the state to develop a process to expedite the license or certification process by giving priority review status to the application of an applicant for a license or certificate who demonstrates that he or she intends to practice in historically underserved community as defined by NRS 704.78343. This will increase access to care and prioritize licensure and onboarding for providers who wish to serve in rural and underserved areas. The majority of the Commission is in support of sending a letter regarding this BDR, and no discussion was held.

The fourth letter of support would allow for the commission to support the recommendation submitted by the Nevada Silver Haired Legislative Forum to the Nevada System of Higher Education and the Sandford Center for

Aging, University of Nevada, Reno, School of Medicine to include courses in basic geriatric care for all health care training programs in Nevada. This will help the state address the growing deficit in geriatricians providing care for older adults and support clinicians, especially family medicine and general practitioners, who will be providing the majority of care to older adults. The majority of the Commission is in support of sending a letter regarding this BDR, and no discussion was held.

The final letter of support would allow for the commission to support BDR-456 developed by the Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs that establishes a system of care for the diagnosis and care of Nevadans with dementia called the Nevada Memory Network. The network will be responsible for expanding capacity at memory assessment clinics and expand the workforce in Nevada by hiring or contracting with neurologists, neuropsychologists, and geriatricians to provide services to patients with dementia as well as four community health workers that specialize in dementia to perform necessary duties. The majority of the Commission is in support of sending a letter regarding this BDR, and no discussion was held.

Chairman Khan motioned to approve the recommendations as discussed, including any modifications to the recommendation language. The final recommendations will be included in the next report due to the the Governor and the Legislature in January 2025. Commissioner Simons made a motion to approve the recommendations as presented and modified and Commissioner Andria Peterson seconded. The motion passed unanimously, and the recommendations, along with the discussed modifications, were approved.

6. Public Comment *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Jacqueline Nguyen, representing the Nevada State Medical Association, thanked the Patient Protection Commission for their hard work in preparing the Bill Draft Requests, recommendations, and letters of support. Ms. Nguyen expressed strong support for several of these initiatives and stated that the NSMA offers its physician and physician assistant members as collaborative partners to the PPC to help improve access to quality health care in Nevada.

7. Adjournment
By: Dr. Ikram Khan, Chairman

Chairman Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 11:04 AM.

MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
December 13, 2024

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, December 13, 2024, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2024/PPC2024/.

1. Call to order: Roll call
By: Dr. Ikram Khan, Chairman

The meeting was called to order at 9:02 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

Commission Members Present
Dr. Ikram Khan, Chair
Marilyn Kirkpatrick, Vice Chair
Bethany Sexton
Jalyn Behunin
Walter Davis
Wendy Simons

Commission Members Absent
Dr. Andria Peterson – Excused
Dr. Bayo Curry-Winchell – Excused
Flo Kahn – Excused

Advisory Commission Members Present
Scott Kipper, Insurance Commissioner, Division of Insurance (DOI); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP); Shannon Litz, Deputy Director on behalf of Richard Whitley, Director, Department of Health and Human Services; Russell Cook, Executive Director, Silver State Health Insurance Exchange

Staff Present
Joseph Filippi, Executive Director, PPC; Dylan Malmlov, Policy Analyst, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Guests Present

Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Lindsey Miller, Constituent Services, Governor's Office; Stacie Weeks, Administrator, DHCFP; Todd Rich, Agency Manager, DHCFP; Melorine Morki, Social Services Program Specialist III, DHCFP; Sarah Dearborn, Social Services Chief 3, DHCFP; Adam Plain, Insurance Regulation Liaison, DOI; Jack Childress, Insurance Actuarial Analyst III, DOI; Autum Blattman, Regional Coordinator, ADSD; Dawn Lyons, Social Services Program Specialist, ADSD; Lori Lutu, Regional Coordinator, ADSD; Danacamile Roscom, Health Program Manager II, DPBH; Megan Comlossy, Academic Health Department Liaison, DPBH; Mitch DeValliere, Agency Manager, DPBH; Maria Tello-Magna, Executive Assistant, Director's Office; Kareen Filippi, Management Analyst III, WIC; Cathy Dinauer, NSBN; Andrea Gregg, CEO, High Sierra Area Health Education Center (AHEC); Alexandria Cannito; Alexis Kirby; Allison Genco; Amy Levin; Amy Shogren; Ana Bonillas; Angela Stewart; Ashley DeLanis; Ashley Jonkey; Areli Alarcon; Arielle Hernandez; Bob Baughman; Bob Crockett; Brian Evans; Carley Murray; Cheri Glockner; Chris Muehlmann; Chelsey Booker; Cooper Irvine; Courtney Canova; Diego Trujillo; Don Boyle; Edith Duarte; Eileen Colen; Elissa Secrist; Elyse Monroy-Marsala; Elizabeth Bickle; Emily Rigler-Wright; Eric Schmacker; Esther Badiata; Fergus Laughridge; Gabby McGregor; James Combs; Jason Drake; Jason Worthen; Jennifer Lanahan; Joanna Jacob; Dr. John Packham; Joshua Coello; Joy Thomas; June Cartino; Kathy Triplett; Laurie Curfman; Laurie Drucker; Lea Cartwright; Lee McAllister; Luiza Benisano; Marc Ellis; Mari Nakashima Nielsen; Marianne McKown; Mark Funkhouser; Melodie Osborn; Misty Grimmer; Nicole Flangas; Patrick Kelly; Paul Young; Paula Freund; Philip Ramirez; Reagan Hart; Renee Ruiz; Shandi Ahmed; Shaneka Wiley; Sheryl Morelli; Steven Messinger; Susan Priestman; Tamara Weber; Travis West; Troy Smith; Valerie Haskin

2. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Sheryl Morelli, a general pediatrician with Intermountain Children's Health, provided public comment regarding the Bill Draft Request that the PPC is putting forward. She voiced strong support for Senate Bills 29, 34, and 40. Dr. Morelli stated that Nevada ranks last or near last in several aspects of children's health, including overall well-being, clinical care, mental health treatment, medical reimbursement, and access to care. She emphasized that addressing these issues will require a multifaceted approach. Dr. Morelli highlighted that these senate bills have the potential to significantly address some of these barriers. Specifically, Senate Bill 34 will help decrease the administrative burden of practicing in the state. Senate Bill 29 will improve reimbursement rates, which will help cover the cost of evidence-based care for children in Nevada. Senate Bill 40 will increase Graduate Medical Education (GME) opportunities and help retain more physicians in the state. She thanked the commission for recommending these bills, stating that this is a step forward in improving children's health. Dr. Morelli also pointed out that while children represent 20% of Nevada's population, they are 100% of its future, stressing the importance of continued investment in children's health to ensure the state's future success.

Renee Ruiz, a representative of the National Nurses United, National Nurses Organizing Committee, and California Nurses Association, spoke on behalf of over 200,000 nurses nationwide, including more than 3,000 in Nevada. Ms. Ruiz expressed strong opposition to all licensure compacts, specifically the Nurse Licensure Compact, asserting that her stance reflects the interests of bedside nurses. She argued that Nevada does not have a nursing shortage, stating that there are enough licensed RNs in the state to fill every open position, including those set to be open. Ms. Ruiz emphasized that the issue is not the lack of licensed RNs but the challenge of retaining nurses at the bedside. She pointed to multiple studies and evidence her team has presented to the legislature over the years, highlighting the impact of workplace violence, which nurses and healthcare workers face daily. She argued that addressing this issue, along with implementing safe staffing guidelines, would encourage more nurses to return to bedside care. Ms. Ruiz noted that states that have

adopted safe staffing guidelines have seen nurses returning to bedside positions in significant numbers. She concluded her public comments by asserting that adopting a Nurse Licensure Compact would only serve to lower the standards of nursing in Nevada. Ms. Ruiz stated that her organization plans to take further action in opposition to the compact if necessary.

Elizabeth Bickle, a nurse with over 18 years of experience, also expressed her opposition to the Nurse Licensure Compact, stating that it is unnecessary since Nevada already has an endorsement process in place. This process allows nurses to work with a temporary license while their application for full endorsement is being processed. She noted that temporary licenses are issued within seven to ten business days and are valid for six months. Ms. Bickle emphasized that her primary concern is the weaker licensing requirements in some compact states, which she argued jeopardize patient care. She highlighted that many states do not require 30 hours of continuing education for each renewal period, as Nevada does. For example, Arizona, a compact state, requires zero hours of continuing education. Ms. Bickle also referenced a 2023 multi-state investigation by the Department of Health and Human Services, which uncovered a scheme to sell fraudulent nursing degree diplomas and transcripts. This allowed individuals to sit for the National Nursing Board Examination without proper qualifications. Warrants were issued in several compact states, including Delaware, New Jersey, Florida, Texas, and New York. She claimed that in Florida, the Board of Nursing sold credentials to over 7,600 individuals who never attended classes or clinical rotations, and approximately 2,800 of them passed the NCLEX examination. Ms. Bickle stated that dozens of these fraudulent licenses have since been revoked, but many states are still conducting investigations. She argued that the purpose of a nursing license is to protect the public from harm by establishing minimum qualifications and competencies for nurses. The failure of these boards to uphold these standards undermines the integrity of nursing licenses, endangers patient health and safety, and insults the nursing profession.

Mark Ellis, representing the Communication Workers of America Local 9413 and serving as an Executive of the AFL-CIO, also voiced strong opposition to the Nurse Licensure Compact. Mr. Ellis stated that this bill has been repeatedly rejected, emphasizing that Nevada does not support it. He noted that while Nevada ranks low in education, the state is ranked high in nursing. Mr. Ellis argued that the Nurse Licensure Compact would lower the state's standards, allowing less-qualified nurses to practice in Nevada. He claimed that this bill primarily benefits for-profit hospitals, not the residents of the state. He urged the committee to stop advocating for the compact and instead start listening to the voices of the people.

Adrielle Hernandez, a regulatory policy specialist for National Nurses United (NNU), provided public comment expressing concerns about the recommendation approved during October's PPC meeting regarding the Hospital-at-Home pilot program. She stated that it was unclear in the September and October meetings what the process for authorizing this pilot would be and inquired whether the intent of the pilot is to proceed as a bill or through some other mechanism. Ms. Hernandez argued that NNU strongly opposes hospital-at-home and similar programs, claiming that they endanger patients by allowing hospitals and healthcare providers to treat patients at home for conditions requiring inpatient-level care. She stated that such programs lower the standard of care by waiving numerous provider requirements and patient safety standards. For example, she noted that if this program is similar to the EMS Acute Hospital Care at Home program, it would waive 24-hour on-premises nursing services and the immediate availability of emergency response, allowing delays of up to 30 minutes, which puts patients at significant risk. Ms. Hernandez argued that instead of addressing the crisis of hospital closures, hospital-at-home programs enable hospitals and healthcare industries to obtain financial benefits by reducing labor and overhead costs while still receiving inpatient-level reimbursement rates. She highlighted similar dangers posed by emergency department and home care programs, which allow 911 dispatchers and paramedics to determine whether patients should be transported to a hospital or deemed eligible for home-based care. While acknowledging the vital role EMS providers play as first responders, she asserted that they

lack the licensing and expertise needed to make such patient assessments. She concluded by stating that Nevada should focus on expanding access to quality, in-person care, particularly for Medicaid patients and other disadvantaged communities, rather than reducing it through programs like hospital-at-home.

Chris Gibson also spoke on the licensure compacts, stating that as a nurse in this state, she is voting against Nevada becoming a compact state. As a practicing bedside nurse in this state, she takes great pride in upholding high standards for nursing regulations and training requirements. She argued that compact states have less stringent licensing requirements than non-compact states, with some not even requiring continuing education for nurses. She stated that this could potentially impact the quality-of-care patients receive. Ms. Gibson also expressed concern that the influx of travel nurses could impact the job market and lead to poor oversight by the state nursing board, as well as issues with license verifications, tracking, and coordinating disciplinary actions. She further argued that this change would affect income generation for the state, as nurses would pay licensing fees to the state where they originally obtained their nursing licenses. She concluded by stating that she prioritizes stringent nursing regulations and education over convenience.

Susan Priestman, President of the Nevada PT Association, provided public comment by clarifying the differences between the various therapy compacts (Physical Therapy, Occupational Therapy, and Speech and Language Pathology). Ms. Priestman stated that they are facing a severe staffing crisis, particularly in rural and underserved communities, across the therapy disciplines in Nevada, noting that the state is ranked 50th out of 51 for Physical Therapists per capita. She emphasized that the Physical Therapy Licensure Compact is stringent and requires to follow all rules and regulations, including continuing education. Ms. Priestman explained that the PT regulatory board is bringing forth this bill. She expressed concern about how the severe staffing shortage in one profession might lead to other professions attempting to meet the community's needs without the proper doctorate-level education required to provide safe and effective care. She also mentioned that the Department of Defense supports recommending compact privileges for Nevada to allow military spouses to practice with much greater fluidity if this compact is passed.

3. For Possible Action: Review and Approve Meeting Minutes from October 18, 2024
By: Dr. Ikram Khan, Chairman

Chairman Khan asked for a motion for the approval of the October 18, 2024, meeting minutes. Commissioner Walter Davis motioned to approve the minutes as presented, and Commissioner Wendy Simons seconded the motion. The motion carried, and the October 18, 2024, meeting minutes were approved unanimously.

4. Informational: Update on the Commission's Bill Draft Requests submitted to the 83rd (2025) Legislature.
By: Joseph Filippi, Executive Director

Joseph Filippi provided an informational update on the Commission's three Bill Draft Requests (BDRs), which can be found on the PPC webpage or by clicking here. He reiterated that, per the Governor's Executive Order 2024-002, the Commission has spent the last several months reviewing available data and national best practices to provide additional recommendations for addressing the healthcare workforce shortage in Nevada. Senate Bill 40 aims to establish a Health Care Workforce Account within Nevada Medicaid to enhance the capacity and size of the state's healthcare workforce while increasing access to care for Medicaid recipients. This account would support sustainable funding opportunities for Graduate Medical Education (GME) residency and fellowship programs, as well as apprenticeship and loan repayment programs within the state. Senate Bill 29 focuses on increasing provider reimbursement while incentivizing better quality of care. This bill outlines three main strategies to achieve its goals: requiring Nevada Medicaid to seek federal authority to establish accountable care payment models, increasing Medicaid reimbursement rates for physicians and advanced practice registered nurses (APRNs) to meet the healthcare needs of Nevadans, and requiring Nevada Medicaid to issue a biennial

survey to in-network providers. Senate Bill 34 seeks to reduce barriers for licensed healthcare providers to practice in Nevada by authorizing the state to join multiple licensure compacts, including the Physician Assistant Compact, Nurse Licensure Compact, Audiology and Speech-Language Pathology Interstate Compact, Physical Therapy Licensure Compact, and Occupational Therapy Licensure Compact. This bill also requires the Department of Health and Human Services to study the impact of each compact on access to care and submit a report to the PPC and the Legislature by 2026. Currently, 13 states have joined the Physician Assistant Compact, with 4 states pending. The Nurse Licensure Compact includes 40 states and 2 territories, while the Occupational Therapy Compact has 31 states enrolled. The Audiology and Speech-Language Pathology Compact has 33 states enrolled, and the Physical Therapy Compact has 38 states enrolled.

Commissioner Davis asked whether the next PPC meeting would be dedicated to discussion or action regarding these BDRs. Mr. Filippi confirmed this, acknowledging an oversight on his part and explaining that the agenda item was unintentionally listed as informational. He clarified that although these bills have already been submitted to the legislature, the Commission will still have the opportunity to discuss or propose amendments during the legislative session for modification if needed. He assured the Commission that this opportunity will be available at the next PPC meeting in January.

Chairman Khan inquired whether any proposed changes or amendments to the bills would need to be addressed at the legislative level or if the commission could suggest amendments as a whole. Deputy Attorney General Gabriel Lither confirmed that the commission can still make formal recommendations to submit to the legislature.

5. For Possible Action: Review and Approve Semi-Annual PPC Report required per NRS 439.918
By: Joseph Filippi, Executive Director, PPC

Mr. Filippi presented the draft Semi-Annual PPC Report, available on the webpage or by clicking here. NRS 439.918 requires the Patient Protection Commission to submit a report every six months to the Governor and the Legislature. The report must include, without limitation, a description of issues identified as negatively impacting the quality, accessibility, or affordability of health care in Nevada, along with recommendations for legislative or regulatory changes to policies and budgets to address these issues.

Vice Chair Kirkpatrick thanked Mr. Filippi for compiling the report, noting that it was a great summary of everything the PPC discussed. Commissioner Simons agreed and expressed appreciation, stating that the report was very comprehensive and effectively captured the significant amount of work that went into these BDRs in a short period of time. Chairman Khan also acknowledged Mr. Filippi's hard work in preparing the report, adding that the PPC has become highly efficient and proactive.

Commissioner Simons motioned to approve the Semi-Annual PPC Report, and Vice Chair Kirkpatrick seconded the motion. The motion carried, and the Semi-Annual PPC Report was approved unanimously.

6. For possible Action: Discussion and Approval of Future Meeting Dates.
By: Dr. Ikram Khan, Chairman

Mr. Filippi then addressed the future PPC meeting dates, stating that the next scheduled meeting is on January 17, 2025. With the legislative session approaching, Mr. Filippi acknowledged that most commissioners would be busy but emphasized his intent to hold at least one meeting during the session and another shortly after it ends. These meetings would provide updates on the PPC bills, their progress within the session, and other legislation relevant to the Commission's scope. He also mentioned the possibility of holding an in-person meeting, potentially in Las Vegas or Reno.

Commissioner Davis and Commissioner Behunin expressed support for Mr. Filippi's recommendations, stating that they would like to have one in-person meeting next year, potentially in August.

Vice Chair Kirkpatrick encouraged Mr. Filippi to review the calendar for the First House Passage to schedule PPC meetings, noting that some bills with fiscal impacts are likely to go to Ways and Means or Senate Finance. She suggested holding a meeting before the First House Passage, likely in late March or early April. Commissioner Simons agreed, stating that at least one meeting during the legislative session is beneficial to ensure the commission receives an update on progress.

Commissioner Bethany Sexton agreed but noted the need to be cautious when scheduling in March, as some may be on spring break.

Chairman Khan suggested that if the Commission is set to present to the legislature, Mr. Filippi, the executive director, should represent the Commission. Mr. Lither emphasized that while Mr. Filippi can represent the Commission if needed, the Commission should also be available to provide input on any parameters, ideas, details, and suggestions for his conduct with the legislature. Mr. Filippi agreed, noting that he is happy to represent the Commission and will provide meeting information to invite others to attend the hearings.

Vice Chair Kirkpatrick asked for clarification on whether Mr. Filippi can brief legislators on behalf of the Commission. Mr. Filippi confirmed that he can speak on behalf of the Commission but noted that he can only represent their discussions and comments made publicly.

Commissioner Sexton inquired whether the Commission's presence is historically needed during the session. Chairman Khan stated that, historically, the executive director has attended on behalf of the commission, but as Mr. Filippi mentioned, the commission is welcome to attend as well. Mr. Lither confirmed this.

Mr. Filippi reiterated that the commission supports the proposed future meeting dates outlined and discussed during the meeting, with the exception of moving April's PPC meeting to March.

7. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Dr. John Packham, Associate Dean at the UNR School of Medicine and Co-Director of the Nevada Workforce Research Center, shared his frustrations regarding suggestions that Nevada does not currently face a nursing shortage and will not face one for the next five to ten years. He emphasized that this is not only incorrect but also reckless, as it undermines the purpose of having lawmakers if there is no shortage. He stated that his office is more than willing to provide additional information on the scope and severity of shortages in nursing and other fields outlined in the Compact bill, SB 34.

Renee Ruiz, a representative of the National Nurses United, National Nurses Organizing Committee, and California Nurses Association, made another public comment regarding the Nurse Licensure Compact. She stated that the Nurse Licensure Compact is a money-making institution, with much of that money being drawn from nurses in Nevada and urged the commission to take this into consideration. She also noted that the Nurse Licensure Compact is an ironclad contract that is almost impossible to withdraw from. Ms. Ruiz reiterated her stance that there are enough RN licenses to fill every open position currently available. She stated that while there will be a need for nurses in the state, the way to grow the nursing workforce in Nevada is by improving working conditions, such as implementing safe staffing guidelines. She mentioned that there is various evidence supporting this and is happy to provide it to the commission.

Cathy Dinauer, Executive Director for the Nevada State Board of Nursing, thanked the commission for moving forward and supporting the Nurse Licensure Compact. She clarified a few statements from recent comments,

stating that the Nurse Licensure Compact does not generate any income, as it is a licensure tool. She mentioned that while this may not necessarily solve the nursing shortage, it will help. She cited a 2022 survey indicating that 92% of nurses in Nevada, including those who were part of existing unions, supported the Nurse Licensure Compact. The Nurse Licensure Compact Commission is made up of individuals from each compact state, with regular discussions on the nursing compact. Ms. Dinauer stated that this will not lower the standard of nursing care, as there are uniform requirements for all compact states that must be followed.

Valerie Haskin, Rural Regional Behavioral Health Coordinator, shared that she serves on the Rural Regional Behavioral Health Policy Board, which has used its bill this legislative session to enter the Nevada Board of Examiners for Social Workers into the newly formed Social Worker Interstate Licensure Compact through Bill SB 68. She noted that additional language has been added to specify the requirements for each of the four behavioral health licensing boards to create annual data reports. She emphasized the importance of ensuring these reports are consistent, clear, and useful. She is also willing to provide more information about SB 68 if needed.

Commissioner Simons took this opportunity to thank Dr. Packham for his longevity and extensive research over the years regarding Nevada, as well as Cathy Dinauer for her long tenure in her current role and her dedication and passion for improving the quality of the nursing pool.

Elizabeth Bickle provided another public comment regarding some of the points made by Ms. Dinauer. Ms. Bickle stated that in order to become a nurse in the United States, everyone must pass the nursing examination to be licensed, which is why nurses can apply for licensure by endorsement in all 50 states. However, she argued and reiterated that there are other compact states that do not have nearly the same continuing education standards as Nevada. This is one of the reasons of why she is proud to be a nurse in Nevada and fears that, if Nevada joins the compact, the standard of care and continuing education could be diluted.

8. Adjournment
By: Dr. Ikram Khan, Chairman

Chairman Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 10:26 AM.

DATE: June 3, 2024

TO: All Interested Parties

FROM: Ikram Khan, MD, Chair, Nevada Patient Protection Commission (Nevada Revised Statutes [NRS] 439.908)

RE: Solicitation of Health Care Workforce Recommendations

The Nevada Patient Protection Commission (PPC) is required to systematically review issues related to the health care needs of Nevada residents and the accessibility, affordability, and quality of health care. In order to ensure more patients have access to quality health care, the Governor issued Executive Order 2024-002 directing the PPC to review and make recommendations on how to address the health care workforce shortages in the State. The Executive Order requests the PPC review available data and national best practices to develop recommendations for:

1. Attracting and retaining talent to address health care workforce challenges in urban and rural communities;
2. Improving access to primary care and public health services;
3. Removing unnecessary state administrative hurdles to recruiting and retaining health care workers;
4. Identifying sustainable funding strategies for strengthening the state's health care workforce, which includes supporting competitive Medicaid reimbursements;
5. Ensuring recommended strategies for increasing provider reimbursement are based on payment methodologies that incentivize and reward for better quality and value for the taxpayer dollar; and
6. Identifying strategies for evaluating new and existing state investments in efforts to improve the capacity and size of the state's health care workforce.

Pursuant to NRS 218D.213, the Commission may request no more than 3 legislative bill draft requests (BDRs) on or before September 1, 2024, which relate to matters within the scope of the Commission. In addition to BDRs, the Commission is required to provide recommendations to the Governor and the Legislature in the Commission's report submitted in accordance with NRS 439.918.

The PPC will conduct one or more work sessions to consider health care workforce policy recommendations at its meetings. Commission staff will review meeting materials and testimony received at meetings to develop a list of recommendations for review by the Chair and possible consideration by the Commission during the work session phase of the meetings.

Additionally, I am inviting all interested parties to provide recommendations in writing for possible consideration during a work session. Submission of a recommendation to the Commission does not guarantee its consideration during a work session.

Please follow these guidelines to submit a recommendation to the Commission:

- Submit the recommendation in writing;
- Indicate your name, the date, and the organization you represent;
- Explain in detail the policy you recommend;

• Provide references to NRS potentially affected by the recommendation; and
• Include any background information supporting or explaining the recommendation, such as: (1) pertinent bills or laws from other states; (2) model legislation; (3) policy briefs or proposals; et cetera. You can also link to or attach any supporting documents.

Please submit your recommendations by using the provided online fillable form or via email to ppcinfo@dhhs.nv.gov. Please do not hesitate to contact Commission staff at the same email address with any questions.

DATE: June 28, 2024

TO: Nevada Health Care Providers

FROM: Ikram Khan, MD, Chair, Nevada Patient Protection Commission (Nevada Revised Statutes [NRS] 439.908)

RE: Solicitation of Health Care Provider Recommendations Relating to Nevada Medicaid

The Nevada Patient Protection Commission (PPC) is required to systematically review issues related to the health care needs of Nevada residents and the accessibility, affordability, and quality of health care. In order to ensure more patients have access to quality health care, the Governor issued Executive Order 2024-002 directing the PPC to review and make recommendations on how to address the health care workforce shortages in the State. The Executive Order requests the PPC review available data and national best practices to develop recommendations for:

1. Attracting and retaining talent to address health care workforce challenges in urban and rural communities;
2. Improving access to primary care and public health services;
3. Removing unnecessary state administrative hurdles to recruiting and retaining health care workers;
4. Identifying sustainable funding strategies for strengthening the state's health care workforce, which includes supporting competitive Medicaid reimbursements;
5. Ensuring recommended strategies for increasing provider reimbursement are based on payment methodologies that incentivize and reward for better quality and value for the taxpayer dollar; and
6. Identifying strategies for evaluating new and existing state investments in efforts to improve the capacity and size of the state's health care workforce.

As directed by the Governor's Executive Order 2024-002, the PPC has been charged with identifying sustainable funding strategies for strengthening Nevada's health care workforce and recommending strategies for increasing provider reimbursement. Insurance reimbursement rates, including Medicaid reimbursement rates, incentivize health care professionals to practice in Nevada, thereby improving the quality of patient care and access to comprehensive health care services across the state.

The PPC will conduct one or more work sessions to consider health care workforce policy recommendations at its meetings. Commission staff will review meeting materials and testimony received at meetings to develop a list of recommendations for review by the Chair and possible consideration by the Commission during the work session phase of the meetings.

As Chair to the PPC, I am inviting **all interested health care providers to provide recommendations in writing for possible considerations for improving provider experience with billing and increasing utilization with Nevada Medicaid.** Submission of a recommendation to the Commission does not guarantee its consideration during a work session.

Please follow these guidelines to submit a recommendation to the Commission:

• Submit the recommendation in writing;
• Indicate your name, the date, and the organization you represent;
• Explain in detail the policy you recommend regarding Nevada Medicaid and how it will address the health care workforce shortage;
• If possible, provide references to specific provider types; and
• Include any background information supporting or explaining the recommendation, such as: (1) pertinent bills or laws from other states; (2) model legislation; (3) policy briefs or proposals; et cetera. You can also link to or attach any supporting documents.

Please submit your recommendations by using the provided online fillable form or via email to ppcinfo@dhhs.nv.gov. Please do not hesitate to contact Commission staff at the same email address with any questions.