Patient Protection Commission (PPC)
Final 3 Bill Draft Requests (BDR) for 2025 Session - Discussion

Updated 8.9.24

Topic 1: MEDICAID HEALTH CARE WORKFORCE DEVELOPMENT FUND

BDR Intent (Describe the problem to be solved, intended effect, and/or the goal(s) of the proposed bill or resolution):

In order to increase the number of providers practicing in the state long term as well as attract more individuals looking to come to Nevada to complete their training, Nevada must invest in Graduate Medical Education (GME) programs and provide opportunities for more physicians to complete their GME in the state. This legislative measure intends to establish a fund that could leverage Medicaid federal funds to support the expansion of GME programs, improve the capacity and size of the state's health care workforce, and increase access to care.

BDR Proposed Language:

1. ***Establish a new Medicaid Health Care Workforce Fund at the Division of Health Care Financing and Policy to support efforts to expand the state's health care workforce, including, but not limited to:***
    a. ***Eligible Graduate Medical Education programs;***
    b. ***Eligible Indirect Medical Education programs;***
    c. ***Provider fellowship and apprenticeship programs; and***
    d. ***Loan repayment programs.***
2. ***The Fund may consist of state and local monies and private donations to the state that are deposited into the account or appropriated by the Legislature and any available federal funds under Title XIX of the Social Security Act.***
3. ***The Administrator must ensure all activities or programs funded by monies in the Fund are eligible to receive federal funds under Title XIX of the Social Security Act.***
4. ***Any money remaining in the Account at the end of a fiscal year does not revert to the State General Fund, and the balance of the Account must be carried forward to the next fiscal year.***

PPC Authority: NRS 439.916; NRS 218D.213

If known, NRS sought to be changed or affected by measure: Chapter 422 - Health Care Financing and Policy

Documentation and Analysis:

(May include any relevant legislative measures, cases or federal laws or other supporting materials)

- New Mexico – HB 480 (2019) was created to expand GME, create a GME grant program fund, expand and create residency programs, and creating the GME expansion review board. $5M was appropriated from the general fund to the GME grant program fund.
  - HB0480 (nmlegis.gov)
- Florida – 2015 Florida Statutes 409.909 outlines how much funding to provide for programs and which specialties are considered primary care to qualify for the program. Funding for their program is primarily through Medicare and Medicaid
  - Chapter 409 Section 909 - 2015 Florida Statutes - The Florida Senate (flsenate.org)
- Massachusetts –
  - Massachusetts League of Community Health Centers (Massachusetts General Laws, Chapter 13, Sections 106-108) implements the MA Repay Program which provides loan repayment for health professions in primary care, BH, and SU. Health professionals receiving the loan have to commit to working for a specified amount of time in the area. These loans are partially paid for by HRSA.
    - MLRP_Program_Guide_2024_Final.pdf (massleague.org)

CMS authority for GME spending:
Direct Graduate Medical Education (DGME) | Guidance Portal (hhs.gov)
Indirect Medical Education (IME) | CMS

Description of any known cost to the State or a local government:
If approved, the amount of general funding allocated to the account must be determined by the Governor and the Legislature during the 2025 legislative process. To extent possible under federal law, funding allocated to the account will be matched with federal Medicaid funds, which will more than double the initial investment. This will ensure a high return on investment and provide the most value for the taxpayer dollar.

Relates to the following sections of Governor Lombardo's Executive Order 2024-002:
(a) Attracting and retaining talent to address health-care workforce challenges in urban and rural communities;
(b) Improving access to primary care and public health services;
(d) Identifying sustainable funding strategies for strengthening the state's health-care workforce, which includes supporting competitive Medicaid reimbursements;
(e) 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
(f) Identifying strategies for evaluating new and existing state investments in efforts to improve the capacity and size of the state's health-care workforce.

Topic 2: INCREASE MEDICAID REIMBURSEMENT RATES FOR PHYSICIANS AND OTHER MEDICAL PROVIDERS IN KEY AREAS OF NEED WITH A TARGETED APPROACH

- **BDR Intent (Describe the problem to be solved, intended effect, and/or the goal(s) of the proposed bill or resolution):**
  This legislative measure requests an increase to Medicaid reimbursement rates for physicians and APRNs to meet the health care needs of Nevadans. Increased Medicaid reimbursement rates would incentivize providers to continue to accept patients covered by Medicaid, increase access to care throughout the state, and encourage providers to practice within the state.

  The measure requires the Division of Health Care Financing and Policy (DHCFP) to seek federal authority to establish accountable care payment models that promote care coordination, preventative services, and efficient use of health care resources. The Centers for Medicare and Medicaid Services (CMS) Innovation Center has awarded several grants to states to implement alternative payment models to move the healthcare system towards paying providers for quality of services rather than quantity of services. The goal of these models is to save money and provide better health care services by creating person-centered organizations where providers of all specialties communicate and collaborate on the patient's needs to reduce duplication and unnecessary services, boost preventative screenings, move record keeping to a central location, improve health education for patients, and spend less time and money on post-acute care, hospital, and emergency department 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.

  Lastly, the measure requires the Division to survey providers of health care each biennium requesting recommendations on how to improve the provider utilization and billing experience with Nevada Medicaid.

BDR Proposed Language:

1. ***Increase Medicaid reimbursement rates for physicians (which applies to APRNs under parity laws) by another 5 percent this next biennium with a 3 percent bump for any Medicaid-covered services rendered to recipients in rural areas. Provide a 3 percent bump for physicians and APRNs participating in the Department's value-based payment models for services funded by Title XIX of the Social Security Act.***

2. ***The Division of Health Care Financing and Policy shall seek all federal authority necessary to establish an accountable care payment model in Medicaid that focuses on expanding high-quality, coordinated primary care. This model will include incentive payments and other value-based payment arrangements for networks of providers, group practices, hospital systems, and other providers that agree to establish new health care partnerships aimed at coordinating care and utilizing innovative approaches to care delivery for a specified patient population in a manner that improves health outcomes and lowers the total cost of care for such population.***

3. ***The Division of Health Care Financing and Policy shall issue a survey each biennium to providers of health care requesting recommendations on how to improve the provider billing experience and increasing provider utilization with Nevada Medicaid.***

PPC Authority: NRS 439.916; NRS 218D.213

If known, NRS sought to be changed or affected by measure: Chapter 422 - Health Care Financing and Policy

Documentation and Analysis:

(May include any relevant legislative measures, cases or federal laws or other supporting materials)

Accountable care model: A person-centered care team takes responsibility for improving quality of care, care coordination, and health outcomes for a defined group of individuals, to reduce care fragmentation and avoid unnecessary costs for individuals and the health system.

Accountable Care Organizations (ACOs): Groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs.

When ACOs provide higher quality, coordinated care that improves patient health outcomes and reduces Medicare spending, they may be eligible to share in a portion of those savings. Conversely, ACOs could pay a penalty if they provide fragmented care that increases Medicare costs. ACOs can invest any financial rewards they receive into more patient care services and supports, or they can share a portion with health providers participating in the ACO.
Accountable Care and Accountable Care Organizations | CMS

Vermont – first state to implement an all-payer ACO that expands beyond Medicaid/Medicare
All Payer Model ACO Agreement.pdf (vermont.gov)

Minnesota – Integrated Health Partnerships (IHPs) are direct contracting between the state and health care providers that focused on value-based payment model
Chapter 358 - MN Laws

Tennessee – episodes of care model
Tennessee General Assembly Legislation (tn.gov)

Description of any known cost to the State or a local government:
Last session, Nevada invested approximately $37 million in state general funds annually to increase physician rates by 5 percent. When matched with federal Medicaid funds, the state would more than double the initial investment and have an estimated $100 million dollars to increase provider Medicaid reimbursement rates. DHCFP is still conducting its fiscal analysis for these items and will provide final amounts as soon as possible.

Relates to the following sections of Governor Lombardo's Executive Order 2024-002:
(a) Attracting and retaining talent to address health-care workforce challenges in urban and rural communities;
(b) Improving access to primary care and public health services;
(d) Identifying sustainable funding strategies for strengthening the state's health-care workforce, which includes supporting competitive Medicaid reimbursements;
(e) 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
(f) Identifying strategies for evaluating new and existing state investments in efforts to improve the capacity and size of the state's health-care workforce.

Topic 3: HEALTH CARE OCCUPATIONAL LICENSURE

BDR Intent (Describe the problem to be solved, intended effect, and/or the goal(s) of the proposed bill or resolution):
In order to tackle the ongoing challenges with building an adequate health care workforce to care for Nevada residents, Nevada must remove any unnecessary barriers for recruiting and retaining health care providers. One of the barriers that providers face when enrolling to practice in Nevada is the administrative process and prolonged duration before they are licensed in the state. In some instances, it can take several months from time of application submitted to time license is issued. These delays can make Nevada a less competitive market for health care candidates to consider given the barriers to entry they face. States can benefit from joining interstate licensure compacts, as they provide more access to care and enhance licensure portability. Providing increased mobility for essential care providers is accomplished by expediting the process for licensure and providing a quick timeframe for providers to practice in Nevada.

BDR Proposed Language:

1. ***NURSE LICENSURE COMPACT***
    a. ***Enact and enter into the Nurse Licensure Compact and conduct a study on the impacts to addressing the nursing shortage. Joining the Nurse Licensure Compact will eliminate unnecessary administrative hurdles to recruiting and retaining nurses in the State. The Nurse Licensure Compact will allow for easier mobility of these essential care providers by expediting the process for licensure and providing a quick timeframe for nurses to practice in Nevada.***
    b. ***21_MODEL_ACT.PDF (NCSBN.ORG)***

2. ***PHYSICIAN ASSISTANT COMPACT***
    a. ***Enact and enter into the Physician Assistant (PA) Compact and conduct a study on the impacts to addressing the PA shortage. Joining the Physician Assistant Compact will eliminate unnecessary administrative hurdles to recruiting and retaining PAs in the***

State. The Physicians Assistant Compact will allow for easier mobility of these essential care providers by expediting the process for licensure and providing a quick timeframe for providers to practice in Nevada.

b. *PA-COMPACT-MODEL-LEGISLATION.PDF (PACOMPACT.ORG)*

3. *PHYSICAL THERAPY COMPACT*
   a. *Enact and enter into the Physical Therapy Compact and conduct a study on the impacts to addressing the physical therapist shortage. Joining the Physical Therapy Compact will eliminate unnecessary administrative hurdles to recruiting and retaining physical therapists in the State. The Physical Therapy Compact will allow for easier mobility of these essential care providers by expediting the process for licensure and providing a quick timeframe for providers to practice in Nevada.*
   b. *PT_COMPACT_LANGUAGE_FINAL WITH COVER PAGE1_11_2021.PDF (PTCOMPACT.ORG)*

4. *AUDIOLOGY AND SPEECH LANGUAGE PATHOLOGY COMPACT*
   a. *Enact and enter into the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) and conduct a study on the impacts to addressing the audiologist and speech language pathologist shortage. Joining the ASLP-IC will eliminate unnecessary administrative hurdles to recruiting and retaining audiologists and speech language pathologists in the State. The ASLP-IC will allow for easier mobility of these essential care providers by expediting the process for licensure and providing a quick timeframe for providers to practice in Nevada.*
   b. *FINAL_ASLP-IC_LEGISLATION_CORRECT_1.6.21.PDF (ASLPCOMPACT.COM)*

5. *OCCUPATIONAL THERAPY COMPACT*
   a. *Enact and enter into the Occupational Therapy Compact and conduct a study on the impacts to addressing the occupational therapy shortage. Joining the Occupational Therapy Compact will eliminate unnecessary administrative hurdles to recruiting and retaining occupational therapists in the State. The Occupational Therapy Compact will allow for easier mobility of these essential care providers by expediting the process for licensure and providing a quick timeframe for providers to practice in Nevada.*
   b. *FINAL_OCCUPATIONAL_THERAPY_COMPACT_3.1.2022PDF.PDF (OTCOMPACT.ORG)*

PPC Authority: NRS 439.916; NRS 218D.213

If known, NRS sought to be changed or affected by measure:

Documentation and Analysis:

(May include any relevant legislative measures, cases or federal laws or other supporting materials)

The following list outlines interstate licensure compacts Nevada is not currently participating in (excluding social work, counseling).

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
Dietician 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

The below list outlines the compacts that have been activated due to meeting the state threshold and having a higher number of member states. Certain compacts were excluded from recommended list due to low number of states in Compact. The Social Work and Counseling Compacts are not included due to another policy board intending to use their BDR on those.

Compact	States/Territories in Compact	Provider Type	National Rate (per 100,000 Residents)	Nevada Rate (per 100,000 Residents)	Nevada Ranking
Audiology and Speech Language Pathology Interstate Compact	33 states	Audiologists	4.2	2.5	49
		Speech Language Pathologists	59.3	30.2	50
Nurse Licensure Compact	40 states and 2 territories	Registered Nurses (RNs)	948.1	810.5	45
Occupational Therapy Licensure Compact	31 states	Occupational Therapists	43.2	38.2	35
Physical Therapy Licensure Compact	38 states and 1 territory	Physical Therapists	71.9	58.9	46
PA Licensure Compact	13 states	Physician Assistants	43.5	45.4	22

Washington DC is excluded in the rankings

Sources: U.S. Bureau of Labor Statistics (https://www.bls.gov/oes/tables.htm), American Speech-Language-Hearing Association (https://www.asha.org/siteassets/surveys/audiologist-and-slp-to-population-ratios-report.pdf), Population estimates are from the US Census

The Physician Assistant (PA) licensure compact is not currently operational. There is a seven-state threshold in order to activate the compact, which was met in May 2024, and currently 13 states are participating. Those states are currently working through creating the commission and setting up the compact to be fully operational which is expected to take 18-24 months.
Description of any known cost to the State or a local government: There are potential costs to each occupational licensure board associated with processing information related to participating in the interstate licensure compact. Certain occupational licensing boards may be required to pay an annual assessment fee to remain in the compact. For example, according to the National Council of State Boards of Nursing, there is a nominal annual fee (currently $6,000) for Nurse Licensure Compact (NLC) membership, though the overall fiscal impact of the NLC is unique and varies from state to state. https://www.nursecompact.com/files/Updated-Legislator-FAQ.pdf Necessary funding may be obtained through licensure fees the Board collects or state general funds.
Relates to the following sections of Governor Lombardo's Executive Order 2024-002: *(a) Attracting and retaining talent to address health-care workforce challenges in urban and rural communities;* *(b) Improving access to primary care and public health services;* *(c) Removing unnecessary state administrative hurdles to recruiting and retaining health-care workers;*