Summary of Workforce Solicitation of Recommendations (Updated 7/16/2024)

- **35 submissions** received with recommendations
- 16 related to insurance and increasing reimbursement rates
    - Of those, 11 recommendations directly addressed Medicaid
- 11 related to access to care
- 10 related to reducing administrative barriers related to onboarding, training, and licensure requirements
- 8 related to interstate licensure and reciprocity
- 8 related to education and training programs
- 7 related to offering loan forgiveness and/or tuition assistance
- 5 related to monitoring the effectiveness of new and existing programs
- 4 related to offering competitive compensation and incentive packages
- 3 related to provider wellness and mental health

PPC WORKFORCE POLICY SUGGESTIONS		
ONGOING DISCUSSION (UPDATED 7/16/24)		
Submitter Name	**Subject Number**	**Policy Concept Description**
Interstate Licensure and Reciprocity		
Amy Roukie, WC Health	1	Recommend more disciplines' reciprocity with neighboring states- i.e. RN/ APRN, LCSW. Incentives such as cost-sharing for healthcare training programs such as the RN programs- as they are at capacity at TMCC and UNR, and the others are much more expensive.
Holly Armstrong	2	Please tell the Nevada State Nursing Board they need to join the Nurse Licensure Compact so that it isn't so difficult for nurses licensed in other states to become licensed here.
Toni Inserra, South Lyon Medical Center	3	Nevada needs to make licensing for out of state clinicians more efficient with a goal of a 30-day turnaround. New Doctors of Osteopath take at least four months for licensing. These procedures not only create hurdles but inhibit professionals from seeking employment in Nevada. This is evident for all licensed staff including physicians, nurses, radiology technicians, laboratory technicians, etc.
Kira Green, Revive Health Senior Care Management	4	Compact State Status: Nevada should become a compact state to facilitate the recruitment and relocation of nurses from outside the state. This would expedite the hiring process and enable us to fill staffing gaps more efficiently.

Travis Shaffer	5	Reciprocity for therapists to increase therapist recruiting efforts. Make Nevada a part of the Nursing compact to increase the ability for Nevada to recruit nurses.
Annette Logan, Cure 4 The Kids Foundation	6	Licensure Process Streamlining: Simplify and expedite the licensure process for health care professionals, including interstate licensure compacts to allow for easier mobility of providers.
Matt Olivier	7	There is a national therapy (i.e. physical therapy (/assistant), occupational therapy (/assistant) & speech therapy) shortage; NV is acutely feeling the issue. The OT national licensure compact would aid in making it easier for practitioners to work in the state - including remotely. This is course also speaks to the ongoing needs for service expansion and reimbursement opportunities to remain and expand in tele-rehab spheres, especially for our rural and frontier residents.
Jeanne Bishop-Parise, Retired: 1984 NFA Nv License #506 signed by #2 and #4; Retired: currently HSE #3 NV	8	Compact Interstate Licensure which has ""portability of license"" such as Nurses, Physical Therapists, EME or National Association of Long Term Care Administrators Boards (NAB) approach with ""portability of qualifications"" based on a national standard like my Health Services Executive standards. (Nevada was one of the first states to legislate for this in 2017 so our HSE's were some of the first in the nation.) With either portability of license or portability of qualifications, each state still licenses and there are state required testing of applicable state regulations and practices. (This was ""NAB's solution for this critical workforce issue with a value-added blending of classroom and internship skill building for the contemporary executive"".) (Unfortunately, the unions often oppose these interstate provisions as it lessens the number of votes represented collectively.)
Reducing Administrative Barriers with onboarding, training, and licensure requirements		
Holly Armstrong	1	Requiring facilities to require their staff to complete 8 hours of cultural competency is excessive. Please align with the nursing board and make it 4 hours (or less).
Kira Green, Revive Health Senior Care Management	2	Reduced Red Tape: Simplify the onboarding process by eliminating redundant requirements, such as the need for nursing staff to undergo separate cultural competency training for facility approval. By aligning licensing and facility training, we can reduce administrative burdens and expedite onboarding. Timely Onboarding: Implement measures to reduce waiting times for new hires, such as the two-step TB testing process. Delays in starting work can lead to loss of talent as candidates seek employment elsewhere due to financial constraints.
Walter Dimitroff, American Comprehensive Counseling Services	3	One consideration is the length of time that it takes new therapists to be credentialed by the MCO Medicaid providers. This can take up to 6 months resulting in a hardship for the organization to hire to therapists. For providers providing domestic violence services the ongoing audit and regulations that are non-existent in other areas of mental health treatment also create a provider shortage.

Lindsey Harmon, Planned Parenthood	4	Obtaining dispensing licenses for providers is an arduous process. The test is proctored in person and the content is less about the practical knowledge of dispensing law and more about the specific language in the regulation. This process takes away from patient time and has been difficult for our providers to obtain in a timely manner, especially with high turnover. Also, the requirements for dispensing technicians are too rigid. They shouldn't need to have a provider unlock a cabinet every single dispensing activity (when training) if there are no controlled substances kept in said closet. Most technicians are always in the training phase because of high turnover in the industry. Obtaining a conscious sedation license is incredibly confusing and there is no clear contact within the state to provide support through the process. The process also requires accreditation from organizations that require more than standard practices for care.
Giovanni F. Margaroli, At Home Solutions	5	Removing unnecessary state administrative hurdles to recruiting and retaining health care workers - simplify requirements for workforce, skip all the nonsense like cultural competency, infection control, 2nd step tb, just chest xray like hospitals can do, same regs for all or exclude pcs from NRS 449, give them their own chapter with rules for the "baby sitting service" as we are so pleasantly called sometimes (non medical non skilled)
Annette Logan, Cure 4 The Kids Foundation	6	Regulatory Flexibility: Review and amend state regulations that may unnecessarily hinder the recruitment and retention of health care workers, such as restrictive scope-of-practice laws for nurse practitioners and physician assistants.
Amia MulHolland	7	Ease credentialing and authorization hurdles with commercial insurance and Medicaid. As a behavioral health provider, there isn't a shortage more of a we are abandoning hurdles too getting paid (auth and waiting over 2 weeks for reimbursement, not knowing HOW to get reimbursed and having to sign up with third party claims admin) and getting approved through insurance panels (credentialing). Now we are more and more just talking cash. The burden on independent providers is too great.
Nevada AHEC Program	8	Implement administrative simplification and prior authorization improvement strategies that apply FHIR apps and interoperability interventions that automate sharing of medical necessity and covered benefit criteria between electronic health records and payer decision systems as well as gold card programs that reduce time delays and avoid unnecessary administrative barriers to safe effective clinical practice and reduce clinician burnout. Implement health data utility interventions that integrate data and information from health information exchanges, electronic health records, community information exchanges, and public health information systems to improve communication and care coordination for patients with medical, social, and behavioral needs and optimize efficiency and effectiveness of services.
Marisa Wiseman	9	As the NV ABA Board is the present entity that requires the most amount of time to successfully process and approve RBT registrations received, I make the following recommendation: 1) Award temporary, state-registration to those applicants who have a) an active RBT certification number issued by the BACB and b) have an active RBT Supervisor/RBT Requirements Coordinator attached to his/her/their RBT certification number that must be fully approved by the NV ABA Board, in accordance with all applicable laws and statutes, in no more than 120 days from the date their state registration number (e.g., "RBT####") was first issued. [This will allow those interested in becoming RBT paraprofessionals an opportunity

		to access income required to pay the state's fees and afford those individuals seeking the services RBTs provide access to such qualified, paraprofessionals (as the state does not require any RBT to complete any further curriculum other than what is presently required by the BACB).] 1a) A temporary, state-registration for the position of RBT will not change in assigned, RBT-number. Rather, their status within the Board of Applied Behavior Analysis' internal system and public registry will change from "Temporary" to "Not Expired" once his/her/their application for registration has been fully approved on or before the 120-day grace-period. 1b) The status of "Temporary" will be awarded to all RBT registration applications submitted to the NV ABA Board that meet the following criteria: 1) a valid, RBT certification number has been supplied within the application, 2) the applicant does not have any unresolved sanctions against their license/certification with the BACB, and 3) the RBT Supervisor/Requirements Coordinator information is complete and remains within good standing with the BACB.
Jeanne Bishop-Parise, Retired: 1984 NFA Nv License #506 signed by #2 and #4; Retired: currently HSE #3 NV	10	1) Provisional Licenses - accelerate processing ease and times and change regulations where they are too far out. 2) Minimize the classroom and competency testing times with online videos and learning materials done outside of the classroom for certifications like first aid/cpr, medication administration basics, infection control, caregiving/community health worker. As with first aid/cpr there should be national standards for basic training. 3) Periodic renewal timeframes can be pushed out to every two years or every three years for most that are set at annual. 4) Recruit and accelerate out-of-country positions to practice in Nevada. We had 3 nurses from Philippines and 1 doctor from Romania that worked entry level positions while completing English proficiency and Board Exam requirements before licensure. a. Refugee Programs b. Work/Wedding Visas 5) Nevada's Medicaid System for processing applications is cumbersome and takes far too long to process resulting in six months to one year delays where Nevadans are ""Medicaid Pending"". The cash flow lag from time of clean application to time of payment is crippling and as such Long Term Care facilities do not openly accept for admission Medicaid Pending Nevadans. Other states have accelerated the approval process where Nevada lags behind.
Increase Insurance Reimbursement Rates		
Adele Newberry, Caring Nurses Inc.	1	Providing a higher reimbursement rate for Medicaid RN visits so that companies like home health can send a nurse out and not lose money on their direct costs. Often times we have to decline patients from hospitals because we have already done too many visits at a loss. If we lower the pay rate for nurses for specific visits then they may not accept the visits and no one will take the case.

Robert Haze, Desert Orthopedic Center	2	Related to "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": Many commercial insurances reimburse below Medicare rates and sometimes below Medicaid. This makes care delivery in an ever increasing cost environment difficult. Is there a way to require them to provide coverage at or above basic government coverage?
Kira Green, Revive Health Senior Care Management	3	Improved Reimbursement Rates: Increase Medicaid reimbursement rates to enable facilities to offer more competitive salaries. Higher compensation would help attract and retain qualified nursing staff, ultimately improving patient care and satisfaction.
Sara Peterson, Genesis Counseling	4	Insurances should allow reimbursement for counseling sessions conducted by graduate student interns under the supervision of the onsite supervisor. The absence of reimbursement places a financial hardship on clients who cannot pay cash. It also reduces the amount of counselors available to lighten the burden of an overwhelmed mental health community. Also, students do not receive needed hours to graduate because facilities cannot provide pro bono therapists to supervise unpaid or low rate sessions. We need more graduating clinicians to assist with the overwhelmed burden and lack of clinicians.
Cory Pearce	5	United Healthcare seems to pretty much a monopoly on third party payment. Most decent behavioral healthcare providers go cash pay, precluding many people from getting treatment. I also wonder if the high number of Medicaid recipients prevents them and others from paying a decent commercial rate. Providers are prevented from refusing to see people because of low reimbursement, preventing feedback to UHC that they need to raise their reimbursement rates. That should change to put a price mechanism back into the system.
Amia MulHolland	6	As master's level clinicians, mental health therapy reimbursement rates and salaries need to mirror other master level clinicians.
Peter Bekas, Relevium Pain & Fort Apache Surgery Center	7	Commercial insurance rates in Las Vegas are very low, it is hard to recruit physicians when other places pay more because they have higher reimbursements. Most contracts are below Medicare rates. These low rates mean that physicians need to balance spending time with patients and seeing a lot per day to pay for higher expenses (rent, labor, medical supplies).
Andrew Freeman	8	Work to provide sustainable Medicaid rates that are in the 80-90th percentile of reimbursement for procedures across all types of Medicaid plans (including HMOs, not just FFS) in the US.
Lindsey Harmon, Planned Parenthood	9	Medicaid rates in Nevada are universally low. The PPC should consider Medicaid expansion or a Reproductive Health program like FPACT. The volume of self-pay patients is truly hurting NV. Patients cannot access basic Reproductive Health services due to the lack of coverage which results in higher STI rates, unplanned pregnancies, maternal mortality and morbidity.

Annette Logan, Cure 4 The Kids Foundation	10	Competitive Medicaid Reimbursements: Advocate for competitive Medicaid reimbursement rates that reflect the cost of providing care and attract more providers to serve Medicaid patients. Advocate for Reform of the Nevada Physician Administered Drug Fee (PAD) Schedule. The new Nevada PAD Fee Schedule determines reimbursement rates based on the lesser of Nevada Medicaid's PAD Fee Schedule or the Medicare Part B Fee Schedule. If a drug is not listed in either schedule, reimbursement is determined based on other unspecified criteria set by the state. This shift away from using national benchmarks like WAC and AWP has led to lower reimbursement rates and significant financial challenges for physicians' offices (DHCFP_NVGov) (US Pharmacist).
Rande Paige, Legacy Health and Wellness	11	We recommend #4 - Identifying sustainable funding strategies for strengthening the state's healthcare workforce, which includes supporting competitive Medicaid reimbursements. It is believed that addressing this issue would address more than just this particular issue and positively impact the other foci listed. The cost of living and associated demands of employable individuals in the workforce are disproportionate and as a result, individuals currently employed are having to do more because the reimbursement rates do not allow companies to hire the workforce needed to provide care and services without lowering the standard of care or going out of business. Healthcare companies would struggle less to provide the services needed. With the current reimbursement, the quality of candidate is significantly impacted by what companies can pay. It is difficult to provide excellence in services with a Cadillac demand and a Pinto budget.
Toni Inserra, South Lyon Medical Center	12	Nevada offers so many great opportunities and beautiful diverse lifestyle, we need to be one of the first states that attract health care workers not one of the last. Without easier licensing and fair reimbursement from insurers and state programs, more providers will not only refuse to accept Medicaid and Medicare Advantage programs but will eventually relocate.
Robert Johnson, BCBA, LBA, Nevada Behavior and Autism	13	We provide behavioral assessments and treatment one-on-one with children with autism. One of the most valuable services we also offer is parent training. The CPT billing code for parent training is 97156. Parent training helps parents gain the skills needed to provide in-home therapy and to have the tools to meet the behavioral and communication challenges of their child. We strive to provide one hour of parent training to each client per month. I'm a BCBA (Board Certified Behavior Analyst.) My company has two BCBAs and three BCaBAs (Assistant Behavior Analyst) on staff. Many payors allow parent training (97156) to be performed by a BCaBA. Medicaid in many states allow 97156 to be performed by a BCaBA. However, Nevada Medicaid only allows parent training to be performed by a BCBA. Our BCBAs are very busy with clients. Thus, too many families are not receiving the benefit of parent training. Allowing BCaBAs to perform this valuable service and be reimbursed by Medicaid would be very helpful.

Shawna Ross, Sierra Therapy Group	14	I am here to make a comment regarding speech-swallowing codes that are not being reimbursed through Nevada Medicaid. The following CPT codes are currently reimbursed at $0: 92612 (Flexible firberoptic endoscopic evaluation of swallowing/FEES), 92511 (nasopharyngoscopy with endoscope), and 31579 (diagnostic laryngoscopy with stroboscopy). It is our understanding that these codes are included in the Medicaid fee schedule but are reimbursed at $0 for Speech-Language Pathologists. Physicians will be reimbursed for these codes; however, it is reported in Southern and Northern Nevada that physicians are not completing these procedures which is presenting a barrier to care. It is also difficult to recruit/employ a robust workforce when receiving payments of $0 for the highly skilled work. These codes are within the scope of practice for Speech-Language Pathologists and are reimbursed under other insurance plans. With the written comment, I have included a joint letter that was submitted to Medicaid on November 8, 2023 by the American Speech-Language Hearing Association (ASHA) and NSHA. We ask that legislators support these requests in the budget and with any policy changes needed in the 2025 session. We are happy to provide any additional information and look forward to hearing how we can continue to advocate for these changes. We appreciate the consideration.
Katie Allen, Nevada Speech – Language Hearing Association	15	1. Advocate for an immediate increase in Medicaid, Medicare, and private insurance reimbursement rates that accurately reflect the cost of providing services, inflation, skill level, and the increased cost of living. 2. Support legislation requiring annually increasing adjustments to reimbursement rates to account for inflation, skill level, and cost of living increases. 3. Encourage greater accountability from insurance companies by implementing measures to ensure the following: ● accurate and timely information regarding patient eligibility and benefits ● transparent reimbursement practices that support the No Surprises Act ● reduce or eliminate prior authorization burdens for providers ● a process for providers to hold payers accountable that includes penalizing insurers for incorrect claim processing
Jeanne Bishop-Parise, Retired: 1984 NFA Nv License #506 signed by #2 and #4; Retired: currently HSE #3 NV	16	Getting our Medicaid Rates to reasonable and our workforce to stable without agency has to be our priority.
Offer Loan Forgiveness and Tuition Assistance		

Jeremy Gallas	1	I would like to make the following recommendation regarding the recruitment and retention of our healthcare workforce. Student loan forgiveness should be extended to providers in the private sector accepting assignment of patients from both Medicare and Medicaid, and potentially active-duty service members covered by Tricare. This should apply to both rural and urban areas. There could be criteria based on minimum annual hours served or procedures done, tracked by the provider's unique NPI. In our underserved communities, many independent mental health providers are able to thrive seeing private pay clients only. They can earn more and are insulated from the obstacles of billing insurances. Modern healthcare-related events like the recent hack of Change Healthcare make working with HMOs even less appealing. While employed in settings that already qualify for loan forgiveness, mainly universities, I did not serve the community as directly and to the degree that I have in private practice. Additionally, because of the lack of providers at the Airforce base, universities, etc., we wind up treating the sub-populations that exceed their capacities. Thank you for the opportunity to share my idea.
Andrew Freeman	2	Provide loan forgiveness options for providers who choose to live and work rurally. While there are federal options, the state should consider state level options that supplement the federal options. Something along the lines of $25,000 per year ($20k for loan payments, $5k towards additional taxes & tax preparation) that is renewable in 2 year increments until student loans are paid off. Incentive rural students to attend healthcare or healthcare related fields with upfront tuition payments in return for service in rural communities (e.g., medicine, nursing, nurse practitioner, physician assistant, occupational therapy, speech therapy, physical therapy, marriage and family therapy, social work, professional counseling, & clinical psychology). Consider modeling it after the contracts the military uses to fund medical education.
Lindsey Harmon, Planned Parenthood	3	The loan repayment program from the treasurer is a great program! BUT the qualifications for providers are too rigid. It should be less important that the Health Center is located in the marginalized community census block and more important that the HC can prove they are treating patients from those census blocks (regardless of if they are enrolled in Medicaid).
Annette Logan, Cure 4 The Kids Foundation	4	Loan Repayment and Scholarship Programs: Expand loan repayment and scholarship programs for medical, nursing, and allied health professionals who commit to working in underserved areas and underserved specialties.
Natalie Gautereaux, Nevada Public Health Foundation	5	Increase opportunities for paid internships and/or stipends for travel and expenses, and scholarships for rural placements; and modify policies and NRS to include bachelor and master level social workers in the state loan repayment program
Nevada AHEC Program	6	Future Support with Adequate Resources: With adequate resources, AHEC can further develop and expand its efforts to recruit and retain a more diverse healthcare workforce. Examples include: • AHEC can offer scholarships, stipends, and tuition reimbursement programs specifically aimed at underrepresented minorities in the healthcare field. These financial incentives can help attract a more diverse pool of medical students and residents.

		• AHEC can establish mentorship programs that connect diverse medical students and residents with experienced healthcare professionals from similar backgrounds. This support can help retain minority students by providing guidance, encouragement, and career advice. • AHEC can formalize their current collaborations with healthcare organizations and industry partners to create internships and job placement programs. These partnerships can help ensure that diverse graduates have opportunities to start and advance their careers in Nevada. • AHEC affiliated program (Nevada Health Service Corps) support and possible Scholarship portion of this program.
Jeanne Bishop-Parise, Retired: 1984 NFA Nv License #506 signed by #2 and #4; Retired: currently HSE #3 NV	7	Scholarships / Tuition Forgiveness (like the Americorp program)
Offer Competitive Compensation and Incentives		
Nichole Nelson, Productive Homecare Services	1	Pay increase for the healthcare workers (Personal Care Aides)
Diane McGinnis DNP APRN FNP-C, McGinnis MICA Medical PC	2	Some sort of rural healthcare provider bonus? When I see my rural patients, I am basically volunteering my time. What I mean is that it is a 4 hour round trip, and when I get there, I do not often have a full schedule, vs if I stayed in the urban area where I currently live I would have a full schedule including during those 4 commuting hours. I am not sure how this would look, just presenting the idea.
Giovanni F. Margaroli, At Home Solutions	3	Attracting and retaining talent to address health care workforce challenges in urban and rural communities; Attractive salaries, mileage reimbursement, holiday pay etc (overtime pay when lack of PCAs and you need to service a client, current OT pay for PCA is 24/hr, agency gets 25/hr ..... not making any sense), create categories for level of care, the higher the level of care the higher the reimbursement hence the higher pay for the caregiver.
Annette Logan, Cure 4 The Kids Foundation	4	Incentive Packages: Develop comprehensive incentive packages, including housing allowances, signing bonuses, and relocation assistance for health care professionals in high-need areas. Implement value-based payment models that incentivize and reward providers for delivering high-quality, cost-effective care. Encourage the adoption of performance metrics that focus on patient outcomes and satisfaction.
Monitor the Effectiveness of New and Existing Programs		
Toni Inserra, South Lyon Medical Center	1	Our state representatives need to look closely at current programs to see if they are under producing. Investing in those programs that truly make a difference and are successful should be a priority.

Annette Logan, Cure 4 The Kids Foundation	2	Data-Driven Evaluation: Establish a framework for evaluating new and existing state investments in health care workforce initiatives. Use data analytics to assess the effectiveness of programs and make informed adjustments as needed. Regular Reporting and Accountability: Implement regular reporting requirements for funded programs to ensure transparency and accountability. Engage stakeholders in the evaluation process to gather diverse perspectives.
Germelyn Torio, Silver State Hospice inc DBA: Elite Hospice Aces Home Health Services Inc	3	Comprehensive Workforce Analysis: Conduct a thorough analysis of current workforce trends, including shortages in various healthcare professions such as physicians, nurses, allied health professionals, and mental health providers. Identify specific geographic areas within Nevada that are experiencing the most significant shortages, considering both urban and rural regions.
Rande Paige, Legacy Health and Wellness	4	An example of a strategy would also be an analysis of programming that demonstrates a large output of funds with little by way of measurable outcomes. One such program we suggest is a review of the tier program for behaviorally complex individuals. Originally designed to provide additional services to these behaviorally challenging individuals, there were no clear checks and balances to ensure this occurred built into the program. As a result, these stipends/incentives to SNFs have become monetized as a part of their budget with no, or few services being provided. Millions of dollars are being spent with no true accountability or audit controls in place and it is being abused. The money pouring out to SNFs has done very little by way of doing what was initially proposed. As a result, the facilities are at a staff deficit AND dealing with the challenges of caring for these complex individuals. Reallocating funds through a reform of this program with the inclusion of compliance standards would likely free up significant funds to sustainably increase wages, decrease burnout and entice employable providers. This is just one example of a strategy that could make a difference.
Nevada AHEC Program	5	Instead of creating new programs from scratch, a more effective approach could involve bolstering funding for the established programs. This would enable them to expand their reach and impact. Additionally, increased funding would facilitate the implementation of robust tracking mechanisms to longitudinally monitor participants' progress and evaluate the long-term impact of these programs. This includes tracking educational outcomes, job placements, and career trajectories of graduates in areas of high demand within the healthcare sector. Area Health Education Centers (AHEC) can play a pivotal role in supporting and expanding these initiatives. AHECs have a proven track record of connecting educational institutions with healthcare providers, offering mentorship programs, and facilitating clinical experiences for students. By enhancing partnerships with AHECs, existing healthcare career academies in Nevada can gain access to a broader network of resources, mentorship opportunities, and potentially additional funding sources. AHECs could also serve as their talent acquisition partner aiming to place students into experiential learning opportunities and/or directly into jobs.
Access to Care		

Toni Inserra, South Lyon Medical Center	1	Cost based reimbursement for rural facilities for all state and federal insurance products is critical. Funding strategies should include a formidable vetting process for all applicants on federal programs. There is no doubt there is a need for state and federal assistance for citizens at different times in their lives. Ensuring that the funds are being allocated to appropriate individuals is vital. There is unquestionable abuse of participants of the Medicaid program. A significant amount of funds could be saved by ensuring those who truly need the assistance are the ones eligible.
Nichole Nelson, Productive Homecare Services	2	Allow more services to the recipients/clients such as Companion Care which is highly needed, increase in Medicaid hours for recipients/clients
Jennifer Mckinnish	3	In Nevada pay the parent caregivers who are forced to be the parent and caregiver due to no choice of their own and lack of community supports, primarily profound autism. We parents in this situation are forced to live at poverty level confined both by the inability to work outside the home or find remote careers and by the income restrictions placed by SNAP SSI and other assistance programs. When you are a parent and caregiver the job never ends, you become bookkeeper, mother and father, advocate, maid, scheduler, chef, all without support or breaks. If you would like a detailed list of things involved with this position, I can provide one. The level of exhaustion and defeat is a level that most cannot understand. Essentially without money you cannot find respite or nannies or specialized programs. Palco will pay anyone, but the parent thing is most of us in a position such as mine don't have that family and friend circle to seek help from.
Diane McGinnis DNP APRN FNP-C, McGinnis MICA Medical PC	4	Additional to this EMS suggestion, is a way for Medicaid patients who ARE transported out of town via ambulance or fixed or rotor wing to get a ride home. A taxi or an Uber or Lyft for an hour or two is not in the budget. Many patients do not call EMS because they are afraid they can't get home again. So, they wait until there situation is very critical instead of participating in preventative care, or early interventions.
Giovanni F. Margaroli, At Home Solutions	5	Improving access to primary care and public health services; Clearer direct websites, not searching from page to page. elderly hardly use a computer and get confused.
Natalie Gautereaux, Nevada Public Health Foundation	6	Include both non-clinical and clinical social workers as part of a multidisciplinary approach to provide a more comprehensive and holistic approach to patent care and address needs at the lowest level of care.
Travis Shaffer	7	Overhaul the MCO system and limit financial incentives for them to limit patient care- especially pertaining to mental health case rates that encourage unsafe and early discharges and limit access to care while financially incentivizing MCOs
Lindsey Harmon, Planned Parenthood	8	In order to incentivize provision of services, prioritize same day access, not quality metrics like VBC i.e. Prob 56/FPACT type programs (but set up better).
Toni Inserra, South Lyon Medical Center	9	Nevada needs to review its plan to convert to 100% managed care Medicaid. Managed Care Medicare has proven to be an obstruction for patients, providers and facilities, not only in attempting to get authorization, but then to successfully submit claims for payment. Private providers have dropped many of the Managed Care Medicare products within their practices. With managed care Medicare having a failing track record, currently

		private providers are also dropping Medicaid. This process does exactly the opposite of the state's mission to improve access to healthcare. Without thoughtful and detailed guidelines, this will continue to reduce access to healthcare for those patients that may need it most. Nevada has a critically low number of specialty providers, and the managed care process has only made that problem worse.
Annette Logan, Cure 4 The Kids Foundation	10	Telehealth Expansion: Continue to expand telehealth services to improve access to care, particularly in rural and underserved areas. Ensure robust telehealth infrastructure and training for providers.
Ken Kunke, PharmD Nevada Pharmacy Alliance	11	Introduce a bill that would require Pharmacy Benefit Managers (PBMs) operating in Nevada to obtain a license and follow specific policies designed to lower out-of-pocket costs and maintain access to prescription medications for patients. The overwhelming majority of the prices paid at the pharmacy counter are based on price points established by PBMs. To protect patient's out-of-pocket medication costs and access to care, transparency must be established through statute.
Education and Training Programs		
Andrew Freeman	1	Provide sustainable long-term grants to local universities so that they can expand training of new clinicians. Focus on high return on investment professions first. For example, invest in master's level marriage and family therapy, social workers, and professional counselors over clinical psychology programs. Invest in physician assistant and nurse practitioner programs. Each additional faculty that this money awards should be calculated against a return on investment for the community over a specified period of time (e.g., 4-5 years).
Annette Logan, Cure 4 The Kids Foundation	2	Rural Training Tracks and Residency Programs: Increase the number of rural training tracks and residency programs to encourage medical students and residents to practice in rural communities.
Natalie Gautereaux, Nevada Public Health Foundation	3	Develop stronger education paths for social workers pursuing careers in medical social work, children's mental health, family services, the justice system, aging and disability services, and family services, especially those with inclusive backgrounds from rural and frontier communities
Nevada AHEC Program	4	Train interprofessional teams who collaborate with protocols and collaborative agreements to deliver optimal therapies using each professional practicing at the top of their license with appropriate supervision and safety. Implement-outcome based payments and value based payments for care teams and reduce the proportion of payments based on fee for service administratively complex processes.
Nevada AHEC Program	5	Medicaid Match for GME: • States should provide a match to enhance GME funding. • Establish a dedicated Medicaid match GME fund to support the expansion and sustainability of residency and fellowship programs. Start-up and Ongoing Support Funds: • Allocate start-up funds and ongoing support funds to state institutions to foster the development and maintenance of GME programs. Allocate some of the funds from opioid settlements and cannabis taxes to sustained funding of new and expanded graduate medical education residency and fellowship programs to expand our workforce in shortage

		specialties. The funds must be used to remediate the harms of the opioid epidemic, so there could be an opportunity to fund GME funds to build out residencies for substance abuse treatment providers. As it relates to the cannabis tax, per NRS 372A.290 this money is split (75/25) between the Distributive School Account (DSA) and the State General Fund. Allocate from the state general fund, if applicable.
Jeanne Bishop-Parise, Retired: 1984 NFA Nv License #506 signed by #2 and #4; Retired: currently HSE #3 NV	6	1. Have more Signature High Schools for LTC and affordable Post Secondary Education Programs for Caregiver/Med Techs and Certified Nursing Assistants, LPNs, and Culinary Health Care Positions as well as Community Health Aides. We need to get more in the pipeline to fall in love with Long Term Care facilities knowing that those non-degree work force positions are 90% on our workforce, not the college graduates. (If students choose to then pursue a career as an RN, Therapist, or Dietitian it increases the likelihood that they will stay in Long Term Care, despite the disparity in wage and benefit packages that high revenue hospitals and specialty clinics afford these positions.) 2. Have RFFGs be internship sites. (Park Place had Cal State Northridge Pharmacy Interns as well as UNR Orvis School of Nursing 2nd semester Clinicals.) 3. Have RFFGs be college practicum sites where the upper classmen proctor the Freshmen, Sophomores and Junior Transfer students. 4. University of Nevada System has failed us and needs a major overhaul. They have not been held accountable to have a proportionate increase in nursing, health science or medical graduate program enrollment size since the 1980's when I went out of state for my training and internship. The PA program has only 24 openings, the Physical Therapy Program only 48 openings. So we lose Nevada's best to nearby programs in Idaho, Arizona, or California. I applaud Renown for subcontracting with Grand Canyon University so that my Stagecoach niece valedictorian and childhood sweetheart husband both returned from Boise State Nursing with Cook's Hospital Residency in Texas so that they could do their Masters while working - geriatric acute specialty for Jack just completed. 5. Career Fairs/Speakers in Middle School using AHCA (NvHCA/NCAL) collateral materials 6. Expand Community College or Career College Associate Programs for LPN, Pharm Tech, Maintenance, Dietary Services 7. Increase number of Voc Tech Programs in state 8. Practicum experiences for High School and Community College with Proctor Students (background checks/TB one step) in RFFGs. 9. Expand Partners in Education Program as other states have to grow out a Partners in HEALTH CARE Education (Reno Ortho Clinic ROC mentored trainers at area High School / College Sports.
Nevada AHEC Program	7	AHEC, due to our vast partnership network, has the ability to serve as a strong partner to help strengthen partnerships with healthcare providers and organizations in rural and underserved areas to create sustainable workforce solutions. By working collaboratively, AHEC can facilitate the placement of healthcare professionals in areas of need and supports them with mentorship, continuing education opportunities, and professional development.

Nevada AHEC Program	8	BeHERE The Behavioral Health Education, Retention, and Expansion Network of Nevada (BeHERE NV) is a new workforce development initiative to increase the number of providers of behavioral health care in Nevada. BeHERE NV will focus on growing a diverse mental health workforce to care for Nevada's diverse population. In 2023, the Nevada Legislature unanimously passed Assembly Bill 37 to create a statewide behavioral health workforce development center within the Nevada System of Higher Education (NSHE). Opportunity to increase funding to the Nevada AHEC Program, working alongside BeHERE, focusing on primary care and other healthcare disciplines.
Provider Wellness and Mental Health		
Natalie Gautereaux, Nevada Public Health Foundation	1	Support Social Workers' occupational wellness through enhancing programs promoting awareness, evaluation, mentorship, and ongoing training.
Nevada Physician Wellness Coalition (NPWC) and the Nevada Chapter of the American College of Physicians (ACP)	2	We suggest the following revisions to NAC 679B.0405: • Amending number two by adding a part (c) which states: May not include prohibited application questions. An application for provider credentialing must not: 1. require the provider to disclose past health conditions; 2. require the provider to disclose current health conditions, if they are being treated so that the condition does not affect the provider's ability to practice medicine; or 3. require the disclosure of any health conditions which would not affect the provider's ability to practice medicine in a competent, safe, and ethical manner. • Add regulation to include: Each insurer, carrier, society, corporation, health maintenance organization and managed care organization [*as of the date this is accepted*] shall amend its licensure, certification, and registration applications to remove any existing questions pertaining to mental health conditions and impairment and to include the following questions: 1. Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No) and 2. Do you have any mental or physical condition that currently impairs your ability to practice medicine or to exercise the particular privileges that you have requested? If so, do you believe that, with reasonable accommodation, you will be able to provide safe, competent medical care meeting the standards of your particular specialty and the specific privileges and status that you seek?" 3. Rather than asking questions about disclosure of a past substance use disorder using: "Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."

		• Add regulation which states: Each insurer, carrier, society, corporation, health maintenance organization and managed care organization must submit their copy of this form that they are using annually to [email they will be directed to] to ensure compliance with the above referenced requirements. Include words and terms as the final item of the regulation.
Nevada Physician Wellness Coalition (NPWC) and the Nevada Chapter of the American College of Physicians (ACP)	3	We recommend the state provide financial support as a state line item in the budget for an autonomous and independent 501c3 that supports physician wellbeing initiatives, specifically the Nevada Physician Wellness Coalition. This will support critical aspects of healthcare, safety and quality outcomes by focusing on the well-being of physicians throughout the state with the intention of retaining physicians, growing our physician workforce, and keeping physicians practicing at full time capacity for longer into their careers.
Other		
John Phoenix, Huntridge Family Clinic	1	Enact shield laws for those who provide gender affirming care to the LGBTQ+ community, similar to the law passed in 2023 for reproductive health care providers.
Diane McGinnis DNP APRN FNP-C, McGinnis MICA Medical PC	2	for RURAL and URBAN areas: Ability for Ambulances to transport to a clinic of patient choice and get paid (may not have physician staffing-might be an NP staffing the clinic). If rural allow EMS to stay in their town instead of having to transport a "stubbed toe" to an ER hours away. Save Medicaid money as longer ambulance transports are paid a higher fee. Better for Patients if they do not have to leave their town for minor issues, better for volunteer EMS providers that they stay in their area in case there are more emergency patients that need transport.
Diane McGinnis DNP APRN FNP-C, McGinnis MICA Medical PC	3	I would like to see a provision for development and pay for a Community Health Aid Provider program like Alaska has for its rural villages. Maybe contract with Alaska to "lease" their already well-established program? Including: medical, dental and behavioral health.
Rosvi	4	Promote and establish providers' conscience rights and moral standing when practicing medical care in Nevada.
Peter Bekas, Relevium Pain & Fort Apache Surgery Center	5	High medical malpractice insurance cost. New laws make Medmal premiums more expensive for coverage and to operate. This is going to make it harder to bring new physicians to the Valley.
Annette Logan, Cure 4 The Kids Foundation	6	Integrated Care Models: Promote integrated care models that combine primary care, behavioral health, and public health services to provide comprehensive care and improve health outcomes. Alternative Payment Models (APMs): Support the adoption of APMs that promote care coordination, preventive services, and efficient use of health care resources.
Annette Logan, Cure 4 The Kids Foundation	7	Develop public-private partnerships to fund health care workforce initiatives, leveraging resources from both sectors to maximize impact.
Germelyn Torio, Silver State Hospice inc DBA: Elite Hospice Aces Home Health Services Inc	8	Stakeholder Engagement: Engage with key stakeholders including healthcare providers, professional associations, educational institutions, state agencies, and community organizations to gather insights and

		perspectives on workforce challenges and potential solutions. Establish advisory committees or task forces comprised of diverse stakeholders to provide ongoing input and guidance throughout the process.
Nevada AHEC Program	9	Address root causes that lead to health professionals serving in rural settings and underserved health professional shortage areas. The factors influencing where physicians choose to practice can be quite complex and multifaceted. Here are some key factors identified through research: 1) Personal Background: Physicians who graduate from a rural high school are significantly more likely to practice in a rural setting. 2) Family Considerations: Support of and for a significant other is often the most important factor in choosing a practice location. Employment opportunities for spouses and quality of life for the family also play a crucial role. 3) Financial Incentives: These can include salary, benefits, loan repayment programs, and cost of living considerations. 4) Career Development: Opportunities for professional growth, continuing education, and advancement within a practice or health system are influential. 5) Work Environment: A professional work environment that offers autonomy, a manageable workload, and supportive infrastructure and staffing is attractive to physicians 6) Community Needs: The desire to serve in underserved areas, whether rural or urban, can motivate physicians to practice in specific locations. 7) Scope of Practice: The ability to practice to the full extent of their training and expertise is important for many physicians. 8) Lifestyle Preferences: Recreational opportunities, community culture, and overall quality of life are significant factors for many practitioners. 9) Medical School and Residency Experience: The training environment and experiences during medical school and residency can influence practice location choices, with some programs focusing on preparing students for rural or underserved area practice. 10) Community Integration: Factors such as community size, demographics, and the presence of other healthcare providers can influence a physician's decision.

Jeanne Bishop-Parise, Retired: 1984 NFA Nv License #506 signed by #2 and #4; Retired: currently HSE #3 NV	10	1) Public/Private Partnerships & Resources: With whatever solutions we put in place we should not ""throw money at it"" or ""create additional government positions"". There are so many nonprofit options and faith-based organizations that could do the ""heavy lifting"". 2) Drop Caregiver Age from 18 to 17 so High School Students can do training and be employed at 17. NAC 449.196 Personnel Files 449.200 2(b). (Both my sister and I graduated at 16 and 17 years of age as well as her daughters from remote Single A High Schools.) 3) Have the RFFGs be the clinical training sites for Certified Nursing Assistant Programs. (They don't have the Quality Indicator restrictions imposed by CMS and RFFGs are in all rural and urban settings.) I directed Park Place for 10 years before retirement. It was in closest proximity to UNR. The Seniors loved the UNR students and helping to raise up the next generation. 4) Modify Nurse Apprentice Program to LPNs in settings that don't ""staff"" with RNs but have oversight required by Nurse Practice Act with RN(s) hired for that program. 5) Displaced Homemaker Re-entry programs for second career or later career when children older 6) Recruit by sharing materials at 10 year and 20 year High School Reunions 7) Recruit by sharing materials with Veterans and Homeless networks. Life happens and some of my best staff were hired, trained and pulled out of poverty. 8) Develop a Prospective Interim Payment for 90% In-House Pending Medicaid residents could work with an imprest account established through either taking some unused ARPA funds or ""average annual Medicaid approvals"" payout to establish. Then it replenishes as the Medicaid pendings are approved and restored to the account. 9) Redeterminations were pushed out through COVID waiver from annually to biennially and could stay there. Some states abbreviate that whole redetermination process or don't do it at all. 10) Cost of Living Increases and appropriate Health Care specific Indexers need to be built into program. 11) The Divided Income Trusts are burdensome and since the 90's more need to have them. They should NOT have to route through the Attorney General's Office for approval. Can there be Certified Eligibility Specialist attorneys instead? 12) Folks have gotten good at once again diverting assets to meet the look behind period requirements. With computers and everything set up by Social Security Number or Tax ID number, can we extend the look behind period? Also, I found that Veterans Aide and Attendance applications allow for homes to be ""sold for $10"" to family which then is not allowed by Medicaid so the person will either be denied, pended, or penalized. So, consistency in state/federal programs needed. 13) Other states are doing auxiliary grants up to $2500 to low income which makes Residential Facilities for Groups (RFFGs) affordable in some business models. And, with the grant vs. Medicaid daily rate that Nv Medicaid uses, providers don't worry about NONPAID DAYS when the resident is either on Medicare in Hospital or Skilled Nursing Facility while living in the RFFG. Some of the smaller group homes that participated in Medicaid for the first time had to return those monies to the state or be subject to Medicaid Fraud charges.

		14) Other states allow for residents that have paid the private RFFG rate for 4-5 years to qualify for Medicaid and age in place at their current facility receiving Medicaid payments or grants without the facility having to open up to all Medicaid's. 15) Change the 1-6 staffing ratio in RFFG secure Memory Care. This exceeds any other state's requirement. Our state's SNF's Memory/Behavioral secure units have no staffing ratios mandated. In other state's RFFGs 8-12 to one staff is the norm if there is a staffing mandate. 16) With growing need for Behavioral Mental Health Care, I foresee that SNFs and RFFGs will be front-runners once again providing a model for CBLAs with available mentors for operations. 17) It seems that too many of the bills and the American Rescue Funding were politically parlayed and did not solve our industry's exacerbated problems from COVID-19 era.
Anne-Elizabeth Northan, Join Together Northern Nevada	11	Development and contents of policy for prevention of substance misuse and substance use disorder in certain grades; duty of Department in collaboration with Nevada Prevention Coalitions as defined in SB 69 to develop model policy; posting of link to Internet website of Coordinator of Statewide Program for Substance Abuse and Treatment Agency (SAPTA) 1. The board of trustees of each school district, the governing body of each charter school that provides instruction to pupils in grades K to 12, inclusive, and the governing body of each university school for profoundly gifted pupils shall, in consultation with pupils, parents or guardians of pupils, school employees, persons who provide mental health services to pupils, persons and substance misuse prevention coalitions defined in SB 69 and other interested persons and entities: (a) Adopt a policy for the prevention of substance misuse in grades K to 12, inclusive; and (b) Review the policy at least once every 5 years and update the policy as necessary. 2. The policy adopted pursuant to subsection 1 must include, without limitation: a. Upstream prevention measures that address risk and protective factors present in school climate. b. Trauma informed schools' implementation plan. c. Develop Education Standards related to Prevention Programming d. Institutionalize a recognized prevention Framework. e. Procedures for the prevention of substance misuse and a tiered intervention response with pupils identified at risk. (b) Procedures for outreach to persons and organizations in the community in which the school is located, including, without limitation, Substance Misuse Coalitions serving the state of Nevada as defined in SB 69, religious, community-based, and other nonprofit organizations, that may be able to assist with the collective prevention of substance misuse in schools. (c) Required training for teachers, pupils and families concerning the prevention of substance misuse. Such training: (1) Must include, without limitation, instruction content including: (I) Appropriate mental health services at the school and in the community in which the school is located and when and how to refer pupils and their families for such services; and

		(II) Trauma-Informed Schools (III) Adverse Childhood Experiences mitigation with Positive Childhood Experiences. (IV) Evidence Based Programs, practices, and policies specific to substance misuse prevention. 5. The Prevention Coalitions as established in SB69 shall develop a model policy on the prevention of substance misuse in grades K to 12, inclusive, to provide guidance to: (a) Boards of trustees of school districts and governing bodies of charter schools and university schools for profoundly gifted pupils in the adoption of policies pursuant to subsection 1; and (b) Governing bodies of private schools in the adoption of policies 6. The Department, each school district and each public school that maintains an Internet website shall post on the Internet website maintained by the Department, school district or public school, as applicable, a link to the Internet or network site maintained by the relative coalition/s serving each county.
Ken Kunke, PharmD Nevada Pharmacy Alliance	12	Introduce a bill that would require Nevada Medicaid Fee-For-Service (FFS) and Managed Care Organizations (MCOs) to use a single Pharmacy Benefit Manager (PBM) to serve as the state's third-party administrator. As the financial burden of healthcare increases, Nevada must pass legislation to protect patients and the state. PBMs processing claims for Nevada FFS and MCOs are unchecked, and their business practices lack transparency. PBMs have mismatched incentives, often prioritizing their internal profit over what is best for the state, patient, and plans. This bill aims to create transparency. Other states that have passed similar legislation have seen lower prescription healthcare costs since implementation.