# *Semi-Annual Report of the Patient Protection Commission*

## *July 2025*

Patient Protection Commission

(NRS 439.908)



**Joe Lombardo**
*Governor*
*State of Nevada*

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# I. Membership

## Voting 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***
***Dr. Mark Glyman***
*Two members who are persons with expertise and experience in advocating on behalf of patients.*

***Dr. Travis Walker***
*One member who is a physician or registered nurse who practices primarily at a federally-qualified health center.*

***Floriene Kahn***
*Representative of the General Public*

***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.*

***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.*

***Dr. Adam Porath***
*One member who is a pharmacist at a pharmacy not affiliated with any chain of pharmacies or a person who has expertise and experience in advocating on behalf of patients.*

## 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*

***Dylan Malmlov**, Policy Analyst*

***Meybelin Rodriguez**, Executive Assistant*

# II. Introduction

The Nevada Patient Protection Commission (PPC; Commission) is a public body located within the Executive Branch of state government. The PPC is comprised of 12 voting members and 4 nonvoting members 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 to the Governor and the Legislature 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.

# III. Meetings and Activities

Over the past six months, the Commission held three public meetings. The summary meeting minutes surrounding each meeting are attached for reference. For more information about these meetings and to view meeting materials, please go to: https://ppc.nv.gov/. Highlights of PPC meeting discussion and action items over the reporting period included:

- Overview of Nevada's Health Care Industry and Insurance Market
- Overview of AB 7 (2023) and Implementation Update Regarding Approved Regulation LCB File No. R173-24
- Update Regarding Nevada Health Insurance Claim Denial Data and Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance
- 83rd Legislative Session Update Regarding PPC Bills (SB29, SB34 and SB40)
- Review and Discuss PPC Policy Focus Areas for 2025-2026 Interim
- Discuss formation of certain subcommittees

# IV. 83rd Legislative Session

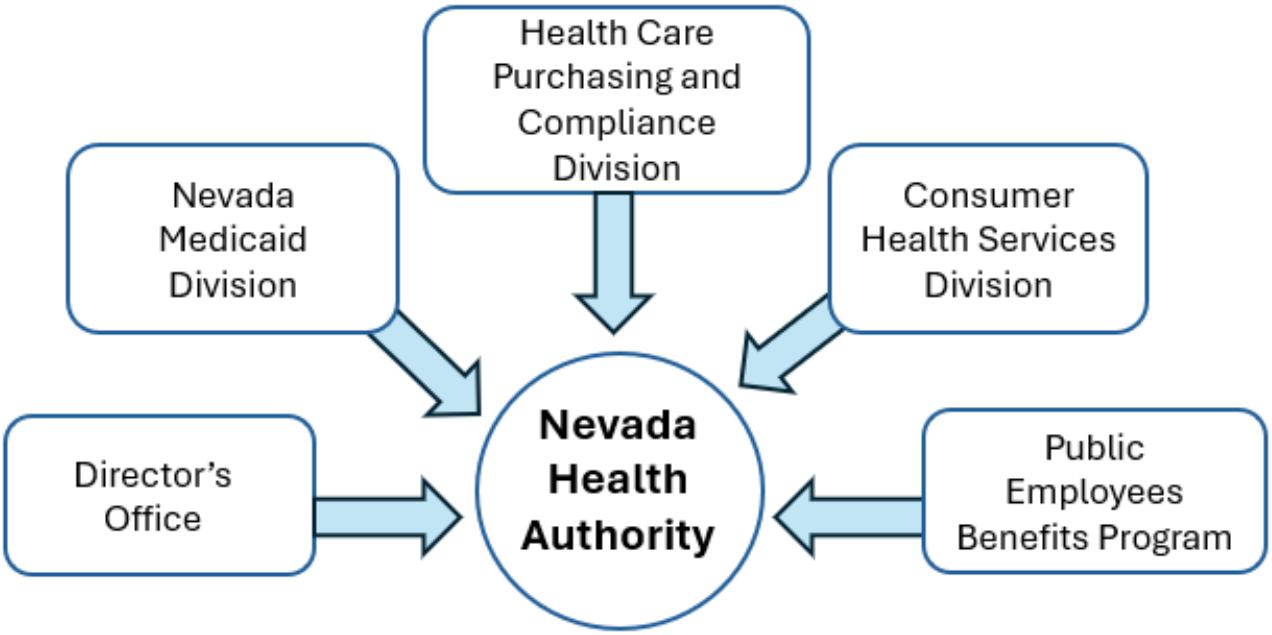
As part of the Commission's systematic review of health care, and in accordance with NRS 439.916.1(i), the PPC is responsible for reviewing proposed and enacted legislation, regulations and other changes to state and local policy related to health care in this State. The Commission's Executive Director and staff monitored hundreds of bills during the 83rd Legislative Session that relate to health care. This section of the report highlights a few bills the Governor signed into law that relate to the Commission's scope and will have substantial impact to Nevada's health care system.

## Nevada Health Authority (SB 494)

On January 15th, during the State of the State Address, Governor Joe Lombardo announced his recommendation to reorganize the Nevada Department of Health and Human Services (DHHS) into two distinct entities – the Department of Human Services (DHS) and the Nevada Health Authority (NVHA). SB 494 establishes the Nevada Health Authority, a new department with the mission to improve access to health care that is safe, of high quality and affordable. According to the Governor, by splitting DHHS, the State's largest agency, the State of Nevada is streamlining operations to better serve Nevadans. The DHS will be primarily responsible for providing direct care services through 4 of the 5 existing DHHS divisions (Aging and Disability Services, Public and Behavioral Health, Child and Family Services, and Welfare and Supportive Services, which will be renamed the "Division of Social Services"). The Division of Health Care Finance and Policy will transfer under the new NVHA and be renamed "Nevada Medicaid", which will provide much-needed clarity for consumers, simplifying their search for information and improving their overall experience. The new Nevada Health Authority is intended to capitalize on the broad and strong purchasing power of the State when it comes to health insurance. Along with Nevada Medicaid, the Silver State Health Insurance Exchange (SSHIX) and the Public Employee's Benefit Plan (PEBP) will be housed under the umbrella of NVHA. By doing so, the state is strengthening its

buying power with insurers to cut a better deal for taxpayers while offering better insurance options to 1 in every 3 Nevadans – Medicaid members, those enrolled in the exchange, and state employees. This will help the State better maximize public dollars and lower the cost of health care for the State by consolidating resources.

Under the reorganization, the Nevada Health Authority will consist of three new divisions: the Medicaid Division, the Health Care Purchasing and Compliance Division and the Consumer Health Division. The Authority will also include a Director's Office and the Public Employees Benefits Program as shown in the diagram below.




The PPC will be housed within the new Consumer Health Division, which will also consist of the Silver State Health Insurance Exchange, Medicaid Express, the Public Option, and Nevada's Graduate Medical Education Grant fund. SB 494 also transfers from the Governor to the Director of the Nevada Health Authority the responsibility to appoint the members and Executive Director of the Commission. The PPC's statutory authority and scope will remain the same as currently outlined within NRS Chapter 439.

## PPC Bills

Pursuant to NRS 218D.213, the Commission may submit up to three bill draft requests (BDRs) to the Nevada Legislature which relate to matters within its scope. In alignment with Governor Lombardo's Executive Order 2024-002, the Commission developed three BDRs intended to address the health care workforce needs of the state. The proposed legislation aimed to improve health care provider access, simplify the licensure process for health care professionals, and provide a higher return on state investments for healthcare workforce initiatives, including Graduate Medical Education (GME). 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.

Unfortunately, the PPC's bills Senate Bill 29, Senate Bill 34 and Senate Bill 40 were not considered by the 83rd Nevada Legislature and were among the bills that failed to meet the first committee passage deadline on Friday, April 11th. Although the bills failed to pass, several other pieces of legislation were adopted that align with the Commission's legislative intent and recommendations to simplify the licensure process for health care professionals, reduce provider

administrative burdens and provide state investments for healthcare workforce initiatives, including Graduate Medical Education (GME).

## Occupational Licensure

Nevada continues to rank below the national average when comparing the rate of health care professionals per capita. Occupational licensure compacts represent the gold standard of policy options for states to improve licensure portability and establish collective criteria for multistate practice. Interstate licensure compacts allow Nevada 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, including telehealth.[1]

Prior to the 83rd Legislative Session, the State of Nevada was a member of five occupational interstate licensure compacts, including compacts for physicians, psychologists, and emergency medical services.[2] 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 and increasing access to care. The PPC's SB 34 requested Nevada enact five additional interstate licensure compacts for physician assistants, nurses, occupational therapists, physical therapists, audiologists and speech-language pathologists. The bill also recommended a study be conducted regarding the impacts each compact had on increasing access to health care services. During the 83rd Legislative Session there appeared to be bipartisan support for interstate licensure compact legislation, and legislation was introduced from both Democratic and Republican lawmakers. Among the eight health care licensure compacts bills introduced during session, the following bills were enacted by the Legislature, and signed into law by the Governor:

- AB163: Enters Nevada into the Counseling Compact.
- AB230: Enters Nevada into the Audiology and Speech-Language Pathology Compact.
- AB248: Enters Nevada into the Physical Therapy Compact.

In addition to interstate licensure compacts, the following bills will have substantial impact to health care occupational licensure and aim to provide Nevadans with greater access to health care professionals:

AB483 was sponsored by the Joint Interim Standing Committee on Health and Human Services and requires certain health care licensing boards to develop a process to expedite the process by giving priority review status to the initial license application of an applicant for a license or certificate who demonstrates that he or she intends to practice in a "historically underserved community". The bill applies to licensing boards created by NRS Chapter 630 (Physicians, Physician Assistants, Medical Assistants, Perfusionists, Anesthesiologist Assistants and Practitioners of Respiratory Care), NRS Chapter 631 (Dentistry), NRS Chapter 632 (Nursing) and NRS Chapter 633 (Osteopathic Medicine). By expediting the licensure process for these health care professionals, Nevada will increase access to care and prioritize licensure and onboarding for providers who wish to serve in underserved areas.

SB 124 allows internationally trained physicians to practice healthcare in Nevada. Authorizes the Board of Medical Examiners to issue a limited license to practice medicine to a graduate of a qualified foreign medical school who meets certain criteria and possesses certain qualifications. This creates a pathway for physicians who graduated from a medical

[1] 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

[2] (National Center for Interstate Compacts Chart, 2024)

school and trained in other countries to hold a limited license and practice medicine under the supervision of licensed physician in certain facility types and settings. Once the holder of a limited license has completed at least two years of practice as a full-time physician and remains in good standing, the Board of Medical Examiners is required to issue an unrestricted license to this holder. The bills intent is to allow foreign medical school graduates to practice within Nevada with an unrestricted license in medically underserved areas and increase the physician workforce pipeline.

## Graduate Medical Education (GME)

The PPC's SB 40 failed to pass, but would have established a Medicaid Workforce Account within the Department of Health and Human Services (DHHS) and aimed to provide a higher return on state investments for Graduate Medical Education (GME). SB262 also seeks to invest in GME and identify sustainable opportunities to expand the physician workforce pipeline. The bill received strong bipartisan support during the legislative session and was signed into law by the Governor. The bill transfers oversight of the GME Grant Program from the Governor's Office of Science, Innovation and Technology (OSIT) to the Nevada Health Authority. It appropriates $4.5 million per year ($9 million total) in the next biennium to the account. Funding allocated to the GME Grant Program account does not revert to the state general fund. The bill prohibits an institution that receives a grant through the program from eliminating or reducing the size of the GME program without the review and approval from the Department. This will help promote the sustainability of GME programs funded by the state, and ensure the Department is notified when a program seeks to reduce or eliminate services and reduce access to care. The bill additionally transfers the GME Grant Advisory Council, which is responsible for evaluating GME grant applications and providing recommendations to the Department concerning such applications. Additionally, the Council, in collaboration with the Department, is responsible for making recommendations regarding how to create and retain more GME programs and physicians to meet Nevada's healthcare needs. This includes exploring ways to use federal financial participation in Medicaid to support GME programs and enhance access to care for Medicaid recipients.

## Health Care Workforce

Unfortunately, the Governor's "Nevada Health Care Access Act" (SB495) and the Senate Majority Leader's SB434 both failed to pass during the final days of the 120-day legislative session. As introduced, both bills similarly proposed the creation of a competitive grant program that must award grants for projects that address critical shortages in health care providers in Nevada. The bills required the Department of Health and Human Services to conduct a biennial health care workforce needs assessment, which includes a quantitative analysis of the health care workforce in this State; and compile a report of the results of the assessment. The last reprint of the SB434 appropriated $10 million to the grant program Account and the funding within the Account would not have reverted to State General Fund at end of each fiscal year. The bill imposed certain additional requirements for an entity to be eligible to receive such funding, such as securing matching funding (from federal source or other source) and in-kind services (infrastructure, healthcare staffing, services, research, etc.) that are equal to the amount of the award for a project. Both SB495 and SB434 align with the Commission's recent recommendation(s) to:

- Designate 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.
- Assess existing State programs and funded projects to ensure they are effective in enhancing the state's health care workforce.
- Ensure state investments in workforce initiatives have a high return on investment for the state.

Such efforts are critical to reducing unnecessary duplication of activities and maximizing the use of limited funding and resources to address the critical shortage of health care providers. The following bills were signed into law and will also have an impact on healthcare workforce development in Nevada:

- AB484 expands the data required to be collected by the Department of Human Services and compiled into the Health Care Workforce Database established per NRS 439A.116. The bill requires additional data regarding health care providers to include: 1. The sex of an applicant; 2. Any other jurisdiction where the applicant holds the same type of license; 3. Whether the applicant utilizes telehealth in their practice; and 4. The types of patients the applicant serves.

- SB165 seeks to recognize a new profession known as "behavioral health and wellness practitioners", offer scholarship opportunities, and allow students to complete training in their chosen behavioral health field within Nevada, thereby supporting behavioral health workforce development. The bill directs the Department of Human Services to use opioid settlement dollars from the Fund for a Resilient Nevada to reimburse Nevada state universities and colleges for the costs associated with providing scholarships for students seeking behavioral health and wellness degrees, and degrees for providers that supervise behavioral health and wellness practitioners. The bill also aims to establish an American Psychological Association (APA) certified internship program in the state which is a full-time capstone residency program required for psychology licensure. Currently, students specializing in child psychology must leave Nevada to fulfill this training requirement and this bill aims to eliminate this, by providing funding to the University of Nevada, Las Vegas (UNLV) to establish a pediatric psychiatry residency program.

- SB266: allows certain behavioral health professionals, including marriage and family therapists, clinical alcohol and drug counselors or a licensed or certified alcohol and drug counselors, to qualify for student loan repayment through the Nevada Health Equity and Loan Assistance Program. To qualify, providers must be actively licensed, certified or registered in good standing in Nevada and willing to commit to providing healthcare services in rural or urban underserved communities in the state for at least five years of full-time clinical practice.

## Pharmacy Benefit Managers (PBM)

- SB389 requires the Nevada Health Authority to select a single state pharmacy benefit manager (PBM) by January 1, 2030, to manage all prescription drug coverage for Medicaid and certain health benefit plans. It directs the department to establish methodologies for reimbursement rates, payment for prescription drugs, and benchmarks to assess drug cost data. The legislation also outlines specific duties and prohibitions for the pharmacy benefit manager and mandates that Medicaid managed care organizations contract with and utilize this PBM for the administration of pharmacy benefits, including requirements related to the coverage of drugs not listed as preferred.

## Consumer Health Assistance

- AB343 seeks to increase health care price transparency for consumers by codifying in Nevada law the federal CMS Final Rule for price transparency (Sect. 14(1)(a)and(b) ref. 45 CFR Sect. 180.60). The bill requires hospitals to publish a report of shoppable services, costs of services they provide, as well as require the Department of Health and Human Services to publish the list, ensure compliance and take any action against and impose fines for hospitals who do not comply. Any collection of medical debt while a hospital is knowingly out of compliance would be considered a Deceptive Trade Practice and therefore subject to NRS 598 penalty and civil actions. The Governor's Consumer Health Advocate and Office of Consumer Health Assistance (OCHA) would be required to assist patients with the filing of these claims.

### Prior Authorization and Insurance Claims

Prior authorization (PA) is a requirement by health insurance plans that mandates a health care provider obtain approval before prescribing certain medications or procedures. An insurance claim is a request for payment after services have been rendered. Within the PPC's January report, it recommended Nevada Medicaid review and streamline the health insurance PA process to address inefficiencies and unnecessary barriers to care. Specifically, the PPC suggested identifying and removing PAs required for services that are routinely approved and pose minimal risk of fraud, waste, and abuse. These requirements can add unnecessary administrative burdens for providers while delaying timely access to care for patients. Following the 83rd legislative session, several bills were signed into law by the Governor and align with the PPC's recommendations and aimed to reform prior authorization and insurance claim processes.

- AB52 requires payment of electronic health insurance claims within 21 days or within 30 days for non-electronically submitted claims. Requires information to be sent to providers regarding how to submit claims and how to appeal claim denials. The bill also requires insurers to submit annual report to Nevada Division of Insurance regarding number of claims failed to be paid timely. The bill exempts Nevada Medicaid and the Public Employee Benefits Program (PEBP) from these requirements. These measures aim to establish a reliable and prompt reimbursement system for healthcare providers, thereby fostering a conducive environment for the growth of medical practices and improving healthcare access for Nevada residents.
- AB463 requires insurers covering Medicaid, CHIP, and the public employee benefits program (PEBP) to post on their public websites a list of services that require prior authorization along with the clinical review criteria for these services. The legislation prohibits the requirement of prior authorization for emergency care and medically necessary services, and it prevents insurers from retroactively denying coverage when prior authorization was not required under the published policy at the time the service was provided. Additionally, the bill sets specific timeframes for responses, 48 hours for non-urgent requests and 24 hours for urgent requests, and mandates that both insurers and the Commissioner of Insurance periodically report on compliance and the outcomes of these provisions.

## V. Potential Medicaid Cuts

As of January 2025, 1 in 4 Nevadans (823,570 enrollees) received health care coverage through Medicaid. Nevada Medicaid works in partnership with the federal Centers for Medicare & Medicaid Services (CMS) to assist in providing quality health care services for eligible individuals and families with low incomes and limited resources. Services are provided through a combination of traditional fee-for-service provider networks and managed care organizations. Historically, the federal government has guaranteed it will share with states the cost of all Medicaid expenditures, ensuring that the program is jointly financed without limits or caps. The federal government's commitment to match all a state's Medicaid expenditures makes it possible for states, in turn, to guarantee Medicaid coverage for all eligible individuals.

For most enrollees—including children, older adults, individuals with disabilities, and other adults not covered through Medicaid expansion—the federal government's share of Medicaid costs is determined by the "standard" medical Federal Medical Assistance Percentage (FMAP). The FMAP is computed from a formula that considers the average per capita income for each State relative to the national average. In Nevada, the current standard FMAP percentage is 59.80%, meaning on average, the state covers 40 cents, and the federal government covers 60 cents for every dollar spent on Nevada Medicaid recipients.[3] Nevada is among 40 States and D.C. who have implemented the Affordable Care Act (ACA) Medicaid expansion. For enrollees covered through ACA Medicaid expansion, states currently receive an

[3] KFF. (2025). *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*. Retrieved from https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

enhanced 90% FMAP, meaning the federal government covers 90 cents of every dollar spent on expansion enrollees.[4] According to research published by the National Bureau of Economic Research, Medicaid expansion has significantly reduced mortality rates among low-income adults. The study found that individuals who gained coverage through the states that expanded were 21% less likely to die each year compared to those who were uninsured. Furthermore, states that adopted Medicaid expansion collectively saved 27,400 live between 2010 and 2022.[5]

The U.S. Congress has been considering a variety of federal policy changes that would have significant impacts on the Medicaid program, widely expected to reduce enrollment and federal Medicaid funding to states. In February 2025, the Nevada Department of Health and Human Services shared a report on the estimated impact of potential federal Medicaid reductions. Among other impacts, the report notes that a reduction from 90% FMAP for the expansion population to traditional FMAP would translate to a reduction of $1.858 billion in federal matching funds over the next two years, impacting 300,000 Nevadans covered under expansion. The report also notes that a reduction in a provider tax from a six to a four percent tax would reduce revenue for children's behavioral health by $30 million in state revenues over two years and is estimated to reduce supplemental payments for hospitals by $693 million over the upcoming biennium. The report lists state options if there are federal reductions, including eligibility and benefit reductions and provider reimbursement rate reductions. During a February joint meeting of the Nevada Assembly and Senate Committees on Health and Human Services, state lawmakers acknowledged that federal cuts to Medicaid would cause harm to Nevada's already fragile healthcare system.

Any of the proposed reductions in federal Medicaid funding would have direct negative impacts to Nevada patients and overall access to care. Even with the successes of the ACA expansion, the State of Nevada currently has one of the highest uninsured rates in the nation.[6] Any reductions in Medicaid coverage would cause Nevada's uninsured population to increase and lead to these vulnerable populations to seek uncompensated care. When Nevada first expanded Medicaid in 2014, its uninsured rate dropped from 22% in 2012 to 12% in 2015, and it saw the largest percentage point decline in its rate of uninsured children, which dropped from 14.9% in 2013 to 7.6% in 2015.[7] If the ACA Medicaid expansion match rate was eliminated, Nevada Medicaid is projected to have the 4th highest reduction in Medicaid enrollment, with an estimated 42% enrollment decline (312,000). [8]

As part of the federal budget reconciliation process, on May 22nd, the federal House of Representatives passed language for the H.R.1 – One Big Beautiful Bill Act, which includes proposed healthcare and Medicaid reforms. According to the American Association of Medical Colleges (AAMC), the proposed legislation would reduce federal Medicaid spending by $625 billion over ten years through new restrictions on provider taxes and state-directed payments, limits on Medicaid eligibility and enrollment, and targeted cuts to the FMAP for states that choose to use state funds to support Medicaid coverage for undocumented individuals, among other policies.[9] This proposal did not include some of the most controversial changes that House Republicans have previously discussed, which would have included imposing per-capita spending caps or reducing FMAP for ACA expansion populations.

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[4] The Affordable Care Act (ACA) expanded Medicaid to adults with incomes up to 138% of the federal poverty level (FPL).

[5] Wyse, A., & Meyer, B. D. (2025, May). *Insurance and Mortality from the Universe of Low-Income Adults*. Retrieved from National Bureau of Economic Research: https://www.nber.org/papers/w33719

[6] Foundation, U. H. (2023). Uninsured in Nevada. Retrieved from America's Health Rankings: https://www.americashealthrankings.org/explore/measures/HealthInsurance/NV

[7] https://thenevadaindependent.com/article/a-brief-history-of-medicaid-in-nevada-and-the-people-who-depend-on-it

[8] KFF. (2025). Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates. Retrieved from https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/

[9] AAMC), A. o. (2025, May 13). *AAMC Statement Before the Energy and Commerce Committee U.S. House of Representatives* . Retrieved from https://www.aamc.org/media/83451/download?utm_source=sfmc&utm_medium=email&utm_campaign=highlights&utm_content=newsletter

A proposal that is advancing with a potential start date of December 31, 2026, is the work and community engagement requirements for Medicaid recipients between the ages of 19 and 64 without dependents. These individuals would be required to work, volunteer or attend school for 80 hours a month to qualify and maintain Medicaid coverage. Nevada Medicaid estimates that anywhere between 70,400 to 112,600 adult Nevadans enrolled in Medicaid today — between roughly 8 and 14 % of the state's Medicaid population — could go uninsured because of new rules that would require people prove they are working or looking for a job to receive coverage.[10] People who are pregnant, have disabilities, substance use disorders, are incarcerated, are or were formerly foster youth, or ineligible through the Indian Health Service would be exempt from the work requirements. The federal proposal also includes language that would change states' ability to finance their share of Medicaid spending through provider taxes and would result in a freeze to Nevada's existing provider tax rates, which allows them to remain, but prevents the state from establishing new provider taxes.

As of this writing, the language of the federal budget reconciliation bill is still being finalized, and it is unclear what the Senate may modify. The House and Senate must reconcile differences before the bill is sent to the President who can sign the bill into law or veto the bill. Due to the uncertainty at the federal level and the possibility for a reduction in federal Medicaid funding, it is unclear how the State will address potential budget shortfalls and what health care services may be reduced, cut or eliminated. In accordance with NRS 439.916.1(k), the Patient Protection Commission will continue to monitor and evaluate proposed and actual changes to federal health care policy to determine the impact of such changes on the cost and access to health care in this State.

## 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 forward to continuing this practice through open communication with the Commission and offering direct collaboration from the Executive Director. It is anticipated that future collaboration efforts will be enhanced now that the PPC is located within the newly established Nevada Health Authority.

During the reporting period, the Executive Director collaborated with various state entities and working groups 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. In February 2025, following feedback from the Subcommittee, the Division of Insurance revised the NDOI-901 Universal Credentialing Form and implemented an addendum form to allow healthcare providers to re-certify by simply attesting there had been no changes since the last credentialing form submission. The PPC Executive Director is grateful for the opportunity to

[10] Tabitha Mueller, G. B. (2025, May 18). *House GOP budget avoids Medicaid 'biggest fears,' but 98K Nevadans may yet lose coverage*. Retrieved from https://thenevadaindependent.com/article/house-gop-budget-avoids-medicaid-biggest-fears-but-98k-nevadans-may-yet-lose-coverage

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.

**Direct Care Workforce (DCW) Peer-Learning Collaborative**

The Executive Director participated in a cross-agency collaborative between July 2024 – March 2025 as part of DHHS's participation in the inaugural Peer Learning Collaboratives of the National Direct Care Workforce Strategies Center, a federally-funded project funded by the Administration for Community Living, U.S. Department of Health and Human Services. The DCW State Peer-Learning Collaborative focused on sharing best practices, innovative strategies, and proven models for growing the direct care workforce. Nevada joined a cohort along with state representatives from Vermont, Kentucky and Maine. Each state received technical assistance from a subject matter expert to accomplish one policy or program-related milestone. The experience provided an opportunity for the DHHS Divisions to work collaboratively toward a common goal and have honest conversations with other states about addressing direct care workforce challenges and learn about innovative solutions.

Nevada has one of the highest direct care worker shortages in the country, ranking 50th for number of direct care workers per 100,000 residents. During the technical assistance opportunity with the Direct Care Workforce Strategies Center, our state worked to better understand how this shortage affects our services in Nevada and outlined strategic options for our state to not only successfully recruit direct care workers, but also establish career pathways, provide training and professional development opportunities, develop robust compensation packages, and retain workers.

One of the ways Nevada is aiming to accomplish these goals is through a $2.9 million American Rescue Plan Act (ARPA) State Fiscal Recovery Funding project that the State of Nevada Aging and Disability Services Division (ADSD) was awarded to grow a Personal Care Attendant (PCA) workforce. To help ensure this project is successful and sustainable, the ADSD intends to apply for continued technical assistance which is available from July 2025 – March 2026. The PPC Executive Director intends to continue to contribute and participate in the cross-agency collaborative.

**Health Care Workforce Working Group**

In accordance with NRS 439A.116, the Department of Health and Human Services must establish and maintain a database of information collected from applicants for the renewal of a license, certificate or registration as a provider of health care. The Director must appoint members to the Health Care Workforce Working Group, who are responsible for analyzing data within the database and making recommendations for increasing health care provider recruitment and retention and improving health outcomes. The Director must also annually publish a report of data from the database and analyze the data to make reports to the Legislature and Executive Branch. In 2021, Senate Bill 379 established the database requirement, but did not appropriate funding for implementation. Unfortunately, due to lack of funding the database has not been implemented and thus the Working Group is unable to analyze the relevant workforce data. The PPC Executive Director was appointed as a member of the Working Group by the DHHS Director in July 2024 to serve a two-year term. The Working Group held two meetings in 2024 and discussed the importance of the health care provider database. The next meeting is scheduled for July 2025, which will likely revolve around opportunities for the state to secure necessary funding for the database implementation.

## VII. Next Steps

The Commission has identified areas of focus, and prioritized reviewing issues related to primary care access and addressing issues related to women's health and reproductive care. The state continues to rank near the bottom in the

nation for prevention and treatment[11], women's health and reproductive care[12], and access to primary care providers[13]. This can largely be tied to the shortage of health care providers across the state and lack of access to affordable health care. The Commission is currently forming certain subcommittees, which will consist of Commission members and other subject matter experts to assist in the review of these additional priority areas. The Commission is scheduled to meet next on August 15th.

Enclosures:

1. PPC Meeting Minutes (January – June 2025)
2. PPC Policy Focus Areas



[11] U.S. Healthcare Rankings by State 2023 | Commonwealth Fund
[12] Women's Health and Reproductive Care 2024 | Commonwealth Fund
[13] Explore Primary Care Providers in Nevada | AHR