



Patient Protection Commission

August 7, 2026 Meeting

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Executive Director, PPC



Agenda Item 2

Public Comment



Agenda Item 3

For Possible Action

**Review and Approve
Meeting Minutes
from June 12, 2026**



Agenda Item 4

For Possible Action

**Review, Discuss,
and Approve Bill
Draft Requests
(BDR) Topics**

Purpose and Overview

Goals of this Discussion

To review, discuss, and approve the PPC's third BDR concept reflecting the policy intent to be submitted to the Legislative Counsel Bureau (LCB) for the 84th Legislative Session.

Approved Last Meeting (6/12):

- Pregnancy Medical Home
- Perinatal Quality Collaborative

Steps After Approval:

- Staff will submit all required materials to LCB ahead of the September 1 submission deadline.

Perinatal Services Modernization

BDR Intent

This measure intends to provide Nevada Medicaid the authority to seek federal approvals to develop, expand, or modify perinatal services and care delivery models in order to improve perinatal health outcomes and access to care. This flexible authority is intended to allow the Administrator to respond to emerging evidence, best practices, and changes in the perinatal care delivery landscape over time.

Perinatal Services Modernization

BDR Intent Language

Add a new section to NRS 422 as follows:

1. To the extent sufficient funding is available, the Administrator may seek State Plan and any necessary authorities needed for federal approval to receive federal matching funds under Titles XIX and XXI of the Social Security Act to develop, expand, or modify perinatal services and care delivery models in order to improve perinatal health outcomes and access to care for eligible persons.

Perinatal Services Modernization

BDR Intent Language – Continued (Optional)

2. In the process of complying with this section, the Administrator may consider opportunities to cover under Nevada Medicaid:

(a) Group prenatal care delivered in accordance with an evidence-based model for group prenatal care at a fee schedule rate of reimbursement that is greater than the reimbursement for an individual prenatal visit and may condition the enhanced rate on a provider accreditation or pending accreditation in a recognized group prenatal care model;

(b) Dyadic intervention services that deliver integrated physical and behavioral health screening and services to an infant and the infant's parent or caregiver together including screening for behavioral health needs, maternal mental health conditions, interpersonal safety, and health-related social needs, and referrals to appropriate follow up care;

(c) Clinical lactation Consultation as a distinct, separately billable fee schedule service rather than bundling it into a global maternity or office-visit payment for services rendered to eligible persons;

(d) Prenatal and parenting education services as a distinct, separately billable fee schedule service rather than bundling it into a global maternity or office or facility visit payment; and

(e) Remote patient monitoring services for high-risk pregnant and postpartum persons enrolled in Medicaid.

(f) Increase Medicaid reimbursement for perinatal and maternity care services provided in rural and frontier areas in a manner that will incentivize provider participation, support the sustainability of rural providers and services, and improve access and outcomes for pregnant and postpartum persons in underserved areas of the state;

(g) Establish and fund incentives that increase:

a. Utilization of prenatal and postpartum care;

b. Screenings and brief interventions for maternal and postpartum behavioral health needs; and

c. Screenings for social determinants of health.



Agenda Item 5

Informational

Overview of the SHARP - Nevada Health Workforce Needs Assessment

Introduction and Study Purpose

Statewide Health Care Access and Recruitment Grant Program Assessment

NVHA is required to conduct an assessment in even-numbered years including:

- A quantitative analysis of the health care workforce in Nevada
- A determination of the most critical shortages in the health care workforce in Nevada
- An identification of unmet needs for specific health technology and therapies

Key Research Questions

1. How many providers are practicing in the state by region and profession/specialty?
2. Which health care professions/specialties and regions are experiencing the greatest unmet need?

Background

Key themes identified in literature review

Persistent and Growing Gaps

- Meaningful growth in the licensed health care workforce, but Nevada's provider-to-population ratios remain well below national averages across professions and specialties.

Population Growth and Changing Demographics

- Between 2000 and 2024, the state's population grew from 2.0 M to more than 3.3 M, a 63% increase, with Clark and Washoe County absorbing most growth and continued growth projected through 2044.

Geographic Maldistribution

- Carson City and the state's 14 rural and frontier counties together account for fewer than 6% of the physician workforce.

An Aging Workforce

- The average age of physicians in the state is 54.8 years, and 43.6% of active physicians are over 55, the average age of OBGYNs, exceeds that benchmark at 56.1 years and 48.5% over the age of 55.

Access and Quality Gaps:

- Nevada ranks among the bottom states in metrics tied to coverage & access (49th) and prevention & treatment (51st), with persistently low rates of early and adequate prenatal care and among the lowest rates nationally for children receiving a routine visit.

Methods

Statewide Health Care Access and Recruitment Grant Program Assessment

Measures

- Providers per 100,000 population; location quotient (LQ) against the US average; gap to national = additional providers needed to reach the national ratio.
- Comparison to neighboring states (AZ, NM, UT, CO) and national benchmarks
- Regions follow the Behavioral Health Regions: Clark, Washoe, Northern, Rural, Southern.

Three Phases

- Statewide Supply, by profession and specialty → Priority Area selection and deep dive → Medicaid participation, access, and travel patterns

Data Sources

Bureau of Labor Statistics: *Occupational Employment and Wage Statistics* (May 2025):
<https://www.bls.gov/oes/tables.htm>

Office of Statewide Initiatives, University of Nevada, Reno School of Medicine: *Nevada Instant Atlas* (2024):
<https://med2.unr.edu/SI/CountyData/atlas.html>

AMA: *AMA Physician Professional Data* (2024) accessed via the AAMC U.S. Physician Workforce Data Dashboard (2026). [U.S. Physician Workforce Data Dashboard | AAMC](#)

US Census Bureau: *Population Estimates, Population Change, and Components of Change* (2025). <https://www2.census.gov/programs-surveys/popest/tables/2020-2025/state/totals/NST-EST2025-POP.xlsx>

Nevada Office of Analytics: *Medicaid Enrollment and Claims* (2025).

Nevada Perinatal Health Care Workforce Employment

How does Nevada’s provider supply stack up to other states and nationally?

Profession	Active Providers	Ratio per 100,000 Population						Location Quotient (LQ)	Gap to National Average
		NV	AZ	NM	UT	CO	US		
Obstetric Care									
Obstetrics and Gynecology	339	10.4	10.4	11.2	9.1	14.1	13.0	0.80	85
Infant and Child Health									
Pediatrics	469	14.3	18.9	20.2	20.1	23.1	24.0	0.60	318
Family Medicine/General Practice	952	29.3	30.6	46.6	30.1	47.6	37.1	0.79	253
Behavioral Health									
Psychiatry	241	7.4	9.6	11.3	6.9	10.9	12.0	0.62	150
Child and Adolescent Psychiatry	53	1.6	2.2	3.8	2.1	3.5	3.3	0.48	56
Clinical and Counseling Psychologists	510	15.7	15.1	10.3	28.5	32.4	21.2	0.74	181
SUD, BH, Mental Health Counselors	2240	68.8	118.7	97.3	134.7	228.3	129.5	0.53	1974

Source. U.S. Bureau of Labor Statistics. (2024). Occupational Employment and Wage Statistics (OEWS) Profiles; Association of American Medical Colleges. (2024). U.S. Physician Workforce Data Dashboard; US Census Bureau (2024), population estimates



Key Takeaway: Nevada falls below national supply across nearly every maternal and infant health related profession, with particularly deep gaps in pediatrics and behavioral health.

Medicaid Perinatal Workforce

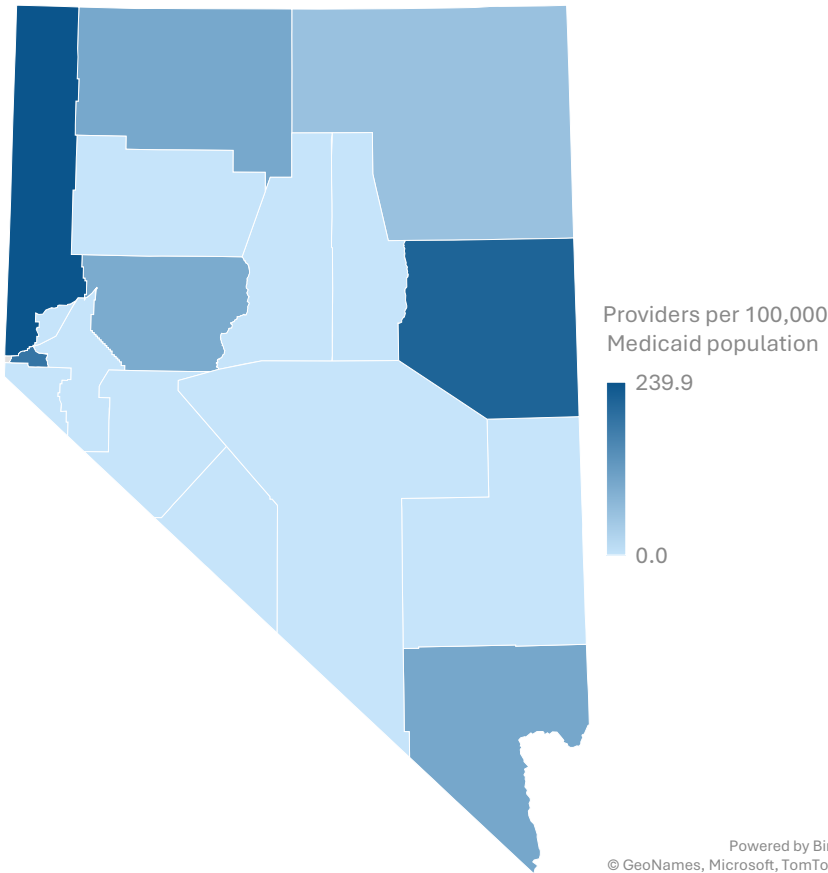
Active Medicaid (2025)

Provider enrollment or active licenses alone may overestimate access capacity, as not all enrolled providers serve patients. This table highlights variation in active Medicaid participation across medical specialties and provides insight into who is currently delivering care to Nevada Medicaid populations.

Profession	Active Medicaid Providers	Number per 100,000 Medicaid Population
Obstetrics and Gynecology	306	77.0
Maternal Fetal Medicine	26	6.5
Neonatology	60	15.1
Perinatal Medicine	2	0.5
Nurse Midwife	57	14.3

Source. Nevada Office of Analytics, Medicaid Claims Data. (2025). Medicaid population is defined as the unique number of females over 10 years old enrolled in Medicaid during the selected timeframe.

Medicaid Perinatal Providers by County
per 100,000 Medicaid Members



Key Takeaway: While Clark County has the largest absolute workforce by volume, but lower provider availability per capita.

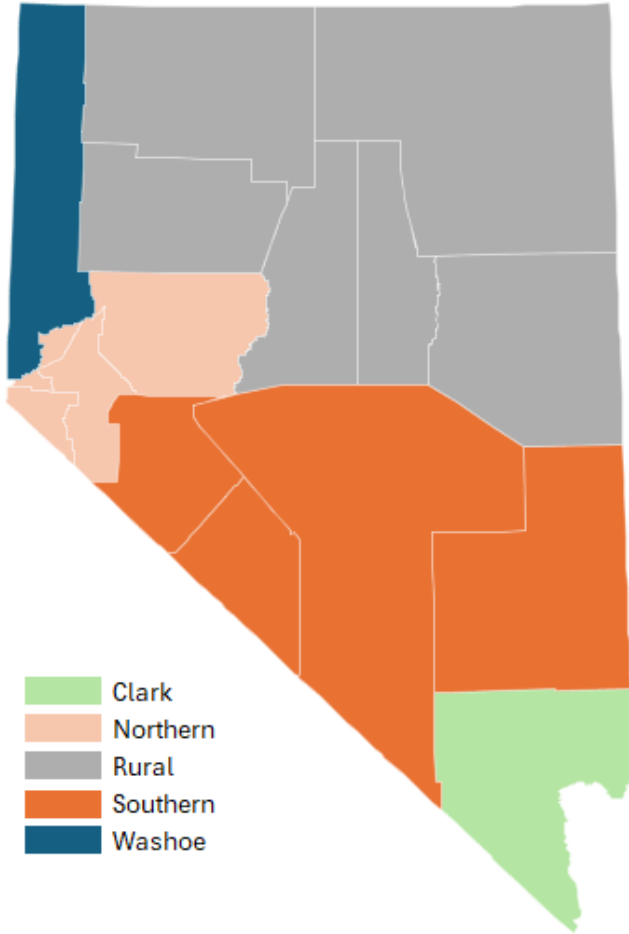
Where People Receive Perinatal Care

Nevada Medicaid (2025)

This table follows Medicaid members claims from their home region to where they received perinatal services, showing how much care is delivered locally, how much requires travel to an urban hub,, and how much leaves Nevada entirely or is delivered virtually.

Provider County	Member County				
	Clark	Washoe	Rural	Southern	Northern
Clark	53,030 (94.1%)	312 (4.8%)	37 (4.3%)	974 (88.5%)	132 (5.9%)
Washoe	409 (0.7%)	5,829 (89.5%)	155 (17.8%)	40 (3.6%)	992 (44.4%)
Rural	0 (0.0%)	0 (0.0%)	342 (39.3%)	3 (0.3%)	0 (0.0%)
Southern	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Northern	6 (0.0%)	28 (0.4%)	20 (2.3%)	20 (1.8%)	852 (38.2%)
Out of State	317 (0.6%)	199 (3.1%)	307 (35.3%)	24 (2.2%)	233 (10.4%)
Telehealth	2,586 (4.5%)	147 (2.3%)	8 (0.9%)	39 (3.5%)	23 (1.0%)

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Percentages are calculated using totals for each member county column.



Key Takeaway: More than 1/3 of members in the rural region received care out of state, and there is a relatively low utilization of telehealth.

Key Findings

Areas with demonstrated evidence of need across supply, quality, and access indicators

Too few providers statewide

Statewide capacity falls below national benchmarks across maternal, infant, primary care, and behavioral health.

Supply

1

Available workforce does not consistently align with need

Rural areas face limited local availability, while high-volume urban areas may still have lower provider availability relative to population size.

Distribution

2

Limited local capacity often requires care outside a member's home region

Rural members frequently receive services elsewhere, while telehealth accounts for a relatively small share of care.

Deployment

3

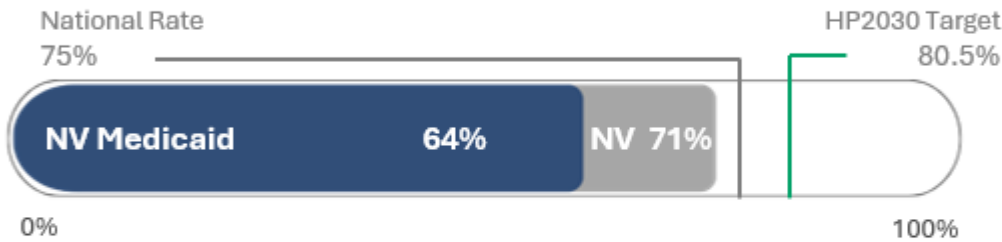
Implications

What does this mean in the context of health outcomes and access to care?

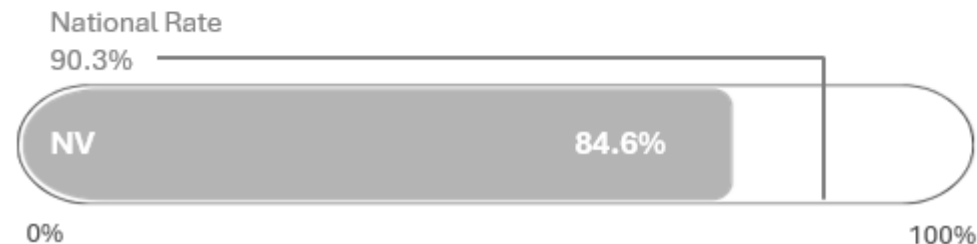
Timely Access to Care

Workforce Constraints may make it harder to connect patients to care early and consistently.

*Early and Adequate Prenatal Care**



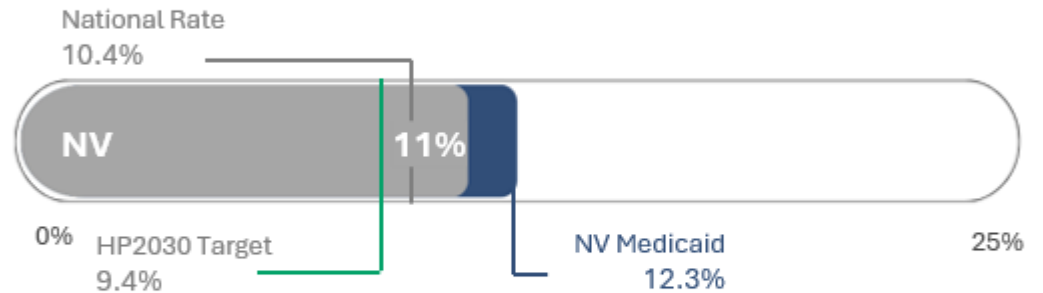
*Postpartum Care**



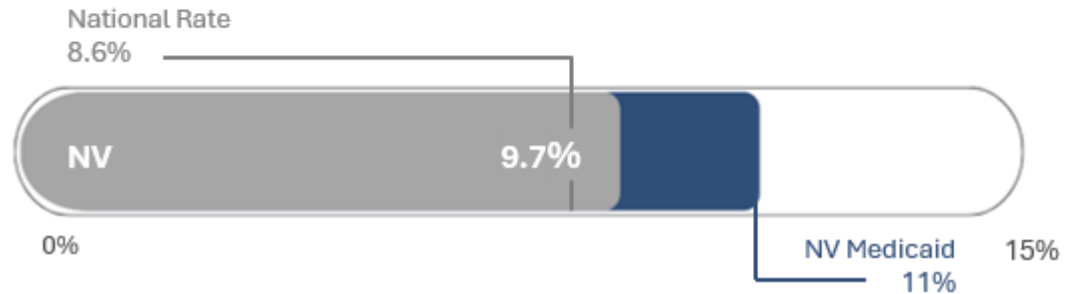
Prevention and Outcomes

Limited capacity can reduce opportunities to identify and manage risk before complications occur

Preterm Birth Rate



Low Birth Weight



* Higher rate indicates better performance

Data: Nevada Office of Vital Records and Nevada Medicaid Enrollment

Sources: Healthy People 2030, *Pregnancy and Childbirth* (OASH, n.d.). <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth>
America's Health Rankings, *Explore Postpartum Visit in Nevada* (AHR, 2023). https://www.americashealthrankings.org/explore/measures/postpartum_visit/NV

Discussion

Where can workforce investments have the greatest impact?

Target demonstrated need

Focus on workforce gaps that are limiting access to priority services and populations

- Look beyond statewide provider counts to specialty, geography, payer, and population
- Prioritize gaps that overlap with documented access and outcome challenges
- Recognize that urban capacity constraints and rural access gaps require different approaches

Match the solution to the problem

Different workforce challenges require different policy levers

- Supply: build, recruit, and retain workforce
- Distribution: direct capacity toward underserved populations and communities
- Deployment: extend the reach and effectiveness of existing capacity

Align and maximize existing investments

Build on what Nevada is already doing and target remaining gaps

- SHARP, RHT, and GME



Shortages across the workforce can affect the ability to provide continuous, comprehensive care before, during, and after pregnancy

Appendix

Literature Review Sources

Nevada Health Workforce Research Center, UNR School of Medicine:

- [Interactive Health Workforce & Population Maps](#)
- [Health Workforce in Nevada](#)
- [Physician Workforce in Nevada](#)
- [Nevada Rural & Frontier Health Data Book](#)
- [Nursing Workforce in Nevada](#)

University of Nevada, Las Vegas

- [The Healthcare Workforce in Nevada, 2024](#)

Nevada Demographers Office

- [2024 ASRHO Estimates and Projections Summary 2000 to 2043.xls](#)

Commonwealth Fund

- [Commonwealth Fund State Scorecard: Nevada](#)

Mental Health America

- [State-of-Mental-Health-2025.pdf](#)

Behavioral Health Risk Factor Surveillance System (BRFSS)

- [Monitoring the BRFSS in Nevada](#)
- [BRFSS Prevalence & Trends Data: Home | DPH | CDC](#)



Nevada's Health Workforce Needs Assessment for 2026

Pursuant to NRS 439A.371

Director's Office

July 1, 2026



Joseph Lombardo
Governor
State of Nevada

Stacie Weeks, JD, MPH
Director
Nevada Health Authority



Agenda Item 6

Informational

An Update on Health Workforce and Rural Access Initiatives



Agenda Item 7

For Possible Action

**Review, Discuss,
and Approve
Perinatal Workforce
Recommendations**

Purpose and Overview

Goals of this Discussion

To discuss and identify formal workforce recommendations the Commission wishes to advance, issued through the January 1 semi-annual report

Commission Action

- Discuss Formal Recommendation Options
- Approve Formal Recommendations; or
- Advance for further consideration

Looking Ahead

- Remaining 2026 meetings will be dedicated to developing non-BDR recommendations, so there will be further opportunity to gather, research, and analyze policies to advance as formal recommendations organized by cross-cutting themes.

How the Policy Options were Developed

Where options came from and how they were analyzed and categorized

Sources of Policy Options

A focused set of sources were used to identify and shape the menu of strategies

- State workforce assessments
- Presentations to the PPC
- National and state perinatal workforce literature review
- Removal of items already covered by BDRs to avoid duplication

Categorization

Organized into thematic policy areas

- Education & Training; Recruitment, Retention, & Practice Flexibility; Innovative Care Models & Technology; Data Systems & Workforce Planning

Assessment Approach

Structured Impact-Feasibility Assessment

- **Impact:** workforce strengthen, shortage reduction, care coordination, evidence alignment
- **Feasibility:** Administrative, regulatory, financial, legislative, and operational complexity; fit within existing infrastructure.

Highest Scoring Options

Highest-impact and feasibility priorities, not in any order

Workforce Training & Pipeline

Expand BH training for perinatal workforce

Builds statewide capacity to screen, assess, and treat perinatal mental health conditions.

Fund Career Pathways and Training Programs

Supports advancement into clinical and specialty roles to strengthen supply.

Strengthen GME Pathways

Increase perinatal training and clinician retention.

Practice Flexibility

Team-based care models

Integrates clinical, behavioral, and community providers to improve coordinated care.

License and reimburse CPMs/CMs

Expands access to community-based perinatal care.

Licensure Portability and Scope of Practice Expansion

Improves provider mobility and capacity across the state.

Behavioral Health Collaborative Care Models

Integrates screening, follow-up, and psych consult to improve access.

Technology & Quality Infrastructure

Technology-enabled perinatal care models

Uses telehealth and digital tools to expand access and specialty support.

Provider incentives aligned with state quality strategy

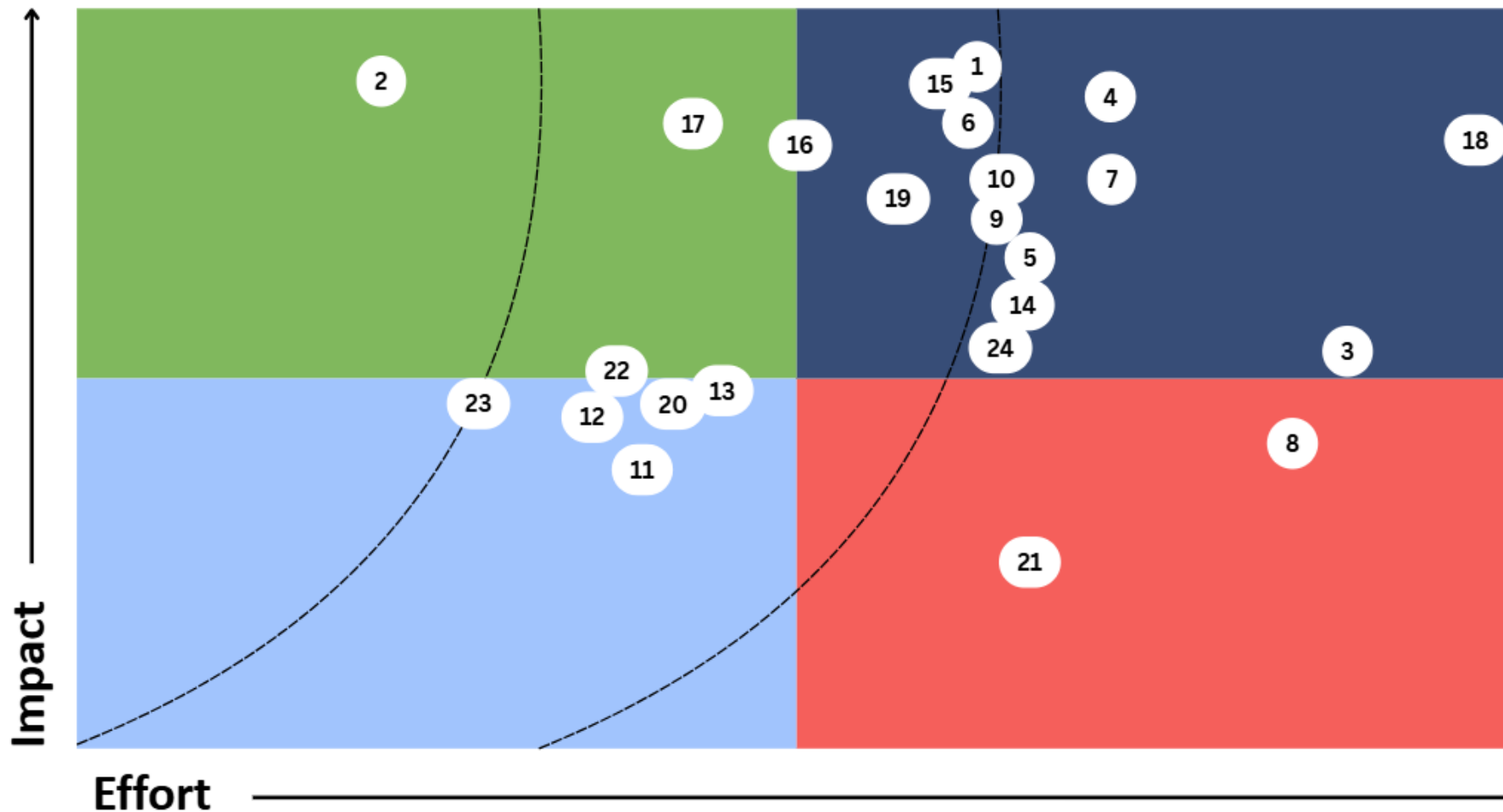
Provides an incentive and links payment to performance on quality measures.

Unified Workforce Database

Enables better statewide workforce planning and decision-making.

Action-Priority Matrix

Workforce options mapped by their relative impact and feasibility



Discussion

1. Do the identified priority items feel like the right ones to move forward?
2. Are there options that commissioners believe should not advance or should be added as a priority?

Discussion

Action Items

Are There Any Additional Options Commissioners Wish to Elevate?

- Are there policy options not included in the highest-scoring list that commissioners believe should be elevated for consideration?
- Are there items where commissioners see emerging need, new evidence, or Nevada-specific urgency that warrants re-prioritization?

For Possible Action

Include selected perinatal workforce recommendations as formal recommendations to be included in the PPC's semi-annual report due on or before January 1, 2026

AND/OR

Advance specific recommendations for further research, refinement, or future considerations.



Agenda Item 8

Public Comment



Agenda Item 9

Adjournment

Thank you!

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Upcoming events listed
<https://ppc.nv.gov/>

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