Amendment No. 942

Senate Amendment to Senate Bill No. 495 (BDR 40-1037)
Proposed by: Senator Doñate
Amends: Summary: No Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 495 (§§ 20-22, 72.8).

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

SENATE BILL NO. 495–COMMITTEE ON
HEALTH AND HUMAN SERVICES

(ON BEHALF OF THE OFFICE OF THE GOVERNOR)

MAY 15, 2025

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to health care. (BDR 40-1037)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Contains Appropriation included in Executive Budget.

CONTAINS UNFUNDED MANDATE (§§ 20-22, ~~[43, 44)]~~ **72.8)**
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~[omitted material]~~ is material to be omitted.

AN ACT relating to health care; ~~[establishing a competitive funding program to address shortages of providers of health care in this State;]~~ **revising requirements governing the electronic maintenance, transmittal and exchange of health information; making revisions relating to emergency medical care;** prescribing certain requirements to expedite the credentialing and privileging of providers of health care; authorizing paramedics to serve as employees or volunteers in hospitals under certain circumstances; ~~[transferring the responsibility for administering the Graduate Medical Education Grant Program to the Department of Health and Human Services; making certain other revisions relating to that Program;]~~ imposing certain requirements governing prior authorization for medical ~~[or dental]~~ care and payment of health insurance claims; ~~[requiring the Department to explore ways to use federal financial participation in Medicaid to support graduate medical education;]~~ making **various** revisions relating to ~~[applying for and determining eligibility for]~~ Medicaid; creating and prescribing the duties of the Office of Mental Health in the Department ~~[.]~~ **of Health and Human Services or the Nevada Health Authority, if it is created;** prohibiting ~~[certain]~~ noncompetition covenants governing **certain** providers of health care **;** ~~[, with certain exceptions;]~~ requiring the prioritization of certain applications for licensure as a physician or osteopathic physician; **requiring certain providers of health care to provide certain data to the Department;** requiring certain reports of the Board of Medical Examiners and the State Board of Osteopathic

Medicine to include certain information; ~~[requiring]~~ **authorizing** the establishment of an alternative pathway to licensure as a dental hygienist; establishing provisions to incentivize the provision of psychological services to rural patients; requiring the Patient Protection Commission to study academic medical centers; making appropriations; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services, or the Director of the Department or the divisions thereof, to conduct various programs for the improvement of public health and health care in this State. (NRS 433.702-433.744, 439.4921-439.525, 439.529-439.5297, 439.630, 439A.111-439A.185, 439A.200-439A.290, 442.710-442.745, 457.230-457.280, 458.025, 458A.090, 458A.100, 458A.110) ~~[Sections 2-18 of this bill establish the Nevada Health Care Workforce and Access Program, which is a competitive funding program managed by the Department to support projects to address critical shortages of providers of health care in this State. Sections 3-5 define certain terms, and section 2 establishes the applicability of those definitions. Section 6 creates the Nevada Health Care Workforce and Access Account to hold money to fund the Program. Section 119 of this bill appropriates money into the Account. Section 6 authorizes the Director of the Department to transfer money from the Account to another account for the purpose of obtaining additional federal financial participation under Medicaid.]~~

Section 7 of this bill requires the Director to conduct a biennial assessment of the health care workforce needs of this State, which must identify health care **professions and** specialties, ~~[populations]~~ **types of clinical services and expertise** and geographic areas experiencing critical shortages of providers of health care **~~[.]~~ or clinical services or expertise.** **Section 42** of this bill provides that such an assessment is not a regulation and is therefore not subject to notice-and-comment rulemaking. ~~[Section 9 authorizes a person or entity to apply for funding from the Account to support a project to address those critical shortages. Section 8 imposes certain additional requirements for a project to be eligible to receive such funding. Sections 10 and 11 prescribe the process for the Department to review applications and recommend applicants for funding. Section 12 provides for a joint committee consisting of the membership of the Board of Economic Development and the Patient Protection Commission to make the final determination concerning which applicants receive funding.~~

~~After the joint committee awards funding, section 13 requires the Department to enter into a funding agreement with the recipient of the funding that outlines the terms and conditions of the funding and the responsibilities of the recipient. Section 13 requires a recipient of funding to notify and submit a revised plan to the Department if: (1) the recipient significantly modifies or terminates a funded project; or (2) the amount of money available for a funded project changes. Section 13 authorizes the Department to take certain actions in response to such notice. Section 14 authorizes the Department and the Office of Finance to provide certain oversight of a funded project. Section 15 authorizes the Department to suspend or terminate funding or take certain other actions if it determines that the recipient of the funding has failed to comply with state or federal law or regulations or a funding agreement. Sections 16 and 17 provide for certain reporting concerning the Program, and section 18 requires the Department to adopt regulations governing the Program.]~~

Existing law requires the Director to prescribe by regulation a framework for the electronic maintenance, transmittal and exchange of electronic health records, prescriptions, health-related information and electronic signatures and requirements for electronic equivalents of written entries or written approvals. With certain exceptions, existing law requires various entities involved in health care, including persons and facilities that provide health care, to maintain, transmit and exchange health information in accordance with those regulations. (NRS 439.589) Section 3.6 of this bill prohibits those regulations from authorizing such a person or entity to comply with that requirement by connecting with a health information exchange or utilizing any other service that charges a fee for providing electronic health records to such a person or entity or a patient upon request. Section 72.8 of this bill: (1) requires a custodian of

health care records to furnish electronic health records to a patient or certain other entities upon the request of a patient within 7 business days; and (2) prohibits a custodian of health care records from charging a fee to furnish health care records under such circumstances.

Sections 3.3, 72.3 and 126 of this bill limit the health care providers that must maintain, transmit and exchange health information electronically to medical facilities and high-level providers of health care. Section 1 of this bill defines the term "high-level provider of health care" to mean a physician, physician assistant, dentist, advanced practice registered nurse, chiropractic physician, podiatric physician or physical therapist. Section 3.3 additionally exempts from requirements to maintain, transmit and exchange health information electronically high-level providers of health care whose solo or group practices are under a certain size. However, section 3.3 requires such high-level providers of health care to furnish the medical records of a patient electronically to the patient or another person or entity upon request of the patient. Section 4.5 of this bill makes conforming changes to revise the applicability of a provision requiring the Department to notify the licensing board of a provider who fails to comply with requirements governing the electronic maintenance, transmittal and exchange of health information. Section 1.5 of this bill establishes the applicability of the definition set forth in section 1, and sections 43, 45.5, 67.9, 116.3 and 116.7 of this bill make other conforming changes to indicate the proper placement of section 1 in the Nevada Revised Statutes. Section 72.5 of this bill updates internal references changed by section 72.3.

Existing law prohibits a person or entity from operating an independent center for emergency medical care without a license issued by the Division of Public and Behavioral Health of the Department. (NRS 449.030) Section 22.5 of this bill requires a facility that is structurally separate from the hospital and provides services for the treatment of a medical emergency, including such a facility that is owned or operated by, or otherwise part of, a hospital, to be licensed as an independent center for emergency medical care. (NRS 449.0151, 449.030) Sections 24.3 and 24.5 of this bill prohibit the Division or the State Board of Health from charging a fee for the issuance of such a license. Section 24.8 of this bill prohibits the Division from issuing a license to operate an independent center for emergency medical care that is located within a 5 mile radius of another independent center for emergency medical care or a hospital with an emergency department. However, section 120.6 of this bill requires the Division to issue a license to certain such independent centers for emergency medical care that are currently licensed or had taken certain steps toward operating by January 1, 2025. Section 26.5 of this bill requires an independent center for emergency medical care to provide urgent care services during all operating hours and imposes certain additional requirements related to the provision of such urgent care, except that section 120.3 of this bill exempts from that requirement independent centers for emergency medical care that are licensed on the date on which this bill is enacted.

Existing law establishes programs to increase awareness of information concerning hospitals and surgical centers for ambulatory patients. (NRS 439A.200-439A.290) Section 9.5 of this bill requires the Department to establish a similar program to increase awareness of information concerning independent centers for emergency medical care. Sections 9.5, 10.5, 12.5, 13.5 and 27.3 of this bill provide for the Department to collect certain information on the operations of independent centers for emergency medical care and the outcomes for patients treated by independent centers for emergency medical care. To facilitate such reporting, section 27.3 requires an independent center for emergency medical care to use the same form prescribed by the Director for discharging patients as a hospital is currently required to use. Section 95.5 of this bill makes a conforming change to reflect that independent centers for emergency medical care will be using the same form. Sections 12.5 and 13.5 require the Department to: (1) make certain information concerning independent centers for emergency medical care available upon request; and (2) post certain information concerning independent centers for emergency medical care on an Internet website maintained by the Department. Sections 11.2 and 41.5 of this bill make conforming changes to add references to independent centers for emergency medical care to sections that discuss the program and associated website. Section 8.5 of this bill defines the term "independent center for emergency medical care" for that purpose. Section 11.5 of this bill establishes the

applicability of certain definitions. Section 27.7 of this bill requires a report prepared by the Director on the status of the programs to increase public awareness of information concerning hospitals and surgical centers for ambulatory patients to additionally include information on the status of the program to increase awareness of information concerning independent centers for emergency medical care. Section 51.3 of this bill requires the Director of the Department, to the extent that money is available, to include under Medicaid a system of value-based payments for care provided by independent centers for emergency medical care to recipients of Medicaid.

Existing law authorizes a court, upon a petition, to order the sealing of records of certain convictions if the person who was convicted: (1) has not been convicted of any additional offense, except for minor traffic violations, for a specified period of time; and (2) does not have charges pending for any offense, except for minor traffic violations. (NRS 179.245) Existing law also authorizes a court, upon a petition, to order the sealing of records of an arrest where the charges were dismissed, the prosecutor declined to prosecute or the person who was arrested was acquitted. (NRS 179.255) Section 32.5 of this bill authorizes the Department or the Division of Health Care Financing and Policy of the Department to review certain sealed records for the purpose of determining the suitability of the person to whom the records pertain to serve as a provider of services under Medicaid or to own or serve as an officer, managing employee or managing agent of such a provider of services.

Existing law prescribes a procedure for conducting a hearing to review an action taken against a provider of services under Medicaid. (NRS 422.306) Section 51.5 of this bill requires such a provider of services to maintain and provide certain documents to the Department for the purpose of verifying claims. Section 51.5 authorizes the Department to deny a claim or recover money already paid if the Department is unable to verify the claim. Section 51.8 of this bill: (1) prescribes a process for the Department to review claims for appropriateness and propriety; and (2) authorizes the Department to deny or recover any amount paid pursuant to such a claim or take certain actions based on such a review. Section 119.5 of this bill makes an appropriation to the Division of Health Care Financing and Policy of the Department and authorizes the expenditure of certain other money to carry out sections 51.3-51.8.

Section 67 of this bill: (1) creates the Office of Mental Health within the Department; and (2) **requires the Director to appoint the Executive Director of the Office. Section 67.2 of this bill** requires the Office to perform certain duties to improve access to and the effectiveness of mental health services in this State. ~~[Section 67 authorizes the Office to request an allocation of money from the Account]~~ **Section 67.4 of this bill requires the Office to perform certain additional duties related to the mental and behavioral health of children. Sections 67.6-67.8 of this bill require the subcommittee on the mental health of children of the Commission on Behavioral Health and each mental health consortium** to support those duties. **Section 67.5 of this bill requires the Office to submit a biennial report to the Legislature. Section 66.6 of this bill defines the term "Office" for the purposes of sections 67-67.5 to refer to the Office of Mental Health. Senate Bill No. 494 of this legislative session proposes to create a new department in the Executive Branch of State Government known as the Nevada Health Authority to perform certain duties related to health care, including behavioral health care, in this State. Section 121.5 of this bill transfers the Office to the Nevada Health Authority if Senate Bill No. 494 is enacted.**

Section 89 of this bill requires the Board of Psychological Examiners to: (1) ~~[provide]~~ **take certain actions to incentivize licensees to receive** continuing education concerning the mental health needs of patients in rural areas; and (2) establish a program to recognize psychologists who provide at least 200 hours of services through telehealth to such patients.

Sections 20, ~~[43, 47,]~~ **46, 50, 75, 85, 109 and 113** of this bill prescribe requirements to expedite the process of credentialing providers of health care to participate in public and private health insurance plans. Beginning on January 1, 2027, **sections 117 and 118** of this bill require insurers that issue such plans, or entities to which such insurers delegate credentialing functions, to process least 95 percent of complete requests for such credentialing not later than 60 days after receiving all of the information necessary to complete such a request. Beginning on January 1, 2027, **section 21** of this bill similarly requires a hospital to process at least 95 percent of complete requests from providers of health care for privileges to

perform services at the hospital not later than 60 days after receiving all of the information necessary to complete such a request.

Existing law authorizes an emergency medical technician, advanced emergency medical technician or paramedic who holds the proper endorsement to provide services, known as community paramedicine services, to patients who do not require emergency medical transportation. (NRS 450B.1993) **Sections 29-31** of this bill authorize paramedics to serve as employees or volunteers in a hospital under certain circumstances and with certain limitations.

~~[Existing law requires the Director of the Office of Science, Innovation and Technology in the Office of the Governor to implement the Graduate Medical Education Grant Program, which is a program to award grants to institutions in this State seeking to create, expand or retain programs for residency training and postdoctoral fellowships for physicians. (NRS 223.610, 223.637) Sections 36-40 of this bill transfer duties related to the administration of the Program from the Office of Science, Innovation and Technology to the Department. Sections 34 and 35 of this bill make conforming changes to remove the Program from the duties that the Director of the Office of Science, Innovation and Technology is required to perform. Section 39: (1) authorizes the Department to award limited grants for certain purposes relating to the establishment of a program for residency training and postdoctoral fellowships for physicians; and (2) establishes certain priorities for the awarding of grants. Section 33 of this bill prohibits a grantee from eliminating or reducing the size of a program for residency training and postdoctoral fellowships without the approval of the Department. Section 49 of this bill requires the Department to explore ways to use federal financial participation in Medicaid to support such programs. Section 121 of this bill requires the Patient Protection Commission to conduct a study during the 2025-2026 interim concerning academic medical centers in this State, and section 120 of this bill appropriates money for the study. Section 121 authorizes the Patient Protection Commission to request not more than two legislative measures to implement any recommendations resulting from the study.]~~

Existing law provides that a noncompetition covenant is void unless the covenant: (1) is supported by valuable consideration; (2) does not impose any restraint that is greater than is required for the protection of the employer; (3) does not impose any undue hardship on the employee; and (4) imposes restrictions that are appropriately related to the consideration for the covenant. (NRS 613.195) **Section 71** of this bill provides that **~~[, in general, a noncompetition covenant may not restrict a provider of health care from providing care at any location during or after the term of his or her employment or contract. Section 70 of this bill prescribes certain exceptions to that general prohibition.]~~ a noncompetition covenant may not apply to a provider of health care whose primary duties involve providing clinical care to patients and who is not employed or contracted to primarily perform administrative tasks.**

Sections 74 and 84 of this bill require the Board of Medical Examiners and the State Board of Osteopathic Medicine, respectively, to establish by regulation a procedure for prioritizing applications for licensure as a physician or osteopathic physician of applicants who plan to: (1) serve underserved geographic areas or populations in this State; or (2) practice a specialty for which there is a shortage in this State. **Sections 76 and 86** of this bill require certain reports submitted by those Boards to the Governor and Legislature to include information relating to the efficiency of the process for licensing physicians or osteopathic physicians, as applicable.

Existing law requires the Director to: (1) develop and make available to each professional licensing board that licenses, certifies or registers providers of health care an electronic data request that solicits certain information relating to the demographics and practices of providers of health care; and (2) establish and maintain a database of information collected through the data request. (NRS 439A.116) Under existing law, providers of health care applying to renew a license, certificate or registration may, but are not required to, complete the data request. (NRS 450B.805, 630.2671, 630A.327, 631.332, 632.3423, 633.4716, 634.1303, 634A.169, 635.111, 636.262, 637.145, 637B.192, 639.183, 640.152, 640A.185, 640B.405, 640D.135, 640E.225, 641.2215, 641A.217, 641B.281, 641C.455, 652.126) Sections 76.5, 82.3, 82.6, 86.2-86.8 and 89.2-89.9 of this bill make completion of the data request mandatory to renew a license, certificate or registration issued by: (1) the Board of Medical Examiners; (2) the Board of Dental Examiners of Nevada; (3) the State Board of Nursing; (4) the State Board of Osteopathic Medicine; (5) the State Board of Podiatry; (6) the Nevada State Board of Optometry; (7)

the Board of Dispensing Opticians; (8) the Board of Psychological Examiners; (9) the Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors; (10) the Board of Examiners for Social Workers; (11) the Board of Examiners for Alcohol, Drug and Gambling Counselors; and (12) the Board of Applied Behavior Analysis. Section 42.5 of this bill makes a conforming change to ensure the confidentiality of information submitted through such a data request.

Existing law requires an applicant for licensure as a dental hygienist to have graduated from an accredited program of dental hygiene that meets certain requirements. (NRS 631.290) **Sections 77 and 79** of this bill ~~[require]~~ **authorize** the Board of Dental Examiners of Nevada to establish by regulation an alternative training pathway involving a course of training under the supervision of a licensed dentist that an applicant for such a license may complete instead of graduating from such a program. **Section 77** requires an applicant who has completed the alternative training pathway to have also successfully passed: (1) a competency examination conducted by the supervising dentist; (2) a written examination; and (3) a clinical examination approved by the Board. **Section 78** of this bill requires such an applicant to submit with his or her application for licensure proof that he or she has passed those examinations. **Section 77** provides that a person who completes the alternative training pathway is only eligible for licensure if he or she began the pathway during a biennium during which there was shortage of dental hygienists, as documented by the assessment conducted pursuant to **section 7**. **Section 77** requires the Board to adopt regulations establishing the scope of practice of a dental hygienist who has completed the alternative training pathway **.** ~~[, including regulations authorizing such a dental hygienist to: (1) practice at locations in addition to the locations where a dental hygienist is authorized to practice under existing law; and (2) prescribe and dispense]~~ **Section 81 of this bill prohibits a dental hygienist who has completed the alternative training pathway and has not subsequently graduated from an accredited program of dental hygiene from prescribing and dispensing** preventive agents **.** ~~[, in addition to the preventive agents that a dental hygienist is authorized to prescribe and dispense under existing law. (NRS 631.310, 631.3105) Sections 32, 80-82, 87 and 88 of this bill make conforming changes to authorize such a dental hygienist to practice at such locations and prescribe and dispense such protective agents.]~~

Existing law requires the Department to administer Medicaid and the Children's Health Insurance Program. (NRS 422.270) Existing federal law authorizes: (1) a hospital to elect to make determinations concerning whether certain persons are presumptively eligible for Medicaid; and (2) a state to allow certain other entities to make such determinations. (42 U.S.C. §§ 1396a(a)(47), 1396r-1, 1396r-1a, 1396r-1b, 1396r-1c) **Section 51** of this bill requires the Department to take certain measures to facilitate such presumptive eligibility determinations by the personnel of hospitals and qualified community-based organizations. **Section 51** also requires the Department to audit such entities to ensure that the presumptive eligibility determinations made by the personnel of those entities are accurate and comply with applicable law.

Existing law authorizes certain health insurers to require prior authorization before an insured may receive coverage for medical and dental care in certain circumstances. If an insurer requires prior authorization, existing law requires the insurer to: (1) file its procedure for obtaining prior authorization with the Commissioner of Insurance for approval; and (2) respond to a request for prior authorization within 20 days after receiving the request. (NRS 687B.225) Beginning on January 1, 2028, **sections** ~~[44,]~~ **47, 53-62, 69, 97-108 and 110** of this bill establish additional requirements relating to the use of prior authorization for medical ~~[and dental]~~ care by health insurers, including Medicaid, the Children's Health Insurance Program and insurance for ~~[public]~~ **state** employees, as well as certain entities with which such insurers contract to perform functions relating to prior authorization. **Sections** 53.5, **54, 55 and 98-100** define certain terms, and **sections 53 and 97** establish the applicability of those definitions. **Section 101.6 of this bill requires certain insurers and other entities that employ or utilize an artificial intelligence system or automated decision tool to process requests for prior authorization to transmit a notice to each insured that: (1) discloses the insurer's use of the system or tool to process requests for prior authorization; and (2) describes certain aspects of the system or tool. Sections 56 and 110** require an insurer or other entity that performs functions relating to prior authorization to respond to a request for prior authorization within ~~[the]~~ **a specified** period of time **.** ~~[prescribed by certain nationally recognized operating rules governing prior authorization.]~~ If an insurer or other entity that

performs functions relating to prior authorization is unable to approve or deny a request for prior authorization within that time period, **sections 56 and 110** require the insurer or entity to notify the insured and his or her provider of health care of the delay. **Sections 58 and 102** prescribe the required contents of that notice. **Sections 59 and 103** require an insurer or other entity that performs functions relating to prior authorization to provide similar notice upon denying a request for prior authorization and establish a process to appeal such a denial.

Sections 56 and 110 prohibit insurers and other entities that perform functions relating to prior authorization from requiring prior authorization for covered emergency services. **Sections 57 and 101** require insurers and other entities that perform functions relating to prior authorization to implement an electronic system for receiving and processing requests for prior authorization. **Sections 22 and 72** of this bill require certain medical facilities and providers of health care to submit requests for prior authorization through those systems.

Sections 60 and 104 limit the circumstances under which an insurer or other entity that performs functions relating to prior authorization may: (1) revoke the approval of a request for prior authorization; (2) delay or deny payment for care to which such a request pertains; or (3) assign a lower billing code or otherwise reduce the payment for such care. ~~[Section 126 of this bill eliminates certain similar requirements in existing law governing dental insurance that are less stringent than the requirements of section 104.]~~ **Sections 61 and 105** prescribe certain requirements to ensure the continuity of care for an insured whose benefits are terminated or who switches health insurance plans. **Sections 62 and 106** provide for the reporting and publication of certain information relating to prior authorization and the payment of claims. **Section 107** establishes the Gold Card Exemption Program to exempt providers of health care whose requests for prior authorization are approved at a rate of at least 95 percent from the requirement to obtain prior authorization for certain services. **Section 56** requires the Department, with respect to Medicaid and the Children's Health Insurance Program, or a Medicaid managed care organization to grant Gold Card Exemptions to providers of health care in accordance with **section 107** except in certain circumstances. ~~[Sections 44 and]~~ **Section 63** of this bill ~~[require insurance for the employees of local governments,]~~ **requires** Medicaid and the Children's Health Insurance Program to comply with certain requirements governing the prompt payment of claims that apply under existing law to private insurers and the Public Employees' Benefits Program. (NRS 683A.0879, 689A.410, 689B.255, 689C.355, 689A.188, 695B.2505, 695C.185, 695D.215) **Section 63** additionally requires Medicaid to comply with certain federal requirements governing the timely payment of claims under Medicaid. (42 C.F.R. § 447.45(d)(2),(3))

Section 108 requires the Commissioner to adopt regulations prescribing: (1) requirements to ensure that applicants for certain certificates or approval to engage in business related to insurance are equipped to comply with certain requirements governing prior authorization and the payment of health claims; and (2) criteria to ensure that an insurer or other entity that enters into a contract to provide services for certain public insurance programs is in compliance with those requirements. **Sections 45,** ~~[64, 66,]~~ **91, 93-95** ~~[, 115]~~ **and 116** of this bill make various changes to establish the applicability of those regulations. **Section 92** of this bill makes a conforming change to indicate the proper placement of **section 91** in the Nevada Revised Statutes. **Section 108** additionally requires the Commissioner to perform certain other duties relating to the implementation and enforcement of requirements governing prior authorization and the payment of health claims. **Section 65** of this bill requires the prior authorization policies and procedures for prescription drugs under Medicaid to comply with **sections 53-63**. **Section 41** of this bill requires the Director of the Department to administer **sections** ~~[49-63]~~ **50-63** in the same manner as other provisions governing Medicaid. **Sections** ~~[44,]~~ **47,** ~~[52,]~~ **69 and 114** of this bill make **sections 97-108 and 110** applicable to insurance for ~~[public]~~ **state** and private employees ~~[, Medicaid managed care organizations]~~ and nonprofit hospital or medical services corporations. **Section 101.3 of this bill makes sections 101.8-105 and 110 inapplicable to Medicaid managed care organizations, which are instead required to comply with sections 56 and 58-61. Sections** ~~[23-27,]~~ **23, 24, 25, 26, 27, 90, 111 and 112** of this bill make conforming changes concerning the applicability and enforcement of **sections 20-22 and 109**.

Section 121 of this bill requires the Patient Protection Commission to conduct a study during the 2025-2026 interim concerning academic medical centers in this State, and section 120 of this bill appropriates money for the study.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter ~~[439A]~~ **439** of NRS is hereby amended by adding thereto ~~[the provisions set forth as sections 2 to 18, inclusive, of this act.]~~ **a new section to read as follows:**

"High-level provider of health care" means a physician or physician assistant licensed pursuant to chapter 630 or 633 of NRS, dentist, advanced practice registered nurse, chiropractic physician, podiatric physician or physical therapist.

Sec. 1.5. **NRS 439.581 is hereby amended to read as follows:**

439.581 As used in NRS 439.581 to 439.597, inclusive, ***and section 1 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 439.582 to 439.585, inclusive, ***and section 1 of this act*** have the meanings ascribed to them in those sections.

Sec. 2. ~~***[As used in sections 2 to 18, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3, 4 and 5 of this act have the meanings ascribed to them in those sections.]***~~ **(Deleted by amendment.)**

Sec. 2.5. **NRS 439.588 is hereby amended to read as follows:**

439.588 1. A health information exchange shall not operate in this State without first obtaining certification as provided in subsection 2.

2. The Director shall by regulation establish the manner in which a health information exchange may apply for certification and the requirements for granting such certification, which must include, without limitation, that the health information exchange demonstrate its financial and operational sustainability, adherence to the privacy, security and patient consent standards adopted pursuant to NRS 439.589 and capacity for interoperability with any other health information exchange certified pursuant to this section.

3. The Director may deny an application for certification or may suspend or revoke any certification issued pursuant to subsection 2 for failure to comply with the provisions of NRS 439.581 to 439.597, inclusive, ***and section 1 of this act*** or the regulations adopted pursuant thereto or any applicable federal or state law.

4. When the Director intends to deny, suspend or revoke a certification, he or she shall give reasonable notice to all parties by certified mail. The notice must contain the legal authority, jurisdiction and reasons for the action to be taken. A health information exchange that wishes to contest the action of the Director must file an appeal with the Director.

5. The Director shall adopt regulations establishing the manner in which a person may file a complaint with the Director regarding a violation of the provisions of this section.

6. The Director may impose an administrative fine against a health information exchange which operates in this State without holding a certification in an amount established by the Director by regulation. The Director shall afford a health information exchange so fined an opportunity for a hearing pursuant to the provisions of NRS 233B.121.

7. The Director may adopt such regulations as he or she determines are necessary to carry out the provisions of this section.

Sec. 3. ~~***["Account" means the Nevada Health Care Workforce and Access Account created by section 6 of this act.]***~~ **(Deleted by amendment.)**

Sec. 3.3. **NRS 439.589 is hereby amended to read as follows:**

439.589 1. The Director, in consultation with health care providers, third parties and other interested persons and entities, shall by regulation prescribe a

framework for the electronic maintenance, transmittal and exchange of electronic health records, prescriptions, health-related information and electronic signatures and requirements for electronic equivalents of written entries or written approvals in accordance with federal law. The regulations must:

(a) Establish standards for networks and technologies to be used to maintain, transmit and exchange health information, including, without limitation, standards:

(1) That require:

(I) The use of networks and technologies that allow patients to access electronic health records directly from the health care provider of the patient and forward such electronic health records electronically to other persons and entities; and

(II) The interoperability of such networks and technologies in accordance with the applicable standards for the interoperability of Qualified Health Information Networks prescribed by the Office of the National Coordinator for Health Information Technology of the United States Department of Health and Human Services;

(2) To ensure that electronic health records retained or shared are secure;

(3) To maintain the confidentiality of electronic health records and health-related information, including, without limitation, standards to maintain the confidentiality of electronic health records relating to a child who has received health care services without the consent of a parent or guardian and which ensure that a child's right to access such health care services is not impaired;

(4) To ensure the privacy of individually identifiable health information, including, without limitation, standards to ensure the privacy of information relating to a child who has received health care services without the consent of a parent or guardian;

(5) For obtaining consent from a patient before retrieving the patient's health records from a health information exchange, including, without limitation, standards for obtaining such consent from a child who has received health care services without the consent of a parent or guardian;

(6) For making any necessary corrections to information or records;

(7) For notifying a patient if the confidentiality of information contained in an electronic health record of the patient is breached;

(8) Governing the ownership, management and use of electronic health records, health-related information and related data; and

(9) For the electronic transmission of prior authorizations for prescription medication;

(b) Ensure compliance with the requirements, specifications and protocols for exchanging, securing and disclosing electronic health records, health-related information and related data prescribed pursuant to the provisions of the Health Information Technology for Economic and Clinical Health Act, 42 U.S.C. §§ 300jj et seq. and 17901 et seq., the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and other applicable federal and state law; and

(c) Be based on nationally recognized best practices for maintaining, transmitting and exchanging health information electronically.

2. The standards prescribed pursuant to this section must include, without limitation:

(a) Requirements for the creation, maintenance and transmittal of electronic health records;

(b) Requirements for protecting confidentiality, including control over, access to and the collection, organization and maintenance of electronic health records, health-related information and individually identifiable health information;

(c) Requirements for the manner in which a patient may, through a health care provider who participates in the sharing of health records using a health information exchange, revoke his or her consent for a health care provider to retrieve the patient's health records from the health information exchange;

(d) A secure and traceable electronic audit system for identifying access points and trails to electronic health records and health information exchanges; and

(e) Any other requirements necessary to comply with all applicable federal laws relating to electronic health records, health-related information, health information exchanges and the security and confidentiality of such records and exchanges.

3. The regulations adopted pursuant to this section must not require any person or entity to use a health information exchange.

4. Except as otherwise provided in subsections 5, 6 and 7, the Department and the divisions thereof, other state and local governmental entities, ***medical facilities, high-level providers of*** health care ***,*** ~~[providers,]~~ third parties, pharmacy benefit managers and other entities licensed or certified pursuant to title 57 of NRS shall maintain, transmit and exchange health information in accordance with the regulations adopted pursuant to this section, the provisions of NRS 439.581 to 439.597, inclusive, ***and section 1 of this act*** and any other regulations adopted pursuant thereto.

5. The Federal Government and employees thereof, a provider of health coverage for federal employees, a provider of health coverage that is subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq., or a Taft-Hartley trust formed pursuant to 29 U.S.C. § 186(c)(5) is not required to but may maintain, transmit and exchange electronic information in accordance with the regulations adopted pursuant to this section.

6. A ***high-level provider of*** health care ~~[provider]~~ may apply to the Department for a waiver from the provisions of subsection 4 on the basis that the ***high-level provider of*** health care ~~[provider]~~ does not have the infrastructure necessary to comply with those provisions, including, without limitation, because the health care provider does not have access to the Internet. The Department shall grant a waiver if it determines that:

(a) The ***high-level provider of*** health care ~~[provider]~~ does not currently have the infrastructure necessary to comply with the provisions of subsection 4; and

(b) Obtaining such infrastructure is not reasonably practicable, including, without limitation, because the cost of such infrastructure would make it difficult for the ***high-level provider of*** health care ~~[provider]~~ to continue to operate.

7. The provisions of subsection 4 do not apply to ~~[the]~~ ***:***

(a) The Department of Corrections ~~[.]~~ ***;***

(b) A high-level provider of health care whose solo practice provided care to fewer than 500 patients during the immediately preceding year and reasonably expects to provide care to fewer than 500 patients during the current year; or

(c) A high-level provider of health care who, in combination with all other members of his or her group practice provided care to fewer than 500 patients during the immediately preceding year and reasonably expects to provide care to fewer than 500 patients during the current year.

8. ***A high-level provider of health care described in paragraphs (b) and (c) of subsection 7 shall furnish the medical records of a patient electronically to the patient or, upon the request of the patient, another person or entity, in accordance with NRS 629.062.***

9. A violation of the provisions of this section or any regulations adopted pursuant thereto is not a misdemeanor.

~~[9.]~~ ***10.*** As used in this section:

(a) ***"Medical facility" has the meaning ascribed to it in NRS 449.0151.***

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

~~(b)~~ ***(c)*** "Third party" means any insurer, governmental entity or other organization providing health coverage or benefits in accordance with state or federal law.

Sec. 3.6. **NRS 439.589 is hereby amended to read as follows:**

439.589 1. The Director, in consultation with health care providers, third parties and other interested persons and entities, shall by regulation prescribe a framework for the electronic maintenance, transmittal and exchange of electronic health records, prescriptions, health-related information and electronic signatures and requirements for electronic equivalents of written entries or written approvals in accordance with federal law. The regulations must:

(a) Establish standards for networks and technologies to be used to maintain, transmit and exchange health information, including, without limitation, standards:

(1) That require:

(I) The use of networks and technologies that allow patients to access electronic health records directly from the health care provider of the patient and forward such electronic health records electronically to other persons and entities; and

(II) The interoperability of such networks and technologies in accordance with the applicable standards for the interoperability of Qualified Health Information Networks prescribed by the Office of the National Coordinator for Health Information Technology of the United States Department of Health and Human Services;

(2) To ensure that electronic health records retained or shared are secure;

(3) To maintain the confidentiality of electronic health records and health-related information, including, without limitation, standards to maintain the confidentiality of electronic health records relating to a child who has received health care services without the consent of a parent or guardian and which ensure that a child's right to access such health care services is not impaired;

(4) To ensure the privacy of individually identifiable health information, including, without limitation, standards to ensure the privacy of information relating to a child who has received health care services without the consent of a parent or guardian;

(5) For obtaining consent from a patient before retrieving the patient's health records from a health information exchange, including, without limitation, standards for obtaining such consent from a child who has received health care services without the consent of a parent or guardian;

(6) For making any necessary corrections to information or records;

(7) For notifying a patient if the confidentiality of information contained in an electronic health record of the patient is breached;

(8) Governing the ownership, management and use of electronic health records, health-related information and related data; and

(9) For the electronic transmission of prior authorizations for prescription medication;

(b) Ensure compliance with the requirements, specifications and protocols for exchanging, securing and disclosing electronic health records, health-related information and related data prescribed pursuant to the provisions of the Health Information Technology for Economic and Clinical Health Act, 42 U.S.C. §§ 300jj et seq. and 17901 et seq., the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and other applicable federal and state law; and

(c) Be based on nationally recognized best practices for maintaining, transmitting and exchanging health information electronically.

2. The standards prescribed pursuant to this section must include, without limitation:

(a) Requirements for the creation, maintenance and transmittal of electronic health records;

(b) Requirements for protecting confidentiality, including control over, access to and the collection, organization and maintenance of electronic health records, health-related information and individually identifiable health information;

(c) Requirements for the manner in which a patient may, through a health care provider who participates in the sharing of health records using a health information exchange, revoke his or her consent for a health care provider to retrieve the patient's health records from the health information exchange;

(d) A secure and traceable electronic audit system for identifying access points and trails to electronic health records and health information exchanges; and

(e) Any other requirements necessary to comply with all applicable federal laws relating to electronic health records, health-related information, health information exchanges and the security and confidentiality of such records and exchanges.

3. The regulations adopted pursuant to this section must not ~~[require]~~ ***:***

(a) Require any person or entity to use a health information exchange ~~[.]~~ ***; or***

(b) Authorize a person or entity described in subsection 4 to comply with the requirements of that subsection by:

(1) Connecting with a health information exchange; or

(2) Utilizing any other service that charges a fee to such a person or entity or a patient for providing electronic health records to a patient upon request in violation of NRS 629.062.

4. Except as otherwise provided in subsections 5, 6 and 7, the Department and the divisions thereof, other state and local governmental entities, medical facilities, high-level providers of health care, third parties, pharmacy benefit managers and other entities licensed or certified pursuant to title 57 of NRS shall maintain, transmit and exchange health information in accordance with the regulations adopted pursuant to this section, the provisions of NRS 439.581 to 439.597, inclusive, and section 1 of this act and any other regulations adopted pursuant thereto.

5. The Federal Government and employees thereof, a provider of health coverage for federal employees, a provider of health coverage that is subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq., or a Taft-Hartley trust formed pursuant to 29 U.S.C. § 186(c)(5) is not required to but may maintain, transmit and exchange electronic information in accordance with the regulations adopted pursuant to this section.

6. A high-level provider of health care may apply to the Department for a waiver from the provisions of subsection 4 on the basis that the high-level provider of health care does not have the infrastructure necessary to comply with those provisions, including, without limitation, because the health care provider does not have access to the Internet. The Department shall grant a waiver if it determines that:

(a) The high-level provider of health care does not currently have the infrastructure necessary to comply with the provisions of subsection 4; and

(b) Obtaining such infrastructure is not reasonably practicable, including, without limitation, because the cost of such infrastructure would make it difficult for the high-level provider of health care to continue to operate.

7. The provisions of subsection 4 do not apply to:

(a) The Department of Corrections;

(b) A high-level provider of health care whose solo practice provided care to fewer than 500 patients during the immediately preceding year and reasonably expects to provide care to fewer than 500 patients during the current year; or

(c) A high-level provider of health care who, in combination with all other members of his or her group practice provided care to fewer than 500 patients during the immediately preceding year and reasonably expects to provide care to fewer than 500 patients during the current year.

8. A high-level provider of health care described in paragraphs (b) and (c) of subsection 7 shall furnish the medical records of a patient electronically to the patient or, upon the request of the patient, another person or entity, in accordance with NRS 629.062.

9. A violation of the provisions of this section or any regulations adopted pursuant thereto is not a misdemeanor.

10. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

(c) "Third party" means any insurer, governmental entity or other organization providing health coverage or benefits in accordance with state or federal law.

Sec. 4. ~~[*"Board of Economic Development" means the Board of Economic Development created by NRS 231.023.*]~~ **(Deleted by amendment.)**

Sec. 4.5. **NRS 439.5895 is hereby amended to read as follows:**

439.5895 1. The Department shall notify each regulatory body of this State that has issued a current, valid license to a licensed provider or insurer if:

(a) The Department determines that the licensed provider or insurer is not in compliance with the requirements of subsection 4 of NRS 439.589 ~~[.]~~ and

~~[(b) The]~~ ***the*** licensed provider or insurer:

(1) Is not exempt from those requirements pursuant to subsection 5 of NRS 439.589; and

(2) Has not received a waiver of those requirements pursuant to subsection 6 of NRS 439.589 ~~[.]~~ ***; or***

(b) The licensed provider or insurer is a high-level provider of health care who is exempt from the requirements of subsection 4 of NRS 439.589 pursuant to paragraph (b) or (c) of subsection 7 of NRS 439.589 and the Department determines that the high-level provider of health care is not in compliance with subsection 8 of NRS 439.589.

2. If the Department determines that a licensed provider or insurer for which notice was previously provided pursuant to subsection 1 has come into compliance with the requirements of subsection 4 of NRS 439.589, the Department shall immediately notify the regulatory body that issued the license.

3. As used in this section:

(a) "License" means any license, certificate, registration, permit or similar type of authorization to practice an occupation or profession or engage in a business in this State issued to a licensed provider or insurer.

(b) "Licensed provider or insurer" means:

(1) A medical facility licensed pursuant to chapter 449 of NRS;

(2) ~~[The holder of a permit to operate an ambulance, an air ambulance or a vehicle of a fire fighting agency pursuant to chapter 450B of NRS;~~

~~(3)]~~ A provider of health care, as defined in NRS 629.031, who is licensed pursuant to title 54 of NRS; or

~~[(4)]~~ ***(3)*** Any person licensed pursuant to title 57 of NRS.

(c) "Regulatory body" means any governmental entity that issues a license.

Sec. 5. ~~[*"Provider of health care" has the meaning ascribed to it in NRS 629.031.*]~~ (Deleted by amendment.)

Sec. 5.5. Chapter 439A of NRS is hereby amended by adding thereto the provisions set forth as sections 7 to 10.5, inclusive, of this act.

Sec. 6. ~~[*1. There is hereby created in the State General Fund the Nevada Health Care Workforce and Access Account. The Account must be administered by the Director of the Department.*~~

~~*2. Any interest earned on money in the Account, after deducting any applicable charges, must be credited to the Account. Money that remains in the Account at the end of a fiscal year does not revert to the State General Fund, and the balance in the Account must be carried forward to the next fiscal year.*~~

~~*3. Except as otherwise provided in subsection 4 and section 67 of this act, money in the Account must be used to carry out the provisions of sections 2 to 18, inclusive, of this act.*~~

~~*4. Upon approval of the Interim Finance Committee, the Director may transfer money from the Account to another account under the control of the Director or the Department for the purpose of obtaining additional federal financial participation under Medicaid.*~~

~~*5. The Director may accept gifts, grants and donations to carry out the provisions of sections 2 to 18, inclusive, of this act.*~~ *]* (Deleted by amendment.)

Sec. 7. ***1. On or before July 1 of each even-numbered year, the*** ~~[*Director, in collaboration with the Division of Public and Behavioral Health of the*~~ ***Department, in collaboration with the Health Care Workforce Working Group established pursuant to NRS 439A.118, shall:***

(a) Conduct a comprehensive assessment of needs with regard to the health care workforce in this State; and

(b) ~~[*Submit*~~ ***Compile a report of the results of the assessment and submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to the Joint Interim Standing Committee on Health and Human Services and the next regular session of the Legislature.***

2. The assessment conducted pursuant to paragraph (a) of subsection 1 must consist of:

(a) ~~[*An identification of the needs of this State with regard to its health care workforce, including, without limitation, identification of:*~~

~~*(1) Shortages of providers of health care by geographic region, including rural and urban areas, and the types of services provided;*~~

~~*(2) Populations in this State that are experiencing difficulties in accessing health care, with consideration of socioeconomic factors, health outcomes and access to all necessary types of health care;*~~

~~*(3) Geographic areas and populations of this State where the shortage of providers of health care is most critical and the types of services needed; and*~~

~~*(4) Specialty providers of health care for which the need in this State, and in the geographic areas and among the populations identified pursuant to subparagraph (3), is most critical;*~~

~~*(b) Suggestions for strategic investments targeted to meet the needs identified pursuant to paragraph (a), including, where possible, suggestions for meeting those needs in a manner that is sustainable over the long term; and*~~

~~*(c) A description of how the projects funded through the investments described in paragraph (b) will integrate with and enhance existing health care infrastructure.*~~ *]* ***A quantitative analysis of the health care workforce in this State, including, without limitation:***

(1) A determination of the total number of providers of health care in this State and the total number of providers of health care in this State who practice different professions and different specialties within those professions;

(2) A determination of the total number of providers of health care who practice in different geographic areas of this State and the total number of providers of health care who practice different professions and different specialties within those geographic areas; and

(3) A comparison of the numbers of providers of health care identified pursuant to subparagraphs (1) and (2) with benchmarks established by the Health Resources and Services Administration of the United States Department of Health and Human Services or nationally recognized organizations that prescribe such benchmarks;

(b) A determination of the most critical shortages in the health care workforce of this State, prioritizing:

(1) Essential health care professions and specialties and essential clinical services or expertise currently experiencing shortages; and

(2) Geographic areas of this State that are experiencing the most critical shortages of providers of health care or clinical services or expertise;

(c) An identification of unmet needs for specific health technology and therapies, including, without limitation, genomic testing, clinical trials, cellular therapies and palliative care; and

(d) A determination of any areas where there is an oversupply of providers of health care, including, without limitation, specialists or clinical services.

3. The report compiled pursuant to paragraph (b) of subsection 1 must include, without limitation:

(a) A summary of the assessment conducted pursuant to paragraph (a) of subsection 1, including, without limitation:

(1) An analysis of shortages of providers of health care, shortages of clinical services or expertise and unmet health needs in this State; and

(2) A description of shortages of providers of health care and the shortages of clinical services or expertise by geographic region, including rural and urban areas; and

(b) Recommendations for legislation and regulatory changes to improve the recruitment and retention of providers of health care.

4. As used in this section:

(a) "Palliative care" means a multidisciplinary and patient- and family-centered approach to specialized medical care for a person with a serious illness, which approach focuses on the care of a patient throughout the continuum of an illness and involves addressing the physical, emotional, social and spiritual needs of the patient, as well as facilitating patient autonomy, access to information and choice of care. The term includes, without limitation, discussion of the goals of the patient for treatment and discussion of treatment options appropriate to the patient, including, where appropriate, hospice care and comprehensive management of pain and symptoms.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 8. ~~*[1. The Department shall, in accordance with sections 2 to 18, inclusive, of this act, establish and administer a Nevada Health Care Workforce and Access Program as a competitive program to award money from the Account to persons and entities in this State seeking to address shortages of providers of health care and difficulties in accessing health care identified in the assessment conducted pursuant to section 7 of this act. Money from the Account may be awarded through grants, loans, reimbursements or investments.*~~

~~2. To be eligible to receive money pursuant to sections 2 to 18, inclusive, of this act, a proposed project must:~~

~~(a) Directly address shortages of providers of health care or difficulties in accessing health care identified in the assessment conducted pursuant to section 7 of this act.~~

~~(b) Include specific, measurable outcomes to demonstrate an increase in the number of providers of health care, improved access to health care and enhanced capacity of the health care workforce in a manner that addresses the shortages of providers of health care or difficulties in accessing health care identified pursuant to paragraph (a).~~

~~(c) Secure from the Federal Government or any other source an amount of matching funds that is at least equal to the amount of the award. Matching funds from the Federal Government only meet the requirements of this paragraph if federal approval has already been granted.~~

~~(d) Demonstrate the potential for financial and operational sustainability after the expiration of the award, including, without limitation by:~~

~~(1) Planning for continued staffing, budget sustainability and continued allocation of resources; and~~

~~(2) Conducting an impact assessment concerning the sustainability of the project after the expiration of the award.]~~ **(Deleted by amendment.)**

Sec. 8.5. ***"Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.***

Sec. 9. ~~*[A person or entity that wishes to receive funding pursuant to sections 2 to 18, inclusive, of this act must apply to the Department in the form prescribed by the Department during an open application period established pursuant to section 18 of this act. The application must include, without limitation:*~~

~~1. A comprehensive proposal for the project to be funded that outlines:~~

~~(a) The goals and objectives of the proposed project;~~

~~(b) The specific needs in the health care workforce identified in the assessment conducted pursuant to section 7 of this act that the proposed project will address; and~~

~~(c) The manner in which the proposed project will recruit, retain or train providers of health care to address the specific needs outlined pursuant to paragraph (b).~~

~~2. A detailed budget that clearly sets forth the projected costs of and sources of funding for the proposed project. Such sources of funding must include, without limitation, the matching funds described in paragraph (c) of subsection 2 of section 8 of this act.~~

~~3. Evidence of approval or commitment from the persons and entities that will provide the matching funds described in paragraph (c) of subsection 2 of section 8 of this act.~~

~~4. Documentation of the qualifications and relevant experience of the applicant.~~

~~5. Evidence that the applicant has the organizational capacity to successfully implement and sustain the proposed project, including, without limitation, a description of the key personnel who will be involved and any relevant partnerships with persons and entities engaged in the provision of health care, educational institutions, governmental entities or other persons and entities.~~

~~6. A timeline for implementing the proposed project that includes, without limitation, defined milestones, measurable performance indicators and a plan for reporting progress and evaluating outcomes at regular intervals.~~

~~7. A detailed operational plan for the proposed project that:~~

~~(a) Outlines staffing, facilities, equipment and other logistical requirements; and~~

~~(b) Addresses potential challenges in recruiting and retaining providers of health care.~~

~~8. A plan for sustainability that addresses the manner in which the proposed project will continue to provide benefits after the expiration of the funding including, without limitation, possible sources of funding, partnerships or strategies for reinvestment.~~

~~9. Any additional information required by the regulations adopted pursuant to section 18 of this act.]~~ **(Deleted by amendment.)**

Sec. 9.5. *1. The Department shall establish and maintain a program to increase public awareness of health care information concerning the independent centers for emergency medical care in this State. The program must be designed to assist consumers with comparing the quality of care provided by the independent centers for emergency medical care in this State and the charges for that care.*

2. The program must include, without limitation, the collection, maintenance and provision of information concerning:

(a) Patients of each independent center for emergency medical care in this State as reported in the forms submitted pursuant to NRS 449.485;

(b) The quality of care provided by each independent center for emergency medical care in this State as determined by applying measures of quality endorsed by the entities described in subparagraph (1) of paragraph (b) of subsection 1 of section 10.5 of this act, expressed as a number of events and rate of occurrence, if such measures can be applied to the information reported in the forms submitted pursuant to NRS 449.485;

(c) How consistently each independent center for emergency medical care follows recognized practices to prevent the infection of patients, to speed the recovery of patients and to avoid medical complications of patients;

(d) The total number of patients discharged from the independent center for emergency medical care and the total number of potentially preventable readmissions to a hospital or independent center for emergency medical care, which must be expressed as a total number and a rate of occurrence of potentially preventable readmissions, and the average length of stay and the average billed charges for those potentially preventable readmissions; and

(e) Any other information relating to the charges imposed and the quality of the services provided by the independent centers for emergency medical care in this State which the Department determines is:

(1) Useful to consumers;

(2) Nationally recognized; and

(3) Reported in a standard and reliable manner.

Sec. 10. ~~[1. The Department shall review applications submitted pursuant to section 9 of this act to determine which applicants to recommend for funding pursuant to section 11 of this act.~~

~~2. In making determinations pursuant to subsection 1 concerning which applicants to recommend for funding pursuant to section 11 of this act, the Department shall prioritize applicants who:~~

~~(a) Possess strong qualifications, appropriate experience and high organizational capacity to effectively implement and sustain the proposed project, including, without limitation, a proven ability to manage similar projects, meet projected outcomes and maintain compliance with the requirements of sections 2 to 18, inclusive, of this act and any regulations adopted pursuant thereto;~~

~~(b) Demonstrate strong collaboration with entities in the public and private sectors, including secured financial commitments from multiple entities where practicable based on the proposed project;~~

~~(c) Maximize the amount of funding available for the proposed project from sources other than the public revenue of this State;~~

~~(d) Address areas with severe and urgent shortages of providers of health care or severe and urgent issues with access to health care, with the highest priority given to projects that address needs identified pursuant to subparagraph (3) of paragraph (a) of subsection 2 of section 7 of this act;~~

~~(e) Demonstrate the potential to create lasting improvement in accessibility to health care and the availability of providers of health care in the community affected by the proposed project, including, without limitation, by meeting specific metrics for improvements to access to health care, health care outcomes and the capacity of the health care workforce over time;~~

~~(f) Illustrate a clear and feasible path to sustainability for the proposed project, thereby reducing the likelihood of needing additional state funding in the future;~~

~~(g) Include a substantial investment in and establishment of capital infrastructure to address needs identified in the assessment conducted pursuant to section 7 of this act over the long term and support sustainable access to health care, including, without limitation:~~

~~(1) The construction of medical facilities;~~

~~(2) The expansion of capabilities for delivering services through telehealth; and~~

~~(3) The development of facilities for residencies or other training of providers of health care; and~~

~~(h) Propose to use technology or innovative models of delivering health care in a manner that may reduce costs, improve outcomes and expand access to underserved populations.~~

~~3. In making determinations pursuant to subsection 1 concerning which applicants to recommend for funding pursuant to section 11 of this act, the Department may consider in-kind contributions to support the project, but such contributions must not be counted toward the matching contributions required by paragraph (c) of subsection 2 of section 8 of this act.~~

~~4. As used in this section:~~

~~(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.~~

~~(b) "Telehealth" has the meaning ascribed to it in NRS 629.515.]~~ **(Deleted by amendment.)**

Sec. 10.5. ***1. The Department shall, by regulation:***

(a) Prescribe the information that each independent center for emergency medical care in this State must submit to the Department for the program established pursuant to section 9.5 of this act.

(b) Prescribe the measures of quality for independent centers for emergency medical care that are required pursuant to paragraph (b) of subsection 2 of section 9.5 of this act. In adopting the regulations, the Department shall:

(1) Use the measures of quality endorsed by the Agency for Healthcare Research and Quality, the National Quality Forum, Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, a quality improvement organization of the Centers for Medicare and Medicaid Services and the Joint Commission;

(2) Prescribe a reasonable number of measures of quality which must not be unduly burdensome on the independent centers for emergency medical care; and

(3) Take into consideration the financial burden placed on the independent centers for emergency medical care to comply with the regulations.

(c) Prescribe the manner in which an independent center for emergency medical care must determine whether the readmission of a patient must be reported pursuant to section 9.5 of this act as a potentially preventable readmission and prescribe the form for submission of such information.

(d) Require each independent center for emergency medical care to provide the information prescribed in paragraphs (a), (b) and (c) in the format required by the Department.

2. The information required pursuant to this section and section 9.5 of this act must be submitted to the Department not later than 45 days after the last day of each calendar month.

3. If an independent center for emergency medical care fails to submit the information required pursuant to this section or section 9.5 of this act or submits information that is incomplete or inaccurate, the Department shall send a notice of such failure to the independent center for emergency medical care and to the Division of Public and Behavioral Health of the Department.

Sec. 11. ~~*[1. After reviewing applications pursuant to section 10 of this act, the Department shall submit to the Board of Economic Development its recommendations for awarding funding pursuant to sections 2 to 18, inclusive, of this act.*~~

~~*2. Except as otherwise provided in this subsection, the Department shall ensure that all applicants for funding pursuant to sections 2 to 18, inclusive, of this act meet the requirements of sections 8 and 9 of this act. The Director may waive any such requirement to maximize the ability of the Department to utilize matching funds from the Federal Government and other sources. If the Department makes a recommendation for funding a project to which such a waiver applies, the Department must include in the recommendation a statement of the reason for the waiver.*~~

~~*3. When making recommendations pursuant to this section, the Department:*~~

~~*(a) May recommend funding one or more proposed projects, within the limits of money in the Account; and*~~

~~*(b) May not award a total amount of money during any funding period that exceeds the amount available in the Account for that funding period.]*~~ **(Deleted by amendment.)**

Sec. 11.2. **NRS 439A.020 is hereby amended to read as follows:**

439A.020 The purposes of this chapter are to:

1. Promote equal access to quality health care at a reasonable cost;
2. Promote an adequate supply and distribution of health resources;
3. Promote uniform, effective methods of delivering health care;
4. Promote and encourage the adequate distribution of health and care facilities and human resources;
5. Promote and encourage the effective use of methods for controlling increases in the cost of health care;
6. Encourage participation in health planning by members of the several health professions, representatives of institutions and agencies interested in the provision of health care and the reduction of the cost of such care, and the general public;
7. Utilize the viewpoint of the general public for making decisions;
8. Provide information to the general public concerning the charges imposed and the quality of the services provided by the hospitals**,** ~~[and]~~ surgical centers for

ambulatory patients ***and independent centers for emergency medical care*** in this State;

9. Encourage public education regarding proper personal health care and methods for the effective use of available health services; and

10. Promote a program of technical assistance to purchasers to contain effectively the cost of health care, including:

(a) Providing information to purchasers regarding the charges made by practitioners.

(b) Training purchasers to negotiate successfully for a policy of health insurance.

(c) Conducting studies and providing other information about measures to assist purchasers in containing the cost of health care.

Sec. 11.5. **NRS 439A.200 is hereby amended to read as follows:**

439A.200 As used in NRS 439A.200 to 439A.290, inclusive, ***and sections 8.5, 9.5 and 10.5 of this act*** unless the context otherwise requires, the words and terms defined in NRS 439A.205, 439A.207 and 439A.210 ***and section 8.5 of this act*** have the meanings ascribed to them in those sections.

Sec. 12. ~~*[1. A joint committee consisting of the members of the Board of Economic Development and the members of the Patient Protection Commission created by NRS 439.908 shall review each recommendation for awarding funding submitted to the Board of Economic Development pursuant to section 11 of this act.*~~

~~*2. When reviewing a recommendation pursuant to subsection 1, the joint committee shall consider, without limitation, the degree to which the recommendation addresses the needs identified in the assessment conducted pursuant to section 7 of this act.*~~

~~*3. After reviewing a recommendation pursuant to subsection 1, the joint committee may, by a majority vote of its members, approve, deny or request revisions to a recommendation. If the joint committee requests revisions to a recommendation, the Department shall work with the applicant to whom the recommendation applies to make those revisions.*~~

~~*4. If a member of the joint committee has a conflict of interest or the appearance of a conflict of interest concerning a recommendation under review, the member shall:*~~

~~*(a) Disclose the actual or apparent conflict of interest before any discussion of or vote on the recommendation;*~~

~~*(b) Abstain from voting on the recommendation; and*~~

~~*(c) Recuse himself or herself from participating in discussions where the actual or apparent conflict of interest may compromise the objectivity of the review process.*~~

~~*5. If the joint committee votes to approve a recommendation pursuant to subsection 3, the Department shall issue a written notice of the approval to the applicant to whom the recommendation pertains. Such written notice must include, without limitation:*~~

~~*(a) The total amount of money being awarded; and*~~

~~*(b) The schedule of disbursements and specific conditions that will be included in the funding agreement entered into pursuant to section 13 of this act.*~~

~~*6. The Department shall maintain a public record of all proceedings of the joint committee conducted pursuant to this section, including, without limitation, all votes conducted pursuant to subsection 3.*~~

~~*7. As used in this section, "conflict of interest" includes, without limitation, any conflict of interest based on:*~~

~~*(a) The personal interests of the member of the joint committee described in subsection 1 or a person within the first degree of consanguinity or affinity of such a member; and*~~

~~*(b) The interests of a business or organization that employs or contracts with a person described in paragraph (a) or with which such a person is otherwise affiliated.]*~~ **(Deleted by amendment.)**

Sec. 12.5. **NRS 439A.260 is hereby amended to read as follows:**

439A.260 1. The Department shall collect and maintain all information that it receives from the hospitals , ~~[and]~~ surgical centers for ambulatory patients ***and independent centers for emergency medical care*** in this State pursuant to NRS 439A.220 to 439A.250, inclusive ~~.~~ ~~[]~~ ***and sections 8.5, 9.5 and 10.5 of this act.*** Upon request, the Department shall make a summary of the information available to:

(a) Consumers of health care;

(b) Providers of health care;

(c) Representatives of the health insurance industry; and

(d) The general public.

2. The Department shall ensure that the information it provides pursuant to this section is aggregated so as not to reveal the identity of a specific inpatient or outpatient of a hospital , ~~[or]~~ of a surgical center for ambulatory patients ~~.~~ ~~[]~~ ***or of an independent center for emergency medical care.***

Sec. 13. ~~*[1. Not later than 60 days after a recommendation is approved pursuant to section 12 of this act, the Department shall enter into a funding agreement with the applicant to whom the recommendation pertains.*~~

~~*2. A funding agreement entered into pursuant to subsection 1 must:*~~

~~*(a) Provide for the distribution of the funding in installments that are contingent on the achievement of specific goals and indicators of performance mutually agreed upon by the Department and the recipient of funding which demonstrate measurable progress toward increasing the number of providers of health care, improving access to health care or enhancing health care infrastructure, as appropriate for the specific project;*~~

~~*(b) Require the recipient of funding to submit documentation that the recipient has achieved the goals and indicators of performance prescribed in the agreement pursuant to paragraph (a) before money may be disbursed;*~~

~~*(c) Establish requirements governing matching funds in accordance with the provisions of paragraph (c) of subsection 2 of section 8 of this act, including, without limitation, requirements for the recipient of funding to submit to the Department documented proof of adherence to those requirements before money may be disbursed;*~~

~~*(d) Require the recipient of funding to submit to the Department an annual report that includes, without limitation:*~~

~~*(1) Detailed financial statements that include, without limitation, expenditures, allocations of matching funds and receipts for major purchases;*~~

~~*(2) Updates on the progress of the recipient toward achieving the goals and indicators of performance specified pursuant to paragraph (a);*~~

~~*(3) Identification of any issues or delays in achieving the goals and indicators of performance specified pursuant to paragraph (a) and any adjustments made to address unforeseen challenges in achieving those goals and indicators;*~~

~~*(4) Documentation of partnerships with public and private entities, including, without limitation, financial contributions, collaborations and commitments for financial contributions and collaborations; and*~~

~~*(5) Such additional information as may be required by the Department to assess the progress and impact of the project;*~~

~~*(e) Require that the recipient of funding comply with any request made by the Department or the Office of Finance as part of an action taken pursuant to section 14 of this act; and*~~

~~*(f) Include any other provisions deemed necessary by the Department to ensure the accountability of the recipient of funding and the achievement of the objectives of the project, which may include, without limitation, caps on disbursements for projects with extensive capital infrastructure.*~~

~~*3. If a recipient of funding pursuant to sections 2 to 18, inclusive, of this act significantly modifies or terminates a funded project, or if there are changes in the availability of funding for such a project, the recipient shall immediately notify the Department and, if the recipient is not terminating the project, submit to the Department a revised plan for the project that details all of the modifications. Upon receiving such notification, the Department may, to ensure that money from the Account is used efficiently and effectively in a manner that complies with section 8 of this act:*~~

~~*(a) Adjust the terms of the funding agreement, including, without limitation, the terms for disbursement and the amount of funding, or terminate the funding agreement; and*~~

~~*(b) Reallocate unspent money to other approved projects or deposit unspent money in the Account to support allocations for other projects funded pursuant to sections 2 to 18, inclusive, of this act.]~~ **(Deleted by amendment.)**

Sec. 13.5. **NRS 439A.270 is hereby amended to read as follows:**

439A.270 1. The Department shall establish and maintain an Internet website that includes the information concerning the charges imposed and the quality of the services provided by the hospitals**,** ~~[and]~~ surgical centers for ambulatory patients ***and independent centers for emergency medical care*** in this State as required by the programs established pursuant to NRS 439A.220 and 439A.240 ~~[.]~~ ***and section 9.5 of this act.*** The information must:

(a) Include, for each hospital in this State, the:

(1) Total number of patients discharged, the average length of stay and the average billed charges, reported for the diagnosis-related groups for inpatients and the 50 medical treatments for outpatients that the Department determines are most useful for consumers;

(2) Total number of potentially preventable readmissions reported pursuant to NRS 439A.220, the rate of occurrence of potentially preventable readmissions, and the average length of stay and average billed charges of those potentially preventable readmissions, reported by the diagnosis-related group for inpatients for which the patient originally received treatment at a hospital; and

(3) Name of each physician who performed a surgical procedure in the hospital and the total number of surgical procedures performed by each physician in the hospital, reported for the most frequent surgical procedures that the Department determines are most useful for consumers if the information is available;

(b) Include, for each surgical center for ambulatory patients in this State, the:

(1) Total number of patients discharged and the average billed charges, reported for 50 medical treatments for outpatients that the Department determines are most useful for consumers; and

(2) Name of each physician who performed a surgical procedure in the surgical center for ambulatory patients and the total number of surgical procedures performed by each physician in the surgical center for ambulatory patients, reported for the most frequent surgical procedures that the Department determines are most useful for consumers;

(c) ***Include, for each independent center for emergency medical care in this State, the:***

(1) Total number of patients discharged and the average billed charges, reported for the 50 medical treatments for patients of independent centers for emergency medical care that the Department determines are most useful for consumers; and

(2) Total number of potentially preventable readmissions reported pursuant to section 9.5 of this act, the rate of occurrence of potentially preventable readmissions, and the average length of stay and average billed charges of those potentially preventable readmissions, reported for the diagnosis for which the patient originally received treatment at an independent center for emergency medical care;

(d) Be presented in a manner that allows a person to view and compare the information for the hospitals by:

(1) Geographic location of each hospital;

(2) Type of medical diagnosis; and

(3) Type of medical treatment;

~~[(d)]~~ ***(e)*** Be presented in a manner that allows a person to view and compare the information for the surgical centers for ambulatory patients by:

(1) Geographic location of each surgical center for ambulatory patients;

(2) Type of medical diagnosis; and

(3) Type of medical treatment;

~~[(e)]~~ ***(f) Be presented in a manner that allows a person to view and compare the information for the independent centers for emergency medical care by:***

(1) Geographic location of each independent center for emergency medical care;

(2) Type of medical diagnosis; and

(3) Type of medical treatment;

(g) Be presented in a manner that allows a person to view and compare the information separately for:

(1) The inpatients and outpatients of each hospital; ~~[and]~~

(2) The outpatients of each surgical center for ambulatory patients; ***and***

(3) The patients of each independent center for emergency medical care;

~~[(f)]~~ ***(h)*** Be readily accessible and understandable by a member of the general public;

~~[(g)]~~ ***(i)*** Include the annual summary of reports of sentinel events prepared for each health facility pursuant to paragraph (c) of subsection 1 of NRS 439.840;

~~[(h)]~~ ***(j)*** Include the annual summary of reports of sentinel events prepared pursuant to paragraph (d) of subsection 1 of NRS 439.840;

~~[(i)]~~ ***(k)*** Include the reports of information prepared for each medical facility pursuant to paragraph (b) of subsection 4 of NRS 439.847;

~~[(j)]~~ ***(l)*** Include a link to electronic copies of all reports, summaries, compilations and supplementary reports required by NRS 449.450 to 449.530, inclusive;

~~[(k)]~~ ***(m)*** Include, for each hospital with 100 or more beds, a summary of financial information which is readily understandable by a member of the general public and which includes, without limitation, a summary of:

(1) The expenses of the hospital which are attributable to providing community benefits and in-kind services as reported pursuant to NRS 449.490;

(2) The capital improvement report submitted to the Department pursuant to NRS 449.490;

(3) The net income of the hospital;

(4) The net income of the consolidated corporation, if the hospital is owned by such a corporation and if that information is publicly available;

(5) The operating margin of the hospital;

(6) The ratio of the cost of providing care to patients covered by Medicare to the charges for such care;

(7) The ratio of the total costs to charges of the hospital; and

(8) The average daily occupancy of the hospital; and

~~[(i)]~~ ***(n)*** Provide any other information relating to the charges imposed and the quality of the services provided by the hospitals ***,*** ~~[and]~~ surgical centers for ambulatory patients ***and independent centers for emergency medical care*** in this State which the Department determines is:

(1) Useful to consumers;

(2) Nationally recognized; and

(3) Reported in a standard and reliable manner.

2. The Department shall:

(a) Publicize the availability of the Internet website;

(b) Update the information contained on the Internet website at least quarterly;

(c) Ensure that the information contained on the Internet website is accurate and reliable;

(d) Ensure that the information reported by a hospital ***,*** ~~[or]~~ surgical center for ambulatory patients ***or independent center for emergency medical care*** for inpatients and outpatients which is contained on the Internet website is expressed as a total number and as a rate, and ~~[must be]~~ ***is*** reported in a manner so as not to reveal the identity of a specific inpatient or outpatient of a hospital ***,*** ~~[or]~~ surgical center for ambulatory patients ~~[.]~~ ***or independent center for emergency medical care;***

(e) Post a disclaimer on the Internet website indicating that the information contained on the website is provided to assist with the comparison of hospitals ***and independent centers for emergency medical care*** and is not a guarantee by the Department or its employees as to the charges imposed by the hospitals ***and independent centers for emergency medical care*** in this State or the quality of the services provided by the hospitals ***and independent centers for emergency medical care*** in this State, including, without limitation, an explanation that the actual amount charged to a person by a particular hospital ***or independent center for emergency medical care*** may not be the same charge as posted on the website for that hospital ~~[.]~~ ***or independent center for emergency medical care.***

(f) Provide on the Internet website established pursuant to this section a link to the Internet website of the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services; and

(g) Upon request, make the information that is contained on the Internet website available in printed form.

3. As used in this section, "diagnosis-related group" means groupings of medical diagnostic categories used as a basis for hospital payment schedules by Medicare and other third-party health care plans.

Sec. 14. ~~*[1. The Department:*~~

~~*(a) May conduct periodic site visits, audits or reviews to ensure that a project funded pursuant to sections 2 to 18, inclusive, of this act complies with the requirements of those sections and the funding agreement entered into pursuant to section 13 of this act.*~~

~~*(b) Shall annually review each project funded pursuant to sections 2 to 18, inclusive, of this act to analyze the performance and benefits of the project.*~~

~~*2. The Office of Finance may audit any project funded pursuant to sections 2 to 18, inclusive, of this act to ensure that the recipient of the funding is using*~~

~~the money awarded pursuant to sections 2 to 18, inclusive, of this act in an effective and efficient manner that accords with state and federal law and the funding agreement entered into pursuant to section 13 of this act.]~~ (Deleted by amendment.)

Sec. 15. ~~[If the Department concludes, as the result of a site visit, audit or review conducted pursuant to section 14 of this act or for any other reason, that a recipient of funding pursuant to sections 2 to 18, inclusive, of this act has failed to comply with any provision of those sections, any regulation adopted pursuant thereto, any other state or federal law or any funding agreement entered into pursuant to section 13 of this act, the Department may:~~

~~1. Adjust the terms of the funding agreement;~~

~~2. Require the recipient to take corrective action;~~

~~3. Withhold future disbursements to the recipient;~~

~~4. Require the recipient to repay money previously disbursed;~~

~~5. Suspend or terminate the funding; or~~

~~6. Take such other measures as are necessary to ensure compliance with the provisions of sections 2 to 18, inclusive, of this act, the regulations adopted pursuant thereto and the funding agreement entered into pursuant to section 13 of this act.]~~ (Deleted by amendment.)

Sec. 16. ~~[Upon completing a project for which a person or entity received funding pursuant to sections 2 to 18, inclusive, of this act, the recipient of funding shall submit to the Department a report that includes, without limitation:~~

~~1. A summary of the achievements of the project relative to the initial goals of the project, focusing on improvements in access to health care and the capacity of the health care workforce in the area affected by the project;~~

~~2. A financial accounting of all money received for the project pursuant to sections 2 to 18, inclusive, of this act and from other sources, including, without limitation, matching funds, and an itemized statement of expenditures of such money;~~

~~3. A narrative evolution of the impact of the project on the community affected by the project, including, without limitation, benefits realized, challenges encountered and lessons learned for future projects;~~

~~4. Any relevant data on patient outcomes, measurements of community health or retention and expansion of the health care workforce attributable to the project; and~~

~~5. Feedback or testimonials concerning the project from beneficiaries, partners and other affected persons and entities.]~~ (Deleted by amendment.)

Sec. 17. ~~[On or before September 1 of each even-numbered year, the Department shall:~~

~~1. Compile a report concerning the Nevada Health Care Workforce and Access Program established pursuant to section 8 of this act. The report must:~~

~~(a) Summarize the outcomes of projects funded through the Program;~~

~~(b) Describe best practices developed for awarding money pursuant to sections 2 to 18, inclusive, of this act and monitoring projects that receive such money; and~~

~~(c) Recommend any adjustments to the Program necessary to ensure that projects funded through the Program meet the requirements of section 8 of this act.~~

~~2. Submit the report compiled pursuant to subsection 1 to the Governor and the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature.]~~ (Deleted by amendment.)

Sec. 18. ~~*[The Department shall adopt such regulations as are necessary to carry out the provisions of sections 2 to 18, inclusive, of this act. Those regulations must include, without limitation, regulations:*~~

~~*1. Prescribing any information that must be included in an application submitted for funding pursuant to sections 2 to 18, inclusive, of this act, in addition to the information required by section 9 of this act, or other requirements governing applicants for such funding as are necessary to ensure that proposed projects achieve the objectives set forth in section 8 of this act in a sustainable manner and ensure the allocation of money pursuant to sections 2 to 18, inclusive, of this act to diverse projects which maximize the utility of the money awarded. Such requirements may include, without limitation, caps on investment in capital infrastructure.*~~

~~*2. Establishing one or more open application periods during which the Department will accept applications for funding pursuant to section 9 of this act.*~~

~~*3. Establishing any additional requirements, including, without limitation, requirements governing performance and reporting, for projects that receive funding pursuant to sections 2 to 18, inclusive, of this act.]*~~ **(Deleted by amendment.)**

Sec. 19. Chapter 449 of NRS is hereby amended by adding thereto the provisions set forth as sections 20, 21 and 22 of this act.

Sec. 20. ***1. A medical facility to which a third party delegates credentialing functions shall comply with the provisions of section 50 or 109 of this act, where applicable.***

2. As used in this section:

(a) "Credentialing" means verifying the credentials of a provider of health care for the purpose of determining whether the provider of health care meets the requirements for participation in the network of a third party or participation in Medicaid or the Children's Health Insurance Program as a provider of services.

(b) "Network" has the meaning ascribed to it in NRS 687B.640.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Third party" :

(1) Except as otherwise provided in subparagraph (2), means any insurer or organization providing health coverage or benefits in accordance with state or federal law.

(2) Does not include:

(I) A plan that is subject to the Employee Retirement Income Security Act of 1974 or any information relating to such coverage; or

(II) Health coverage provided by a local government agency through a self-insurance reserve fund pursuant to NRS 287.010.

Sec. 21. ***1. A hospital shall, for at least 95 percent of the complete requests for privileging submitted by providers of health care to the hospital, process the request not later than 60 days after the hospital receives all information necessary to complete the request.***

2. Not later than 15 days after a hospital receives an incomplete request for privileging from a provider of health care, the hospital shall notify the provider of health care of the information necessary to complete the request.

3. A hospital shall immediately notify the Division of:

(a) Any delay in privileging that exceeds the time period specified in subsection 1;

(b) Steps taken to ensure that the request that is subject to the delay is processed as quickly as possible; and

(c) An anticipated timeline to complete the processing of the request.

4. On or before February 1 of each year, a hospital shall compile and submit to the Division a report on the privileging of providers of health care which includes, without limitation:

(a) The average time between the submission by a provider of health care of a request for privileging and the request being approved or denied;

(b) The rates at which the hospital processes requests for privileging within the time period specified in subsection 1; and

(c) Any planned improvements to the hospital's process for privileging providers of health care, including, without limitation, improvements to technology or procedures to increase the efficiency of the process.

5. As used in this section, "privileging" means the process of determining whether to authorize a provider of health care to provide specific services at a hospital based on his or her credentials and qualifications.

Sec. 22. ***1. A hospital or surgical center for ambulatory patients shall submit requests for prior authorization to third parties using the electronic systems implemented pursuant to sections 57 and 101 of this act, where applicable.***

2. As used in this section, "third party" ~~[means]~~ :

(a) Except as otherwise provided in paragraph (b), means any insurer or organization providing health coverage or benefits in accordance with state or federal law.

(b) Does not include:

(1) A plan that is subject to the Employee Retirement Income Security Act of 1974 or any information relating to such coverage; or

(2) Health coverage provided by a local government agency through a self-insurance reserve fund pursuant to NRS 287.010.

Sec. 22.5. **NRS 449.013 is hereby amended to read as follows:**

449.013 "Independent center for emergency medical care" means a facility, structurally separate ~~[and distinct]~~ from a hospital, which provides ~~[limited]~~ services for the treatment of a medical emergency. ***The term includes, without limitation, such a facility that is owned or operated by, or otherwise part of, a hospital but is located more than 250 yards from the hospital.***

Sec. 23. NRS 449.029 is hereby amended to read as follows:

449.029 As used in NRS 449.029 to 449.240, inclusive, ***and sections 20, 21 and 22 of this act,*** unless the context otherwise requires, "medical facility" has the meaning ascribed to it in NRS 449.0151 and includes a program of hospice care described in NRS 449.196.

Sec. 24. NRS 449.0301 is hereby amended to read as follows:

449.0301 The provisions of NRS 449.029 to 449.2428, inclusive, ***and sections 20, 21 and 22 of this act*** do not apply to:

1. Any facility conducted by and for the adherents of any church or religious denomination for the purpose of providing facilities for the care and treatment of the sick who depend solely upon spiritual means through prayer for healing in the practice of the religion of the church or denomination, except that such a facility shall comply with all regulations relative to sanitation and safety applicable to other facilities of a similar category.

2. Foster homes as defined in NRS 424.014.

3. Any medical facility, facility for the dependent or facility which is otherwise required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed that is operated and maintained by the United States Government or an agency thereof.

Sec. 24.3. **NRS 449.0308 is hereby amended to read as follows:**

449.0308 1. Except as otherwise provided in this section, the Division may charge and collect from a medical facility, facility for the dependent or facility which is required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or a person who operates such a facility without a license issued by the Division the actual costs incurred by the Division for the enforcement of the provisions of NRS 449.029 to 449.2428, inclusive, ***and sections 20, 21 and 22 of this act*** including, without limitation, the actual cost of conducting an inspection or investigation of the facility.

2. The Division shall not charge and collect the actual cost for enforcement pursuant to subsection 1 if the enforcement activity is:

(a) Related to the issuance or renewal of a license for which the Board charges a fee pursuant to NRS 449.050 or 449.089; ~~[or]~~

(b) ***Related to the issuance or renewal of a license to an independent center for emergency medical care that is owned or operated by, or otherwise part of, a hospital; or***

(c) Conducted pursuant to an agreement with the Federal Government which has appropriated money for that purpose.

3. Any money collected pursuant to subsection 1 may be used by the Division to administer and carry out the provisions of NRS 449.029 to 449.2428, inclusive, ***and sections 20, 21 and 22 of this act*** and the regulations adopted pursuant thereto.

4. The provisions of this section do not apply to any costs incurred by the Division for the enforcement of the provisions of NRS 449.24185, 449.2419 or 449.24195.

Sec. 24.5. **NRS 449.050 is hereby amended to read as follows:**

449.050 1. ~~[Each]~~ ***Except as otherwise provided in this section, each*** application for a license must be accompanied by such fee as may be determined by regulation of the Board. The Board may, by regulation, allow or require payment of a fee for a license in installments and may fix the amount of each payment and the date that the payment is due.

2. The fee imposed by the Board for a facility for transitional living for released offenders must be based on the type of facility that is being licensed and must be calculated to produce the revenue estimated to cover the costs related to the license, but in no case may a fee for a license exceed the actual cost to the Division of issuing or renewing the license.

3. If an application for a license for a facility for transitional living for released offenders is denied, any amount of the fee paid pursuant to this section that exceeds the expenses and costs incurred by the Division must be refunded to the applicant.

4. The Board shall not require a fee for the issuance or renewal of the license of an independent center for emergency medical care that is owned or operated by, or otherwise part of, a hospital.

Sec. 24.8. **NRS 449.080 is hereby amended to read as follows:**

449.080 1. ~~[If,]~~ ***Except as otherwise provided in this section, if,*** after investigation, the Division finds that the:

(a) Applicant is in full compliance with the provisions of NRS 449.029 to 449.2428, inclusive ~~[;]~~ ***, and sections 20, 21 and 22 of this act;***

(b) Applicant is in substantial compliance with the standards and regulations adopted by the Board;

(c) Applicant, if he or she has undertaken a project for which approval is required pursuant to NRS 439A.100 or 439A.102, has obtained the approval of the Director of the Department of Health and Human Services; and

(d) Facility conforms to the applicable zoning regulations,

➥ the Division shall issue the license to the applicant.

2. Any investigation of an applicant for a license to provide community-based living arrangement services conducted pursuant to subsection 1 must include, without limitation, an inspection of any building operated by the applicant in which the applicant proposes to provide community-based living arrangement services.

3. ***The Division may not issue a license to operate an independent center for emergency medical care that is located within a 5 mile radius of:***

(a) An existing independent center for emergency medical care; or

(b) A hospital with an emergency department.

4. A license applies only to the person to whom it is issued, is valid only for the premises described in the license and is not transferable.

Sec. 25. NRS 449.160 is hereby amended to read as follows:

449.160 1. The Division may deny an application for a license or may suspend or revoke any license issued under the provisions of NRS 449.029 to 449.2428, inclusive, ***and sections 20, 21 and 22 of this act*** upon any of the following grounds:

(a) Violation by the applicant or the licensee of any of the provisions of NRS 439B.410, 449.029 to 449.245, inclusive, ***and sections 20, 21 and 22 of this act*** or 449A.100 to 449A.124, inclusive, and 449A.270 to 449A.286, inclusive, or of any other law of this State or of the standards, rules and regulations adopted thereunder.

(b) Aiding, abetting or permitting the commission of any illegal act.

(c) Conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a license is issued.

(d) Conduct or practice detrimental to the health or safety of the occupants or employees of the facility.

(e) Failure of the applicant to obtain written approval from the Director of the Department of Health and Human Services as required by NRS 439A.100 or 439A.102 or as provided in any regulation adopted pursuant to NRS 449.001 to 449.430, inclusive, ***and sections 20, 21 and 22 of this act*** and 449.435 to 449.531, inclusive, and chapter 449A of NRS if such approval is required, including, without limitation, the closure or conversion of any hospital in a county whose population is 100,000 or more that is owned by the licensee without approval pursuant to NRS 439A.102.

(f) Failure to comply with the provisions of NRS 441A.315 and any regulations adopted pursuant thereto or NRS 449.2486.

(g) Violation of the provisions of NRS 458.112.

(h) Failure to comply with the provisions of NRS 449A.170 to 449A.192, inclusive, and any regulation adopted pursuant thereto.

(i) Violation of the provisions of NRS 629.260.

2. In addition to the provisions of subsection 1, the Division may revoke a license to operate a facility for the dependent if, with respect to that facility, the licensee that operates the facility, or an agent or employee of the licensee:

(a) Is convicted of violating any of the provisions of NRS 202.470;

(b) Is ordered to but fails to abate a nuisance pursuant to NRS 244.360, 244.3603 or 268.4124; or

(c) Is ordered by the appropriate governmental agency to correct a violation of a building, safety or health code or regulation but fails to correct the violation.

3. The Division shall maintain a log of any complaints that it receives relating to activities for which the Division may revoke the license to operate a facility for the dependent pursuant to subsection 2. The Division shall provide to a facility for the care of adults during the day:

(a) A summary of a complaint against the facility if the investigation of the complaint by the Division either substantiates the complaint or is inconclusive;

(b) A report of any investigation conducted with respect to the complaint; and

(c) A report of any disciplinary action taken against the facility.

➥ The facility shall make the information available to the public pursuant to NRS 449.2486.

4. On or before February 1 of each odd-numbered year, the Division shall submit to the Director of the Legislative Counsel Bureau a written report setting forth, for the previous biennium:

(a) Any complaints included in the log maintained by the Division pursuant to subsection 3; and

(b) Any disciplinary actions taken by the Division pursuant to subsection 2.

Sec. 26. NRS 449.163 is hereby amended to read as follows:

449.163 1. In addition to the payment of the amount required by NRS 449.0308, if a medical facility, facility for the dependent or facility which is required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed violates any provision related to its licensure, including any provision of NRS 439B.410 or 449.029 to 449.2428, inclusive, ***and sections 20, 21 and 22 of this act*** or any condition, standard or regulation adopted by the Board, the Division, in accordance with the regulations adopted pursuant to NRS 449.165, may:

(a) Prohibit the facility from admitting any patient until it determines that the facility has corrected the violation;

(b) Limit the occupancy of the facility to the number of beds occupied when the violation occurred, until it determines that the facility has corrected the violation;

(c) If the license of the facility limits the occupancy of the facility and the facility has exceeded the approved occupancy, require the facility, at its own expense, to move patients to another facility that is licensed;

(d) Except where a greater penalty is authorized by subsection 2, impose an administrative penalty of not more than $5,000 per day for each violation, together with interest thereon at a rate not to exceed 10 percent per annum; and

(e) Appoint temporary management to oversee the operation of the facility and to ensure the health and safety of the patients of the facility, until:

(1) It determines that the facility has corrected the violation and has management which is capable of ensuring continued compliance with the applicable statutes, conditions, standards and regulations; or

(2) Improvements are made to correct the violation.

2. If an off-campus location of a hospital fails to obtain a national provider identifier that is distinct from the national provider identifier used by the main campus and any other off-campus location of the hospital in violation of NRS 449.1818, the Division may impose against the hospital an administrative penalty of not more than $10,000 for each day of such failure, together with interest thereon at a rate not to exceed 10 percent per annum, in addition to any other action authorized by this chapter.

3. If the facility fails to pay any administrative penalty imposed pursuant to paragraph (d) of subsection 1 or subsection 2, the Division may:

(a) Suspend the license of the facility until the administrative penalty is paid; and

(b) Collect court costs, reasonable attorney's fees and other costs incurred to collect the administrative penalty.

4. The Division may require any facility that violates any provision of NRS 439B.410 or 449.029 to 449.2428, inclusive, ***and sections 20, 21 and 22 of this act*** or any condition, standard or regulation adopted by the Board to make any improvements necessary to correct the violation.

5. Any money collected as administrative penalties pursuant to paragraph (d) of subsection 1 or subsection 2 must be accounted for separately and used to administer and carry out the provisions of NRS 449.001 to 449.430, inclusive, ***and sections 20, 21 and 22 of this act,*** 449.435 to 449.531, inclusive, and chapter 449A of NRS to protect the health, safety, well-being and property of the patients and residents of facilities in accordance with applicable state and federal standards or for any other purpose authorized by the Legislature.

Sec. 26.5. **NRS 449.1818 is hereby amended to read as follows:**

449.1818 1. Each off-campus location of a hospital shall obtain and use and include on all claims for reimbursement or payment for health care services provided at the location a national provider identifier that is distinct from the national provider identifier used by the main campus and any other off-campus location of the hospital. If the off-campus location includes the national provider identifier on such a claim, the off-campus location may also include on the claim the national provider identifier used by the main campus of the hospital. If the off-campus location includes both the national provider identifier used by the off-campus location and the national provider identifier used by the main campus on a claim, the claim must clearly identify which national provider identifier corresponds to the off-campus location and which national provider identifier corresponds to the main campus.

2. An independent center for emergency medical care shall include on all claims for reimbursement or payment for health care services provided at the independent center for emergency medical care the national provider identifier used by the independent center for emergency medical care.

3. An independent center for emergency medical care:

(a) Shall provide urgent care during all operating hours through:

(1) A separate urgent care unit within the independent center for emergency medical care; or

(2) A system that uses the severity of the patient's condition to determine whether the patient receives emergency services or urgent care;

(b) Shall not charge more for urgent care than the amount customarily charged for urgent care by an urgent care center;

(c) If urgent care services are sufficient to treat or manage the condition of a patient, shall inform the patient that he or she may receive urgent care rather than emergency services; and

(d) Shall not require a patient to wait longer to receive urgent care services than a patient with the same condition would be required to wait to receive emergency services.

4. As used in this section:

(a) "National provider identifier" means the standard, unique health identifier for health care providers that is issued by the national provider system in accordance with 45 C.F.R. Part 162.

(b) "Off-campus location" means a facility:

(1) With operations that are directly or indirectly owned or controlled by, in whole or in part, a hospital or which is affiliated with a hospital, regardless of whether it is operated by the same governing body as the hospital;

(2) That is located more than 250 yards from the main campus of the hospital;

(3) That provides services which are organizationally and functionally integrated with the hospital; and

(4) That is an outpatient facility providing ambulatory surgery, urgent care or emergency room services.

(c) "Urgent care" means health care that is furnished to a person whose medical condition is sufficiently acute to require treatment unavailable through, or inappropriate to be provided by, a clinic or the office of a provider of health care, but not so acute as to require treatment in an emergency room.

Sec. 27. NRS 449.240 is hereby amended to read as follows:

449.240 The district attorney of the county in which the facility is located shall, upon application by the Division, institute and conduct the prosecution of any action for violation of any provisions of NRS 449.029 to 449.245, inclusive ~~[.]~~ ***, and sections 20, 21 and 22 of this act.***

Sec. 27.3. **NRS 449.485 is hereby amended to read as follows:**

449.485 1. Each hospital ***and independent center for emergency medical care*** in this State shall use for all patients discharged a form prescribed by the Director and shall include in the form all information required by the Department. Any form prescribed by the Director must be a form that is commonly used nationwide by hospitals ~~[.]~~ ***and independent centers for emergency medical care,*** if applicable, and comply with federal laws and regulations.

2. Each hospital ***and independent center for emergency medical care*** in this State shall, on a monthly basis, report to the Department the information required to be included in the form for each patient. The information reported must be complete, accurate and timely.

3. Each insurance company or other payer shall accept the form as the bill for services provided by hospitals ***and independent centers for emergency medical care*** in this State.

4. Except as otherwise provided in subsection 5, each hospital ***and independent center for emergency medical care*** in this State shall provide the information required pursuant to subsection 2 in an electronic form specified by the Department.

5. The Director may exempt a hospital ***or independent center for emergency medical care*** from the requirements of subsection 4 if requiring the hospital ***or independent center for emergency medical care*** to comply with the requirements would cause the hospital financial hardship.

6. The Department shall use the information submitted pursuant to this section for the ~~[program]~~ ***programs*** established pursuant to NRS 439A.220 ***and section 9.5 of this act*** to increase public awareness of health care information concerning the hospitals ***and independent centers for emergency medical care, respectively,*** in this State.

Sec. 27.7. **NRS 449.520 is hereby amended to read as follows:**

449.520 1. On or before October 1 of each year, the Director shall prepare and transmit to the Governor, the Joint Interim Standing Committee on Health and Human Services and the Interim Finance Committee a report of the Department's operations and activities for the preceding fiscal year.

2. The report prepared pursuant to subsection 1 must include:

(a) Copies of all reports, summaries, compilations and supplementary reports required by NRS 449.450 to 449.530, inclusive, together with such facts, suggestions and policy recommendations as the Director deems necessary;

(b) A summary of the trends of the audits of hospitals in this State that the Department required or performed during the previous year;

(c) An analysis of the trends in the costs, expenses and profits of hospitals in this State;

(d) An analysis of the methodologies used to determine the corporate home office allocation of hospitals in this State;

(e) An examination and analysis of the manner in which hospitals are reporting the information that is required to be filed pursuant to NRS 449.490, including,

without limitation, an examination and analysis of whether that information is being reported in a standard and consistent manner, which fairly reflect the operations of each hospital;

(f) A review and comparison of the policies and procedures used by hospitals in this State to provide discounted services to, and to reduce charges for services provided to, persons without health insurance;

(g) A review and comparison of the policies and procedures used by hospitals in this State to collect unpaid charges for services provided by the hospitals; and

(h) A summary of the status of the programs established pursuant to NRS 439A.220 and 439A.240 ***and section 9.5 of this act*** to increase public awareness of health care information concerning the hospitals**,** ~~[and]~~ surgical centers for ambulatory patients ***and independent centers for emergency medical care*** in this State, including, without limitation, the information that was posted in the preceding fiscal year on the Internet website maintained for those programs pursuant to NRS 439A.270.

3. The Joint Interim Standing Committee on Health and Human Services shall develop a comprehensive plan concerning the provision of health care in this State which includes, without limitation:

(a) A review of the health care needs in this State as identified by state agencies, local governments, providers of health care and the general public; and

(b) A review of the capital improvement reports submitted by hospitals pursuant to subsection 2 of NRS 449.490.

Sec. 28. Chapter 450B of NRS is hereby amended by adding thereto the provisions set forth as sections 29 and 30 of this act.

Sec. 29. ***1. The State Board of Health shall adopt regulations authorizing paramedics to be employed by or volunteer in hospitals, including, without limitation, emergency departments, intensive care units and other areas for acute or specialty care.***

2. The regulations adopted pursuant to this section must:

(a) Ensure that paramedics who are employed by or volunteer in hospitals perform their duties in a manner that enhances the care of patients while maintaining the safety of patients;

(b) Prescribe the duties and responsibilities of a paramedic who is employed by or volunteering in a hospital, which must vary depending on the training and experience of the paramedic;

(c) Prescribe standards of training for a paramedic who is employed by or volunteering in a hospital, including, without limitation:

(1) Any certifications that such a paramedic must hold; and

(2) Any additional training required for paramedics who work in specialty areas or provide care to patient with severe conditions or urgent needs; and

(d) Establish specific protocols for the oversight and periodic evaluation of paramedics who are employed by or are volunteering in hospitals in a manner that ensures compliance with the regulations adopted pursuant to this section and the policies developed pursuant to section 30 of this act.

Sec. 30. ***1. A hospital that employs paramedics or accepts paramedics as volunteers pursuant to section 29 of this act must develop and implement comprehensive written policies that:***

(a) Define the scope of duties of such paramedics within the hospital in accordance with the regulations adopted pursuant to section 29 of this act;

(b) Establish procedures governing the supervision of such paramedics within the hospital in accordance with the regulations adopted pursuant to section 29 of this act, including, without limitation, procedures for:

(1) The delegation of tasks to such paramedics by physicians, nurses and other qualified providers of health care; and

(2) The review by providers of health care described in subparagraph (1) of tasks performed by such paramedics;

(c) Ensure compliance with applicable standards for accreditation and the safety of patients and state and federal law and regulations, including, without limitation, procedures for internal reviews and audits of the duties of such paramedics to ensure adherence to such standards, laws and regulations; and

(d) Establish protocols to document the outcomes of patients who receive services from such paramedics.

2. On or before February 1 of each year, a hospital that employs paramedics or accepts paramedics as volunteers shall submit to the State Board of Health a report that includes, without limitation:

(a) A description of the roles performed by such paramedics within the hospital, including, without limitation, data on the types of services provided by such paramedics;

(b) Metrics on the outcomes of patients who receive services from such paramedics in acute care settings;

(c) Challenges encountered during the integration of such paramedics into the hospital, best practices established concerning the performance of duties by and oversight of such paramedics and areas for improvement related to the performance of duties by and oversight of such paramedics; and

(d) A description to any changes made by the hospital to the policies developed pursuant to subsection 1 in response to the information described in paragraph (c).

Sec. 31. NRS 450B.250 is hereby amended to read as follows:

450B.250 1. Except as otherwise provided in this chapter, a person shall not serve as an attendant on any ambulance or air ambulance and a firefighter shall not provide the level of medical care provided by an advanced emergency medical technician or paramedic to sick or injured persons at the scene of an emergency or while transporting those persons to a medical facility unless the person holds a currently valid license issued by the health authority under the provisions of this chapter.

2. A person shall not provide community paramedicine services unless the person:

(a) Is certified as an emergency medical technician, an advanced emergency medical technician or a paramedic;

(b) Is employed by or serves as a volunteer for a person or governmental entity which has a currently valid permit with an endorsement to provide community paramedicine services issued by the health authority pursuant to NRS 450B.1993; and

(c) Meets the qualifications and has satisfied any training required by regulations adopted pursuant to NRS 450B.1993.

3. A paramedic shall not serve as an employee or volunteer of a hospital unless:

(a) The paramedic meets the qualifications and has satisfied any training required by the regulations adopted pursuant to section 29 of this act; and

(b) The hospital has developed and implemented the comprehensive policies required by section 30 of this act.

4. A paramedic who serves as an employee or volunteer of a hospital shall not work in an area for which additional training is required pursuant to section 29 of this act unless the paramedic has received such additional training.

Sec. 32. ~~[NRS 454.00958 is hereby amended to read as follows:~~

~~454.00958 "Practitioner" means:~~

~~1. A physician, dentist, veterinarian or podiatric physician who holds a valid license to practice his or her profession in this State.~~

~~2. A pharmacy, hospital or other institution licensed or registered to distribute, dispense, conduct research with respect to or to administer a dangerous drug in the course of professional practice in this State.~~

~~3. When relating to the prescription of poisons, dangerous drugs and devices:~~

~~(a) An advanced practice registered nurse who holds a certificate from the State Board of Pharmacy permitting him or her so to prescribe; or~~

~~(b) A physician assistant who holds a license from the Board of Medical Examiners and a certificate from the State Board of Pharmacy permitting him or her so to prescribe.~~

~~4. An optometrist who is certified to prescribe and administer pharmaceutical agents pursuant to NRS 636.288 when the optometrist prescribes or administers dangerous drugs which are within the scope of his or her certification.~~

~~5. A dental hygienist who holds a valid license to practice dental hygiene in this State and:~~

~~(a) Is authorized to prescribe and dispense the dangerous drugs listed in NRS 631.3105 *and, if applicable, the regulations adopted pursuant to section 77 of this act,* in accordance with the provisions of [that section] *those sections* and the regulations adopted pursuant thereto; and~~

~~(b) Holds a certificate issued by the State Board of Pharmacy pursuant to NRS 639.1374 authorizing him or her to so prescribe.~~

~~6. A certified registered nurse anesthetist who orders, prescribes, possesses or administers poisons, dangerous drugs or devices in accordance with NRS 632.2397.~~

~~7. A pharmacist who is registered pursuant to NRS 639.28079 to prescribe and dispense drugs for medication-assisted treatment.]~~ **(Deleted by amendment.)**

Sec. 32.5. **NRS 179.301 is hereby amended to read as follows:**

179.301 1. The Nevada Gaming Control Board and the Nevada Gaming Commission and their employees, agents and representatives may inquire into and inspect any records sealed pursuant to NRS 179.245 or 179.255, if the event or conviction was related to gaming, to determine the suitability or qualifications of any person to hold a state gaming license, manufacturer's, seller's or distributor's license or registration as a gaming employee pursuant to chapter 463 of NRS. Events and convictions, if any, which are the subject of an order sealing records:

(a) May form the basis for recommendation, denial or revocation of those licenses.

(b) Must not form the basis for denial or rejection of a gaming work permit unless the event or conviction relates to the applicant's suitability or qualifications to hold the work permit.

2. The Division of Insurance of the Department of Business and Industry and its employees may inquire into and inspect any records sealed pursuant to NRS 179.245 or 179.255, if the event or conviction was related to insurance, to determine the suitability or qualifications of any person to hold a license, certification or authorization issued in accordance with title 57 of NRS. Events and convictions, if any, which are the subject of an order sealing records may form the basis for recommendation, denial or revocation of those licenses, certifications and authorizations.

3. ***The Department of Health and Human Services, the Division of Health Care Financing and Policy of the Department and their employees, agents and representatives may inquire into and inspect any records sealed pursuant to NRS 179.245 or 179.255, if the event or conviction was related to Medicare or***

Medicaid or the provision of professional services for which a license or certification is required. Such inquiry or inspection must be for the purpose of determining the suitability of the person to render such professional services as a provider of services under Medicaid or to own or serve as an officer, managing employee or managing agent of a business seeking to enter into a contract with the Department or a health maintenance organization with which the Department has entered into a contract pursuant to NRS 422.273 for the provision of services under Medicaid. Events and convictions, if any, which are the subject of an order sealing records may form the basis of a decision of the Department to refuse to enter into or terminate such a contract.

4. A prosecuting attorney may inquire into and inspect any records sealed pursuant to NRS 179.245 or 179.255 if:

(a) The records relate to a violation or alleged violation of NRS 202.485; and

(b) The person who is the subject of the records has been arrested or issued a citation for violating NRS 202.485.

~~[4.]~~ ***5.*** The Central Repository for Nevada Records of Criminal History and its employees may inquire into and inspect any records sealed pursuant to NRS 179.245 or 179.255 that constitute information relating to sexual offenses, and may notify employers of the information in accordance with federal laws and regulations.

~~[5.]~~ ***6.*** Records which have been sealed pursuant to NRS 179.245 or 179.255 and which are retained in the statewide registry established pursuant to NRS 179B.200 may be inspected pursuant to chapter 179B of NRS by an officer or employee of the Central Repository for Nevada Records of Criminal History or a law enforcement officer in the regular course of his or her duties.

~~[6.]~~ ***7.*** The State Board of Pardons Commissioners and its agents and representatives may inquire into and inspect any records sealed pursuant to NRS 179.245 or 179.255 if the person who is the subject of the records has applied for a pardon from the Board.

~~[7.]~~ ***8.*** As used in this section:

(a) "Information relating to sexual offenses" means information contained in or concerning a record relating in any way to a sexual offense.

(b) "Sexual offense" has the meaning ascribed to it in NRS 179A.073.

Sec. 33. ~~[Chapter 223 of NRS is hereby amended by adding thereto a new section to read as follows:~~

~~***1. An institution that receives a grant through the Graduate Medical Education Grant Program established pursuant to NRS 223.637 shall not eliminate or reduce the size of a program for residency training and postdoctoral fellows operated by the institution without the approval of the Department of Health and Human Services.***~~

~~***2. To obtain the approval of the Department of Health and Human Services for the elimination or reduction of the size of a program for residency training and postdoctoral fellows pursuant to subsection 1, an institution must apply to the Department in the form prescribed by the Department. The application must include, without limitation:***~~

~~***(a) An analysis of the current and projected needs of patients in the geographic area served by the program, including, without limitation, the need for physicians who practice in any specialty in which the program provides residency training;***~~

~~***(b) A detailed explanation of the reasons for the proposed elimination or reduction, including, without limitation, a demonstration that the requirements of subsection 3 are satisfied; and***~~

~~*(c) A description of efforts to mitigate the impact of the elimination or reduction, which may include, without limitation, transferring resources to areas of higher need.*~~

~~*3. The Department of Health and Human Services shall not approve an application to eliminate or reduce the size of a program for residency training and postdoctoral fellows submitted pursuant to subsection 2 unless the application demonstrates that the elimination or reduction:*~~

~~*(a) Is justified by a decrease in the needs of patients in the geographic area served by the program, including, without limitation, the need for physicians who practice in any specialty in which the program provides residency training; and*~~

~~*(b) Is not likely to negatively impact the overall availability of providers of health care who practice specialties for which a high need exists in this State or in underserved geographic areas or among underserved populations of this State, as identified in the assessment conducted pursuant to section 7 of this act.*~~

~~*4. If an institution violates subsection 1, the Department of Health and Human Services may:*~~

~~*(a) Suspend or revoke the grant issued to the institution through the Graduate Medical Education Grant Program; and*~~

~~*(b) Disqualify the institution from receiving future grants through the Graduate Medical Education Grant Program.]*~~ **(Deleted by amendment.)**

Sec. 34. ~~[NRS 223.610 is hereby amended to read as follows:~~

~~223.610 The Director of the Office of Science, Innovation and Technology shall:~~

~~1. Advise the Governor and the Executive Director of the Office of Economic Development on matters relating to science, innovation and technology.~~

~~2. Work in coordination with the Office of Economic Development to establish criteria and goals for economic development and diversification in this State in the areas of science, innovation and technology.~~

~~3. As directed by the Governor, identify, recommend and carry out policies related to science, innovation and technology.~~

~~4. Report periodically to the Executive Director of the Office of Economic Development concerning the administration of the policies and programs of the Office of Science, Innovation and Technology.~~

~~5. Coordinate activities in this State relating to the planning, mapping and procurement of broadband service in a competitively neutral and nondiscriminatory manner, which must include, without limitation:~~

~~(a) Development of a strategic plan to improve the delivery of broadband services in this State to schools, libraries, providers of health care, transportation facilities, prisons and other community facilities;~~

~~(b) Applying for state and federal grants on behalf of eligible entities and managing state matching money that has been appropriated by the Legislature;~~

~~(c) Coordinating and processing applications for state and federal money relating to broadband services;~~

~~(d) Prioritizing construction projects which affect or involve the expansion or deployment of broadband services in this State;~~

~~(e) In consultation with providers of health care from various health care settings, the expansion of telehealth services to reduce health care costs and increase health care quality and access in this State, especially in rural, unserved and underserved areas of this State;~~

~~(f) Expansion of the fiber optic infrastructure in this State for the benefit of the public safety radio and communications systems in this State;~~

~~(g) Collection and storage of data relating to agreements and contracts entered into by the State for the provision of fiber optic assets in this State;~~

~~(h) Administration of the trade policy for fiber optic infrastructure in this State; and~~

~~(i) Establishing and administering a program of infrastructure grants for the development or improvement of broadband services for persons with low income and persons in rural areas of this State using money from the Account for the Grant Program for Broadband Infrastructure created by NRS 223.660. The Director may adopt regulations to carry out his or her duties pursuant to this paragraph.~~

~~6. [Provide support to the Advisory Council on Graduate Medical Education and implement the Graduate Medical Education Grant Program established pursuant to NRS 223.637.~~

~~7.] In carrying out his or her duties pursuant to this section, consult with the Executive Director of the Office of Economic Development and cooperate with the Executive Director in implementing the State Plan for Economic Development developed by the Executive Director pursuant to subsection 2 of NRS 231.053.~~

~~[8.] 7. Administer such grants as are provided by legislative appropriation.]~~ **(Deleted by amendment.)**

Sec. 35. ~~[NRS 223.630 is hereby amended to read as follows:~~

~~223.630 1. The Account for the Office of Science, Innovation and Technology is hereby created in the State General Fund. The Account must be administered by the Director of the Office of Science, Innovation and Technology.~~

~~2. Except as otherwise provided in NRS [223.631 and] 223.660, any money accepted pursuant to NRS 223.620 must be deposited in the Account.~~

~~3. The interest and income earned on the money in the Account, after deducting any applicable charges, must be credited to the Account.~~

~~4. The money in the Account must only be used to carry out the duties of the Director.~~

~~5. Claims against the Account must be paid as other claims against the State are paid.]~~ **(Deleted by amendment.)**

Sec. 36. ~~[NRS 223.631 is hereby amended to read as follows:~~

~~223.631 1. The Account for the Graduate Medical Education Grant Program is hereby created in the State General Fund. The Director of the [Office of Science, Innovation and Technology]~~ ~~*Department of Health and Human Services or his or her designee,*~~ ~~shall administer the Account.~~

~~2. The Director of the [Office of Science, Innovation and Technology]~~ ~~*Department of Health and Human Services or his or her designee,*~~ ~~may:~~

~~(a) Accept any gift, donation, bequest or devise; and~~

~~(b) Apply for and accept any grant, loan or other source of money,~~

~~→ for deposit in the Account to assist the Director in carrying out the Graduate Medical Education Grant Program established pursuant to NRS 223.637.~~

~~3. The interest and income earned on the money in the Account, after deducting any applicable charges, must be credited to the Account.~~

~~4. The money in the Account must only be used to:~~

~~(a) Award competitive grants to institutions in this State seeking to create, expand or retain programs for residency training and postdoctoral fellowships that are approved by the Accreditation Council for Graduate Medical Education or its successor organization; and~~

~~(b) Defray the costs of establishing and administering the Graduate Medical Education Grant Program established pursuant to NRS 223.637.~~

~~5. Any money remaining in the Account at the end of the fiscal year does not revert to the State General Fund, and the balance in the Account must be carried forward to the next fiscal year.~~

~~6. Claims against the Account must be paid as other claims against the State are paid.]~~ **(Deleted by amendment.)**

Sec. 37. ~~[NRS 223.633 is hereby amended to read as follows:~~

~~223.633 1. The Advisory Council on Graduate Medical Education is hereby created within the [Office of Science, Innovation and Technology.] *Department of Health and Human Services.* The Council consists of:~~

~~(a) The dean of each medical school in this State that is accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges or their successor organizations, or his or her designee;~~

~~(b) The dean of each school of osteopathic medicine in this State that is accredited by the Commission on Osteopathic College Accreditation of the American Osteopathic Association or its successor organization, or his or her designee;~~

~~(c) Two members appointed by the Governor who are physicians licensed pursuant to chapter 630 or 633 of NRS;~~

~~(d) One member appointed by the Governor who represents hospitals located in counties whose population is less than 100,000;~~

~~(e) One member appointed by the Governor who represents hospitals located in counties whose population is 100,000 or more but less than 700,000;~~

~~(f) One member appointed by the Governor who represents hospitals located in a county whose population is 700,000 or more;~~

~~(g) One member appointed by the Governor who represents the medical corps of any of the Armed Forces of the United States;~~

~~(h) One member appointed by the Governor who represents the Department of Health and Human Services; and~~

~~(i) One member appointed by the Governor who represents the Office of Economic Development in the Office of the Governor.~~

~~2. In addition to the members appointed by the Governor pursuant to subsection 1, the Governor may appoint two members as the Governor determines necessary to carry out the provisions of NRS 223.631 to 223.639, inclusive [.] *, and section 33 of this act.*~~

~~3. After the initial terms, the term of each member of the Council is 3 years, and members shall serve at the pleasure of the Governor.~~

~~4. Any vacancy occurring in the membership of the Council must be filled in the same manner as the original appointment not later than 30 days after the vacancy occurs.~~

~~5. The Council shall select from its members a Chair and a Vice Chair who shall hold office for 1 year and who may be reselected.~~

~~6. The Council shall meet at the call of the Chair as often as necessary to evaluate applications for competitive grants for the Graduate Medical Education Grant Program established pursuant to NRS 223.637 and make recommendations to the [Office of Science, Innovation and Technology] *Department of Health and Human Services* concerning the approval of applications for such grants.~~

~~7. A majority of the members of the Council constitutes a quorum for the transaction of business, and a majority of those members present at any meeting is sufficient for any official action taken by the Council.~~

~~8. The members of the Council serve without compensation, except that each member is entitled to receive the per diem allowance and travel expenses provided for state officers and employees generally while engaged in the official business of the Council.~~

~~9. A member of the Council who is an officer or employee of this State or a political subdivision of this State must be relieved from his or her duties without loss of regular compensation to prepare for and attend meetings of the Council and perform any work necessary to carry out the duties of the Council in the most~~

~~timely manner practicable. A state agency or political subdivision of this State shall not require an officer or employee who is a member of the Council to:~~

~~(a) Make up the time he or she is absent from work to carry out his or her duties as a member of the Council; or~~

~~(b) Take annual leave or compensatory time for the absence.~~] **(Deleted by amendment.)**

Sec. 38. ~~[NRS 223.635 is hereby amended to read as follows:~~

~~223.635 The Advisory Council on Graduate Medical Education shall:~~

~~1. Evaluate applications for competitive grants for the Graduate Medical Education Grant Program established pursuant to NRS 223.637 and make recommendations to the [Office of Science, Innovation and Technology]~~ ***Department of Health and Human Services*** ~~concerning the approval of applications for such grants. In evaluating and making recommendations concerning such applications, the Council shall give priority to the award of grants [for the retention of programs in this State for residency training and postdoctoral fellows when the federal funding for the support of such programs expires.]*** ***in accordance with paragraph (b) of subsection 3 of NRS 223.637.***

~~2. Study and make recommendations to the [Office of Science, Innovation and Technology,]~~ ***Department of Health and Human Services,*** ~~the Governor and the Legislature concerning:~~

~~(a) The creation and retention of programs in this State for residency training and postdoctoral fellows that are approved by the Accreditation Council for Graduate Medical Education or its successor organization; and~~

~~(b) The recruitment and retention of physicians necessary to meet the health care needs of the residents of this State, with the emphasis on those health care needs.~~] **(Deleted by amendment.)**

Sec. 39. ~~[NRS 223.637 is hereby amended to read as follows:~~

~~223.637 1. The [Office of Science, Innovation and Technology]~~ ***Department of Health and Human Services*** ~~shall establish and administer a Graduate Medical Education Grant Program as a competitive grant program to award grants to institutions in this State seeking to create, expand or retain programs for residency training and postdoctoral fellows that are approved by the Accreditation Council for Graduate Medical Education or its successor organization.~~

~~2.~~ ***The Department of Health and Human Services may award limited grants pursuant to the Program established pursuant to subsection 1 to:***

(a) Assist institutions in building administrative and operational capacity as necessary to establish a new program for residency training and postdoctoral fellows.

(b) Recruit personnel essential to the operation of a program for residency training and postdoctoral fellows, including, without limitation, program directors and resident faculty. Such recruitment may consist of paying relocation expenses, providing supplements to salaries and providing professional development.

~~3.~~ ~~In awarding grants pursuant to the Program established pursuant to subsection 1, the [Office of Science, Innovation and Technology]~~ ***Department of Health and Human Services*** ~~shall [consider]~~ ***:***

(a) Consider ~~the recommendations of the Advisory Council on Graduate Medical Education created by NRS 223.633~~ ***;*** ~~and [give]~~

(b) Give ~~priority to the award of grants [for]~~ ***:***

(1) For ~~the retention of programs in this State for residency training and postdoctoral fellows when the federal funding for the support of such programs expires~~ ***[.] ; and***

~~*(2) To programs that:*~~

~~*(I) Will leverage funds from the Federal Government or private persons to maximize the impact of the grants;*~~

~~*(II) Incorporate innovative delivery models, including, without limitation, telehealth, rotations in rural areas and training in underserved settings;*~~

~~*(III) Provide logistical support, which may include, without limitation, transportation, housing and accommodations for family members of residents and fellows, to facilitate the placement of residents and fellows in rural areas and other underserved areas;*~~

~~*(IV) Demonstrate collaboration with rural hospitals, community health centers and other local entities that provide health care to build sustainable pipelines of physicians to underserved areas; and*~~

~~*(V) Address geographic areas and populations of this State where the shortage of providers of health care is most critical and the specialties for which the need in those areas and among those populations is most critical, as identified by the assessment conducted pursuant to section 7 of this act.*~~

~~**[**3.**]** *4.* The **[**Office of Science, Innovation and Technology**]** *Department of Health and Human Services* shall establish a committee to develop a process, procedure and rubric for evaluating applications for grants pursuant to the Program established pursuant to subsection 1 to ensure that the process and procedure are transparent, without bias, fair, equitable and accessible. The committee established pursuant to this subsection must be composed of persons with expertise in **[**subject matters related to**]** graduate medical education *, innovation in health care, health care in rural areas and financial strategy* who are not affiliated with any applicant for a grant pursuant to the Program established pursuant to subsection 1.~~

~~**[**4.**]** *5. The rubric developed pursuant to subsection 4 must include, without limitation:*~~

~~*(a) Criteria to assess the ability of the applicant to secure funding, including, without limitation, investment and matching money, from sources other than the Program established pursuant to subsection 1; and*~~

~~*(b) Advantages in scoring for programs that incorporate training in telehealth, rotations in rural areas, targeted logistical support for such rotations and innovative models of delivering health care.*~~

~~*6. The Department of Health and Human Services may authorize the recipient of a grant pursuant to the Program established pursuant to subsection 1 to use not more than 10 percent of the money awarded to cover indirect administrative costs directly related to the execution and management of the program for residency training and postdoctoral fellows supported by the grant, except where granting such authorization would limit the ability of the Department to fully leverage federal financial participation under Medicaid pursuant to section 49 of this act.*~~

~~*7.* The **[**Office of Science, Innovation and Technology**]** *Department of Health and Human Services* may adopt regulations necessary to carry out the Program established pursuant to subsection 1. Such regulations may include, without limitation, the requirements to apply for and receive a grant.~~**]** **(Deleted by amendment.)**

Sec. 40. ~~**[**NRS 223.639 is hereby amended to read as follows:~~

~~223.639 1. On or before October 1 of each year, the **[**Office of Science, Innovation and Technology**]** *Department of Health and Human Services* shall submit a written report to:~~

~~(a) The Governor; and~~

~~(b) The Director of the Legislative Counsel Bureau for transmittal to:~~

~~(1) The Interim Finance Committee in an odd-numbered year; or~~

~~(2) The next regular session of the Legislature in an even-numbered year.~~

~~2. The report must include, without limitation:~~

~~(a) Information on the Graduate Medical Education Grant Program established pursuant to NRS 223.637; and~~

~~(b) Any recommendations regarding graduate medical education in this State, including, without limitation:~~

~~(1) The creation, expansion and retention of programs in this State for residency training and postdoctoral fellows; and~~

~~(2) Methods by which this State may recruit and retain physicians necessary to meet the health care needs of the residents of this State.~~] **(Deleted by amendment.)**

Sec. 41. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and sections 49 to 63, inclusive, of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic

trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 41.5. **NRS 232.459 is hereby amended to read as follows:**

232.459 1. The Advocate shall:

(a) Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

(b) Assist consumers and injured employees in understanding their rights and responsibilities under health care plans, including, without limitation, the Public Employees' Benefits Program and the Public Option, and policies of industrial insurance;

(c) Identify and investigate complaints of consumers and injured employees regarding their health care plans, including, without limitation, the Public Employees' Benefits Program and the Public Option, and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:

(1) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(2) Providing counseling and assistance to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program and the Public Option, and policies of industrial insurance;

(d) Provide information to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program and the Public Option, and policies of industrial insurance in this State;

(e) Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the Office for Consumer Health Assistance;

(f) Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Advocate pursuant to this section;

(g) In appropriate cases and pursuant to the direction of the Advocate, refer a complaint or the results of an investigation to the Attorney General for further action;

(h) Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

(i) Establish and maintain an Internet website which includes:

(1) Information concerning purchasing prescription drugs from Canadian pharmacies that have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328;

(2) Links to websites of Canadian pharmacies which have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328; and

(3) A link to the website established and maintained pursuant to NRS 439A.270 which provides information to the general public concerning the charges imposed and the quality of the services provided by the hospitals**_ ,** ~~[and]~~ surgical centers for ambulatory patients ***and independent centers for emergency medical care*** in this State;

(j) Assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services;

(k) Assist consumers with scheduling an appointment with a provider of health care who is in the network of providers under contract to provide services to participants in the health care plan under which the consumer is covered;

(l) Assist consumers with filing complaints against health care facilities and health care professionals;

(m) Assist consumers with filing complaints with the Commissioner of Insurance against issuers of health care plans; and

(n) On or before January 31 of each year, compile a report of aggregated information submitted to the Office for Consumer Health Assistance pursuant to NRS 687B.675, aggregated for each type of provider of health care for which such information is provided and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Joint Interim Standing Committee on Health and Human Services; and

(2) In odd-numbered years, the next regular session of the Legislature.

2. The Advocate may adopt regulations to carry out the provisions of this section and NRS 232.461 and 232.462.

3. As used in this section:

(a) "Health care facility" has the meaning ascribed to it in NRS 162A.740.

(b) "Navigator, case manager or facilitator" has the meaning ascribed to it in NRS 687B.675.

Sec. 42. NRS 233B.038 is hereby amended to read as follows:

233B.038 1. "Regulation" means:

(a) An agency rule, standard, directive or statement of general applicability which effectuates or interprets law or policy, or describes the organization, procedure or practice requirements of any agency;

(b) A proposed regulation;

(c) The amendment or repeal of a prior regulation; and

(d) The general application by an agency of a written policy, interpretation, process or procedure to determine whether a person is in compliance with a federal or state statute or regulation in order to assess a fine, monetary penalty or monetary interest.

2. The term does not include:

(a) A statement concerning only the internal management of an agency and not affecting private rights or procedures available to the public;

(b) A declaratory ruling;

(c) An intraagency memorandum;

(d) A manual of internal policies and procedures or audit procedures of an agency which is used solely to train or provide guidance to employees of the agency and which is not used as authority in a contested case to determine whether a person is in compliance with a federal or state statute or regulation;

(e) An agency decision or finding in a contested case;

(f) An advisory opinion issued by an agency that is not of general applicability;

(g) A published opinion of the Attorney General;

(h) An interpretation of an agency that has statutory authority to issue interpretations;

(i) Letters of approval, concurrence or disapproval issued in relation to a permit for a specific project or activity;

(j) A contract or agreement into which an agency has entered;

(k) The provisions of a federal law, regulation or guideline;

(l) An emergency action taken by an agency that is necessary to protect public health and safety;

(m) The application by an agency of a policy, interpretation, process or procedure to a person who has sufficient prior actual notice of the policy, interpretation, process or procedure to determine whether the person is in compliance with a federal or state statute or regulation in order to assess a fine, monetary penalty or monetary interest;

(n) A regulation concerning the use of public roads or facilities which is indicated to the public by means of signs, signals and other traffic-control devices that conform with the manual and specifications for a uniform system of official traffic-control devices adopted pursuant to NRS 484A.430;

(o) The classification of wildlife or the designation of seasons for hunting, fishing or trapping by regulation of the Board of Wildlife Commissioners pursuant to the provisions of title 45 of NRS; ~~[or]~~

(p) A technical bulletin prepared pursuant to NRS 360.133 ~~[.]~~ ***; or***

(q) The assessment conducted by the Director of the Department of Health and Human Services pursuant to section 7 of this act.

Sec. 42.5. **NRS 239.010 is hereby amended to read as follows:**

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 3.2203, 41.0397, 41.071, 49.095, 49.293, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119A.677, 119B.370, 119B.382, 120A.640, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 128.090, 130.312, 130.712, 136.050, 159.044, 159A.044, 164.041, 172.075, 172.245, 176.01334, 176.01385, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 178.5717, 179.495, 179A.070, 179A.165, 179D.160, 180.600, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3923, 209.3925, 209.419, 209.429, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 218G.615, 224.240, 226.462, 226.796, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1285, 231.1473, 232.1369, 233.190, 237.300, 239.0105, 239.0113, 239.014, 239B.026, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 239C.420, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 247.540, 247.545, 247.550, 247.560, 250.087, 250.130, 250.140, 250.145, 250.150, 268.095, 268.0978, 268.490, 268.910, 269.174, 271A.105, 281.195, 281.805, 281A.350, 281A.680, 281A.685, 281A.750, 281A.755, 281A.780, 284.4068, 284.4086, 286.110, 286.118, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.4855, 293.5002, 293.503, 293.504, 293.558, 293.5757, 293.870, 293.906, 293.908, 293.909, 293.910, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.1593, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240,

353D.250, 360.240, 360.247, 360.255, 360.755, 361.044, 361.2242, 361.610, 365.138, 366.160, 368A.180, 370.257, 370.327, 372A.080, 378.290, 378.300, 379.0075, 379.008, 379.1495, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 388A.247, 388A.249, 391.033, 391.035, 391.0365, 391.120, 391.925, 392.029, 392.147, 392.264, 392.271, 392.315, 392.317, 392.325, 392.327, 392.335, 392.850, 393.045, 394.167, 394.16975, 394.1698, 394.447, 394.460, 394.465, 396.1415, 396.1425, 396.143, 396.159, 396.3295, 396.405, 396.525, 396.535, 396.9685, 398A.115, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 414.280, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 427A.940, 432.028, 432.205, 432B.175, 432B.280, 432B.290, 432B.4018, 432B.407, 432B.430, 432B.560, 432B.5902, 432C.140, 432C.150, 433.534, 433A.360, 439.4941, 439.4988, 439.5282, 439.840, 439.914, 439A.116, 439A.124, 439B.420, 439B.754, 439B.760, 439B.845, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 442.735, 442.774, 445A.665, 445B.570, 445B.7773, 449.209, 449.245, 449.4315, 449A.112, 450.140, 450B.188, 450B.805, 453.164, 453.720, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.535, 480.545, 480.935, 480.940, 481.063, 481.091, 481.093, 482.170, 482.368, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484A.469, 484B.830, 484B.833, 484E.070, 485.316, 501.344, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655, 587.877, 598.0964, 598.098, 598A.110, 598A.420, 599B.090, 603.070, 603A.210, 604A.303, 604A.710, 604D.500, 604D.600, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.238, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.043, 629.047, 629.069, 630.133, 630.2671, 630.2672, 630.2673, 630.2687, 630.30665, 630.336, 630A.327, 630A.555, 631.332, 631.368, 632.121, 632.125, 632.3415, 632.3423, 632.405, 633.283, 633.301, 633.427, 633.4715, 633.4716, 633.4717, 633.524, 634.055, 634.1303, 634.214, 634A.169, 634A.185, 634B.730, 635.111, 635.158, 636.262, 636.342, 637.085, 637.145, 637B.192, 637B.288, 638.087, 638.089, 639.183, 639.2485, 639.570, 640.075, 640.152, 640A.185, 640A.220, 640B.405, 640B.730, 640C.580, 640C.600, 640C.620, 640C.745, 640C.760, 640D.135, 640D.190, 640E.225, 640E.340, 641.090, 641.221, 641.2215, 641A.191, 641A.217, 641A.262, 641B.170, 641B.281, 641B.282, 641C.455, 641C.760, 641D.260, 641D.320, 642.524, 643.189, 644A.870, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.126, 652.228, 653.900, 654.110, 656.105, 657A.510, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 670B.680, 671.365, 671.415, 673.450, 673.480, 675.380, 676A.340, 676A.370, 677.243, 678A.470, 678C.710, 678C.800, 679B.122, 679B.124, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.060, 687A.115, 687B.404, 687C.010, 688C.230, 688C.480, 688C.490, 689A.696, 692A.117, 692C.190, 692C.3507, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 696C.120, 703.196, 704B.325, 706.1725, 706A.230, 710.159, 711.600, ***and section 89.9 of this act,*** sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies,

abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate, including, without limitation, electronically, the confidential information from the information included in the public book or record that is not otherwise confidential.

4. If requested, a governmental entity shall provide a copy of a public record in an electronic format by means of an electronic medium. Nothing in this subsection requires a governmental entity to provide a copy of a public record in an electronic format or by means of an electronic medium if:

(a) The public record:

(1) Was not created or prepared in an electronic format; and

(2) Is not available in an electronic format; or

(b) Providing the public record in an electronic format or by means of an electronic medium would:

(1) Give access to proprietary software; or

(2) Require the production of information that is confidential and that cannot be redacted, deleted, concealed or separated from information that is not otherwise confidential.

5. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in the medium that is requested because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 43. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the

fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.408, 687B.692, 687B.723, 687B.725, 687B.805, 689B.030 to 689B.0317, inclusive, paragraphs (b) and (c) of subsection 1 of NRS 689B.0319, subsections 2, 4, 6 and 7 of NRS 689B.0319, 689B.033 to 689B.0369, inclusive, 689B.0375 to 689B.050, inclusive, 689B.0675, 689B.265, 689B.287 and 689B.500 ***and section ~~[109]~~ 1 of this act*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 44. ~~[NRS 287.010 is hereby amended to read as follows:~~

~~287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:~~

~~(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.~~

~~(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.~~

~~(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 439.581 to 439.597, inclusive, 686A.135, *paragraph (b) of subsection 2 and subsections 1, 4, 5 and 6 of NRS 687B.225,* *NRS* 687B.352, 687B.408, 687B.692, **[**687B.723,**]** 687B.725, 687B.805, 689B.030 to 689B.0317, inclusive, paragraphs (b) and (c) of subsection 1 of NRS 689B.0319, subsections 2, 4, 6 and 7 of NRS 689B.0319, 689B.033 to 689B.0369, inclusive, 689B.0375 to 689B.050, inclusive, 689B.0675, *689B.255,* 689B.265, 689B.287 and 689B.500 and **[**section**]** *sections 97 to* 109 *, inclusive,* of this act apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.~~

~~(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.~~

~~2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the~~

~~compensation to which a trustee is entitled, the difference must be paid by the trustee.~~

~~3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.~~

~~4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:~~

~~(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and~~

~~(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.~~

~~5. A contract that is entered into pursuant to subsection 3:~~

~~(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.~~

~~(b) Does not become effective unless approved by the Commissioner.~~

~~(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.~~

~~6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.]~~ **(Deleted by amendment.)**

Sec. 45. NRS 287.0433 is hereby amended to read as follows:

287.0433 1. The Board may establish a plan of life, accident or health insurance and provide for the payment of contributions into the Program Fund, a schedule of benefits and the disbursement of benefits from the Program Fund. The Board may reinsure any risk or any part of such a risk.

2. If the Board provides coverage of prescription drugs pursuant to this section, the Board or any entity with which the Board enters into a contract to provide such coverage may use the list of preferred prescription drugs developed by the Department of Health and Human Services pursuant to subsection 1 of NRS 422.4025 as its formulary and obtain prescription drugs through the purchasing agreements negotiated by the Department pursuant to that section by notifying the Department in the form prescribed by the Department.

3. The Board may not enter into a contract with a health carrier, as defined in section 98 of this act, to perform any function with regard to a plan of health insurance established pursuant to subsection 1 unless the health carrier meets the criteria prescribed by the regulations adopted pursuant to subsection 2 of section 108 of this act.

Sec. 45.5. **NRS 287.04335 is hereby amended to read as follows:**

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 439.581 to 439.597, inclusive, ***and section 1 of this act,*** 686A.135, 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to

695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 46. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 439.581 to 439.597, inclusive, and section 1 of this act, 686A.135, 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, ***and section 109 of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 47. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 439.581 to 439.597, inclusive, and section 1 of this act, 686A.135, ***paragraph (b) of subsection 2 and subsections 1 ~~[, 4, 5 and 6]~~ and 3 to 8, inclusive, of NRS 687B.225, NRS*** 687B.352, 687B.409, 687B.692, ~~[687B.723,]~~ 687B.725, 687B.805, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, and ~~[section]~~ ***sections 97 to*** 109 ***, inclusive,*** of this act in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 48. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 49 to 63, inclusive, of this act.

Sec. 49. ~~***[1. The Department shall explore ways to use federal financial participation in Medicaid to support programs for medical residency training and postdoctoral fellows in this State, including, without limitation, by providing higher rates of reimbursement under Medicaid to incentivize the participation of providers of services in such programs and offset the costs of providers of services who participate in such programs.***~~

~~***2. In allocating federal money pursuant to subsection 1, the Department:***~~

~~***(a) May prioritize programs for medical residency training and postdoctoral fellows serving geographic areas and populations of this State where the shortage of providers of health care is most critical or which provide training in the specialties for which the need is most critical, as identified by the assessment conducted pursuant to section 7 of this act; and***~~

~~***(b) Shall not use or authorize the use of such federal money to supplant existing methods of funding that are available to programs for medical residency training and postdoctoral fellows.]***~~ **(Deleted by amendment.)**

Sec. 50. ***1. The Department or any entity to which the Department delegates credentialing functions for Medicaid or the Children's Health Insurance Program shall:***

(a) Use the Provider Data Portal, or any successor system, established by the Council for Affordable Quality Healthcare, or its successor organization, to accept submissions by providers of health care for credentialing; and

(b) Use an entity that holds the Credentials Verification Organization Certification issued by the National Committee for Quality Assurance, or its

successor organization, for the purpose of verifying the credentials of providers of health care seeking to participate in Medicaid or the Children's Health Insurance Program.

2. On or before February 1 of each year, the Department shall:

(a) Compile a report on the credentialing of providers of health care which includes, without limitation:

(1) The average time between the submission of a request by a provider of health care for credentialing for Medicaid and the Children's Health Insurance Program during the immediately preceding year and the request being approved or denied; and

(2) Recommendations for improvements to the process for credentialing providers of health care for Medicaid and the Children's Health Insurance Program, including, without limitation, recommendations concerning improvements to technology or procedures to increase the efficiency of the process; and

(b) Submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Joint Interim Standing Committee on Health and Human Services; and

(2) In odd-numbered years, the next regular session of the Legislature.

3. As used in this section:

(a) "Credentialing" means verifying the credentials of a provider of health care for the purpose of determining whether the provider of health care meets the requirements for participation in Medicaid or the Children's Health Insurance Program as a provider of services.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 51. *1. The Department shall:*

(a) Take such measures as are necessary to facilitate the determination required pursuant to 42 U.S.C. § 1396a(a)(47) by personnel of hospitals who are certified by the Department of the presumptive eligibility of patients to receive benefits under Medicaid.

(b) Apply to the United States Secretary of Health and Human Services for any waiver of federal law or apply for any amendment of the State Plan for Medicaid that is necessary to authorize personnel of qualified community-based organizations who are certified by the Department to determine whether a person is presumptively eligible to receive benefits under Medicaid.

(c) Fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to paragraph (b).

2. The Department shall establish a comprehensive program to certify employees, contractors and volunteers of the entities described in subsection 1 in determining whether a person is presumptively eligible to receive benefits under Medicaid. The program must include, without limitation, training concerning:

(a) Eligibility criteria for different categories of persons who may be presumptively eligible for benefits under Medicaid;

(b) Standardized procedures for making preliminary assessments to determine whether a person may be presumptively eligible under Medicaid;

(c) Protocols for notifying persons who are determined to be presumptively eligible for Medicaid of the process to apply for full benefits under Medicaid; and

(d) Ensuring the accuracy of determinations concerning the presumptive eligibility of persons for Medicaid.

3. To the extent authorized by the Federal Government, each certification described in subsection 1 must expire 1 year after the certification is issued.

4. The Department shall conduct regular audits of all entities that make determinations concerning the presumptive eligibility of persons for Medicaid pursuant to this section. Such audits must verify:

(a) The accuracy of the determinations made by the personnel of those entities concerning the presumptive eligibility of persons for Medicaid; and

(b) Compliance with other state and federal requirements governing Medicaid.

Sec. 51.3. ***1. To the extent authorized by federal law and to the extent that money is available, the Director shall include under Medicaid a system of value-based payments for care provided by independent centers for emergency medical care. That system must be designed to provide higher rates of reimbursement to independent centers for emergency medical care that:***

(a) Provide high quality of care to recipients of Medicaid; and

(b) Ensure that recipients of Medicaid receive an appropriate level of care for the conditions with which the recipients present at an independent center for emergency medical care.

2. To the extent that money is available to implement the system of value-based payments described in subsection 1, the Department shall:

(a) Apply to the Secretary of Health and Human Services for any waiver of federal law or apply for any amendment of the State Plan for Medicaid that is necessary for the Department to receive federal authorization to implement the system of value-based payments described in subsection 1.

(b) Fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to paragraph (a).

3. As used in this section, "independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

Sec. 51.5. ***1. A provider of services under Medicaid shall:***

(a) Maintain such documents as are required by regulation of the Administrator for the verification of claims for the period of time specified in those regulations; and

(b) Provide the documents maintained pursuant to paragraph (a) to the Department upon the request of the Department.

2. The Department may audit any documents provided pursuant to paragraph (b) of subsection 1. If the Department is unable to verify a claim using the documents maintained pursuant to subsection 1, the Department may deny the claim or, if the Department has already paid the claim, recover the amount of the payment from the provider.

Sec. 51.8. ***1. If the Department determines that a provider of services under Medicaid may be prescribing or providing services in a manner that exceeds the needs of recipients of Medicaid, is unnecessary or otherwise conflicts with applicable professional standards or the requirements of the Medicaid program, the Department shall perform a review of the relevant claims to evaluate the appropriateness and propriety of the services for which payment is claimed. If the Department has not paid the claims, the review must occur before the Department pays the claims.***

2. Upon deciding to conduct a review pursuant to subsection 1, the Department shall:

(a) Notify the provider of services who submitted the claims subject to the review; and

(b) Require the provider of services to submit to the Department within a period of time specified by the Department any documentation necessary to substantiate the claims.

3. If a provider of services fails to submit the documentation required by the Department pursuant to paragraph (b) of subsection 2 within the time specified pursuant to that paragraph, the Department may take the actions described in paragraph (a) of subsection 5 without the opportunity for a hearing pursuant to NRS 422.306.

4. Not later than 60 days after receiving the documentation requested pursuant to paragraph (b) of subsection 2, the Department shall complete a review pursuant to this section and either:

(a) Pay the claims that were subject to the review or, if the Department has already paid such a claim, notify the provider of services who made the claim that the claim has been upheld; or

(b) Take an action described in paragraph (a) of subsection 5 with respect to the claims that were subject to the review.

5. If the Department determines after conducting a review pursuant to this section that a provider of services has prescribed or provided services in a manner that exceeds the needs of recipients of Medicaid, is unnecessary or otherwise conflicts with applicable professional standards or the requirements of the Medicaid program, the Department may, after the opportunity for a hearing pursuant to NRS 422.306:

(a) Deny the affected claims or, if the Department has already paid an affected claim, recover the amount of the payment from the provider;

(b) Require the provider to request and receive authorization for the delivery of services to recipients of Medicaid before delivering the services; or

(c) Take any other action authorized by this chapter and the regulations adopted pursuant thereto.

Sec. 52. ~~*[1. Except as otherwise provided in subsections 4, 5 and 6 of section 56 of this act, the provisions of sections 53 to 63, inclusive, of this act and any policies developed pursuant thereto do not apply to the delivery of services to recipients of Medicaid or the Children's Health Insurance Program through managed care in accordance with NRS 422.273.*~~

~~*2. A health maintenance organization or other managed care organization that enters into a contract with the Department pursuant to NRS 422.273 to provide health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program shall comply with NRS 687B.225 and sections 97 to 108, inclusive, of this act.]*~~ **(Deleted by amendment.)**

Sec. 53. *As used in sections 53 to 63, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 53.5, 54 and 55 of this act have the meanings ascribed to them in those sections.*

Sec. 53.5. *"Medicaid managed care entity" means:*

1. A health maintenance organization or other managed care organization that enters into a contract with the Department or the Division pursuant to NRS 422.273 to provide health care to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program;

2. An administrator, as defined in NRS 683A.025, that performs any function related to prior authorization or the payment of claims for the Department or a health maintenance organization or managed care organization described in subsection 1 with respect to Medicaid or the Children's Health Insurance Program, while acting in its capacity as an administrator for the Department or the health maintenance organization or managed care organization; or

3. A utilization review organization, as defined in NRS 695G.085, that conducts utilization reviews for the Department or a health maintenance organization or managed care organization described in subsection 1 with respect

to Medicaid or the Children's Health Insurance Program, while acting in its capacity as a utilization review organization for the Department or the health maintenance organization or managed care organization.

Sec. 54. *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

Sec. 55. *"Recipient" means a natural person who receives benefits through Medicaid or the Children's Health Insurance Program, as applicable.*

Sec. 56. *1. ~~[Except where a different]~~ Unless a shorter time period is prescribed by a specific statute, the Department or a Medicaid managed care entity, with respect to Medicaid and the Children's Health Insurance Program, shall approve or deny a request for prior authorization for medical or dental care provided to a recipient or provide notice of a delay in accordance with section 58 of this act within ~~[the time period prescribed by]~~ :*

(a) Two business days after receiving the request; or

(b) Except as otherwise provided in subsections 2 and 4, if the Prior Authorization and Referrals Operating Rules prescribed by the Committee on Operating Rules for Information Exchange of the Council for Affordable Quality Healthcare, or its successor organization ~~[,]~~ would allow the Department or Medicaid managed care entity more than 2 business days to respond to a particular request for prior authorization after receiving the request, the period of time prescribed by the Rules.

2. Notwithstanding any period of time prescribed by the Rules described in paragraph (b) of subsection 1, the Department or a Medicaid managed care entity shall respond as required by subsection 1 to a request for prior authorization within 7 calendar days after receiving the request.

3. If the Department fails to comply with ~~[this subsection,]~~ subsection 1, 2 or 4, as applicable, with respect to a particular request for prior authorization, the request shall be deemed approved.

~~[2.]~~ 4. The Department, in collaboration with the Commissioner of Insurance, shall review each revision to the Rules described in paragraph (b) of subsection 1 to ensure their suitability for this State. If the Department determines that a revision is not suitable for this State, the Department shall hold a public hearing within 6 months after the date the Rules were revised to review the determination. If the Department does not revise ~~[his or her]~~ its determination, the Department shall give notice within 30 days after the hearing that the revisions are not suitable for this State. If the Department ~~[does not give]~~ gives such notice, the Department or a Medicaid managed care entity shall ~~[comply with the revision not later than 2 years after the date on which the revision was finalized.]~~ respond as required by subsection 1 to any request for prior authorization that is submitted to the Department or Medicaid managed care entity, as applicable, after the date on which such notice is given within 2 business days after receiving the request.

~~[3.]~~ 5. The Department or a Medicaid managed care entity shall not require prior authorization for emergency services covered by Medicaid or the Children's Health Insurance Program, including, where applicable, transportation by ambulance to a hospital or other medical facility.

*~~[4.]~~ 6. Except as otherwise provided in this ~~[subsection and subsection 6,]~~ section, the Department or a ~~[health maintenance organization or other]~~ Medicaid managed care ~~[organization that enters into a contract with the Department pursuant to NRS 422.273 to provide health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program]~~ entity shall comply with the provisions of section 107 of this

act to the same extent as a health carrier, as defined in section 98 of this act. The provisions of this subsection do not apply to:

(a) Any drug that is in a class of drugs that is included on the list of preferred prescription drugs developed pursuant to subsection 1 of NRS 422.4025;

(b) Any goods or services for which prior authorization is required by the Federal Government; or

(c) Any goods or services for which prior authorization is required by regulation of the Department pursuant to subsection ~~[5.]~~ 7.

~~[5.]~~ 7. The Department may, by regulation, require the holder of a Gold Card Exemption issued pursuant to section 107 of this act to obtain prior authorization for goods or services provided to recipients of Medicaid or benefits under the Children's Health Insurance Program if the Department determines that not requiring prior authorization for such goods or services would create a risk of fraud or abuse or impair the ability of the Department to control the cost of those programs. Any such requirement may only apply to a particular good or service and must not apply to an entire class of goods or services.

*~~[6.]~~ 8. The Department and ~~[health maintenance organizations and other managed care organizations described in subsection 4]~~ Medicaid managed care entities are not subject to the regulations adopted by the Commissioner of Insurance pursuant to subsection 8 of section 107 of this act. The Administrator shall, pursuant to NRS 422.2368, adopt regulations applicable to the Department and ~~[such]~~ Medicaid managed care ~~[organizations]~~ entities that, to the extent practicable, are similar to the regulations adopted by the Commissioner of Insurance pursuant to subsection 8 of section 107 of this act.

~~[7.]~~ 9. In addition to the regulations adopted pursuant to subsection 8, the Department shall adopt regulations to ensure the quality of care provided by the holders of Gold Card Exemptions issued by the Department and Medicaid managed care entities pursuant to section 107 of this act. Those regulations must utilize appropriate measurements and ratings of quality of health care, which may include, without limitation:

(a) The Five-Star Quality Rating System established by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services or other standards and metrics adopted by that agency; or

(b) Standards and metrics prescribed by the National Committee for Quality Assurance, or its successor organization.

10. The Department shall review the status of any holder of a Gold Card Exemption issued by the Department or a Medicaid managed care entity pursuant to section 107 of this act that fails to maintain an average rating for quality in accordance with the applicable standards adopted pursuant to subsection 9. The Department may suspend or revoke the Gold Card Exemption if, after conducting the review, the Department determines that the holder is not taking sufficient measures to improve the quality of the care provided by the holder.

11. The Department shall:

(a) Collect any data necessary to implement the provisions of subsections 9 and 10. Such data must include, without limitation, data related to the quality of care provided by the holders of Gold Card Exemptions issued by the Department and Medicaid managed care entities pursuant to section 107 of this act by age, race, ethnicity, primary language and disability of the recipient of the care.

(b) Annually publish on an Internet website maintained by the Department a summary of the data collected pursuant to paragraph (a).

12. As used in this section, "emergency services" means health care services that are provided by a provider of health care to screen and to stabilize a recipient after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

(a) Serious jeopardy to the health of the recipient;

(b) Serious jeopardy to the health of an unborn child of the recipient;

(c) Serious impairment of a bodily function of the recipient; or

(d) Serious dysfunction of any bodily organ or part of the recipient.

Sec. 57. *1. The Department shall implement an electronic system for receiving and processing requests for prior authorization for medical or dental care provided to recipients under Medicaid and the Children's Health Insurance Program. Such a system must:*

(a) Allow providers of health care to electronically submit, track and receive updates concerning requests for prior authorization; and

(b) Comply with:

(1) The Connectivity Operating Rules, Eligibility and Benefits Operating Rules and Health Care Claims Operating Rules prescribed by the Committee on Operating Rules for Information Exchange of the Council for Affordable Quality Healthcare, or its successor organization;

(2) The provisions of the Prior Authorization and Referrals Operating Rules prescribed by the Committee on Operating Rules for Information Exchange of the Council for Affordable Quality Healthcare, or its successor organization, which relate to prior authorization; and

(3) Any federal laws or regulations governing electronic systems for receiving and processing requests for prior authorization applicable to Medicaid or the Children's Health Insurance Program.

2. The Department, in collaboration with the Commissioner of Insurance, shall review each revision to the Rules described in paragraph (b) of subsection 1 to ensure their suitability for this State. If the Department determines that a revision is not suitable for this State, the Department shall hold a public hearing within 6 months after the date the Rules were revised to review the determination. If the Department does not revise his or her determination, the Department shall give notice within 30 days after the hearing that the revisions are not suitable for this State. If the Department does not give such notice, the Department shall comply with the revision not later than 2 years after the date on which the revision was finalized.

Sec. 58. *Upon determining that it is necessary to delay a response to a request for prior authorization beyond the period prescribed by subsection 1 , 2 or 4, as applicable, of section 56 of this act, the Department or a Medicaid managed care entity shall transmit a written notice to the recipient to whom the request pertains and an electronic notice to the provider of health care who submitted the request ~~.~~ or the person designated by the provider of health care to manage requests for prior authorization. Such notice must contain:*

1. A specific description of all reasons that the Department or Medicaid managed care entity, as applicable, is delaying the response;

2. The steps necessary to resolve the delay; and

3. The anticipated timeline for resolving the delay.

Sec. 59. *1. Upon denying a request for prior authorization, the Department or a Medicaid managed care entity, as applicable, shall transmit to:*

(a) The recipient to whom the request pertains a written notice that contains:

(1) A specific description of all reasons that the Department or Medicaid managed care entity, as applicable, denied the request;

(2) A description of any documentation that the Department or Medicaid managed care entity, as applicable, requested from the recipient or a provider of health care of the recipient and did not receive or deemed insufficient, if the failure to receive sufficient documentation contributed to the denial;

(3) A statement that the recipient has the right to appeal the denial;

(4) Instructions, written in clear language that is understandable to an ordinary layperson, describing how the recipient can appeal the denial through the process established pursuant to subsection 2; and

(5) A description of any documentation that may be necessary or pertinent to an appeal.

(b) The provider of health care who submitted the request or the person designated by the provider of health care to manage requests for prior authorization an electronic notice that includes all the information required by the Rules described in subsection 1 of section 56 of this act.

2. The Department or a Medicaid managed care entity shall establish a process that allows a recipient to appeal the denial of a request for prior authorization. The process must allow for the clear resolution of each appeal within a reasonable time.

Sec. 60. *1. The Department ~~,~~ or a Medicaid managed care entity, with respect to Medicaid and the Children's Health Insurance Program, shall not revoke a request for prior authorization that the Department or Medicaid managed care entity, as applicable, has previously approved or delay or deny payment for the medical or dental care to which such a request pertains unless the Department or Medicaid managed care entity, as applicable, determines that:*

(a) A recipient or a provider of health care procured the approval by fraud or material misrepresentation;

(b) The approval was affected by a clerical error; or

(c) The person to which the medical or dental care was provided was not, on the date on which the care was provided, a recipient.

2. After approving a request for prior authorization, the Department or a Medicaid managed care entity shall not assign a lower level billing code to the medical or dental care to which the request pertains or otherwise reduce the payment for such care below the amount indicated in the request for prior authorization without a clear, documented justification that aligns with applicable standards of care.

3. If the Department or a Medicaid managed care entity takes any action described in subsection 1 or 2, the Department or Medicaid managed care entity shall provide written notice of the action using the same remittance process that the Department or Medicaid managed care entity, as applicable, uses to pay claims to the provider of health care that submitted the request for prior authorization. Such notice must include, without limitation, a detailed description of the justification for the action and documentation supporting that justification.

4. As used in this section, "clerical error" means a typographical or administrative error or an error in calculation. The term does not include any mistake relating to clinical judgment, the medical necessity of care or the appropriateness of a treatment.

Sec. 61. *1. The Department ~~,~~ or a Medicaid managed care entity, with respect to Medicaid and the Children's Health Insurance Program, shall comply with the provisions of 42 U.S.C. § 300gg-113, and any regulations adopted pursuant thereto, to the same extent as a health insurance issuer, as defined in 42 U.S.C. § 300gg-91.*

2. Within the first 90 days that a recipient is enrolled in Medicaid or the Children's Health Insurance Program, as applicable, the Department or a

Medicaid managed care entity shall honor a request for prior authorization that has been approved by a health carrier or other entity that previously provided the recipient with coverage for medical or dental care if:

(a) The approval was issued within the 12 months immediately preceding the first day of the enrollment of the recipient; and

(b) The specific medical or dental care included within the request is not affirmatively excluded under the terms and conditions of Medicaid or the Children's Health Insurance Program, as applicable.

3. The Department or a Medicaid managed care entity may undertake an independent review of the care approved by the previous health carrier of a recipient which is subject to the requirements of subsection 2 for the purpose of granting its own approval of the care. The Department or a Medicaid managed care entity shall not deny approval in violation of subsection 2 as the result of such a review.

4. If the Department or a Medicaid managed care entity approves a request for prior authorization, the Department or Medicaid managed care entity, as applicable, shall not revoke, limit, condition or restrict the approval due to a subsequent change in the coverage under Medicaid or the Children's Health Insurance Program or the criteria under which the approval was initially issued unless the approved services are no longer covered as a result of the change in coverage.

Sec. 62. *1. On or before March 1 of each year, the Department shall:*

(a) Compile, post on an Internet website maintained by the Department and submit to the Commissioner of Insurance the following information for Medicaid and the Children's Health Insurance Program:

(1) The specific goods and services for which the Department requires prior authorization and, for each good or service:

(I) The number of requests for prior authorization received by the Department during the immediately preceding calendar year for the provision of the good or service to recipients;

(II) The number and percentage of the requests included pursuant to sub-subparagraph (I) that were approved; and

(III) The number and percentage of the requests included pursuant to sub-subparagraph (I) that were denied;

(2) The average amounts of time between when the Department received a request for prior authorization during the immediately preceding year and when the Department:

(I) Initially responded to the request;

(II) Approved or denied the request; and

(III) Paid the claim to which the request pertains;

(3) The percentage of claims received by the Department during the immediately preceding year that the Department retroactively denied and detailed written explanations of the reasons for such denials; and

(4) Explanations of corrective actions that the Department is taking or intends to take to:

(I) Lower the rates of delays and denials of requests for prior authorization and payment of claims; and

(II) Correct any failure to comply with the provisions of sections 52 to 63, inclusive, of this act; and

(b) Submit the report compiled pursuant to paragraph (a) to the Commissioner of Insurance for inclusion on the Internet website maintained by the Commissioner pursuant to section 106 of this act.

2. The Department shall not include individually identifiable health information in a report published pursuant to this section.

3. As used in this section, "individually identifiable health information" means information relating to the provision of medical or dental care to a recipient:

(a) That specifically identifies the recipient; or

(b) For which there is a reasonable basis to believe that the information can be used to identify the recipient.

Sec. 63. ***1. The Department shall comply with the requirements of 42 C.F.R. § 447.45(d)(2) and (3).***

2. If the Department approves a claim under Medicaid or the Children's Health Insurance Program, the Department shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the Department shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

3. If the Department requires additional information to determine whether to approve or deny a claim under Medicaid or the Children's Health Insurance Program, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The Department shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The Department shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the Department shall pay interest on the claim in the manner prescribed in subsection 2.

4. The Department shall not request a claimant to resubmit information that the claimant has already provided to the Department, unless the Department provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

5. The Department shall not pay only part of a claim that has been approved and is fully payable.

6. If the failure to pay an approved claim within the time period specified in subsection 2 or 3 is the fault of an entity with which the Department has contracted to perform functions relating to the payment of claims under Medicaid or the Children's Health Insurance Program, the Department may collect from that person reimbursement for the cost of the interest required by those subsections.

Sec. 64. ~~[NRS 422.273 is hereby amended to read as follows:~~

~~422.273 1. To the extent that money is available, the Department shall:~~

~~(a) Establish a Medicaid managed care program to provide health care services to recipients of Medicaid in all geographic areas of this State. The program is not required to provide services to recipients of Medicaid who are aged, blind or disabled pursuant to Title XVI of the Social Security Act, 42 U.S.C. §§ 1381 et seq.~~

~~(b) Conduct a statewide procurement process to select health maintenance organizations to provide the services described in paragraph (a).~~

~~2. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization~~

~~that *meets the criteria prescribed by the regulations adopted pursuant to subsection 2 of section 108 of this act and* has:~~

~~(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;~~

~~(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid;~~

~~(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid; and~~

~~(d) Complied with the provisions of subsection 2 of NRS 695K.220.~~

~~* Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.~~

~~3. During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.~~

~~4. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.~~

~~5. For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.~~

~~6. To the extent that money is available, a Medicaid managed care program must include, without limitation, a state directed payment arrangement established in accordance with 42 C.F.R. § 438.6(c) to require a Medicaid managed care organization to reimburse a critical access hospital and any federally qualified health center or rural health clinic affiliated with a critical access hospital for covered services at a rate that is equal to or greater than the rate received by the critical access hospital, federally qualified health center or rural health clinic, as applicable, for services provided to recipients of Medicaid on a fee for service basis.~~

~~7. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.~~

~~8. As used in this section, unless the context otherwise requires:~~

~~(a) "Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).~~

~~(b) "Federally qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).~~

~~(c) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.~~

~~(d) "Managed care organization" has the meaning ascribed to it in NRS 695C.050.~~

~~(e) "Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.~~] **(Deleted by amendment.)**

Sec. 65. NRS 422.403 is hereby amended to read as follows:

422.403 1. The Department shall, by regulation, establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs.

2. The Drug Use Review Board shall:

(a) Advise the Department concerning the use by the Medicaid program of step therapy and prior authorization for prescription drugs;

(b) Develop step therapy protocols and prior authorization policies and procedures ***that comply with the provisions of sections 53 to 63, inclusive, of this act*** for use by the Medicaid program for prescription drugs; and

(c) Review and approve, based on clinical evidence and best clinical practice guidelines and without consideration of the cost of the prescription drugs being considered, step therapy protocols used by the Medicaid program for prescription drugs.

3. The step therapy protocol established pursuant to this section must not apply to a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of a recipient of Medicaid, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in Medicaid is located 60 miles or more from the residence of the recipient; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the recipient, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

4. The Department shall not require the Drug Use Review Board to develop, review or approve prior authorization policies or procedures necessary for the operation of the list of preferred prescription drugs developed pursuant to NRS 422.4025.

5. The Department shall accept recommendations from the Drug Use Review Board as the basis for developing or revising step therapy protocols and prior authorization policies and procedures used by the Medicaid program for prescription drugs.

6. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Step therapy protocol" means a procedure that requires a recipient of Medicaid to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the recipient before Medicaid provides coverage for the recommended drug.

Sec. 66. ~~[NRS 422.4053 is hereby amended to read as follows:~~

~~422.4053 1. Except as otherwise provided in subsection 2, the Department shall directly manage, direct and coordinate all payments and rebates for prescription drugs and all other services and payments relating to the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program.~~

~~2. The Department may enter into a contract with:~~

~~(a) A pharmacy benefit manager ***that meets the criteria prescribed pursuant to subsection 2 of section 108 of this act*** for the provision of any services described in subsection 1.~~

~~(b) A health maintenance organization pursuant to NRS 422.273 for the provision of any of the services described in subsection 1 for recipients of Medicaid or recipients of insurance through the Children's Health Insurance Program who receive coverage through a Medicaid managed care program.~~

~~(c) One or more public or private entities from this State, the District of Columbia or other states or territories of the United States for the collaborative purchasing of prescription drugs in accordance with subsection 3 of NRS 277.110.~~

~~3. A contract entered into pursuant to paragraph (a) or (b) of subsection 2 must:~~

~~(a) Include the provisions required by NRS 422.4056;~~

~~(b) Require the pharmacy benefit manager or health maintenance organization, as applicable, to disclose to the Department any information relating to the services covered by the contract, including, without limitation, information concerning dispensing fees, measures for the control of costs, rebates collected and paid and any fees and charges imposed by the pharmacy benefit manager or health maintenance organization pursuant to the contract; and~~

~~(c) Require the pharmacy benefit manager or health maintenance organization to comply with the provisions of this chapter regarding the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program to the same extent as the Department.~~

~~4. In addition to meeting the requirements of subsection 3, a contract entered into pursuant to:~~

~~(a) Paragraph (a) of subsection 2 may require the pharmacy benefit manager to provide the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, to the Department.~~

~~(b) Paragraph (b) of subsection 2 must require the health maintenance organization to provide to the Department the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, less an administrative fee in an amount prescribed by the contract. The Department shall adopt policies prescribing the maximum amount of such an administrative fee.]~~ **(Deleted by amendment.)**

Sec. 66.3. **Chapter 433 of NRS is hereby amended by adding thereto the provisions set forth as sections 66.6 to 67.5, inclusive, of this act.**

Sec. 66.6. ***As used in sections 66.6 to 67.5, inclusive, of this act, unless the context otherwise requires, "Office" means the Office of Mental Health created by section 67 of this act.***

Sec. 67. ~~[Chapter 433 of NRS is hereby amended by adding thereto a new section to read as follows:]~~

1. The Office of Mental Health is hereby created within the Department.

2. ~~[The Office shall perform such activities and functions as may be necessary to:~~

~~(a) Expand access to mental health care, with a focus on shortages in the mental health care workforce, promoting economic efficiency and meeting the needs of rural and underserved areas;~~

~~(b) Identify best practices in policy regarding mental health care, including, without limitation, the funding of mental health care, to reduce the long-term costs of mental health care and social services to the State and political subdivisions thereof;~~

~~(c) Coordinate with the Commission on Behavioral Health, the Division of Health Care Financing and Policy of the Department, the Division of Child and Family Services of the Department and the Division of Public and Behavioral Health of the Department, other state agencies, the regional behavioral health policy boards created by NRS 433.429, the mental health consortia established by NRS 433B.333, local governments, providers of health care, schools, school districts, postsecondary educational institutions, community organizations and such other persons and entities as necessary to facilitate a unified approach to the delivery of mental health services and the development of the mental health care workforce in this State;~~

~~(d) Regularly assess the effectiveness of mental health services and programs provided by the State Government and the impact of such programs on access to quality mental health care in this State; and~~

~~(e) Coordinate with the Division of Health Care Financing and Policy of the Department to support participation in Medicaid by providers of mental health care by:~~

~~(1) Providing training and technical assistance concerning billing and the submission of claims under Medicaid; and~~

~~(2) Making recommendations to the Division of Health Care Financing and Policy for:~~

~~(I) Reducing administrative barriers to reimbursement of providers of mental health care under Medicaid; and~~

~~(II) Providing sustainable, competitive rates of reimbursement for providers of mental health services under Medicaid within the limits of available money.~~

~~3.~~ The Governor shall appoint the Executive Director of the Office. The Executive Director:

(a) Serves at the pleasure of the Governor;

(b) Shall serve as the executive head of the Office; and

(c) Must have relevant professional experience in the field of behavioral health. The Governor shall give preference to candidates who have:

(1) Clinical experience in mental health; or

(2) Designing and administering systems of care, including, without limitation, community-based care, for persons with behavioral health needs.

3. The Executive Director must not have any conflicts of interest in the performance of his or her duties. Such prohibited conflicts of interest include, without limitation:

(a) A financial interest or other personal interest in any entity that:

(1) Provides behavioral health services; or

(2) Owns, operates or controls an entity that provides behavioral health services.

(b) Currently receiving payment from any person or entity other than the Department for the provision of behavioral health services.

4. The Office may ~~:~~

~~(a) Submit to the Director of the Department a request for an allocation from the Nevada Health Care Workforce and Access Account created by section 6 of~~

~~this act to support any activity described in subsection 2 that is designed to address shortages of providers of mental health care and difficulties in accessing mental health care identified in the assessment conducted pursuant to section 7 of this act. The Director may approve the request if he or she determines that the activity that will be supported by the proposed allocation is likely to achieve such an objective.~~

~~(b) Accept~~ apply for and accept gifts, grants and donations from any source for the purpose of carrying out the provisions of ~~this section.~~

~~4. On or before February 1 of each year, the Office shall:~~

~~(a) Compile a report that includes, without limitation:~~

~~(1) An assessment of any progress in expanding mental health services and the capacity of the mental health care workforce in this State;~~

~~(2) An analysis of the state budget and the economic impacts of mental health programs;~~

~~(3) Any recommendations for adjustments to policy regarding mental health care or funding for mental health programs; and~~

~~(4) Data on the utilization of mental health services, the outcomes of mental health programs, the distribution of the mental health care workforce of this State and the allocation of funding for mental health programs; and~~

~~(b) Submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to:~~

~~(1) In even-numbered years, the Joint Interim Standing Committee on Health and Human Services; and~~

~~(2) In odd-numbered years, the next regular session of the Legislature.~~] sections 66.6 to 67.5, inclusive, of this act.

5. As used in this section, "behavioral health services" includes, without limitation, treatment or other services for persons with mental illnesses or persons with substance use disorders.

Sec. 67.2. The Office shall perform such activities and functions as may be necessary to:

1. Expand access to behavioral health care, with a focus on meeting the behavioral health needs of children, addressing shortages in the mental health care workforce, promoting economic efficiency and meeting the needs of rural and underserved areas;

2. Identify best practices in policy regarding mental health care, including, without limitation, the funding of mental health care, to reduce the long-term costs of mental health care and social services to the State and political subdivisions thereof;

3. Coordinate with the Commission on Behavioral Health, the Division of Health Care Financing and Policy of the Department, the Division of Child and Family Services of the Department and the Division of Public and Behavioral Health of the Department, other state agencies, the regional behavioral health policy boards created by NRS 433.429, the mental health consortia established by NRS 433B.333, local governments, providers of health care, schools, school districts, postsecondary educational institutions, community organizations and such other persons and entities as necessary to facilitate a unified approach to the delivery of mental health services and the development of the mental health care workforce in this State;

4. Regularly assess the effectiveness of mental health services and programs provided by the State Government and the impact of such programs on access to quality mental health care in this State; and

5. Coordinate with the Division of Health Care Financing and Policy of the Department to support participation in Medicaid by providers of mental health care by:

(a) Providing training and technical assistance concerning billing and the submission of claims under Medicaid; and

(b) Making recommendations to the Division of Health Care Financing and Policy for:

(1) Reducing administrative barriers to reimbursement of providers of mental health care under Medicaid; and

(2) Providing sustainable, competitive rates of reimbursement for providers of mental health services under Medicaid within the limits of available money.

Sec. 67.4. ***The Office shall:***

1. Develop, publish and update as necessary a statewide plan for the provision of mental and behavioral health services to children in this State.

2. Provide expertise and serve as a resource for matters relating to mental and behavioral health services for children in this State.

3. Disseminate information relating to programs, opportunities and resources to improve mental and behavioral health care for children in this State.

4. Review the long-term strategic plan, budget requests and reports submitted to the Executive Director by each mental health consortium pursuant to NRS 433B.335.

5. Track, review and analyze the policies, programs, reports or recommendations of the Commission, each regional behavioral health policy board created by NRS 433.429 and any other agency, board or commission that relate to the mental or behavioral health of children.

6. Study and make recommendations to local, state and federal governmental entities concerning policies that relate to the mental and behavioral health needs of children in this State with the goal of improving access to and the delivery of mental and behavioral health services and resources for children in this State.

7. Develop sustainable partnerships with community-based organizations and other private sector entities that serve children with mental and behavioral health needs in this State.

8. Collaborate with other persons and entities in this State as necessary to streamline and integrate mental and behavioral health services for children in this State.

Sec. 67.5. ***On or before February 1 of each year, the Office shall:***

1. Compile a report that includes, without limitation:

(a) An assessment of any progress in expanding mental health services and the capacity of the mental health care workforce in this State;

(b) An analysis of the state budget and the economic impacts of mental health programs;

(c) Any recommendations for adjustments to policy regarding mental health care or funding for mental health programs;

(d) Data on the utilization of mental health services, the outcomes of mental health programs, the distribution of the mental health care workforce of this State and the allocation of funding for mental health programs; and

(e) A report on the progress of the State in implementing the statewide plan for the provision of mental and behavioral health services to children in this State adopted pursuant to subsection 1 of section 67.4 of this act, which must include, without limitation, any recommendations concerning changes to policy or funding necessary to implement the statewide plan.

2. Submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to:

(a) In even-numbered years, the Joint Interim Standing Committee on Health and Human Services; and

(b) In odd-numbered years, the next regular session of the Legislature.

Sec. 67.6. **NRS 433.317 is hereby amended to read as follows:**

433.317 1. The Commission shall appoint a subcommittee on the mental health of children to review the findings and recommendations of each mental health consortium submitted pursuant to NRS 433B.335 and to ~~[create a]~~ ***advise the Office of Mental Health in the creation and updating of the*** statewide plan for the provision of mental ***and behavioral*** health services to children ~~[.]~~ ***pursuant to subsection 1 of section 67.4 of this act.***

2. The members of the subcommittee appointed pursuant to this section serve at the pleasure of the Commission. The members serve without compensation, except that each member is entitled, while engaged in the business of the subcommittee, to the per diem allowance and travel expenses provided for state officers and employees generally if funding is available for this purpose.

Sec. 67.7. **NRS 433B.335 is hereby amended to read as follows:**

433B.335 1. Each mental health consortium established pursuant to NRS 433B.333 shall prepare and submit to the Director of the Department ***and the Executive Director of the Office of Mental Health*** a long-term strategic plan for the provision of mental health services to children with emotional disturbance in the jurisdiction of the consortium. A plan submitted pursuant to this section is valid for 10 years after the date of submission, and each consortium shall submit a new plan upon its expiration.

2. In preparing the long-term strategic plan pursuant to subsection 1, each mental health consortium must be guided by the following principles:

(a) The system of mental health services set forth in the plan should be centered on children with emotional disturbance and their families, with the needs and strengths of those children and their families dictating the types and mix of services provided.

(b) The families of children with emotional disturbance, including, without limitation, foster parents, should be active participants in all aspects of planning, selecting and delivering mental health services at the local level.

(c) The system of mental health services should be community-based and flexible, with accountability and the focus of the services at the local level.

(d) The system of mental health services should provide timely access to a comprehensive array of cost-effective mental health services.

(e) Children and their families who are in need of mental health services should be identified as early as possible through screening, assessment processes, treatment and systems of support.

(f) Comprehensive mental health services should be made available in the least restrictive but clinically appropriate environment.

(g) The family of a child with an emotional disturbance should be eligible to receive mental health services from the system.

(h) Mental health services should be provided to children with emotional disturbance in a sensitive manner that is responsive to cultural and gender-based differences and the special needs of the children.

3. The long-term strategic plan prepared pursuant to subsection 1 must include:

(a) An assessment of the need for mental health services in the jurisdiction of the consortium;

(b) The long-term strategies and goals of the consortium for providing mental health services to children with emotional disturbance within the jurisdiction of the consortium;

(c) A description of the types of services to be offered to children with emotional disturbance within the jurisdiction of the consortium;

(d) Criteria for eligibility for those services;

(e) A description of the manner in which those services may be obtained by eligible children;

(f) The manner in which the costs for those services will be allocated;

(g) The mechanisms to manage the money provided for those services;

(h) Documentation of the number of children with emotional disturbance who are not currently being provided services, the costs to provide services to those children, the obstacles to providing services to those children and recommendations for removing those obstacles;

(i) Methods for obtaining additional money and services for children with emotional disturbance from private and public entities; and

(j) The manner in which family members of eligible children and other persons may be involved in the treatment of the children.

4. On or before January 31 of each even-numbered year, each mental health consortium shall submit to the Director of the Department ***, the Executive Director of the Office of Mental Health*** and the Commission:

(a) A list of the priorities of services necessary to implement the long-term strategic plan submitted pursuant to subsection 1 and an itemized list of the costs to provide those services;

(b) A description of any revisions to the long-term strategic plan adopted by the consortium during the immediately preceding year; and

(c) Any request for an allocation for administrative expenses of the consortium.

5. In preparing the biennial budget request for the Department, the Director of the Department shall consider the list of priorities and any request for an allocation submitted pursuant to subsection 4 by each mental health consortium. On or before September 30 of each even-numbered year, the Director of the Department shall submit to each mental health consortium a report which includes a description of:

(a) Each item on the list of priorities of the consortium that was included in the biennial budget request for the Department;

(b) Each item on the list of priorities of the consortium that was not included in the biennial budget request for the Department and an explanation for the exclusion; and

(c) Any request for an allocation for administrative expenses of the consortium that was included in the biennial budget request for the Department.

6. On or before January 31 of each odd-numbered year, each consortium shall submit to the Director of the Department ***, the Executive Director of the Office of Mental Health*** and the Commission:

(a) A report regarding the status of the long-term strategic plan submitted pursuant to subsection 1, including, without limitation, the status of the strategies, goals and services included in the plan;

(b) A description of any revisions to the long-term strategic plan adopted by the consortium during the immediately preceding year; and

(c) A report of all expenditures made from an account maintained pursuant to NRS 433B.339, if any.

Sec. 67.8. **NRS 433B.337 is hereby amended to read as follows:**

433B.337 1. A mental health consortium established by NRS 433B.333 may:

(a) Participate in activities within the jurisdiction of the consortium to:

(1) Implement the provisions of the long-term strategic plan established by the consortium pursuant to NRS 433B.335; and

(2) Improve the provision of mental health services to children with emotional disturbance and their families, including, without limitation, advertising the availability of mental health services and carrying out a demonstration project relating to mental health services.

(b) Take other action to carry out its duties set forth in this section and NRS 433B.335 and 433B.339.

2. To the extent practicable, a mental health consortium shall coordinate with the Department to avoid duplicating or contradicting the efforts of the Department to provide mental health services to children with emotional disturbance and their families.

3. A mental health consortium shall collaborate with the Office of Mental Health as necessary to assist the Office in carrying out the duties set forth in sections 67.2 and 67.4 of this act.

Sec. 67.9. **NRS 603A.100 is hereby amended to read as follows:**

603A.100 1. The provisions of NRS 603A.010 to 603A.290, inclusive, do not apply to the maintenance or transmittal of information in accordance with NRS 439.581 to 439.597, inclusive, ***and section 1 of this act*** and the regulations adopted pursuant thereto.

2. A data collector who is also an operator, as defined in NRS 603A.330, shall comply with the provisions of NRS 603A.300 to 603A.360, inclusive.

3. Any waiver of the provisions of NRS 603A.010 to 603A.290, inclusive, is contrary to public policy, void and unenforceable.

Sec. 68. NRS 608.1555 is hereby amended to read as follows:

608.1555 Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS, including, without limitation, as required by NRS 687B.409, 687B.723 and 687B.725 ~~[.]~~ ***and section 109 of this act.***

Sec. 69. NRS 608.1555 is hereby amended to read as follows:

608.1555 Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS, including, without limitation, as required by ***paragraph (b) of subsection 2 and subsections 1 ~~[, 4, 5]~~ and ~~[6]~~ 3 to 8, inclusive, of NRS 687B.225,*** NRS 687B.409 ~~[, 687B.723]~~ and 687B.725 ~~[.]~~ and ~~[section]~~ ***sections 97 to*** 109 ***, inclusive,*** of this act.

Sec. 70. ~~[Chapter 613 of NRS is hereby amended by adding thereto a new section to read as follows:~~

~~***1. Except as otherwise provided in subsection 2, a noncompetition covenant may restrict a provider of health care from providing care at any medical facility, clinic, office or other location if the noncompetition covenant:***~~

~~***(a) Is part of an agreement for the sale of the ownership interest of the provider of health care in a medical practice for which the provider of health care receives reasonable consideration;***~~

~~***(b) Expires 2 years or less after the date of the sale;***~~

~~***(c) Expressly states that the noncompetition covenant is consideration for the goodwill and other intangible assets transferred as part of the sale; and***~~

~~***(d) Is limited to geographic areas necessary to accomplish the objective described in paragraph (c).***~~

~~***2. An employer of a provider of health care may enter into and enforce an agreement requiring a provider of health care to reimburse the employer for the cost of incentives provided to the provider of health care by the employer,***~~

~~*including, without limitation, capital improvements, equipment, incentive payments, repayment of loans or other financial incentives, if the provider of health care does not remain employed by the employer for a specified period of time. Such an agreement must:*~~

~~*(a) Clearly specify the terms of the required reimbursement;*~~

~~*(b) Be independent of and separate from any noncompetition covenant;*~~

~~*(c) Be reasonable in scope based on the actual value of the incentives provided and the time remaining in the period for which the agreement required the provider of health care to remain employed by the employer; and*~~

~~*(d) Not impose undue restrictions on the ability of the provider of health care to provide care at any medical facility, clinic, office or other location of his or her choice.*~~

~~*3. As used in this section:*~~

~~*(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.*~~

~~*(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.]*~~ **(Deleted by amendment.)**

Sec. 71. NRS 613.195 is hereby amended to read as follows:

613.195 1. A noncompetition covenant is void and unenforceable unless the noncompetition covenant:

(a) Is supported by valuable consideration;

(b) Does not impose any restraint that is greater than is required for the protection of the employer for whose benefit the restraint is imposed;

(c) Does not impose any undue hardship on the employee; and

(d) Imposes restrictions that are appropriate in relation to the valuable consideration supporting the noncompetition covenant.

2. A noncompetition covenant may not restrict, and an employer may not bring an action to restrict, a former employee of an employer from providing service to a former customer or client if:

(a) The former employee did not solicit the former customer or client;

(b) The customer or client voluntarily chose to leave and seek services from the former employee; and

(c) The former employee is otherwise complying with the limitations in the covenant as to time, geographical area and scope of activity to be restrained, other than any limitation on providing services to a former customer or client who seeks the services of the former employee without any contact instigated by the former employee.

➥ Any provision in a noncompetition covenant which violates the provisions of this subsection is void and unenforceable.

3. A noncompetition covenant may not apply to ~~[an]~~ ***:***

(a) An employee who is paid solely on an hourly wage basis, exclusive of any tips or gratuities ~~[.]~~ ***; or***

(b) A patient-facing provider of health care.

4. ~~*[Except as otherwise provided in section 70 of this act, a noncompetition covenant may not restrict a provider of health care from providing care at any medical facility, clinic, office or other location during or after the term of his or her employment or contract. Any provision in a noncompetition covenant which violates the provisions of this subsection is void and unenforceable.*~~

~~*5.]*~~ An employer in this State who negotiates, executes or attempts to enforce a noncompetition covenant that is void and unenforceable under this section does not violate the provisions of NRS 613.200.

5. ~~*[6.]*~~ If the termination of the employment of an employee is the result of a reduction of force, reorganization or similar restructuring of the employer, a noncompetition covenant is only enforceable during the period in which the

employer is paying the employee's salary, benefits or equivalent compensation, including, without limitation, severance pay.

6. ~~[7.]~~ If an employer brings an action to enforce a noncompetition covenant or an employee brings an action to challenge a noncompetition covenant and the court finds the covenant is supported by valuable consideration but contains limitations as to time, geographical area or scope of activity to be restrained that are not reasonable, imposes a greater restraint than is necessary for the protection of the employer for whose benefit the restraint is imposed or imposes undue hardship on the employee, the court shall revise the covenant to the extent necessary and enforce the covenant as revised. Such revisions must cause the limitations contained in the covenant as to time, geographical area and scope of activity to be restrained to be reasonable, to not impose undue hardship on the employee and to impose a restraint that is not greater than is necessary for the protection of the employer for whose benefit the restraint is imposed.

7. ~~[8.]~~ If an employer brings an action to enforce a noncompetition covenant or an employee ***or contractor*** brings an action to challenge a noncompetition covenant and the court finds that the noncompetition covenant applies to ~~[an employee]~~ ***a person*** described in subsection 3 or that the employer has restricted or attempted to restrict a former employee in the manner described in subsection 2, the court shall award the employee ***or contractor*** reasonable attorney's fees and costs. Nothing in this subsection shall be construed as prohibiting a court from otherwise awarding attorney's fees to a prevailing party pursuant to NRS 18.010.

8. ~~[9.]~~ As used in this section:

(a) "Employer" means every person having control or custody of any employment, place of employment or any employee.

(b) "Noncompetition covenant" means an agreement between an employer and employee which, upon termination of the employment of the employee, prohibits the employee from pursuing a similar vocation in competition with or becoming employed by a competitor of the employer.

(c) ~~["Provider]~~ "Patient-facing provider of health care" ~~[has the meaning ascribed to it]~~ means a provider of health care, as defined in NRS 629.031 ~~[.]~~ :

(1) Whose primary duties involve providing clinical care to patients; and

(2) Who is not employed or contracted to primarily perform administrative tasks.

Sec. 72. Chapter 629 of NRS is hereby amended by adding thereto a new section to read as follows:

1. A provider of health care who received at least 10 percent of his or her gross revenue during the immediately preceding calendar year from providing services to patients covered by private health insurance shall submit requests for prior authorization to third parties using the electronic systems implemented pursuant to sections 57 and 101 of this act, where applicable.

2. A provider of health care who fails to comply with this section is guilty of unprofessional conduct and is subject to disciplinary action by the board, agency or other entity in this State by which he or she is licensed, certified or regulated.

3. As used in this section:

(a) "Private health insurance" does not include health coverage issued by a health maintenance organization or other managed care organization to recipients of Medicaid or insurance under the Children's Health Insurance Program pursuant to a contract with the Department of Health and Human Services entered into pursuant to NRS 422.273.

(b) "Third party" ~~[means]~~ :

(1) Except as otherwise provided in subparagraph (2), means any insurer or organization providing health coverage or benefits in accordance with state or federal law.

(2) Does not include:

(I) A plan that is subject to the Employee Retirement Income Security Act of 1974 or any information relating to such coverage; or

(II) Health coverage provided by a local government agency through a self-insurance reserve fund pursuant to NRS 287.010.

Sec. 72.3. **NRS 629.051 is hereby amended to read as follows:**

629.051 1. Except as otherwise provided in this section and in regulations adopted by the State Board of Health pursuant to NRS 652.135 with regard to the records of a medical laboratory and unless a longer period is provided by federal law, each custodian of health care records shall retain the health care records of patients as part of the regularly maintained records of the custodian for 5 years after their receipt or production. Health care records may be retained in written form, or by microfilm or any other recognized form of size reduction, including, without limitation, microfiche, computer disc, magnetic tape and optical disc, which does not adversely affect their use for the purposes of NRS 629.061.

2. Except as otherwise provided in subsection 4 of NRS 439.589, a high-level provider of health care shall comply with the requirements of subsection 4 of NRS 439.589 concerning the maintenance, transmittal and exchange of health records. Health care records ~~[:~~

~~(a) Must, except as otherwise provided in subsections 5 and 6 of NRS 439.589, be created, maintained, transmitted and exchanged electronically as required by subsection 4 of NRS 439.589; and~~

~~(b) May]~~ ***may*** be created, authenticated and stored in a health information exchange which meets the requirements of NRS 439.581 to 439.597, inclusive, ***and section 1 of this act,*** and the regulations adopted pursuant thereto.

~~[2.]~~ ***3.*** A provider of health care shall post, in a conspicuous place in each location at which the provider of health care performs health care services, a sign which discloses to patients that their health care records may be destroyed after the period set forth in subsection 1.

~~[3.]~~ ***4.*** When a provider of health care performs health care services for a patient for the first time, the provider of health care shall deliver to the patient a written statement which discloses to the patient that the health care records of the patient may be destroyed after the period set forth in subsection 1.

~~[4.]~~ ***5.*** If a provider of health care fails to deliver the written statement to the patient pursuant to subsection ~~[3,]~~ ***4,*** the provider of health care shall deliver to the patient the written statement described in subsection ~~[3]~~ ***4*** when the provider of health care next performs health care services for the patient.

~~[5.]~~ ***6.*** In addition to delivering a written statement pursuant to subsection ~~[3 or]~~ 4 ~~[,]~~ ***or 5,*** a provider of health care may deliver such a written statement to a patient at any other time.

~~[6.]~~ ***7.*** A written statement delivered to a patient pursuant to this section may be included with other written information delivered to the patient by a provider of health care.

~~[7.]~~ ***8.*** A custodian of health care records shall not destroy the health care records of a person who is less than 23 years of age on the date of the proposed destruction of the records. The health care records of a person who has attained the age of 23 years may be destroyed in accordance with this section for those records which have been retained for at least 5 years or for any longer period provided by federal law.

~~[8.]~~ ***9.*** If a health care licensing board receives notification from the Department of Health and Human Services pursuant to NRS 439.5895 that a ***high-level*** provider of health care to which the health care licensing board has issued a license is not in compliance with the requirements of subsection 4 ***or 8, as applicable,*** of NRS 439.589, the health care licensing board may, after notice and the opportunity for a hearing in accordance with the provisions of this title, require corrective action or impose an administrative penalty in an amount not to exceed the maximum penalty that the health care licensing board is authorized to impose for other violations. The health care licensing board shall not suspend or revoke a license for failure to comply with the requirements of subsection 4 ***or 8*** of NRS 439.589.

~~[9. The provisions of this section, except for the provisions of paragraph (a) of subsection 1 and subsection 8, do not apply to a pharmacist.]~~

10. The State Board of Health shall adopt:

(a) Regulations prescribing the form, size, contents and placement of the signs and written statements required pursuant to this section; and

(b) Any other regulations necessary to carry out the provisions of this section.

11. As used in this section:

(a) "Health care licensing board" means:

(1) A board created pursuant to chapter 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 641, 641A, 641B, 641C or 641D of NRS.

(2) The Division of Public and Behavioral Health of the Department of Health and Human Services.

(3) The State Board of Health with respect to licenses issued pursuant to chapter 640D or 640E of NRS.

(b) ***"High-level provider of health care" has the meaning ascribed to it in section 1 of this act.***

(c) "License" has the meaning ascribed to it in NRS 439.5895.

Sec. 72.5. **NRS 629.053 is hereby amended to read as follows:**

629.053 1. The State Board of Health and each board created pursuant to chapter 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 640, 640A, 640B, 640C, 641, 641A, 641B, 641C or 641D of NRS shall post on its website on the Internet, if any, a statement which discloses that:

(a) Pursuant to the provisions of subsection ~~[7]~~ ***8*** of NRS 629.051:

(1) The health care records of a person who is less than 23 years of age may not be destroyed; and

(2) The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and

(b) Except as otherwise provided in subsection ~~[7]~~ ***8*** of NRS 629.051 and unless a longer period is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

2. The State Board of Health shall adopt regulations prescribing the contents of the statements required pursuant to this section.

Sec. 72.8. **NRS 629.062 is hereby amended to read as follows:**

629.062 1. If a person who is authorized to request a copy of health care records of a patient pursuant to NRS 629.061 requests that a copy of such records be furnished electronically, the custodian of health care records must electronically transmit a copy of the requested records to the person or, if the patient has provided written authorization for records to be furnished to another person or entity, to that person or entity. Such records must be furnished in an electronic format using a

method of secure electronic transmission that complies with applicable federal and state law. ***If a patient requests that a copy of his or her health care records be furnished electronically to the patient or any covered entity, the custodian of health records shall furnish the copy not later than the end of the seventh business day after the request is made.***

2. Except as otherwise provided in ***this subsection and*** subsections 3 and 4, if a custodian of health care records maintains health care records electronically, any fee to furnish those records electronically pursuant to subsection 1 must not exceed $40 or the amount per page prescribed by NRS 629.061, whichever is less. ***A custodian of health care records shall not charge a fee to furnish health care records to a patient or, if the patient has requested a copy of his or her health care records to be furnished to any covered entity, to that covered entity.***

3. If the total amount of the fee chargeable pursuant to subsection 2 for the furnishing of health care records electronically is less than $5, a custodian of health care records, other than a custodian of the health care records of a state or local governmental entity, may charge a fee of $5 for the furnishing of those health care records.

4. ~~[A]~~ ***Except as otherwise provided in subsection 2, a*** custodian of health care records, other than a custodian of the health care records of a state or local governmental entity, may charge the following fees to furnish health care records electronically, in addition to the total amount of the fee charged pursuant to subsection 2 or 3:

(a) A fee of $5 for written confirmation that no health care records were found.

(b) A fee of $5 for furnishing a copy of a certificate of the custodian of health care records.

(c) A fee of $20 for a copy of a printed film sheet.

(d) A fee of $25 for furnishing a copy of radiologic images in any form other than a printed film sheet.

5. As used in this section:

(a) ***"Covered entity" has the meaning ascribed to it in 45 C.F.R. § 160.103.***

(b) "Custodian of health care records" has the meaning ascribed to it in NRS 629.016 and additionally includes a covered entity or business associate, as those terms are defined in 45 C.F.R. § 160.103.

~~[(b)]~~ ***(c)*** "Health care records" has the meaning ascribed to it in NRS 629.021 and additionally includes individually identifiable health information, as defined in 45 C.F.R. § 160.103.

~~[(c)]~~ ***(d)*** "Secure electronic transmission" means the sending of information from one computer system to another computer system in such a manner as to ensure that:

(1) No person other than the intended recipient receives the information;

(2) The identity and signature of the sender of the information can be authenticated; and

(3) The information which is received by the intended recipient is identical to the information that was sent.

Sec. 73. Chapter 630 of NRS is hereby amended by adding thereto the provisions set forth as sections 74 and 75 of this act.

Sec. 74. ***1. The Board shall adopt regulations establishing a procedure to prioritize the processing of applications for the initial issuance of a license to practice medicine submitted by an applicant who intends to practice:***

(a) Serving geographic areas and populations of this State where the shortage of providers of health care is most critical, as identified by the assessment conducted pursuant to section 7 of this act; or

(b) In a specialty for which the need is most critical, as identified by the assessment conducted pursuant to section 7 of this act.

2. In establishing procedures to carry out the regulations adopted pursuant to this section, the Board shall:

(a) Establish metrics to monitor the processing times of applications described in subsection 1 to ensure compliance with the requirements of that subsection; and

(b) In collaboration with the Department of Health and Human Services, annually update the geographic areas, populations and specialties for which applications are prioritized in response to each assessment conducted pursuant to section 7 of this act.

Sec. 75. ***1. The Board shall:***

(a) Establish an electronic system to allow an entity that verifies the credentials of providers of health care pursuant to paragraph (b) of subsection 1 of section 50 of this act or paragraph (b) of subsection 1 of section 109 of this act or a hospital to access data in the possession of the Board for the purpose of privileging or credentialing a physician, physician assistant, anesthesiologist assistant, perfusionist or practitioner of respiratory care who has authorized the Board to share such data pursuant to paragraph (b).

(b) Allow an applicant for the issuance of a license to practice medicine, a physician applying for biennial registration or an applicant for the issuance or renewal of a license as a physician assistant, anesthesiologist assistant, perfusionist or practitioner of respiratory care to indicate whether he or she wishes to allow electronic access to his or her data pursuant to paragraph (a).

2. As used in this section:

(a) "Credentialing" means verifying the credentials of a provider of health care for the purpose of determining whether the provider of health care meets the requirements for participation in the network of a third party or participation in Medicaid or the Children's Health Insurance Program as a provider of services.

(b) "Network" has the meaning ascribed to it in NRS 687B.640.

(c) "Privileging" means the process of determining whether to authorize a provider of health care to provide specific services at a hospital based on his or her credentials and qualifications.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(e) "Third party" ~~***[means]***~~ **:**

(1) *Except as otherwise provided in subparagraph (2), means any insurer or organization providing health coverage or benefits in accordance with state or federal law.*

(2) *Does not include:*

(I) *A plan that is subject to the Employee Retirement Income Security Act of 1974 or any information relating to such coverage; or*

(II) *Health coverage provided by a local government agency through a self-insurance reserve fund pursuant to NRS 287.010.*

Sec. 76. NRS 630.130 is hereby amended to read as follows:

630.130 1. In addition to the other powers and duties provided in this chapter, the Board shall, in the interest of the public, judiciously:

(a) Enforce the provisions of this chapter;

(b) Establish by regulation standards for licensure under this chapter;

(c) Conduct examinations for licensure and establish a system of scoring for those examinations;

(d) Investigate the character of each applicant for a license and issue licenses to those applicants who meet the qualifications set by this chapter and the Board; and

(e) Institute a proceeding in any court to enforce its orders or the provisions of this chapter.

2. On or before February 15 of each odd-numbered year, the Board shall submit to the Governor and to the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature a written report compiling:

(a) Disciplinary action taken by the Board during the previous biennium against any licensee for malpractice or negligence;

(b) Information reported to the Board during the previous biennium pursuant to NRS 630.3067, 630.3068, subsections 3 and 6 of NRS 630.307 and NRS 690B.250; ~~[and]~~

(c) Information reported to the Board during the previous biennium pursuant to NRS 630.30665, including, without limitation, the number and types of surgeries performed by each holder of a license to practice medicine and the occurrence of sentinel events arising from such surgeries, if any ~~[.]~~ ***; and***

(d) Information relating to the efficiency of the process for licensing physicians, including, without limitation:

(1) The average time during the previous biennium between when a person applied for a license to practice medicine and when the license was issued or the application was denied;

(2) The total number of applications for licensure to practice medicine processed by the Board during the immediately preceding biennium; and

(3) Recommendations for improvements to the process for licensing physicians.

➥ The report must include only aggregate information for statistical purposes and exclude any identifying information related to a particular person.

3. The Board may adopt such regulations as are necessary or desirable to enable it to carry out the provisions of this chapter.

Sec. 76.5. **NRS 630.2671 is hereby amended to read as follows:**

630.2671 1. The Board shall ~~[:~~

~~(a) Make]~~ ***make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for a biennial registration pursuant to NRS 630.267 or the renewal of a license pursuant to this chapter through a link on the electronic application for a biennial registration or the renewal of a license ***.*** ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for a biennial registration pursuant to NRS 630.267 or the renewal of a license pursuant to this chapter must, as a condition for such registration or renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for a biennial registration or the renewal of a license pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1,]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for a biennial registration or the renewal of a license is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to issue the biennial registration or renew the license, for failure to do so.]~~

Sec. 77. Chapter 631 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Board ~~[shall]~~ may adopt regulations to establish an alternative training pathway that an applicant for a license as a dental hygienist may, subject to the limitations prescribed by subsection ~~[5,]~~ 4, complete instead of graduating from a program of dental hygiene described in paragraph (c) of subsection 1 of NRS 631.290.

2. ~~[The]~~ Any regulations adopted pursuant to subsection 1 must ~~[:~~

~~(a) Be consistent with the guidance and recommendations of the American Dental Association, or its successor organization, regarding alternative training models for dental hygienists;~~

~~(b) Require]~~ require a person receiving training through the alternative training pathway to:

~~[(1)]~~ (a) Complete ~~[a course of training that meets the requirements prescribed by the Board pursuant to paragraph (a) of subsection 4 under the supervision of a dentist licensed pursuant to this chapter; and]~~ an educational program comparable to the educational program required by a program of dental hygiene described in paragraph (c) of subsection 1 of NRS 631.290. Such a program must include, without limitation:

(1) Two semesters of biology with laboratory components;

(2) Two semesters of chemistry with laboratory components;

(3) Two semesters of anatomy and physiology;

(4) One semester of microbiology; and

(5) One semester of college-level mathematics.

~~[(2)]~~ (b) Complete a program of clinical training under the supervision of a dentist that is comparable to the clinical training provided by a program of dental hygiene described in paragraph (c) of subsection 1 of NRS 631.290 and includes a similar number of hours of training as such a program; and

(c) Successfully pass a competency examination conducted by his or her supervising dentist, the written examination required by subsection 1 of NRS 631.300 and a clinical examination approved by the Board . ~~[; and~~

~~(c) Provide for the issuance of a provisional license to a person who has completed the training described in subparagraph (1) of paragraph (b) but has not met one or more of the requirements prescribed by subparagraph (2) of that paragraph. Such a provisional license is valid for not more than 12 months after the date of issuance, unless extended by the Board for good cause.]~~

3. ~~[The clinical examination required by subparagraph (2) of paragraph (b) of subsection 1 is not required to be approved by the American Dental Association.~~

~~4.]~~ The Board shall adopt regulations establishing:

(a) Requirements for ~~[a course of]~~ the training completed pursuant to ~~[subparagraph (1) of paragraph]~~ paragraphs (a) and (b) of subsection 2.

(b) The scope of practice of a dental hygienist who has completed the alternative training pathway established pursuant to this section. Those regulations must establish:

(1) Locations where such a dental hygienist may practice dental hygiene ~~[other than]~~ , which must be limited to those identified in paragraphs (a) to (e), inclusive, of subsection 1 of NRS 631.310 ; ~~[, which may include, without limitation, mobile dental clinics;]~~ and

(2) ~~[Preventive agents that such a dental hygienist may prescribe and dispense, in addition to those authorized by paragraphs (a) to (d), inclusive, of subsection 1 of NRS 631.3105, if the dental hygienist is authorized by that section to prescribe and dispense drugs and devices.]~~ The manner in which such a dental hygienist must represent himself or herself to patients.

~~[5.]~~ 4. A person who completes the alternative training pathway established pursuant to this section is only eligible for licensure if he or she began the alternative training pathway during a biennium for which the assessment conducted pursuant to section 7 of this act designated dental hygienists as a type of provider of health care for which there is a shortage in this State.

Sec. 78. NRS 631.220 is hereby amended to read as follows:

631.220 1. Every applicant for a license to practice dental hygiene, dental therapy, dentistry or expanded function dental assistance must:

(a) File an application with the Board.

(b) Accompany the application with a recent photograph of the applicant together with the required fee and such other documentation as the Board may require by regulation.

(c) Submit with the application a complete set of fingerprints and written permission authorizing the Board to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report.

(d) If the applicant is required to take an examination pursuant to NRS 631.240, 631.300, 631.3121, 631.31286 or 631.31287, ***or section 77 of this act,*** submit with the application proof satisfactory that the applicant passed the examination.

2. In addition to satisfying the requirements of subsection 1, if an applicant for a license to practice dental hygiene, dental therapy or dentistry intends to provide services through teledentistry, the applicant must submit to the Board proof that the applicant has completed:

(a) At least 2 hours of continuing education concerning teledentistry; or

(b) A course in teledentistry as part of the requirements for graduation from an accredited institution.

3. An application must include all information required to complete the application.

4. The Secretary-Treasurer may, in accordance with regulations adopted by the Board and if the Secretary-Treasurer determines that an application is:

(a) Sufficient, advise the Executive Director of the sufficiency of the application. Upon the advice of the Secretary-Treasurer, the Executive Director may issue a license to the applicant without further review by the Board.

(b) Insufficient, reject the application by sending written notice of the rejection to the applicant.

Sec. 79. NRS 631.290 is hereby amended to read as follows:

631.290 1. Any person is eligible to apply for a license to practice dental hygiene in this State who:

(a) Is of good moral character;

(b) Is over 18 years of age; and

(c) ~~[Is]~~ ***Except as otherwise authorized by section 77 of this act, is*** a graduate of a program of dental hygiene from an institution which is accredited by a regional educational accrediting organization that is recognized by the United States Department of Education. The program of dental hygiene must:

(1) Be accredited by the Commission on Dental Accreditation of the American Dental Association or its successor specialty accrediting organization; and

(2) Include a curriculum of not less than 2 years of academic instruction in dental hygiene or its academic equivalent.

2. To determine whether a person has good moral character, the Board may consider whether his or her license to practice dental hygiene in another state has been suspended or revoked or whether he or she is currently involved in any disciplinary action concerning his or her license in that state.

Sec. 80. NRS 631.310 is hereby amended to read as follows:

631.310 1. Except as otherwise provided in NRS 631.271 and 631.287 ~~[,]~~ ***and section 77 of this act,*** the holder of a license or renewal certificate to practice dental hygiene may practice dental hygiene in this State in the following places:

(a) In the office of any licensed dentist.

(b) In a clinic or in clinics in the public schools of this State as an employee of the Division of Public and Behavioral Health of the Department of Health and Human Services.

(c) In a clinic or in clinics in a state institution as an employee of the institution.

(d) In a clinic established by a hospital approved by the Board as an employee of the hospital where service is rendered only to patients of the hospital, and upon the authorization of a member of the dental staff.

(e) In an accredited school of dental hygiene.

(f) In other places if specified in a regulation adopted by the Board . ~~[, including, for a dental hygienist who has completed the alternative training pathway established pursuant to section 77 of this act, places where practice is authorized by the regulations adopted pursuant to that section.]~~

2. A dental hygienist may perform only the services which are authorized by a dentist licensed in the State of Nevada, unless otherwise provided in a regulation adopted by the Board.

3. Except as otherwise provided in NRS 631.287 or specifically authorized by a regulation adopted by the Board, a dental hygienist shall not provide services to a person unless that person is a patient of the dentist who authorized the performance of those services.

Sec. 81. NRS 631.3105 is hereby amended to read as follows:

631.3105 1. A dental hygienist who meets the requirements prescribed by regulation of the Board pursuant to subsection 4 and is issued a certificate by the State Board of Pharmacy pursuant to NRS 639.1374 may prescribe and dispense only:

(a) Topical or systemic prescription drugs, other than controlled substances, for preventative care;

(b) Fluoride preparations for which a prescription is not required;

(c) Topical antimicrobial oral rinses; and

(d) Medicament trays or mouthguards . ~~[; and~~

~~(e) If the dental hygienist completed the alternative training pathway established pursuant to section 77 of this act, such additional preventive agents as are authorized by the regulations adopted pursuant to that section.]~~

2. A dental hygienist shall not prescribe or dispense:

(a) A controlled substance; or

(b) Any drug or device not listed in subsection 1 or authorized under the certificate issued pursuant to NRS 639.1374.

3. A dental hygienist may only prescribe and dispense a drug or device pursuant to subsection 1:

(a) In compliance with any applicable regulations adopted by the Board; and

(b) In compliance with any applicable law governing the handling, prescribing and dispensing of the drug or device.

4. The Board shall adopt regulations prescribing the:

(a) Education and training that a dental hygienist must complete before prescribing and dispensing a drug or device pursuant to subsection 1; and

(b) Continuing education that a dental hygienist must complete to be authorized to continue prescribing and dispensing drugs or devices pursuant to subsection 1.

5. A dental hygienist who has completed the alternative training pathway established pursuant to section 77 of this act and has not subsequently graduated from a program of dental hygiene described in paragraph (c) of subsection 1 of

NRS 631.290 shall not prescribe and dispense preventive agents pursuant to this section.

Sec. 82. ~~[NRS 631.313 is hereby amended to read as follows:~~

~~631.313 1. Except as otherwise provided in NRS 454.217 and 629.086, a licensed dentist may assign to a person in his or her employ who is a dental hygienist, a dental therapist, a dental assistant, an expanded function dental assistant or other person directly or indirectly involved in the provision of dental care only such intraoral tasks as may be permitted by a regulation of the Board or by the provisions of this chapter.~~

~~2. The performance of these tasks must be:~~

~~(a) If performed by a dental assistant or a person, other than a dental hygienist, dental therapist or expanded function dental assistant, who is directly or indirectly involved in the provision of dental care, under the supervision of the licensed dentist who made the assignment.~~

~~(b) If performed by a dental hygienist, dental therapist or expanded function dental assistant, authorized by the licensed dentist of the patient for whom the tasks will be performed, except as otherwise provided in NRS 631.287.~~

~~3. No such assignment is permitted that requires:~~

~~(a) Except as otherwise provided in NRS 631.3105 and 631.3129, *and section 77 of this act,* the diagnosis, treatment planning, prescribing of drugs or medicaments, or authorizing the use of restorative, prosthodontic or orthodontic appliances.~~

~~(b) Surgery on hard or soft tissues within the oral cavity or any other intraoral procedure that may contribute to or result in an irremediable alteration of the oral anatomy.~~

~~(c) The administration of general anesthesia, minimal sedation, moderate sedation or deep sedation except as otherwise authorized by regulations adopted by the Board.~~

~~(d) The performance of a task outside the authorized scope of practice of the employee who is being assigned the task.~~

~~4. A dental hygienist may, pursuant to regulations adopted by the Board, administer local anesthesia or nitrous oxide in a health care facility, as defined in NRS 162A.740, if:~~

~~(a) The dental hygienist is so authorized by the licensed dentist of the patient to whom the local anesthesia or nitrous oxide is administered; and~~

~~(b) The health care facility has licensed medical personnel and necessary emergency supplies and equipment available when the local anesthesia or nitrous oxide is administered.]~~ **(Deleted by amendment.)**

Sec. 82.3. **NRS 631.332 is hereby amended to read as follows:**

631.332 1. The Board shall ~~[:~~

~~(a) Make]~~ ***make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license pursuant to this chapter through a link on the electronic application for the renewal of a license . ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1,]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license, for failure to do so.]~~

Sec. 82.6. **NRS 632.3423 is hereby amended to read as follows:**

632.3423 1. The Board shall ~~[:~~

~~(a) Make]~~ ***make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license or certificate pursuant to this chapter through a link on the electronic application for the renewal of a license or certificate**.** ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license or certificate pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license or certificate pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1,]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license or certificate is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license or certificate, for failure to do so.]~~

Sec. 83. Chapter 633 of NRS is hereby amended by adding thereto the provisions set forth as sections 84 and 85 of this act.

Sec. 84. 1. The Board shall adopt regulations establishing a procedure to prioritize the processing of applications for the initial issuance of a license to practice osteopathic medicine submitted by an applicant who intends to practice:

(a) Serving geographic areas and populations of this State where the shortage of providers of health care is most critical, as identified by the assessment conducted pursuant to section 7 of this act; or

(b) In a specialty for which the need is most critical, as identified by the assessment conducted pursuant to section 7 of this act.

2. In establishing procedures to carry out the regulations adopted pursuant to this section, the Board shall:

(a) Establish metrics to monitor the processing times of applications described in subsection 1 to ensure compliance with the requirements of that subsection; and

(b) In collaboration with the Department of Health and Human Services, annually update the geographic areas, populations and specialties for which applications are prioritized in response to each assessment conducted pursuant to section 7 of this act.

Sec. 85. 1. The Board shall:

(a) Establish an electronic system to allow an entity that verifies the credentials of providers of health care pursuant to paragraph (b) of subsection 1 of section 50 of this act or paragraph (b) of subsection 1 of section 109 of this act, as applicable, or a hospital to access data in the possession of the Board for the purpose of privileging or credentialing an osteopathic physician, physician assistant or anesthesiologist assistant who has authorized the Board to share such data pursuant to paragraph (b).

(b) Allow an applicant for the issuance or renewal of a license as an osteopathic physician, physician assistant or anesthesiologist assistant to indicate whether he or she wishes to allow electronic access to his or her data pursuant to paragraph (a).

2. As used in this section:

(a) "Credentialing" means verifying the credentials of a provider of health care for the purpose of determining whether the provider of health care meets the requirements for participation in the network of a third party or participation in Medicaid or the Children's Health Insurance Program as a provider of services.

(b) "Network" has the meaning ascribed to it in NRS 687B.640.

(c) "Privileging" means the process of determining whether to authorize a provider of health care to provide specific services at a hospital based on his or her credentials and qualifications.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(e) "Third party" ~~[means]~~ :

(1) Except as otherwise provided in subparagraph (2), means any insurer or organization providing health coverage or benefits in accordance with state or federal law.

(2) Does not include:

(I) A plan that is subject to the Employee Retirement Income Security Act of 1974 or any information relating to such coverage; or

(II) Health coverage provided by a local government agency through a self-insurance reserve fund pursuant to NRS 287.010.

Sec. 86. NRS 633.286 is hereby amended to read as follows:

633.286 1. On or before February 15 of each odd-numbered year, the Board shall submit to the Governor and to the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature a written report compiling:

(a) Disciplinary action taken by the Board during the previous biennium against osteopathic physicians, physician assistants and anesthesiologist assistants for malpractice or negligence;

(b) Information reported to the Board during the previous biennium pursuant to NRS 633.526, 633.527, subsections 3 and 6 of NRS 633.533 and NRS 690B.250; ~~[and]~~

(c) Information reported to the Board during the previous biennium pursuant to NRS 633.524, including, without limitation, the number and types of surgeries performed by each holder of a license to practice osteopathic medicine and the occurrence of sentinel events arising from such surgeries, if any ~~[.]~~ ***; and***

(d) Information relating to the efficiency of the process for licensing osteopathic physicians, including, without limitation:

(1) The average time during the previous biennium between when a person applied for a license to practice osteopathic medicine and when the license was issued or the application was denied;

(2) The total number of applications for licensure to practice osteopathic medicine processed by the Board during the immediately preceding biennium; and

(3) Recommendations for improvements to the process for licensing physicians.

2. The report must include only aggregate information for statistical purposes and exclude any identifying information related to a particular person.

Sec. 86.2. **NRS 633.4716 is hereby amended to read as follows:**

633.4716 1. The Board shall ~~[:~~

~~(a) Make]~~ ***make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license pursuant to this chapter through a link on the electronic application for the renewal of a license . ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1,]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license, for failure to do so.]~~

Sec. 86.4. **NRS 635.111 is hereby amended to read as follows:**

635.111 1. The Board ~~[may:~~

~~(a) Make]~~ ***shall make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license pursuant to this chapter through a link on the electronic application for the renewal of a license ***.*** ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1,]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license, for failure to do so.]~~

Sec. 86.6. **NRS 636.262 is hereby amended to read as follows:**

636.262 1. The Board ~~[may:~~

~~(a) Make]~~ ***shall make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license pursuant to this chapter through a link on the electronic application for the renewal of a license ***.*** ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1,]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license, for failure to do so.]~~

Sec. 86.8. **NRS 637.145 is hereby amended to read as follows:**

637.145 1. The Board ~~[may:~~

~~(a) Make]~~ ***shall make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license pursuant to this chapter through a link on the electronic application for the renewal of a license ***.*** ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1,]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license, for failure to do so.]~~

Sec. 87. ~~[NRS 639.0125 is hereby amended to read as follows:~~

~~639.0125 "Practitioner" means:~~

~~1. A physician, dentist, veterinarian or podiatric physician who holds a license to practice his or her profession in this State;~~

~~2. A hospital, pharmacy or other institution licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or administer drugs in the course of professional practice or research in this State;~~

~~3. An advanced practice registered nurse who has been authorized to prescribe controlled substances, poisons, dangerous drugs and devices;~~

~~4. A physician assistant who:~~

~~(a) Holds a license issued by the Board of Medical Examiners; and~~

~~(b) Is authorized by the Board to possess, administer, prescribe or dispense controlled substances, poisons, dangerous drugs or devices under the supervision of a physician as required by chapter 630 of NRS;~~

~~5. A physician assistant who:~~

~~(a) Holds a license issued by the State Board of Osteopathic Medicine; and~~

~~(b) Is authorized by the Board to possess, administer, prescribe or dispense controlled substances, poisons, dangerous drugs or devices under the supervision of an osteopathic physician as required by chapter 633 of NRS;~~

~~6. An optometrist who is certified by the Nevada State Board of Optometry to prescribe and administer pharmaceutical agents pursuant to NRS 636.288, when the optometrist prescribes or administers pharmaceutical agents within the scope of his or her certification;~~

~~7. A dental hygienist who:~~

~~(a) Holds a valid license to practice dental hygiene in this State;~~

~~(b) Is authorized to prescribe and dispense the dangerous drugs and devices listed in NRS 631.3105 *and, if applicable, the regulations adopted pursuant to section 77 of this act,* in accordance with the provisions of that section and the regulations adopted pursuant thereto; and~~

~~(c) Holds a certificate issued pursuant to NRS 639.1374 by the State Board of Pharmacy authorizing him or her to so prescribe;~~

~~8. A pharmacist who is registered pursuant to NRS 639.28079 to prescribe and dispense drugs for medication-assisted treatment; or~~

~~9. A certified registered nurse anesthetist who orders, prescribes, possesses or administers controlled substances, poisons, dangerous drugs or devices in accordance with NRS 632.2397.]~~ **(Deleted by amendment.)**

Sec. 88. ~~[NRS 639.1374 is hereby amended to read as follows:~~

~~639.1374 1. Except as otherwise provided in subsection 5, a dental hygienist licensed pursuant to chapter 631 of NRS may, if authorized by the Board, possess, prescribe or dispense dangerous drugs and devices only to the extent and subject to the limitations specified in NRS 631.3105 *and, if applicable, the regulations adopted pursuant to section 77 of this act* and the certificate issued to the dental hygienist by the Board pursuant to this section.~~

~~2. If a dental hygienist wishes to possess, prescribe or dispense dangerous drugs and devices and is authorized to do so by NRS 631.3105 and the regulations adopted pursuant thereto, the dental hygienist must apply to the Board for a certificate to possess, prescribe or dispense dangerous drugs and devices and pay~~

~~the applicable fee for authorization of a practitioner to dispense dangerous drugs pursuant to NRS 639.170.~~

~~3. The Board shall consider each application separately and, except as otherwise provided in subsection 5, may, even though the dental hygienist is otherwise authorized by NRS 631.3105 *and, if applicable, the regulations adopted pursuant to section 77 of this act* to possess, prescribe or dispense dangerous drugs and devices:~~

~~(a) Refuse to issue a certificate;~~

~~(b) Issue a certificate limiting the authority of the dental hygienist to possess, prescribe or dispense dangerous drugs and devices, the area in which the dental hygienist may possess dangerous drugs and devices or the kind and amount of dangerous drugs or devices; or~~

~~(c) Issue a certificate imposing other limitations or restrictions which the Board feels are necessary and required to protect the health, safety and welfare of the public.~~

~~4. The Board may adopt regulations controlling the maximum amount to be possessed, prescribed or dispensed and the storage, security, recordkeeping and transportation of dangerous drugs or devices by a dental hygienist licensed pursuant to chapter 631 of NRS.~~

~~5. The provisions of this section do not limit or authorize the Board to limit the authority of a dental hygienist to possess dangerous drugs under the circumstances authorized by paragraph (b) of subsection 1 of NRS 454.213, regardless of whether the dental hygienist holds a certificate issued pursuant to this section.~~ **(Deleted by amendment.)**

Sec. 89. Chapter 641 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Board shall ~~*[:*~~

~~*(a) Develop and provide continuing education for]*~~ ***, to encourage psychologists to receive training in the mental health needs of patients in rural areas*** ~~*[;*~~

~~*(b) Provide the continuing education described in paragraph (a) at a reduced cost or no cost for psychologists who practice in rural areas or provide services through telehealth to patients in rural areas, including, without limitation, psychologists who are authorized to practice or provide services through telehealth in this State pursuant to the Psychology Interjurisdictional Compact enacted in NRS 641.227; and*~~

~~*(c) Ensure that the continuing education described in paragraph (a) meets the requirements for credit in the home states of psychologists who practice or provide services through telehealth in this State pursuant to the Psychology Interjurisdictional Compact enacted in NRS 641.227.]*~~ ***:***

(a) Make available to licensees information concerning continuing education on the mental health needs of such patients provided by the Committee on Rural Health of the American Psychological Association; and

(b) Accept any such continuing education completed by a licensee for credit toward the continuing education required by paragraph (b) of subsection 4 of NRS 641.220.

2. The Board shall establish a program to recognize psychologists, including, without limitation ~~*[,]*~~ ***and to the extent practicable, psychologists who practice or provide services through telehealth in this State pursuant to the Psychology Interjurisdictional Compact enacted in NRS 641.227, who provide at least 200 hours of services through telehealth to patients in rural areas of this State. The program must provide for a psychologist who meets that requirement to:***

(a) Receive a certificate of distinction; and

(b) With the consent of the psychologist, be recognized on an Internet website maintained by the Board as a "Committed Rural Service Provider."

3. The Board may ~~[adopt]~~ :

(a) Adopt any regulations necessary to carry out the provisions of this section.

(b) Collect any information from holders of licenses and certificates issued by the Board necessary to carry out the provisions of this section.

4. On or before ~~[September]~~ October 1 of each odd-numbered year, the Board shall:

(a) Compile a report concerning the implementation of and outcomes resulting from the provisions of this section, including, without limitation ~~[:]~~ and to the extent that such information is available:

(1) Participation in the continuing education ~~[provided pursuant to]~~ described in subsection 1; and

(2) The number of psychologists recognized under the program established pursuant to subsection 2 and the estimated number of hours of services provided through telehealth to patients in rural areas of this State by such psychologists during the immediately preceding ~~[12 months;]~~ calendar year; and

(b) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to ~~[:~~

~~(1) In odd-numbered years,~~] the Joint Interim Standing Committee on Health and Human Services . ~~[; and~~

~~(2) In even-numbered years, the next regular session of the Legislature.~~]

5. As used in this section, "telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 89.2. **NRS 641.2215 is hereby amended to read as follows:**

641.2215 1. The Board shall ~~[:~~

~~(a) Make]~~ ***make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license or registration pursuant to this chapter through a link on the electronic application for the renewal of a license or registration . ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license or registration pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license or registration pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1,]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license or registration is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license or registration, for failure to do so.]~~

Sec. 89.4. **NRS 641A.217 is hereby amended to read as follows:**

641A.217 1. The Board shall ~~[:~~

~~(a) Make]~~ ***make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license pursuant to this chapter through a link on the electronic application for the renewal of a license . ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1.]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license, for failure to do so.]~~

Sec. 89.6. **NRS 641B.281 is hereby amended to read as follows:**

641B.281 1. The Board shall ~~[:~~

~~(a) Make]~~ ***make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license pursuant to this chapter through a link on the electronic application for the renewal of a license. ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1.]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license, for failure to do so.]~~

Sec. 89.8. **NRS 641C.455 is hereby amended to read as follows:**

641C.455 1. The Board ~~[may:~~

~~(a) Make]~~ ***shall make*** the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license or certificate pursuant to this chapter through a link on the electronic application for the renewal of a license or certificate. ~~[; and~~

~~(b) Request each]~~

2. Each applicant ~~[to]~~ ***for the renewal of a license or certificate pursuant to this chapter must, as a condition for such renewal,*** complete and electronically submit the data request to the Director.

~~[2.]~~ ***3.*** The information provided by an applicant for the renewal of a license or certificate pursuant to subsection ~~[1]~~ ***2*** is confidential and, except as required by subsection ~~[1.]~~ ***2,*** must not be disclosed to any person or entity.

~~[3. An applicant for the renewal of a license or certificate is not required to complete a data request pursuant to subsection 1 and is not subject to disciplinary action, including, without limitation, refusal to renew the license or certificate, for failure to do so.]~~

Sec. 89.9. **Chapter 641D of NRS is hereby amended by adding thereto a new section to read as follows:**

1. The Board shall make the data request developed by the Director of the Department of Health and Human Services pursuant to NRS 439A.116 available to applicants for the renewal of a license or registration pursuant to this chapter through a link on the electronic application for the renewal of a license or certificate.

2. Each applicant for the renewal of a license or registration pursuant to this chapter must, as a condition for such renewal, complete and electronically submit the data request to the Director.

3. The information provided by an applicant for the renewal of a license or registration pursuant to subsection 2 is confidential and, except as required by subsection 2, must not be disclosed to any person or entity.

Sec. 90. NRS 654.190 is hereby amended to read as follows:

654.190 1. The Board may, after notice and an opportunity for a hearing as required by law, impose an administrative fine of not more than $10,000 for each violation on, recover reasonable investigative fees and costs incurred from, suspend, revoke, deny the issuance or renewal of or place conditions on the license of, and place on probation or impose any combination of the foregoing on any licensee who:

(a) Is convicted of a felony relating to the practice of administering a facility for skilled nursing or facility for intermediate care or residential facility for groups or of any offense involving moral turpitude.

(b) Has obtained his or her license by the use of fraud or deceit.

(c) Violates any of the provisions of this chapter.

(d) Aids or abets any person in the violation of any of the provisions of NRS 449.029 to 449.2428, inclusive, ***and sections 20, 21 and 22 of this act,*** or 449A.100 to 449A.124, inclusive, and 449A.270 to 449A.286, inclusive, as those provisions pertain to a facility for skilled nursing, facility for intermediate care or residential facility for groups.

(e) Violates any regulation of the Board prescribing additional standards of conduct for licensees, including, without limitation, a code of ethics.

(f) Engages in conduct that violates the trust of a patient or resident or exploits the relationship between the licensee and the patient or resident for the financial or other gain of the licensee.

2. If a licensee requests a hearing pursuant to subsection 1, the Board shall give the licensee written notice of a hearing pursuant to NRS 233B.121 and 241.0333. A licensee may waive, in writing, his or her right to attend the hearing.

3. The Board may compel the attendance of witnesses or the production of documents or objects by subpoena. The Board may adopt regulations that set forth a procedure pursuant to which the Chair of the Board may issue subpoenas on behalf of the Board. Any person who is subpoenaed pursuant to this subsection may request the Board to modify the terms of the subpoena or grant additional time for compliance.

4. An order that imposes discipline and the findings of fact and conclusions of law supporting that order are public records.

5. The expiration of a license by operation of law or by order or decision of the Board or a court, or the voluntary surrender of a license, does not deprive the Board of jurisdiction to proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

Sec. 91. Chapter 680A of NRS is hereby amended by adding thereto a new section to read as follows:

The Commissioner may not issue a certificate of authority to an insurer that will provide health benefits if the insurer does not meet the requirements established by the regulations adopted pursuant to subsection 1 of section 108 of this act.

Sec. 92. NRS 680A.095 is hereby amended to read as follows:

680A.095 1. Except as otherwise provided in subsection 3, an insurer which is not authorized to transact insurance in this State may not transact reinsurance with a domestic insurer in this State, by mail or otherwise, unless the insurer holds a certificate of authority as a reinsurer in accordance with the provisions of NRS

680A.010 to 680A.150, inclusive, ***and section 91 of this act,*** 680A.160 to 680A.280, inclusive, 680A.320 and 680A.330.

2. To qualify for authority only to transact reinsurance, an insurer must meet the same requirements for capital and surplus as are imposed on an insurer which is authorized to transact insurance in this State.

3. This section does not apply to the joint reinsurance of title insurance risks or to reciprocal insurance authorized pursuant to chapter 694B of NRS.

Sec. 93. NRS 683A.08524 is hereby amended to read as follows:

683A.08524 1. Except as otherwise provided in subsection 2 or 3, the Commissioner shall issue a certificate of registration as an administrator to an applicant who:

(a) Submits an application on a form prescribed by the Commissioner;

(b) Has complied with the provisions of NRS 683A.08522; and

(c) Pays the fee for the issuance of a certificate of registration prescribed in NRS 680B.010 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

2. The Commissioner may refuse to issue a certificate of registration as an administrator to an applicant if the Commissioner determines that the applicant or any person who has completed an affidavit pursuant to subsection 6 of NRS 683A.08522:

(a) Is not competent to act as an administrator;

(b) Is not trustworthy or financially responsible;

(c) Does not have a good personal or business reputation;

(d) Has had a license or certificate to transact insurance denied for cause, suspended or revoked in this state or any other state;

(e) Has failed to comply with any provision of this chapter;

(f) Does not meet the requirements of the regulations adopted pursuant to subsection 1 of section 108 of this act; or

~~[(f)]~~ ***(g)*** Is financially unsound.

3. If an applicant seeks final approval by the Division of Industrial Relations of the Department of Business and Industry in accordance with regulations adopted pursuant to subsection 8 of NRS 616A.400, the Commissioner shall submit to the Division the information supplied by the applicant pursuant to subsection 1. Unless the Division provides final approval for the applicant to the Commissioner, the Commissioner shall not issue a certificate of registration as an administrator to the applicant.

Sec. 94. NRS 683A.3715 is hereby amended to read as follows:

683A.3715 1. An independent review organization must be approved by the Commissioner to be eligible to be assigned to conduct external reviews.

2. In order to be eligible for approval or reapproval by the Commissioner to conduct external reviews, an independent review organization:

(a) Except as otherwise provided in this section, must be accredited by a nationally recognized private accrediting entity which the Commissioner has determined has standards for the accreditation of independent review organizations that are equivalent to or exceed the minimum qualifications for independent review organizations established under NRS 683A.372;

(b) Must meet the requirements of the regulations adopted pursuant to subsection 1 of section 108 of this act; and

~~[(b)]~~ ***(c)*** Must submit an application in accordance with subsection 4.

3. The Commissioner shall develop an application form for the initial approval and reapproval of an independent review organization to conduct external reviews.

4. An independent review organization wishing to be approved or reapproved to conduct external reviews must submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the independent review organization satisfies the minimum qualifications established under NRS 683A.372 ~~[.]~~ ***and the regulations adopted pursuant to subsection 1 of section 108 of this act.***

5. The Commissioner may approve an independent review organization that is not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing accreditation of independent review organizations.

6. The Commissioner may charge any applicable fee which an independent review organization must submit to the Commissioner with its application for initial approval or reapproval.

7. An approval or reapproval is effective for 2 years unless the Commissioner determines before its expiration that the independent review organization does not satisfy the minimum qualifications established under NRS 683A.372.

8. Whenever the Commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under NRS 683A.372, the Commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews that is maintained by the Commissioner pursuant to subsection 9.

9. The Commissioner shall maintain and periodically update a list of approved independent review organizations.

10. The Commissioner may adopt regulations to carry out the provisions of this section.

11. As used in this section, "independent review organization" has the meaning ascribed to it in NRS 695G.026.

Sec. 95. NRS 683A.378 is hereby amended to read as follows:

683A.378 1. A person shall not conduct utilization review unless the person is:

(a) Registered with the Commissioner as an agent who performs utilization review and has a medical director who is a physician or, in the case of an agent who reviews dental services, a dentist, licensed in any state; or

(b) Employed by a registered agent who performs utilization review.

2. A person may apply for registration by filing with the Commissioner the fee specified in NRS 680B.010 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110 and the following information on a form provided by the Commissioner:

(a) The applicant's name, address, telephone number, valid electronic mail address and normal business hours;

(b) The name and telephone number of a person the Commissioner may contact for information concerning the applicant;

(c) The name of the medical director of the applicant and the state in which he or she is licensed to practice medicine or dentistry; ~~[and]~~

(d) A summary of the plan for utilization review, including procedures for appealing determinations made through utilization review ~~[.]~~ ***; and***

(e) Any additional information required by the Commissioner to ensure that the applicant will meet the requirements of the regulations adopted pursuant to subsection 1 of section 108 of this act.

3. An agent who performs utilization review shall file with the Commissioner any material changes in the information provided pursuant to subsection 1 within 30 days after the change occurs.

4. The Commissioner shall not evaluate the plan submitted pursuant to paragraph (d) of subsection 2. The Commissioner shall make the plan available upon request and shall charge a reasonable fee for providing a copy of the plan.

5. ***The Commissioner may not approve an application for registration as an agent who performs utilization review if the applicant does not meet the requirements of the regulations adopted pursuant to subsection 1 of section 108 of this act.***

6. Registration pursuant to this section must be renewed on or before March 1 of each year by providing the information specified in subsection 2 and paying the renewal fee specified in NRS 680B.010 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

Sec. 95.5. **NRS 686A.315 is hereby amended to read as follows:**

686A.315 1. If a hospital ***or independent center for emergency medical care*** submits to an insurer the form prescribed by the Director of the Department of Health and Human Services pursuant to NRS 449.485, that form must contain or be accompanied by a statement that reads substantially as follows:

> Any person who misrepresents or falsifies essential information requested on this form may, upon conviction, be subject to a fine and imprisonment under state or federal law, or both.

2. If a person who is licensed to practice one of the health professions regulated by title 54 of NRS submits to an insurer the form commonly referred to as the "HCFA-1500" for a patient who is not covered by any governmental program which offers insurance coverage for health care, the form must be accompanied by a statement that reads substantially as follows:

> Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

3. The failure to provide any of the statements required by this section is not a defense in a prosecution for insurance fraud pursuant to NRS 686A.291.

Sec. 96. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 97 to 109, inclusive, of this act.

Sec. 97. ***As used in sections 97 to 108, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 98, 99 and 100 of this act have the meanings ascribed to them in those sections.***

Sec. 98. ***"Health carrier" has the meaning ascribed to it in NRS 695G.024, and includes, without limitation : [, an organization for dental care, as defined in NRS 695D.060. The term additionally includes:]***

1. An administrator, as defined in NRS 683A.025, that performs any function related to prior authorization for medical [for dental] care or the payment of claims under a policy or contract of health insurance [.] , except for health coverage provided by a local government agency through a self-insurance reserve fund pursuant to NRS 287.010; and

2. A utilization review organization, as defined in NRS 695G.085 [.] , except when performing utilization reviews related to health coverage provided by a

local government agency through a self-insurance reserve fund pursuant to NRS 287.010.

Sec. 99. ***"Insured" means a policyholder, subscriber, enrollee or other person covered by a health carrier.***

Sec. 100. ***"Provider of health care" has the meaning ascribed to it in NRS 695G.070.***

Sec. 101. ***1. Each health carrier in this State shall implement an electronic system for receiving and processing requests for prior authorization. Such a system must:***

(a) Allow providers of health care to electronically submit, track and receive updates concerning requests for prior authorization; and

(b) Comply with:

(1) The Connectivity Rules, Eligibility and Benefits Operating Rules and Health Care Claims Operating Rules prescribed by the Committee on Operating Rules for Information Exchange of the Council for Affordable Quality Healthcare, or its successor organization;

(2) The provisions of the Prior Authorization and Referrals Operating Rules prescribed by the Committee on Operating Rules for Information Exchange of the Council for Affordable Quality Healthcare, or its successor organization, which relate to prior authorization; and

(3) Where applicable, any federal laws or regulations governing electronic systems for receiving and processing requests for prior authorization applicable to Medicare Advantage plans and health care plans to provide health care services to recipients of Medicaid or insurance pursuant to the Children's Health Insurance Program.

2. The Commissioner, in collaboration with the Department of Health and Human Services, shall review each revision to the Rules described in subparagraphs (1) and (2) of paragraph (b) of subsection 1 to ensure their suitability for this State. If the Commissioner determines that a revision is not suitable for this State, the Commissioner shall hold a public hearing within 6 months after the date the Rules were revised to review his or her determination. If the Commissioner does not revise his or her determination, the Commissioner shall give notice within 30 days after the hearing that the revisions are not suitable for this State.

3. If the Commissioner does not give notice pursuant to subsection 2 that a revision to the Rules described in subparagraphs (1) and (2) of paragraph (b) of subsection 1 are not suitable for this State within the time period prescribed in subsection 2, each system implemented by a health carrier pursuant to subsection 1 must comply with the revision not later than 2 years after the date on which the revision was finalized.

4. The Commissioner shall annually publish a report on an Internet website maintained by the Commissioner concerning the compliance of health carriers in this State with the requirements of this section.

5. As used in this section, "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C, as described in 42 U.S.C. § 1395w-28(b)(1), and includes:

(a) Coordinated care plans that provide health care services, including, without limitation:

(1) Health maintenance organization plans, with or without a point-of-service provider;

(2) Plans offered by provider-sponsored organizations; and

(3) Preferred provider organization plans;

(b) Medical savings account plans that are coupled with a contribution into Medicare Advantage medical savings accounts; and

(c) Medicare Advantage private fee-for-service plans.

Sec. 101.3. *The provisions of NRS 687B.225 and sections 101.6 to 105, inclusive, of this act, do not apply to:*

1. A health maintenance organization or other managed care organization that enters into a contract with the Department of Health and Human Services or the Division of Health Care Financing and Policy of the Department pursuant to NRS 422.273 to provide health care services to recipients of Medicaid under the State Plan for Medicaid or insurance under the Children's Health Insurance Program to the extent that the organization is providing such services.

2. An administrator or utilization review organization that performs any function related to prior authorization for an entity described in subsection 1, while the administrator or utilization review organization, as applicable, is performing such functions.

Sec. 101.6. *1. If a health carrier utilizes an artificial intelligence system or automated decision tool to process requests for prior authorization, the health carrier shall make available, in a place that is readily accessible and conspicuous to insureds and the public:*

(a) A statement that the health carrier utilizes an artificial intelligence system or automated decision tool to process requests for prior authorization;

(b) A general description of how the artificial intelligence system or automated decision tool works; and

(c) A description of the specific types of information or data utilized by the artificial intelligence system or automated decision tool to generate an outcome.

2. As used in this section:

(a) "Artificial intelligence system" means a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations or decisions influencing real or virtual environments.

(b) "Automated decision tool" means an automated or computerized system that is specifically developed or modified to make, or be a controlling factor in making, consequential decisions.

Sec. 102. *Upon determining that it is necessary to delay approving or denying a request for prior authorization beyond the period prescribed by paragraph (b) of subsection 2 or subsection 3 or 4, as applicable, of NRS 687B.225, a health carrier shall transmit a written notice to the insured to whom the request pertains and an electronic notice to the provider of health care who submitted the request ~~.~~ or the person designated by the provider of health care to manage requests for prior authorization. Such notice must contain:*

1. A specific description of all reasons that the health carrier is delaying the response;

2. The steps necessary to resolve the delay; and

3. The anticipated timeline for resolving the delay.

Sec. 103. *1. Upon denying a request for prior authorization, a health carrier shall transmit to:*

(a) The insured to whom the request pertains a written notice that contains:

(1) A specific description of all reasons that the health carrier denied the request;

(2) A description of any documentation that the health carrier requested from the insured or a provider of health care of the insured and did not receive or deemed insufficient, if the failure to receive sufficient documentation contributed to the denial;

(3) A statement that the insured has the right to appeal the denial;

(4) Instructions, written in clear language that is understandable to an ordinary layperson, describing how the insured can appeal the denial through the process established pursuant to subsection 2; and

(5) A description of any documentation that may be necessary or pertinent to an appeal.

(b) The provider of health care who submitted the request or the person designated by the provider of health care to manage requests for prior authorization an electronic notice that includes all the information required by the Rules described in paragraph (b) of subsection 2 of NRS 687B.225.

2. A health carrier shall establish a process that allows an insured to appeal the denial of a request for prior authorization. The process must allow for the clear resolution of each appeal within a reasonable time.

Sec. 104. *1. A health carrier shall not revoke a request for prior authorization that the health carrier has previously approved or delay or deny payment for the medical ~~[or dental]~~ care to which such a request pertains unless the health carrier determines that:*

(a) An insured or a provider of health care procured the approval by fraud or material misrepresentation;

(b) The approval was affected by a clerical error; or

(c) The person to which the medical ~~[or dental]~~ care was provided was not, on the date on which the care was provided, an insured of the health carrier.

2. After a health carrier approves a request for prior authorization, the health carrier shall not assign a lower level billing code to the medical ~~[or dental]~~ care to which the request pertains or otherwise reduce the payment for such care below the amount indicated in the request for prior authorization without a clear, documented justification that aligns with applicable standards of care.

3. A health carrier that takes any action described in subsection 1 or 2 shall provide written notice of the action using the same remittance process that the health carrier uses to pay claims to the provider of health care that submitted the request for prior authorization. Such notice must include, without limitation, a detailed description of the justification for the action and documentation supporting that justification.

4. As used in this section, "clerical error" means a typographical or administrative error or an error in calculation. The term does not include any mistake relating to clinical judgment, the medical necessity of care or the appropriateness of a treatment.

Sec. 105. *1. A health carrier shall comply with the provisions of 26 U.S.C. § 9818 and 42 U.S.C. § 300gg-113, and any regulations adopted pursuant thereto.*

2. Within the first 90 days of the coverage period for an insured, a health carrier shall honor a request for prior authorization that has been approved by a health carrier or other entity that previously provided the insured with coverage for medical ~~[or dental]~~ care if the specific medical ~~[or dental]~~ care included within the request is not affirmatively excluded under the terms and conditions of the contract or policy of insurance issued by the health carrier.

3. The health carrier may, within the 90-day period established by subsection 2, undertake an independent review of the medical ~~[or dental]~~ care that was approved by the health carrier or other entity that previously provided the insured with coverage. The health carrier shall not deny approval in violation of subsection 2 as the result of such a review.

4. A change in the health carrier's procedure for obtaining prior authorization or a new exclusion or limitation of coverage adopted by a health carrier may not take effect until the next coverage period with respect to:

(a) An insured for whom the health carrier has, within the current coverage period, approved a request for prior authorization; and

(b) The medical ~~[or dental]~~ care that is identical to the care for which the health carrier had previously approved a request for prior authorization within the current coverage period.

5. If an insured for whom a request for prior authorization has been approved by a health carrier obtains coverage under a different policy or contract of health insurance issued by the same health carrier, the health carrier shall honor the approval to the same extent as if the insured were still covered under the policy or contract of health insurance under which the insured was covered when the health carrier approved the request.

6. As used in this section, "coverage period" means the current term of a contract or policy of insurance issued by a health carrier.

Sec. 106. *1. Each health carrier shall annually compile and transmit to the Commissioner in the form prescribed by the Commissioner pursuant to subsection 6 a report containing the following information:*

(a) The specific goods and services for which the health carrier requires prior authorization and, for each good or service:

(1) The number of requests for prior authorization received by the health carrier during the immediately preceding calendar year for the provision of the good or service to insureds in this State;

(2) The number and percentage of the requests included pursuant to subparagraph (1) that were approved; and

(3) The number and percentage of the requests included pursuant to subparagraph (1) that were denied;

(b) The average amounts of time between when the health carrier received a request for prior authorization during the immediately preceding calendar year and when the health carrier:

(1) Initially responded to the request;

(2) Approved or denied the request; and

(3) Paid the claim to which the request pertains;

(c) The percentage of claims received by the health carrier during the immediately preceding calendar year that the health carrier retroactively denied and detailed written explanations of the reasons for such denials;

(d) Explanations of corrective actions that the health carrier is taking or intends to take to:

(1) Lower the rates of delays and denials of requests for prior authorization and payment of claims; and

(2) Correct any failure to comply with the provisions of NRS 687B.225 and sections 97 to 108, inclusive, of this act; and

(e) Such additional information as the Commissioner may prescribe by regulation.

2. A health carrier shall not include individually identifiable health information in a report published pursuant to subsection 1.

3. The Commissioner shall aggregate and post on a centralized, publicly accessible Internet website maintained by the Commissioner the information submitted to the Commissioner pursuant to subsection 1 and section 62 of this act. The Internet website must allow a user to:

(a) View the information submitted pursuant to:

(1) Subsection 1 by each health carrier that does business in this State; and

(2) The Department of Health and Human Services pursuant to section 62 of this act.

(b) Compare the information described in paragraph (a) to performance benchmarks established by the Commissioner.

4. The Commissioner shall annually:

(a) Compile a report:

(1) Summarizing the information submitted to the Commissioner pursuant to subsection 1 and section 62 of this act;

(2) Describing trends and challenges relating to compliance with the provisions of NRS 687B.225 and sections 97 to 108, inclusive, of this act; and

(3) Making recommendations to address the challenges described in subparagraph (2) and improve the administration of health insurance in this State; and

(b) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to the Joint Interim Standing Committee on Health and Human Services and the Joint Interim Standing Committee on Commerce and Labor.

5. The Commissioner may:

(a) Audit the accuracy of reports submitted by health carriers pursuant to this section; and

(b) Require independent audits for health carriers that have repeatedly failed to comply with the requirements of this section or submitted reports that the Commissioner has reason to believe are inaccurate.

6. The Commissioner shall adopt regulations to carry out the requirements of this section, including, without limitation, regulations establishing:

(a) A standardized form for submitting a report pursuant to subsection 1;

(b) The dates on which:

(1) Health carriers must submit the reports required by subsection 1; and

(2) The Commissioner will submit the report required by subsection 4; and

(c) Procedures for conducting audits pursuant to subsection 5.

7. As used in this section, "individually identifiable health information" means information relating to the provision of medical ~~[or dental]~~ care to an insured:

(a) That specifically identifies the insured; or

(b) For which there is a reasonable basis to believe that the information can be used to identify the insured.

Sec. 107. *1. The Gold Card Exemption Program is hereby established to exempt providers of health care who receive Gold Card Exemptions pursuant to subsection 2 from requirements imposed by health carriers to obtain prior authorization for specific goods and services set forth in the regulations adopted pursuant to subsection 8.*

2. A health carrier shall issue a Gold Card Exemption to a provider of health care who participates in the network of the health carrier if:

(a) Within the immediately preceding 24 months, the health carrier approved 95 percent or more of the requests for prior authorization submitted by the provider of health care for a specific good or service which is eligible for a Gold Card Exemption under the regulations adopted pursuant to subsection 8; and

(b) The provider of health care meets any other requirements established by the regulations adopted pursuant to subsection 8.

3. A health carrier shall:

(a) Annually review the continued eligibility of a provider of health care who has been granted a Gold Card Exemption pursuant to this section for that Gold Card Exemption; and

(b) If the health carrier determines through a review conducted pursuant to paragraph (a) that a provider of health care who holds a Gold Card Exemption no longer meets the requirements of subsection 2:

(1) Notify the provider of health care that he or she:

(I) Does not meet the requirements to continue to hold a Gold Card Exemption; and

(II) May appeal the determination of the health carrier in accordance with the regulations adopted pursuant to subsection 8; and

(2) Unless the determination that the provider no longer meets the requirements of subsection 2 is reversed on appeal, revoke the Gold Card Exemption.

4. Except as otherwise provided in subsections ~~[4, 5 and]~~ 6 , 7 and 8 of section 56 of this act, a health carrier shall not require a provider of health care who holds a Gold Card Exemption to obtain prior authorization for any goods and services to which the Gold Card Exemption applies.

5. A health carrier shall maintain on an Internet website maintained by the health carrier a list of all providers of health care who hold a Gold Card Exemption. The list must include, for each provider, the specialty of the provider and the goods and services covered by the Gold Card Exemption.

6. A health carrier may audit providers of health care who hold Gold Card Exemptions to determine whether those providers of health care meet the requirements of this section and the regulations adopted thereto. If a health carrier determines that such a provider of health care does not meet those requirements, the health carrier may, after notice and the opportunity for an appeal:

(a) Suspend or revoke the Gold Card Exemption; or

(b) Impose any other penalties authorized by the regulations adopted pursuant to subsection 8.

7. The Commissioner shall periodically:

(a) Evaluate, including, without limitation, by soliciting input from interested persons and entities, the effectiveness of the Gold Card Exemption Program in reducing administrative burdens and improving the delivery of health care; and

(b) Revise the regulations adopted pursuant to subsection 8 and submit such recommendations to the Legislature as are necessary to improve the Gold Card Exemption Program based on the evaluations conducted pursuant to paragraph (a).

8. The Commissioner, in collaboration with the Department of Health and Human Services, shall adopt such regulations as are necessary to carry out the provisions of this section, including, without limitation, regulations establishing:

(a) The goods and services which are eligible for a Gold Card Exemption;

(b) The procedure to determine the eligibility of a provider of health care for a Gold Card Exemption;

(c) Any requirements, in addition to the requirements prescribed in subsection 2, for a provider of health care to be eligible to receive or continue to hold a Gold Card Exemption, which may include, without limitation, requirements governing the quality of care provided by the provider of health care;

(d) Procedures for appeals pursuant to subsections 3 and 6;

(e) Procedures for conducting audits pursuant to subsection 6; and

(f) Penalties that may be imposed pursuant to subsection 6.

9. As used in this section:

(a) "Network" means a defined set of providers of health care who are under contract with a health carrier to provide health care services pursuant to a network plan offered or issued by the health carrier.

(b) "Network plan" means a contract or policy of health insurance offered by a health carrier under which the financing and delivery of medical ~~[or dental]~~ care is provided, in whole or in part, through a defined set of providers under contract with the health carrier.

Sec. 108. *1. The Commissioner shall prescribe by regulation such additional requirements for the issuance of a certificate of authority pursuant to NRS 680A.160 to an insurer that will provide health benefits, the issuance of a certificate of registration pursuant to NRS 683A.08524 to an administrator that will perform any function related to prior authorization for medical ~~[or dental]~~ care or the payment of claims under a policy or contract of health insurance, the approval of an independent review organization pursuant to NRS 683A.3715 ~~[,]~~ or the registration of an agent who performs utilization review pursuant to NRS 683A.378 ~~[or the issuance of a certificate of authority to an organization for dental care pursuant to NRS 695D.130]~~ to ensure that the insurer, administrator, organization or agent, as applicable, is equipped to comply with the provisions of NRS 687B.225 and sections 97 to 108, inclusive, of this act, and, where applicable, NRS 683A.0879, 689A.410, 689B.255, 689C.335, 695A.188, 695B.2505 ~~[,]~~ or 695C.185 . ~~[or 695D.215.]~~*

2. The Commissioner, in consultation with the ~~[Department of Health and Human Services and the]~~ Board of the Public Employees' Benefits Program, shall adopt regulations establishing criteria to ensure that any health carrier with which the ~~[Department of Health and Human Services or the]~~ Board contracts is in compliance with the requirements of NRS 687B.225, sections 97 to 108, inclusive, of this act and, where applicable, NRS 683A.0879, 689A.410, 689B.255, 689C.335, 695A.188, 695B.2505 ~~[,]~~ or 695C.185 . ~~[or 695D.215.]~~

3. The Commissioner shall:

(a) Perform an annual audit of each health carrier that operates in this State to ensure compliance with the requirements of NRS 687B.225, sections 97 to 108, inclusive, of this act, and, where applicable, NRS 683A.0879, 689A.410, 689B.255, 689C.335, 695A.188, 695B.2505 ~~[,]~~ or 695C.185 ; ~~[or 695D.215;]~~

(b) Annually publish on an Internet website maintained by the Commissioner a report concerning compliance by health carriers with the requirements of NRS 687B.225, sections 97 to 108, inclusive, of this act, and, where applicable, NRS 683A.0879, 689A.410, 689B.255, 689C.335, 695A.188, 695B.2505 ~~[,]~~ or 695C.185 ; ~~[or 695D.215;]~~ and

(c) Accept and investigate grievances from providers of health care concerning possible violations of NRS 687B.225, sections 97 to 108, inclusive, of this act, and, where applicable, NRS 683A.0879, 689A.410, 689B.255, 689C.335, 695A.188, 695B.2505 ~~[,]~~ or 695C.185 . ~~[or 695D.215.]~~

4. The Commissioner, in collaboration with the Department of Health and Human Services, shall:

(a) Annually hold a public meeting to:

(1) Review the implementation of NRS 687B.225 and sections 53 to 63, inclusive, and 97 to 108, inclusive, of this act; and

(2) Solicit input on the implementation of NRS 687B.225 and sections 53 to 63, inclusive, and 97 to 108, inclusive, of this act from health carriers, providers of health care, patients and other interested persons and entities; and

(b) Based on the input provided pursuant to subparagraph (2) of paragraph (a), adopt such regulations or submit such recommendations to the Legislature as

are necessary to improve the process for requesting prior authorization in this State.

Sec. 109. ***1. A health carrier, or any entity to which a health carrier delegates credentialing functions, shall:***

(a) Use the Provider Data Portal, or any successor system, established by the Council for Affordable Quality Healthcare, or its successor organization, to accept submissions by providers of health care for credentialing; and

(b) Use an entity that holds the Credentials Verification Organization Certification issued by the National Committee for Quality Assurance, or its successor organization, for the purpose of verifying the credentials of providers of health care seeking to participate in the network of the health carrier. A health carrier or entity to which a health carrier delegates credentialing functions may itself perform the functions described in this paragraph if the health carrier or entity, as applicable, holds such certification.

2. The Commissioner shall:

(a) Perform an annual audit of each health carrier that operates in this State to ensure compliance with the requirements of this section;

(b) Collect from health carriers and entities to which health carriers designate credentialing functions such data as is necessary to compile the report required by paragraph (c); and

(c) On or before February 1 of each year:

(1) Compile a report on the credentialing of providers of health care which includes, without limitation:

(I) The average time between the submission by a provider of health care of a request to a health carrier for credentialing and the request being approved or denied, for each health carrier in this State and aggregated for all health carriers in this State; and

(II) Recommendations for improvements to the process for credentialing providers of health care, including, without limitation, recommendations concerning improvements to technology or procedures to increase the efficiency of the process; and

(2) Submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to:

(I) In even-numbered years, the Joint Interim Standing Committee on Health and Human Services; and

(II) In odd-numbered years, the next regular session of the Legislature.

3. As used in this section:

(a) "Credentialing" means verifying the credentials of a provider of health care for the purpose of determining whether the provider of health care meets the requirements for participation in the network of a health carrier.

(b) ~~***["Health carrier" includes, without limitation, an organization for dental care.***~~

~~***(c)]***~~ ***"Provider of health care" has the meaning ascribed to it in NRS 629.031.***

Sec. 110. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.0418, 689A.0437, 689A.044, 689A.0445, 689A.0459, 689B.031, 689B.0312, 689B.0313, 689B.0315, 689B.0317, 689B.0319, 689B.0374, 689B.0378, 689C.1665, 689C.1671, 689C.1675, 689C.1676, 695A.1843, 695A.1856, 695A.1865, 695A.1874, 695B.1912, 695B.1913, 695B.1914, 695B.1919, 695B.19197, 695B.1924, 695B.1925, 695B.1942, 695C.1696, 695C.1699, 695C.1713, 695C.1735, 695C.1737, 695C.1743, 695C.1745,

695C.1751, 695G.170, 695G.1705, 695G.171, 695G.1714, 695G.1715, 695G.1719 and 695G.177, any contract ~~[for group, blanket or individual health]~~ ***or policy of*** insurance ~~[or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care]~~ ***issued by a health carrier*** which provides for payment of a certain part of medical ~~[or dental]~~ care may require the insured ~~[or member]~~ to obtain prior authorization for that care from the insurer ***.*** ~~[or organization. The insurer or organization]~~

2. A health carrier shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

(b) Unless a ~~[shorter]~~ ***different*** time period is prescribed by a specific statute, including, without limitation, NRS 689A.0446, 689B.0361, 689C.1688, 695A.1859, 695B.19087, 695C.16932 and 695G.1703 ~~[, respond to]~~ ***and except as otherwise provided in subsections 3 and 4, approve or deny*** any request for approval by the insured ~~[or member]~~ pursuant to this section ***or provide notice of a delay in accordance with section 102 of this act*** within ~~[20]~~ ***:***

(1) Two business days after it receives the request ~~[. the time period prescribed by]~~ ***; or***

(2) If the Prior Authorization and Referrals Operating Rules prescribed by the Committee on Operating Rules for Information Exchange of the Council for Affordable Quality Healthcare, or its successor organization ~~[,]~~ ***, would allow the health carrier more than 2 business days to respond to the particular request for prior authorization after receiving the request, the time period prescribed by the Rules.***

3. Notwithstanding any time period prescribed by the rules described in subparagraph (2) of paragraph (b) of subsection 2, a health carrier shall respond as required by paragraph (b) of subsection 2 to a request for prior authorization within 7 calendar days after receiving the request.

4. The Commissioner, in collaboration with the Department of Health and Human Services, shall review each revision to the Rules described in subparagraph (2) of paragraph (b) of subsection 2 to ensure their suitability for this State. If the Commissioner determines that a revision is not suitable for this State, the Commissioner shall hold a public hearing within 6 months after the date the Rules were revised to review his or her determination. If the Commissioner does not revise his or her determination, the Commissioner shall give notice within 30 days after the hearing that the revisions are not suitable for this State. If the Commissioner ~~[does not give]~~ ***gives such notice, a health carrier shall*** ~~[comply with the revision not later than 2 years after the date on which the revision was finalized.~~

~~2.~~ ~~4.]~~ ***respond as required by paragraph (b) of subsection 2 to any request for prior authorization that is submitted to the health carrier after the date on which such notice is given within 2 business days after receiving the request.***

5. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

~~[5.]~~ ***6. If a health carrier fails to comply with paragraph (b) of subsection 2 or subsection 3 or 4, as applicable, with respect to a particular request for prior authorization, the request shall be deemed approved.***

~~[6.]~~ ***7. A health carrier shall not require prior authorization for emergency services covered by the health carrier, including, where applicable, transportation by ambulance to a hospital or other medical facility.***

~~[7.]~~ ***8. As used in this section, "emergency services" means health care services that are provided by a provider of health care to screen and to stabilize an insured after the sudden onset of a medical condition that manifests itself by***

symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

(a) Serious jeopardy to the health of the insured;

(b) Serious jeopardy to the health of an unborn child of the insured;

(c) Serious impairment of a bodily function of the insured; or

(d) Serious dysfunction of any bodily organ or part of the insured.

Sec. 111. NRS 687B.600 is hereby amended to read as follows:

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, ***and section 109 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 687B.602 to 687B.665, inclusive, have the meanings ascribed to them in those sections.

Sec. 112. NRS 687B.670 is hereby amended to read as follows:

687B.670 If a health carrier offers or issues a network plan, the health carrier shall, with regard to that network plan:

1. Comply with all applicable requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[,]~~ ***and section 109 of this act;***

2. As applicable, ensure that each contract entered into for the purposes of the network plan between a participating provider of health care and the health carrier complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[,]~~ ***, and section 109 of this act;*** and

3. As applicable, ensure that the network plan complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[.]~~ ***, and section 109 of this act.***

Sec. 113. NRS 695B.320 is hereby amended to read as follows:

695B.320 1. Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, subsections 2, 4, 17, 18 and 30 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, chapter 681B of NRS, NRS 686A.010 to 686A.315, inclusive, 686B.010 to 686B.175, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200 to 687B.255, inclusive, 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, 687B.500 ***and section 109 of this act*** and chapters 692B, 692C, 693A and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

2. For the purposes of this section and the provisions set forth in subsection 1, a nonprofit hospital and medical or dental service corporation is included in the meaning of the term "insurer."

Sec. 114. NRS 695B.320 is hereby amended to read as follows:

695B.320 1. Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, subsections 2, 4, 17, 18 and 30 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, chapter 681B of NRS, NRS 686A.010 to 686A.315, inclusive, 686B.010 to 686B.175, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200 to 687B.255, inclusive, ***and sections 97 to 108, inclusive, of this act,*** 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, 687B.500 and section 109 of this act and chapters 692B, 692C, 693A and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

2. For the purposes of this section and the provisions set forth in subsection 1, a nonprofit hospital and medical or dental service corporation is included in the meaning of the term "insurer."

Sec. 115. ~~[NRS 695D.130 is hereby amended to read as follows:~~

~~695D.130 The Commissioner shall issue a certificate of authority to an organization for dental care after the organization has paid an application fee of $2,450 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110, and the Commissioner is satisfied that:~~

~~1. The persons responsible for operating the organization are competent, trustworthy, have not been convicted of a felony and have good reputations.~~

~~2. The plan for dental care includes care which is appropriate for the plan and the plan is appropriate for providing that care.~~

~~3. The organization is financially responsible and may reasonably be expected to meet its obligations to its members. To determine financial responsibility the Commissioner may consider:~~

~~(a) The organization's arrangements for dental care and the schedule of charges to be used;~~

~~(b) The agreements with an insurer, government or any other organizations for ensuring payment for the dental care;~~

~~(c) Any provisions for alternative coverage if the plan for dental care is discontinued; and~~

~~(d) The agreements with the dentists providing dental care to the organization's members.~~

~~4. *The organization meets the requirements of the regulations adopted pursuant to subsection 1 of section 108 of this act.*~~

~~5. The appropriate deposits or bonds have been filed with the Commissioner by the organization and its officers.~~~~]~~ **(Deleted by amendment.)**

Sec. 116. NRS 695K.220 is hereby amended to read as follows:

695K.220 1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall use a statewide competitive bidding process, including, without limitation, a request for proposals, to solicit and enter into contracts with health carriers or other qualified persons or entities to administer the Public Option. If a statewide Medicaid managed care program is established pursuant to subsection 1 of NRS 422.273, the competitive bidding process must coincide with the statewide procurement process for that Medicaid managed care program.

2. Each health carrier that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program shall, as a condition of continued participation in any Medicaid managed care program established in this State, submit a good faith proposal in response to a request for proposals issued pursuant to subsection 1.

3. Each proposal submitted pursuant to subsection 2 must demonstrate that the applicant is able to meet the requirements of NRS 695K.200 ~~[.]~~ ***and meets the criteria prescribed by the regulations adopted pursuant to subsection 2 of section 108 of this act.***

4. When selecting a health carrier or other qualified person or entity to administer the Public Option, the Director shall prioritize applicants whose proposals:

(a) Demonstrate alignment of networks of providers between the Public Option and Medicaid managed care, where applicable;

(b) Provide for the inclusion of critical access hospitals, rural health clinics, certified community behavioral health clinics and federally-qualified health centers in the networks of providers for the Public Option and Medicaid managed care, where applicable;

(c) Include proposals for strengthening the workforce in this State and particularly in rural areas of this State for providers of primary care, mental health care and treatment for substance use disorders;

(d) Use payment models for providers included in the networks of providers for the Public Option that increase value for persons enrolled in the Public Option and the State; and

(e) Include proposals to contract with providers of health care in a manner that decreases disparities among different populations in this State with regard to access to health care and health outcomes and supports culturally competent care.

5. Notwithstanding the provisions of subsections 1 to 4, inclusive, the Director may directly administer the Public Option if necessary to carry out the provisions of this chapter.

6. Any health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to this section or the Director, if the Director directly administers the Public Option pursuant to subsection 5, shall take any measures necessary to make the Public Option available as described in paragraph (a) of subsection 2 of NRS 695K.200 and, if required by the Director, paragraph (b) of that subsection. Such measures include, without limitation:

(a) Filing rates and supporting information with the Commissioner of Insurance as required by NRS 686B.010 to 686B.1799, inclusive; and

(b) Obtaining certification as a qualified health plan pursuant to 42 U.S.C. § 18031.

7. The Director shall deposit into the Trust Fund any money received from:

(a) A health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to subsection 1 which relates to duties performed under the contract; or

(b) If the Director directly administers the Public Option pursuant to subsection 5, any money received from any person or entity in the course of administering the Public Option.

8. As used in this section:

(a) "Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

(b) "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

Sec. 116.3. **NRS 719.200 is hereby amended to read as follows:**

719.200 1. Except as otherwise provided in subsection 2, the provisions of this chapter apply to electronic records and electronic signatures relating to a transaction.

2. The provisions of this chapter do not apply to a transaction to the extent it is governed by:

(a) Except as otherwise specifically provided by law, a law governing the creation and execution of wills, codicils or testamentary trusts;

(b) The Uniform Commercial Code other than NRS 104.1306, 104.2101 to 104.2725, inclusive, and 104A.2101 to 104A.2532, inclusive; or

(c) The provisions of NRS 439.581 to 439.597, inclusive, ***and section 1 of this act*** and the regulations adopted pursuant thereto.

3. The provisions of this chapter apply to an electronic record or electronic signature otherwise excluded from the application of this chapter under subsection 2 to the extent it is governed by a law other than those specified in subsection 2.

4. A transaction subject to the provisions of this chapter is also subject to other applicable substantive law.

Sec. 116.7. **NRS 720.140 is hereby amended to read as follows:**

720.140 1. Except as otherwise provided in this subsection, the provisions of this chapter apply to any transaction for which a digital signature is used to sign an electronic record. The provisions of this chapter do not apply to a digital signature that is used to sign an electronic health record in accordance with NRS 439.581 to 439.597, inclusive, ***and section 1 of this act*** and the regulations adopted pursuant thereto.

2. As used in this section, "electronic record" has the meaning ascribed to it in NRS 719.090.

Sec. 117. Section 50 of this act is hereby amended to read as follows:

Sec. 50. 1. The Department or any entity to which the Department delegates credentialing functions for Medicaid or the Children's Health Insurance Program shall:

(a) Use the Provider Data Portal, or any successor system, established by the Council for Affordable Quality Healthcare, or its successor organization, to accept submissions by providers of health care for credentialing; and

(b) Use an entity that holds the Credentials Verification Organization Certification issued by the National Committee for Quality Assurance, or its successor organization, for the purpose of verifying the credentials of providers of health care seeking to participate in Medicaid or the Children's Health Insurance Program.

2. ***The Department shall ensure that, for at least 95 percent of the complete requests for credentialing submitted by providers of health care to the Department or an entity to which the Department delegates credentialing functions, the Department or entity processes the request not later than 60 days after the Department or entity, as applicable, receives all information necessary to complete the request.***

3. For the purposes of subsection 2, a request for credentialing shall be deemed to be complete if:

(a) The provider of health care who submitted the request has completed all fields prescribed by the Council for Affordable Quality Healthcare, or its successor organization;

(b) The provider of health care receives electronic notice that the credentialing application is complete; and

(c) The completed request is made available through the Portal or successor system described in paragraph (a) of subsection 1 to the Department or the entity to which the Department delegates credentialing functions.

4. An entity to which the Department delegates credentialing functions shall immediately notify the Department of:

(a) Any delay in credentialing that exceeds the time period specified in subsection 2;

(b) Steps taken to ensure that the request that is subject to the delay is processed as quickly as possible; and

(c) An anticipated timeline to complete the processing of the request.

5. On or before February 1 of each year, the Department shall:

(a) Compile a report on the credentialing of providers of health care which includes, without limitation:

(1) The average time between the submission of a request by a provider of health care for credentialing for Medicaid and the Children's Health Insurance Program during the immediately preceding year and the request being approved or denied; and

(2) The rates at which requests for credentialing are processed within the time period specified in subsection 2, for Medicaid and the Children's Health Insurance Program; and

~~[(2)]~~ ***(3)*** Recommendations for improvements to the process for credentialing providers of health care for Medicaid and the Children's Health Insurance Program, including, without limitation, recommendations concerning improvements to technology or procedures to increase the efficiency of the process; and

(b) Submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Joint Interim Standing Committee on Health and Human Services; and

(2) In odd-numbered years, the next regular session of the Legislature.

~~[3.]~~ ***6.*** As used in this section:

(a) "Credentialing" means verifying the credentials of a provider of health care for the purpose of determining whether the provider of health care meets the requirements for participation in Medicaid or the Children's Health Insurance Program as a provider of services.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 118. Section 109 of this act is hereby amended to read as follows:

Sec. 109. 1. A health carrier, or any entity to which a health carrier delegates credentialing functions, shall:

(a) Use the Provider Data Portal, or any successor system, established by the Council for Affordable Quality Healthcare, or its successor organization, to accept submissions by providers of health care for credentialing; and

(b) Use an entity that holds the Credentials Verification Organization Certification issued by the National Committee for Quality Assurance, or its successor organization, for the purpose of verifying the credentials of providers of health care seeking to participate in the network of the health carrier. A health carrier or entity to which a health carrier delegates credentialing functions may itself perform the functions described in this paragraph if the health carrier or entity, as applicable, holds such certification.

2. ***A health carrier shall:***

(a) Ensure that, for at least 95 percent of the complete requests for credentialing submitted by providers of health care to the health carrier or an entity to which the health carrier delegates credentialing functions, the health carrier or entity processes the request not later than 60 days after the health carrier or entity, as applicable, receives all information necessary to complete the request; and

(b) Immediately notify the Commissioner of:

(1) Any delay in credentialing that exceeds the time period specified in paragraph (a);

(2) Steps taken to ensure that the request that is subject to the delay is processed as quickly as possible; and

(3) An anticipated timeline to complete the processing of the request.

3. For the purposes of subsection 2, a request for credentialing shall be deemed to be complete if:

(a) The provider of health care who submitted the request has completed all fields prescribed by the Council for Affordable Quality Healthcare, or its successor organization;

(b) The provider of health care receives electronic notice that the credentialing application is complete; and

(c) The completed request is made available through the Portal or successor system described in paragraph (a) of subsection 1 to the health carrier or the entity to which the health carrier delegates credentialing functions.

4. An entity to which a health carrier delegates credentialing functions shall immediately notify the health carrier of any delay in credentialing that exceeds the time period specified in paragraph (a) of subsection 2. Such notice must include the information listed in paragraph (b) of subsection 2.

5. The Commissioner shall:

(a) Perform an annual audit of each health carrier that operates in this State to ensure compliance with the requirements of this section;

(b) Collect from health carriers and entities to which health carriers designate credentialing functions such data as is necessary to compile the report required by paragraph (b); and

(c) On or before February 1 of each year:

(1) Compile a report on the credentialing of providers of health care which includes, without limitation:

(I) The average time between the submission by a provider of health care of a request to a health carrier for credentialing and the request being approved or denied, for each health carrier in this State and aggregated for all health carriers in this State; ~~[and]~~

(II) ***The rates at which requests for credentialing are processed within the time period specified in paragraph (a) of subsection 2, for each health carrier in this State and aggregated for all health carriers in this State; and***

(III) Recommendations for improvements to the process for credentialing providers of health care, including, without limitation, recommendations concerning improvements to technology or procedures to increase the efficiency of the process; and

(2) Submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to:

(I) In even-numbered years, the Joint Interim Standing Committee on Health and Human Services; and

(II) In odd-numbered years, the next regular session of the Legislature.

~~[3.]~~ ***6.*** As used in this section:

(a) "Credentialing" means verifying the credentials of a provider of health care for the purpose of determining whether the provider of health care meets the requirements for participation in the network of a health carrier.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 119. ~~[1. There is hereby appropriated from the State General Fund to the Nevada Health Care Workforce and Access Account created by section 6 of this act the following sums:~~

~~For the Fiscal Year 2025-2026..... $25,000,000~~

~~For the Fiscal Year 2026-2027..... $25,000,000~~

~~2. On July 1, 2026, the State Controller shall transfer $10,000,000 from the Prescription Drug Rebate budget account to the Nevada Health Care Workforce and Access Account created by section 6 of this act.]~~ **(Deleted by amendment.)**

Sec. 119.5. **1. There is hereby appropriated from the State General Fund to the Division of Health Care Financing and Policy of the Department of Health and Human Services the sum of $291,296 to carry out the provisions of sections 51.3, 51.5 and 51.8 of this act.**

2. Expenditure of $1,149,153 not appropriated from the State General Fund or the State Highway Fund is hereby authorized during Fiscal Year 2026-2027 by the Division of Health Care Financing and Policy of the Department of Health and Human Services for the same purpose as set forth in subsection 1.

3. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2027, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 17, 2027, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 17, 2027.

Sec. 120. 1. There is hereby appropriated from the State General Fund to the Patient Protection Commission created by NRS 439.908 the sum of $200,000 to conduct the study required by section 121 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2027, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 17, 2027, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 17, 2027.

Sec. 120.3. **1. An independent center for emergency medical care that was licensed on the date on which this act was enacted is exempt from the requirements of subsection 3 of NRS 449.1818, as amended by section 26.5 of this act.**

2. As used in this section, "independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013, as that section existed on January 1, 2025.

Sec. 120.6. **1. Notwithstanding the amendatory provisions of section 22.5 of this act, an independent center for emergency medical care that is owned or operated by, or otherwise part of, a hospital may continue to operate without obtaining a license separate from the license of the hospital pursuant to NRS 449.080 until July 1, 2026.**

2. Notwithstanding the amendatory provisions of section 24.8 of this act, the Division of Public and Behavioral Health of the Department of Health and

Human Services shall issue a license to operate an independent center for emergency medical care that was operating on the date on which this act was enacted and is located within 5 miles of another independent center for emergency medical care or a hospital with an emergency department if the independent center for emergency medical care otherwise qualifies for licensure pursuant to NRS 449.080.

3. Notwithstanding the amendatory provisions of section 24.8 of this act, the Division of Public and Behavioral Health of the Department of Health and Human Services shall issue a license to operate an independent center for emergency medical care that is located within 5 miles of another independent center for emergency medical care or a hospital with an emergency department and that otherwise qualifies for licensure pursuant to NRS 449.080 at the time of the application for licensure if, on or before January 1, 2025, the owner or operator of the independent center for emergency medical care had:

(a) Acquired the land upon which the independent center for emergency medical care is to be constructed;

(b) Obtained or was in the process of obtaining all necessary permits, licenses or other required approvals necessary for the construction of the independent center for emergency medical care; and

(c) Commenced the process of obtaining approval from the Director of the Department of Health and Human Services pursuant to NRS 439A.100 or 439A.102, if applicable.

4. As used in this section, "independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013, as amended by section 22.5 of this act.

Sec. 121. 1. During the 2025-2026 interim, the Patient Protection Commission shall study the adequacy of the academic medical centers in this State. The study must include, without limitation:

(a) An assessment of the current and projected health care workforce in this State;

(b) An evaluation of potential locations for the development or enhancement of academic medical centers in this State, which must consider, without limitation:

(1) Equity among the geographic areas of this State; and

(2) The needs of the population in the diverse geographic areas of this State for the services of an academic medical center;

(c) An analysis of models for sustainable funding of academic medical centers that utilize money from the State and Federal Governments and private persons and entities;

(d) Recommendations for integrating existing public and private medical institutions into a cohesive statewide academic medical system;

(e) Identification of strategies to expand programs for residency training and postdoctoral fellowships for physicians with a focus on specialties for which a high need exists and on underserved geographic areas of this State;

(f) Exploration of opportunities for partnerships between the public and private sector to support the operations of academic medical centers and economic development relating to health care; and

(g) An evaluation of the ability of various models of governance for academic medical centers to ensure accountability, facilitate the input of interested persons and entities and align the activities of the academic medical center with the long-term goals of the State Government relating to health care.

2. In conducting the study described in subsection 1, the Patient Protection Commission shall consult with:

(a) Experts in health care, academic institutions and economics; and

(b) Representatives of various communities in this State.

3. ~~[The Patient Protection Commission may request the drafting of not more than two legislative measures to implement any recommendations resulting from the study conducted pursuant to subsection 1. Any such request must be submitted to the Legislative Counsel on or before September 1, 2026. Such requests are in addition to the requests for the drafting of legislative measures authorized by NRS 218D.213.~~

~~4.]~~ On or before November 6, 2026, the Patient Protection Commission shall:

(a) Compile a comprehensive report of the findings and recommendations resulting from the study conducted pursuant to subsection 1; and

(b) Submit the report to:

(1) The Governor; and

(2) The Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature.

~~[5.]~~ **4.** As used in this section:

(a) "Academic medical center" means a medical school and its affiliated teaching hospitals and clinics that:

(1) Operate a program for residency training and postdoctoral fellowships for physicians, and

(2) Conduct research that is overseen by the United States Department of Health and Human Services and involves human subjects.

(b) "Patient Protection Commission" means the Patient Protection Commission created by NRS 439.908.

Sec. 121.5. **If Senate Bill No. 494 of this session is enacted and creates the Nevada Health Authority, the Office of Mental Health created by section 67 of this act is transferred from the Department of Health and Human Services to the Nevada Health Authority.**

Sec. 122. 1. The amendatory provisions of this act do not apply to a request for prior authorization submitted:

(a) Under a contract or policy of health insurance issued before January 1, 2028, but apply to any request for prior authorization submitted under any renewal of such a contract or policy.

(b) To the Department of Health and Human Services before January 1, 2028, for medical or dental care provided to a recipient of Medicaid.

2. A health carrier must, in order to continue requiring prior authorization in contracts or policies of health insurance issued or renewed after January 1, 2028:

(a) Develop a procedure for obtaining prior authorization that complies with NRS 687B.225, as amended by section 110 of this act, and sections 97 to 108, inclusive, of this act; and

(b) Obtain the approval of the Commissioner of Insurance pursuant to NRS 687B.225, as amended by section 110 of this act, and sections 97 to 108, inclusive, of this act for the procedure developed pursuant to paragraph (a).

3. As used in this section, "health carrier" has the meaning ascribed to it in section 98 of this act.

Sec. 122.5. **The Department of Health and Human Services:**

1. Is not required to implement the provisions of subsections 9, 10 and 11 of section 56 of this act until January 1, 2029; and

2. May, between January 1, 2028, and January 1, 2029, collect such data from providers of services under Medicaid as may be necessary to prepare to implement those provisions.

Sec. 123. 1. Any administrative regulations adopted by an officer, agency or other entity whose name has been changed or whose responsibilities have been transferred pursuant to the provisions of this act to another officer, agency or other

entity remain in force until amended by the officer, agency or other entity to which the responsibility for the adoption of the regulations has been transferred.

2. Any contracts or other agreements entered into by an officer or agency whose name has been changed or whose responsibilities have been transferred pursuant to the provisions of this act to another officer or agency are binding upon the officer or agency to which the responsibility for the administration of the provisions of the contract or other agreement has been transferred. Such contracts and other agreements may be enforced by the officer or agency to which the responsibility for the enforcement of the provisions of the contract or other agreement has been transferred.

3. Any action taken by an officer or agency whose name has been changed or whose responsibilities have been transferred pursuant to the provisions of this act to another officer or agency remains in effect as if taken by the officer or agency to which the responsibility for the enforcement of such actions has been transferred.

Sec. 124. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 125. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 126. NRS ~~[687B.723 and 695D.2153 are]~~ **450B.215 is** hereby repealed.

Sec. 127. 1. This section and sections 1 to ~~[18,]~~ **3.3,** inclusive, ~~[42,]~~ **4, 4.5, 5, 6, 8, 14 to 18, inclusive, 32.5, 43, 45.5, 67.9,** 70, 71, **72.3, 72.5, 116.3, 116.7 and** 123 ~~[, 124 and 125]~~ **to 126, inclusive,** of this act become effective upon passage and approval.

2. Sections **5.5, 7,** 33 to 40, inclusive, ~~[67,]~~ **42, 66.3 to 67.8, inclusive,** 119, 120 **,** ~~[and]~~ 121 **and 121.5** of this act become effective on July 1, 2025.

3. Sections **3.6, 8.5 to 13.5, inclusive,** 19, 20, ~~[23]~~ **22.5** to 32, inclusive, 41, ~~[43,]~~ **41.5, 42.5,** 46, 48 to ~~[51,]~~ **51.3,** inclusive, 68, **72.8,** 73, 74, 76 to 84, inclusive, 86 to 90, inclusive, **95.5,** 109, 111, 112 **,** ~~[and]~~ 113 **, 120.3 and 120.6** of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2026, for all other purposes.

4. Sections 75 and 85 of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On July 1, 2026, for all other purposes.

5. **Section 119.5 of this act becomes effective on July 1, 2026.**

6. Sections 51.5 and 51.8 of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On October 1, 2026, for all other purposes.

7. Sections 21, 117 and 118 of this act become effective on January 1, 2027.

~~[6.]~~ **8.** Sections 22, 44, 45, 47, 52 to 66, inclusive, 69, 72, 91 to **95, inclusive, and 96 to** 108, inclusive, 110, 114, 115, 116, 122 and ~~[126]~~ **122.5** of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2028, for all other purposes.

TEXT OF REPEALED ~~[SECTIONS]~~ SECTION

~~[~~~~687B.723 Claim for dental care: Health carrier or administrator of health benefit plan prohibited from denying claim for which prior authorization has been granted; exceptions.~~

~~1. A health carrier which provides dental coverage or an administrator of a health benefit plan that includes dental coverage shall not refuse to pay a claim for dental care for which the health carrier or administrator, as applicable, has granted prior authorization unless:~~

~~(a) A limitation on coverage provided under the applicable health benefit plan, including, without limitation, a limitation on total costs or frequency of services:~~

~~(1) Did not apply at the time the prior authorization was granted; and~~

~~(2) Applied at the time of the provision of the dental care for which the prior authorization was granted because additional covered dental care was provided to the insured after the prior authorization was granted and before the provision of the dental care for which prior authorization was granted;~~

~~(b) The documentation provided by the person submitting the claim clearly fails to support the claim for which prior authorization was originally granted;~~

~~(c) After the prior authorization was granted, additional dental care was provided to the insured or the condition of the insured otherwise changed such that:~~

~~(1) The dental care for which prior authorization was granted is no longer medically necessary; or~~

~~(2) The health carrier or administrator, as applicable, would be required to deny prior authorization under the terms and conditions of the applicable health benefit plan that were in effect at the time of the provision of the dental care for which prior authorization was granted;~~

~~(d) Another person or entity is responsible for the payment;~~

~~(e) The dentist has previously been paid for the procedures covered by the claim;~~

~~(f) The claim was fraudulent or the prior authorization was based, in whole or in part, on materially false information provided by the dentist or insured or another person who is not affiliated with the health carrier or administrator, as applicable; or~~

~~(g) The insured was not eligible to receive the dental care for which the claim was made on the date that the dental care was provided.~~

~~2. Any provision of a contract that conflicts with this section is against public policy, void and unenforceable.~~

~~3. As used in this section:~~

~~(a) "Medically necessary" means dental care that a prudent dentist would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that is necessary and:~~

~~(1) Provided in accordance with generally accepted standards of dental practice;~~

~~(2) Clinically appropriate with regard to type, frequency, extent, location and duration;~~

~~(3) Not primarily provided for the convenience of the patient or dentist;~~

~~(4) Required to improve a specific dental condition of a patient or to preserve the existing state of oral health of the patient; and~~

(5) The most clinically appropriate level of dental care that may be safely provided to the patient.

(b) "Prior authorization" means any communication issued by a health carrier which provides dental coverage or an administrator of a health benefit plan that includes dental coverage in response to a request by a dentist in the form prescribed by the health carrier or administrator, as applicable, which indicates that specific dental care provided to an insured is:

(1) Covered under the health benefit plan issued to the insured; and

(2) Reimbursable in a specific amount, subject to applicable deductibles, copayments and coinsurance.

695D.2153 Claims: Organization for dental care or administrator prohibited from denying claim for which prior authorization has been granted; exceptions.

1. An organization for dental care or an administrator of a dental plan shall not refuse to pay a claim for dental care for which the organization for dental care or administrator, as applicable, has granted prior authorization unless:

(a) A limitation on coverage provided under the applicable plan for dental care, including, without limitation, a limitation on total costs or frequency of services:

(1) Did not apply at the time the prior authorization was granted; and

(2) Applied at the time of the provision of the dental care for which the prior authorization was granted because additional covered dental care was provided to the member after the prior authorization was granted and before the provision of the dental care for which prior authorization was granted;

(b) The documentation provided by the person submitting the claim clearly fails to support the claim for which prior authorization was originally granted;

(c) After the prior authorization was granted, additional dental care was provided to the member or the condition of the member otherwise changed such that:

(1) The dental care for which prior authorization was granted is no longer medically necessary; or

(2) The organization for dental care or administrator, as applicable, would be required to deny prior authorization under the terms and conditions of the applicable plan for dental care that were in effect at the time of the provision of the dental care for which prior authorization was granted;

(d) Another person or entity is responsible for the payment;

(e) The dentist has previously been paid for the procedures covered by the claim;

(f) The claim was fraudulent or the prior authorization was based, in whole or in part, on materially false information provided by the dentist or member or another person who is not affiliated with the organization for dental care or administrator, as applicable; or

(g) The member was not eligible to receive the dental care for which the claim was made on the date that the dental care was provided.

2. Any provision of a contract that conflicts with this section is against public policy, void and unenforceable.

3. As used in this section:

(a) "Medically necessary" means dental care that a prudent dentist would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that is necessary and:

(1) Provided in accordance with generally accepted standards of dental practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not primarily provided for the convenience of the patient or dentist;

~~(4) Required to improve a specific dental condition of a patient or to preserve the existing state of oral health of the patient; and~~

~~(5) The most clinically appropriate level of dental care that may be safely provided to the patient.~~

~~(b) "Prior authorization" means any communication issued by an organization for dental care or the administrator of a dental plan in response to a request by a dentist in the form prescribed by the organization for dental care or administrator, as applicable, which indicates that specific dental care provided to a patient is:~~

~~(1) Covered under the plan for dental care issued to the member; and~~

~~(2) Reimbursable in a specific amount, subject to applicable deductibles, copayments and coinsurance.~~**]**

450B.215 Administrative sanctions for failure to comply with requirements concerning electronic health information.

1. If the health authority receives notification from the Department of Health and Human Services pursuant to NRS 439.5895 that the holder of a permit to operate an ambulance, air ambulance or vehicle of a fire-fighting agency is not in compliance with the requirements of subsection 4 of NRS 439.589, the health authority may, after notice and the opportunity for a hearing in accordance with the provisions of this chapter, require corrective action or impose an administrative penalty in an amount established by regulation of the board.

2. The health authority shall not suspend or revoke a permit for failure to comply with the requirements of subsection 4 of NRS 439.589.