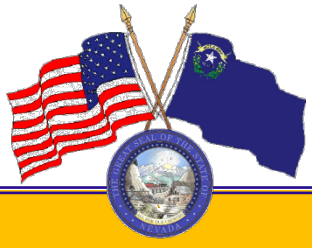
Bulletin No. 11-18



Legislative Committee on Health Care

Legislative Counsel Bureau

January 2011

LEGISLATIVE COMMITTEE ON HEALTH CARE

BULLETIN NO. 11-18

JANUARY 2011

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SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMITTEE ON HEALTH CARE

Nevada Revised Statutes 439B.200

This summary presents the recommendations approved by the Legislative Committee on Health Care (LCHC) (*Nevada Revised Statutes* [NRS] 439B.200) at its July 20, 2010, meeting. The LCHC submits the following recommendations and bill draft requests (BDRs) to the 76th Session of the Nevada Legislature:

PROPOSALS RELATING TO THE EXAMINATION OF THE HEIGHT AND WEIGHT OF CHILDREN PURSUANT TO ASSEMBLY BILL 191 (CHAPTER 285, *STATUTES OF NEVADA 2009*)

1. Codify the Statewide School Wellness Policy in accordance with the federal guidelines. Create the Statewide School Wellness Rating System. **(BDR 34–188)**

2. Draft a letter to the Health Division, Nevada's Department of Health and Human Services (DHHS), and include in the LCHC bulletin a statement of support for the Health Division's development of Web Education Modules concerning nutrition and physical activity for day care providers, school teachers, health care providers, and homeschool and distance education students.

3. Draft a letter to the Health Division and include in the LCHC bulletin a statement of support for the Health Division to utilize the Silver State Stars Quality Rating Improvement System for child care centers to educate parents about child care centers that limit sugar-sweetened beverages and serve low-fat milk.

4. Draft a Committee proclamation and include in the LCHC bulletin a statement of support for the Health Division to revisit the *2006 Strategic Plan for the Prevention of Obesity in Nevada*, make obesity-related issues a priority policy and program area for Nevada, evaluate changes since 2006, and create a new five-year obesity plan.

PROPOSALS RELATING TO THE REGULATION OF MEDICAL ASSISTANTS

5. Draft legislation to establish two tiers of medical assistants (medical assistants authorized to administer dangerous drugs and medical assistants not authorized to administer dangerous drugs) and to require medical assistants to meet one of the following qualifications for employment **(BDR –189)**:

a. Medical assistants (MAs) who are currently employed are allowed to continue working as MAs; however, they must pass a national medical assistant examination and receive their certification and are not eligible to administer dangerous drugs until they are certified;

b. The test must be taken within one year after becoming eligible to take the exam if not eligible on the date of passage. If they do not pass the exam, they may retake the exam within 90 days; and

c. Medical assistants hired following the passage of this legislation are required to successfully pass the MA exam administered by either the American Association of Medical Assistants or the American Medical Technologists and must complete a training program before taking that exam and receiving their certification.

PROPOSALS RELATING TO THE STUDY OF THE ABUSE OF PRESCRIPTION NARCOTIC DRUGS IN NEVADA PURSUANT TO ASSEMBLY BILL 326 (CHAPTER 301, *STATUTES OF NEVADA 2009*)

6. Draft legislation to allow interoperability of the Prescription Controlled Substance Abuse Prevention Task Force to share information with other prescription monitoring programs. The proposed language was adopted in principle from the Alliance of States with Prescription Monitoring Programs Model Act. The language proposed by the group is as follows **(BDR 40–190)**:

> **NRS 453.154 Division required to prepare certain reports concerning controlled substances; Division and Board may enter into agreements with public agencies; requirements.**
>
> 1. In this section, "diversion" means the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use.
>
> 2. The Division shall regularly prepare and make available to other state regulatory, licensing and law enforcement agencies a report on the patterns and trends of distribution, diversion and abuse of controlled substances.
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> 3. The Board and the Division may enter into written agreements with local, state and federal agencies to improve identification of sources of diversion and to improve enforcement of and compliance with NRS 453.011 to 453.348, inclusive, and other laws and regulations pertaining to unlawful conduct involving controlled substances. An agreement must specify the roles and responsibilities of each agency that has information or authority to identify, prevent or control diversion and abuse of controlled substances. The Board and the Division may convene periodic meetings to coordinate a state program to prevent and control diversion. The Board and the Division may arrange for cooperation and exchange of information among agencies and with other states and the Federal Government.

4. The Division shall report annually to the Governor, ***Legislative Committee on Health Care***, and biennially to the presiding officer of each house of the Legislature on the outcome of the program with respect to its effect on distribution and abuse of controlled substances, including recommendations for improving control and prevention of the diversion of controlled substances in this State.

5. The Board may provide prescription monitoring information to other states' prescription monitoring programs and such information may be used by those programs consistent with this chapter.

6. The Board may request and receive prescription monitoring information from other states' prescription monitoring programs and may use such information consistent with this chapter.

7. The Board may develop the capability to transmit information to and receive information from other prescription monitoring programs employing the standards of interoperability.

8. The Board is authorized to enter into written agreements with other states' prescription monitoring programs for the purpose of sharing information to carry out the provisions of this chapter.

7. Amend NRS to provide legal immunity for a pharmacist, pharmacy, or other dispenser that makes a report in good faith to the State prescription drug monitoring program. The language proposed is as follows **(BDR 40–190)**:

A pharmacist, pharmacy, or other dispenser making a report to the program reasonably and in good faith pursuant to this provision is immune from any liability, civil, criminal, or administrative, which might otherwise be incurred or imposed as a result of the report.

PROPOSALS RELATING TO THE CONSOLIDATION OF ADMINISTRATIVE SERVICES FOR HEALTH PROFESSIONALS AND OCCUPATIONAL LICENSING BOARDS

8. Draft a letter of support for Senator Wiener's BDR related to reviewing issues regarding various boards and holding them accountable. A copy of the letter is required to be forwarded to the Senate Committee on Health and Education and the Assembly Committee on Health and Human Services.

PROPOSAL RELATING TO THE FEASIBILITY OF ESTABLISHING REGIONAL CENTERS FOR THE PREVENTION AND TREATMENT OF ALCOHOL AND SUBSTANCE ABUSE PURSUANT TO SENATE BILL 278 (CHAPTER 267, *STATUTES OF NEVADA 2009*)

9. Draft an LCHC proclamation to recognize the efforts of the Local Community Coalition System for Prevention in Nevada (local alcohol and drug abuse prevention coalitions).

PROPOSAL RELATING TO THE RECENTLY ENACTED PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (PUBLIC LAW 111-148), THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (PUBLIC LAW 111-152), AND THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (PUBLIC LAW 111-3)

10. Draft an LCHC proclamation urging Nevada's Department of Health and Human Services to support meritorious applications from State organizations to obtain available outreach grants from the United States Department of Health and Human Services to enroll children and their families in Nevada Medicaid/Nevada Check Up.

11. Draft an LCHC proclamation urging the DHHS to adopt five of the eight program features required by the Children's Health Insurance Program Reauthorization Act in order to qualify for a performance bonus.

12. Draft an LCHC proclamation urging the DHHS to study the feasibility of applying for a "Community First Choice Option" under Section 1915 of the Social Security Act to provide community-based attendant support services to individuals with disabilities who are Medicaid eligible and require an institutional level of care.

13. Draft an LCHC proclamation urging the DHHS to study the feasibility of applying for the new Medicaid State Plan option, which will provide medical assistance to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals, or a health team as the individual's health home, for the purpose of providing the individual with a *medical home*.

PROPOSAL RELATING TO CERTAIN FEDERAL SCHOOL PROGRAMS

14. Draft a letter to the superintendents of all school districts in Nevada encouraging them to adopt district-wide breakfast policies, and at the beginning of each school year, to notify the principals and teachers that it is allowable to have breakfast in the classroom. The letter may be transmitted electronically.

15. Draft legislation that requires schools that do not meet adequate yearly progress (AYP) for three or more years to implement breakfast after the bell (breakfast in the classroom or grab-and-go breakfast). **(BDR 34–191)**

16. Draft legislation that requires **(BDR 34–191)**:

    a. Each school to report the following information to the LCHC and the Interim Finance Committee annually:

        (1) Breakfast participation rates for the previous four years. Include the number of children who receive free and reduced-price breakfast that participate and the number of enrolled children who are qualified to access meals compared to the total enrollment of each school. Identify the method of breakfasts being offered (breakfast in the classroom, breakfast in the cafeteria, or grab-and-go breakfast) and the percentage of qualified students participating by each form of school breakfast; and

        (2) The AYP for the school.

    b. Each school district is required to report:

        (1) A district-level summary of the breakfast participation report;

        (2) A list of each school that is participating in a summer meal program. Include the number of qualified students participating in the program versus those students who would qualify for a summer meal program if one were being offered. Each district should indicate the number of dollars currently received by Nevada schools for this program and the dollars that remain in Washington, D.C., because the qualified students are not offered this program or are not participating; and

        (3) The amount of federal dollars received by Nevada due to participation in school breakfast and school lunch programs. The number of qualified students who did not participate and, based on the lack of participation, the amount of federal money Nevada did not receive.

    c. Each school district to increase by at least 15 percent annually the number of pupils who participate in the school breakfast program until the school district has total participation of pupils eligible for free or reduced-price breakfasts.

PROPOSAL RELATING TO ESTABLISHING A FAIR AND EQUITABLE SYSTEM FOR THE PAYMENT OF MEDICAL SERVICES PURSUANT TO SENATE CONCURRENT RESOLUTION NO. 39 (FILE NO. 101, *STATUTES OF NEVADA 2009*)

17. Draft legislation to establish that **(BDR 40–192)**:

a. An out-of-network hospital must accept for the provision of emergency services and care, as payment in full, a rate which does not exceed the amount set forth for emergency services and care pursuant to the formula established by federal regulation (see 75 Fed. Reg. 37,233-4 (June 28, 2010)). This rate would apply for any patient who is transported by ambulance or otherwise seeks emergency care (as determined pursuant to the Emergency Medical Treatment and Labor Act [EMTALA]) at an out-of-network hospital and who has a policy of insurance that covers emergency care at not less than two other hospitals in this State;

b. An out-of-network physician at an out-of-network hospital must accept for emergency services and care, other than services and care required to stabilize a patient, as payment in full, a rate that does not exceed the amount set forth for emergency services and care pursuant to the formula established by federal regulation. This rate would apply for any patient who is transported by ambulance or otherwise seeks emergency care (as determined pursuant to EMTALA) at an out-of-network hospital and who has a policy of insurance which covers emergency care by not less than two other physicians who provide emergency services and care at that hospital; and

c. An out-of-network physician at an in-network hospital must accept for medical services and care, other than services and care required to stabilize a patient, as payment in full, a rate that does not exceed the amount set forth for services and care pursuant to the formula established by federal regulation. This rate would apply for any patient who has a policy of insurance, which covers the type of services and care by not less than two other physicians who provide that type of service and care.

This rate would apply if the following criteria are met:

(1) The third party that issued the policy of insurance or other contractual agreement, which provides coverage to the patient, has submitted reports as required in this request;

(2) The third party, which provides coverage to the patient has, in good faith, participated in negotiations or mediations pursuant to this request and has documented the occurrence and outcome of any negotiations or mediation;

(3) The patient has paid the deductible, copayment, or coinsurance that the patient would have paid for the provision of health care by an in-network provider; and

(4) The third party has paid the hospital or physician for the services and care within 60 days after receipt of the bill or, if applicable, within 60 days after the Office for Consumer Health Assistance, Office of the Governor, concludes mediation between the third party and the hospital.

d. If an out-of-network hospital or physician believes that the rates are insufficient to compensate the hospital or physician for the services and care, the hospital or physician may enter into negotiations with the third party that provides coverage to the patient to resolve the difference between the amount charged and the amount paid by the third party. If such negotiations do not result in an agreement on the amount that will be paid for services and care, the hospital or physician may file a complaint with the Director of the Office for Consumer Health Assistance, Office of the Governor, and request that the Director mediate to determine the amount that must be paid for such services and care. Require the Director to establish a process for filing and handling complaints and mediate those complaints to determine whether the rates paid are sufficient in a particular circumstance and, if a rate is not sufficient, an acceptable rate that must be paid to the hospital or physician that filed the complaint.

Each third party that wishes for out-of-network hospitals and out-of-network physicians to accept, as payment in full, the amounts prescribed in this request shall:

(1) Review the in-network hospitals and in-network physicians of the third party to determine whether a person who is covered by that policy of insurance or other contractual agreement, which provides coverage for health care, has adequate access to health care. Require the Commissioner of Insurance to annually study the providers of health care that are included in the networks, which are established by third parties, to determine whether those networks are adequate. The Commissioner shall prescribe standards of adequacy, which are based on the results of that study. The Commissioner will make the findings public and provide a copy to the LCHC;

(2) Review the frequency with which persons covered by the policy of insurance are treated for emergency services and care by out-of-network physicians at in-network hospitals and the rate at which those services and care are reimbursed by the third party;

(3) Ensure that persons covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care receive adequate information regarding in-network hospitals and in-network physicians and the financial impact of receiving medical services and care from out-of-network hospitals and out-of-network physicians, including, without limitation, the financial impact of receiving services and care from an out-of-network physician on the medical staff of an in-network hospital. The information must be provided in a format that is meaningful for persons

making an informed decision concerning medical services and care. This information must be accessible to persons covered by the policy of insurance or other contractual agreement; and

(4) Submit, once each calendar quarter, a summary of the reviews and the educational efforts to the Commissioner of Insurance and the LCHC.

e. On or before June 30, 2014, the LCHC shall review the rate of payment to determine whether providers of health care are being adequately compensated for the provision of services and care. The LCHC shall forward the results of the review and any proposed changes to the Senate Committee on Health and Education and the Assembly Committee on Health and Human Services.

Make this legislation effective January 1, 2012, to allow sufficient time for regulations to be adopted.

PROPOSALS RELATING TO TRACKING AND REPORTING NEAR-MISS EVENTS THAT OCCUR AT MEDICAL FACILITIES IN THIS STATE PURSUANT TO SENATE BILL 319 (CHAPTER 502, *STATUTES OF NEVADA 2009*)

18. Draft legislation to require each medical facility that is required to report information pursuant to NRS 439.847 to grant permission for the Health Division to report publicly, and in a facility-specific manner, the information submitted to the National Healthcare Safety Network. The information must be presented in an equitable and comparable format, including, without limitation, as a percentage or as a ratio of incidents to 1,000 patients. **(BDR 40–193)**

19. Draft legislation to require the Health Division to include on the Internet website established and maintained pursuant to NRS 439A.270, the reports of sentinel events, which are prepared pursuant to paragraph (c) of subsection 1 of NRS 439.840 and the facility-specific information reported pursuant to NRS 439.847 for each medical facility that has given permission for such reports. **(BDR 40–193)**

PROPOSAL RELATING TO POSTGRADUATE EDUCATION FOR A LICENSE TO PRACTICE MEDICINE

20. Draft legislation to revise NRS 630.160 to allow the licensing process to begin for an applicant who: (a) is enrolled in a postgraduate residency program in this State; (b) has completed 24 months of the program; and (c) has committed, in writing, to complete a third year of the program. **(BDR 54–194)**

REPORT TO THE 76TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE

I. INTRODUCTION

The Legislative Committee on Health Care (LCHC), in compliance with *Nevada Revised Statutes* (NRS) 439B.200 through 439B.240, oversees a broad spectrum of issues related to the quality, access, and cost of health care for all Nevadans. The LCHC was established in 1987 to provide continuous oversight of matters relating to health care.

The LCHC for the 2009-2010 Interim was composed of six members. The members of the LCHC were as follows:

Senator Valerie Wiener, Chair
Assemblywoman Peggy Pierce, Vice Chair
Senator Allison Copening
Senator Maurice E. Washington
Assemblyman Joseph (Joe) P. Hardy, M.D.
Assemblywoman Ellen B. Spiegel

The following Legislative Counsel Bureau staff members provided support for the LCHC:

Marsheilah D. Lyons, Principal Research Analyst
Marjorie Paslov Thomas, Principal Research Analyst
Jennifer Chisel, Senior Research Analyst
Melinda Martini, Senior Research Analyst
Sara L. Partida, Principal Deputy Legislative Counsel
Sally Trotter, Senior Research Secretary

The LCHC held a total of eight meetings, including a work session. All public hearings were conducted through simultaneous videoconferences between legislative meeting rooms at the Grant Sawyer State Office Building in Las Vegas, Nevada, and the Legislative Building in Carson City, Nevada. The summaries of testimony and exhibits are available online at: http://leg.state.nv.us/Interim/75th2009/Committee/StatCom/HealthCare/?ID=18

II. REVIEW OF COMMITTEE FUNCTIONS

The primary responsibilities of the LCHC are established pursuant to NRS 439B.220 through 439B.240. These responsibilities include: (a) reviewing and evaluating the quality and effectiveness of programs for the prevention of illness; (b) reviewing and comparing the costs of medical care among communities in Nevada with similar communities in other states; and (c) analyzing the overall system of medical care in the State. In addition, members strive

to avoid duplication of services and achieve the most efficient use of all available resources. The LCHC may also review health insurance issues, as well as examine hospital-related issues, medical malpractice issues, and the health education system. (See **Appendix A** for the statute that governs the LCHC.)

Further, certain entities are required by statute to submit reports to the LCHC, including:

- A report of the activities and operations of the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS), concerning the review of health care costs. The report must be submitted on or before October 1 of each year as required by NRS 449.520.

- An annual report concerning the review of the health and health needs of the residents of this State and a system to rank the health problems of the residents of this State, including, without limitation, the specific health problems that are endemic to urban and rural communities and the allocations of money from the Fund for a Healthy Nevada pursuant to NRS 439.630 to determine whether the allocations reflect the needs of this State and the residents of this State.

- A quarterly report, as required by NRS 450B.795, from the Health Division, DHHS, State Board of Health, regarding its finding in the study concerning the cause of excessive waiting time for a person to receive emergency services and care from a hospital after being transported to the hospital by a provider of emergency medical services.

- A quarterly report as required by NRS 422.2728, from the DHHS concerning program benefits provided through the Health Insurance Flexibility and Accountability waiver.

III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS FOR THE STATE OF NEVADA

A variety of issues were addressed at the meetings of the LCHC. This section provides background information and discusses only those issues for which the LCHC made recommendations. These issues relate to:

A. Height and Weight of Children;
B. Medical Assistants;
C. Abuse of Prescription Narcotic Drugs in Nevada;
D. Health Professional and Occupational Licensing Boards;
E. Local Alcohol and Substance Abuse Prevention Coalitions;
F. Federal Health Care Reform and Reauthorization Legislation;
G. Federal School Nutrition Programs;
H. System for the Payment of Medical Services;
I. Near-Miss Events That Occur in Medical Facilities; and
J. Postgraduate Education for a License to Practice Medicine.

At the eighth meeting, members conducted a work session at which they adopted ten recommendations to be included in seven bill draft requests (BDRs). The BDRs concern: (1) the establishment of a statewide school wellness policy; (2) regulation of medical assistants; (3) provisions related to controlled substances; (4) school nutrition programs; (5) payment for provision of certain services and care and reports relating to those services and care; (6) reporting of sentinel and near-miss events; and (7) provisions governing licensure of certain physicians. Lastly, members authorized the Chair to send five proclamations and four letters on behalf of the LCHC.

A. HEIGHT AND WEIGHT OF CHILDREN

Assembly Bill 191 (Chapter 285, *Statutes of Nevada 2009*) extended the date for the LCHC study on the height and weight of pupils to June 30, 2015, and authorized the LCHC to identify any programs, practices, and studies that would address the needs of children in Nevada to maintain a healthy weight. Several areas related to this topic were considered, including: data collection concerning the height and weight of pupils; nutrition and physical activity programs and information; and obesity prevention in Nevada. In addition, recommendations that address school nutrition programs are addressed in the section of this bulletin related to Federal School Nutrition Programs.

1. Nutrition and Physical Activity Information

Testimony from the Advisory Council on the State Program for Fitness and Wellness indicated the benefits of developing web-based educational modules on nutrition and physical activity for day care providers, school teachers, and health care providers. The Nutrition Module will increase providers' and teachers' understanding of how calories, carbohydrates, fats, proteins, and fiber impact children's weight, learning ability, and behavioral actions. This increased education encourages day care providers to offer healthier food options for children, school teachers advocating for healthier snacks in class, as well as educating their own students; and for health care providers to educate parents on the importance and impact of good nutrition. Additionally, the Physical Activity Module increases their understanding of how physical activity creates a healthier body and mind, which can result in increased learning, improved behavior, and decreased Body Mass Index (BMI) scores. At the conclusion of each module a knowledge-based examination is taken to ensure knowledge retention and to encourage implementation.

Testimony indicated that child care centers contribute to problems related to poor nutrition by serving sugar-sweetened beverages to children. To address this and other nutrition concerns related to child care centers a recommendation was made to utilize the Silver State Stars Quality Rating Improvement System for child care centers to educate parents about child care centers that limit sugar-sweetened beverages and serve low-fat milk. Testimony indicated that this effort would allow parents to make informed decisions about which child care facilities are choosing appropriate healthy foods as well as proper portion sizes. This initiative has the

potential to impact up to 943 licensed child care facilities and approximately 37,000 children and their parents.

Following consideration of these recommendations, the LCHC agreed to:

> **Draft a letter to the Health Division and include in the LCHC bulletin a statement of support for the Health Division's development of Web Education Modules concerning nutrition and physical activity for day care providers, school teachers, health care providers, and home school and distance education students.**
>
> AND
>
> **Draft a letter to the Health Division and include in the LCHC bulletin a statement of support for the Health Division to utilize the Silver State Stars for Quality Rating Improvement System for child care centers to educate parents about child care centers that limit sugar-sweetened beverages and serve low-fat milk.**

2. Strategic Plan for the Prevention of Obesity in Nevada

Nevada currently has a State Obesity Plan that was established in 2006. Testimony indicated that although the plan was developed, it has not been regularly updated nor has it been used to make obesity related issues a priority area in Nevada. It was recommended that: the plan is revisited; obesity becomes a priority area for Nevada; the changes in Nevada since 2006 are evaluated; and a new five-year obesity plan be created. It was further recommended that the BMI data that is currently being collected through 2015 serve as supporting data to assist in showing that Nevada is meeting certain goals among the youth segment of the population.

After discussion concerning this recommendation, the LCHC moved to:

> **Draft a Committee proclamation and include in the LCHC bulletin a statement of support for the Health Division to revisit the *2006 Strategic Plan for the Prevention of Obesity in Nevada*, make obesity-related issues a priority policy and program area for Nevada, evaluate changes since 2006, and create a new five-year obesity plan.**

B. MEDICAL ASSISTANTS

During the 2010 interim, questions arose regarding the supervision of medical assistants (MAs), the qualification of MAs, the identification of MAs, and the scope of services that may be provided by MAs in Nevada. Nevada law does not require certification or licensure of MAs. While some organizations offer voluntary certification of MAs, such certification is not required for employment in Nevada.

Nevada Administrative Code 630.230, provides that a physician or physician assistant shall not allow any person to act as a MA in the treatment of a patient unless the MA has sufficient training and the physician or physician assistant provides adequate supervision of a MA who is employed or supervised by the physician or physician assistant. However, Nevada law does not contain any further references to the scope of services that may be provided by MAs or the supervision of MAs. Additionally, the provisions of Chapter 454 of NRS relating to the possession, administration, and dispensing of dangerous drugs does not enumerate MAs among those who have authority to possess and administer dangerous drugs.

Testimony provided by the Board of Medical Examiners, the State Board of Osteopathic Medicine, and other professionals emphasized the role of physicians in training and supervising MAs. Furthermore, testimony indicated that both entities were attempting to provide certain clarification on this issue through regulation. The LCHC also received testimony regarding key scope of practice laws in other states, training requirements, and certifications for MAs, and exemptions in other states.

Following a review of the testimony on this issue, the LCHC indicated its intentions to define the qualification of MAs in Nevada. The LCHC agreed to:

> **Draft legislation to establish two tiers of medical assistants (medical assistants authorized to administer dangerous drugs and medical assistants not authorized to administer dangerous drugs) and to require medical assistants to meet one of the following qualifications for employment (BDR –189)**:
>
> 1. **Medical assistants who are currently employed are allowed to continue working as MAs; however, they must pass a national medical assistant examination and receive their certification and are not eligible to administer dangerous drugs until they are certified;**
>
> 2. **The test must be taken within one year after becoming eligible to take the exam if not eligible on the date of passage. If they do not pass the exam, they may retake the exam within 90 days; and**

3. **Medical assistants hired following the passage of this legislation are required to successfully pass the MA exam administered by either the American Association of Medical Examiners or the American Medical Technologists and must complete a training program before taking that exam and receiving their certification.**

C. ABUSE OF PRESCRIPTION NARCOTIC DRUGS IN NEVADA

The LCHC, in cooperation with the State Board of Pharmacy, the State Board of Medical Examiners, and the State Board of Osteopathic Medicine, was directed to conduct a study of the abuse of prescription narcotic drugs in Nevada pursuant to Assembly Bill 326 (Chapter 301, *Statutes of Nevada 2009*). Several recommendations resulted from the collaborative work of the various boards and interested parties. In addition to other recommendations, it was recommended that NRS be amended to: (1) allow for the Prescription Controlled Substance Abuse Prevention Task Force to share information with other prescription monitoring programs; and (2) provide legal immunity for a pharmacist, pharmacy, or other dispenser that makes a report in good faith to the State prescription drug monitoring program.

1. Sharing Information With Prescription Monitoring Programs in Other States

Testimony indicated that 34 states have prescription drug monitoring programs (PMPs). Additionally, it was emphasized that the implementation of the first recommendation would assist the Task Force in efforts to continue to be eligible to receive grants from the federal government, which is promoting the interoperability of PMPs. Appreciating the opportunities for additional funding to support this effort, and the safeguards that are in place as this information is shared, the LCHC chose to:

Draft legislation to allow interoperability of the Prescription Controlled Substance Abuse Prevention Task Force to share information with other prescription monitoring programs. The proposed language was adopted in principle from the Alliance of States with Prescription Monitoring Programs Model Act. The language proposed by the group is as follows (BDR 40–190):

NRS 453.154 Division required to prepare certain reports concerning controlled substances; Division and Board may enter into agreements with public agencies; requirements.

1. In this section, "diversion" means the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use.

2. The Division shall regularly prepare and make available to other state regulatory, licensing and law enforcement agencies a report on the patterns and trends of distribution, diversion, and abuse of controlled substances.

3. The Board and the Division may enter into written agreements with local, state, and federal agencies to improve identification of sources of diversion and to improve enforcement of and compliance with NRS 453.011 to 453.348, inclusive, and other laws and regulations pertaining to unlawful conduct involving controlled substances. An agreement must specify the roles and responsibilities of each agency that has information or authority to identify, prevent, or control diversion and abuse of controlled substances. The Board and the Division may convene periodic meetings to coordinate a state program to prevent and control diversion. The Board and the Division may arrange for cooperation and exchange of information among agencies and with other states and the Federal Government.

4. The Division shall report annually to the Governor, *Legislative Committee on Health Care*, and biennially to the presiding officer of each house of the Legislature on the outcome of the program with respect to its effect on distribution and abuse of controlled substances, including recommendations for improving control and prevention of the diversion of controlled substances in this State.

5. The Board may provide prescription monitoring information to other states' prescription monitoring programs and such information may be used by those programs consistent with this chapter.

6. The Board may request and receive prescription monitoring information from other states' prescription monitoring programs and may use such information consistent with this chapter.

7. The Board may develop the capability to transmit information to and receive information from other prescription monitoring programs employing the standards of interoperability.

8. The Board is authorized to enter into written agreements with other states' prescription monitoring programs for the purpose of sharing information to carry out the provisions of this chapter.

2. Legal Immunity for Reporting to the Prescription Monitoring Program

Testimony also urged the LCHC to consider the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 and potential legal ramifications for providing information to a database. It was commented that many states that have a PMP provide immunity to persons who have access to that information. As a result, the LCHC recommended the following:

Amend NRS to provide legal immunity for a pharmacist, pharmacy, or other dispenser that makes a report in good faith to the State prescription drug monitoring program. The language proposed is as follows (BDR 40-190):

A pharmacist, pharmacy, or other dispenser making a report to the program reasonably and in good faith pursuant to this division is immune from any liability, civil, criminal, or administrative, which might otherwise be incurred or imposed as a result of the report.

D. HEALTH PROFESSIONAL AND OCCUPATIONAL LICENSING BOARDS

The LCHC considered a proposal to consolidate the administrative services for health professional and occupational licensing boards. Testimony indicated that the intent of the proposal was to reduce costs and increase efficiency. Specifically, the proposal recommended the consolidation of similar administrative support functions, including: form development; application reviews; background checks; complaint processing; investigations; fee and fine collection; legal counsel; regulatory and legislative drafting and processing; and public information, including web access through a single portal to all information about all State-licensed professionals. The boards could then focus on the basic and important functions of reviewing licenses and conducting hearings as needed on complaints.

The LCHC discussed the recommendations and determined that more input from stakeholders and the affected entities was necessary. Further study of the issue and the importance of oversight were mentioned. Following deliberations the LCHC approved the following action:

Draft a letter of support for Senator Wiener's BDR related to reviewing issues regarding various boards and holding them accountable. A copy of the letter is required to be forwarded to the Senate Committee on Health and Education and the Assembly Committee on Health and Human Services.

E. LOCAL ALCOHOL AND SUBSTANCE ABUSE PREVENTION COALITIONS

The LCHC was directed to study various issues concerning the provision of public health pursuant to Senate Bill 278 (Chapter 267, *Statutes of Nevada 2009*). Three separate studies were required: (1) The Feasibility of Establishing Health Districts in Counties With Populations Less Than 100,000; (2) The Feasibility of Consolidating or Integrating Certain Health and Social Services in Counties With Populations of 400,000 or More; and (3) The Feasibility of Establishing Regional Centers for the Prevention and Treatment of Alcohol and Substance Abuse. While all three studies were considered during the current interim, the only recommendations presented were for the final study concerning the prevention and treatment of alcohol and substance abuse.

Testimony indicated that 12 community substance prevention coalitions exist. Together the 12 coalitions comprise the Nevada Statewide Partnership of Prevention Coalitions and, along with the Substance Abuse Prevention and Treatment Agency (SAPTA), Division of Mental Health and Developmental Services, DHHS, they constitute the community substance abuse prevention planning system in Nevada. The coalitions are funded through the State Prevention Infrastructure, Methamphetamine Prevention Education and Public Awareness Grant, the

Governor's portion of the Safe and Drug-Free Schools Grant, and the Substance Abuse Prevention and Treatment Block Grant.

Testimony indicated that the coalition system may be susceptible to structural revisions, despite the consistent support of SAPTA and national recognition from the Center for Substance Abuse Prevention for the local coalition process and the model established in Nevada. Thus, the Statewide Partnership of Prevention Coalition Association recommended legislatively recognizing the local Community Coalition System for Prevention in Nevada.

The LCHC considered: potential funding constraints and fluctuations to support prevention efforts; the ability to maintain local input with regard to decisions related to services offered at the local level; and the ability of the local community coalitions to provide staffing and support for community strategic prevention planning activities. Following deliberation on this issue, the LCHC approved the following action:

> **Draft an LCHC proclamation to recognize the efforts of the local Community Coalition System for Prevention in Nevada (local alcohol and drug abuse prevention coalitions).**

F. FEDERAL HEALTH CARE REFORM AND REAUTHORIZATION LEGISLATION

Major changes in health care came about in Nevada and across the nation with the recently enacted Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Additional challenges and opportunities were presented with passage of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3).

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 expand coverage to 32 million additional Americans. It relies on a combination of Medicaid expansions, subsidies, tax credits, and mandates. The law also allocates money to improve quality and halts certain widely criticized insurance practices. The biggest changes come in 2014 when Medicaid expands and states create exchanges or marketplaces for health insurance. Currently, the federal changes provide a list of competitive grants and funding to help states set up consumer assistance offices, review insurers' rate hikes, support home nurse visits to high-risk pregnant women, and provide sex education and abstinence programs, among other things. Plus, the federal law directly allocates $11 billion to support community health centers.[1]

Nevada Medicaid and Nevada Check Up

The Patient Protection and Affordable Care Act of 2010, the Health Care and Education Reconciliation Act of 2010, and the Children's Health Insurance Program Reauthorization Act

[1] Health Reform Overview, Health Reform Implementation, NCSL Website

of 2009 offer opportunities for grants, performance bonuses, and new options to expand coverage or services through the Medicaid and Nevada Check Up programs. Recommendations were presented to encourage the DHHS to: apply for outreach grants to enroll eligible families in Nevada Medicaid and Nevada Check Up; implement required program features in the Children's Health Insurance Program Reauthorization Act in order to qualify for a performance bonus; study the feasibility of applying for a "Community First Choice Option," and study the feasibility of applying for the new Medicaid State Plan option, which will provide medical assistance to eligible individuals with chronic conditions who select a medical home. Following discussion on this issue, the LCHC members recommended the following:

Draft an LCHC proclamation urging the DHHS to support meritorious applications from State organizations to obtain available outreach grants from the United States Department of Health and Human Services to enroll children and their families in Nevada Medicaid/Nevada Check Up.

Draft an LCHC proclamation urging the DHHS to adopt five of the eight program features required by the Children's Health Insurance Program Reauthorization Act in order to qualify for a performance bonus.

Draft an LCHC proclamation urging the DHHS to study the feasibility of applying for a "Community First Choice Option" under Section 1915 of the Social Security Act to provide community-based attendant support services to individuals with disabilities who are Medicaid eligible and require an institutional level of care.

Draft an LCHC proclamation urging the DHHS to study the feasibility of applying for the new Medicaid State Plan option, which will provide medical assistance to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals, or a health team as the individual's health home, for the purpose of providing the individual with a *medical home*.

G. FEDERAL SCHOOL NUTRITION PROGRAMS

During presentations regarding the Study of the Height and Weight of Children, food insecurity, and obesity, the significance of federally funded nutrition programs in Nevada was emphasized. Testimony based on 2008 data indicated that 11.3 percent of Nevadans live below the poverty threshold, while 15 percent of Nevada's children live below the poverty threshold. Additionally, testimony outlined that 12.4 percent of Nevada's overall population and 18.5 percent of Nevada's children are food insecure. Food insecurity is defined as the lack of adequate food at all times to live a healthy lifestyle. Several presenters emphasized the relationship between food insecurity and obesity.

According to testimony, the ability to leverage federal funding to address hunger and food insecurity is substantial. Testimony further reported that there are $200 million federal dollars available to combat hunger. Several recommendations were presented to offer services to children, families, and seniors to end hunger, which include: (1) food stamp outreach; (2) mobile pantry programs; (3) nutrition education; (4) summer and afterschool meals; (5) full implementation of the U.S. Department of Agriculture nutrition programs; (6) education for social service providers and the public regarding nutrition programs; (7) public-private partnerships; (8) simplifying the food stamp application process; (9) developing a State plan to end hunger and food insecurity; and (10) a benchmark measurement for successfully combating hunger in Nevada.

Considering these recommendations and others, the LCHC focused on several ways to better utilize federal school nutrition programs to address the problem of hunger in Nevada.

1. Statewide School Wellness Policy and Rating System

The Child Nutrition and WIC Reauthorization Act of 2004 (Public Law 108-265) required each local educational agency participating in a program authorized by the Richard B. Russell National School Lunch Act to establish a local school wellness policy for schools under the local educational agency. The Nevada Statewide School Wellness Policy was drafted from recommendations made by community shareholders and the Nevada Nutrition Advisory Committee and became effective in July 2005.

Testimony indicated an increase in the number of free and reduced-price eligible students in 15 out of Nevada's 17 school districts. In addition, it was indicated that high-poverty schools with a high eligibility rate for the school meal program also have low participation rates. Testimony indicated that one of the primary reasons for the lack of participation is "competitive foods," which are foods found in vending machines and ala carte school stores. While the Nevada Statewide School Wellness Policy directs schools to establish policies that prohibit (with some exceptions) foods of minimal nutritional value from being given away, sold, or used as incentives for students or student activities during the school day, reports regarding the implementation of the wellness policy in classrooms are inconsistent. According to testimony, a low number of schools return questionnaires regarding their compliance with the policy. To provide greater accountability regarding adherence to the Nevada Statewide School Wellness Policy, it was recommended that the school wellness policy be placed in statute with sanctions for noncompliance. Additionally, it was recommended that a consistent statewide school wellness rating system be established. After deliberations the LCHC agreed to:

> **Codify the Statewide School Wellness Policy in accordance with the federal guidelines. Create the Statewide School Wellness Rating System. (BDR 34-188)**

2. School Breakfast and Summer Meal Programs

Testimony indicated that major differences exist in the participation rates for school nutrition programs among schools across the State, even when considering the number of schools that have a higher percentage of students that qualify for free or reduced-price lunch. According to testimony, 482 schools in Nevada currently participate in the school breakfast program with 168 of those schools at an 18 percent or greater participation rate. To encourage greater participation in school nutrition programs and to provide greater accountability and data to review efforts to increase participation, the LCHC agreed to:

Draft a letter to the superintendents of all school districts in Nevada encouraging them to adopt district-wide breakfast policies, and at the beginning of each school year, to notify the principals and teachers that it is allowable to have breakfast in the classroom. The letter may be transmitted electronically.

Draft legislation that requires schools that do not meet adequate yearly progress (AYP) for three or more years to implement breakfast after the bell (breakfast in the classroom or grab-and-go breakfast). (BDR 34–191)

Draft legislation that requires (BDR 34–191):

a. Each school to report the following information to the LCHC and the Interim Finance Committee annually:

(1) Breakfast participation rates for the previous four years. Include the number of children who receive free and reduced-price breakfast that participate and the number of enrolled children who are qualified to access meals compared to the total enrollment of each school. Identify the method of breakfasts being offered (breakfast in the classroom, breakfast in the cafeteria, or grab-and-go breakfast) and the percentage of qualified students participating by each form of school breakfast; and

(2) The AYP for the school.

b. Each school district to report:

(1) A district-level summary of the breakfast participation report;

(2) A list of each school that is participating in a summer meal program. Include the number of qualified students participating in the program versus those students who would qualify for a summer meal program if one were being offered. Each district should indicate the number of dollars currently received by

Nevada schools for this program and the dollars that remain in Washington, D.C., because the qualified students are not offered this program or are not participating; and

(3) The amount of federal dollars received by Nevada due to participation in school breakfast and school lunch programs. The number of qualified students who did not participate and, based on the lack of participation, the amount of federal money Nevada did not receive.

c. Each school district to increase by at least 15 percent annually the number of pupils who participate in the school breakfast program until the school district has total participation of pupils eligible for free or reduced-price breakfasts.

H. SYSTEM FOR THE PAYMENT OF MEDICAL SERVICES

Pursuant to Senate Concurrent Resolution No. 39 (File No. 101, *Statutes of Nevada 2009*), the LCHC was directed to review methods for establishing a fair and equitable system for the payment of certain medical services. Specifically, the payment system addresses individuals who are covered by a policy of insurance or other contractual agreement with a third party for their health care coverage; but their insurance or other contractual agreement does not cover expenses by the specific hospital or physician that provided the service or care. Frequently this is referred to as a "noncontracted" or "out-of-plan" hospital or physician.

In conducting this review, the LCHC considered:

- The relationship between the actual cost to hospitals and physicians to provide medical services and care and the charges billed by those providers of health care;

- The process used by providers of health care in this State and health insurers and other third parties that provide coverage for the provision of health care to negotiate contracts;

- The process for granting hospital privileges to physicians in this State and related issues concerning contracts with health insurers and other third parties that provide coverage for the provision of health care; and

- Balance billing and collection practices implemented by providers of health care in this State and the effects of the escalation of billed charges on the cost of health care.

In addition to other issues raised, the LCHC heard testimony regarding: rising health care costs and their impact on consumers, third-party payers, and facilities; concerns regarding the shifting of costs, nonpayment by patients, and Medicaid payment reductions; third-party payer network adequacy concerns; differences between traditional commercial insurance and

managed care insurance; the differences between State-licensed insurance plans and other types of contractual agreements with third-party payers; the impact of health care professional shortages; and patient education with regard to coverage and the cost of services or care.

Following deliberations on this issue the LCHC voted to recommend the following:

Draft legislation to establish that (BDR 40–192):

1. **An out-of-network hospital must accept for the provision of emergency services and care, as payment in full, a rate which does not exceed the amount set forth for emergency services and care pursuant to the formula established by federal regulation (see 75 Fed. Reg. 37,233-4 (June 28, 2010)). This rate would apply for any patient who is transported by ambulance or otherwise seeks emergency care (as determined pursuant to the Emergency Medical Treatment and Active Labor Act [EMTALA]) at an out-of-network hospital and who has a policy of insurance that covers emergency care at not less than two other hospitals in this State;**

2. **An out-of-network physician at an out-of-network hospital must accept for emergency services and care, other than services and care required to stabilize a patient, as payment in full, a rate that does not exceed the amount set forth for emergency services and care pursuant to the formula established by federal regulation. This rate would apply for any patient who is transported by ambulance or otherwise seeks emergency care (as determined pursuant to EMTALA) at an out-of-network hospital and who has a policy of insurance which covers emergency care by not less than two other physicians who provide emergency services and care at that hospital; and**

3. **An out-of-network physician at an in-network hospital must accept for medical services and care, other than services and care required to stabilize a patient, as payment in full, a rate that does not exceed the amount set forth for services and care pursuant to the formula established by federal regulation. This rate would apply for any patient who has a policy of insurance, which covers the type of services and care by not less than two other physicians who provide that type of service and care.**

4. **This rate would apply if the following criteria are met:**

    a. **The third party that issued the policy of insurance or other contractual agreement, which provides coverage to the patient, has submitted reports as required in this request;**

b. The third party, which provides coverage to the patient has, in good faith, participated in negotiations or mediations pursuant to this request and has documented the occurrence and outcome of any negotiations or mediation;

c. The patient has paid the deductible, copayment, or coinsurance that the patient would have paid for the provision of health care by an in-network provider; and

d. The third party has paid the hospital or physician for the services and care within 60 days after receipt of the bill or, if applicable, within 60 days after the Office for Consumer Health Assistance concludes mediation between the third party and the hospital.

5. If an out-of-network hospital or physician believes that the rates are insufficient to compensate the hospital or physician for the services and care, the hospital or physician may enter into negotiations with the third party that provides coverage to the patient to resolve the difference between the amount charged and the amount paid by the third party. If such negotiations do not result in an agreement on the amount that will be paid for services and care, the hospital or physician may file a complaint with the Director of the Office for Consumer Health Assistance and request that the Director mediate to determine the amount that must be paid for such services and care. Require the Director to establish a process for filing and handling complaints and mediate those complaints to determine whether the rates paid are sufficient in a particular circumstance and, if a rate is not sufficient, an acceptable rate that must be paid to the hospital or physician that filed the complaint.

Each third party that wishes for out-of-network hospitals and out-of-network physicians to accept, as payment in full, the amounts prescribed in this request shall:

a. Review the in-network hospitals and in-network physicians of the third party to determine whether a person who is covered by that policy of insurance or other contractual agreement, which provides coverage for health care, has adequate access to health care. Require the Commissioner of Insurance to annually study the providers of health care that are included in the networks, which are established by third parties, to determine whether those networks are adequate. The Commissioner shall prescribe standards of adequacy, which are based on the results of that

study. The Commissioner will make the findings public and provide a copy to the LCHC;

b. Review the frequency with which persons covered by the policy of insurance are treated for emergency services and care by out-of-network physicians at in-network hospitals and the rate at which those services and care are reimbursed by the third party;

c. Ensure that persons covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care receive adequate information regarding in-network hospitals and in-network physicians and the financial impact of receiving medical services and care from out-of-network hospitals and out-of-network physicians, including, without limitation, the financial impact of receiving services and care from an out-of-network physician on the medical staff of an in-network hospital. The information must be provided in a format that is meaningful for persons making an informed decision concerning medical services and care. This information must be accessible to persons covered by the policy of insurance or other contractual agreement; and

d. Submit, once each calendar quarter, a summary of the reviews and the educational efforts to the Commissioner of Insurance and the LCHC.

6. On or before June 30, 2014, the LCHC shall review the rate of payment to determine whether providers of health care are being adequately compensated for the provision of services and care. The LCHC shall forward the results of the review and any proposed changes to the Senate Committee on Health and Education and the Assembly Committee on Health and Human Services.

Make this legislation effective January 1, 2012, to allow sufficient time for regulations to be adopted.

I. NEAR-MISS EVENTS THAT OCCUR AT MEDICAL FACILITIES

Senate Bill 319 (Chapter 502, *Statutes of Nevada 2009*), in addition to other provisions, required the Health Division to conduct a study of near-miss events and a study of unique patient-identifier information. As a result of the study, the Health Division's Near-Miss Study Group determined that it was not feasible to provide a separate near-miss definition for two reasons: (1) the current statutory definition of a sentinel event contains a separate near-miss concept which would lead to crossover in the reporting between the two definitions;

and (2) a clear definition of a sentinel event would need to be determined so that individuals who report will plainly know what falls into the near-miss event category.

Further recommendations were presented to grant permission for the Health Division to report publicly, and in a facility-specific manner, the medical facility information submitted to the National Healthcare Safety Network and to include on the Internet website established and maintained pursuant to NRS 439A.270, the reports of sentinel events. Following discussion concerning the recommendations and the perceived benefits to the public of having the information on the transparency website, the LCHC agreed to:

> **Draft legislation to require each medical facility that is required to report information pursuant to NRS 439.847 to grant permission for the Health Division to report publicly, and in a facility-specific manner, the information submitted to the National Healthcare Safety Network. The information must be presented in an equitable and comparable format, including, without limitation, as a percentage or as a ratio of incidents to 1,000 patients. (BDR 40–193)**
>
> **Draft legislation to require the Health Division to include on the Internet website established and maintained pursuant to NRS 439A.270, the reports of sentinel events, which are prepared pursuant to paragraph (c) of subsection 1 of NRS 439.840 and the facility-specific information reported pursuant to NRS 439.847 for each medical facility that has given permission for such reports. (BDR 40–193)**

J. POSTGRADUATE EDUCATION FOR A LICENSE TO PRACTICE MEDICINE

Testimony indicated that a physician resident must hold an unrestricted license to practice medicine before registering to take the board certification examination. Testimony indicated this regulation makes it difficult for resident physicians to work in Nevada. Further testimony indicated that Maine and Nevada are the only states that do not allow primary care physicians to take the board certification examination without a license. Thus, a recommendation was made to revise the timing of the license application in Nevada. Following deliberations, the LCHC approved the following action:

> **Draft legislation to revise NRS 630.160 to allow the licensing process to begin for an applicant who: (1) is enrolled in a postgraduate residency program in this State; (2) has completed 24 months of the program; and (3) has committed, in writing, to complete a third year of the program. (BDR 54–194)**

IV. CONCLUSION

This report presents a summary of the bill drafts requested by the LCHC members for discussion before the 2011 Nevada State Legislature. In addition, this document provides information identifying certain other issues that were addressed during the 2009-2010 Interim. Persons wishing to have more specific information concering these issues may find it useful to review the Summary Minutes and Action Reports and related exhibits for each of the LCHC meetings at: http://leg.state.nv.us/Interim/75th2009/Committee/StatCom/HealthCare/?ID=18.

V. APPENDICES

APPENDIX A

Nevada Revised Statutes 439B.200
"Legislative Committee on Health Care"

NRS 439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.

1. There is hereby established a Legislative Committee on Health Care consisting of three members of the Senate and three members of the Assembly, appointed by the Legislative Commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.
2. No member of the Committee may:
   (a) Have a financial interest in a health facility in this State;
   (b) Be a member of a board of directors or trustees of a health facility in this State;
   (c) Hold a position with a health facility in this State in which the Legislator exercises control over any policies established for the health facility; or
   (d) Receive a salary or other compensation from a health facility in this State.
3. The provisions of subsection 2 do not:
(a) Prohibit a member of the Committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.
(b) Prohibit a member of the Legislature from serving as a member of the Committee if:
   (1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and
   (2) Serving on the Committee would not materially affect any financial interest the member has in a health facility in a manner greater than that accruing to any other person who has a similar interest.

4. The Legislative Commission shall review and approve the budget and work program for the Committee and any changes to the budget or work program. The Legislative Commission shall select the Chair and Vice Chair of the Committee from among the members of the Committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The office of the Chair of the Committee must alternate each biennium between the houses of the Legislature.

5. Any member of the Committee who does not become a candidate for reelection or who is defeated for reelection continues to serve after the general election until the next regular or special session of the Legislature convenes.

6. Vacancies on the Committee must be filled in the same manner as original appointments.

7. The Committee shall report annually to the Legislative Commission concerning its activities and any recommendations.

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333; 1993, 2590; 2009, 1154, 1568)

APPENDIX B

Suggested Legislation

The following Bill Draft Requests will be available during the 2011 Legislative Session, or can be accessed after "Introduction" at the following website: http://leg.state.nv.us/Session/76th2011/BDRList/page.cfm?showAll=1**.**

BDR 34–188	Establishes a statewide school wellness policy.
BDR –189	Prescribes provisions relating to medical assistants.
BDR 40–190	Revises provisions relating to controlled substances.
BDR 34–191	Revises provisions relating to school nutrition programs.
BDR 40–192	Establishes provisions governing payment for provision of certain services and care and reports relating to those services and care.
BDR 40–193	Revises provisions relating to reports of sentinel events and related events.
BDR 54–194	Revises provisions governing licensure of certain physicians.