Legislative Committee on Health Care

(*Nevada Revised Statutes* 439B.200)

WORK SESSION DOCUMENT

(Includes Attachments)

June 2, 2014

Prepared by the Research Division
Legislative Counsel Bureau

WORK SESSION DOCUMENT

LEGISLATIVE COMMITTEE ON HEALTH CARE
(*NEVADA REVISED STATUTES* 439B.200)

June 2, 2014

The following "Work Session Document" has been prepared by the staff of the Legislative Committee on Health Care (LCHC) (*Nevada Revised Statutes* [NRS] 439B.200). Pursuant to NRS 218D.160, the Committee is limited to ten legislative measures and must submit its bill draft requests (BDRs) for drafting by September 1, 2014, unless the Legislative Commission authorizes submission of a request after that date.

This document contains a summary of BDRs and other actions that have been presented during public hearings, through communication with individual Committee members, or through correspondence or communications submitted to the LCHC. It is designed to assist the Committee members in making decisions during the work session. The Committee may accept, reject, modify, or take no action on any of the proposals. The concepts contained within this document are arranged under broad topics to allow members to review related issues. Actions available to the Committee members include: legislation to amend the NRS; transitory sections that do not amend the statutes; resolutions; statements in the Committee's final report; and letters of recommendation or support.

Committee members should be advised that Legislative Counsel Bureau staff may, at the direction of the Chair, coordinate with interested parties to obtain additional information for drafting purposes or for information to be included in the final report. The recommendations may have been modified by being combined with similar proposals or by the addition of necessary legal or fiscal information. It should also be noted that some of the recommendations may contain an unknown fiscal impact.

Additional recommendations may be considered based on discussions held and presentations made at the June 2, 2014, hearing. Please see the agenda for details concerning the scheduled presentations.

The approved recommendations for legislation resulting from these deliberations will be prepared as BDRs and submitted for introduction as a bill to the 2015 Legislature.

Committee members will use a "Consent Calendar" to quickly approve those recommendations, as determined by the Chair, that need no further consideration or clarification beyond what is set forth in the recommendation summary. Any Committee member may request that items on the consent calendar be removed from the consent calendar for further discussion and consideration.

RECOMMENDATIONS

Recommendations Nos. 2, 3, 4, 7, 8, 9, 10, 12, 13, 17, and 18 included in the listing below have been placed on a Consent Calendar by the Chair and Committee staff to assist the Committee in quickly taking action on certain selected items. Committee members may request to remove items from this list for further discussion and consideration. If so desired, other recommendations from the "Work Session Document" may be added to the Consent Calendar with the approval of the Committee.

PROPOSALS RELATING TO BEHAVIORAL HEALTH

1. **Redraft** Senate Bill 323 (2013), which authorized the Division of Public and Behavioral Health (DPBH) of the Department of Health and Human Services (DHHS) to enter into a contract with a person, organization, or agency to carry out or assist in carrying out a program that allows certain defendants declared incompetent to receive outpatient treatment to restore competency while incarcerated in jail or prison. (See **Tab A**.) *(Concepts discussed at the November 21, 2013, meeting)*

2. **Send a letter** to the DHHS and the Department of Employment, Training and Rehabilitation encouraging collaborative efforts to develop and expand supported employment programs for mentally ill persons.

3. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the Committee's support for increasing the number of school-based psychologists, counselors, and social workers to help coordinate services and supports and to create effective links between schools and the community mental health system. *(Recommendation Nos. 2 and 3 proposed by Sita Diehl, Director, State Policy and Advocacy, National Alliance on Mental Illness)*

4. **Send a letter** to the Senate Committee on Finance, the Assembly Committee on Ways and Means, the DHHS, and Nevada's Department of Veterans Services expressing the Committee's support for mental health and other specialty courts. The letter will encourage collaboration to develop or support the development of:

    a. Aggressive aftercare programs to check in with participants and encourage them to stay connected to necessary services, especially with medication management;

    b. Additional supported housing options to increase stability;

    c. Institutional support for the specialty court system;
    (Recommendation Nos. 4a, 4b and 4c proposed by The Honorable Peter Breen, Senior District Court Judge, Second Judicial District Court, Washoe County)

    d. Patient-aligned care teams in southern Nevada;

    e. Specialized psychiatric nursing homes for chronically ill patients who have previously been placed in group homes and have had frequent emergency readmissions to a mental health hospital or a detention center; and

    f. A forensic psychiatric facility in southern Nevada.
    (Recommendation Nos. 4d, 4e, and 4f proposed by The Honorable William O. Voy, Family Division, Department A, Eighth Judicial District Court, Clark County)

5. **Amend NRS** to authorize paramedics to initiate an emergency admission to a mental health facility or hospital and to detain and transport a nonviolent individual, alleged to be a person with mental illness, without police presence.
    (Proposed by Chuck Callaway, Police Director, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department)

6. **Amend NRS** by revising the emergency admission process outlined in NRS 433A, related to emergency admissions in the following manner: (See **Tab B** for Sample Language).

    a. Amend NRS 433A.160 and NRS 433A.200 to expand the types of professionals who may initiate taking a person into custody and who may file a petition for the involuntary court-ordered admission of a person to a mental health facility or hospital. In addition to the existing professionals authorized, add a physician's assistant who is licensed pursuant to NRS Chapter 630 or Chapter 633 of NRS and a nurse practitioner who is licensed pursuant to Chapter 632 of NRS.

b. Amend NRS 433A.195, and any other applicable statutes, to authorize a physician's assistant, psychologist, social worker, registered nurse, nurse practitioner, or a accredited agent of the DHHS (in addition to a licensed physician) to complete the certificate for the release of a person admitted pursuant to NRS 433A.160 (emergency admission) without the signature of a licensed physician if it is determined that the person admitted is not a person with a mental illness.
(Proposed by Tracey D. Green, M.D. Chief Medical Officer, DPBH, DHHS and Marissa Brown, R.N. Director of Clinical and Nursing Services, Nevada Hospital Association [NHA])

PROPOSAL RELATING TO CHILDREN'S HEALTH

7. **Draft a Letter** to the State Board of Health (Board) requesting that the Board consider the following guidelines in the adoption of licensing standards, practices, and polices of child care facilities pursuant to NRS 432A.077:

    a. Require child care entities governed by *Nevada Administrative C*ode (NAC) 432A.380 to:
        i. Establish age appropriate portions;
        ii. Limit the amounts of foods with added sugars or low nutritional value, with specific requirements regarding milk, milk products, and juice;
        iii. Encourage staff to set good examples by:
            1. Eating with the children (currently in NAC);
            2. Eating items that meet the U.S. Department of Agriculture Child and Adult Care Food Program (CACFP) standards; and
            3. Teaching children appropriate portion sizes.
        iv. Use meal patterns established by the CACFP;
        v. Develop a feeding plan with the child's parent that includes:
            1. Introduction of age-appropriate solid foods; and
            2. Encourages and supports breastfeeding (offering onsite arrangement for moms to breastfeed).

    b. Strengthen the standards for child care facility programs governed by NAC 432A.390 by defining the following terms in accordance with physical activity guidelines based on the developmental age of children:
        i. Moderate physical activity
        ii. Vigorous physical activity
        iii. Muscular strengthening activities
        iv. Bone strengthening activities
        v. Sedentary activities
        vi. Screen/media time

c. Require child care facility programs governed by NAC 432A.390 to:
    i. Provide a program of physical activity that includes moderate to vigorous activity for all children, in addition to daily periods of outdoor play (weather permitting).
    ii. Require caregivers/teachers to participate in activities, when it is safe to do so.
    iii. Prohibit withholding or forcing physical activity as a form of discipline.

(Proposed by Denise Tanata Ashby, J.D., Executive Director, Children's Advocacy Alliance)

PROPOSALS RELATING TO THE HEALTH CARE WORKFORCE

8. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the Committee's support for the development and expansion of Graduate Medical Education (GME). The letter will specifically request that as funding is available:

    a. The number of residency slots within Nevada be increased. To fund a residency, an estimate of $100,000 to $110,000 a year was provided.
    (Proposed by Gerald Ackerman, Statewide Director, Area Health Education Center, University of Nevada School of Medicine and Stacy M. Woodbury, M.P.A., Executive Director, Nevada State Medical Association [NSMA])

    b. Medicaid funding for GME be revised to establish a method that reimburses hospitals with Medicaid payments that cover a proportionate share of the cost of the program.
    (Proposed by Bill Welch, President and Chief Executive Officer [CEO], NHA)

9. **Send a letter** to Nevada's Congressional Delegation advocating for:

    a. No additional GME funding cuts; and
    b. Redistributing FTEs/slots to Nevada hospitals.

(Proposed by Bill Welch, President and CEO, NHA)

10. **Send a letter** to DHHS and the Nevada System of Higher Education expressing the Committee's support for increasing the health care work force in Nevada by formalizing the role of community health workers (CHWs). Specifically, the Committee supports the development of a CHW type that meets the requirements for Medicaid reimbursement. This effort should consider the necessity and feasibility of:

    a. Changing the Nevada Medicaid State Plan to include CHWs as a provider type;
    b. Establishing additional reimbursement mechanisms to support prevention services by CHWs;

c. Creating and expanding training programs for CHWs at the university and/or the community college level;
d. Creating a governing body to oversee CHW activities;
e. Educating providers and the community about the role of the CHW; and
f. Developing a pipeline of individuals interested in becoming a CHW.

(Proposed by Tracey D. Green, M.D. Chief Medical Officer, DPBH, DHHS and Monica Morales, M.P.A., Program Development Manager, Chronic Disease Prevention and Health Promotion, DPBH, DHHS)

11. **Redraft** Senate Bill 324, First Reprint (2013), which authorized certain qualified professionals who hold a license in another state or territory of the United States to apply for a license by endorsement to practice in this State. In addition, the measure authorized certain regulatory bodies to enter into a reciprocal agreement with the corresponding regulatory authority in another state or territory of the United States for the purposes of authorizing a licensee to practice concurrently in this State and another jurisdiction and the regulation of such licensees. In addition to other provisions, the measure authorized a medical facility to employ or contract with a physician to provide health care to patients of the medical facility. (See **Tab C**.)
(Concepts discussed at the January 8, 2014, meeting)

PROPOSALS RELATING TO RURAL AND COMMUNITY HEALTH CENTERS

12. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the Committee's support for the expansion of Rural and Community Health Centers in Nevada. The letter will:

    a. Convey the significant role Rural and Community Health Centers play in meeting the needs of the uninsured and underinsured.

    b. Convey the significant return on investment received by states that have committed state funding to support the development or expansion of Rural and Community Health Centers by:
        i. Establishing a state-funded Primary Care Grant that is used in part to support capital needs.
        ii. Establishing competitive awards to support the start-up of a new health center and the expansion of existing health centers.
        iii. Providing funds to support technical assistance to develop proposals to secure federal funds through the New Access Program.

c. Encouraging priority be given to provide financial support for these endeavors as it becomes economically feasible.

13. **Include a Statement of Support** in the final report for the development of an expedited credentialing process for providers, who join the staff of an established Community Health Center.

14. **Redraft** Senate Bill 340, Second Reprint (2013), which proposed the creation of the Office for Patient-Centered Medical Homes and the Advisory Council on Patient-Centered Medical Homes. The redraft will exclude the provisions related to medical records. (See **Tab D**.)
(Recommendation Nos. 12, 13, and 14 concepts proposed by Nancy E. Hook, CEO, Nevada Primary Care Association)

PROPOSAL RELATING TO HEALTH INSURANCE COVERAGE

15. **Amend NRS** to require any insurer issuing a policy of insurance to contract with any qualified providers who meet the terms of the insurer if:

    a. The Division of Insurance has determined that the insurer has an inadequate number of the specified provider types for all insurance including those required to have an adequacy review, or

    b. The area in which the services are to be provided has been designated by the Health Resources and Services Administrations, U. S. Department of Health and Human Services as a Health Professional Shortage Area.

(Proposed by Stacy M. Woodbury, M.P.A., Executive Director, NSMA)

PROPOSAL RELATING TO THE EMERGENCY USE OF EPINEPHRINE AUTO-INJECTORS IN NEVADA

16. **Amend NRS** to authorize certain entities or organizations at which allergens capable of causing anaphylaxis may be present, including, but not limited to, amusement parks, recreation camps, restaurants, sports arenas, and youth sports leagues, to obtain and maintain a supply of epinephrine auto-injectors for emergency administration. Authorize a trained employee or agent of the entity or organization to administer an epinephrine auto-injector under certain circumstances. (See **Tab E** for Sample Language.)
(Proposed by Senator Debbie Smith, Colin Chiles, Senior Director, State Government Relations, Mylan Inc., and Susanne Stark, Co-leader, Food Allergy Parent Education, Las Vegas)

PROPOSAL RELATING TO TELEMEDICINE

17. **Draft a letter** supporting the advancement of Telemedicine in Nevada. Acknowledging the efforts of the Nevada Broadband Task Force and other entities in promoting telemedicine as a "standard of care" and recognizing how telemedicine supports:

    a. The expansion of services to patients in rural and urban communities;
    b. Inadequate provider distribution;
    c. Access to high quality, cost-effective care;
    d. The reduction of health care spending caused by treatment delays;
    e. Increased convenience when:
        i. Licensed health care facility limits are removed,
        ii. Health care provider licensing is clarified, and
        iii. All telemedicine-enabled care is able to be provided.
    f. Increased innovation and investment when reimbursement parity is provided for covered services;
    g. Strengthening the health care infrastructure; and
    h. Economic development by preserving and increasing health care related jobs and keeping patients' care in Nevada.

    (Proposed by Bill Welch, President and CEO, NHA)

PROPOSALS RELATING TO AUTISM TREATMENT AND SERVICES IN NEVADA

18. **Draft a Letter** to the DHHS encouraging the Department to:

    a. Develop mechanisms to provide readily available access to the Modified Checklist for Autism in Toddler screenings that assess risk for autism spectrum disorder in rural Nevada and a mobile diagnostic clinic for those who have red flags identified by the screenings. In rural Nevada, accessing a diagnostic evaluation is a significant barrier to treatment.

    b. Allow Autism Treatment Assistance Program (ATAP) funds to be used to support diagnostic clinics across rural Nevada, if it is determined to be feasible and appropriate.

    (Recommendation Nos. 18a and 18b proposed by Korri Ward, B.S., Founder and President, Northern Nevada Autism Network)

c. Encourage coordination between ATAP, Nevada Early Intervention Services, and rural school districts with the intent of promoting autism diagnoses, treatment, and helping coordinate providers and services to increase access to treatment and services in rural communities.

d. Require Nevada Medicaid to cover Applied Behavior Analysis (ABA) services as soon as possible by:
   i. Seeking clarification from Centers for Medicare and Medicaid Services regarding whether ABA can be included in the Nevada Medicaid State Plan via a plan amendment;
   ii. Preparing and submitting such an amendment;
   iii. Initiating the process of certifying providers of ABA services and establishing rates;
   iv. Providing ABA services to Early Periodic Screening Diagnosis, and Treatment children;
   v. Making the necessary request to shift available funding during this biennium to cover these services; and
   vi. Developing a budget for the next biennium that includes sufficient funding for Medicaid coverage of ABA and to eliminate the ATAP waiting list.

19. **Revise the following provisions of NRS** related to autism services and insurance coverage:

a. Remove the requirement that autism behavior interventionists be certified by the Board of Psychological Examiners. Instead, autism behavior interventionists will continue to work under the supervision of a licensed and Board Certified Behavior Analyst or a Board Certified Assistant Behavior Analyst but without their own certification.

b. Remove the requirement that an autism behavior interventionist be certified as a condition to insurance coverage for autism spectrum disorders.

c. Remove the statutory limitation of $36,000 per year for applied behavior analysis treatment for consistency with the Affordable Care Act.

(Recommendation Nos. 18c, 18d, and 19 proposed by Barbara Buckley, Esq. Executive Director, Legal Aid Center of Southern Nevada, Jan Crandy, Chair, Nevada Commission on Autism Spectrum Disorders, DHHS, and Korri Ward, B.S., Founder and President, Northern Nevada Autism Network)

LIST OF ATTACHMENTS

TAB A

SENATE BILL NO. 323–SENATOR HARDY

MARCH 18, 2013

Referred to Committee on Judiciary

SUMMARY—Revises provisions relating to incompetent defendants. (BDR 14-1063)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

~

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

AN ACT relating to criminal procedure; allowing the Division of Mental Health and Developmental Services of the Department of Health and Human Services to establish a program to provide certain services to a criminal defendant while the criminal defendant is incarcerated; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law allows a court to order a psychiatric examination of a criminal defendant and requires the evaluation of criminal defendants found incompetent to stand trial at certain intervals to determine whether the defendant has attained competency. (NRS 178.415, 178.450, 178.455) Existing law also allows a court to order a defendant who is found incompetent but not dangerous to himself or herself or society to undergo outpatient treatment. (NRS 178.425, 178.460) This bill allows the Division of Mental Health and Developmental Services of the Department of Health and Human Services to establish a program to allow certain defendants declared incompetent to receive outpatient treatment to competency while incarcerated in jail or prison. If such a program is established, this bill allows the Division to enter into a contract with a person, organization or agency to carry out or assist in carrying out the program.

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

Section 1. NRS 178.417 is hereby amended to read as follows:

178.417 1. A person may not provide a report or an evaluation concerning the competency of a defendant to stand trial or receive pronouncement of judgment pursuant to this section and

NRS 178.400 to 178.460, inclusive, unless the person is certified by the Division for that purpose.

2. The Division shall adopt regulations to establish:

(a) Requirements for certification of a person who provides reports and evaluations concerning the competency of a defendant pursuant to this section and NRS 178.400 to 178.460, inclusive;

(b) Reasonable fees for issuing and renewing such certificates; and

(c) Requirements for continuing education for the renewal of a certificate.

3. The fees so collected must be used only to:

(a) Defray the cost of issuing and renewing certificates; and

(b) Pay any other expenses incurred by the Division in carrying out its duties pursuant to this section.

4. The Division shall establish and administer examinations to determine the eligibility of any person who applies for certification. An applicant is entitled to certification upon satisfaction of the requirements of the Division. The Division may enter into a contract with another person, organization or agency to carry out or assist in carrying out the provisions of this subsection.

5. The Division may adopt regulations to establish a program that allows certain defendants who are determined to be incompetent to stand trial or receive pronouncement of judgment pursuant to this section and NRS 178.400 to 178.460, inclusive, but who are determined not to be dangerous to themselves or to society to receive outpatient treatment to competency while incarcerated in jail or prison. If the Division establishes such a program, the Division must specify the qualifications for participation in the program and the type of treatment that may be provided to such defendants. The Division may enter into a contract with another person, organization or agency to carry out or assist in carrying out the program.

Sec. 2. This act becomes effective upon passage and approval.

㉚

TAB B

Tab B

A physician, physician's assistant, psychologist, social worker, registered nurse, nurse practitioner, or an accredited agent of the Department may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person (is not a person with a mental illness, as defined in 433a.195) no longer meets the criteria for involuntary court-ordered admission and stating the observations upon which that conclusion is based.

(Submitted by Tracey D. Green, M.D. Chief Medical Officer, DPBH, DHHS)

TAB C

REQUIRES TWO-THIRDS MAJORITY VOTE
(§§ 2, 4, 10, 14)

(Reprinted with amendments adopted on April 22, 2013)

FIRST REPRINT **S.B. 324**

SENATE BILL NO. 324–SENATOR HARDY

MARCH 18, 2013

JOINT SPONSOR: ASSEMBLYMAN EISEN

Referred to Committee on Commerce, Labor and Energy

SUMMARY—Revises provisions governing professions. (BDR 54-701)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

~

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

AN ACT relating to professions; authorizing certain qualified professionals who hold a license in another state or territory of the United States to apply for a license by endorsement to practice in this State; authorizing certain regulatory bodies to enter into a reciprocal agreement with the corresponding regulatory authority in another state or territory of the United States for the purposes of authorizing a licensee to practice concurrently in this State and another jurisdiction and regulating such licensees; authorizing a medical facility to employ or contract with a physician to provide health care to a patient of the medical facility; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law generally provides for the regulation of professions in this State. (Title 54 of NRS) **Section 2** of this bill authorizes certain qualified professionals who are licensed in another state or territory of the United States and who are active members or veterans of, the spouse of an active member or veteran of, or the surviving spouse of a veteran of, the Armed Forces of the United States to apply for and receive a license by endorsement to practice their respective profession in this State. A person who receives a license by endorsement pursuant to **section 2** is entitled to a 50 percent reduction in the fee for the initial issuance of a license or for an examination as a prerequisite to licensure. **Section 3** of this bill authorizes

certain regulatory bodies of this State to enter into a reciprocal agreement with the corresponding regulatory authority of another state or territory of the United States for the purposes of authorizing and regulating the practice of certain professions concurrently in this State and another jurisdiction. **Sections 4, 10 and 14** of this bill authorize certain qualified physicians and certain qualified podiatrists to obtain a license by endorsement to practice in this State if the physician or podiatrist holds a valid and unrestricted license to practice in another state or territory of the United States, is certified in a specialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, as applicable, and meets certain other requirements.

Section 17 of this bill authorizes a medical facility to employ or contract with a physician to provide health care to a patient of the medical facility. **Section 17** requires a medical facility, other than a hospital, that employs or contracts with a physician to provide health care to a patient to: (1) have credentialing and privileging standards and a process for peer review for the medical facility; and (2) have a physician or committee of physicians oversee those standards and the process for peer review.

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

Section 1. Chapter 622 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. ***1. Notwithstanding the applicable provisions for obtaining a license pursuant to chapters 630 to 641C, inclusive, or 644 of NRS, a regulatory body may issue such a license by endorsement to an applicant if:***

(a) The applicant holds a corresponding valid and unrestricted license to practice his or her respective profession in the District of Columbia or any state or territory of the United States;

(b) As applicable to the profession, the applicant is certified in a specialty recognized by the American Board of Medical Specialties or the American Osteopathic Association;

(c) The applicant is an active member or veteran of, the spouse of an active member or veteran of, or the surviving spouse of a veteran of, the Armed Forces of the United States; and

(d) The regulatory body determines that the provisions of law in the state or territory in which the applicant holds a license as described in paragraph (a) are substantially equivalent to the applicable provisions of law in this State.

2. An applicant for a license by endorsement pursuant to this section must submit to the applicable regulatory body with his or her application:

(a) Proof satisfactory to the regulatory body that the applicant:

(1) Satisfies the requirements of paragraphs (a), (b) and (c) of subsection 1;

(2) Is a citizen of the United States or otherwise has the legal right to work in the United States;

(3) Has not been disciplined or investigated by the corresponding regulatory authority of the state or territory in which the applicant holds a license to practice his or her respective profession; and

(4) If applicable to the profession, has not been held civilly or criminally liable for malpractice in the District of Columbia or any state or territory of the United States more than once;

(b) An affidavit stating that the information contained in the application and any accompanying material is true and correct; and

(c) Any other information required by the regulatory body in this State under whose jurisdiction the license may be issued.

3. Not later than 15 business days after receiving an application for a license by endorsement pursuant to this section, a regulatory body shall provide written notice to the applicant of any additional information required by the regulatory body to consider the application. Unless the regulatory body denies the application for good cause, the regulatory body shall approve the application and issue the license by endorsement to the applicant not later than:

(a) Thirty days after receiving all the additional information required by the regulatory body to complete the application; or

(b) If the regulatory body requires the applicant to submit fingerprints for the purpose of obtaining a report on the applicant's background, 10 days after receiving the report from the appropriate authority,

➥ whichever occurs last.

4. A license by endorsement may be issued at a meeting of the regulatory body or between its meetings by the chief executive officer of the regulatory body. Such an action shall be deemed to be an action of the regulatory body.

5. Notwithstanding any applicable provision of chapters 630 to 641C, inclusive, or 644 of NRS establishing a fee for any examination required as a prerequisite to licensure or for the issuance of a license, a regulatory body shall not collect from any person to whom a license by endorsement is issued pursuant to this section more than one-half of the specified fee for the examination or initial issuance of the license.

6. At any time before making a final decision on an application for a license by endorsement, a regulatory body may grant a provisional license authorizing an applicant to practice his or her respective profession in accordance with regulations adopted by the regulatory body.

7. As used in this section, "veteran" means a person who qualifies for an exemption pursuant to NRS 361.090.

Sec. 3. ***1. A regulatory body that regulates a profession pursuant to chapters 630, 630A, 632 to 641C, inclusive, or 644 of NRS in this State may enter into a reciprocal agreement with the corresponding regulatory authority of the District of Columbia or any other state or territory of the United States for the purposes of:***

(a) Authorizing a qualified person licensed in the profession in that state or territory to practice concurrently in this State and one or more other states or territories of the United States; and

(b) Regulating the practice of such a person.

2. A regulatory body may enter into a reciprocal agreement pursuant to subsection 1 only if the regulatory body determines that:

(a) The corresponding regulatory authority is authorized by law to enter into such an agreement with the regulatory body; and

(b) The applicable provisions of law governing the practice of the respective profession in the state or territory on whose behalf the corresponding regulatory authority would execute the reciprocal agreement are substantially similar to the corresponding provisions of law in this State.

3. If the regulatory body enters into a reciprocal agreement pursuant to subsection 1, the regulatory body shall prepare an annual report before January 31 of each year outlining the progress of the regulatory body as it relates to such reciprocal agreements and shall submit the report to the Director of the Legislative Counsel Bureau for transmittal to the next session of the Legislature in odd-numbered years or to the Legislative Committee on Health Care in even-numbered years.

Sec. 4. Chapter 630 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in NRS 630.161, the Board may issue a license by endorsement to practice medicine to an applicant who meets the requirements set forth in this section. An applicant may submit to the Board an application for such a license if the applicant:

(a) Holds a corresponding valid and unrestricted license to practice medicine in the District of Columbia or any state or territory of the United States; and

(b) Is certified in a specialty recognized by the American Board of Medical Specialties.

2. An applicant for a license by endorsement pursuant to this section must submit to the Board with his or her application:

(a) Proof satisfactory to the Board that the applicant:

(1) Satisfies the requirements of subsection 1;

(2) Is a citizen of the United States or otherwise has the legal right to work in the United States;

(3) Has not been disciplined or been the subject of multiple investigations by the corresponding regulatory authority of the state or territory in which the applicant holds a license to practice medicine; and

(4) Has not been held civilly or criminally liable for malpractice in the District of Columbia or any state or territory of the United States more than once;

(b) An affidavit stating that the information contained in the application and any accompanying material is true and correct; and

(c) Any other information required by the Board.

3. Not later than 15 business days after receiving an application for a license by endorsement to practice medicine pursuant to this section, the Board shall provide written notice to the applicant of any additional information required by the Board to consider the application. Unless the Board denies the application for good cause, the Board shall approve the application and issue a license by endorsement to practice medicine to the applicant not later than 45 days after receiving all the additional information required by the Board to complete the application.

4. A license by endorsement to practice medicine may be issued at a meeting of the Board or between its meetings by the President and Executive Director of the Board. Such an action shall be deemed to be an action of the Board.

Sec. 5. NRS 630.160 is hereby amended to read as follows:

630.160 1. Every person desiring to practice medicine must, before beginning to practice, procure from the Board a license authorizing the person to practice.

2. Except as otherwise provided in NRS 630.1605, 630.161 and 630.258 to 630.266, inclusive, ***and sections 2 and 4 of this act,*** a license may be issued to any person who:

(a) Is a citizen of the United States or is lawfully entitled to remain and work in the United States;

(b) Has received the degree of doctor of medicine from a medical school:

(1) Approved by the Liaison Committee on Medical Education of the American Medical Association and Association of American Medical Colleges; or

(2) Which provides a course of professional instruction equivalent to that provided in medical schools in the United States approved by the Liaison Committee on Medical Education;

(c) Is currently certified by a specialty board of the American Board of Medical Specialties and who agrees to maintain the certification for the duration of the licensure, or has passed:

(1) All parts of the examination given by the National Board of Medical Examiners;

(2) All parts of the Federation Licensing Examination;

(3) All parts of the United States Medical Licensing Examination;

(4) All parts of a licensing examination given by any state or territory of the United States, if the applicant is certified by a specialty board of the American Board of Medical Specialties;

(5) All parts of the examination to become a licentiate of the Medical Council of Canada; or

(6) Any combination of the examinations specified in subparagraphs (1), (2) and (3) that the Board determines to be sufficient;

(d) Is currently certified by a specialty board of the American Board of Medical Specialties in the specialty of emergency medicine, preventive medicine or family practice and who agrees to maintain certification in at least one of these specialties for the duration of the licensure, or:

(1) Has completed 36 months of progressive postgraduate:

(I) Education as a resident in the United States or Canada in a program approved by the Board, the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association; or

(II) Fellowship training in the United States or Canada approved by the Board or the Accreditation Council for Graduate Medical Education;

(2) Has completed at least 36 months of postgraduate education, not less than 24 months of which must have been completed as a resident after receiving a medical degree from a combined dental and medical degree program approved by the Board; or

(3) Is a resident who is enrolled in a progressive postgraduate training program in the United States or Canada approved by the Board, the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association, has completed at least 24 months of the program and has committed, in writing, to the Board that he or she will complete the program; and

(e) Passes a written or oral examination, or both, as to his or her qualifications to practice medicine and provides the Board with a description of the clinical program completed demonstrating that the applicant's clinical training met the requirements of paragraph (b).

3. The Board may issue a license to practice medicine after the Board verifies, through any readily available source, that the applicant has complied with the provisions of subsection 2. The verification may include, but is not limited to, using the Federation Credentials Verification Service. If any information is verified by a source other than the primary source of the information, the Board may require subsequent verification of the information by the primary source of the information.

4. Notwithstanding any provision of this chapter to the contrary, if, after issuing a license to practice medicine, the Board obtains information from a primary or other source of information and that information differs from the information provided by the applicant or otherwise received by the Board, the Board may:

(a) Temporarily suspend the license;

(b) Promptly review the differing information with the Board as a whole or in a committee appointed by the Board;

(c) Declare the license void if the Board or a committee appointed by the Board determines that the information submitted by the applicant was false, fraudulent or intended to deceive the Board;

(d) Refer the applicant to the Attorney General for possible criminal prosecution pursuant to NRS 630.400; or

(e) If the Board temporarily suspends the license, allow the license to return to active status subject to any terms and conditions specified by the Board, including:

(1) Placing the licensee on probation for a specified period with specified conditions;

(2) Administering a public reprimand;

(3) Limiting the practice of the licensee;

(4) Suspending the license for a specified period or until further order of the Board;

(5) Requiring the licensee to participate in a program to correct alcohol or drug dependence or any other impairment;

(6) Requiring supervision of the practice of the licensee;

(7) Imposing an administrative fine not to exceed $5,000;

(8) Requiring the licensee to perform community service without compensation;

(9) Requiring the licensee to take a physical or mental examination or an examination testing his or her competence to practice medicine;

(10) Requiring the licensee to complete any training or educational requirements specified by the Board; and

(11) Requiring the licensee to submit a corrected application, including the payment of all appropriate fees and costs incident to submitting an application.

5. If the Board determines after reviewing the differing information to allow the license to remain in active status, the action of the Board is not a disciplinary action and must not be reported to any national database. If the Board determines after reviewing the differing information to declare the license void, its action shall be deemed a disciplinary action and shall be reportable to national databases.

Sec. 6. NRS 630.165 is hereby amended to read as follows:

630.165 1. Except as otherwise provided in subsection 2, an applicant for a license to practice medicine must submit to the Board, on a form provided by the Board, an application in writing, accompanied by an affidavit stating that:

(a) The applicant is the person named in the proof of graduation and that it was obtained without fraud or misrepresentation or any mistake of which the applicant is aware; and

(b) The information contained in the application and any accompanying material is complete and correct.

2. An applicant for a license by endorsement to practice medicine pursuant to NRS 630.1605 ***or section 2 or 4 of this act*** must submit to the Board, on a form provided by the Board, an application in writing, accompanied by an affidavit stating that:

(a) The applicant is the person named in the license to practice medicine issued by the District of Columbia or any state or territory of the United States and that the license was obtained without fraud or misrepresentation or any mistake of which the applicant is aware; and

(b) The information contained in the application and any accompanying material is complete and correct.

3. An application submitted pursuant to subsection 1 or 2 must include all information required to complete the application.

4. In addition to the other requirements for licensure, the Board may require such further evidence of the mental, physical, medical or other qualifications of the applicant as it considers necessary.

5. The applicant bears the burden of proving and documenting his or her qualifications for licensure.

Sec. 7. NRS 630.258 is hereby amended to read as follows:

630.258 1. A physician who is retired from active practice and who:

(a) Wishes to donate his or her expertise for the medical care and treatment of persons in this State who are indigent, uninsured or unable to afford health care; or

(b) Wishes to provide services for any disaster relief operations conducted by a governmental entity or nonprofit organization,

➥ may obtain a special volunteer medical license by submitting an application to the Board pursuant to this section.

2. An application for a special volunteer medical license must be on a form provided by the Board and must include:

(a) Documentation of the history of medical practice of the physician;

(b) Proof that the physician previously has been issued an unrestricted license to practice medicine in any state of the United States and that the physician has never been the subject of disciplinary action by a medical board in any jurisdiction;

(c) Proof that the physician satisfies the requirements for licensure set forth in NRS 630.160 or the requirements for licensure by endorsement set forth in NRS 630.1605 ~~[,]~~ ***or section 2 or 4 of this act;***

(d) Acknowledgment that the practice of the physician under the special volunteer medical license will be exclusively devoted to providing medical care:

(1) To persons in this State who are indigent, uninsured or unable to afford health care; or

(2) As part of any disaster relief operations conducted by a governmental entity or nonprofit organization; and

(e) Acknowledgment that the physician will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for providing medical care under the special volunteer medical license, except for payment by a medical facility at which the physician provides volunteer medical services of the expenses of the physician for necessary travel, continuing education, malpractice insurance or fees of the State Board of Pharmacy.

3. If the Board finds that the application of a physician satisfies the requirements of subsection 2 and that the retired physician is competent to practice medicine, the Board shall issue a special volunteer medical license to the physician.

4. The initial special volunteer medical license issued pursuant to this section expires 1 year after the date of issuance. The license may be renewed pursuant to this section, and any license that is renewed expires 2 years after the date of issuance.

5. The Board shall not charge a fee for:

(a) The review of an application for a special volunteer medical license; or

(b) The issuance or renewal of a special volunteer medical license pursuant to this section.

6. A physician who is issued a special volunteer medical license pursuant to this section and who accepts the privilege of practicing medicine in this State pursuant to the provisions of the special volunteer medical license is subject to all the provisions governing disciplinary action set forth in this chapter.

7. A physician who is issued a special volunteer medical license pursuant to this section shall comply with the requirements for continuing education adopted by the Board.

Sec. 8. NRS 630.265 is hereby amended to read as follows:

630.265 1. ~~[Except as otherwise provided in]~~ ***Unless the Board denies such licensure pursuant to*** NRS 630.161 ~~[,]~~ ***or for other good cause,*** the Board ~~[may]~~ ***shall*** issue to a qualified applicant a limited license to practice medicine as a resident physician in a graduate program approved by the Accreditation Council for Graduate Medical Education if the applicant is:

(a) A graduate of an accredited medical school in the United States or Canada; or

(b) A graduate of a foreign medical school and has received the standard certificate of the Educational Commission for Foreign Medical Graduates or a written statement from that Commission that the applicant passed the examination given by it.

2. The medical school or other institution sponsoring the program shall provide the Board with written confirmation that the applicant has been appointed to a position in the program and is a citizen of the United States or lawfully entitled to remain and work in the United States. A limited license remains valid only while the licensee is actively practicing medicine in the residency program and is legally entitled to work and remain in the United States.

3. The Board may issue a limited license for not more than 1 year but may renew the license if the applicant for the limited license meets the requirements set forth by the Board by regulation.

4. The holder of a limited license may practice medicine only in connection with his or her duties as a resident physician or under such conditions as are approved by the director of the program.

5. The holder of a limited license granted pursuant to this section may be disciplined by the Board at any time for any of the grounds provided in NRS 630.161 or 630.301 to 630.3065, inclusive.

Sec. 9. NRS 630.268 is hereby amended to read as follows:

630.268 1. The Board shall charge and collect not more than the following fees:

For application for and issuance of a license to practice as a physician, including a license by endorsement ***issued pursuant to NRS 630.1605 or section 4 of this act***	$600
For application for and issuance of a temporary, locum tenens, limited, restricted, authorized facility, special, special purpose or special event license	400

For renewal of a limited, restricted, authorized facility or special license	$400
For application for and issuance of a license as a physician assistant	400
For biennial registration of a physician assistant	800
For biennial registration of a physician	800
For application for and issuance of a license as a perfusionist or practitioner of respiratory care	400
For biennial renewal of a license as a perfusionist	600
For biennial registration of a practitioner of respiratory care	600
For biennial registration for a physician who is on inactive status	400
For written verification of licensure	50
For a duplicate identification card	25
For a duplicate license	50
For computer printouts or labels	500
For verification of a listing of physicians, per hour	20
For furnishing a list of new physicians	100

2. In addition to the fees prescribed in subsection 1, the Board shall charge and collect necessary and reasonable fees for the expedited processing of a request or for any other incidental service the Board provides.

3. The cost of any special meeting called at the request of a licensee, an institution, an organization, a state agency or an applicant for licensure must be paid for by the person or entity requesting the special meeting. Such a special meeting must not be called until the person or entity requesting it has paid a cash deposit with the Board sufficient to defray all expenses of the meeting.

Sec. 10. Chapter 633 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in NRS 633.315, the Board may issue a license by endorsement to practice osteopathic medicine to an applicant who meets the requirements set forth in this section. An applicant may submit to the Board an application for such a license if the applicant:

(a) Holds a corresponding valid and unrestricted license to practice osteopathic medicine in the District of Columbia or any state or territory of the United States; and

(b) Is certified in a specialty recognized by the American Board of Medical Specialties or the American Osteopathic Association.

2. An applicant for a license by endorsement pursuant to this section must submit to the Board with his or her application:

(a) Proof satisfactory that the applicant:

(1) Satisfies the requirements of subsection 1;

(2) Is a citizen of the United States or otherwise has the legal right to work in the United States;

(3) Has not been disciplined or investigated by the corresponding regulatory authority of the state or territory in which the applicant holds a license to practice osteopathic medicine; and

(4) Has not been held civilly or criminally liable for malpractice in the District of Columbia or any state or territory of the United States more than once;

(b) A complete set of fingerprints and written permission authorizing the Board to forward the fingerprints in the manner provided in NRS 633.309;

(c) An affidavit stating that the information contained in the application and any accompanying material is true and correct; and

(d) Any other information required by the Board.

3. Not later than 15 business days after receiving an application for a license by endorsement to practice osteopathic medicine pursuant to this section, the Board shall provide written notice to the applicant of any additional information required by the Board to consider the application. Unless the Board denies the application for good cause, the Board shall approve the application and issue a license by endorsement to practice osteopathic medicine to the applicant not later than:

(a) Forty-five days after receiving the application; or

(b) Ten days after the Board receives a report on the applicant's background based on the submission of the applicant's fingerprints,

➥ whichever occurs last.

4. A license by endorsement to practice osteopathic medicine may be issued at a meeting of the Board or between its meetings by the President of the Board. Such an action shall be deemed to be an action of the Board.

Sec. 11. NRS 633.311 is hereby amended to read as follows:

633.311 Except as otherwise provided in NRS 633.315, ***NRS 633.381 to 633.419, inclusive, and sections 2 and 10 of this act,*** an applicant for a license to practice osteopathic medicine may be issued a license by the Board if:

1. The applicant is 21 years of age or older;

2. The applicant is a citizen of the United States or is lawfully entitled to remain and work in the United States;

3. The applicant is a graduate of a school of osteopathic medicine;

4. The applicant:

(a) Has graduated from a school of osteopathic medicine before 1995 and has completed:

(1) A hospital internship; or

(2) One year of postgraduate training that complies with the standards of intern training established by the American Osteopathic Association;

(b) Has completed 3 years, or such other length of time as required by a specific program, of postgraduate medical education as a resident in the United States or Canada in a program approved by the Board, the Bureau of Professional Education of the American Osteopathic Association or the Accreditation Council for Graduate Medical Education; or

(c) Is a resident who is enrolled in a postgraduate training program in this State, has completed 24 months of the program and has committed, in writing, that he or she will complete the program;

5. The applicant applies for the license as provided by law;

6. The applicant passes:

(a) All parts of the licensing examination of the National Board of Osteopathic Medical Examiners;

(b) All parts of the licensing examination of the Federation of State Medical Boards of the United States, Inc.;

(c) All parts of the licensing examination of the Board, a state, territory or possession of the United States, or the District of Columbia, and is certified by a specialty board of the American Osteopathic Association or by the American Board of Medical Specialties; or

(d) A combination of the parts of the licensing examinations specified in paragraphs (a), (b) and (c) that is approved by the Board;

7. The applicant pays the fees provided for in this chapter; and

8. The applicant submits all information required to complete an application for a license.

Sec. 12. NRS 633.401 is hereby amended to read as follows:

633.401 1. ~~[Except as otherwise provided in]~~ ***Unless the Board denies such licensure pursuant to*** NRS 633.315 ~~[,]~~ ***or for other good cause,*** the Board ~~[may]~~ ***shall*** issue a special license to practice osteopathic medicine:

(a) To authorize a person who is licensed to practice osteopathic medicine in an adjoining state to come into Nevada to care for or assist in the treatment of his or her patients in association with an osteopathic physician in this State who has primary care of the patients.

(b) To a resident while the resident is enrolled in a postgraduate training program required pursuant to the provisions of paragraph (c) of subsection 4 of NRS 633.311.

(c) Other than a license issued pursuant to NRS 633.419, for a specified period and for specified purposes to a person who is licensed to practice osteopathic medicine in another jurisdiction.

2. For the purpose of paragraph (c) of subsection 1, the osteopathic physician must:

(a) Hold a full and unrestricted license to practice osteopathic medicine in another state;

(b) Not have had any disciplinary or other action taken against him or her by any state or other jurisdiction; and

(c) Be certified by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association or their successors.

3. A special license issued under this section may be renewed by the Board upon application of the licensee.

4. Every person who applies for or renews a special license under this section shall pay respectively the special license fee or special license renewal fee specified in this chapter.

Sec. 13. NRS 633.416 is hereby amended to read as follows:

633.416 1. An osteopathic physician who is retired from active practice and who:

(a) Wishes to donate his or her expertise for the medical care and treatment of persons in this State who are indigent, uninsured or unable to afford health care; or

(b) Wishes to provide services for any disaster relief operations conducted by a governmental entity or nonprofit organization,

➥ may obtain a special volunteer license to practice osteopathic medicine by submitting an application to the Board pursuant to this section.

2. An application for a special volunteer license to practice osteopathic medicine must be on a form provided by the Board and must include:

(a) Documentation of the history of medical practice of the osteopathic physician;

(b) Proof that the osteopathic physician previously has been issued an unrestricted license to practice osteopathic medicine in any state of the United States and that the osteopathic physician has never been the subject of disciplinary action by a medical board in any jurisdiction;

(c) Proof that the osteopathic physician satisfies the requirements for licensure set forth in NRS 633.311 or the requirements for licensure by endorsement set forth in NRS 633.400 ~~[,]~~ ***or section 2 or 10 of this act;***

(d) Acknowledgment that the practice of the osteopathic physician under the special volunteer license to practice osteopathic medicine will be exclusively devoted to providing medical care:

(1) To persons in this State who are indigent, uninsured or unable to afford health care; or

(2) As part of any disaster relief operations conducted by a governmental entity or nonprofit organization; and

(e) Acknowledgment that the osteopathic physician will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for providing medical care under the special volunteer license to practice osteopathic medicine, except for payment by a medical facility at which the osteopathic physician provides volunteer medical services of the expenses of the osteopathic physician for necessary travel, continuing education, malpractice insurance or fees of the State Board of Pharmacy.

3. If the Board finds that the application of an osteopathic physician satisfies the requirements of subsection 2 and that the retired osteopathic physician is competent to practice osteopathic medicine, the Board shall issue a special volunteer license to practice osteopathic medicine to the osteopathic physician.

4. The initial special volunteer license to practice osteopathic medicine issued pursuant to this section expires 1 year after the date of issuance. The license may be renewed pursuant to this section, and any license that is renewed expires 2 years after the date of issuance.

5. The Board shall not charge a fee for:

(a) The review of an application for a special volunteer license to practice osteopathic medicine; or

(b) The issuance or renewal of a special volunteer license to practice osteopathic medicine pursuant to this section.

6. An osteopathic physician who is issued a special volunteer license to practice osteopathic medicine pursuant to this section and who accepts the privilege of practicing osteopathic medicine in this State pursuant to the provisions of the special volunteer license to practice osteopathic medicine is subject to all the provisions governing disciplinary action set forth in this chapter.

7. An osteopathic physician who is issued a special volunteer license to practice osteopathic medicine pursuant to this section shall comply with the requirements for continuing education adopted by the Board.

Sec. 14. Chapter 635 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Board may issue a license by endorsement to practice podiatry to an applicant who meets the requirements set forth in

this section. An applicant may submit to the Board an application for such a license if the applicant:

(a) Holds a corresponding valid and unrestricted license to practice podiatry in the District of Columbia or any state or territory of the United States; and

(b) Is certified in a specialty recognized by the American Board of Medical Specialties.

2. An applicant for a license by endorsement pursuant to this section must submit to the Board with his or her application:

(a) Proof satisfactory to the Board that the applicant:

(1) Satisfies the requirements of subsection 1;

(2) Is a citizen of the United States or otherwise has the legal right to work in the United States;

(3) Has not been disciplined or investigated by the corresponding regulatory authority of the state or territory in which the applicant holds a license to practice podiatry; and

(4) Has not been held civilly or criminally liable for malpractice in the District of Columbia or any state or territory of the United States more than once;

(b) An affidavit stating that the information contained in the application and any accompanying material is true and correct; and

(c) Any other information required by the Board.

3. Not later than 15 business days after receiving an application for a license by endorsement to practice podiatry pursuant to this section, the Board shall provide written notice to the applicant of any additional information required by the Board to consider the application. Unless the Board denies the application for good cause, the Board shall approve the application and issue a license by endorsement to practice podiatry to the applicant not later than 45 days after receiving the application.

4. A license by endorsement to practice podiatry may be issued at a meeting of the Board or between its meetings by the President of the Board. Such an action shall be deemed to be an action of the Board.

Sec. 15. NRS 635.050 is hereby amended to read as follows:

635.050 1. Any person wishing to practice podiatry in this State must, before beginning to practice, procure from the Board a license to practice podiatry.

2. ~~[A]~~ *Except as otherwise provided in section 2 or 14 of this act, a* license to practice podiatry may be issued by the Board to any person who:

(a) Is of good moral character.

(b) Is a citizen of the United States or is lawfully entitled to remain and work in the United States.

(c) Has received the degree of D.P.M., Doctor of Podiatric Medicine, from an accredited school of podiatry.

(d) Has completed a residency approved by the Board.

(e) Has passed the examination given by the National Board of Podiatric Medical Examiners.

(f) Has not committed any act described in subsection 2 of NRS 635.130. For the purposes of this paragraph, an affidavit signed by the applicant stating that the applicant has not committed any act described in subsection 2 of NRS 635.130 constitutes satisfactory proof.

3. An applicant for a license to practice podiatry must submit to the Board or a committee thereof pursuant to such regulations as the Board may adopt:

(a) The fee for an application for a license of not more than $600;

(b) Proof satisfactory to the Board that the requirements of subsection 2 have been met; and

(c) All other information required by the Board to complete an application for a license.

➥ The Board shall, by regulation, establish the fee required to be paid pursuant to this subsection.

4. The Board may reject an application if it appears that the applicant's credentials are fraudulent or the applicant has practiced podiatry without a license or committed any act described in subsection 2 of NRS 635.130.

5. The Board may require such further documentation or proof of qualification as it may deem proper.

6. The provisions of this section do not apply to a person who applies for:

(a) A limited license to practice podiatry pursuant to NRS 635.075; or

(b) A provisional license to practice podiatry pursuant to NRS 635.082.

Sec. 16. NRS 635.065 is hereby amended to read as follows:

635.065 1. In addition to the other requirements for licensure set forth in this chapter, an applicant for a license to practice podiatry in this State who has been licensed to practice podiatry in another state or the District of Columbia must submit:

(a) An affidavit signed by the applicant that:

(1) Identifies each jurisdiction in which the applicant has been licensed to practice; and

(2) States whether a disciplinary proceeding has ever been instituted against the applicant by the licensing board of that jurisdiction and, if so, the status of the proceeding; and

(b) If the applicant is currently licensed to practice podiatry in another state or the District of Columbia, a certificate from the licensing board of that jurisdiction stating that the applicant is in good standing and no disciplinary proceedings are pending against the applicant.

2. ~~[The]~~ ***Except as otherwise provided in section 2 or 14 of this act, the*** Board may require an applicant who has been licensed to practice podiatry in another state or the District of Columbia to:

(a) Pass an examination prescribed by the Board concerning the provisions of this chapter and any regulations adopted pursuant thereto; or

(b) Submit satisfactory proof that:

(1) The applicant maintained an active practice in another state or the District of Columbia within the 5 years immediately preceding the application;

(2) No disciplinary proceeding has ever been instituted against the applicant by a licensing board in any jurisdiction in which he or she is licensed to practice podiatry; and

(3) The applicant has participated in a program of continuing education that is equivalent to the program of continuing education that is required pursuant to NRS 635.115 for podiatric physicians licensed in this State.

Sec. 17. Chapter 449 of NRS is hereby amended by adding thereto a new section to read as follows:

1. A medical facility may employ or contract with a physician to provide health care to a patient of the medical facility.

2. If a medical facility, other than a hospital, employs or contracts with a physician pursuant to subsection 1, the medical facility must:

(a) Have credentialing and privileging standards and a process for peer review for the medical facility; and

(b) Have a physician or committee of physicians who oversee the standards and process required pursuant to paragraph (a).

3. If a medical facility employs or contracts with a physician pursuant to subsection 1, the medical facility shall not, by virtue of its employment of or contract with the physician, interfere with, limit or otherwise impede the ability of the physician to care for a patient in a manner consistent with the professional medical judgment of the physician.

4. As used in this section:

(a) "Credentialing" means obtaining, verifying and assessing the qualifications of a physician to provide treatment, care or services in or for a medical facility.

(b) "Physician" means a person licensed to practice medicine pursuant to chapter 630 or 633 of NRS.

(c) "Privileging" means the authorizing by an appropriate authority of a physician to provide specific treatment, care or services at a medical facility subject to limits based on factors that include, without limitation, the physician's license, education, training, experience, competence, health status and specialized skill.

㉚

TAB D

(Reprinted with amendments adopted on May 28, 2013)

SECOND REPRINT **S.B. 340**

SENATE BILL NO. 340–SENATOR HARDY

MARCH 18, 2013

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to the delivery of health care. (BDR 40-595)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

~

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

AN ACT relating to health care; providing for the creation of the Office for Patient-Centered Medical Homes and the Advisory Council on Patient-Centered Medical Homes; revising provisions relating to medical records; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Sections 2-12.1 of this bill provide for the creation of the Office for Patient-Centered Medical Homes and the Advisory Council on Patient-Centered Medical Homes within the Health Division of the Department of Health and Human Services. **Section 10** of this bill requires the Administrator of the Health Division to administer the Office and to adopt regulations to establish certain standards and processes relating to the Office. **Section 10.5** of this bill requires a primary care practice to be certified by the Office before operating as a patient-centered medical home. **Section 11** of this bill allows an insurer which registers with the Office: (1) to pay a patient-centered medical home for the coordination of care for insureds; (2) to pay incentives to a patient-centered medical home; and (3) if authorized by an insured, to share information about the insured with a patient-centered medical home and any other practitioner or health facility that provides health services to the insured. **Sections 10.5 and 11** require the Administrator to adopt necessary regulations to provide for the certification of patient-centered medical homes and the registration of insurers, including regulations to impose a fee for certification and registration.

Section 12 of this bill requires the Administrator to evaluate the effectiveness of patient-centered medical homes and the efforts of the Office to promote and regulate such homes and report to the Legislature with the results of the evaluation on or before January 1 of each odd-numbered year. **Section 14.5** of this bill requires the Administrator, to the extent that money is available for that purpose and as soon as practicable, to adopt certain regulations relating to certain payments made by insurers to patient-centered medical homes and federal antitrust laws.

Section 14.5 also requires the Administrator to carry out the provisions of this bill relating to patient-centered medical homes as soon as practicable after receiving money to cover the costs necessary to carry out those provisions. **Section 15** of this bill makes the provisions of this bill relating to patient-centered medical homes: (1) effective on the date on which the Administrator determines that sufficient money has been received to carry out those provisions; and (2) expire by limitation on June 30, 2019.

Existing law requires a provider of health care, including a facility that maintains the health care records of patients, to make the health care records of a patient available for inspection in certain circumstances. (NRS 629.021, 629.061) **Section 13** of this bill: (1) extends the period of time within which a provider of health care must make health care records available for inspection in certain circumstances; and (2) absolves certain providers of health care who have transferred custody of a health care record to a facility that maintains the health care records of patients from the requirement to make the health care record available for inspection. **Section 14** of this bill repeals a provision making it a misdemeanor for a physician licensed pursuant to chapter 630 of NRS to willfully fail or refuse to comply with this requirement.

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

Section 1. Chapter 439A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 12.1, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 12.1, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 2.3 to 7, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 2.3. ***"Administrator" means the Administrator of the Health Division.***

Sec. 2.7. ***"Advisory Council" means the Advisory Council on Patient-Centered Medical Homes established pursuant to section 11.5 of this act.***

Sec. 3. ***"Federally qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(1)(2)(B).***

Sec. 3.5. ***"Health Division" means the Health Division of the Department.***

Sec. 4. ***"Insured" means a person who receives health coverage or benefits in accordance with state law from an insurer.***

Sec. 5. ***"Insurer" means a person or governmental entity that provides health coverage or benefits in accordance with state law. The term includes, without limitation:***

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 that

provides health insurance through a plan of self-insurance pursuant to NRS 287.010 to 287.040, inclusive.

2. The Board of the Public Employees' Benefits Program if the Board provides health insurance through a plan of self-insurance pursuant to NRS 287.04335.

3. The Division of Health Care Financing and Policy of the Department for the purpose of administering the Medicaid program and the Children's Health Insurance Program pursuant to chapter 422 of NRS.

4. An insurer that issues policies of individual health insurance pursuant to chapter 689A of NRS or policies of group health insurance pursuant to chapter 689B of NRS.

5. A carrier who provides health benefit plans pursuant to chapter 689C of NRS.

6. A fraternal benefit society that provides hospital, medical or nursing benefits pursuant to chapter 695A of NRS.

7. A corporation organized for the purpose of maintaining and operating a hospital, medical or dental service plan pursuant to chapter 695B of NRS.

8. A health maintenance organization established and operated pursuant to chapter 695C of NRS.

9. A managed care organization established and operated pursuant to chapter 695G of NRS.

10. The Silver State Health Insurance Exchange established pursuant to NRS 695I.200.

Sec. 5.5. *"Office" means the Office for Patient-Centered Medical Homes created pursuant to section 9 of this act.*

Sec. 6. *"Patient-centered medical home" means a primary care practice certified by the Office pursuant to section 10.5 of this act.*

Sec. 7. *"Primary care practice" means a federally qualified health center or a business where health services are provided by one or more nurse practitioners or one or more physicians who are licensed pursuant to chapter 630 or 633 of NRS and who practice in the area of family practice, internal medicine or pediatrics.*

Sec. 8. (Deleted by amendment.)

Sec. 9. *1. There is hereby created within the Health Division the Office for Patient-Centered Medical Homes.*

2. The Office shall encourage the development of patient-centered medical homes and adopt standards to encourage insurers to provide coverage for health services provided to insureds by patient-centered medical homes.

Sec. 10. *1. The Administrator or his or her designee shall administer the Office.*

2. The Administrator or his or her designee shall adopt regulations to carry out the provisions of sections 2 to 12.1, inclusive, of this act, which may include, without limitation, regulations to establish:

(a) Standards for the qualification and operation of a patient-centered medical home;

(b) Standards for submitting claims to an insurer for health services received by an insured from a patient-centered medical home;

(c) Standards for any payment for services associated with the coordination of care or incentive that may be provided by an insurer to a patient-centered medical home pursuant to section 11 of this act;

(d) A method to measure the effectiveness of a patient-centered medical home; and

(e) A process for insureds to determine whether to receive health services from a patient-centered medical home when such services are available.

3. In adopting regulations pursuant to this section, the Administrator or his or her designee may adopt the standards of the National Committee for Quality Assurance, or its successor organization, and the certification process of that organization, that relate to patient-centered medical homes.

4. In adopting regulations pursuant to this section, the Administrator or his or her designee shall:

(a) Ensure that the Office carries out its duties in the public interest and in such a manner as to promote the efficient and effective provision of health services;

(b) Consider the use of health information technology, including, without limitation, electronic medical records;

(c) Consider the relationship between the patient-centered medical home and other practitioners and health facilities;

(d) Consider the ability of a patient-centered medical home to foster a partnership with insureds and provide services to insureds in a timely manner; and

(e) Consider the use of comprehensive management of medication to improve outcomes.

5. The Administrator shall monitor insurers and patient-centered medical homes and adopt such regulations as necessary to ensure that the insurers and patient-centered medical homes may engage in the activities authorized pursuant to sections 2 to 12.1, inclusive, of this act, and any regulations adopted pursuant thereto, to the greatest extent possible without violating federal antitrust laws. Any act of an insurer or a patient-centered medical home which is in compliance with sections 2 to 12.1, inclusive, of

this act, and any regulations adopted pursuant thereto, does not constitute an unfair trade practice for the purposes of chapter 598A of NRS.

Sec. 10.5. *1. Before a primary care practice may operate as a patient-centered medical home, the primary care practice must obtain certification from the Office.*

2. The Office shall certify a primary care practice for the purpose of operating as a patient-centered medical home if the primary care practice demonstrates to the Office that:

(a) Insureds will receive health services from a team of medical professionals who are directed by one or more physicians who practice in the area of family practice, internal medicine or pediatrics;

(b) The provision of health services at the patient-centered medical home will be evidence-based and provided on a comprehensive and ongoing basis;

(c) Insureds who receive services at the patient-centered medical home will have enhanced access to health services and improved communication with practitioners and coordination of health services;

(d) Health information technology will be used to improve the delivery of health services to insureds;

(e) Improved outcomes for insureds will be possible and provided in a more cost-effective manner; and

(f) The practice is in compliance with any other requirements established by the Administrator by regulation.

3. The Administrator shall adopt any regulations necessary to carry out the provisions of this section, which may include, without limitation, regulations establishing:

(a) A fee for certification by the Office which may be set at an amount not to exceed the costs related to certification;

(b) The manner in which to apply for certification; and

(c) The expiration and renewal of registration.

Sec. 11. *1. An insurer that registers with the Office may provide an incentive to a patient-centered medical home that offers services to its insureds in the manner and amount authorized by the Administrator by regulation.*

2. An insurer that registers with the Office pursuant to subsection 1 may:

(a) Pay a patient-centered medical home for services associated with the coordination of care for any health services provided to an insured; and

(b) Except as otherwise provided in subsection 3, share health care records and other related information about an insured who has elected to receive services from a patient-centered medical

home with the patient-centered medical home and any other practitioner or health facility that provides health services to the insured.

3. An insurer that registers with the Office, a patient-centered medical home and any other practitioner or health facility may share health care records and other related information about an insured only if the insured provides authorization to share such information. An authorization to share information pursuant to this subsection:

(a) Must be made on a form prescribed by the Administrator or his or her designee that is signed by the insured;

(b) Expires 1 year after the date on which the insured signed the form; and

(c) May be renewed.

4. The Administrator shall adopt any regulations necessary to carry out the provisions of this section, which may include, without limitation, regulations establishing:

(a) A fee for registering with the Office which may be set at an amount not to exceed the costs related to registration;

(b) The manner in which to apply for registration; and

(c) The expiration and renewal of registration.

5. As used in this section, "health care records" has the meaning ascribed to it in NRS 629.021.

Sec. 11.5. *1. Within the limits of available money, the Health Division shall establish the Advisory Council on Patient-Centered Medical Homes to advise and make recommendations to the Health Division concerning the Office.*

2. The Administrator shall appoint to the Advisory Council the following six voting members:

(a) The State Health Officer or his or her designee;

(b) The Commissioner of Insurance or his or her designee;

(c) The Director of the Department or his or her designee;

(d) The Administrator of the Division of Health Care Financing and Policy of the Department or his or her designee;

(e) One representative of the health insurance industry who serves at the pleasure of the Administrator; and

(f) One provider of health care who serves at the pleasure of the Administrator.

3. The Legislative Commission shall appoint to the Advisory Council the following two voting members:

(a) One member of the Senate; and

(b) One member of the Assembly.

4. In addition to the members appointed pursuant to subsections 2 and 3, the following persons shall serve on the Advisory Council as voting members:

(a) The Governor or his or her designee; and

(b) One representative of consumers of health care who is appointed by and serves at the pleasure of the Governor.

5. A majority of the voting members of the Advisory Council may appoint nonvoting members to the Advisory Council.

Sec. 11.7. ***1. The members of the Advisory Council serve terms of 2 years and may be reappointed. Vacancies must be filled in the same manner as the original appointment.***

2. At its first meeting and annually thereafter, a majority of the voting members of the Advisory Council shall select a Chair and a Vice Chair of the Advisory Council.

3. A majority of the voting members of the Advisory Council may appoint committees or subcommittees to study issues relating to patient-centered medical homes.

4. The Health Division shall, within the limits of available money, provide the necessary professional staff and a secretary for the Advisory Council.

5. A majority of the voting members of the Advisory Council constitutes a quorum to transact all business, and a majority of those voting members present, physically or via telecommunications, must concur in any decision.

6. The Advisory Council shall, within the limits of available money, meet at the call of the Administrator, the Chair or a majority of the voting members of the Advisory Council quarterly or as is necessary.

7. A member of the Advisory 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 so that he or she may prepare for and attend meetings of the Advisory Council and perform any work necessary to carry out the duties of the Advisory 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 Advisory Council to:

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

(b) Take annual leave or compensatory time for the absence.

8. The members of the Advisory Council serve without compensation, except that:

(a) For each day or portion of a day during which a member of the Advisory Council who is a Legislator attends a meeting of the Advisory Council or is otherwise engaged in the business of the Advisory Council, except during a regular or special session of the Legislature, the Legislator is entitled to receive the:

(1) Compensation provided for a majority of the members of the Legislature during the first 60 days of the preceding regular session;

(2) Per diem allowance provided for state officers generally; and

(3) Travel expenses provided pursuant to NRS 218A.655; and

(b) Each member who is not a Legislator is entitled, while engaged in the business of the Advisory Council and within the limits of available money, to the per diem allowance and travel expenses provided for state officers and employees generally.

9. The compensation, per diem allowances and travel expenses of the members of the Advisory Council who are Legislators must be paid from the Legislative Fund.

Sec. 11.9. *To assist the Office in carrying out the provisions of sections 2 to 12.1, inclusive, of this act, the Advisory Council shall, within the limits of available money, investigate, consider and advise the Office on:*

1. Standards that relate to patient-centered medical homes; and

2. Any other issue relating to patient-centered medical homes.

Sec. 12. *1. On or before January 1 of each odd-numbered year, the Administrator or his or her designee shall:*

(a) Conduct an evaluation of the effectiveness of patient-centered medical homes in this State and of the efforts of the Office to promote and regulate patient-centered medical homes; and

(b) Submit a written report compiling the results of the evaluation to the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature.

2. The evaluation must include, without limitation, information relating to the effects of patient-centered medical homes and the Office on:

(a) The costs and outcomes of health care;

(b) The delivery of health care;

(c) The quality of processes for the delivery of health care;

(d) Access to services for the coordination of health care;

(e) Whether the enhanced payments allowed to patient-centered medical homes provide adequate compensation for the expanded services provided by patient-centered medical homes;

(f) The satisfaction of insureds with the quality and delivery of health care received from patient-centered medical homes;

(g) The satisfaction of practitioners with the quality and delivery of health care at patient-centered medical homes; and

(h) Any existing disparities in the ability of different groups of persons to obtain health care.

Sec. 12.1. ***The Health Division and the Office may accept gifts, grants, donations and bequests from any source to carry out the provisions of sections 2 to 12.1, inclusive, of this act.***

Sec. 13. NRS 629.061 is hereby amended to read as follows:

629.061 1. ~~[Each]~~ ***Except as otherwise provided in subsection 10, each*** provider of health care shall make the health care records of a patient available for physical inspection by:

(a) The patient or a representative with written authorization from the patient;

(b) The personal representative of the estate of a deceased patient;

(c) Any trustee of a living trust created by a deceased patient;

(d) The parent or guardian of a deceased patient who died before reaching the age of majority;

(e) An investigator for the Attorney General or a grand jury investigating an alleged violation of NRS 200.495, 200.5091 to 200.50995, inclusive, or 422.540 to 422.570, inclusive;

(f) An investigator for the Attorney General investigating an alleged violation of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive, or any fraud in the administration of chapter 616A, 616B, 616C, 616D or 617 of NRS or in the provision of benefits for industrial insurance; or

(g) Any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law.

~~[→]~~ ***2.*** The records ***described in subsection 1*** must be made available at a place within the depository convenient for physical inspection. ~~[If]~~ ***Except as otherwise provided in subsection 3, if*** the records are located ~~[within]~~ ***:***

(a) Within this State, the provider shall make any records requested pursuant to this section available for inspection within ~~[5]~~ ***15*** working days after the request. ~~[If the records are located outside]~~

(b) Outside this State, the provider shall make any records requested pursuant to this section available in this State for inspection within ~~[10]~~ ***20*** working days after the request.

~~[2.]~~ ***3. If the records described in subsection 1 are requested pursuant to paragraph (e), (f) or (g) of subsection 1 and the investigator, grand jury or authorized representative, as applicable, declares that exigent circumstances exist which require the immediate production of the records, the provider shall make any records which are located:***

(a) Within this State available for inspection within 5 working days after the request.

(b) Outside this State available for inspection within 10 working days after the request.

4. Except as otherwise provided in subsection ~~[3,]~~ ***5,*** the provider of health care shall also furnish a copy of the records to each person described in subsection 1 who requests it and pays the actual cost of postage, if any, the costs of making the copy, not to exceed 60 cents per page for photocopies and a reasonable cost for copies of X-ray photographs and other health care records produced by similar processes. No administrative fee or additional service fee of any kind may be charged for furnishing such a copy.

~~[3.]~~ ***5.*** The provider of health care shall also furnish a copy of any records that are necessary to support a claim or appeal under any provision of the Social Security Act, 42 U.S.C. §§ 301 et seq., or under any federal or state financial needs-based benefit program, without charge, to a patient, or a representative with written authorization from the patient, who requests it, if the request is accompanied by documentation of the claim or appeal. A copying fee, not to exceed 60 cents per page for photocopies and a reasonable cost for copies of X-ray photographs and other health care records produced by similar processes, may be charged by the provider of health care for furnishing a second copy of the records to support the same claim or appeal. No administrative fee or additional service fee of any kind may be charged for furnishing such a copy. The provider of health care shall furnish the copy of the records requested pursuant to this subsection within 30 days after the date of receipt of the request, and the provider of health care shall not deny the furnishing of a copy of the records pursuant to this subsection solely because the patient is unable to pay the fees established in this subsection.

~~[4.]~~ ***6.*** Each person who owns or operates an ambulance in this State shall make the records regarding a sick or injured patient available for physical inspection by:

(a) The patient or a representative with written authorization from the patient;

(b) The personal representative of the estate of a deceased patient;

(c) Any trustee of a living trust created by a deceased patient;

(d) The parent or guardian of a deceased patient who died before reaching the age of majority; or

(e) Any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law.

➥ The records must be made available at a place within the depository convenient for physical inspection, and inspection must be permitted at all reasonable office hours and for a reasonable length of time. The person who owns or operates an ambulance shall also furnish a copy of the records to each person described in this subsection who requests it and pays the actual cost of postage, if any, and the costs of making the copy, not to exceed 60 cents per page for photocopies. No administrative fee or additional service fee of any kind may be charged for furnishing a copy of the records.

~~[5.]~~ ***7.*** Records made available to a representative or investigator must not be used at any public hearing unless:

(a) The patient named in the records has consented in writing to their use; or

(b) Appropriate procedures are utilized to protect the identity of the patient from public disclosure.

~~[6.]~~ ***8.*** Subsection ~~[5]~~ ***7*** does not prohibit:

(a) A state licensing board from providing to a provider of health care or owner or operator of an ambulance against whom a complaint or written allegation has been filed, or to his or her attorney, information on the identity of a patient whose records may be used in a public hearing relating to the complaint or allegation, but the provider of health care or owner or operator of an ambulance and the attorney shall keep the information confidential.

(b) The Attorney General from using health care records in the course of a civil or criminal action against the patient or provider of health care.

~~[7.]~~ ***9.*** A provider of health care or owner or operator of an ambulance and his or her agents and employees are immune from any civil action for any disclosures made in accordance with the provisions of this section or any consequential damages.

~~[8.]~~ ***10. A provider of health care described in subsection 1 of NRS 629.031 who has transferred custody of a health care record to a facility that maintains the health care records of patients is not required to perform any other action to comply with the requirements of this section unless the person is notified by the facility that additional information is required by the facility to comply with the requirements of this section.***

11. For the purposes of this section:

(a) "Guardian" means a person who has qualified as the guardian of a minor pursuant to testamentary or judicial appointment, but does not include a guardian ad litem.

(b) "Living trust" means an inter vivos trust created by a natural person:

(1) Which was revocable by the person during the lifetime of the person; and

(2) Who was one of the beneficiaries of the trust during the lifetime of the person.

(c) "Parent" means a natural or adoptive parent whose parental rights have not been terminated.

(d) "Personal representative" has the meaning ascribed to it in NRS 132.265.

Sec. 13.5. NRS 686A.110 is hereby amended to read as follows:

686A.110 Except as otherwise expressly provided by law, ***including, without limitation, section 11 of this act,*** no person shall knowingly:

1. Permit to be made or offer to make or make any contract of life insurance, life annuity or health insurance, or agreement as to such contract, other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow or give, directly or indirectly, or knowingly accept, as an inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever not specified in the contract; or

2. Directly or indirectly give or sell or purchase or offer or agree to give, sell, purchase, or allow as an inducement to such insurance or annuity or in connection therewith, whether or not to be specified in the policy or contract, any agreement of any form or nature promising returns and profits, or any stocks, bonds or other securities, or interest present or contingent therein or as measured thereby, of any insurer or other corporation, association or partnership, or any dividends or profits accrued or to accrue thereon.

Sec. 14. NRS 630.405 is hereby repealed.

Sec. 14.5. The Administrator of the Health Division of the Department of Health and Human Services shall:

1. To the extent that money is available for that purpose and as soon as practicable, adopt the regulations necessary to carry out the provisions of paragraph (c) of subsection 2 and subsection 5 of section 10 of this act.

2. Carry out the provisions of sections 2 to 12.1, inclusive, of this act, other than the adoption of regulations described in subsection 1, as soon as practicable after adopting the regulations described in subsection 1 and receiving money through gifts, grants, donations or bequests or other money made available to cover the costs necessary to carry out those provisions.

Sec. 15. 1. This section and sections 12.1 and 14.5 of this act become effective upon passage and approval.

2. Sections 13 and 14 of this act become effective on October 1, 2013.

3. Sections 1 to 12, inclusive, and 13.5 of this act become effective on the date on which the Administrator of the Health Division of the Department of Health and Human Services determines that sufficient money has been received to carry out the provisions of sections 2 to 12.1, inclusive, of this act.

4. Sections 1 to 12.1, inclusive, and 13.5 of this act expire by limitation on June 30, 2019.

TEXT OF REPEALED SECTION

630.405 Penalty for failure to make records concerning health care available for inspection or copying. A physician licensed pursuant to this chapter who willfully fails or refuses to make the health care records of a patient available for physical inspection or copying as provided in NRS 629.061 is guilty of a misdemeanor.

㉚

TAB E

Nevada

ENTITY PRESCRIBING FOR OTHER ENTITIES

Sec. 1. Chapter 450B of NRS is hereby amended by adding thereto a new section to read as follows:

Sec. _____. Life-saving allergy medication: stock supply of epinephrine auto-injectors; emergency administration.

Notwithstanding any provision of law to the contrary:

1. Prescribing to an Authorized Entity Permitted. A physician or osteopathic physician may prescribe epinephrine auto-injectors in the name of an authorized entity as provided in NRS 630.374 or NRS 633.707 for use in accordance with this section, and pharmacists may dispense epinephrine auto-injectors pursuant to such prescription.
2. Designated Entities Permitted To Maintain Supply. An authorized entity may acquire and stock a supply of epinephrine auto-injectors pursuant to a prescription issued in accordance with NRS 630.374 or NRS 633.707. Such epinephrine auto-injectors shall be stored in a location readily accessible in an emergency and in accordance with the epinephrine auto-injector's instructions for use and any additional requirements that may be established by the board. An authorized entity shall designate employees or agents who have completed the training required by subsection 4 to be responsible for the storage, maintenance, and general oversight of epinephrine auto-injectors acquired by the authorized entity.
3. Use of Epinephrine Auto-Injectors. An employee or agent of an authorized entity, or other individual, who has completed the training required by subsection 4 may, on the premises of or in connection with the authorized entity, use epinephrine auto-injectors prescribed pursuant to subsection 1 to:
    (a) provide an epinephrine auto-injector to any individual who the employee, agent, or other individual believes in good faith is experiencing anaphylaxis for immediate self-administration, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.
    (b) administer an epinephrine auto-injector to any individual who the employee, agent, or other individual believes in good faith is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.
4. Training. An employee, agent, or other individual described in subsection 3 must complete an anaphylaxis training program prior to providing or administering an epinephrine auto-injector made available by an authorized entity[***optional:*** and at least every two years following completion of the initial anaphylaxis training program]. Such training shall be conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment or an entity or individual approved by the board. Training may be conducted online or in person and, at a minimum, shall cover:
    (a) techniques on how to recognize symptoms of severe allergic reactions, including anaphylaxis;
    (b) standards and procedures for the storage and administration of an epinephrine auto-injector; and

(c) emergency follow-up procedures.

The entity that conducts the training shall issue a certificate, on a form developed or approved by the board, to each person who successfully completes the anaphylaxis training program.

5. Good Samaritan Protections. An authorized entity that possesses and makes available epinephrine auto-injectors and its employees, agents, and other trained individuals; a person that uses an epinephrine auto-injector made available pursuant to subsection 7; a physician or osteopathic physician who prescribes epinephrine auto-injectors to an authorized entity; and an individual or entity that conducts the training described in subsection 4 is not liable for any civil damages that result from any act or omission not amounting to gross negligence related to the acquisition, possession, administration, or provision of an epinephrine auto-injector. The administration of an epinephrine auto-injector in accordance with this section is not the practice of medicine. This section does not eliminate, limit, or reduce any other immunity or defense that may be available under state law, including that provided under NRS 41.500. An entity located in this state shall not be liable for any injuries or related damages that result from the provision or administration of an epinephrine auto-injector by its employees or agents outside of this state if the entity or its employee or agent (1) would not have been liable for such injuries or related damages had the provision or administration occurred within this state, or (2) are not liable for such injuries or related damages under the law of the state in which such provision or administration occurred.
6. Reporting. An authorized entity that possesses and makes available epinephrine auto-injectors shall submit to the board, on a form developed by the board, a report of each incident on the authorized entity's premises that involves the administration of an epinephrine auto-injector. The board shall annually publish a report that summarizes and analyzes all reports submitted to it under this subsection.
7. Expanded Availability. An authorized entity that acquires a stock supply of epinephrine auto-injectors pursuant to a prescription issued in accordance with this section may make such epinephrine auto-injectors available to individuals other than those trained individuals described in subsection 3, and such individuals may administer such epinephrine auto-injector to any individual believed in good faith to be experiencing anaphylaxis, if the epinephrine auto-injectors are stored in a locked, secure container and are made available only upon remote authorization by a physician or osteopathic physician after consultation with the a physician or osteopathic physician by audio, televideo, or other similar means of electronic communication. Consultation with a physician or osteopathic physician for this purpose shall not be considered the practice of telemedicine or otherwise be construed as violating any law or rule regulating the practice of medicine, practice of osteopathic medicine, or practice of respiratory care.
8. Definitions. As used in this section:
   (a) "Administer" means the direct application of an epinephrine auto-injector to the body of an individual.
   (b) "Authorized entity" means any entity or organization at or in connection with which allergens capable of causing anaphylaxis may be present, including, but not limited to, restaurants, recreation camps, youth sports leagues, amusement parks, and sports arenas; provided however, a school described in NRS 388.424 or

394.1995 is an authorized entity for purposes of subsections 5 and 7 of this section only.

(c) "Epinephrine auto-injector" means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(d) "Provide" means the supply of one or more epinephrine auto-injectors to an individual.

(e) "Self-administration" means a person's discretionary use of an epinephrine auto-injector.

Sec. 2. Section 374 of Chapter 630 of NRS is hereby amended to read as follows:

1. A physician may issue to a public or private school or an authorized entity an order to allow the school or authorized entity to obtain and maintain auto-injectable epinephrine at the school or authorized entity, regardless of whether any person at the school or authorized entity has been diagnosed with a condition which may cause the person to require such medication for the treatment of anaphylaxis.
2. An order issued pursuant to subsection 1 must contain:
   (a) The name and signature of the physician and the address of the physician if not immediately available to the pharmacist;
   (b) The classification of his or her license;
   (c) The name of the public or private school or authorized entity to which the order is issued;
   (d) The name, strength and quantity of the drug authorized to be obtained and maintained by the order; and
   (e) The date of issue.
3. A physician is not subject to disciplinary action solely for issuing a valid order pursuant to subsection 1 to an entity other than a natural person and without knowledge of a specific natural person who requires the medication.
4. As used in this section:
   (a) "Authorized entity" has the meaning ascribed to it in NRS 450B.[ ].
   (b) "Private school" has the meaning ascribed to it in NRS 394.103.
   (c) "Public school" has the meaning ascribed to it in NRS 385.007.

Sec. 3. Section 707 of Chapter 633 of NRS is hereby amended to read as follows:

1. An osteopathic physician may issue to a public or private school or an authorized entity an order to allow the school or authorized entity to obtain and maintain auto-injectable epinephrine at the school or authorized entity, regardless of whether any person at the school or authorized entity has been diagnosed with a condition which may cause the person to require such medication for the treatment of anaphylaxis.
2. An order issued pursuant to subsection 1 must contain:

(a) The name and signature of the osteopathic physician and the address of the osteopathic physician if not immediately available to the pharmacist;
(b) The classification of his or her license;
(c) The name of the public or private school or authorized entity to which the order is issued;
(d) The name, strength and quantity of the drug authorized to be obtained and maintained by the order; and
(e) The date of issue.

3. An osteopathic physician is not subject to disciplinary action solely for issuing a valid order pursuant to subsection 1 to an entity other than a natural person and without knowledge of a specific natural person who requires the medication.
4. As used in this section:
   (a) "Authorized entity" has the meaning ascribed to it in 450B.[ ].
   (b) "Private school" has the meaning ascribed to it in NRS 394.103.
   (c) "Public school" has the meaning ascribed to it in NRS 385.007.

Sec. 4. NRS 639.2357 is hereby amended to read as follows:

1. Upon the request of a patient, or a public or private school or authorized entity for which an order was issued pursuant to NRS 630.374, ~~or~~ 633.707, or 450B.[ ], a registered pharmacist shall transfer a prescription or order to another registered pharmacist.
2. A registered pharmacist who transfers a prescription or order pursuant to subsection 1 shall comply with any applicable regulations adopted by the Board relating to the transfer.
3. The provisions of this section do not authorize or require a pharmacist to transfer a prescription or order in violation of:
   (a) Any law or regulation of this State;
   (b) Federal law or regulation; or
   (c) A contract for payment by a third party if the patient is a party to that contract.