BULLETIN 25-7

Joint Interim Standing Committee on Health and Human Services

(NRS 218E.320)

OCTOBER 2024

LEGISLATIVE COUNSEL BUREAU

JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

Nevada Revised Statutes (NRS) 218E.320

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NEVADA REVISED STATUTES (NRS) 218E.320

NRS 218E.320 Creation; membership; officers; vacancies.

1. There are hereby created the following Joint Interim Standing Committees of the Legislature:

(a) Commerce and Labor;

(b) Education;

(c) Government Affairs;

(d) Growth and Infrastructure;

(e) Health and Human Services;

(f) Judiciary;

(g) Legislative Operations and Elections;

(h) Natural Resources; and

(i) Revenue.

2. Each Joint Interim Standing Committee consists of eight regular members and five alternate members. As soon as is practicable after the adjournment of each regular session:

(a) The Speaker of the Assembly shall appoint three members of the Assembly as regular members of each Committee and two members of the Assembly as alternate members of each Committee.

(b) The Minority Leader of the Assembly shall appoint two members of the Assembly as regular members of each Committee and one member of the Assembly as an alternate member of each Committee.

(c) The Majority Leader of the Senate shall appoint two Senators as regular members of each Committee and one Senator as an alternate member of each Committee.

(d) The Minority Leader of the Senate shall appoint one Senator as a regular member of each Committee and one Senator as an alternate member of each Committee.

3. Before making their respective appointments, the Speaker of the Assembly, the Majority Leader of the Senate and the Minority Leaders of the Senate and Assembly shall consult so that, to the extent practicable:

(a) At least five of the regular members appointed to each Joint Interim Standing Committee served on the corresponding standing committee or committees during the preceding regular session.

(b) Not more than five of the regular members appointed to each Joint Interim Standing Committee are members of the same political party.

4. The Legislative Commission shall select the Chair and Vice Chair of each Joint Interim Standing Committee from among the members of the Committee. The Chair must be appointed from one House of the Legislature and the Vice Chair from the other House. The position of Chair must alternate each biennium between the Houses of the Legislature. Each of those officers holds the position until a successor is appointed after the next regular session. If a vacancy occurs in the position of Chair or Vice Chair, the vacancy must be filled in the same manner as the original selection for the remainder of the unexpired term.

5. The membership of any member of a Joint Interim Standing Committee who does not become a candidate for reelection or who is defeated for reelection terminates on the day next after the general election. The Speaker designate of the Assembly or the Majority Leader designate of

the Senate, as the case may be, may appoint a member to fill the vacancy for the remainder of the unexpired term.

6. Vacancies on a Joint Interim Standing Committee must be filled in the same manner as original appointments.

(Added to NRS by 2021, 2505)

INTRODUCTION

The Joint Interim Standing Committee on Health and Human Services (JISC HHS) is a permanent interim committee of the Nevada Legislature whose authority and responsibilities are set forth in NRS 218E.330 and NRS 439B.220 through 439B.227. Responsibilities include reviewing and evaluating the quality and effectiveness of programs for the prevention of illness and analyzing the overall system of medical care in Nevada. Additionally, the Committee may: (1) review health insurance issues and certain health care regulations; (2) examine hospital-related matters, medical malpractice issues, and the health education system; and (3) evaluate and review issues relating to child welfare. Finally, its jurisdiction includes issues that fall under the purview of the Senate and Assembly Standing Committees on Health and Human Services from the 2023 Legislative Session.

The JISC HHS held seven meetings during the 2023–2024 Interim, including a work session during its last meeting on August 12, 2024. Throughout the interim, the JISC HHS considered topics relating to access to health care, behavioral and mental health, child welfare, health care workforce and occupational licensing, and public health, as follows:

1. February 16, 2024—Overview of the JISC HHS and interim studies; Nevada's health rankings and priority issues; objectives and priorities of the Department of Health and Human Services (DHHS); updates from the Nevada Medicaid program regarding bill implementations and certain other topics; hospital-based rural health care; and rural tribal health care;

2. March 11, 2024—Graduate medical education and education of health care professionals; health care workforce; medical licensure; and health care consolidation;

3. April 8, 2024—Public health needs and priorities; immunization rates and vaccination outreach efforts; chronic disease prevention; food security; and expansion of health care insurance coverage to certain immigrants;

4. May 13, 2024—Access to and funding of behavioral health services for adults; crisis intervention and stabilization; behavioral health workforce; and forensic mental health services;

5. June 10, 2024—Children's behavioral and mental health; child welfare services; and implementation status of regulations for the interoperability of health information;

6. July 17, 2024[1]—Pedestrian and road safety; Complete Streets Program policies and initiatives throughout the State; impact of extreme heat and urban heat mitigation; and Healthy Homes Program; and

[1] The July 17, 2024, meeting of the JISC HHS was a joint meeting with the JISC on Growth and Infrastructure (JISC GI). The JISC GI hosted this meeting, and the agenda and meeting materials can be found on the JISC GI's meeting page.

7. August 12, 2024—Final meeting and work session.

At its final meeting and work session on August 12, 2024, the JISC HHS approved recommendations for 14 bill draft requests (BDRs) to be considered by the 2025 Session of the Nevada Legislature. The BDRs concern:

1. Emergency medical services;
2. Silver State Health Insurance Exchange;
3. Tribal health care;
4. Health services provided to Medicaid-enrolled pupils;
5. Account for public health and public health data interoperability;
6. Medicaid reimbursement for community-based living arrangement services provided to adults with serious mental illness;
7. Health insurance coverage for the screening and assessment of certain disorders and disabilities;
8. Social work apprentices;
9. Health care workforce and occupational licensing;
10. Priority review of health care license or certificate applications;
11. Categorical grants for adoption assistance programs;
12. Immunity for reporting child abuse or neglect;
13. Adoption of children and adults; and
14. The Office of Children's Mental and Behavioral Health.

In addition, the JISC HHS approved a recommendation to include a statement in the Committee's final report that supports an update to Nevada's Department of Transportation (NDOT) Complete Streets policy to promote cardiovascular health.

More information about the Committee's activities—including minutes, recordings of meetings, and copies of presentations and other exhibits—may be accessed on the Legislature's website for the 2023–2024 Interim.

BACKGROUND

The 2023 Legislature passed two legislative measures requiring the JISC HHS to study certain topics. The first measure, Senate Concurrent Resolution 5, required the Committee to review

existing cardiovascular screening programs in Nevada and how State agencies may collaborate with federal agencies, programs, and private organizations in the evaluation and expansion of such programs, which must include:

- A review of the Get With The Guidelines program of the American Heart Association, the degree to which the program has been adopted by health facilities in Nevada, and the success of the program where it has been adopted by Nevadan health facilities;

- Consideration of reimbursement provisions under the Medicaid program for the remote monitoring of cardiovascular health; and

- A review of the implementation of Complete Streets Programs pursuant to NRS 403.575 and the identification of gaps in reforms to zoning laws in order to promote zoning that is more conducive to good cardiovascular health.

The Committee heard several presentations on the Complete Streets Programs and initiatives throughout the State at its joint meeting with the JISC GI on July 17, 2024, and approved a recommendation concerning these programs (see Item F. [Cardiovascular Health] in the section of this report titled, "Discussion of Testimony and Recommendations").

The second measure, Assembly Bill 155, required the Committee—in coordination with DHHS—to study the cost-effectiveness of biomarker testing: (1) for the diagnosis, treatment, management, or ongoing monitoring of specific diseases or conditions; and (2) to screen for specific diseases or conditions or traits associated with specific diseases or conditions.

The bill appropriated $325,000 from the State General Fund to the Division of Health Care Financing and Policy (DHCFP or Nevada Medicaid), DHHS, to contract with a qualified person to determine the cost-effectiveness of providing coverage for biomarker testing under Medicaid for the diagnosis, treatment, management, or ongoing monitoring of diseases or conditions other than cancer. According to representatives of Nevada Medicaid, study results will be available before the commencement of the 2025 Legislative Session, which is in accordance with the provisions of AB 155.

DISCUSSION OF TESTIMONY AND RECOMMENDATIONS

Pursuant to NRS 218D.160, the Committee may request the drafting of no more than 15 legislative measures on or before September 1, 2024, which relate to matters within the scope of the Committee. Five of the fifteen BDRs allocated to the Committee are limited to issues that address child welfare matters.

At its final meeting and work session on August 12, 2024, the JISC HHS considered a total of 15 proposed actions for legislation or statements to include in its final report. Additional information regarding all recommendations considered is available in the Committee's Work Session Document.

A. Access to Care

Many Nevadans face challenges in accessing necessary health care services due to a range of factors, including limited or lack of health insurance coverage, high out-of-pocket costs, inadequate transportation—particularly in rural areas—and a shortage of health care providers, to name a few. The United States Centers for Disease Control and Prevention (CDC) highlights several indicators for access to health care that can, for instance, significantly influence cardiovascular disease prevention and management. Individuals with health insurance are more likely to receive timely screenings, diagnostic tests, and preventive interventions. Early detection and appropriate management of risk factors reduce major cardiac events.

Disparities in health care access persist across different population groups. Racial and ethnic minorities, such as African American, American Indian and Alaska Native, or Latino populations, face various barriers to care, which are influenced by historical, social, and economic factors. Low-income individuals also encounter challenges related to affordability, transportation, and provider availability. Geographic disparities further exacerbate inequities, particularly in rural, frontier, and underserved urban areas.

Nearly 90 percent of Nevadans have health insurance through public or private providers. However, almost 11 percent are uninsured—a figure that has remained relatively stable over the years. Those who are uninsured or underinsured often struggle to access health care, with the cost of care being a significant barrier. Many uninsured individuals, including, without limitation, immigrants with a temporary or undocumented status, turn to hospital emergency departments, federally qualified health centers, or other community health centers, which function as safety nets.

Recommendation 1—Emergency Medical Services (EMS)

At its meeting on March 11, 2024, the JISC HHS heard presentations that provided an overview of EMS in Nevada, EMS workforce challenges, and licensing issues. According to Cindy Green, EMS Chief, Reno Fire Department, the State's EMS program within DHHS is currently understaffed and under-resourced. Public comment from multiple stakeholders further indicated these issues may impact the provision of EMS in Nevada's communities, except Clark County, which is able to administer its own EMS program.

The following recommendation was proposed by David Cochran, President, Nevada Fire Chiefs Association; Assemblyman Ken Gray, JISC HHS member; and Senator Fabian Doñate, Chair of the JISC HHS, in consultation with Committee staff. At its final meeting and work session on August 12, 2024, the Committee approved the drafting of legislation to:

a. Revise Chapters 439 ("Administration of Public Health") and 450B ("Emergency Medical Services") of NRS to authorize the district board of health in a county whose population is 100,000 or more but less than 700,000 to administer emergency medical services in the same manner as a county whose population is 700,000 or more;

b. Remove the need for an individual to be licensed as an Ambulance Attendant for an Emergency Medical Technician (EMT) trainee in order to participate in a "ride along" with ambulance services during his or her training if the trainee participating in the ride along is not caring for a patient being transported in the ambulance; and

c. Authorize an individual between 16 and 18 years of age to become licensed as an Ambulance Attendant or as an EMT in Nevada. **(BDR 40–345)**

Recommendation 2—Silver State Health Insurance Exchange

The JISC HHS heard testimony from a representative of the Washington Health Benefit Exchange regarding the State of Washington's expansion of health care coverage to all state residents pursuant to a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act (ACA) (H.R.3590, 111th Congress).

During the Committee's work session on August 12, 2024, Chair Doñate proposed, and the Committee approved, a recommendation for the drafting of a bill to:

a. Require the Silver State Health Insurance Exchange—in consultation with the Commissioner of Insurance, Division of Insurance, Department of Business and Industry, and the Director of DHHS—to apply for a State Innovation Waiver under Section 1332 of ACA through the Centers for Medicare and Medicaid Services (CMS). Specifically, the Exchange shall seek a waiver to Section 1312(f)(3) of the ACA to the extent it would otherwise require excluding certain Nevada residents from enrolling in qualified dental and health plans of the State's Exchange Section;

b. Require the Exchange to conduct an actuarial analysis for the waiver application to determine, without limitation, that the waiver meets the requirements of Section 1332(b)(1) of the ACA, which requires a waiver to:

    i. Provide coverage that is at least as comprehensive as the coverage provided without the waiver;

    ii. Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver;

    iii. Provide coverage to at least a comparable number of residents as without the waiver; and

    iv. Not increase the federal deficit;

c. Make an appropriation totaling $1,000,000 from the State General Fund to the Exchange over the 2025–2027 Biennium to conduct the actuarial analysis and any other administrative activities related to the waiver application and implementation;

d. Require the Exchange to complete the analysis and apply for the waiver in such a manner that it can offer health insurance under the waiver starting on January 1, 2028; and

e. Amend subsection 2 of NRS 695I.300 by requiring the Senate Majority Leader and the Speaker of the Assembly to each appoint one additional voting member to the Board of Directors of the Silver State Health Insurance Exchange. **(BDR 57–346)**

Recommendation 3—Tribal Health Care

At its meeting on February 16, 2024, the JISC HHS heard a presentation on rural tribal health care in Nevada from Angie Wilson, Director of the Tribal Health Center, Reno-Sparks Indian Colony.

During its final meeting and work session on August 12, 2024, the Committee approved the following recommendation for the drafting of legislation proposed by Chair Doñate and Ms. Wilson:

a. Create the Tribal Health Authority Council to:

   i. Serve as the principal tribal health authority body to the Governor and DHHS on issues related to health and health care for American Indians and Alaska Natives;

   ii. Adopt a tribal health advisory plan to increase access to care and address and eliminate any barriers. The plan may include, without limitation: (1) an assessment of Indian health and Indian health care in the State; and (2) development of specific recommendations for programs, projects, or activities to support advancement of health initiatives for American Indians and Alaska Natives in the State; and

   iii. Address issues with tribal health implications that cannot be resolved at the State agency level;

b. Establish the membership and terms of the Council as follows:

   i. Voting members: one tribal health representative or designee of each Nevada tribe as defined in NRS 233A.220, the director or designee of each urban tribal health organization, and the directors or designees of tribal health programs, one person who is a member of a Native Hawaiian community in Nevada, one representative of the Office of the Governor, and one member each from the majority and minority caucuses of the Senate and the Assembly;

   ii. Nonvoting members: one representative or designee of the Indian Health Service Phoenix Area Office and Service Units and any tribal liaisons of State agencies involved in health care;

   iii. Each member appointed to the Council serves for a term of four years. A vacancy on the Council must be filled consistent with voting and nonvoting membership criteria;

   iv. A member may be reappointed to the Council without limitation of terms served;

   v. The members of the Council shall elect—from tribal health representatives—a Chair and Vice Chair by majority vote. After the initial election, the Chair and Vice Chair shall hold office for a term of one year beginning on July 1 of each year. If the position of Chair or Vice Chair becomes vacant, the members of the Council shall elect a Chair or Vice Chair, as appropriate, from among its members for the remainder of the unexpired term; and

vi. The members of the Council serve without compensation;

c. Require the Council to meet at least once every quarter and at the times and places specified by a call of the Chair or a majority of the members of the Council. A Council member who is a tribal health representative may designate in writing a person to represent him or her at a meeting of the Council if it is impractical for the Council member to attend the meeting. The designated representative shall be deemed to be a member of the Council for the purpose of tribal participation during the meeting and may vote on any matter that is voted on by the regular Council members at the meeting;

d. Require the Director of DHHS to request federal approval from CMS authorizing tribal health benefit coordinators to determine eligibility for the Medicaid program of any American Indian and Alaska Native in the State. Upon approval, DHHS shall collaborate with the Council and any tribal health clinic in the State for activities that will enable such coordinators to make Medicaid determinations, including, without limitation: (1) providing necessary training; (2) coordinating information technology upgrades; (3) establishing interfaces to any Medicaid or welfare management software; and (4) any other necessary activities;

e. Create the Account for Tribal Health in the State General Fund. The Council may seek opportunities to apply for matching federal funds and may accept any gift, donation, bequest, grant, or other source of money to fulfill the purposes of the Council. Any money remaining in the Account at the end of a fiscal year does not revert to the State General Fund, and the balance in the Account must be carried forward to the next fiscal year;

f. Make an appropriation totaling $224,000 from the State General Fund to Nevada's Department of Native American Affairs over the 2025–2027 Biennium for the personnel and operating costs of the Coordinator for the Council; and

g. Direct the Director of DHHS to collaborate with the Council during the 2025–2026 Legislative Interim to:

i. Develop a proposal to seek the establishment of a tribal reinvestment program of savings that may be achieved from the enhanced Medicaid federal medical assistance percentage of 100 percent provided for certain health care services rendered to American Indians and Alaska Natives who are enrolled in Medicaid, which is similar to Oregon House Bill 2286 (2023) or any pertinent legislation from other states; and

ii. Submit a report to and present the report at a meeting of the JISC HHS no later than June 30, 2026, that includes, without limitation, the developed proposals and any recommendations for legislation. **(BDR 40–347)**

Recommendation 4—Health Services Provided to Medicaid-Enrolled Pupils

According to Nevada Medicaid, there are two different provider types for School Health Services (SHS) and School-Based Health Centers (SBHCs): (1) SHS are health care services provided in

the school setting[2] to Medicaid-eligible pupils (Provider Type 60); and (2) SBHCs provide primary and preventive medical services to Medicaid-eligible students at health centers located on or near a school facility of a school district, independent school, or board of an Indian tribe or tribal organization (Provider Type 17).

In June 2024, CMS awarded a grant to Nevada Medicaid for "the Implementation, Enhancement, and Expansion of Medicaid and the Children's Health Insurance Program (CHIP) School-Based Services," which will be used to expand access to critical health care services for pupils, especially mental health care (see also DHCFP's press release).

During the work session on August 12, 2024, Chair Doñate—in consultation with Committee staff and representatives of DHCFP—proposed the drafting of a bill to supplement the current efforts of Nevada Medicaid to expand access to these services. Subsequently, the Committee voted to approve this recommendation to:

a. Require the Director of DHHS to:

    i. Take any action necessary to ensure that local and State educational agencies are able to receive reimbursement for health services covered by Medicaid when provided on the premises of a school and establish incentives for certain providers to enter into an agreement with a school district or charter school or Nevada's Department of Education (NDE) to provide SHS;

    ii. Apply for any necessary federal authority to increase by at least 5 percent the rates of reimbursement for any SHS covered by Medicaid when provided on the premises of a school by an employee or independent contractor of a school district or charter school or NDE; and

    iii. Apply for any necessary federal authority to simplify and streamline reimbursement methodology and increase by 10 percent any service provided by an SBHC located on or near a school facility of a school district which provides primary and preventive medical services to Medicaid-eligible pupils;

b. Establish the School Health Access Resource Center in DHCFP, for the purpose of assisting persons and entities who wish to provide health services in schools to evaluate and utilize different methods of participating in and billing Medicaid;

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[2] Reimbursable SHS for Medicaid-eligible pupils who are between 3 and 21 years of age, includes, without limitation: (1) screening and diagnostic services, including hearing and vision screening through the Healthy Kids Program; (2) physicians services; (3) physician's assistant services; (4) nursing services provided by registered nurses, licensed practical nurses, and advanced nurse practitioners; (5) psychological services; (6) physical therapy services; (7) speech therapy, language disorders, and audiology services; (8) occupational therapy services; (9) applied behavior analysis; (10) personal care services; (11) home health care services, such as those which may be written into an Individualized Educational Plan; (12) case management; (13) dental services; (14) optometry services; (15) nonresidential mental health rehabilitative services; (16) outpatient alcohol and substance abuse services; (17) audiological supplies, such as Assistive Communication Devices; and (18) durable medical equipment and supplies.

c. Make an appropriation totaling $600,000 from the State General Fund to DHCFP over the 2025–2027 Biennium for vendor support to conceptualize and establish the Resource Center and all other related activities; and

d. Make an appropriation totaling $224,000 from the State General Fund to DHCFP over the 2025–2027 Biennium for the personnel and operating costs of the Resource Center created in the Division and make an additional appropriation of $5,000 for equipment and office supplies for Fiscal Year (FY) 2025–2026. **(BDR 38–348)**

B. Public Health

Public health focuses on preventing disease, promoting healthy behaviors, and protecting the well-being of entire communities, whether they be neighborhoods, cities, or the State. Key issues in public health include: (1) access to health care and social services; (2) preventing mortality and morbidity from noncommunicable diseases and injuries; (3) substance use prevention and treatment; (4) developing community-based strategies to address social determinants of health; and (5) preventing and treating the spread of infectious diseases.

In Nevada, State and local governments share responsibility for public health, and it is one of only two states with a highly decentralized public health system. Most of its population is served by two mostly independent urban health districts—the Southern Nevada Health District and Northern Nevada Public Health. A third district, the Central Nevada Health District, serves four counties in exclusively rural communities. The State provides direct public health services in most other rural and frontier counties.

Nevada largely depends on federal funding to support public health initiatives. Traditionally, limited State funding and restrictions on how these funds can be used have hindered the State's ability to prioritize public health needs, as seen during the Coronavirus Disease of 2019 (COVID-19) pandemic. Recognizing the need to address this issue, the Nevada Legislature passed Senate Bill 118 in 2023, which appropriated $15 million from the State General Fund to the Division of Public and Behavioral Health (DPBH), DHHS, for the improvement of public health in Nevada. The bill required the Division to distribute these funds to specified public health districts and to itself, following prescribed percentage allocations. Each of these entities had to evaluate and determine the priority level of public health needs within its jurisdiction and expend the allocated funds based on those priorities.

Nevada improved its national ranking[3] for public health funding from spending $72 per capita (2019–2020) to $135 per capita (2021–2022), which could be contributed to large injections of federal funds into the State's public health system to combat the COVID-19 pandemic. However, this amount is still below the national average of $183 per capita. In contrast, Alaska spends about $465 per capita. The additional funding provided by SB 118 in 2023—among other allocations for public health initiatives—may assist to further increase the per capita public health funding in the State for the 2023–2024 ranking. However, SB 118 was a one-time allocation of funds to only

[3] America's Health Rankings, United Health Foundation, retrieved in August 2024.

certain public health entities and did not establish similar funding of statewide public health efforts in the future.

Recommendation 1—Account for Public Health and Public Health Data Interoperability

At its meetings on February 16 and April 8, 2024, the JISC HHS heard testimony related to Nevada's health rankings and priority issues, public health infrastructure, and considerations to address the funding gaps and other challenges of Nevada's public health system.

At its final meeting and work session on August 12, 2024, Chair Doñate—in consultation with Committee staff and representatives of the Nevada Association of Counties—proposed, and the Committee voted to approve, the drafting of legislation to:

a. Create the Account for Public Health in the State General Fund. The Division of Public and Behavioral Health shall administer the Account. The Account shall be funded with the first $30 million per biennium of the Insurance Premium Tax collected by the Department of Taxation. The money in the Account must be expended to address the tribal, county, district, and State public health needs in Nevada;

b. Define "health authority" as a county or district board of health pursuant to Chapter 439 ("Administration of Public Health") of NRS or each Nevada tribe as defined in NRS 233A.220;

c. Require DPBH on or before April 1 of an even-numbered year and upon approving proposals from each health authority to allocate the money in the Account to the following health authorities based on the following prescribed percentages of the total appropriated money:

    i. To DPBH for distribution to each Nevada tribe as defined in NRS 233A.220, 10 percent;

    ii. To DPBH, 5 percent;

    iii. To each county or district board of health in Nevada, 1 percent. A district board of health formed by more than one county shall receive 1 percent for each county within its jurisdiction;

    iv. After this allocation, the remaining money in the Account shall be allocated to the county or district boards of health in proportion to their respective population. The population shall be based on the demographic projection of the current calendar year from the State Demographer;

    v. Any balance of the sums allocated to a health authority remaining at the end of the following fiscal year must not be committed for expenditure and must be reverted to the Account. The Division of Public and Behavioral Health must use reverted sums for public health improvement efforts within the health authority's jurisdiction that reverted these sums or to support any other statewide public health efforts; and

vi. The Account may retain no more than 4 percent of the total appropriations received in the biennium as a reserve. The reserve can be used in a future biennium based on public health needs. Any reserve in excess of the 4 percent is considered excess reserve and must be reverted to the State General Fund by the end of the fiscal year. The portion of any money remaining in the Account at the end of a fiscal year from the sums allocated to a health authority that is reverted to the Account pursuant to item (v) is excluded for the purpose of calculating the reserve, does not revert to the State General Fund, and may be carried forward to the next fiscal year to be used for public health efforts. Any such money remaining by the end of the fiscal year to which the money was carried forward is included for the purpose of calculating the reserve and reverts to the State General Fund accordingly;

d. Require DPBH to:

i. Provide each health authority with an estimate of allocations in the Account at the beginning of a fiscal year in an odd-numbered year;

ii. Request from each health authority who may receive allocations from the Account a proposal that includes, without limitation, a list of public health priorities and associated spending plans; and

iii. Review the priorities and process for alignment with requirements pursuant to paragraph (e), approve or deny the proposals, and make biennial progress reports to the State Board of Health;

e. Require a health authority to include in its proposal to DPBH: (1) an evaluation of the public health needs of residents of the area under the jurisdiction of the authority; (2) a determination of the level of priority of the public health needs identified; and (3) a spending plan of the allocated money in accordance with the levels of priority. Areas of public health improvement that can be part of a proposal include:

i. Control of communicable diseases and other notifiable conditions;

ii. Chronic disease and injury prevention;

iii. Environmental public health;

iv. Maternal, child, and family health;

v. Access to and linkage with medical, oral, and behavioral health services;

vi. Vital records;

vii. Assessing the health of populations;

viii. Public health emergency planning;

ix. Communications;

x. Policy development and support;

xi. Community partnership development;

xii. Business competencies; and

xiii. Any other area as defined by DPBH;

f. Require a health authority that received allocations from the Account to submit a report to DPBH in the format and on the timeline recommended by the Division no later than 90 days after the end of each fiscal year. The report must include, without limitation:

i. A description of the process used by the health authority pursuant to paragraph (e) to evaluate the public health needs of residents of the area under the jurisdiction of the health authority and the public health needs identified through that process;

ii. A description of each expenditure of the allocated money made by the health authority;

iii. The unexpended balance of the allocated money at the end of the fiscal year; and

iv. Reporting and metrics requested by the Division in the format and on the timeline prescribed by the Division;

g. Revise NRS 439.362 to add two additional members—one appointed by the Senate Majority Leader and one appointed by the Speaker of the Assembly—to any district board of health created in counties whose population is 700,000 or more;

h. Revise NRS 439.390 to add two additional members—one appointed by the Senate Majority Leader and one appointed by the Speaker of the Assembly—to any district board of health created in counties whose population is less than 700,000; and

i. Require health authorities to establish a framework that includes standards on public health data interoperability and data exchange by 2030. The framework should use any public health reporting standards established on a federal level by the CDC, the Office of the National Coordinator for Health Information Technology, or any other federal agency that establishes nationwide frameworks and standards, including, without limitation, the Trusted Exchange Framework and Common Agreement. For this purpose, all health authorities must use funding allocated from the Account for Public Health to establish the framework for their respective jurisdictions. **(BDR 40–349)**

C. Behavioral Health

Access to mental and behavioral health care services is vital to overall well-being. In Nevada, limited access to these services has long been a concern since almost 25 percent of adults report having a mental illness, and nearly 7 percent report having a serious mental illness with severe impairments in daily functioning and quality of life.

Despite perennial efforts to improve services, Nevada's behavioral health care system has consistently ranked low in the State of Mental Health in America reports. These rankings, published by a community-based nonprofit, consider indicators like the prevalence of mental illness, substance use, access to behavioral health care, and health insurance coverage among adults and youth. In the 2024 report, Nevada's overall ranking once again[4] dropped to the bottom (51st) of all other states and the District of Columbia. The largest effect on this current ranking were youth indicators for substance use disorders, major depressive disorder, and health insurance coverage of mental or emotional problems.

Research indicates the treatment of mental illnesses during adolescence is crucial as about half of them begin by age 14, and three-quarters by age 24, according to the National Alliance on Mental Illness. The children's behavioral and mental health system in Nevada has consistently ranked among the worst with the State, ranking last (51st) in the 2024 State of Mental Health in America report. In the report, almost 24 percent of Nevada youth reported suffering from at least one major depressive episode in the past year, and of those, almost three-quarters did not receive any mental health treatment. Further, Nevada had the lowest percentage of families reporting their children lived in supportive neighborhoods. Having protective environments, social connections, and community support is considered a core prevention strategy for the negative impacts caused by mental health crises.

During the JISC HHS meeting on June 10, 2024, the Committee heard testimony related to children's behavioral health and child welfare. Stacie Weeks, Administrator of Nevada Medicaid, DHHS, provided an update on the U.S. Department of Justice[5] (DOJ) investigation into Nevada's behavioral health care system. According to Ms. Weeks, the State is still in confidential negotiations with the DOJ on a settlement agreement to come into compliance with the ADA. Other states with similar violations needed three years or longer to finalize such an agreement with the DOJ. Therefore, it is uncertain at what point the agreement between the State and DOJ will be finalized. However, Nevada Medicaid has begun a multi-year process to establish new home- and community-based services and other benefits for youth and to increase rates of existing services, which is partially made possible by funding generated through Senate Bill 435 (2023).

Further, Marla McDade Williams, Administrator of the Division of Child and Family Services (DCFS), DHHS, testified regarding the provision of direct mental health services by the Division and stated DCFS is a safety net provider of last resort in case children cannot find services in the community. She emphasized that Nevada Medicaid has the responsibility to provide an adequate number of providers throughout the State, and DCFS attempts to fill the gaps in services of

[4] In the State of Mental Health in America 2023 report, Nevada's overall ranking had improved to the 29th rank. However, the 2023 report states that "the rankings presented throughout this year's […] report cannot be reliably compared to the rankings of previous years' reports, and therefore should be interpreted as a snapshot in time ranking rather than a reflection of trends over time." The 2023 report relied on several studies using data from 2020, which had much smaller sample sizes than previous data collections due to the COVID-19 pandemic.

[5] In October 2022, the DOJ concluded an investigation into Nevada's behavioral health care system and determined that the State subjects children with behavioral health disabilities to unnecessary institutionalization. This violates Title II of the Americans with Disabilities Act (ADA), which means that Nevada fails to provide adequate community-based services to children with behavioral health disabilities and instead relies on segregated, institutional settings like hospitals and residential treatment facilities, among others.

Medicaid's provider network. However, Ms. McDade Williams illustrated the challenges of DCFS to provide children's mental health services due to significant internal staffing issues, among other issues.

Recommendation 1—Medicaid Reimbursement for Community-Based Living Arrangement Services Provided to Adults With Serious Mental Illness

At the Committee's final meeting and work session on August 12, 2024, Chair Doñate—in consultation with Committee staff and representatives of Nevada Medicaid—proposed, and the Committee voted to approve, a recommendation for the drafting of legislation to:

> Require DHCFP to coordinate with DPBH to establish a method of reimbursement for a therapeutic group home model of care for adults with serious mental illness who are recipients of Medicaid. "Therapeutic group home" means a provider certified by DPBH to provide community-based living arrangement services as defined in NRS 449.0026 that supports independent, community-based living for individuals with serious mental illness. Additionally, the Director of DHHS shall seek all necessary federal authority under Title XIX of the Social Security Act (H.R.4366, 118th Congress) to provide Medicaid reimbursement for services provided in such group home settings by qualified providers. **(BDR 38–350)**

Recommendation 2— Health Insurance Coverage for the Screening and Assessment of Certain Disorders and Disabilities

At the JISC HHS meeting on June 10, 2024, Brian Knudsen, City Council, City of Las Vegas, presented policy recommendations relating to child mental health priorities developed by the Children's Advocacy Alliance of Nevada (CAA).

During the Committee's work session on August 12, 2024, the Committee approved a recommendation for the drafting of a bill proposed by Mr. Knudsen and Holly Welborn, Executive Director, CAA, to:

> Require private and public health insurers to provide coverage for individuals under 18 years of age or, if enrolled in high school, until the person reaches 22 years of age, for the screening and assessment of attention deficit and hyperactivity disorder, fetal alcohol spectrum disorder, intellectual disabilities, and specific learning disorders. **(BDR 57–351)**

Recommendation 3—Office of Children's Mental and Behavioral Health

At the JISC HHS meeting on June 10, 2024, Mr. Knudsen presented policy recommendations relating to child mental health priorities. During the Committee's work session on August 12, 2024, the Committee approved a recommendation for legislation proposed by Mr. Knudsen and Ms. Welborn to:

a. Create the Office of Children's Mental and Behavioral Health in the Director's Office of DHHS;

b. Require the Director of DHHS to appoint a Director of the Office. The Director of the Office shall connect all State children's mental and behavioral health efforts in Nevada;

c. Require the Director of the Office to ensure that the Office:

   i. Develops a statewide child behavioral health plan;

   ii. Disseminates statewide information, resources, and opportunities that will improve child behavioral health care;

   iii. Provides expertise in and acts as a resource for certain matters related to children's mental and behavioral health solutions;

   iv. Tracks, reviews, and analyzes the policies and programs of State agencies relating to child behavioral and mental health outcomes;

   v. Engages in State and federal policy affecting children and adolescents with mental and behavioral health needs to improve access and delivery of services and resources; and

   vi. Develops sustainable partnerships with community foundations and other nonprofit or private sector entities that serve children and adolescents with mental and behavioral health needs in this State;

d. Require each agency, board, commission, department, officer, employee, or agent of a local government in Nevada to assist the Office; and

e. Make an appropriation totaling $1,113,364 from the State General Fund to DHHS over the 2025–2027 Biennium for the personnel and operating costs of the Office created in the Department and make an additional appropriation of $15,000 for equipment and office supplies in FY 2025–2026. **(BDR –358)**

D. Health Care Workforce and Occupational Licensing

Nevada continues to experience a significant shortage of health care professionals. Although the supply of providers has increased over the years, it has not kept pace with the rising demand for care. The number of health care providers per 100,000 residents remains well below the national average. According to the *Health Workforce in Nevada: A Chartbook* (2023), the State would need an additional 255 family medicine physicians, 626 nurse practitioners, and 3,162 registered nurses to match national per capita rates. Further, the primary and behavioral health care workforce is geographically maldistributed throughout the State, with significant workforce gaps in rural and frontier areas of Nevada. The State also faces a severe shortage of behavioral health care providers, with nearly 87 percent of Nevada's population living in areas with a federally designated shortage of mental health professionals.

These shortages can hinder timely diagnosis and appropriate care. Several factors influence whether health care providers choose to practice in Nevada, including the availability of health education and training programs, occupational licensing and regulatory practices, and the effectiveness of recruitment and retention strategies.

At the JISC HHS meetings on March 11, May 13, and June 10, 2024, multiple entities presented on issues relating to graduate medical education, health care occupational licensing, and behavioral health care workforce.

Recommendation 1—Social Work Apprentices

At its final meeting and work session on August 12, 2024, the JISC HHS approved a recommendation for the drafting of legislation proposed by Senator Robin L. Titus, Committee member, to:

a. Require the Board of Examiners for Social Workers to promulgate regulations[6] authorizing a social work student to perform social work functions as a social work apprentice. The regulations shall include, without limitation, the following conditions:

   i. The social work student must be enrolled as a student in a social work program to pursue a baccalaureate degree or master's degree in social work from a college or university accredited by the Council on Social Work Education, or its successor organization, or which is a candidate for such accreditation;

   ii. The social work student is employed at an apprenticeship site or facility as approved by the Board. An apprenticeship site or facility may include, without limitation: (1) medical facilities; (2) State or local agencies; (3) public schools; or (4) any other site as defined by the Board;

   iii. The social work student is supervised by a licensed social worker, licensed master social worker, licensed independent social worker, or licensed clinical social worker or any other licensed behavioral health or health care professional as determined by the Board and depending on the social work program in which the social work student is enrolled;

   iv. The social work student presents to his or her employer satisfactory evidence from his or her school of social work of the successful demonstration of his or her skills;

   v. The Board must approve a list of tasks a social work student may perform at an approved apprenticeship site. The tasks' difficulties and complexities may increase on a social work student's progress in a social work program for a baccalaureate or master's degree;

   vi. The apprenticeship site must: (1) evaluate a social work student as safe to perform those tasks; (2) identify the roles and responsibilities of the apprentice position of a social work student; (3) identify the tasks delegated to the social work student acting as a social work apprentice; (4) establish a formal procedure for the social work student to refuse to perform any task until he or she is comfortable with his

[6] The State Board of Nursing adopted *Nevada Administrative Code* (NAC) 632.252 (see also R018-22) to allow nursing students to be employed as apprentice nurses at certain medical facilities. The recommendation on social work apprentices is using these nursing regulations as a model.

or her ability to do so safely; and (5) require the social work student, acting as a social work apprentice, to identify himself or herself as such with clients of the apprenticeship site; and

vii. The social work student must demonstrate acquired skills to his or her employer and only perform tasks approved by the Board. Social work apprentices must adhere to the laws and regulations set forth for social workers in Chapters 641B ("Social Workers") of NRS and of NAC.

b. Establish the Social Work Apprentice program in DHHS. The Department shall oversee the program and may:

i. Contract with any third party to administer the program and reimburse the third party for its services;

ii. Set up a process for facilities and sites approved by the Board to enroll in the program;

iii. Determine the amount of reimbursement of each social work apprentice's salary at an hourly rate that the facility may receive. The hourly rate shall progressively increase for social work apprentices enrolled as students in a baccalaureate degree or master's degree in social work;

iv. Determine the amount of reimbursement of a health care professional approved by the Board to supervise the social work apprentice;

v. Determine the amount of a retention or sign-on bonus—to the extent of available funding—for a facility or site who employs a social work apprentice upon successful graduation and licensure of the social work apprentice;

vi. Determine the parameters to reimburse a social work apprentice for travel, per diem meals, and lodging to work at a remote-employing facility or site; and

c. Make an appropriation totaling $2,000,000 from the State General Fund to DHHS over the 2025–2027 Biennium to establish the Social Work Apprentice program and any other administrative activities related to the program. **(BDR –352)**

Recommendation 2—Health Care Occupational Licensing

Part of the following recommendation is based on Senate Bill 26 of the Utah State Legislature, which passed during its 2024 Legislative Session. Among other provisions, the bill established the Behavioral Health Board (see also *Utah Code* § 58-60-102.5, included in the section of this report titled, "Appendices"), a multi-professional board to consolidate certain individual licensing boards of various behavioral health professions. The Board is comprised of at least six licensed behavioral health providers, two other licensed providers, and four members of the public. The Board's responsibilities and powers include overseeing behavioral health licensees and recommending statutory changes to support workforce adequacy, public safety, and revisions to burdensome regulations, among others. Senate Bill 26 also established three advisory committees—

Qualifications and Professional Development, Background and Investigations, and Probation and Compliance—to advise the Board on licensure, professional development, criteria for licensure of applicants with criminal backgrounds, and probation compliance. Additionally, the measure authorizes Utah's Division of Integrated Healthcare, Utah Department of Health and Human Services—in consultation with the Behavioral Health Board—to establish standing or ad hoc subcommittees to address various aspects of licensing, such as client or patient access to qualified licensees; education, examination, and supervision of applicants for licensure; continuing education requirements; et cetera. The bill also made multiple other changes to behavioral health licensing.

During the Committee's final meeting and work session on August 12, 2024, Chair Doñate—in consultation with Committee staff—proposed, and the JISC HHS voted to approve, the drafting of a bill to:

a. Establish the State Office of Health Care Workforce and Licensing within DPBH;

b. Move to the State Office of Health Care Workforce and Licensing from the Office of Science, Innovation and Technology, Office of the Governor, all funding, power, and responsibilities pertaining to the Graduate Medical Education Grant Program and the Advisory Council on Graduate Medical Education established in Chapter 223 ("Governor") of NRS;

c. Create under the State Office of Health Care Workforce and Licensing a Behavioral Health Board and advisory committees modeled after *Utah Code* § 58-60-102.5 and consolidate under the Behavioral Health Board the following boards established in NRS:

    i. Board of Psychological Examiners (NRS 641.030);

    ii. Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors (NRS 641A.090);

    iii. Board of Examiners for Social Workers (NRS 641B.100);

    iv. Board of Examiners for Alcohol, Drug and Gambling Counselors (NRS 641C.150); and

    v. Board of Applied Behavior Analysis (NRS 641D.200).

d. Require the Behavioral Health Board to assume responsibility for administration of licensure, investigations, and complaint resolution for all behavioral health professionals currently licensed in Chapters 641, 641A, 641B, 641C, and 641D of NRS;

e. Redirect board fees and funds generated through licensure and other funding streams from boards established pursuant to Chapters 641, 641A, 641B, 641C and 641D of NRS to the Behavioral Health Board to support the activities of licensure administration, investigation, and regulatory oversight for behavioral health professionals;

f. Require the Behavioral Health Board to make necessary regulatory changes to existing regulations in Chapters 641, 641A, 641B, 641C, and 641D of NAC and develop new regulations to comply with these legislative changes;

g. Establish that any laws and regulations pertaining to disciplinary processes adopted by boards established pursuant to Chapters 641, 641A, 641B, 641C, and 641D of NRS remain in effect and may be enforced by the Behavioral Health Board until the Behavioral Health Board adopts regulations to repeal or replace those regulations;

h. Provide that contracts and agreements, disciplinary and administrative actions, and licenses issued by such boards remain in effect as if taken by the officer or entity to which the responsibility for the enforcement of such action has been transferred;

i. Require DPBH to:

   i. Develop a plan for transitioning from the existing licensing structure of the professions in Chapters 641, 641A, 641B, 641C, and 641D of NRS to the Behavioral Health Board, so licensees and the public can follow and participate in the transition process. The plan must be presented at a meeting in compliance with the Open Meeting Law and adopted at a second meeting in compliance with the Open Meeting Law. Provisions of Chapter 233B ("Nevada Administrative Procedure Act") of NRS do not apply to this transition plan. The transitioning must be completed in such a manner that the Behavioral Health Board starts to conduct its business no later than January 1, 2027; and

   ii. Develop and provide recommendations to the JISC HHS during the 2025–2026 Interim that outline the consolidation of all other health care licensing boards and other health care professions under the State Office of Health Care Workforce and Licensing. Health care licensing board or profession means a licensing authority as established in the following Chapters of NRS:

      (1) Chapters 641, 641A, 641B, 641C, and 641D;

      (2) Chapter 630 ("Physicians, Physician Assistants, Medical Assistants, Perfusionists, Anesthesiologist Assistants and Practitioners of Respiratory Care");

      (3) Chapter 630A ("Homeopathic Physicians, Advanced Practitioners of Homeopathy and Homeopathic Assistants");

      (4) Chapter 631 ("Dentistry, Dental Hygiene, Dental Therapy and Expanded Function Dental Assistance");

      (5) Chapter 632 ("Nursing");

      (6) Chapter 633 ("Osteopathic Medicine");

      (7) Chapter 634 ("Chiropractic Physicians and Chiropractic Assistants");

(8) Chapter 634A ("Doctors of Oriental Medicine");

(9) Chapter 634B ("Naprapaths");

(10) Chapter 635 ("Podiatric Physicians and Podiatry Hygienists");

(11) Chapter 636 ("Optometry");

(12) Chapter 637 ("Dispensing Opticians");

(13) Chapter 637B ("Audiologists, Speech-Language Pathologists and Hearing Aid Specialists");

(14) Chapter 639 ("Pharmacists and Pharmacy");

(15) Chapter 640 ("Physical Therapists, Physical Therapist Assistants and Physical Therapist Technicians");

(16) Chapter 640A ("Occupational Therapists and Occupational Therapy Assistants");

(17) Chapter 640B ("Athletic Trainers");

(18) Chapter 640C ("Massage Therapy");

(19) Chapter 640D ("Music Therapists");

(20) Chapter 640E ("Dietitians");

(21) Chapter 652 ("Medical Laboratories");

(22) Chapter 653 ("Radiation Therapy and Radiologic Imaging"); and

(23) Chapter 654 ("Administrators of Facilities for Long-Term Care"). **(BDR 40–353)**

Recommendation 3—Priority Review of Health Care License or Certificate Applications

During the work session on August 12, 2024, Chair Doñate—in consultation with Committee staff—proposed, and the Committee voted to approve, the drafting of a bill to:

> Require all entities that license or certify health care professions to develop a process to expedite the licensure or certification process by giving priority review status to the license or certificate application of an applicant who demonstrates that he or she intends to practice in a historically underserved community as defined in NRS 704.78343. An applicant shall provide proper documentation, including, without limitation, a letter from an employer located in a historically underserved community indicating that the applicant has accepted employment and stating the start date. **(BDR –354)**

E. Child Welfare

The State provides numerous services to ensure the welfare of children—one of the most vulnerable segments of society. Services include, without limitation, direct child protective services, foster care, independent living services, and adoption. The Division of Child and Family Services, DHHS, is responsible for the oversight of programs and services for child welfare and children's mental health. It also provides direct services to children and families in all counties except those with a population of 100,000 or more. The Clark County Department of Family Services and the Washoe County Human Services Agency provide child welfare services in Clark and Washoe Counties, respectively.

Recommendation 1—Categorical Grants for Adoption Assistance Programs

At its meeting on June 10, 2024, the JISC HHS heard testimony on child welfare services in Clark County from Jill Marano, Director of Clark County Department of Family Services. Among others, Ms. Marano highlighted a policy issue regarding the need to return funds from categorical grants for adoption assistance programs to the State General Fund after a certain time frame. According to Ms. Marano, Clark County has annually reverted approximately $2 million of these funds to the State General Fund, which instead could have been invested in supporting adoptions.

During its final meeting and work session on August 12, 2024, the Committee approved the following recommendation for the drafting of legislation, proposed by Ms. Marano and Ashley Garza Kennedy, Principal Management Analyst, Government Affairs, Clark County, to:

a. Revise subsection 1 of NRS 432B.219 to stipulate that the amount allocated to a child welfare agency's adoption assistance program through a categorical grant shall also be determined based on the calculations prescribed under the Adoption and Guardianship Assistance Program set forth in 42 U.S.C. § 673(a)(8)(A). This requires the state to calculate certain savings—if any—to all applicable children for a fiscal year using a methodology specified by the U.S. Secretary of Health and Human Services or an alternate methodology proposed by the state and approved by the Secretary; and

b. Revise subsection 4 of NRS 432B.219 to allow any savings from categorical grants that have been awarded to a child welfare agency's adoption assistance program to be carried forward with that agency for two fiscal years instead of only one fiscal year. **(BDR 38–355)**

Recommendation 2—Adoption of Children and Adults

At the Committee's final meeting and work session on August 12, 2024, the Administrator of DCFS proposed, and the Committee voted to approve, a recommendation for the drafting of legislation to:

a. Codify NAC 127.140 in Chapter 127 ("Adoption of Children and Adults") of NRS to authorize the fingerprinting of an applicant for an initial license as a director of a private child-placing agency;

b. Revise subsection 3 of NRS 127.007 by authorizing DCFS to release information to relatives under extenuating circumstances as determined by the Division. The intent is

to allow, for example, two siblings to locate each other who were adopted by different adoptive parents. Currently, this may only occur if the natural parent provided consent to the Division or if the siblings have a death certificate of the natural parent; and

c. Revise NRS 127.145 by authorizing prospective adoptive parents to attend a court hearing by videoconference or any other technological means available to the court in addition to attending a hearing by telephone. **(BDR 11–356)**

Recommendation 3—Immunity for Reporting Child Abuse or Neglect

During its final meeting and work session on August 12, 2024, the Committee approved another recommendation proposed by Ms. Marano and Ms. Garza Kennedy for the drafting of legislation to:

a. Amend NRS 432B.160 to clarify the provisions regarding the protection from criminal and civil liability for individuals who make a good faith report of suspected or known child abuse or neglect or who provide assistance, such as medical evaluations or consultations, in connection with such reports or investigations. Specifically, extend immunity from civil or criminal liability as set forth in Section 3 of the Victims of Child Abuse Act Reauthorization Act of 2018 (S.2961, 115th Congress); and

b. Provide that a mandatory reporter who prevailed as a defendant in a civil action may be awarded by the court costs and reasonable attorney's fees incurred by the defendant. **(BDR –357)**

F. Cardiovascular Health

Senate Concurrent Resolution 5 (2023) required the JISC HHS—among other provisions—to complete a review of the implementation of Complete Streets Programs pursuant to NRS 403.575 and to identify gaps in reforms to zoning laws in order to promote zoning that is more conducive to good cardiovascular health.

Recommendation 1

At the joint meeting of the JISC GI and the JISC HHS on July 17, 2024, representatives of Carson City Public Works, NDOT, and the Regional Transportation Commissions of Southern Nevada and Washoe County presented on their respective Complete Streets policies and initiatives.

During the Committee's final meeting and work session on August 12, 2024, Chair Doñate proposed, and the JISC HHS voted to approve, a recommendation to:

Include a statement of support in this final report that supports an updated Complete Streets Policy to promote cardiovascular health as developed through the Context Sensitive Design approach of NDOT.

SUGGESTED LEGISLATION

The following bill draft requests will be available during the 2025 Legislative Session at the following website: https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bdrs/List

BDR	40–345	Revises provisions relating to emergency medical services.
BDR	57–346	Makes revisions relating to the Silver State Health Insurance Exchange.
BDR	40–347	Makes revisions relating to tribal health programs.
BDR	38–348	Makes revisions relating to Medicaid.
BDR	40–349	Makes revisions relating to public health.
BDR	38–350	Makes revisions relating to Medicaid.
BDR	57–351	Requires health insurance to cover certain screenings and assessments.
BDR	–352	Revises provisions relating to social work.
BDR	40–353	Makes revisions relating to health professions.
BDR	–354	Establishes priority review for certain applicants for licensure to practice health professions.
BDR	38–355	Revises provisions relating to adoption assistance programs.
BDR	11–356	Revises provisions relating to adoption.
BDR	–357	Revises provisions concerning the investigation of child abuse or neglect.
BDR	–358	Creates the Office of Children's Mental and Behavioral Health.

APPENDICES

Appendix A: *Utah Code* § 58 60-102.5

This is related to Recommendation 2 in the section of this report titled, "Health Care Workforce and Occupational Licensing."

Effective 5/1/2024

58-60-102.5 Behavioral Health Board — Advisory committees.

(1) There is created the Behavioral Health Board consisting of:

(a) no less than six behavioral health care providers licensed in Utah to practice as a:

(i) clinical social worker;

(ii) marriage and family therapist;

(iii) clinical mental health counselor;

(iv) master addiction counselor;

(v) psychologist under Chapter 61, Psychologist Licensing Act; or

(vi) behavior analyst or specialist;

(b) no less than two other behavioral health care providers licensed in Utah to practice as:

(i) a certified social worker;

(ii) a social service worker;

(iii) an associate marriage and family therapist;

(iv) an associate clinical mental health counselor;

(v) an associate master addiction counselor;

(vi) an advanced substance use disorder counselor;

(vii) a substance use disorder counselor;

(viii) a certified psychology resident; or

(ix) an assistant behavior analyst or specialist;

(c) no less than four public members:

(i) who comprise no less than 1/3 of the total membership of the board;

(ii) who are not licensed to practice under:

(A) this chapter; or

(B) Chapter 61, Psychologist Licensing Act;

(iii) two of whom shall, at the time of appointment to the board, hold a leadership position with:

(A) a behavioral health consumer advocacy organization;

(B) a behavioral health employer;

(C) a behavioral health payor;

(D) an academic institution conducting research related to the behavioral health licenses under Subsection (3)(b), including public health, epidemiology, economics, and the health care workforce;

(E) a training institution providing education credentials required for a license under Subsection (3)(b);

(F) a licensed health care facility as defined in Section 26B-2-201; or

(G) a licensed human services program as defined in Section 26B-2-101;

(iv) one of whom the executive director of the Department of Health and Human Services appoints; and

(v) one of whom is licensed in Utah to practice as a:

(A) physician under Chapter 67, Utah Medical Practice Act, or Chapter 68, Utah Osteopathic Medical Practice Act;
(B) physician assistant under Chapter 70a, Utah Physician Assistant Act; or
(C) nurse under Chapter 31b, Nurse Practice Act, or Chapter 31e, Nurse Licensure Compact - Revised.

(2) Board members shall be appointed, serve terms, and be compensated in accordance with Section 58-1-201.

(3) The board shall:

(a) operate in accordance with Section 58-1-202, unless otherwise provided in this section;

(b) oversee licenses under:

(i) this chapter; and

(ii) Chapter 61, Psychologist Licensing Act;

(c) recommend to the appropriate legislative committee statutory changes to:

(i) ensure that regulation supports an adequate workforce to meet consumer demand for behavioral health services; and

(ii) prevent harm to the health, safety, and financial welfare of the public;

(d) recommend to the appropriate legislative committee statutory changes to remove regulations that are no longer necessary or effective in protecting the public and enhancing commerce; and

(e) disqualify any member from acting as a presiding officer in any administrative procedure in which that member has previously reviewed the complaint or advised the division.

(4)

(a) There are created the following advisory committees to the board:

(i) the Qualifications and Professional Development Advisory Committee;

(ii) the Background and Investigations Advisory Committee; and

(iii) the Probation and Compliance Advisory Committee.

(b) Each advisory committee shall consist of:

(i) a committee chair who is a member of the Behavioral Health Board;

(ii) a member of each profession regulated under this chapter;

(iii) Chapter 61, Psychologist Licensing Act; and

(iv) as determined by the division in rule, additional members from the professions licensed under this chapter or Chapter 61, Psychologist Licensing Act.

(c) In addition to the requirements of Subsection (4)(b):

(i) the Qualifications and Professional Development Advisory Committee shall also consist of an educator for each profession regulated under this chapter and Chapter 61, Psychologist Licensing Act; and

(ii) the Background and Investigations Advisory Committee shall also consist of a criminal justice professional.

(d) The Qualifications and Professional Development Advisory Committee shall:

(i) advise the division regarding qualifications for licensure, including passing scores for applicant examinations and standards of supervision for students or persons in training to become licensed;

(ii) recommend evidence-based ongoing professional development requirements for licensure that:

(A) ensure an adequate workforce to meet consumer demand; and

(B) prevent harm to the health, safety, and financial welfare of the public;

(iii) advise the division on the licensing, renewal, reinstatement, and relicensure of:
(A) internationally trained applicants;
(B) applicants applying via licensure by endorsement; and
(C) applicants applying using an alternate pathway to licensure including a non-exam or equivalent field degree path;
(iv) draw on additional profession-specific advisors as needed;
(v) make policy recommendations to the board regarding qualifications for licensure or renewal for a specific profession, including the committee chair assigning at least one committee member licensed under that profession to serve as a subject matter expert; and
(vi) make recommendations to the board related to an individual applicant for a specific license, including the committee chair assigning at least one committee member licensed under the same profession as the applicant to serve as a subject matter expert.

(e) The Background and Investigations Advisory Committee shall:
(i) advise the division on establishing criteria for licensure for those with a criminal conviction according to Section 58-1-401;
(ii) advise the division on establishing criteria for referral to the Utah Professionals Health Program under Chapter 4a, Utah Professionals Health Program;
(iii) screen applicants with a criminal history for licensing, renewal, reinstatement, and relicensure and recommending licensing, renewal, reinstatement, and relicensure actions to the division;
(iv) advise the division on investigative practices and procedures and administrative sanctions for consistency and fairness across relevant occupations;
(v) make recommendations to the board for sanctions against individual licensees and certificate holders and referral to the Utah Professionals Health Program under Chapter 4a, Utah Professionals Health Program;
(vi) draw on additional profession-specific advisors as needed; and
(vii) make recommendations to the board related to the disposition for any specific applicant or licensee, including the committee chair assigning at least one committee member licensed under the same profession as the applicant or licensee to serve as a subject matter expert.

(f) The Probation and Compliance Advisory Committee shall:
(i) review compliance with probationary orders;
(ii) review early termination and make any recommendations as requested by the board;
(iii) advise the board regarding the screening of applicants previously sanctioned for licensing, renewal, reinstatement, and relicensure, including recommending licensing, renewal, reinstatement, and relicensure actions to the board;
(iv) establish procedures for monitoring sanctioned licensees or certificate holders;
(v) draw on additional profession-specific advisors as needed; and
(vi) make recommendations to the board related to the disposition for any specific licensee or certification holder, including the committee chair assigning a committee member licensed under the same profession as the licensee or certification holder to serve as a subject-matter expert related to that disposition.

(5) The division, in consultation with the board, may establish one or more standing or ad hoc subcommittees to consider and advise the board regarding any aspect of licensing, including:
(a) client or patient access to qualified licensees;

(b) education, examination, and supervision of applicants for licensure;
(c) verification of applicant for licensure qualifications;
(d) continuing education requirements;
(e) alternate pathways to licensure; and
(f) probation and recovery assistance.

(6) The division may consult with licensed psychologists on matters specific to the oversight of doctoral-level licensed psychologists.

(7) Members of the board and any subcommittees created under this section may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:
(a) Section 63A-3-106;
(b) Section 63A-3-107; and
(c) rules made by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(8) The division shall consult with the Physicians Licensing Board created in Section 58-67-201 on any matters relating to:
(a) the licensing of individual certified prescribing psychologists and provisional prescribing psychologists; and
(b) rulemaking related to the occupation of prescribing psychology.

Enacted by Chapter 420, 2024 General Session

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