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MEETING NOTICE AND AGENDA

Name of Organization:	Legislative Committee on Health Care (*Nevada Revised Statutes* [NRS] 439B.200)
Date and Time of Meeting:	Monday, September 14, 2020 9 a.m.
Place of Meeting:	Pursuant to Sections 2 through 9, inclusive, of Chapter 2, *Statutes of Nevada 2020*, 32nd Special Session, pages 9 through 11, there will be no physical location for this meeting. The meeting can be listened to or viewed live over the Internet. The address for the Nevada Legislature's website is http://www.leg.state.nv.us. Click on the link "View Meetings & Press Conferences."

We are pleased to make reasonable accommodations for members of the public with a disability. If accommodations for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at research@lcb.state.nv.us, or call the Research Division at (775) 684-6825 as soon as possible.

Minutes of this meeting will be produced in summary format. Please submit electronic copies of testimony and visual presentations if you wish to have complete versions included as exhibits with the minutes to HealthCare@lcb.state.nv.us. You may also mail written documents to the Research Division, 401 South Carson St., Carson City, NV 89701, or fax them to (775) 684-6600.

Items on this agenda may be taken in a different order than listed. Two or more agenda items may be combined for consideration. An item may be removed from this agenda or discussion relating to an item on this agenda may be delayed at any time.

I. Opening Remarks
Assemblymwoman Lesley E. Cohen, Chair

II. Public Comment
Because there is no physical location for this meeting, public testimony under this agenda item may be presented by phone or written comment.

Because of time considerations, each caller offering testimony during this period for public comment will be limited to not more than 2 minutes. To call in to provide testimony during this period of public comment in the meeting any time after 8:30 a.m. on September 14, 2020, dial (669) 900-6833. When prompted to provide the Meeting ID, please enter 965 0852 2608 and then press #. When prompted for a Participant ID, please press #. To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-6990.

A person may also have comments added to the minutes of the meeting by submitting them in writing either in addition to testifying or in lieu of testifying. Written comments may be submitted electronically before, during, or after the meeting by email to HealthCare@lcb.state.nv.us. You may also mail written

documents to the Research Division, 401 South Carson St., Carson City, NV 89701, or fax them to (775) 684-6600.

For Possible Action

III. Approval of the Minutes for the Meeting on August 19, 2020

For Possible Action

IV. Report Regarding the Committee to Conduct an Interim Study Concerning the Costs of Prescription Drugs, as Required by Senate Bill 276 of the 2019 Legislative Session

Senator Yvanna D. Cancela, Chair, Committee to Conduct an Interim Study Concerning the Costs of Prescription Drugs

For Possible Action

V. Work Session—Discussion and Possible Recommendations Relating to:

A. Public Health

B. Behavioral Health and Substance Use Prevention

C. Maternal Health

D. Training for Caregivers

E. Health Workforce Data Collection

F. Oral Health

The "Work Session Document" (WSD) contains recommendations proposed at this and other meetings of the Legislative Committee on Health Care during the 2019–2020 Interim. The WSD is available on the Committee's Meeting Page. A written copy may be obtained by contacting Megan Comlossy, Principal Policy Analyst, Research Division, Legislative Counsel Bureau, at megan.comlossy@lcb.state.nv.us or (775) 684-6825.

VI. Public Comment

Because there is no physical location for this meeting, public testimony under this agenda item may be presented by phone or written comment.

Because of time considerations, each caller offering testimony during this period for public comment will be limited to not more than 2 minutes. To provide public testimony by telephone during this period of public comment, members of the public may call any time after the Chair announces this second period of public comment on September 14, 2020. To call in, dial (669) 900-6833. When prompted to provide the Meeting ID, please enter 965 0852 2608 and then press #. When prompted for a Participant ID, please press #. To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-6990.

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VII. Adjournment

Notice of this meeting was posted on the Internet through the Nevada Legislature's website at www.leg.state.nv.us.

Supporting public material provided to Committee members for this meeting may be requested from Janet Coons, Manager of Research Policy Assistants, Research Division, Legislative Counsel Bureau, at (775) 684-6825 or by email at HealthCare@lcb.state.nv.us and is/will be available at the Nevada Legislature's website at www.leg.state.nv.us.

WORK SESSION DOCUMENT

LEGISLATIVE COMMITTEE ON HEALTH CARE

(*Nevada Revised Statutes* [NRS] 439B.200)

September 14, 2020

INTRODUCTION

The chair and Legislative Counsel Bureau (LCB) staff of the Legislative Committee on Health Care (LCHC) have prepared this "Work Session Document" (WSD) to assist the Committee in determining which legislative measures it will request for the 2021 Session of the Nevada Legislature as well as other actions the Committee may endorse. The WSD contains a summary of recommendations presented during public hearings, through communication with individual Committee members, or through correspondence submitted to the Committee members or staff.

The members of the Committee do not necessarily support or oppose the recommendations in this WSD. Committee staff has compiled and organized the proposals so that Committee members can review them and decide whether they want to accept, reject, modify, or take no action on the recommendations. The WSD groups the proposals by topic and they are not preferentially ordered.

Pursuant to NRS 218D.160, the Committee is limited to ten legislative measures, which includes both bill draft requests (BDRs) and requests for the drafting of resolutions. The Committee may also vote to: (1) send as many statements or letters of recommendation or support as it chooses; and (2) include statements in its final report.

Committee members are advised that LCB staff, at the direction of the chair, may coordinate with interested parties to obtain additional information for drafting purposes or for information to be included in the Committee's final report.

RECOMMENDATIONS

A. PUBLIC HEALTH

1. **Propose legislation** to require Medicaid to reimburse the services of community health workers who provide services under the supervision of a physician, physician assistant, or advanced practice registered nurse.

Recommendation discussed by DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS),

at the Committee meeting on December 11, 2019. Also recommended by Children's Advocacy Alliance.

2. **Include a statement of support** for Health in All Policies (HiAP) in Nevada in the Committee's final report. Health in All Policies is an approach to addressing the social determinants of health and supporting health equity through collaboration between public health entities and nontraditional stakeholders. The topic was discussed by Gerold Dermid, M.B.A., Director, Nevada Public Health Training Center, School of Community Health Sciences, University of Nevada Reno (UNR), during the Committee meeting on February 19, 2020.

   The HiAP concept relies on incorporating health considerations into decision-making across sectors and policy areas and includes five key elements: (1) promoting health and equity; (2) supporting intersectoral collaboration; (3) creating mutual benefits for multiple partners; (4) engaging stakeholders; and (5) creating structural or process change. An ongoing HiAP pilot program between Nevada Public Health Training Center and the Office of Minority Health and Equity, DHHS, aims to reduce practices that contribute to health disparities experienced by minority populations through collaboration with agencies whose services address social determinants of health.

B. BEHAVIORAL HEALTH AND SUBSTANCE USE PREVENTION

3. **Propose legislation to**:

   a. Define SBIRT—Screening, Brief Intervention, and Referral to Treatment—to mean an evidence-based method of delivering early intervention and treatment to persons with substance use disorder or at risk of developing substance use disorder that consists of: (1) screening to assess the severity of substance use and identify the appropriate level of treatment; (2) brief intervention to increase insight and awareness of substance use and motivation toward behavioral change; and (3) referral to treatment for those who need more extensive treatment and access to specialty care.

   b. Require health care professionals who are authorized to prescribe controlled substances in Nevada, as a condition for licensure or license renewal, to obtain two hours of continuing education in SBIRT; such controlled substance prescribers must complete SBIRT training only once during licensure in the state.

   c. Allow completion of approved SBIRT training to fulfill continuing education requirements related to substance use, other addictive disorders, and the prescribing of opioids and similar topics (such as requirements in NRS 630.2535, NRS 631.344, NRS 632.2375, NRS 633.473, NRS 635.116, and NRS 636.2881) for the licensing period in which the SBIRT training is completed.

   d. Require training to be completed by January 1, 2024, for license renewal, and prior to licensure for controlled substance prescribers applying for licensure on or after this date.

e. Allow a controlled substance prescriber who, on or after July 1, 2021, obtains a waiver to treat opioid dependency with narcotic medications, in accordance with the Drug Addiction Treatment Act of 2000, 21 U.S.C. Sec. 823 et seq., to use the waiver to satisfy the SBIRT continuing education requirement.

Recommendation submitted by representatives of Dignity Health-St. Rose Dominican EMPOWERED (Empowering Mothers for Positive Outcomes With Education, Recovery, and Early Development) Program.

4. Federal law prohibits federal payment for services provided to patients residing in "institutions for mental disease (IMD)," facilities that have more than 16 beds and primarily provide services to "individuals with mental diseases." This prohibition means Medicaid may not use federal matching funds to pay for services at mental and behavioral health facilities with more than 16 beds. However, in recent years the federal Centers for Medicare and Medicaid Services (CMS) has authorized two Section 1115 waivers from the IMD exclusion policy. The first allows states to apply for a waiver to pay for substance use disorder (SUD) treatment in IMDs; these waivers have been approved in 28 states. The second allows a waiver to pay for services for adults with serious mental illness or children with a serious emotional disturbance; such waivers have been approved in four states.[1]

   Propose legislation to:

   a. Require DHCFP to apply for a Medicaid 1115 demonstration waiver to pay for SUD treatment services in IMDs.

   b. Authorize DHCFP to apply for a 1115 waiver of the federal IMD payment exclusion for services for adults with serious mental illness or children with a serious emotional disturbance.

Recommended by DHCFP and the Washoe Regional Behavioral Health Policy Board.

5. **Send letters** to the Senate and Assembly Committees on Health and Human Services and the director of DHHS expressing the Committee's support for the priorities identified by the Children's Mental Health Consortiums. (See Agenda Item V-1—Information From the Children's Mental Health Consortiums on the LCHC's Meeting Page.)

Recommendation submitted by Dan Musgrove on behalf of the Children's Mental Health Consortiums.

C. MATERNAL HEALTH

6. **Propose legislation** to require DHCFP, to the extent authorized by federal law, to expand Medicaid coverage to pregnant women in Nevada by:

[1] Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State, Kaiser Family Foundation, Updated September 1, 2020.

a. Increasing Medicaid coverage for pregnant women in Nevada from 165 percent to 200 percent of the federal poverty level.

b. Implementing presumptive Medicaid eligibility for pregnant women, wherein qualified entities, such as health care providers; schools; Head Start; the Women, Infants, and Children Program; and other community organizations are authorized to determine that pregnant women are presumptively eligible for the Medicaid program. Presumptive eligibility lasts until the end of the month following enrollment, during which time the recipient must submit a Medicaid application to continue coverage.

c. Eliminating the requirement that lawfully residing pregnant women must have lived in the United States for five years prior to being eligible for Medicaid.

d. Expanding postpartum Medicaid coverage from 60 days to 12 months following childbirth. This option will require DHCFP to apply for a Section 1115 waiver from CMS.

Recommendations proposed by various presenters at the LCHC meeting on January 15, 2020.

7. **Propose legislation to**:

a. Revise NRS 442.010(1)(a) to clarify when a pregnant woman must be tested for syphilis as follows:

i. The first trimester of pregnancy, at the woman's first visit or as soon thereafter as practicable;

ii. The third trimester of pregnancy, between the 27th and 36th week of gestation or as soon thereafter as practicable; and

iii. At delivery for women who are at high risk for syphilis, as defined by the federal Centers for Disease Control and Prevention (CDC); live in areas of high syphilis morbidity; did not receive prenatal care; or deliver a stillborn infant.

b. Revise NRS 442.020 to make the penalty for violating NRS 442.010 a civil penalty not to exceed $500, instead of a misdemeanor, and authorize DPBH to impose such fines.

and/or

c. Require hospital emergency departments and other medical facilities to test pregnant women who seek care in the facility for syphilis, if a woman indicates that she has not had prenatal care as recommended by the American College of Obstetricians and Gynecologists or its successor organization.

and/or

d. Require screening for chlamydia, gonorrhea, hepatitis B, and hepatitis C for all pregnant women as recommended by the CDC or its successor organization.

Recommendation submitted by Julia Peek, M.H.A., C.P.M., Deputy Administrator, Community Health Services, Division of Public and Behavioral Health (DPBH), DHHS, and Candice McDaniel, M.S., Maternal and Child Health Director and Bureau Chief, Bureau of Child, Family and Community Wellness, DPBH, DHHS, at the Committee meeting on January 15, 2020.

D. TRAINING FOR CAREGIVERS

8. **Propose legislation to**:

   a. Require DPBH to adopt regulations regarding mandatory training for unlicensed caregivers who provide care at certain facilities, homes, agencies, or providers licensed under Chapter 449 of NRS. The DPBH must:

      i. Identify the facilities/facility types subject to this training;

      ii. Set minimum standards of training on topics related to infection control and prevention and any other topics it deems appropriate;

      iii. Review and revise required topics of training periodically to address new or relevant issues that impact health and safety; and

      iv. Identify nationally recognized, evidence-based organizations that provide free or low-cost training modules on required topics and whose training may be used to satisfy training requirements.

   b. Provide that the administrator of each facility subject to these regulations:

      i. Is responsible for ensuring appropriate staff complete required training annually, documenting the completion of such training in personnel files, and ensuring the implementation of best practices addressed in the training throughout the facility; and

      ii. Must develop and implement an infection control plan based on nationally recognized, evidence-based guidelines for the facility. The infection control plan must be updated annually. It must be provided in writing upon development and annually thereafter to all facility employees, contractors, others who regularly provide services on the premises, and residents.

Recommendation submitted in response to Assembly Bill 131 (2019) study by Assemblywoman Lesley E. Cohen, Chair, LCHC, in consultation with Margot Chappel, Deputy Administrator, Regulatory and Planning Services, DPBH, DHHS.

E. HEALTH WORKFORCE DATA COLLECTION

9. **Propose legislation** to enact the Health Care Workforce Data Collection, Analysis, and Policy Act to improve available data on the health care workforce in Nevada. This data will be used to inform health policy planning and workforce development, including health professional shortage area (HPSA) designations and funding tied to HPSA designations for health professionals and facilities in medically underserved areas of the state. Specifically:

a. The director of DHHS shall establish and maintain a database, analyze data collected, develop reports for the Legislature or the Executive Branch, and perform other duties to carry out the provisions of the Health Care Workforce Data Collection, Analysis, and Policy Act. The Department may contract or collaborate with a private or public entity to conduct the aforementioned activities.

    i. An entity that establishes, maintains, or analyzes data or develops reports by contract pursuant to subsection a of this section shall provide to DHHS, in a manner that conforms to DHHS rules, access to any health care workforce data that the entity establishes, maintains, analyzes, or reports; and

    ii. Aggregated, de-identified data must be made available to the public.

b. An applicant for renewal of a license by a board shall provide the information prescribed by DHHS pursuant to subsection d of this section. Subsection b applies to applicants for renewal of health professional licensure under the following boards:

    i. Board of Medical Examiners;

    ii. State Board of Osteopathic Medicine;

    iii. Board of Dental Examiners of Nevada;

    iv. Board of Psychological Examiners;

    v. Board of Examiners for Social Workers;

    vi. Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors;

    vii. State Board of Nursing; and

    viii. State Board of Pharmacy.

c. A board shall not approve a subsequent application for renewal of a license until the applicant provides the information pursuant to subsection d of this section.

d. The State Board of Health, with input from licensing boards and other health care stakeholders, shall adopt rules regarding the manner, form, and content of reporting data; the consistency of data entry fields used; and the information that an applicant, pursuant to subsection b of this section, shall provide to a board. At a minimum, the rules shall provide for a core essential data set, including the applicant's:

    i. Demographics, including, but not limited to race, ethnicity, and primary and other languages spoken;

    ii. Practice status, including, but not limited to:

        - Active practices in Nevada and other locations;

- Practice type, such as individual practice or multispecialty group practices; and

- Practice settings, such as hospital, clinic, or other clinical settings;

iii. Education, training, and primary and secondary specialties;

iv. Average hours worked per week and the average number of weeks worked per year in the licensed profession;

v. Percentage of practice engaged in direct patient care and in other activities, such as teaching, research, and administration in the licensed profession;

vi. Practice plans for the next five years, including retiring from the health care profession, moving out of state, or changing health care work hours; and

vii. Additional data elements identified by the State Board of Health.

If boards already collect information required by the State Board of Health, they do not need to duplicate the same questions for the purposes of the required data collection, but all required information must be provided to DHHS.

e. The following boards shall report health care workforce information collected pursuant to this section to DHHS on a regular basis, to be determined by the State Board of Health in regulation, but no less than annually. Required data must be collected for all license renewals beginning July 1, 2022, and may be collected earlier if regulations are in place:

i. Board of Medical Examiners;

ii. State Board of Osteopathic Medicine;

iii. Board of Dental Examiners of Nevada;

iv. Board of Psychological Examiners;

v. Board of Examiners for Social Workers;

vi. Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors;

vii. State Board of Nursing; and

viii. Board of Pharmacy.

f. Other health professional licensure boards may choose to require applicants for license renewal to submit data as prescribed by the State Board of Health, and the board may provide such data to DHHS pursuant to the Health Care Workforce Data Collection, Analysis, and Policy Act.

g. A board shall keep confidential and not release personally identifiable data collected under this section for any person licensed, registered, or certified by the

board. The provisions of this subsection do not apply to the release of information to a law enforcement agency for investigative purposes or to DHHS for state health planning purposes. The Department, or a person with whom DHHS contracts to perform data collection, storage, and analysis shall protect the privacy of that data. The Department shall ensure that the responses of applicants shall be kept confidential, including taking special precautions when the identity of an applicant may be ascertained due to the applicant's location or occupation.

i. Only aggregate, de-identifiable data may be made public; and

ii. None of the data required to be collected by the State Board of Health that is not typically collected as part of the license renewal process may be used by boards to make decisions regarding licensure renewal.

h. A board shall promulgate rules as necessary to perform the board's duties pursuant to this section, including rules for collecting, storing, and analyzing data in addition to the information required to be collected by the Health Care Workforce Data Collection, Analysis, and Policy Act.

i. Health Care Workforce Advisory Group—The director of DHHS shall convene a health care workforce advisory group that includes representatives of health care consumers; health care providers and industry; organized groups representing physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, pharmacists, behavioral health providers, and allied health professions; health care workforce training institutions; institutions of higher education; health professional licensing boards; and appropriate representatives of DHHS. The workforce advisory group shall advise:

i. The State Board of Health on the development of regulations related to required questions/data collection, survey methodology, and other related issues; and

ii. The State Board of Health and other health stakeholders on the use of health workforce data to inform policymaking, the federal HPSA designation process, health policy planning, and improve health outcomes in Nevada.

The advisory group must convene within 90 days of the effective date of this bill.

j. Requested effective date: July 1, 2021.

Recommendation submitted by John Packham, Ph.D., Associate Dean, Office of Statewide Initiatives, UNR School of Medicine, at the Committee meeting on June 17, 2020.

F. ORAL HEALTH

10. **Propose legislation to** enhance access to dental care through teledentistry, establish emergency dental responders, and revise provisions related to the dental loss ratio as follows:

Teledentistry

a. Definitions:

i. “Board" means the Board of Dental Examiners of Nevada;

ii. "Dental practitioner" means a dentist, dental hygienist, dental hygienist with a public health endorsement, or dental therapist who is licensed pursuant to Chapter 631 of NRS;

iii. “Teledentistry” means the mode of delivering dental health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s dental health care while the patient is at an originating site and the dental practitioner is at a distant site. Teledentistry facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers;

iv. “Teledental services” means the use of telehealth systems and methodologies as outlined in Chapter 629 of NRS by a licensed dental practitioner operating within the scope of his or her practice or specified in rules adopted by the Board;

v. “Dental home” means that a child's oral health care is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist;

vi. “Asynchronous store and forward” means the transmission of a patient’s medical and dental information from an originating site to the dental practitioner at a distant site;

vii. “Distant site” means a site where a dental practitioner who provides dental health care services is located while providing these services via a telecommunications system;

viii. “Originating site” means a site where a patient is located at the time dental health care services are provided via a telecommunications system or where the asynchronous store and forward service originates; and

ix. “Synchronous interaction” means a real-time interaction between a patient and a dental practitioner located at a distant site.

b. Practice of teledentisry—To practice teledentistry, dental practitioners must meet requirements related to licensure, teledentistry general provisions, practitioner-patient relationship standards, patient rights and informed consent, and coordination of care, as outlined below.

c. Licensure—Require dental practitioners to obtain two hours of continuing education in teledentistry for initial licensure and, for those who are already licensed, for licensure renewal by 2022. The Board must establish regulations identifying courses that qualify for teledentistry continuing education.

    i. This requirement is waived if the dental practitioner presents a certificate of completion in a teledentistry course as part of his or her coursework for graduation from an institution accredited by the Commission on Dental Accreditation; and

    ii. A dental practitioner using teledentistry to practice dentistry, dental hygiene, or dental therapy on patients in Nevada must be licensed to practice in Nevada. This includes dental practitioners who treat or prescribe to Nevada patients through online service sites.

d. Professional liability insurance policies must provide malpractice coverage for teledentistry.

e. The Board is authorized to adopt regulations as necessary to carry out the provisions of the bill. These regulations should address, at a minimum:

    i. Prescribing policies;

    ii. Patient records and privacy;

    iii. Collaborative practices between medical and dental offices;

    iv. Consultation, referrals, and billing between different dental specialty types; and

    v. Definitions and interaction between dentists, dental hygienists, and dental therapists, including supervision and delivery of care.

f. Teledentistry may be used in real time to provide limited diagnostic or emergency treatment planning services in collaboration with a nondental community liaison, such as a community health worker, teacher, or emergency medical responder, or a student enrolled in a program of study to become a dental hygienist, dental therapist, or dentist.

g. For the purposes of this chapter, “telehealth” as referenced in Chapter 629 of NRS shall include “teledentistry.”

h. Teledentistry general provisions:

    i. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means or initial diagnosis and correction of malpositions of human teeth or initial use of orthodontic

appliances, will be held to the same standards of appropriate practice as those in traditional, in-person encounters as outlined in Chapter 631 of NRS. Treatment, including issuing a prescription or orthodontic appliance based solely on an online questionnaire, does not constitute an acceptable standard of care;

ii. Pursuant to Chapter 631 of NRS, the standards of professional conduct are the same whether a patient is seen in person or through a teledentistry encounter. A dentist shall not conduct a dental examination using teledentistry if in his or her professional judgement, the patient requires an in-person dental examination;

iii. Dental practitioners using teledentistry will be held to the same standard of professional conduct as practitioners engaging in more traditional in-person care delivery, including the requirement to meet all technical, clinical, confidential, and ethical standards required by law;

iv. This section shall not be construed to alter the scope of practice of any dental practitioner or authorize the delivery of dental health care services in a setting, or in a manner, not otherwise authorized by law;

v. All laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a dental practitioner under his or her Nevada license shall apply while providing teledental services; and

vi. The Board may adopt regulation to specify evidence-based standards of practice and practice guidelines during a teledental procedure to ensure patient safety, quality of care, and positive outcomes.

i. Dental practitioner-patient relationship standards:

i. A dental practitioner may use teledentistry to conduct an examination for a new patient or for a new diagnosis if the examination is conducted in accordance with evidence-based standards of practice to sufficiently establish an informed diagnosis;

ii. Practitioner-patient relationship is the relationship between a dental practitioner and a receiver of oral health care services (patient) based on mutual understanding of their shared responsibility for the patient's oral health care;

iii. When practicing teledentistry, a dental practitioner must establish a practitioner-patient relationship with the patient. The absence of in-person contact does not eliminate this requirement. Patient completion of a questionnaire does not, by itself, establish a practitioner-patient relationship, and therefore treatment, including prescriptions, based solely on a questionnaire, does not constitute an acceptable standard of care;

iv. The dental practitioner must provide proof of identity, jurisdiction, and licensure status to the patient;

v. The dental practitioner must make appropriate effort to confirm the patient's identity. If the patient is a minor, the dental practitioner must make appropriate effort to confirm the parent or legal guardian is present when required;

vi. The dental practitioner must make appropriate effort to confirm and document the patient is physically located in a jurisdiction in which the dental practitioner is licensed;

vii. Any individual, partnership, corporation, or other entity that provides dental services through teledentistry shall make available the name, telephone number, practice address, and Nevada state license number of any dentist who will be involved in the provision of services to a patient prior to the rendering of services and when requested by a patient; and

viii. A violation of this section shall constitute unprofessional conduct.

j. Patient rights and informed consent:

i. When teledentistry will be utilized, the patient will be actively involved in treatment decisions. Prior to the delivery of dental health care via teledentistry, the dental practitioner initiating the use of teledentistry shall inform the patient about the use of teledenistry and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering dental health care services and public health. The consent shall be documented;

ii. The dental practitioner shall ensure informed consent covers the following:

- A description of the types of dental care services provided via teledentistry, including limitations on services;

- The identity, contact information, practice location, licensure, credentials, and qualifications of all dental practitioners involved in the patient's dental care, which must be publicly displayed on a website or provided in writing to the patient;

- Precautions for technological failures or emergency situations; and

- Any other regulations established by the Board of Dental Examiners of Nevada;

iii. Patient information must be stored and shared through a secure server. Electronic devices being used to record or store patient information must be encrypted and password-protected;

iv. The dental practitioner shall ensure that the use of teledentistry complies with the privacy and security requirements of the federal Health Insurance Portability and Accountability Act of 1996;

v. A dental practitioner providing teledentistry services must document the encounter appropriately and completely so that the record clearly, concisely,

and accurately reflects what occurred during the encounter. Such records should be permanent and easily available to or on behalf of the patient and other practitioners in accordance with patient consent, direction, and applicable standards. Dental practitioners should maintain security and confidentiality of the patient record in compliance with applicable laws and regulations related to the maintenance and transmission of such records. A dental practitioner who delivers dental services using teledentistry shall, upon request of the patient, provide health records in a timely manner;

vi. A provider of dental services shall not require a patient to sign an agreement that limits the patient's ability to file a complaint with the board; and

vii. Nothing in this section shall preclude a patient from receiving in-person dental health care delivery services during a specified course of dental health care and treatment after agreeing to receive services via teledentistry.

k. Coordination of care:

i. A dental practitioner who uses teledentistry shall have adequate knowledge of the nature and availability of local dental resources to provide appropriate follow-up care to a patient following a teledentistry encounter. A dental practitioner shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of emergency; and

ii. If the information transmitted through electronic or other means as part of a patient's encounter is not of sufficient quality or does not contain adequate information for the dental practitioner to form an opinion or if the procedure is beyond the practitioner's capability, the dental practitioner must declare he or she cannot make an adequate diagnosis and shall refer the patient for care. The dental practitioner may either complete an in-person physical examination, request additional data, or recommend the patient be evaluated by the patient's primary dentist or other local oral health care provider.

l. Teledentistry in Medicaid:

i. Require DHCFP, in requests for proposals (RFPs) for Medicaid medical managed care organizations (MCOs), to mandate that MCOs provide referrals to teledentistry services within any telehealth packages;

ii. Require DHCFP, dental MCOs, and fee-for-service programs to cover services provided through teledentistry including the synchronous or asynchronous encounter code;

iii. As a condition of payment, synchronous and asynchronous "store and forward" technology is permitted;

iv. Medicaid dental MCOs must create a list of currently available teledentistry services and providers in their network. This information must be updated and provided to hospital emergency departments annually; and

v. Require hospital emergency departments to provide the list of available teledentistry services to patients who present with nontraumatic dental conditions.

m. A dental screening, exam, or assessment provided to patients through teledentistry meets the requirements for an oral health exam or assessment for entrance into an educational facility such as Head Start, licensed childcare facilities, and public or private schools as long as the dental screening, exam, or assessment identifies definitive dental or oral lesions and provides care, coordination, and referrals to locating a dental home.

Emergency Dental Responders

a. Definitions:

i. "Dental responders" means a dentist, dental hygienist, or dental therapist who is appropriately certified in disaster preparedness, immunizations, and dental humanitarian medical response consistent with the Society of Disaster Medicine and Public Health and certified by the National Incident Management System of the Federal Emergency Management Agency (FEMA), U.S. Department of Homeland Security; the National Disaster Life Support Foundation; or their successor organizations and holds a permit from the Nevada State Board of Health;

ii. "Dental abandonment" means temporary or permanent unilateral severance of professional relationship between a dental practitioner and patient without sufficient notice when the necessity of continuing dental services exists;

iii. "Administrator" means the administrator of the Division of Public and Behavioral Health;

iv. "Division" means the Division of Public and Behavioral Health;

v. "Department" means the Department of Health and Human Services; and

vi. "Chief" means the chief of the Division of Emergency Management of the Department of Public Safety (DPS).

b. A dentist, dental hygienist, or dental therapist in good standing with the Board of Dental Examiners of Nevada who is appropriately certified in disaster preparedness, immunizations, and dental humanitarian emergency medical response consistent with the Society of Disaster Medicine and Public Health and certified by the National Incident Management System of FEMA, the National Disaster Life Support Foundation, or their successor organizations may apply for a dental responder permit from the State Board of Health.

c. Dental responders are deemed to be acting within the bounds of licensure when providing emergency medical care, immunizations, and mobile and humanitarian care during the existence of a state of emergency or declaration of disaster pursuant to NRS 414.070 or a public health emergency or other health event pursuant to NRS 439.970.

d. The State Board of Health, in association with the newly created Committee on Dental Emergency Management, shall adopt regulations as necessary to carry out the provisions of the bill.

e. A dental responder who provides care is not liable for any civil damages, liability, or legal action as a result of any act or omission by that person in rendering care or assistance in good faith for the purpose of exercising functions related to an emergency. This does not exempt any harm that occurs because a dental responder committed intentional misconduct, gross negligence, or provided services under the influence of alcohol or drugs.

f. A dental responder is afforded additional protections under NRS 41.500.

g. Expand the membership of the Committee on Emergency Medical Services, as outlined in NRS 450B.151, to include one member who is licensed pursuant to Chapter 631 of NRS, holds a dental responder permit, and who has experience providing emergency medical services.

h. Establish the Committee on Dental Emergency Management within Chapter 439 of NRS:

   i. The Committee on Dental Emergency Management is hereby established within DPBH;

   ii. The administrator shall appoint to the Committee on Dental Emergency Management:

      - One representative of the Nevada Dental Association;
      - One representative of the Nevada Dental Hygienists' Association;
      - One representative of the Board of Dental Examiners of Nevada;
      - One or more representatives of a dental or dental hygiene school in the Nevada System of Higher Education;
      - One representative who is a county health officer, appointed pursuant to NRS 439.290 in a county whose population is 100,000 or less, or the county health officer's designee;
      - The chief medical officer;
      - The state dental health officer;
      - The state public health dental hygienist;
      - One or more representatives of a state or local public health agency whose duties relate to emergency preparedness; and
      - One representative who is a consumer of dental healthcare services;

iii. The term of each representative appointed to the Committee on Dental Emergency Management is three years. A representative may not serve more than two consecutive terms but may serve more than two terms if there is a break in service of not less than two years;

iv. Each representative of the Committee shall appoint an alternate to serve in the member's place if the member is temporarily unable to perform the duties required; and

v. A position on the Committee that becomes vacant before the end of the term of the member must be filled in the same manner as the original appointment.

i. The Committee shall elect a chair from among its members. The term of the chair is one year with the possibility for reappointment.

j. The Committee shall adopt rules for its own management.

k. Representatives of the Committee serve without compensation, except that, for each day or portion of a day during which a member attends a meeting of the Committee or is otherwise engaged in the business of the Committee, the member of the Committee is entitled to receive the per diem allowance and travel expenses provided for state officers and employees generally. The per diem allowance and travel expenses must be paid by DPBH from money not allocated by specific statute for another use.

l. Duties—The Committee on Dental Emergency Management shall:

i. Advise the Board of Dental Examiners of Nevada and DPBH with respect to the preparation and adoption of regulations regarding any issues related to the delivery of dental services, dental practitioners, educational requirements, licensure, and emergency management during the existence of a state of emergency or declaration of disaster pursuant to NRS 414.070 or a public health emergency or other health event pursuant to NRS 439.970;

ii. Report any incidence of patient abandonment or unprofessional conduct to the Board of Dental Examiners of Nevada for investigation;

iii. Review and advise DPBH and the Committee on Emergency Medical Service regarding the management and performance of dental services during an emergency and regarding statewide emergency dental protocols;

iv. Organize and activate dental emergency responders in coordination with the Medical Reserve Corps, U.S. Department of Health and Human Services; Statewide Volunteer Pool; Battle Born Medical Corps; or any other state emergency health care workforce;

v. Request DPBH action through public health announcements, memorandums, or emergency declarations;

vi. Develop an emergency service plan for the continuation of dental services during a declared local, state, or national emergency and establish associated

protocols and notification systems including clear protocols for patient communication and emergency treatment, including patient screening and the appropriate use of personal protective equipment for the dental practitioner and dental staff;

vii. Encourage the training and education of dental emergency responders to improve the system of public safety in this state; and

viii. On or before January 31 of each year, submit a report to DPBH and the chief of the Division of Emergency Management, DPS:

- A summary of any policies or procedures adopted by the Committee on Dental Emergency Management; and
- A description of the activities of the Committee on Dental Emergency Management for the immediately preceding calendar year; and

ix. Perform such other duties as may be required by law or regulation.

m. The Committee on Dental Emergency Management shall meet at least twice each calendar year.

n. The chief or state dental health officer may activate the Committee on Dental Emergency Management or any subcommittee thereof.

o. During the existence of a state of emergency or declaration of disaster pursuant to NRS 414.070 or a public health emergency or other health event pursuant to NRS 439.970, the provisions of Chapter 241 of NRS do not apply to any meeting held by the Committee on Dental Emergency Management or a subcommittee thereof.

p. The DPBH shall adopt such regulations as are necessary to govern the Committee on Dental Emergency Management.

Dental Loss Ratio

a. Revise NRS 695D.240 as follows:

i. “Medical loss ratio” means a financial measurement to determine the percentage of prepaid charges or premiums collected that are used to pay for dental care. For example, a medical loss ratio of 75 percent indicates that the organization for dental care is using the remaining 25 percent of premiums to pay marketing and administration expenses, including profits, agent commissions, and salaries for employees at the organization for dental care;

ii. Marketing and administrative expenses must include agent commissions, profits, and salaries of employees at organizations for dental care;

iii. An organization for dental care that issues, sells, renews, or offers a contract covering dental services shall file a report with the department by July 31 of each year, which shall be known as the Medical Loss Ratio (MLR) annual report. The MLR annual report shall be organized by market and product type

and shall contain the same information required in the 2013 federal MLR Annual Reporting Form (CMS-10418). The Department shall post a health care service plan's MLR annual report on its website within 45 days after receiving the report;

iv. The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. As applicable, all terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with Section 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003;

v. If the commissioner decides to conduct a financial examination as described in NRS 695D.270 because the commissioner finds it necessary to verify the organization for dental care's representations in the MLR annual report, the Department shall provide the health care service plan with a notification 30 days before the commencement of the financial examination;

vi. The organization for dental care shall have 30 days from the date of notification to electronically submit to the Department all requested records, books, and papers. The commissioner may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause;

vii. The Department shall make available to the public all of the data provided to the Department pursuant to this section; and

viii. Organizations for dental care are exempt from this reporting requirement for products offered under Nevada Medicaid, Children's Health Insurance Program, or other state sponsored health programs.

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