Our Mission

We are dedicated to helping our clients navigate Government’s rocky waters, advocating for our clients’ issues ethically and responsibly.
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Firm Profile

Honesty, Respect & Determination

Since 2008, the Perkins Company has represented and advocated for clients at all levels of government. Regardless of strategy, the best representation is based on the same core principles: honesty, respect and determination. Whether shepherding a bill through the legislature, building coalitions around a client’s goals or just keeping an eye on that political atmosphere, the Perkins Company will bring these principles to the table each and every time.

Honesty in all our dealings is paramount. While we obviously protect all of our clients’ privileged information, the key to anybody’s legitimacy in a negotiation is that their word can be trusted. We have worked tirelessly to build and maintain trust-based relationships with lawmakers, regulators and our colleagues to ensure we can be effective for our clients.

This honesty extends to conflicts of interest. We work diligently before taking on a new client to deal with any potential conflicts before they arise.

In the last decade, lobbyists have gotten a bad rap and – in many cases – rightfully so. Citizens have been confronted by stories of hubris amongst the lobby corps, nationally and locally. It is clear that, somewhere along the line, some people in this business lost respect for the institutions it is their job to lobby. At The Perkins Company we stress this respect for institutions, its members and the other people with whom we interact as a cornerstone of our business.

Honesty and respect on their own are next to meaningless without the determination to service our clients and get the work done. The Perkins Company is ready and equipped to do the research, build the coalitions and conduct the education required to accomplish our clients’ goals. Often, Lobbyists have to get up-to-speed on issues affecting a client in short order, or quickly become experts on foreign issues. The Perkins Company is always ready to build our repertoire and put in the hours to accomplish our clients’ goals.

As a result of the honesty, respect and determination we bring to the table, clients and lawmakers all turn to the Perkins Company for counsel and education. We take our duty to these individuals seriously, and we look forward the opportunity to demonstrate the quality of work we bring to the table.
Our People
President
Richard D. Perkins

Native Nevadan Richard Perkins spent 14 years in the Nevada Legislature, including 2 years as Democratic Floor Leader, 4 years as Majority Leader, and 6 years as Speaker of the Assembly. With a record for consensus and coalition-building, he is considered a bipartisan leader and counts his friends in both major parties. In 2006, he chose not to seek re-election to the Legislature and focused on his law enforcement career as the Chief of the Henderson Police Department, a career he retired from after 25 years. As president of the Perkins Company, Richard oversees the quality political and strategic consulting services clients have come to expect.

Perkins’ extensive political and law enforcement network reaches all corners of Nevada and all across the country. He is also very involved in the National Speakers’ Conference (Past President), the State Legislative Leaders Foundation (past Board Member), the National Conference of State Legislatures, the Council of State Governments, the International Association of Chiefs of Police, and many other political, policy, and law enforcement organizations. He has developed a network of elected and police officials whom he considers friends in other states and on Capitol Hill who include U.S. Senate Majority Leader Harry Reid, the entire Nevada delegation, dozens of other members of Congress, and many Governors, Speakers, and other legislators.

For fourteen years, Perkins helped guide Nevada’s $14 billion biennial budget that included more than 425 state agencies. In this time he worked closely with HHS officials to draft budget, build programs and write policy. His relationships with career leaders in HHS and other departments remain to this day. In this time, Perkins also established the Nevada State College, spearheaded K-12 education funding and reforms, provided leadership on energy and water issues and developed expertise in gaming, labor/management, health care, and public lands issues.

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Perkins served as the President of the National Speakers Conference in 2005 and still serves on its executive committee. Richard participated with the National Conference of State Legislatures (NCSL) Law and Criminal Justice Committee and Task Force on Homeland Security and Emergency Preparedness. Perkins has been a guest speaker on anti-terrorism, criminal justice and many other topics for the NCSL, State Government Affairs Council (SCAC), and the Council of State Governments (CSG). In 2004, Perkins was invited as a guest lecturer at an international anti-terrorism conference in Gdansk, Poland.

After a distinguished career in the ranks, Perkins became the Police Chief for Nevada’s second largest city in April of 2006. Throughout his career, he was recognized for his work with crime victims and in 1991 was honored by the Clark County District Attorney and the Nevada Attorney General. Perkins attended the 183rd Session of the FBI National Academy in 1995, and is active in the Nevada Sheriffs and Chiefs Association (NSCA) and the International Association of Chiefs of Police (IACP).

Richard is the proud father of five children. Privately, he enjoys hunting, fishing, reading, traveling and competitive sports. Perkins holds two degrees – one in Criminal Justice, one in Political Science – from the University of Nevada, Las Vegas. Perkins is a Council of State Governments Toll Fellow, an American Swiss Foundation Young Political Leader, a Leadership Las Vegas graduate, an attendee of the John F. Kennedy School of Government at Harvard University and is listed in Who’s Who in American Politics. Chief Perkins also serves on the Board of Directors for Paramount Bank of Nevada, Opportunity Village and several other non-profit boards and committees.

**Richard Perkins,**

**in his own words**

*When times are tough, it’s important to have quality representation. I look forward to working with you to ensure you meet your goals.*

Perkins is proud to serve our clients as President and chief lobbyist for the Perkins Company. From current clients like Newmont Mining or the City of Henderson or former clients like the Building Trades Council or Diageo Liquor, Perkins has brought his all to the lobbying arena. Politics is about relationships, integrity, and credibility and Richard Perkins brings all three to the table. In a fast-paced environment where many situations can be handled with a phone call, it’s difficult to imagine a circumstance in which he wouldn’t know who to contact.
Our People
Client Services Manager
Sara L. Partida

Sara Partida joins The Perkins Company having served as the committee counsel for the Nevada Assembly Committee on Commerce and Labor during the 2011 Legislative Session. Sara spent nearly 8 years working for the Legal Division of the Legislative Counsel Bureau. During her time with the Legislative Counsel Bureau, Sara worked on numerous high profile issues, including facility and professional licensing issues, public health emergencies, Medicaid and insurance matters, and mortgage lending concerns. Prior to her time with Assembly Commerce and Labor, she worked on several committees, including over 4 years working on health care issues as the legal counsel for the Senate Health and Education Committee, the Legislative Committee on Health Care, and the Legislative Committee on Child Welfare and Juvenile Justice.

Sara grew up in southern Nevada and graduated high school at 16 years of age. She was accepted into the Honors College at the University of Nevada Las Vegas and went on to earn her baccalaureate degree in Political Science. During the 2001 Session of the Nevada Legislature, Ms. Partida interned with the Office of Governor Guinn and the Assembly Republican Caucus. After graduating college, she moved to Washington, D.C. to attend her top choice graduate program at the George Washington University Law School.

While in Washington, D.C., Ms. Partida worked for the Center for Public Integrity, researching issues concerning ethics in government. She also worked as a summer associate and law clerk for Fitzpatrick and Associates, a law firm specializing in employment law. During the summer of 2002, Ms. Partida returned home to Nevada to once again work in the Office of Governor Guinn, this time as a law clerk assisting with legal matters, including, preparations for the upcoming 2003 Legislative Session and research for the 18th Special Session concerning medical malpractice issues. After graduating from the George Washington University Law School in 2004, Sara became a member of the Nevada Bar and began her career with the Legislative Counsel Bureau.
Our People
Legislative Assistant
Brian Evans

Brian Evans first joined the Perkins Company in the 2013 Legislative Session as a committee monitor and bill tracker. Brian brought an enthusiasm and work ethic to the job that helped him grow and learn in the legislative process. Brian returned for the 2015 Legislative Session, taking on a more significant role as a lobbyist and helped with efforts on behalf of various clients. Brian again played a key role in tracking and monitoring bills and budgets while also identifying future bills and budgets that may have been of concern.

Brian grew up in Reno Nevada, where he attended Galena High School. He played baseball, making the varsity team as a sophomore while also maintaining high grades. Brian went on to attend Grand Canyon University in Phoenix, AZ. He graduated college in 4 years with a Baccalaureate in Business Administration, having done so while also playing on the baseball team all 4 years. Brian became captain and leader of the baseball team and demonstrated his leadership abilities during his tenure. During his college years, Brian took many classes in and developed an interest in history and political science. He enjoyed U.S. history and the development of Federal and State laws which served him well when he joined the Perkins Company.
2015 Legislative Session Review

The 2015 Session of the Nevada legislature began on February 2, 2015, and adjourned on June 1, 2015. The 120 day Session was unique in that there were 20 new legislators out of 63 on the first day of Session, 17 new Assembly members and 3 new Senate members. Both houses switched majority parties since the previous Session. In the Assembly, this was the first time that the Republicans fully controlled the house since the 1980’s. These drastic changes led to some difficulties in processing bills and adhering to long standing rules, but the Session ended on time and without a special session.

NSMA Priorities

Prescription Drug Abuse

One of the biggest issues this Legislative Session in health care was tackling the prescription drug abuse issue. During the 2013-2015 interim, the NSMA together with other industry representatives, such as law enforcement, retailers, pharmacists, other providers and pharmaceutical companies, got together and worked on industry recommendations to combat the issue. These meetings addressed over prescribing concerns, patient responsibility, diversion and recovery and everything in between. One of the first discoveries made during these meetings was that diversion was a high concern because of the lack of patient education and programs to take back unused medications. Other discussions revealed that the prescription drug monitoring program was greatly underutilized, in part because physicians and other providers were never asked to sign up or told of the benefits of using the newly improved system. Once the Board of Pharmacy made such a request, the enrollment of providers quickly jumped from below 20% to approximately 50% of all prescribers. Going into the 2015 Legislative Session, the NSMA thought that the bills would be coming from those who participated in these working groups and that the recommendations would be those already vetted by the coalition.

Senate Bill 459 (SB459) was the Governor’s bill which required, as introduced, that every provider check the prescription drug monitoring program every time the provider initiated a prescription for a controlled substance, required a person who dispensed a controlled substance to upload the information into the system within 24 hours, authorized the writing of prescriptions for an opioid antagonist and provided certain persons with immunity from liability if the person sought assistance for a person at risk of overdosing. Failure to check the prescription drug monitoring program would have been a misdemeanor; however, the NSMA successfully obtained an amendment to remove the criminal penalty. The NSMA was also successful in getting “initiating a prescription” defined, providing that the requirement only applies for a new course of treatment lasting more than 7 days, and getting special concessions for hospital emergency departments. The amendment also provided that, if the prescription drug
monitoring program is unavailable for any reason, noting the attempt to check in the record of the patient constituted full compliance with the law. The First Lady of Nevada was determined to see this bill enacted and, although the NSMA opposed the bill, it was well received by many legislators. The amendments will help alleviate some of the worst consequences of passing such legislation. AB459 was approved by the Governor on May 5, and physicians must begin complying with the new law on October 1, 2015.

**Senate Bill 114** (SB114) was amended significantly from its original version and, as finally enrolled, will require the Board of Pharmacy to send existing reports which identify inappropriate use of controlled substances by patients to additional state and local governmental entities, including law enforcement and occupational licensing boards. These reports do not constitute a complaint against a particular licensee. The bill also allows certain, limited access by law enforcement agencies which have a full time responsibility for investigating prescription drug abuse, but only to investigate specific cases. SB114 also requires consequences to a law enforcement officer who inappropriately accesses the prescription drug monitoring program. SB114 was signed by the Governor on June 1.

**Senate Bill 288** (SB288) duplicates the provisions of SB459 requiring each prescriber to enroll in the prescription drug monitoring program. SB288 also includes a requirement that each person who is enrolled in the program must query the person’s own information twice annually to determine accuracy of the information and confirm the accuracy of such information to the Board of Pharmacy. According to testimony of the Board of Pharmacy, this functionality is not yet available so a physician would not be required to complete this query until such time as the system is capable of performing this function.

Assemblyman Sprinkle, who had been participating in the industry working groups, had proposed to bring a bill this Session to require prescribers to enroll in the prescription drug monitoring program and to address the other aspects of prescription drug abuse. Unfortunately, this bill was never introduced and he was instead asked to introduce **Assembly Bill 279** (AB279), which required a practitioner to check before writing every prescription for a controlled substance and to upload into the program every prescription that was written by the practitioner within 24 hours after prescribing the controlled substance. This bill would have been a catastrophic burden on the provider community and the NSMA was opposed. The bill was heard in the Assembly Committee on Health and Human Services, but failed to pass out of the Committee.

**Telehealth**

**Assembly Bill 292** (AB292) was introduced by Assemblyman Oscarson, after the Governor’s Office spent time working with hospitals and insurers during the interim to draft a bill relating to telehealth. The NSMA opposed this bill because it provided an authority to practice healthcare via telehealth in Nevada by persons who were not required to be licensed in Nevada. Although unlicensed practice was the intent, the bill as introduced provided that a person may not provide a service through telehealth unless the
person was first licensed in Nevada. The NSMA was satisfied with this wording; however, the bill was then revised to provide that a person may not direct or manage the care of a patient, diagnose a patient or write a treatment order or prescription for a patient, unless the provider is licensed in Nevada. This language provides significant room for interpretation and requires the occupational licensing boards to adopt regulations to interpret this language and determine whether a person has violated Nevada law. The testimony and conversations with the various boards indicated that the boards believe they have sufficient regulatory authority to monitor the implementation of the telehealth laws and prevent unlicensed practice. The NSMA will need to continue following this issue in the regulatory process to ensure that these regulations are adopted. AB292 also addresses provisions governing insurance reimbursement and requires an insurance provider and Medicaid to provide coverage for all services provided via telehealth if the service is covered through in-person visits, but does not require any parity in those coverage amounts.

**Senate Bill 299 (SB299)** as introduced duplicated the telehealth laws found in AB292 and additionally proposed to adopt the Psychology Interjurisdictional Compact. The Compact proposed to allow unlicensed practice in Nevada; therefore, the sponsor of the bill chose to not pursue the bill. Late in session there was some suggestion that the bill could be amended to make some further changes to the telehealth bill and to possibly address issues surrounding the policy of employing of physicians- often referred to as corporate practice of medicine. These amendments were controversial and came too late in the Legislative Session to be moved through both houses, so the amendment was never heard. These issues may come forward during the interim and the NSMA should be prepared to continue the dialogue through the next Session.

**Medicaid Reimbursement**

**Budget #3243- Medicaid Reimbursement Rates**

The Governor recommended an increase in funding totaling $97.8 million over the upcoming biennium for reimbursement rates for physicians, physician assistants and certified nurse practitioners beginning in FY16. The intent is to increase current rates, which are based on the 2002 Medicare fee schedule, to align more closely with rates in the 2014 Medicare fee schedule. This reportedly would increase the aggregate the Division pays out for physician, physician assistants and certified nurse practitioners services by 10%. This is to try and help offset the Primary Care Physician (PCP) supplemental payment that is set to expire on June 30, 2015. The agency indicates that the reimbursement rate increase would not apply equally to all medical services provided by physicians, physician assistants and certified nurse practitioners. Rather, the reimbursement rate for some services would increase and the reimbursement rate for other services would decrease. However, the Senate Finance Committee and the Assembly Ways and Means Committee approved an increase in the Radiology and Laboratory rates from the Governor’s recommendation. The current rates were set at 90% and 94% each year of the biennium for Radiology and 50% in both years of the biennium for Laboratory. The increase would bring the Radiology rates up to 100% in both years of
the biennium and the Laboratory rates up to 95% in both years of the biennium. This in large part was to make sure these services didn’t take such a drastic hit from their previous rates. The Attachment contains the handout with all Medicaid reimbursement rate changes, which was reviewed by the committees; however, this does not reflect the last minute increases to radiology and laboratory reimbursements and other changes made on the record at the time the budgets were closed.

GME and Medical School Funding

Budget #1301 Graduate Medical Education (GME)
The Governor’s Executive Budget recommended $10 million over the upcoming biennium for GME grants. The money is to be split evenly, $5 million in each year of the biennium. The Senate Finance Committee and Assembly Ways and Means Committee approved the Governor’s recommendation and closed the budget on May 13th. The NSMA provided a letter of support to the Committees on this budget account and expressed the need to help address the primary care provider shortage in this State. Being able to retain the physicians trained in our medical schools and attract medical school graduates from other states depends greatly on the GME programs.

Budget #3014 UNLV School of Medicine
In the Governor’s Executive Budget he recommended a total of $8.3 million over the upcoming biennium, $1.2 million in FY16 and $7.1 million in FY17, for start-up costs for the development of a “full-scale research-intensive” allopathic medical school at UNLV. However, the Nevada System of Higher Education (NSHE) had recommended a total of $26.7 million over the upcoming biennium, $7.1 million in FY16 and $19.6 million in FY17. The Senate Finance Committee and Assembly Ways and Means Committee approved the Governor’s recommendation with hopes that funding from another source would become available to fund the additional $19 million needed to fully fund NSHE’s recommendation. The development of the fully functional Medical School at UNLV is supposed to help with educating and developing more physicians to meet the expanding needs within this State.

KODIN
The NSMA had as one of its top priorities making sure that no changes were made to KODIN. Keeping KODIN intact and un-amended has been a priority of the NSMA since KODIN was first enacted by the voters in 2002. Senate Bill 292 (SB292) was brought by Senator Michael Roberson at the request of the KODIN board. The bill made several changes to the KODIN legislation, including clarifying how the $350,000 cap should be applied; consistently using the term “professional negligence” and eliminating the terms medical and dental malpractice; revising the term “provider of health care” to include physician assistants, clinics and other entities; and amending provisions relating to the affidavit which must be filed under certain circumstances. The NSMA broke with its tradition of opposing changes to KODIN and supported SB292. SB292 was heard in Senate Committee on Judiciary in March, but did not move out of Committee until mid-May. This was made possible because the bill was granted a waiver from the deadlines
prescribed by the Legislature. In addition the provisions mentioned above, SB292 also included a provision which would have required a trier of fact to attribute a percent of liability to all liable persons, including nonparties. This provision was the most adamantly opposed and was removed by the Senate Committee on Judiciary. All other provisions were kept and the bill delivered to the Governor.

**Other Legislation of Interest**

**Scope of Practice Issues**

**Assembly Bill 115** (AB115) restructured certain boards to become a single licensing board governing audiologists, speech-language pathologists and hearing aid specialists. The bill was brought, in part, as a result of the interim work of the Sunset Subcommittee of the Legislative Commission, which reviews boards created by the Legislature and proposes changes to and repeal of those boards as deemed necessary. There were other changes made in the bill draft that did not reflect the restructuring, including newly added scope of practice authority to diagnose certain hearing-related health concerns. After much discussion, it was determined that this expanded scope was not the intent of the bill and the bill sponsor agreed to remove “diagnose” from the definitions of those professions and from the scopes of practices. Although the NSMA did not initially take a position on this bill, after concerns were brought to the attention of the lobbying team by the American Association of Otolaryngology- Head and Neck Surgery, the NSMA registered its opposition and obtained the appropriate amendments. This bill, as amended, was signed by the Governor on June 8.

**Assembly Bill 231** (AB231) makes various changes to the practice of chiropractic and to the Chiropractic Physicians’ Board of Nevada. In the past, the legislature has proposed changes to the scope of practice of chiropractic, including a proposal for use of invasive testing last Session. For this reason, the NSMA carefully monitored this bill and was successful in keeping the bill from being amended to include scope of practice changes. AB231 was approved by the Governor on May 21.

**Assembly Bill 295** (AB295) proposed to regulate unlicensed persons who practice complementary and alternative medicine. As introduced, the NSMA was opposed to this bill because it would have allowed unlicensed and unregulated practice of certain services that are more appropriately provided by licensed providers of health care. The NSMA worked extensively with the proponents of the bill to accomplish the true intent of the bill without infringing on the practice of health care. The amendment first and foremost revised the term to be “wellness services” instead of “complementary and alternative medicine”. The bill also provided a broad list of practices that were not acceptable for persons who provide wellness services and provided an exclusive list of those services that may be provided. In addition to these two lists limiting the provision of wellness services, the bill requires a person to disclosure to a client the education, or lack thereof,
and experience of the person and to advise the client to seek the opinion of a physician before beginning a wellness service. AB295 was approved by the Governor on June 8.

**Assembly Bill 305** (AB305) authorizes the provision of community paramedicine services by certain holders of a permit to operate an ambulance service, air ambulance service or fire-fighting agency. If an operator wishes to provide such services, the operator must obtain an endorsement on the permit to allow certain employees and volunteers to provide community paramedicine services. The NSMA had concerns about this expanded scope of practice, but overall stayed out of the debate. The community paramedicine idea took root last interim when several rural counties received grants to operate a pilot program for this type of community service. The bill was sponsored by Assemblyman Oscarson, who was familiar with and a proponent of these programs. According to the testimony, this bill was more about payment for services than a true change of the scope of practice of paramedicine. Currently, an ambulance will not receive reimbursement unless the patient is actually transported to a medical facility by the ambulance. This is problematic because an ambulance is frequently dispatched to respond to cases of nonemergency. With the passage of AB305, the ambulance company can dispatch a community paramedicine team instead of an emergency response team in cases in which there is a known nonemergency and receive reimbursement for such calls. The bill becomes effective January 1, 2016, for purposes of providing community paramedicine.

**Senate Bill 181** (SB181) would have provided for the licensure of anesthesiologist assistants by the Board of Medical Examiners and the State Board of Osteopathic Medicine. SB181 required an anesthesiologist assistant only to perform anesthesia services within the scope of practice of a supervising anesthesiologist and under the medically direct supervision of that supervising anesthesiologist. An anesthesiologist assistant may only administer controlled substances to a patient with the patient’s written consent. SB181 would require each respective board to adopt regulations establishing requirements for the licensure of anesthesiologist assistants. The boards will also establish the maximum fees for the issuance, renewal or registration of a license which would be set at $400 with a biennial renewal option of $800. SB181 was passed out of the Senate on April 9th and then heard in the Assembly Commerce and Labor Committee. It was passed out of committee but never received a floor vote. SB181 failed to meet the deadline for the second house passage.

**Senate Bill 357** (SB357) proposed to expand the scope of a registered pharmacist or registered intern pharmacist. SB357 would have allowed the registered pharmacist to administer certain vaccines without the authorization of a physician, allowed the registered pharmacist to administer a drug to the body of a patient by injection, inhalation, ingestion or any other means, and also authorizes the registered pharmacist to furnish those drugs to a patient without a prescription from a practitioner. Finally, SB357 authorized the State Board of Pharmacy to endorse as an advanced practice pharmacist a registered pharmacist who has met certain training or experience requirements. This
newly created advanced practice pharmacist then would have been able to perform
physical assessments of a patient, independently order and interpret lab tests and refer
patients to other health care providers without the collaboration with a physician. The
NSMA was strongly opposed to the bill and worked with the proponent of the bill to
drastically amend SB357. The amendment worked out by the NSMA would have
eliminated all reference to the authority to administer and furnish drugs without a
prescription. The amendment further restricted all new authorized practice to be done in
collaboration with a physician in a medical facility. As with other scope of practice bills,
this bill was more about payment from Medicaid for existing services performed by
pharmacists than truly seeking to expand a scope of practice. SB357 was heard in the
Senate Commerce, Labor and Energy Committee on April 8th and then was re-referred
to the Senate Finance Committee and declared exempt. SB357 never had another hearing
and failed to pass the final deadline on June 1st. This was a win for the NSMA and a
protection to physician practices.

**Senate Bill 393** (SB393) exempts acupuncturists from provisions of the law governing
the practice of Oriental medicine if they meet certain requirements. In order for an
acupuncturist to be exempted they must meet certain criteria, including being employed
by an accredited school of Oriental medicine located in this State; being licensed to
practice acupuncture in another state or jurisdiction; limiting his or her practice in
Nevada to teaching, supervising or demonstrating the methods and practices of
acupuncture to students; and not accepting payment from a patient for service relating to
his or her practice of acupuncture. SB393 addressed concerns with the Wongu University
of Oriental Medicine, an acupuncture and Oriental medicine university in Las Vegas.
Wongu University officials want to bring in masters from around the country and foreign
nations, including China, to teach. However, NRS 634A.200 prohibits practitioners not
licensed in Nevada from doing so. SB393 would allow Wongu University to bring
in unlicensed experts from around the world and Nation to teach. SB393 was passed out
of both houses and signed by the Governor on May 29th.

**Senate Bill 408** (SB408) proposed to create the Board of Naturopathic Medicine. The
Board would regulate licensure of naturopathic physicians, certification of naturopathic
physicians as specialists, certification of naturopathic assistants, certification of
naturopathic medical students who wish to participate in a clinical training program and
certification of graduates of an approved school of naturopathic medicine who wish to
participate in an internship, preceptorship or fellowship training program. The NSMA
was opposed to the bill and had significant concerns about the advisability of recognizing
naturopathic medicine generally and specifically with the scope of practice. The NSMA
further took issue with referring to this as “medicine” of any sort and allowing the
persons to call themselves “physicians.” During the hearing on March 25 significant
concern was raised around the prescriptive authority and the use of the word “physician.”
There had also been discussion, led by the NSMA, on the fact that there was a board of
naturopathic healing from 1981 to 1987 that had been repealed. This was an indication
that the board wasn’t right for the State. SB408 never received a work session and failed to meet the April 10th deadline.

**Mental and Behavioral Health**

At the end of the 2013 Legislative Session, a news story broke which alleged that patients of the Rawson Neal Psychiatric Hospital in Las Vegas were being discharged and provided with a bus ticket out of State. The patients claimed that there were no resources or continuation of care once they reached their ultimate destination. These stories were sensationalized and became national headlines. The Governor and legislators decided to take proactive steps in addressing the mental health system in Nevada. The Governor created the Governor’s Behavioral Health and Wellness Council and the legislators created a Southern Nevada Forum on Health Care, which focused on mental and behavioral health issues. These groups came up with solutions, both short-term and long-term, to help with improving the mental and behavioral health system in Nevada. In addition to the emergency budgets passed during the last interim, there were several policy bills introduced for the 2015 Legislative Session.

**Assembly Bill 38** (AB38), brought by the Division of Public and Behavioral Health, authorized a physician assistant to initiate court-ordered mental health admissions. AB38 also expands the list of persons authorized to file a certificate to release persons from the 72-hour mandated mental health hold to include a physician assistant, psychologist, social worker or registered nurse. The bill was never heard.

**Assembly Bill 91** (AB91), requested by Assemblywoman Benitez-Thompson, was similar to AB38 except that it required a physician to approve a certificate of release that was authorized by a physician assistant, psychologist, social worker or registered nurse. The bill was amended to additionally authorize a paramedic to conduct the physical examination required before a patient may be admitted to a mental health facility. The bill was sent to Senate Health and Human Services, where Chairman Hardy declined to bring the bill for a vote and it died in his Committee. The bill was actively opposed by the Nevada Psychiatric Association and the NSMA followed the lead of the Association.

**Assembly Bill 93** (AB93) requires psychiatrists and other providers of health care who provide mental and behavioral health to receive continuing education in suicide awareness and prevention. The bill also encourages other providers of health care to get similar training. There is a current requirement for nearly identical continuing education, so the NSMA was neutral on this bill but closely monitored AB93 to ensure that the requirements did not go beyond the current, similar mandates.

**Assembly Bill 289** (AB289) would have required the Legislative Commission to appoint an interim committee to study mental health services. As previously mentioned, there were several groups which studied mental and behavioral health services during the previous interim and there is also an interim Committee on Health Care. For these
reasons and because the number of interim studies is limited, the Legislature did not process this bill.

**Senate Bill 7** (SB7) deals with the legal 2000 process by adding to the list of persons authorized to initiate an emergency admission to include a physician assistant, clinical social worker, advanced practice registered nurse or an accredited agent of the department. It also added to the list of who can release a patient on a 72-hour hold to include a physician assistant under the supervision of a psychiatrist, psychologist, a clinical social worker who has the psychiatric training and experience prescribed by the Board of Examiners for Social Workers, an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing or an accredited agent of the Department. SB7 was amended to restrict the persons who may initiate the legal 2000 hold, but increased the persons authorized to release a patient. SB7 was successfully passed by both houses, but in the final hours on June 1st the Senate did not concur with the Assembly amendment. The Assembly then receded from that amendment, which resulted in the removal of the Assembly amendments. Many of the Assembly members were upset with, but it was a procedural move used by Assembly leadership to get the bill enrolled and delivered to the Governor. It is important to note that the situation with emergency room overcrowding as a result of mental health patients who are awaiting transportation to a psychiatric facility has drastically improved since the start of the Session. It was the opinion of Dr. Hardy and others that this bill was unnecessary in light of the change of circumstances.

**Senate Bill 15** (SB15) adopts in Nevada the Tarasoff rule requiring a mental health professional who feels that the patient has the intent and ability to carry out a threat of harm against self or others to report such threats or initiate a 72-hour hold on the patient. SB15 requires a mental health professional to apply for the emergency admission of the patient to a mental health facility or to make a reasonable attempt to notify the person threatened with imminent serious physical harm or death and the closest law enforcement agency. SB15 also provides that a mental health professional who exercises reasonable care in determining whether to apply for the emergency admission of a patient or communicate such a threat is not subject to civil or criminal liability or disciplinary action by a professional licensing board for disclosing confidential or privileged information or for any damages caused by the actions of a patient. SB15 was brought at the request of the Nevada Psychiatric Association (NPA) and the NSMA supported the NPA. It is important to note that the definition of a mental health professional includes all physicians, not just psychiatrists. SB15 passed through both houses in its final amended form and was signed by the Governor on June 1st.

**Senate Bill 464** (SB464) in its original form provided an exemption from criminal liability for consumption or possession of alcohol if a person who is less than 21 years of age requests emergency medical assistance for himself, herself or another person in certain circumstances. The testimony on SB464 demonstrated that persons under the age of 21 years sometimes do not acquire the appropriate medical help for themselves or
others because they didn’t want to get into trouble with the law for being a minor in possession of alcohol. SB464 requires a minor who wishes to benefit from such immunity to request emergency medical assistance for the person who suffering from alcohol-related medical issues, remain with the person requiring medical assistance until emergency medical assistance or law enforcement arrives, and cooperate with medical personnel and law enforcement. The person on whose behalf the request was made for assistance is also exempt. SB464 was later amended to add a new section pertaining to powdered alcohol. This is a new and uncommon form of alcohol but there are concerns surrounding the use and availability of this new product. SB464 prohibits a person from selling, offering to sell, distributing, possessing or using powdered alcohol. SB464 was passed out of both houses and signed by the Governor on May 29th.

**Licensure Issues**

*Assembly Bill 39* (AB39) as introduced would have removed the cap on the fee that may be charged for an application for a J-1 visa as part the Physician Visa Waiver Program. This change was opposed by the NSMA because of the potential for an unreasonable fee to be adopted by the Program. The legislature instead amended the bill so that the maximum fee that could be charged would be $2,000, which more accurately reflects the costs of maintaining the Program. The new cap will become effective on July 1, 2015; however, this will still require the Program to change its fee by regulation.

*Assembly Bill 89* (AB89) generally authorized physicians and other providers of health care to receive expedited licenses by endorsement to practice their respective professions if the person currently holds an unrestricted license in another state and is a member of or the spouse of a member of the armed services or is a veteran. As introduced, AB89 provided for health care facilities to employ physicians. The NSMA was opposed to this provision and were told that it was a drafting error that such a provision was included in the bill. The section was removed from the bill. The remaining provisions of the bill were signed into law on June 12.

*Assembly Bill 227* (AB227) was brought by the Assembly Committee on Commerce, Labor and Energy at the request of the Board of Medical Examiners. AB227 touched on everything from cleaning up references to obsolete associations to reports of disciplinary action to posting on the Board’s website and everything in between. The NSMA originally had some concern with provisions of the bill relating to the process in disciplinary actions, specifically the lengthening of time for a board to hold a hearing after a summary suspension while shortening the time for which a licensee has to get a mental or physical examination or an examination testing his or her competence to practice, if such an examination is required. After many conversations with the Board of Medical Examiners and listening to the testimony provided at the hearings, it was determined that these changes were not detrimental to licensee and were intended to better enable the administration of summary suspension processes. The NSMA was neutral on AB227. These changes will become effective on October 1, 2015.
**Senate Bill 68** (SB68) deals with expedited licenses by endorsement for physicians, podiatrists, other providers of health care and professionals who hold a valid and unrestricted license to practice in another state or territory of the United States and meet certain other requirements. A physician must be certified in a specialty recognized by the American Board of Medical Specialists or the American Osteopathic Association to obtain an expedited license by endorsement. SB68 also allows for the Board of Medical Examiners and the State Board of Osteopathic Medicine to issue a limited license to practice medicine as a resident physician to an applicant that meets certain requirements. The bill states that 15 days after a board receives the original application the board must give notice to the applicant of any additional information required to complete the application. Within 45 days after receiving an application or 10 days after the board receives a report on the applicant’s background based on the submission of the applicant’s fingerprints, whichever occurs later, the board must approve the application and issue a license by endorsement, unless the application was denied for some other cause. This process, for the most part, is already being done but this will help with the flow to bring more providers of health care to the State. SB68 was passed out of both houses unanimously and signed by the Governor on May 29th.

**Senate Bill 116** (SB116) was Dr Hardy’s bill dealing with physician assistants. SB116 would have required a supervising physician or supervising osteopathic physician to ensure that his or her physician assistant is clearly identified to patients and performs only medical services approved by the supervising physician or osteopathic physician. SB116 also required a supervising physician or osteopathic physician to review and initial at least 5% of the medical records of the patients of the physician assistant at least once each calendar quarter or at a greater frequency prescribed by the Board of Medical Examiners or the State Board of Osteopathic Medicine. SB116 would have further required a supervising physician or osteopathic physician to develop and carry out a program to ensure the quality of care provided by the physician assistant. Finally, SB116 would have required a physician assistant who has more than one supervising physician or osteopathic physician to record in the record of the patient the name of the supervising physician or osteopathic physician for each patient. This bill was brought after similar language was proposed during the regulatory process. SB116 never received a hearing and it failed to meet the first house committee passage deadline on April 10th.

**Senate Bill 172** (SB172) as introduced would prohibit a medical facility or a physician from allowing a person to perform or participate in activities for credit towards a medical degree unless the person is enrolled in good standing at an accredited medical school that is a school of osteopathic medicine or is accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges or their successor organizations. This was intended to allow for the residency positions to be more open to Nevada or US students and not have foreign students taking up the spots. SB172 was later amended to exempt a physician from this prohibition if the activity takes place in a primary care practice that is located in a designated health professional shortage area and is entirely under the supervision of the
physician and the physician is not currently supervising other medical students. This was a concern mainly brought by the rural areas and they felt if they were limited on whom they could bring in for residency they wouldn’t have enough to draw from. This exemption would help address that concern. SB172 was passed out of both houses and signed by the Governor on May 30th.

**Senate Bill 251** (SB251) ratifies the Interstate Medical Licensure Compact. This would allow for a physician who is licensed in this State to receive reciprocal licensure in any other state which has joined the Compact, and vice versa. The Compact regulates the licensure and discipline of physicians holding reciprocal licenses through the Compact. The Compact becomes effective upon ratification by 7 states. SB251 was passed out of both houses unanimously and signed by the Governor on May 27th. As of June 10th there are 9 states that have ratified the Compact (Nevada, Alabama, Utah, Idaho, Montana, Wyoming, South Dakota, West Virginia, and Minnesota) and 10 other states that are considering legislation (Nebraska, Iowa, Wisconsin, Michigan, Illinois, Texas, Oklahoma, Vermont, Rhode Island and Maryland). This Compact will help bring more health care throughout the country to patients and areas that need it with more ease.

**Legal and Enforcement Issues**

**Assembly Bill 48** (AB48) was the Attorney General’s bill to address issues with fraudulent claims and Medicaid fraud. The bill had two major components, first to make Nevada law consistent with the federal False Claims Act and second to allow civil forfeiture in Medicaid fraud claims. Civil forfeiture statutes would have authorized the permanent taking of all medical and office equipment used in an alleged crime of Medicaid fraud, but the concern is that civil forfeiture does not require that the person be convicted of any crime. Given that a conviction is not necessary to move forward with civil forfeiture, the NSMA was opposed to the forfeiture provisions of AB48 and successfully amended that section out of the bill. The remaining provisions of the bill were signed into law on May 27, 2015.

**Assembly Bill 72** (AB72) sought to enact a universal provision giving every occupational licensing board the authority to issue a notice to cease and desist to a person who was practicing an occupation without a license. This provision already exists in the physicians’ licensing chapters and in nearly every other health occupation, including nursing and dentistry. The manner in which this bill was drafted was problematic in that authority to issue such notices and fine persons for unlicensed practice should have been identified in each chapter in which such authority did not already exist. The Legal Division of the Legislative Counsel Bureau decided to pull back AB72 and redraft the bill to amend each chapter, where appropriate, instead of providing a general, title-wide authority. Drafting the bill in this way would have better provided clarity in showing which boards already have, and did not have, this power. This became quite controversial and the Attorney General’s Office decided not to pursue the bill. It never received a vote out of the first house committee.
Insurance

Assembly Bill 86 (AB86) revises provisions governing the Silver State Health Insurance Exchange in light of the decision to turn over the exchange to the federal government. AB86 eliminates the requirement that the exchange be a state run exchange, revises the membership and changes required minimum number of meetings of the board. With these changes, the board for the exchange may now include a representative with experience working for a large provider of insurance. Although the NSMA opposed this change, it remained part of the bill. The changes become effective on July 1, 2015.

Assembly Bill 310 (AB310) would have required the Department of Health and Human Services to provide services to Medicaid recipients who are aged, blind or disabled through managed care for any recipient who resided in Washoe or Clark County. This bill never received a hearing.

Senate Bill 48 (SB48) deleted the requirement for the Director of the Department of Health and Human Services to establish the statewide health information exchange and a governing entity for the system. SB 48 redefines the definition of “health information exchange” to mean a person who makes an electronic means of connecting disparate systems available for the secure transfer of certain health-related information between certain persons. SB48 instead allows the Director to establish or contract with not more than one health information exchange to serve as the statewide health information exchange. A health information exchange must be certified by the Director before it can operate in this State, and certain administrative fines may be imposed by the Director on a health information exchange operating without a certification. Existing health information exchanges in the State have until July 1st, 2016, to comply with these new requirements. SB 48 was passed out of both houses unanimously and signed by the Governor on May 27th.

Senate Bill 217 (SB217) would prohibit certain public and private policies of insurance and health care plans from denying coverage for otherwise covered topical ophthalmic products, if refills are provided early. A pharmacist is then required to provide early refills of topical ophthalmic products to a patient if the patient is experiencing inadvertent wastage of the product due to difficulty applying the product to the eye or if the patient requests the early refill and the early refill is dispensed pursuant to a valid prescription which bears specific authorization to refill. This would allow a physician to write a prescription indication that early refills may be needed if the patient is having difficulty and not receiving the full treatment. On a typical 30 day prescription a patient must go 21 days before being able to receive early refills of a topical ophthalmic product. This fluctuates based on the length of the prescription. SB217 doesn’t affect any deductibles, copayments or coinsurance authorized or required pursuant to the policy of health
insurance, group health insurance, health benefit plan or health care plan. SB217 was passed out of both houses unanimously and signed by the Governor on May 11th.

Senate Bill 222 (SB222) proposed to require certain public and private policies of insurance and health care plans to limit a person’s copayment or coinsurance for prescription drugs to not more than $50 per prescription per month and not more than 20% of the maximum out-of-pocket limit included in the federal Patient Protection and Affordable Care Act for all prescription drugs within a given year. SB222 also tried to limit the amount of coinsurance that is applied regardless of whether the amount of the annual deductible had been satisfied. SB222 further proposed to disallow placing all prescription drugs within a given class within the highest cost tier provided by the policy or plan. Finally, SB222 provided a process whereby a person could request an exception to the drug formulary if his or her doctor determined that a prescription drug which is not included on the formulary would be the best course of treatment. SB222 never received a hearing in the Senate and failed to get out of the first house by the deadline on April 10th.

Senate Bill 231 (SB231) as introduced would have prohibited a provider of health care (not including a pharmacist) who prescribes and dispenses a drug to an injured employee from being able to charge more than 110% of the average wholesale price of the prescribed drug based on the original manufacturer’s National Drug Code for the drug. Also, the provider of health care may not charge or seek reimbursement for more than an initial 15-day supply of the drug. SB231 also requires an insurer that provides coverage for a prescription drug to provide coverage for any drug that is prescribed for a covered indication that is approved by the United States Food and Drug Administration (FDA) for the indication, recognized in the standard reference compendia for treatment of the indication, or is substantially accepted for the treatment for the indication in peer-reviewed medical literature, effectively prohibiting off-label uses. SB231 further changes the time frame in which an insurer must pay a bill from a total of 60 days to 45 days. Finally, SB231 removed the rebuttable presumption regarding intoxication and replaces it with a requirement that the employee not receive compensation whenever an injury occurs to the employee while the employee is intoxicated or under the influence of a controlled or prohibited substance. An employee is deemed intoxicated or under the influence of a controlled substance for the purposes of not receiving compensation whether the employee meets or exceeds the limits for intoxication or use of a controlled substance as used for driving under the influence. The NSMA strongly opposed the provisions setting the reimbursement rate at 110% of wholesale and prohibiting off-label use. These provisions were amended out of the bill. The amendments were also responsive to the NSMA testimony concerning the inappropriate standard set to determine intoxication and SB231 allowed for an injured employee who was intoxicated to prove by clear and convincing evidence that his or her intoxication was not the proximate cause of the injury. SB231 passed out of both houses and was signed by the Governor on May 27th.
Senate Bill 250 (SB250) requires a public or private policy of insurance or health care plan to authorize certain prescriptions to be divided into more than one dispensing for the purpose of synchronizing a patient’s multiple prescriptions. SB250 prohibits these policies and plans from prorating the pharmacy dispensing fees for such prescriptions unless otherwise provided by a contract or other agreement. However, an insurer may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply. The NSMA was in strong support of SB250 because studies have shown that synchronized prescriptions lead to better patient compliance with courses of treatment. SB250 passed out of both houses unanimously and was signed by the Governor on June 5th.

Senate Bill 284 (SB284) would have required the Director of the Department of Health and Human Services, to the extent authorized by federal law, to include in the State Plan for Medicaid a requirement that the State will provide transportation services to recipients of Medicaid traveling to and returning from services and activities from providers of services not covered by federal law. The State may contract with a common motor carrier, a contract motor carrier or a broker for the provisions of such transportation services. This would allow more people to participate in their community and live independently. SB284 was originally in the Senate Health and Human Services Committee but was not heard. It was later re-referred to the Senate Finance Committee where it became exempt but never received a hearing. SB284 failed to meet the final deadline on June 1st.

Senate Bill 328 (SB328) wanted to require the Commissioner of Insurance to create a standardized format for online posting of drug formularies and post links to certain drug formularies and other information on his or her Internet website. SB328 also required certain insurers to post their formularies online as well as requiring the Silver State Health Insurance Exchange to provide links on its Internet website to the drug formularies of certain qualified plans offered for sale through the Exchange. The goal of this bill was to allow people looking for insurance to window shop and see what formulary would be best for them. This bill was debated in committee and insurance companies felt that it was too difficult and intrusive for them to post this information. SB328 was declared exempt and was voted out of the Senate on May 15th. SB328 got a hearing in the Assembly on May 20th; however, the bill never made it out of the Assembly Commerce and Labor Committee and failed the final deadline on June 1st.

Senate Bill 341 (SB341) was the dental discount plan rental network bill. SB341, as introduced, would require a notice containing certain information be provided to a dentist relating to agreements between an organization for dental care and a third party to provide access to dentists. SB341 also required a third party to comply with any applicable provisions in the contract between an organization for dental care and a dentist as if the third party were the organization for dental care, furnish certain information to dentists and maintain a website or toll-free telephone number for a dentist to obtain contact information for the person used by the third party to reimburse the dentist for
covered services. SB341 would allow a dentist to decline to provide services pursuant to a plan for dental care operated by a third party if the dentist does not have the capacity to care for the additional patients. SB341 was later amended in the Senate to be more specific to dentists and not just dental care while also addressing insurers who offer individual health insurance, insurers who offer group health insurance, nonprofit corporations for dental service, health maintenance organizations and organizations for dental care. SB341 was passed out of the Senate and heard in the Assembly Committee on Commerce, Labor. During the Assembly hearing, the dentists offered an amendment to apply the provisions to all providers of health care. This amendment was supported by the NSMA. However, after the hearing the amendment was deemed to not be germane to the bill and was not allowed by the Legal Division of the LCB. SB341 ended up passing out of the Assembly with just medical discount plans pertaining to dentists and nothing else. SB341 was signed by the Governor on June 8th.

Senate Bill 422 (SB422) revises provisions relating to the prescription drugs excluded from the restrictions set forth by Medicaid. The Department of Health and Human Services is required to exclude certain atypical and typical antipsychotic medication, anticonvulsant medications and antidiabetic medications from the restrictions that are imposed on drugs which are covered by Medicaid. The Legislature had suspended this requirement until June 30, 2015, and with the passage of SB422 it will be suspended another 2 years, until June 30, 2017. SB422 was signed by the Governor on June 5th.

Patient and Practice Issues

Assembly Bill 158 (AB158) – During the 2013 Legislative Session, a bill was passed which requires each public school to acquire two orders of an auto-injectable epinephrine. AB158 is intended to expand this public availability of auto-injectable epinephrine by allowing any entity where allergens capable of causing anaphylaxis may be present on the premises of the entity or in connection with activities conducted by the entity to obtain the auto-injectable epinephrine. The NSMA was officially neutral on this bill; however, it is interesting to note that while public schools are required to obtain an order for the epinephrine the only physician in the State who has written such an order is the State Health Officer. It is unclear whether any provider will write these orders for entities; however, he or she is authorized to do so. AB158 was signed by the Governor on May 21st.

Assembly Bill 164 (AB164), known as the “Right to Try” bill, provides for the use of certain investigational drugs, biological products or devices outside an FDA approved trial by certain patients who are considered terminally ill. The NSMA had initial concerns surrounding the implementation of the policy and the effect on patients who may decide to take such a drug. The main concerns of the NSMA surrounded the disclosure to the patient and the manner in which eligibility would be determined. Once these concerns were addressed, the NSMA became neutral on this issue. Assembly Bill 358 was a similar bill that had many good policies not included in the original version of AB164.
The bills were combined into the final version of AB164, which was approved by the Governor on May 27th.

**Assembly Bill 248** (AB248) repeals the requirement that a physician notify the DMV of every patient diagnosed with epilepsy and instead provides a physician with discretion in determining whether a patient’s epilepsy severely impairs the ability of the patient to operate a motor vehicle. AB248 provides a process whereby such a patient is notified of the physician’s concern and a physician could then submit a letter to the DMV. The bill also provides immunity from liability based on the professional judgment of the physician as to whether or not a patient’s epilepsy should be reported. The NSMA generally supported this bill because it allows discretion and professional judgment instead of requiring all patients diagnosed with epilepsy to be reported to the DMV. AB248 was signed by the Governor and becomes effective October 1, 2015.

**Assembly Bill 277** (AB277) proposed to enact the Nevada Protection of Religious Freedom Act. Similar legislation has recently been enacted or contemplated by other states, and has not been well received. The primary concern for the NSMA was that this bill would infringe on the ability of some patients to seek appropriate medical care and impede the ability of physicians to adequately care for patients. This bill died without ever receiving a hearing. Senate Bill 272 was identical and also died without ever receiving a hearing.

**Assembly Bill 405** (AB405) would have required parental notification before performing an abortion on a person under the age of 18 years or, if parental notification is not feasible, to petition a court for an order authorizing the abortion. This bill was adamantly opposed by the obstetrics community although the official position of the NSMA was neutral. The bill was not being heard by the Assembly Committee on Health and Human Services and, at the last possible minute, was moved into the Assembly Committee on Judiciary to ensure a hearing. It was voted out of the Assembly and moved to the Senate where it, again at the last minute, was moved from one committee to another for a late hearing. The bill was never voted on by the Senate Committee on Health and Human Services and died on June 1st.

**Senate Bill 6** (SB6) deals with the patient-centered medical home. SB 6 was amended greatly from its original form to leave only 2 substantive sections in from its introduction. The final bill defines the term “patient-centered medical home” and requires a patient-centered medical home to be certified, accredited or otherwise officially recognized as such by a nationally recognized accrediting organization before a primary care practice can represent itself as one. SB6 also authorizes coordination between patient-centered medical homes and insurers and allows incentives provided by insurers to patient-centered medical homes that would otherwise constitute unfair trade practices to the extent that such coordination and incentives are authorized under federal law. Finally, SB6 authorizes the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease to establish an advisory group of interested persons and
governmental agencies that include, without limitation, public health agencies, public and private insurers, providers of primary care such as physicians and advanced practice registered nurses and recipients of health care services to study the delivery of health care through patient-centered medical homes. SB6 was passed out of both houses and signed by the Governor on June 1st.

Senate Bill 117 (SB117) added human papillomavirus (HPV) and meningococcal disease to the list of diseases for which a child must obtain an immunization as a condition to enrollment in a school or admittance to a child care facility in this State. Even before the hearing, the bill became very controversial among certain groups who did not want their children vaccinated against HPV. After conversations with the school districts and State Health Officer, it was determined that these changes can be made through the regulatory process and did not need a change in the law. At the hearing, Dr. Hardy proposed an amendment that would have replaced the bill in its entirety. The proposed amendment required a residential facility for groups to annually offer on-site to its health care workers and other employees who have direct contact with residents, at no cost, vaccinations for the influenza virus, subject to the availability of the vaccine. The amendment would then require each nursing home to keep on record a signed statement from each health care worker and employee stating that he or she has been offered the vaccination and if they have either accepted or declined the vaccination. SB117 never received a work session and failed to meet the deadline on April 10th.

Senate Bill 142 (SB142) as introduced would have weakened the helmet laws for people who ride motorcycles. SB142 would have allowed anyone 21 years of age and older to not wear a helmet either as a driver, who has been licensed for more than a year, or passenger. SB142 was later amended by deleting all sections related to safety requirements and instead revised the definition of a “trimobile.” This took any concern the NSMA had with the bill out.

Senate Bill 177 (SB177) allows for the designation of a caregiver upon admission of a patient to a hospital as an inpatient. Such designation may be made by a patient, a legal representative of a patient who is incompetent or a parent or guardian of a patient who is a minor, as appropriate. SB177 also allows for the designation of another caregiver if the person originally designated is unable or unwilling to perform his or her duties. SB177 requires a hospital to allow the designation of a caregiver by a patient and record the designation of a caregiver or declaration in the medical record of the patient. SB177 was passed out of both houses unanimously and signed by the Governor on May 6th.

Senate Bill 273 (SB273) as introduced would revise provisions relating to duties of certain custodians of health care records. SB273 ensures that a provider of health care would be able to access health care records of a patient whether or not the custodian of the health care record continues to do business in this State or if the provider of health care ceased to be employed by the custodian of the health care records. SB273 also made it a gross misdemeanor to violate the law and provided a fine of not more than $25,000
for each violation. A custodian of health care records would also be subject to civil penalty of not less than $10,000 for each violation. SB273 was later amended to exclude certain medical facilities from the definition of “custodian of health care records.” SB273 also removed the language which required the records be provided to a physician who was no longer employed by the custodian of health care records. If a custodian of health care records ceases to do business in this State, within 10 days after ceasing to do business, the custodian must deliver the health care records to the provider of health care, or copies thereof, to the provider of health care. The NSMA was generally in support of this bill, but worked to ensure that any statute meant to protect individual providers didn’t hurt group practices. SB273 was signed by the Governor on June 1st.

**Senate Bill 458** (SB458) revises the notice received by a patient regarding breast density. Under existing law, after a mammography a patient must be given a notice which includes a report of the patients breast density and which includes a statement regarding the relationship between breast density, breast cancer and the impact of breast density on the effectiveness of mammography. SB458 changed the notice to only go out to a patient who showed dense breast and not to all patients. SB458 also put into statute exactly how the notice should be written, removing the State Board of Health from regulating the notice. This was in part to eliminate the overuse of the word “cancer” in the notice and to make sure that patients weren’t scared by the notice. The OB/Gyn community and the NSMA were in full support of this bill. SB458 was signed by the Governor on June 1st.

**Tax Bills**

**Senate Bill 252** (SB252) was the Governor’s Business License Fee. SB252 would have created 27 different business industry categories based off of the North American Industry Classification System or “NAICS.” This business license fee would have set an amount owed based on the gross revenue earned by the business in Nevada. Charts were given to show how much a business owed based on those gross revenue earnings. For the health care providers however, they would be able to subtract any federal or state funded care, such as Medicare, Medicaid, CHIP, Tricare and more, from the gross revenue of their business. Health care providers would also be able to subtract any uncompensated care from the gross revenue. SB252 was passed out of the Senate, but after several hearings in the Assembly, SB252 was eventually abandoned as the tax vehicle. Ultimately bits and pieces were placed into SB483 as the final tax package passed by the Legislature.

**Senate Bill 483** (SB483) revised certain existing taxes on businesses and imposed a new broad-based commerce tax on businesses whose Nevada gross revenue in a fiscal year exceed $4,000,000. The rate of the commerce tax varies by industry. For a health care provider other than a facility, any revenue received from a government source (Medicare, Medicaid, CHIP, Tricare, some indigent funds, etc.) and uncompensated care are not subject to the commerce tax; however, revenue from other sources are subject to the tax. SB483 also changes the rate and threshold of the Modified Business Tax (MBT) from the current 1.17% and $85,000 per calendar quarter to 1.475% and $50,000 per calendar

quarter. AB483 also raises the rate on businesses that are subject to the net proceeds of mining to a rate of 2%, which is currently imposed on financial institutions. SB483 allows a business to subtract 50% of the commerce tax it paid and use that as a credit when determining the total tax owed for the MBT. The bill also allows for a reduction in the rate to the MBT if the total amount from the Commerce Tax and MBT exceeds by 4% the combined anticipated revenue from those taxes for that fiscal year, as projected by the economic forum. This allows for a buy down of the MBT so as not to exceed projected revenues needed. The bill also raises the excise tax on cigarettes from the current 80 cents a pack to $1.80 a pack. SB483 changes the state business license fee on corporations organized pursuant to the laws of this State and all foreign corporations transacting business in this State to a $500 fee. All other businesses are left at the current $200 fee. SB483 also increases other fees associated with business filings. During the downturn of the economy, the Legislature enacted temporary increases to certain fees and taxes. SB483 eliminates the sunset on many of the fees and taxes and continues those increases indefinitely.

**Miscellaneous Issues**

**Assembly Bill 42 (AB42)** - Existing law requires a physician who diagnoses or treats a patient for cancer or other neoplasms to report that information to the State Board of Health, which compiles and maintains a database with such information. In certain circumstances, there is a fee associated with compliance with this law. AB42 removes the fee and makes other changes which reflect the reality that persons other than physicians could be involved in the diagnosis and treatment of a patient and applies the requirements to other providers of health care. This bill removes a fee which may be assessed to providers of health care and makes other administrative changes. The official NSMA position was neutral. AB42 was approved by the Governor on May 18.

**Senate Bill 14 (SB14)** changes the requirements within the Pharmacy and Therapeutics Committee by making it less stringent and eliminating strict numbers of type of provider who must be members. SB14 changes the committee size from the minimum of 9 members and max of 11 to a minimum of 5 members and a max of 11. SB14 also removes the requirement that at least one-third but not more than 51% of the members be active physicians licensed to practice medicine in this State, and that at least one-third but not more than 51% of the members be active pharmacists registered in this State or a person in this State with a doctoral degree in pharmacy. These two changes are to make it easier to recruit and retain members. A member serves a 2-year term and is appointed by the Governor. With the current requirements it was difficult to recruit the exact membership needed for compliance with statute. SB14 was not amended and passed out of both houses. SB14 was signed by the Governor on May 14th.

**Senate Bill 84 (SB84)** as introduced would add certain alcohol and drug abuse counselors and problem gambling counselors in the definition of “provider of health care” in NRS 629.031. SB84 was then further amended to also add an associate in social work, a social worker, an independent social worker or a clinical social worker, a clinical
alcohol and drug abuse counselor and a medical facility, and the employer of any person in this bill, to the definition of “provider of health care.” Adding these persons and medical facilities to the list of provider of health care makes them subject to other requirements that are currently applicable to other providers of health care currently. The Nevada Skilled Nursing Facilities proposed an amendment to add the definition of “medical facility” as found in NRS 449.0151 but was unsuccessful. SB84 was signed by the Governor on June 1st.

**Senate Bill 189** (SB189) would require the Division of Public and Behavioral Health of the Department of Health and Human Services to develop a standardized system for the collection of information concerning the treatment of trauma and also create the Fund for the State Trauma Registry. The system must provide for the recording of information concerning treatment received before and after admission to a hospital. The money in the Fund for the State Trauma Registry may only be used to develop a standardized system for the collection of the information concerning the treatment of trauma and to carry out a system for the management of that information. SB189 was heard and passed out of the Senate Health and Human Services committee but re-referred to the Senate Finance committee and was declared exempt. It was later heard but never moved out of committee. SB189 failed to meet the final Deadline on June 1st.

**Senate Bill 196** (SB196) would require the Division of Public and Behavioral Health of the Department of Health and Human Services to establish and maintain the Stroke Registry to compile information and statistics concerning the treatment of patients who suffer from strokes. SB196 would also require the Division to compile an annual report concerning the Registry and, on or before June 1 of each year, post the report on the Division’s Internet website and submit the report to the Governor and the Legislative Committee on Health Care. SB196 would help provide better quality of care provided to patients who suffer from strokes in this State. Finally, SB196 would authorize a provider of health care to use credit earned for continuing education relating to Alzheimer’s disease in place of not more than 2 hours each year of the requirements for continuing education, other than any requirements for continuing education relating to ethics. SB196 was passed out of both houses unanimously and signed by the Governor on May 13th.

**Senate Bill 206** (SB206) as introduced would require the Department of Motor Vehicles, upon issuance of a driver’s license or identification card, to give the holder the opportunity to have indicated on his or her driver’s license or identification card that the holder wishes to be a donor, or doesn’t at this time wish to be a donor as well as indicating whether he or she wishes to donate $1 or more to the Anatomical Gift Account. The Department then must indicate to the holder upon renewal of the driver’s license or identification card the fact that if they are already a donor that indication will remain on the card unless they change it. The Department is also required to notify a person who chose not to be a donor that they may change the indication at any time. SB 206 also allows for this on authorization cards and certain instruction permits to be
included in this was well. SB206 was passed out of both houses unanimously and signed by the Governor on May 29th.

**Senate Bill 210** (SB210) proposed to require the Division of Public and Behavioral Health of the Department of Health and Human Services to establish a grading system for medical facilities and facilities for the dependent. The grading system would have been an A, B, C, D scale with A being the highest. Also SB 210 would have required the Division to reduce by 25% the amount of the fee charged by the Division for the next consecutive renewal of the license of the facility if the facility received a grade of A on two concurrent inspections. This would allow a facility to maintain a high grade and receive a reduction in renewal cost for their continued A inspections. SB210 was passed out of the Senate Health and Human Services Committee and re-referred to the Senate Finance Committee where it was declared exempt. However, SB 210 never received another hearing and failed to meet the final deadline on June 1st.

**Senate Bill 265** (SB265) would have created the Advisory Council on Palliative Care and Quality of Life within the Department of Health and Human Services. SB265 defined “palliative care” as a multidisciplinary approach to specialized medical care for a person with a serious illness, which approach focuses on the care of a patient throughout the continuum of an illness and involves addressing the physical, emotional, social and spiritual needs of the patient, as well as facilitating patient autonomy, access to information and choice. SB265 was heard in the Senate Government Affairs Committee and then re-referred to the Senate Finance Committee where it was exempted. SB265 never received another hearing and failed to meet the final deadline on June 1st.

**Senate Bill 269** (SB269) would have established an interim study committee to research: (1) potential sources of state funding to support programs to aid caregivers that are providing care to older persons with behavioral and cognitive health issues; (2) potential sources of funding to assist Nevada’s Care Connection and Nevada 2-1-1 in creating a “No Wrong Door” program to assist caregivers of older adults with behavioral and cognitive health issues; (3) the potential for establishing a higher rate of reimbursement by Medicaid for nursing facilities prepared and trained to support older persons with behavioral and cognitive needs; and (4) the provision of education and training for health care professionals in the screening, diagnosis and treatment of behavioral and cognitive diseases prevalent in older persons. SB269 was declared exempt on April 3rd and later passed out of the Senate on May 27th. It received a hearing in the Assembly but never made it out. SB269 failed to meet the final deadline on June 1st.

**Senate Bill 291** (SB291) was a tort reform bill which addressed the “collateral source rule.” This is a common law doctrine that prohibits a defendant in a tort case from introducing into evidence proof of the amounts that the plaintiff received or was entitled to receive from a source other than the defendant in compensation for the harms or injuries caused by the defendant. There is limited exception in current law to the collateral source rule by allowing a defendant in a case against a provider of health care
based upon professional negligence to introduce evidence of amounts paid or payable to a plaintiff pursuant to policies of health or accident insurance, the United States Social Security Act, worker’s compensation statutes and other programs or contracts that pay for or reimburse costs of health care. SB291 as amended removed the limited exception and instead require a court, upon a motion by a defendant in any tort case, to reduce the amount of damages initially determined by the jury or other finder of fact by the amount of past medical expenses paid in relation to the injury or death sustained. Although the NSMA did not take an official position on this bill, the Nevada Rural Hospital Association had expressed some concern with the effect these changes would have on professional negligence cases. SB291 was passed out of the Senate and heard in the Assembly Judiciary Committee. SB291 failed to be passed out of committee and didn’t meet the final deadline on June 1st.

**Senate Bill 314** (SB314) revised the composition of the Southern Nevada Health District. SB314 changed the job description, qualifications and compensation of the district health officer and provided for a chief medical officer, if necessary. SB314 also revises the makeup of the Board and provides for a public health advisory board to ensure that certain persons who were removed from the Board continue to have a voice in the decisions. SB 314 had a companion bill, Assembly Bill 232, which failed to make it out of the Assembly. Pieces of AB232 were ultimately amended into SB314. The NSMA had opposed AB232 in its original form but as it was amended and placed into SB314 the opposition went away. The main reason for opposition was that the original bill created to equal heads at the top of the Health District, which would have created problems in authority. That structure was not amended into SB314. SB 314 was passed out of both houses, on a narrow margin in the Assembly on a 22-20 vote. SB314 was delivered to the Governor on May 29.

**Senate Bill 402** (SB402) defines obesity as an abnormal and unhealthy accumulation of body fat which is statistically correlated with premature mortality, hypertension, heart disease, diabetes, cancer and other health conditions, and can be indicated by several factors including body mass index, body fat percentage and waist size. SB402 also indicates that obesity is used in other chapter of NRS for different meanings and should not be included in this definition. SB402 also required the board of trustees of the Clark and Washoe county school districts to direct school nurses, qualified health personnel, teachers who teach physical education or health or other licensed educational personnel who have completed training in measuring the height and weight of a pupil to measure the height and weight of a representative sample of pupils who are enrolled in grades 4, 7, and 10 within the school districts. The NSMA has historically been very supportive of this provision, but did not actively engage on this issue this Session. The Division of Public and Behavioral Health of the Department of Health and Human Services will then compile a report of the data collected regarding the height and weight of pupils measured and report to the Chief Medical Officer and publish and disseminate the reports. SB402 was passed out of the Senate but never received a vote on the Assembly floor and failed to meet the second house deadline on May 22nd.
**Senate Concurrent Resolution 2** (SCR2) encourages the Board of Medical Examiners, the State Board of Osteopathic Medicine, the State Board of Nursing, professional associations of health care providers and educational institutions to incentivize and promote awareness and education of health care providers concerning Alzheimer’s disease and other forms of dementia. SCR2 also would encourage primary care physicians to refer persons with cognitive deficits for specialized cognitive testing when appropriate and refer persons with dementia and their families to dementia-related community resources and supportive programs. SCR2 further encourages first responders, law enforcement and fire department personnel to attend training adequate to help them assess and learn how to respond people with Alzheimer’s disease and other forms of dementia. SCR2 could add training and educational requirements to primary care physicians and other providers of health care if their respective boards decide to do so. SCR2 was enrolled and is currently in the Office of the Secretary of State awaiting dissemination to the required persons.
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Attachment
### Blended FMAP Rates, FY 2015 - FY 2017

<table>
<thead>
<tr>
<th>FMAP Type</th>
<th>Related Eligibility Groups</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017 Gov Rec</th>
<th>FY 2017 Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard FMAP</td>
<td>Traditional Medicaid (Temporary Assistance for Needy Families/Children's Health Assurance Program (TANF/CHAP); Medical Assistance to the Aged, Blind, and Disabled (MAABD); Waiver; County Indigent; Child Welfare)</td>
<td>64.05%</td>
<td>64.76%</td>
<td>65.30%</td>
<td>65.25%</td>
</tr>
<tr>
<td>Newly Eligible FMAP</td>
<td>Newly Eligible Medicaid</td>
<td>100.00%</td>
<td>100.00%</td>
<td>97.50%</td>
<td>97.50%</td>
</tr>
<tr>
<td>Enhanced Check Up FMAP *</td>
<td>Check Up to Medicaid</td>
<td>74.83%</td>
<td>92.60%</td>
<td>98.71%</td>
<td>98.68%</td>
</tr>
</tbody>
</table>

* A provision in the Patient Protection and Affordable Care Act (ACA) temporarily increases the Enhanced Check Up FMAP rate by 23 percent beginning October 1, 2015. The increase is set to expire September 30, 2019.

The decrease in the blended FMAP rates for FY 2017 is a projection at this time. The official federal FY 2017 FMAP rates will be released by the federal Department of Health and Human Services in the fall of 2016. Historically, the Governor and the Legislature have used FMAP rate projections prepared by FFIS in developing and modifying the division’s budgets because FFIS is widely recognized for the accuracy and reliability of the information and data it publishes.

**Does the Subcommittee wish to approve the revised FMAP rates for FY 2017, requiring additional General Fund appropriations of $921,436 in FY 2017, across all decision units in this budget?**

#### The Subcommittee recommended approving the revised FY 2017 FMAP projections.

3. **Provider Reimbursement Rate Increases**: The Executive Budget recommends additional funding totaling $240.3 million ($59.7 million General Fund appropriation) over the 2015-17 biennium to support increased costs resulting from mandatory and discretionary medical service reimbursement rate increases, as described below.

**Mandatory Rate Increases (M-101, DHHS-DHCFP-42)**: The Executive Budget recommends $44.0 million ($12.4 million General Fund appropriation) in FY 2016 and $71.3 million ($16.7 million General Fund appropriation) in FY 2017 for federally mandated reimbursement rate increases for Medicaid providers. The mandatory Medicaid rate increases include Managed Care Organizations (MCO), Federally Qualified Health Centers, Rural Health Centers, Indian Health Services, hospice services, and prescription drugs. The table below displays the mandatory annual rate increase percentages by provider type.

<table>
<thead>
<tr>
<th>Recommended Mandatory Provider Rate Increases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
</tr>
<tr>
<td>Managed Care Organizations</td>
</tr>
<tr>
<td>Rural Health Centers and Federally Qualified Health Centers</td>
</tr>
<tr>
<td>Indian Health Services</td>
</tr>
<tr>
<td>Hospice Services</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
</tbody>
</table>
Technical Adjustments to Mandatory Rate Increases

Clawback: On April 14, 2015, FFIS released an issue brief, which indicated that state clawback payments are projected to increase, beginning in 2016. The Medicare Modernization and Improvement Act (MMA) of 2003 enacted prescription drug coverage for Medicare recipients, known as Medicare Part D. The MMA requires states to reimburse Medicare for the costs of providing prescription drug coverage to individuals who are eligible for both Medicare and Medicaid (known as dual eligibles). This reimbursement is referred to as the clawback. The state’s clawback payment is calculated based on the number of dual eligibles and state’s per capita expenditures for prescription drugs covered by Medicare Part D.

Considering the FFIS issue brief, Fiscal staff asked the agency to reproject clawback payments for the 2015-17 biennium. Based on the agency’s re-projections, Fiscal staff has completed technical adjustments to this decision unit, shown on the closing document, to align budgeted clawback payments with the updated projections, resulting in a net General Fund appropriation increase of $1.7 million over the 2015-17 biennium.

MCO Maternity Payments: The state pays MCOs a supplemental payment for the care of pregnant women, known as a maternity kick payment. Fiscal staff determined that the agency’s July to December 2015 maternity kick payments were overstated due to a calculation error. Fiscal staff has completed technical adjustments, shown on this closing document, to correct the calculation error, resulting in savings totaling $852,168 ($204,982 General Fund appropriation) in FY 2016. This adjustment was calculated based the agency’s March 2015 caseload and cost per eligible projection. The agency agrees that this technical adjustment is reasonable.

Does the Subcommittee wish to approve mandatory rate increases as recommended by the Governor with the noted technical adjustments, including additional General Fund appropriations of $1.7 million over the 2015-17 biennium for clawback payments and General Fund savings of $204,982 in FY 2016 to correct a calculation error?

The Subcommittee recommended approving mandatory rate increases as recommended by the Governor, with the noted technical adjustments.

Discretionary Rate Increases: The Governor recommends $37.6 million ($8.9 million General Fund appropriation) in FY 2016 and $87.3 million ($21.8 million General Fund appropriation) in FY 2017 for discretionary provider reimbursement rate increases. Beginning in FY 2016, the Governor recommends increasing reimbursement rates for physicians, physician assistants and certified nurse practitioners. Beginning in FY 2017, the Governor recommends increasing reimbursement rates for acute inpatient hospital services, home-based nursing services, and for Individuals with Intellectual Disabilities and Related Conditions (IDRC) waiver services. The discretionary reimbursement rate increases are discussed individually below.

- **Physician, Physician Assistant and Certified Nurse Practitioner Rate Increase (E-277, DHHS-DHCFP-51):** Additional funding totaling $97.8 million ($23.2 million General Fund appropriation) is recommended over the upcoming biennium to increase reimbursement rates for physicians, physician assistants and certified nurse practitioners beginning in FY 2016. The intent is to increase current rates, which are based on the 2002 Medicare fee schedule, to align more closely with rates in the 2014 Medicare fee schedule. According to the agency, the recommended funding would result in a 10 percent increase in the aggregate in the amount the division pays for physician, physician assistant and certified nurse practitioner services. The Subcommittee should
note that the 2013 Legislature approved a temporary Primary Care Physician (PCP) supplemental payment as required by the ACA for the 2013-15 biennium, which is set to expire on June 30, 2015.

The agency indicates that the reimbursement rate increase would not apply equally to all medical services provided by physicians, physician assistants and certified nurse practitioners. Rather, the reimbursement rate for some services would increase and the reimbursement rate for other services would decrease. The table on the following page shows the percentage the agency estimates revised reimbursement rates would vary from the current reimbursement rates, excluding the temporary PCP supplemental payment, and the percentage of the 2014 Medicare fee schedule the revised reimbursement rates would be set at, by service type.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of 2014 Med(SC)</td>
<td>% Change</td>
</tr>
<tr>
<td>Surgery</td>
<td>95%</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>95%</td>
<td>-6.9%</td>
</tr>
<tr>
<td>Radiology</td>
<td>90%</td>
<td>-25.6%</td>
</tr>
<tr>
<td>Laboratory</td>
<td>50%</td>
<td>-48.7%</td>
</tr>
<tr>
<td>Vaccine</td>
<td>85%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Medicine</td>
<td>85%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Evaluation and Management</td>
<td>90%</td>
<td>38.4%</td>
</tr>
</tbody>
</table>

* Percentage change is from the FY 2015 rate excluding the temporary Primary Care Physician Supplemental Payment and is not cumulative.

According to the agency, Nevada has a statewide primary care shortage and Medicaid has to compete with other payer sources for access to services. Considering the stated provider shortage and the pending expiration of the temporary PCP supplemental payment, the division indicates its focus is on increasing access for primary care services. Accordingly, the recommended reimbursement methodology was intended to focus on primary care reimbursement rates, shown in the table above as evaluation and management services.

Fiscal staff asked the agency whether the temporary PCP supplemental payment has increased recipient access to primary care services. In a March 18, 2015, follow-up memo, the agency indicated that at the time the PCP supplemental payment was implemented, there were 1,170 PCP providers. As of March 2015, the agency indicates that there were 1,365 providers, an increase of 17 percent.

During the budget hearing, the Subcommittee expressed concern that the reimbursement rates for radiology and laboratory services would decrease. Additionally, the Subcommittee expressed concern that the reimbursement rate for evaluation and management would decrease from the current reimbursement level, which includes a temporary increase due to the supplemental payment. For example, reimbursement for a primary care service office visit is currently $75 with the temporary supplemental payment. Reimbursement for the same service is recommended in The Executive Budget to be $67 in FY 2016 and $71 in FY 2017.

During the budget hearing, the Subcommittee expressed concern that the reimbursement rates for radiology services is recommended to be 90 percent and 94 percent of the 2014 Medicare fee schedule in FY 2016 and FY 2017, respectively. To maintain radiology rates at the current level, which is above the 2014 Medicare fee schedule, the agency indicates that additional funding totaling $71.2 million ($17.1 million General Fund appropriation) would be required over the 2015-17 biennium beyond the amounts included in The Executive Budget. The agency indicates that Medicaid is currently reimbursing providers above the upper payment limit (UPL), which is the amount Medicare reimburses providers
for the same service, for radiology services. In 2014, the agency estimates that Medicaid paid 23 percent over the UPL amount for radiology services. The agency also notes that paying over the UPL amount for radiology services would not provide equity among reimbursement methodologies for services provided by physicians. Accordingly, the agency does not recommend maintaining reimbursement rates for radiology at the current level. However, the agency indicates it would be reasonable to increase the radiology reimbursement rate to 100 percent of the 2014 Medicare fee schedule, requiring additional funding totaling $22 million ($5.3 million General Fund appropriation) over the 2015-17 biennium.

The agency also indicates that the reimbursement rate for laboratory services is recommended to be 50 percent of the 2014 Medicare fee schedule in the 2015-17 biennium. In a March 18, 2015, follow-up memo, the agency indicated that the laboratory reimbursement rate decrease was unintentional. The agency stated that if it would have recommended to set the laboratory services reimbursement rate at 95 percent of the 2014 Medicare fee schedule, the additional cost would be $12.5 million ($3.0 million General Fund appropriation) over the 2015-17 biennium beyond the amount included in The Executive Budget. Setting the reimbursement rate for laboratory services at 85 percent of the 2014 Medicare fee schedule would require additional funding totaling $10.4 million ($2.6 million General Fund appropriation) over the biennium, while setting the reimbursement rate at 100 percent of the Medicare fee schedule would cost $13.5 million ($3.2 million General Fund appropriation) over the biennium.

The agency further indicates that the reimbursement rate for evaluation and management services is recommended to be 90 and 95 percent of the 2014 Medicare fee schedule in FY 2016 and FY 2017, respectively. During the budget hearing, the agency noted that certain services currently qualify for the previously mentioned temporary Primary Care Physician (PCP) supplemental payment as required by the ACA for the 2013-15 biennium, which is set to expire on June 30, 2015. The recommended evaluation and management reimbursement rates for the 2015-17 biennium would be lower than the current reimbursement rates for certain services, when including the PCP supplemental payment. The agency indicates that setting the evaluation and management reimbursement rate at 100 percent of the 2014 Medicare fee schedule would require additional funding totaling $51.9 million over the 2015-17 biennium beyond the amounts included in The Executive Budget. The agency indicates the General Fund cost would be $13.3 over the biennium, calculated at the standard FMAP rate. Considering the 100 percent FMAP associated with the Newly Eligible population, Fiscal staff calculates a $12.4 million General Fund appropriation for this option. The agency indicates that another option would be to continue the current ACA primary care physician supplemental payment and maintain the rates for other physician, physician assistant and certified nurse practitioner services at the current level, at an additional cost of $5.0 million ($3.0 million General Fund appropriation) over the biennium.

Based upon previous Subcommittee discussions regarding provider rate adjustments, the Subcommittee may wish to consider the following options:

a) Approve physician, physician assistant, and certified nurse practitioner reimbursement rate increases as recommended by the Governor, including additional General Fund appropriations of $23.2 million over the 2015-17 biennium; or

b) Approve physician, physician assistant, and certified nurse practitioner rates as recommended by the Governor, including additional General Fund appropriations of $23.2 million over the 2015-17 biennium, modified to include one or a combination of the following options:
i. Maintain radiology reimbursement rates at the current level above the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $17.1 million;

ii. Set radiology reimbursement rates at 100 percent of the 2014 Medicare fee schedule, compared with the 90 and 94 percent level in FY 2016 and FY 2017, respectively, recommended by the Governor requiring additional General Fund appropriations of $5.3 million over the 2015-17 biennium;

iii. Increase the laboratory reimbursement rate above the 50 percent of the 2014 Medicare fee schedule recommended by the Governor to:

A. 85 percent of the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $2.6 million over the 2015-17 biennium;

B. 95 percent of the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $3.0 million over the 2015-17 biennium;

C. 100 percent of the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $3.2 million over the 2015-17 biennium;

iv. Increase the evaluation and management reimbursement rate from the 90 and 95 percent of the 2014 Medicare fee schedule in FY 2016 and FY 2017, respectively, to 100 percent of the Medicare fee schedule, requiring additional General Fund appropriations of $12.4 million over the 2015-17 biennium.

c) Continue the ACA primary care physician supplemental payment and maintain reimbursement rates for other services as the current levels, requiring additional General Fund appropriations of $3.0 million over the 2015-17 biennium.

d) Disapprove the physician, physician assistant, and certified nurse practitioner rate increases as recommended by the Governor.

The Subcommittee recommended approving physician, physician assistant, and certified nurse practitioner rate increases as recommended by the Governor, with additional rate increases to align the reimbursement rate for radiology services with 100 percent of the 2014 Medicare fee schedule (option B(ii)) and to align the reimbursement rate for laboratory services with 95 percent of the 2014 Medicare fee schedule (option b(iii)(B)), including additional General Funds totaling $8.3 million over the biennium.

- Acute Inpatient Hospital Rate Increase (E-275, DHHS-DHCFP-50 & 51): Additional funding of $14.4 million ($4.4 million General Fund appropriation) in FY 2017 is recommended to increase the reimbursement rate for acute inpatient hospital services by 2.5 percent beginning in FY 2017. The agency indicates that the acute inpatient hospital rate increase is intended to partially rectify previous reimbursement rate decreases. In FY 2009, inpatient hospital reimbursement rates were reduced by 5 percent as a cost-saving measure to address a statewide budget shortfall.

The agency indicates that the 2.5 percent increase applies to acute inpatient hospital services in the aggregate rather than a 2.5 percent increase to each individual service. The agency intends to work with the Nevada Hospital Association to target rate increases to ensure access to care for Medicaid recipients.
Based upon previous Subcommittee discussion, if the Subcommittee wishes to begin the acute inpatient hospital services 2.5 percent rate increase in FY 2016 rather than FY 2017, additional funding totaling $15.0 million, including $4.6 million in General Fund appropriations, would be required.

If the Subcommittee wishes to increase the acute inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017 (5.06 percent cumulative increase from the FY 2015 level), additional funding totaling $30.0 million, including $9.2 million in General Fund appropriations, would be required.

If the Subcommittee wishes to increase the acute inpatient hospital services reimbursement rate by 5 percent beginning in FY 2016, additional funding totaling $44.5 million, including $13.7 million in General Fund appropriations, would be required.

The Subcommittee may wish to consider the following options:

a) Increase the reimbursement rate for acute inpatient hospital services by 2.5 percent beginning in FY 2017 as recommended by the Governor; or

b) Increase the reimbursement rate for acute inpatient hospital services by 2.5 percent beginning in FY 2016, requiring additional General Fund appropriations of $4.6 million in FY 2016; or

c) Increase the reimbursement rate for acute inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017, requiring additional General Fund appropriations of $9.2 million over the 2015-17 biennium; or

d) Increase the reimbursement rate for acute inpatient hospital services by 5 percent beginning in FY 2016, requiring additional General Fund appropriations of $13.7 million over the 2015-17 biennium; or

e) Disapprove the Governor’s recommendation to increase the reimbursement rate for acute inpatient hospital services.

The Subcommittee recommended approving option c, to increase the reimbursement rate for acute inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017, including additional General Funds totaling $9.4 million over the biennium. The Subcommittee recommended issuing a letter of intent, instructing the agency to report to the Interim Finance Committee on options for providing Medicaid reimbursement for telemedicine, community paramedicine and community health worker services.

- Home-Based Nursing Services Rate Increase (E-278, DHHS-DHCFP-52): Additional funding of $8.8 million ($3.0 million General Fund appropriation) is recommended in FY 2017 to increase the reimbursement rate for nursing services provided in the home by 25 percent in the aggregate beginning in FY 2017. The agency indicates that it is currently experiencing access to care issues with home-based nursing services, putting recipients at risk of institutionalization. According to the agency, home-based nursing service providers have indicated that their costs for providing home-based nursing services amount to approximately $65.00 per hour, while Medicaid reimburses providers $47.48 per hour for these services. Accordingly, providers indicate that they lose money when serving Medicaid recipients, and the agency indicates providers have been refusing to serve Medicaid recipients.