

SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMITTEE ON HEALTH CARE

Nevada Revised Statutes (NRS) 439B.200

This summary presents the recommendations approved by the Legislative Committee on Health Care (LCHC) at its August 24, 2016, meeting. The LCHC submits the following recommendations and bill draft requests (BDRs) to the 79th Session of the Nevada Legislature:

PROPOSALS RELATING TO THE HEALTH CARE WORKFORCE

1. **Nurse Licensure Compact**—Send a letter to the Governor of the State of Nevada and the Director of the Department of Health and Human Services (DHHS) expressing the Committee’s support for bill draft request (BDR 54–182, which would adopt the Nurse Licensure Compact.
2. **Health Professional Licensure Compacts**—Propose legislation to enact the:
 - a. Recognition of Emergency Medical Services Personnel Licensure Interstate [Compact](#); and
 - b. Psychology Interjurisdictional Compact—redraft the sections of Senate Bill 299 of the 2015 Legislative Session enacting the [Psychology Interjurisdictional Compact](#). **(BDR XX–351)**
3. **National Health Service Corps and Nurse Corps**—Send letters to medical facilities in Nevada that are eligible to serve as National Health Service Corps sites or Nurse Corps sites, strongly encouraging them to apply to and participate in these programs.
4. **Advanced Practice Registered Nurses**—Propose legislation to:
 - a. Amend the following sections of NRS to allow advanced practice registered nurses (APRNs) to perform the following tasks, which currently may only be performed by a physician:
 - i. [NRS 440.380](#): Amend to allow an APRN to sign a death certificate;
 - ii. [NRS 482.3831](#) through [482.384](#): Amend to allow an APRN to make all applicable diagnoses and certifications authorizing a person with a disability to obtain a special license plate or a temporary parking placard or sticker; and

- iii. [NRS 706.8842](#): Amend to include an APRN in the definition of “medical examiner,” thereby allowing an APRN to issue a medical examiner’s certificate for a taxicab commercial driver’s license. **(BDR 40–352)**
- 5. **Graduate Medical Education Funding**—Send a letter to the Governor of the State of Nevada expressing the Committee’s support for and urging continuation of a \$5.25 million annual budget appropriation for graduate medical education (GME) in each year of the 2017–2019 Biennium.
- 6. **Graduate Medical Education**—Send a letter to Nevada’s Congressional Delegation advocating for:
 - a. No additional GME funding cuts; and
 - b. Redistributing full-time equivalent GME slots to Nevada hospitals.
- 7. **State Employee Contracting**—Propose legislation to amend subsection 9 of [NRS 333.705](#) to add “former state employees who are not receiving monetary retirement benefits through the Public Employee Retirement System of Nevada during the time period they are under contract” to the list of entities that are exempt from the prohibition on contracting with a former State employee for two years after the termination of the person’s State employment. **(BDR 27–354)**

PROPOSALS RELATING TO PUBLIC HEALTH

- 8. **Body Mass Index Measurement in Schools**—Redraft Section 9 of Senate Bill 178 (2015) to reestablish the requirements below concerning measurement of the height and weight of a representative sample of pupils. These requirements had sunset in 2015. Specifically, amend [NRS 392.420](#) to:
 - a. Reestablish the requirement that the board of trustees of each school district in a county whose population is 100,000 or more (currently Clark and Washoe Counties) 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 provided by the school district to measure the height and weight of a representative sample of pupils who are enrolled in grades 4, 7, and 10 in the schools within the school district;
 - b. Require the Division of Public and Behavioral Health (DPBH), DHHS, to determine the number of pupils necessary to include in the representative sample;
 - c. Not require school authorities to provide notice to a student’s parent or guardian before measuring the child’s height or weight if it is not practicable to do so; and

d. Require each school nurse or his or her designee to report the results to the Chief Medical Officer. **(BDR 34–353)**

9. **Vapor Products and Tobacco Products**—Propose legislation to:

a. Amend [NRS 202.2483](#), the “Nevada Clean Indoor Air Act,” to prohibit the use of vapor products, as defined in [NRS 202.2485](#), in all areas where tobacco smoking is prohibited; and

b. Add new provisions that:

i. Require nicotine containers used in vapor products to be sold in child resistant packaging, in accordance with the federal [Poison Prevention Packaging Act of 1970](#), 15 U.S.C. §§ 1471-1476, and 16 C.F.R. § 1700; and

ii. Require labels on vapor products and alternative nicotine products to include ingredients, nicotine level, and age restrictions. **(BDR 15–355)**

PROPOSALS RELATING TO MEDICAID MANAGED CARE

10. **Medicaid Managed Care Expansion**—Send letters to the Governor of the State of Nevada and the Director of the DHHS urging consideration of the concerns and recommendations expressed by the National Alliance on Mental Illness, Nevada, in its June 16, 2016, letter to the LCHC, as the DHHS determines whether and how to expand Medicaid managed care to additional populations and geographic areas.

11. **Medicaid Managed Care Agreements/Request for Proposals**—Send a letter to the Division of Health Care Financing and Policy (DHCFP), DHHS, encouraging consideration of its relationship with Medicaid managed care organizations (MCOs) and requesting that DHCFP clarify the following in future managed care requests for proposals and contracts:

a. The State has the authority to oversee the performance of MCOs and must ensure that specific performance criteria are included in the MCO contract and measured at least monthly. The results of performance criteria must be transparent and shared publically, including on the DHCFP’s website.

b. The MCOs must administer their provider contracts in accordance with Medicaid policies unless mutually agreed upon otherwise and documented by the State and providers.

c. Contracts between the State and MCOs must require each MCO to independently meet network adequacy standards, comparable to those established annually by

Nevada's Division of Insurance, through direct contracting with providers and hospitals.

- d. The State is responsible for final policy/claims appeal if an MCO and a provider cannot reach an agreement.
- e. Geographic expansion of Medicaid managed care into the rural areas of Nevada will not occur until rural communities are ready.

PROPOSAL RELATING TO PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

12. Physician Orders for Life-Sustaining Treatment—Propose legislation to:

- a. Amend [NRS 449.535](#) through [449.690](#) to allow an APRN to make all diagnoses applicable to a declaration to withhold or withdraw life-sustaining treatment and accept such a declaration;
- b. Amend subsection 2 of [NRS 449.6946](#) to require providers of health care to honor a patient's most recent health care declaration, directive, or order to guide treatment instead of allowing a do-not-resuscitate identification that is on the person of a patient to take precedence over a subsequently executed physician orders for life-sustaining treatment (POLST);
- c. Establish who may serve as a health care surrogate for purposes related to a POLST, and authorize a health care surrogate to complete and sign a POLST for a patient who lacks decisional capacity if the patient does not have a Durable Power of Attorney for Health Care or a legal guardian. Amend NRS to provide that:
 - i. A health care surrogate has authority to consent to or withhold consent for treatment for a patient lacking decisional capacity.
 - ii. The following individuals may act as a health care surrogate for a patient, in order of priority: (1) spouse; (2) adult child; (3) parent; (4) sibling; (5) nearest other adult relative; or (6) an adult who has exhibited special care and concern for the patient, who is familiar with the patient's values and willing and able to make health care decisions for the patient.
 - iii. Health care surrogates may not revoke a POLST completed by a patient or his or her durable power of attorney or guardian, and a surrogate's consent is not valid if it conflicts with the patient's valid POLST or advance directive.

- iv. The physician has the right to determine fitness of a health care surrogate pursuant to the federal [Privacy Act of 1974](#), 45 CFR 164.502(g).
- v. If a health care provider, a patient’s legal representative, or a patient’s health care surrogate believes the patient has regained decisional capacity, the patient may be reexamined and a decision shall be entered into the medical record and the health care surrogate must be notified.
- d. Establish that artificial nutrition and hydration must not be withheld from a patient who does not have an effective declaration as defined in [NRS 449.600](#) or POLST, unless a different desire is expressed in writing by the patient’s health authorized representative or family member; and
- e. Establish that life-sustaining treatment must not be withheld or withdrawn from a patient known to be pregnant, so long as it is probable that a fetus will develop to the point of live birth with continued application of life-sustaining treatment. **(BDR 40–365)**

PROPOSAL RELATING TO RARE DISEASES

- 13. **Medical Education for Residents**—Send letters to GME residency programs in Nevada expressing the Committee’s awareness of, and concern for, the population of Nevadans who are at risk for, and affected by, rare diseases such as Postural Orthostatic Tachycardia Syndrome, Ehlers-Danlos syndrome, and numerous others. In the letter:
 - a. Request that residency programs report to the LCHC and to the Senate and Assembly Committees on Health and Human Services on existing curriculum, requirements, and efforts to educate residents about rare disease, as well as future plans to include education and training on rare disease in residency curriculum;
 - b. Provide data on the incidence of rare disease. According to the National Institutes of Health, U.S. Department of Health and Human Services, an estimated 25 million to 30 million Americans have 1 of the 7,000 known rare diseases; and
 - c. Discuss the challenges experienced by those who have received a rare disease diagnosis due to the limited experience many providers have identifying and diagnosing such conditions. In addition, discuss promising therapies that are under development.

PROPOSALS RELATING TO CHILDREN'S HEALTH

14. **Children's Mental Health**—Send a letter to the Governor of the State of Nevada and the Director of the DHHS supporting the priorities of the Clark County Children's Mental Health Consortium, which include:
 - a. Restructuring the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families;
 - b. Providing mobile crisis intervention and stabilization services to Clark County youths in crisis;
 - c. Expanding access to family-to-family peer support services for the families of Clark County's children at risk for long-term institutional placement; and
 - d. Developing partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

15. **Posting of Child Abuse Hotline Number in Schools**—Propose legislation to amend NRS to require all public schools, including charter schools, to post the State and local (if applicable) child abuse hotline telephone number in a clearly visible location in a public area of the school. Specifically, amend NRS to:
 - a. Require each public school and charter school to post in a clearly visible location, in a public area of the school that is readily accessible to students, a sign that contains the toll-free hotline telephone number established by the Division of Child and Family Services (DCFS), DHHS, for reports of abuse or neglect pursuant to [NRS 432B.200](#) and the local child abuse hotline, if one is available;
 - b. Authorize the Director of the DHHS to adopt rules and regulations relating to the size and location of the sign provided that, at a minimum, it shall:
 - i. Be in English and Spanish;
 - ii. Be 11 inches by 17 inches or larger;
 - iii. Include text in a font large enough to be clear, simple, and understandable to students;
 - iv. Be posted in a high traffic location at the eye level of students;

- v. Contain the current telephone number for the DCFS child abuse and neglect hotline and the local child abuse hotline, if applicable, in bold print;
 - vi. Contain instructions for calling 9-1-1 in an emergency; and
 - vii. Contain instructions for accessing DCFS's website for more information on reporting abuse and neglect; and
- c. Authorize the DCFS to design a poster that complies with these requirements and distribute the poster to schools in hard copy form or in electronic form for printing. **(BDR 34-362)**
16. **Children's Health Insurance Program**—Send a letter to the DHHS encouraging DHCNP to examine Nevada's Children's Health Insurance Program (CHIP) eligibility policies to provide health insurance coverage to lawfully residing immigrant children who have not been in the country for five years. In the letter, provide information regarding other states' eligibility policies, including the fact that CHIP programs in 29 states and the District of Columbia cover lawfully residing immigrant children without a five-year wait.

PROPOSALS RELATING TO AUTISM TREATMENT AND SERVICES IN NEVADA

17. **Autism Treatment Assistance Program and Medicaid**—Send a letter to the Director of the DHHS conveying the variety of concerns related to accessing services the Committee heard from numerous parents of children with autism, as well as providers of autism services. Include the following concerns.
- a. The reimbursement rate for services provided to adults with autism under the Medicaid Home and Community-Based Services (HCBS) Waiver, especially in rural areas. Specifically mentioned were concerns regarding the residential support services rate for severely impacted adults with autism, the need to authorize day habilitation services provided in the home at a higher reimbursement rate, and the Medicaid reimbursement rate for Board Certified Behavior Analysts (BCBAs) who provide services to adults on the Medicaid HCBS Waiver to match the reimbursement rate for services provided to children.
 - b. Concerns expressed regarding Autism Treatment Assistance Program (ATAP) policies and programs include:
 - i. Allowing parents to continue to be able to hire their own interventionists with the assistance of a fiscal agent;

- ii. Allowing payment to interventionists working under the supervision of a BCBA, without requiring a registered behavior technician (RBT) credential, until such time as there is a sufficient RBT workforce;
 - iii. Delaying the transfer of Medicaid-eligible children to Medicaid providers for individual children until a Medicaid provider is available to seamlessly accept and treat the child; and
 - iv. Continuing to ramp up efforts to serve children through Medicaid providers, using their current providers as much as is practicable.
- c. Concerns regarding Medicaid policy and programs include:
- i. The need to review the RBT rate;
 - ii. Exploring with the Centers for Medicare and Medicaid Services the possibility of adopting the approach taken by ATAP to allow payment for services provided by an interventionist under the supervision of a BCBA for up to six months while the interventionist obtains an RBT credential;
 - iii. Supporting efforts to grow the State’s BCBA and Board Certified Assistant Behavior Analyst (BCaBA) workforce through the higher education system and encourage the Department of Employment, Training and Rehabilitation to include the BCaBA and RBT in their programs; and
 - iv. The need to review available programs and reimbursement rates for adults with autism.

18. **Redefine Autism**—Propose legislation to:

- a. Amend subsection 1 of [NRS 427A.875](#) to authorize ATAP to provide and coordinate services to persons “diagnosed or determined, including, without limitation, through use of a standardized assessment” to have autism spectrum disorders, through 19 years of age; and
- b. Amend [NRS 287.0276](#), [427A.875](#), [689A.0435](#), [689B.0335](#), [689C.1655](#), [695C.1717](#), and [695G.1645](#) to redefine “autism spectrum disorder” as “a condition that meets the diagnostic criteria published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders or the edition that was in effect at the time of diagnosis.”
(BDR 38–363)

19. **Collaboration Between School and Out-of-School ABA Services**—Send a letter to the Superintendent of Public Instruction urging Nevada’s Department of Education to develop a clear and consistent State policy, with guidance to school districts, for students

with an Individualized Education Program (IEP) who require Applied Behavior Analysis (ABA) therapy. In developing the policy, the Department should consider:

- a. Whether an IEP should be required to specify the number of weekly ABA hours needed by the student, with a distinction between the hours to be provided in school and out of school;
- b. Specifying the credentials required of an ABA professional who assists in determining the total weekly ABA hours needed by the student;
- c. Requiring collaboration for ABA services to maximize their effectiveness and to ensure continuity of service across environments;
- d. Requiring schools to support access to ABA by endorsing the following or similar language in the IEP: “The IEP recognizes the student’s need to receive medically necessary treatment, which may impact full-time school attendance. An adjusted schedule is supported to allow student to receive treatment, which may occur in and/or outside of the school environment without incurring truancy”;
- e. Requiring the school to encourage a parent, through written communication from the school, to invite the student’s outside ABA professional(s) to participate in relevant IEP meetings; and
- f. Allowing a student’s out-of-school ABA Professional (i.e., BCBA or licensed psychologist)—who is funded by private insurance, Medicaid, or ATAP and who passes appropriate background checks—to observe the student in the school environment quarterly and/or allowing such a provider to support the student during the school day if the student’s behavior impedes learning or if the student’s history includes elopement, suspension, or aggression.

PROPOSAL RELATING TO MEDICAID REIMBURSEMENT RATES

20. **Medicaid Reimbursement Rates**—Send a letter to the Director of the DHHS expressing the Committee’s support for continuing to conduct regular evaluations of Medicaid provider reimbursement rates. Specifically, recommend that the DHHS review reimbursement rates for personal care services; home health services; and providers of community-based, long-term services and supports. Include with the letter the written testimony received related to increasing rates for these specialties.

**PROPOSALS RELATING TO HEALTH PROFESSION LICENSING
AND LICENSING BOARDS**

21. **Oversight of Health Profession Licensing Boards**—Send a letter to the Interim Finance Committee; the Sunset Subcommittee of the Legislative Commission; the Senate Committee on Commerce, Labor, and Energy; the Assembly Committee on Commerce and Labor; and the Governor of the State of Nevada, expressing the LCHC’s concern regarding the lack of oversight of health profession licensing and licensing boards and its support for statutory changes necessary to provide such oversight. Specifically, express the Committee’s concern regarding the:
- a. Numerous complaints the Committee received related to various health care profession licensing boards;
 - b. General lack of oversight of health profession licensing boards and the need for accountability;
 - c. Investigation and appeals processes used by certain boards and the need for oversight over certain board decisions;
 - d. Lack of transparency with regard to licensure data, the inability of some boards to provide requested data, and the need to increase data reporting requirements;
 - e. Need for increased transparency and oversight of the finances of health profession licensing boards and for comprehensive, detailed reporting requirements to improve fiscal accountability;
 - f. Application and licensure inefficiencies and extended application timelines due to the systems used by certain boards;
 - g. Performance audit of the Board of Dental Examiners of Nevada by the Legislative Auditor and the refusal of the Board to accept 3 of the 14 recommendations made by the audit; and
 - h. Direct impact boards have on the health care workforce and their ability to exacerbate the workforce shortage or to improve it, as exemplified by the challenges the Governor of the State of Nevada’s Social Workers in Schools program faced recruiting social workers and other qualified behavioral health providers in 2016.
22. **Behavioral Health Licensing Boards**—Propose legislation to:
- a. Consolidate, under the State Board of Health, within the DHHS, the behavioral health boards established in:

- i. Chapter 641 (“Psychologists, Behavior Analysts, Assistant Behavior Analysts and Autism Behavior Interventionists”) of NRS;
 - ii. Chapter 641A (“Marriage and Family Therapists and Clinical Professional Counselors”) of NRS;
 - iii. Chapter 641B (“Social Workers“) of NRS; and
 - iv. Chapter 641C (“Alcohol, Drug and Gambling Counselors”) of NRS.
- b. Amend [NRS 439.030](#), which establishes the State Board of Health, to add four additional members to the Board appointed by the Governor of the State of Nevada, including:
- i. One member who is a psychologist or a board certified behavior analyst;
 - ii. One member who is a marriage and family therapist or a clinical professional counselor;
 - iii. One member who is a social worker; and
 - iv. One member who is an alcohol, drug, and gambling counselor and who has engaged in the practice of his or her specific profession in this State for not less than five years immediately prior to the appointment.
- c. Require the Bureau of Health Care Quality and Compliance (HCQC), DPBH, DHHS, to assume responsibility for administration of licensure, investigations, and complaint resolution for all mental health professionals currently licensed in Chapters 641, 641A, 641B, and 641C of NRS.
- d. Establish, under the State Board of Health, four profession-specific “subcommittees” through which each professional area licensed under Chapters 641 through 641C of NRS will make recommendations to the Board regarding licensure requirements, standards-of-practice, and regulations.
- i. One subcommittee will be established for each of the existing NRS behavioral health profession chapters (641, 641A, 641B, and 641C).
 - ii. Each subcommittee consists of three members who have been residents of this State for at least one year before appointment. Subcommittees are comprised of:
 - (1) One member who is a member of the State Board of Health;

- (2) At least one member, but not more than two, who is licensed in the professional area he or she regulates and has five years of experience in the applicable profession;
 - (3) At least one member, but not more than two, must have served within the previous ten years as core or full-time faculty at a regionally accredited college or university in a program related to the applicable profession and have experience in the design and development of the curriculum of a related program; and
 - (4) If qualified, a subcommittee member may serve on more than one subcommittee.
- iii. Subcommittee members are initially appointed by the State Board of Health. After initial appointment, the Governor of the State of Nevada shall appoint subcommittee members. A member first appointed by the Board shall continue to serve until appointed or replaced by the Governor of the State of Nevada. Initially, members will serve staggered terms.
- iv. After the initial term, subcommittee members serve at the pleasure of the Governor of the State of Nevada for terms of three years. A member shall not serve more than two full consecutive terms.
- v. Each member of a subcommittee is entitled to receive:
 - (1) A salary of not more than \$80 per day, as fixed by the State Board of Health, while engaged in and necessarily spent in performance of his or her subcommittee duties; and
 - (2) A per diem allowance and travel expenses at a rate fixed by the State Board of Health, while engaged in the business of the subcommittee. The rate must not exceed the rate provided for State officers and employees generally.
- vi. Each subcommittee shall annually elect a chairman and secretary from its membership.
- vii. Subcommittee members are personally immune from suit with respect to all acts done and actions taken in good faith and in furtherance of the purposes of this bill.
- viii. Subcommittee members shall receive at least five hours of training as prescribed by the State Board of Health within one year after the member is initially appointed. Training must include instruction on ethics and open meeting requirements.

- e. Require the State Board of Health to review each subcommittee's regulations before being submitted to the Legislative Commission for final approval to ensure that the regulations are in the best interest of the public and do not unnecessarily restrict individuals from entering or practicing the profession.
- f. Establish that the HCQC shall be responsible for disciplining licensees.
 - i. The HCQC may establish in regulation peer review panels to evaluate complaints against similarly licensed behavioral health professionals.
 - ii. The State Board of Health may authorize continuing education credits to qualified behavioral health professionals who choose to serve on such peer review panels.
 - iii. The HCQC will conduct an investigation of a complaint against a behavioral health professional with the assistance of a peer review panel, if the HCQC decides to establish such panels.
 - iv. The results of an investigation of a complaint will be submitted to the appropriate subcommittee.
 - v. Based on the results of an investigation, each subcommittee shall recommend appropriate disciplinary action to the HCQC, if the recommendation is not license revocation. Recommendations of license revocation shall be submitted to the State Board of Health.
 - vi. The HCQC or the State Board of Health, as applicable, will review recommendations for disciplinary action and discipline licensees.
- g. Redirect board fees and funds generated through licensure and other funding streams from boards established pursuant to Chapters 641, 641A, 641B, and 641C of NRS to DPBH to support the activities of licensure administration, investigation, and regulatory oversight for behavioral health professionals.
- h. Require the State Board of Health to make necessary regulatory changes to existing regulation in Chapters 641, 641A, 641B, and 641C of *Nevada Administrative Code*, and develop new regulations to comply with these legislative changes.
- i. Establish that any regulations adopted by boards established pursuant to Chapters 641, 641A, 641B, and 641C of NRS which do not conflict with the provisions outlined above remain in effect and may be enforced by the appropriate board until the State Board of Health adopts regulations to repeal or replace those regulations. Any regulations adopted by the above boards that conflict with these provisions are void.

- j. Require the DHHS to develop a plan for transitioning from the existing licensing board structure to the new behavioral health profession licensing structure within the State Board of Health so that licensees and the public can follow and participate in the transition process. The plan must be presented at a meeting in compliance with the open meeting law and adopted at a second meeting in compliance with the open meeting law. Provisions of Chapter 233B (“Nevada Administrative Procedure Act”) of NRS do not apply to this transition plan.
- k. Contracts and agreements, disciplinary and administrative actions, and licenses issued by such boards remain in effect as if taken by the officer or entity to which the responsibility for the enforcement of such action has been transferred. **(BDR 54–410)**

PROPOSALS RELATING TO BEHAVIORAL HEALTH

- 23. **Behavioral Health Education for Law Enforcement**—Send a letter to the Directors of the Department of Public Safety and the DHHS and to the heads of local law enforcement expressing the Committee’s support for the development of a statewide behavioral health education/training requirement for law enforcement officers.
- 24. **Mental Health Courts**—Send a letter to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the Director of the DHHS expressing the LCHC’s support for mental health and other specialty courts. The letter will:
 - a. Encourage and support the development of additional residential substance abuse treatment beds and the establishment of treatment beds for people diagnosed with co-occurring disorders, as there are currently no such beds in the State;
 - b. Express the Committee’s continued support for providing funding for housing, transportation, and drug testing for specialty court participants; and
 - c. Mention the potential of public-private partnerships to assist in providing such funding.
- 25. **Crisis Intervention**—Send a letter to the Senate Committee on Finance, the Assembly Committee on Ways and Means, and the Director of the DHHS expressing the LCHC’s support for expansion and development of crisis intervention services and crisis stabilization centers. The letter will express support for:
 - a. Expansion of crisis intervention and jail diversion programs such as the Forensic Assessment Services Triage Team, Mobile Outreach Safety Team, and crisis intervention training; and

- b. Development of crisis stabilization centers in the State, where people experiencing a crisis related to a mental health condition can access services 24 hours per day, 7 days per week. This type of center can provide timely de-escalation, early intervention, and patient stabilization to prevent the need for higher levels—and more costly—care.

PROPOSALS RELATING TO AMBULATORY SURGICAL CENTERS

26. **Ambulatory Surgical Centers**—Propose legislation to:

- a. Amend Chapter 449 (“Medical Facilities and Other Related Entities”) of NRS to prohibit an ambulatory surgical center from performing surgical services that routinely result in admission to another licensed medical facility within 24 hours after discharge from the surgical center;
- b. Amend [NRS 439A.250](#) to require the DHHS to impose a penalty on surgical centers for ambulatory patients, pursuant to [NRS 439A.310](#), after sending two notices indicating that the center failed to submit the required information, or the information was incomplete or inaccurate.
- c. Amend subsection 2 of [NRS 439A.280](#) to exempt [NRS 439A.240](#) and [439A.250](#) from the programs and duties for which the DHHS can temporarily suspend if it determines sufficient funds are not available. **(BDR 40–364)**