Amendment No. 176

Assembly Amendment to Assembly Bill No. 237 (BDR 38-328)

Proposed by: Assembly Committee on Health and Human Services

Amends: Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

EWR/AAK Date: 4/19/2023

A.B. No. 237—Makes revisions relating to Medicaid. (BDR 38-328)

ASSEMBLY BILL NO. 237–COMMITTEE ON
HEALTH AND HUMAN SERVICES

(ON BEHALF OF THE JOINT INTERIM STANDING COMMITTEE
ON HEALTH AND HUMAN SERVICES)

MARCH 2, 2023

Referred to Committee on Health and Human Services

SUMMARY—Makes revisions relating to ~~[Medicaid.]~~ **health care.** (BDR 38-328)

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

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

AN ACT relating to ~~[Medicaid; establishing the Alternative Billing Resource Office in the Division of Health Care Financing and Policy of the Department of Health and Human Services for the purpose of providing certain assistance relating to participation in Medicaid as a provider;]~~ **health care; requiring the Director of the Department of Health and Human Services to take certain measures to facilitate the provision of health services to pupils who are recipients of Medicaid;** requiring a Medicaid managed care program to negotiate in good faith with each school-based health center for the provision of health care services to recipients of Medicaid; ~~[providing for a study of the requirements applicable to school-based health centers that provide health care services to recipients of;]~~ **requiring a private insurer to provide certain reimbursement for certain services provided by a school health services program; providing for the increase of certain rates of reimbursement under** Medicaid; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services, through the Division of Health Care Financing and Policy of the Department, to administer Medicaid. (NRS 422.2357, 422.270) **Section 2** of this bill defines "school-based health center" to mean a health center located or based on, in or near school grounds, property, buildings or any other school district facilities for the purpose of rendering care or services to any person. ~~[Section 3 of this bill establishes the Alternative Billing Resource Office within the Division for the purpose of assisting school-based health centers and other providers of services under the State Plan for Medicaid and persons and entities who wish to provide such services to evaluate and utilize different methods of participating in and billing Medicaid.]~~ **Section 3.5 of this bill requires the Director of the Department to establish a means to facilitate the sharing of data concerning a child who is a recipient of Medicaid between: (1)**

educational agencies; and (2) school-based health centers and other qualified providers of services covered by Medicaid. Section 3.5 also requires the Director to: (1) take any action necessary to ensure that local and state educational agencies are able to receive reimbursement for health services covered by Medicaid when provided on the premises of a school; and (2) establish incentives for certain providers to enter into an agreement with a school district or charter school or the Department of Education to provide health services to pupils. **Sections 4 and 6** of this bill make conforming changes to indicate the proper placement of **sections 2 and** ~~[3]~~ **3.5** in the Nevada Revised Statutes. ~~[Section 7 of this bill requires the Division and the Department of Education to: (1) conduct a study of the requirements applicable to school-based health centers that provide health care services to recipients of Medicaid; and (2) report to the Joint Interim Standing Committee on Health and Human Services concerning the results of the study.]~~

Existing law requires a health maintenance organization with which the Department of Health and Human Services contracts for the provision of services through a Medicaid managed care program to negotiate in good faith with federally-qualified health centers, the University Medical Center of Southern Nevada and the University of Nevada School of Medicine to provide services to recipients of Medicaid. (NRS 422.273) **Section 5** of this bill similarly requires such a health maintenance organization to negotiate in good faith with each school-based health center in this State to provide services to recipients of Medicaid. **Section 7.5 of this bill requires the Director to apply for any necessary federal authority to increase by at least 5 percent the rates of reimbursement for services covered by Medicaid when provided on the premises of a school by an employee or independent contractor of: (1) a school district or charter school; or (2) the Department of Education.**

Sections 6.1, 6.2-6.6 and 6.8 of this bill require private health insurers to reimburse a school health services program for certain health services provided to an insured who is a pupil enrolled in a public school in this State at certain rates. Sections 6.7 and 6.9 of this bill exclude insurers that provide services to recipients of Medicaid or members of the Public Employees' Benefits Program through managed care from that requirement. Section 6.15 of this bill makes a conforming change to indicate the proper placement of section 6.1 in the Nevada Revised Statutes. Section 6.75 of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of a health maintenance organization that fails to comply with the requirements of section 6.6 of this bill. The Commissioner would also be authorized to take such action against other health insurers who fail to comply with the requirements of sections 6.1, 6.2-6.5 and 6.8. (NRS 680A.200)

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and ~~[3]~~ **3.5** of this act.

Sec. 2. ***"School-based health center" means a health center located or based on, in or near school grounds, property, buildings or any other school district facilities for the purpose of rendering health care or services to any person.***

Sec. 3. ~~*[1. The Alternative Billing Resource Office is hereby established within the Division.*~~

~~*2. The Alternative Billing Resource Office shall assist school-based health centers and other providers of services under the State Plan for Medicaid and persons and entities that wish to provide such services to:*~~

~~*(a) Evaluate the benefits and drawbacks of various methods of participating in and billing Medicaid that are available to the provider, person or entity, including, without limitation, different provider types under which a provider, person or entity may be authorized to participate in and bill Medicaid; and*~~

~~*(b) Meet the requirements and carry out the procedures necessary to participate in and bill Medicaid using the methods chosen by the provider, person or entity, as applicable.*~~

~~*3. The Division shall provide the necessary facilities, equipment, staff, supplies and other usual operating expenses necessary to enable the Office to carry out its functions.*~~ **(Deleted by amendment.)**

Sec. 3.5. ***1. The Director shall:***

(a) Establish a means to facilitate the sharing of data concerning a child who is a recipient of Medicaid between:

(1) The Department of Education, school districts and charter schools; and

(2) School-based health centers and other qualified providers of health services covered by Medicaid.

(b) Allow an applicant for Medicaid to opt out of the sharing of data pursuant to paragraph (a).

(c) Take any action necessary to ensure that school districts, charter schools and the Department of Education are able to receive reimbursement for health services covered by Medicaid when such services are provided on the premises of a school to children who are recipients of Medicaid.

(d) Establish a program of incentive payments that increase the effective rates of reimbursement provided under Medicaid to a certified community behavioral health clinic or federally-qualified health center that enters into an agreement with a school district, a charter school or the Department of Education to provide services covered by Medicaid to pupils who are:

(1) Enrolled in a public school; and

(2) Recipients of Medicaid.

2. The incentives provided pursuant to paragraph (d) of subsection 1 may be provided through increased rates of reimbursement or value-based payment models.

3. The Department shall apply to the Secretary of Health and Human Services for any necessary waiver, amendment of the State Plan for Medicaid or other federal authority that authorizes the Department to receive federal funding to carry out the provisions of this section. The Department shall fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver, amendment or other federal authority pursuant to this section.

4. As used in this section:

(a) "Certified community behavioral health clinic" means a community behavioral health clinic certified in accordance with section 223 of the Protecting Access to Medicare Act of 2014, Public Law No. 113-93.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Value-based payment model" means a method of payment for health care services that provides incentives based on the quality of care.

Sec. 4. NRS 422.001 is hereby amended to read as follows:

422.001 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 422.003 to 422.054, inclusive, ***and section 2 of this act*** have the meanings ascribed to them in those sections.

Sec. 5. NRS 422.273 is hereby amended to read as follows:

422.273 1. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) ***Negotiated in good faith with each school-based health center in this State to provide health care services to recipients of Medicaid;***

(c) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; and

~~[(c)]~~ ***(d)*** Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid.

➥ Nothing in this section shall be construed as exempting a federally-qualified health center, ***a school-based health center,*** the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

2. During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

3. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

4. For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

5. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

6. As used in this section, unless the context otherwise requires:

(a) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(b) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

(c) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

Sec. 6. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410,

inclusive, ***and sections 2 and ~~[2]~~ 3.5 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 6.1. **Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:**

1. If a policy of health insurance provides coverage for a qualified health-related service:

(a) An insured who is a pupil enrolled in a public school in this State is entitled for reimbursement for the qualified health-related service provided by a school health services program, regardless of whether the school health services program participates in the network plan of the insurer; and

(b) The insurer shall not require an insured to pay any deductible, copayment or coinsurance for any qualified health-related service to which paragraph (a) applies or impose any other cost-sharing requirement for such a service.

2. Reimbursement pursuant to subsection 1 for a qualified health-related service provided by a school health services program that does not participate in the network plan of the insurer must be:

(a) If the insurer covers the service through a network plan when provided in the same geographic area where the service to which the reimbursement applies is provided, in an amount that is equal to or greater than the lowest amount provided for the service under a provider network contract between a provider of health care in the relevant geographic area and the insurer;

(b) If the provisions of paragraph (a) do not apply and the service is covered by Medicare, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicare; or

(c) If the provisions of paragraph (a) or (b) do not apply, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicaid.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(b) "Provider network contract" means a contract between an insurer and a provider of health care specifying the rights and responsibilities of the insurer and the provider of health care for delivery of health care services pursuant to a network plan.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Qualified health-related service" means a service that is:

(1) Medically appropriate for the diagnosis, treatment or prevention of a medical or behavioral health condition; and

(2) Reimbursable under a provider network contract into which an insurer has entered with a provider of health care in the same geographic area in which the service is provided or under Medicare or Medicaid.

(e) "School health services program" means a program established by a school district, a charter school or the Department of Education to provide health services to pupils.

Sec. 6.15. **NRS 689A.330 is hereby amended to read as follows:**

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~.~~ ***, and section 6.1 of this act.***

Sec. 6.2. **Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:**

1. If a policy of group health insurance provides coverage for a qualified health-related service:

(a) An insured who is a pupil enrolled in a public school in this State is entitled for reimbursement for the qualified health-related service provided by a school health services program, regardless of whether the school health services program participates in the network plan of the insurer; and

(b) The insurer shall not require an insured to pay any deductible, copayment or coinsurance for any qualified health-related service to which paragraph (a) applies or impose any other cost-sharing requirement for such a service.

2. Reimbursement pursuant to subsection 1 for a qualified health-related service provided by a school health services program that does not participate in the network plan of the insurer must be:

(a) If the insurer covers the service through a network plan when provided in the same geographic area where the service to which the reimbursement applies is provided, in an amount that is equal to or greater than the lowest amount provided for the service under a provider network contract between a provider of health care in the relevant geographic area and the insurer;

(b) If the provisions of paragraph (a) do not apply and the service is covered by Medicare, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicare; or

(c) If the provisions of paragraph (a) or (b) do not apply, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicaid.

3. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(b) "Provider network contract" means a contract between an insurer and a provider of health care specifying the rights and responsibilities of the insurer and the provider of health care for delivery of health care services pursuant to a network plan.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Qualified health-related service" means a service that is:

(1) Medically appropriate for the diagnosis, treatment or prevention of a medical or behavioral health condition; and

(2) Reimbursable under a provider network contract into which an insurer has entered with a provider of health care in the same geographic area in which the service is provided or under Medicare or Medicaid.

(e) "School health services program" means a program established by a school district, a charter school or the Department of Education to provide health services to pupils.

Sec. 6.3. **Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:**

1. If a health benefit plan provides coverage for a qualified health-related service:

(a) An insured who is a pupil enrolled in a public school in this State is entitled for reimbursement for the qualified health-related service provided by a school health services program, regardless of whether the school health services program participates in the network plan of the carrier; and

(b) The carrier shall not require an insured to pay any deductible, copayment or coinsurance for any qualified health-related service to which paragraph (a) applies or impose any other cost-sharing requirement for such a service.

2. Reimbursement pursuant to subsection 1 for a qualified health-related service provided by a school health services program that does not participate in the network plan of the carrier must be:

(a) If the carrier covers the service through a network plan when provided in the same geographic area where the service to which the reimbursement applies is provided, in an amount that is equal to or greater than the lowest amount provided for the service under a provider network contract between a provider of health care in the relevant geographic area and the carrier;

(b) If the provisions of paragraph (a) do not apply and the service is covered by Medicare, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicare; or

(c) If the provisions of paragraph (a) or (b) do not apply, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicaid.

3. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Network plan" means a policy of health insurance offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(b) "Provider network contract" means a contract between a carrier and a provider of health care specifying the rights and responsibilities of the carrier and the provider of health care for delivery of health care services pursuant to a network plan.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Qualified health-related service" means a service that is:

(1) Medically appropriate for the diagnosis, treatment or prevention of a medical or behavioral health condition; and

(2) Reimbursable under a provider network contract into which a carrier has entered with a provider of health care in the same geographic area in which the service is provided or under Medicare or Medicaid.

(e) "School health services program" means a program established by a school district, a charter school or the Department of Education to provide health services to pupils.

Sec. 6.35. **NRS 689C.425 is hereby amended to read as follows:**

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and section 6.3 of this act,*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 6.4. **Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:**

1. If a benefit contract provides coverage for a qualified health-related service:

(a) An insured who is a pupil enrolled in a public school in this State is entitled for reimbursement for the qualified health-related service provided by a

school health services program, regardless of whether the school health services program participates in the network plan of the society; and

(b) The society shall not require an insured to pay any deductible, copayment or coinsurance for any qualified health-related service to which paragraph (a) applies or impose any other cost-sharing requirement for such a service.

2. Reimbursement pursuant to subsection 1 for a qualified health-related service provided by a school health services program that does not participate in the network plan of the society must be:

(a) If the society covers the service through a network plan when provided in the same geographic area where the service to which the reimbursement applies is provided, in an amount that is equal to or greater than the lowest amount provided for the service under a provider network contract between a provider of health care in the relevant geographic area and the society;

(b) If the provisions of paragraph (a) do not apply and the service is covered by Medicare, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicare; or

(c) If the provisions of paragraph (a) or (b) do not apply, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicaid.

3. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Network plan" means a policy of health insurance offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(b) "Provider network contract" means a contract between a society and a provider of health care specifying the rights and responsibilities of the society and the provider of health care for delivery of health care services pursuant to a network plan.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Qualified health-related service" means a service that is:

(1) Medically appropriate for the diagnosis, treatment or prevention of a medical or behavioral health condition; and

(2) Reimbursable under a provider network contract into which a society has entered with a provider of health care in the same geographic area in which the service is provided or under Medicare or Medicaid.

(e) "School health services program" means a program established by a school district, a charter school or the Department of Education to provide health services to pupils.

Sec. 6.5. **Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:**

1. If a policy of health insurance provides coverage for a qualified health-related service:

(a) An insured who is a pupil enrolled in a public school in this State is entitled for reimbursement for the qualified health-related service provided by a school health services program, regardless of whether the school health services program participates in the network plan of the hospital or medical services corporation; and

(b) The hospital or medical services corporation shall not require an insured to pay any deductible, copayment or coinsurance for any qualified health-related service to which paragraph (a) applies or impose any other cost-sharing requirement for such a service.

2. Reimbursement pursuant to subsection 1 for a qualified health-related service provided by a school health services program that does not participate in the network plan of the hospital or medical services corporation must be:

(a) If the hospital or medical services corporation covers the service through a network plan when provided in the same geographic area where the service to which the reimbursement applies is provided, in an amount that is equal to or greater than the lowest amount provided for the service under a provider network contract between a provider of health care in the relevant geographic area and the hospital or medical services corporation;

(b) If the provisions of paragraph (a) do not apply and the service is covered by Medicare, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicare; or

(c) If the provisions of paragraph (a) or (b) do not apply, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicaid.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Network plan" means a policy of health insurance offered by a hospital or medical services corporation under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the hospital or medical services corporation. The term does not include an arrangement for the financing of premiums.

(b) "Provider network contract" means a contract between a hospital or medical services corporation and a provider of health care specifying the rights and responsibilities of the hospital or medical services corporation and the provider of health care for delivery of health care services pursuant to a network plan.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Qualified health-related service" means a service that is:

(1) Medically appropriate for the diagnosis, treatment or prevention of a medical or behavioral health condition; and

(2) Reimbursable under a provider network contract into which a hospital or medical services corporation has entered with a provider of health care in the same geographic area in which the service is provided or under Medicare or Medicaid.

(e) "School health services program" means a program established by a school district, a charter school or the Department of Education to provide health services to pupils.

Sec. 6.6. **Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:**

1. If a health care plan provides coverage for a qualified health-related service:

(a) An enrollee who is a pupil enrolled in a public school in this State is entitled for reimbursement for the qualified health-related service provided by a school health services program, regardless of whether the school health services

program participates in the network plan of the health maintenance organization; and

(b) The health maintenance organization shall not require an enrollee to pay any deductible, copayment or coinsurance for any qualified health-related service to which paragraph (a) applies or impose any other cost-sharing requirement for such a service.

2. Reimbursement pursuant to subsection 1 for a qualified health-related service provided by a school health services program that does not participate in the network plan of the health maintenance organization must be:

(a) If the health maintenance organization covers the service through a network plan when provided in the same geographic area where the service to which the reimbursement applies is provided, in an amount that is equal to or greater than the lowest amount provided for the service under a provider network contract between a provider of health care in the relevant geographic area and the health maintenance organization;

(b) If the provisions of paragraph (a) do not apply and the service is covered by Medicare, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicare; or

(c) If the provisions of paragraph (a) or (b) do not apply, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicaid.

3. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Network plan" means a policy of health insurance offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(b) "Provider network contract" means a contract between a health maintenance organization and a provider of health care specifying the rights and responsibilities of the health maintenance organization and the provider of health care for delivery of health care services pursuant to a network plan.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Qualified health-related service" means a service that is:

(1) Medically appropriate for the diagnosis, treatment or prevention of a medical or behavioral health condition; and

(2) Reimbursable under a provider network contract into which a health maintenance organization has entered with a provider of health care in the same geographic area in which the service is provided or under Medicare or Medicaid.

(e) "School health services program" means a program established by a school district, a charter school or the Department of Education to provide health services to pupils.

Sec. 6.7. **NRS 695C.050 is hereby amended to read as follows:**

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200, inclusive, and 695C.265 ***and section 6.6 of this act*** do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743, 695C.1745 and 695C.1757 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

6. The provisions of section 6.6 of this act do not apply to a health maintenance organization that provides health care services to members of the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 6.75. **NRS 695C.330 is hereby amended to read as follows:**

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and section 6.6 of this act*** or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees or creditors or to the general public;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 6.8. **Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:**

1. If a health care plan provides coverage for a qualified health-related service:

(a) An insured who is a pupil enrolled in a public school in this State is entitled for reimbursement for the qualified health-related service provided by a school health services program, regardless of whether the school health services program participates in the network plan of the managed care organization; and

(b) The managed care organization shall not require an insured to pay any deductible, copayment or coinsurance for any qualified health-related service to which paragraph (a) applies or impose any other cost-sharing requirement for such a service.

2. Reimbursement pursuant to subsection 1 for a qualified health-related service provided by a school health services program that does not participate in the network plan of the managed care organization must be:

(a) If the managed care organization covers the service through a network plan when provided in the same geographic area where the service to which the reimbursement applies is provided, in an amount that is equal to or greater than the lowest amount provided for the service under a provider network contract

between a provider of health care in the relevant geographic area and the managed care organization;

(b) If the provisions of paragraph (a) do not apply and the service is covered by Medicare, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicare; or

(c) If the provisions of paragraph (a) or (b) do not apply, in an amount that is equal to or greater than the amount at which the service would be reimbursed under Medicaid.

3. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Network plan" means a policy of health insurance offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(b) "Provider network contract" means a contract between a managed care organization and a provider of health care specifying the rights and responsibilities of the managed care organization and the provider of health care for delivery of health care services pursuant to a network plan.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Qualified health-related service" means a service that is:

(1) Medically appropriate for the diagnosis, treatment, or prevention of a medical or behavioral health condition; and

(2) Reimbursable under a provider network contract into which a managed care organization has entered with a provider of health care in the same geographic area in which the service is provided or under Medicare or Medicaid.

(e) "School health services program" means a program established by a school district or charter school or the Department of Education to provide health services to pupils.

Sec. 6.9. **NRS 695G.090 is hereby amended to read as follows:**

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.127, 695G.164, 695G.1645, 695G.167 and 695G.200 to 695G.230, inclusive, ***and section 6.8 of this act*** do not apply to a managed care organization that provides health care services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. ~~[This subsection does]~~

4. The provisions of section 6.8 of this act do not apply to a managed care organization that provides health care services to members of the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043.

5. Subsections 3 and 4 do not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 7. ~~[1. The Division of Health Care Financing and Policy of the Department of Health and Human Services and the Department of Education shall:~~

~~(a) Conduct a study of the requirements applicable to school-based health centers that provide health care services to recipients of Medicaid. The study must consist of:~~

~~(1) A review of the standards for school-based health centers to become eligible to provide health care services to recipients of Medicaid and possible ways of increasing the flexibility and reducing the complexity of those standards, including, without limitation:~~

~~(I) Increased flexibility for school-based health centers to operate on or off the premises of a school or as a mobile unit;~~

~~(II) The use of telehealth in each setting in which a school-based health center is authorized to operate;~~

~~(III) Authorization for school-based health centers to offer behavioral health services and dental services;~~

~~(IV) The integration of school-based health centers into other health services offered by, on the premises of or in association with schools; and~~

~~(V) Opportunities to serve parents, siblings and other family members of pupils;~~

~~(2) An evaluation of the need for an on-site laboratory at a school-based health center;~~

~~(3) A review of the need for the board of trustees of a school district to approve the operation of a school-based health center that is near to or associated with, but not on the premises of, a school;~~

~~(4) A review of rates of reimbursement under the State Plan for Medicaid for school-based health centers, a comparison of those rates of reimbursement to the rates of reimbursement under the State Plan for physicians and federally-qualified health centers and possible ways to create parity between rates of reimbursement under the State Plan for all persons and entities described in this subparagraph; and~~

~~(5) A consideration of strategies to incentivize the formation and operation of school-based health centers including, without limitation, through the promotion of well visits and the use of value-based payments.~~

~~(b) On or before December 31, 2023, submit a report of the findings of the study conducted pursuant to paragraph (a) and any recommendations resulting from those findings to the Director of the Legislative Counsel Bureau for transmittal to the Joint Interim Standing Committee on Health and Human Services.~~

~~2. As used in this section:~~

~~(a) "Federally qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).~~

~~(b) "School-based health center" has the meaning ascribed to it in section 2 of this act.~~

~~(c) "Telehealth" has the meaning ascribed to it in NRS 629.515.~~

~~(d) "Value-based payment" means a model of paying for health care in which providers are reimbursed based on health outcomes including, without limitation, helping patients improve their health, reduce the effects and incidence of chronic disease and live healthier lives, in an evidence-based manner.~~

~~(e) "Well visit" means a regularly scheduled physical examination.~~ **(Deleted by amendment.)**

Sec. 7.5. **On or before October 1, 2023, the Director of the Department of Health and Human Services shall submit to the United States Secretary of Health and Human Services a request to amend the State Plan for Medicaid or for any other necessary federal authority to increase by at least 5 percent the rates of reimbursement for services covered by Medicaid when provided:**

1. On the premises of a school; and

2. By an employee or independent contractor of a school district, a charter school or the Department of Education.

Sec. 8. 1. This section becomes effective upon passage and approval.

2. Section ~~[7]~~ **7.5** of this act becomes effective ~~[:~~

~~(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and~~

~~(b) On]~~ **on** July 1, 2023 ~~[, for all other purposes.]~~

3. Sections 1 to ~~[6,]~~ **7,** inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2024, for all other purposes.