MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-second Session
June 1, 2023

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:38 a.m. on Thursday, June 1, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Roberta Lange, Vice Chair
Senator Melanie Scheible
Senator Skip Daly
Senator Julie Pazina
Senator Scott Hammond
Senator Carrie A. Buck
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Assemblywoman Elaine Marzola, Assembly District No. 21

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Bradley Wilkinson, Chief Deputy Legislative Counsel Attorney
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Eddie Ableser, Nevada Dental Association
Sasha Sutcliffe-Stephenson, American Association of Orthodontists
William Horne, SmileDirectClub
Jeffrey Sulitzer, D.M.D., SmileDirectClub

Connor Cain, HCA Healthcare; Sunrise Hospital and Medical Center; Sunrise Children's Hospital
Patrick Nuzzo, D.N., President, Southwest University of Naprapathic Medicine and Health Sciences
Tanya Haggins
Beau Hightower, D.C.
Rick Miera
Mary Kay Papen
Harris Silver, M.D.
Jennifer Stever, C.A.A., American Academy of Anesthesiologist Assistants
Shaina Richardson, M.D.
Stephanie Zunini, Nevada Academy of Anesthesiologist Assistants
Rachel Matsumura, C.A.A., Nevada Academy of Anesthesiologist Assistants
Susan Fisher, State Board of Osteopathic Medicine
Sarah Watkins, Nevada State Medical Association
Jada Wabanimkee, C.A.A., Nevada Academy of Anesthesiologist Assistants
Mikaela Rezaei, Nevada Orthopaedic Society
Amy Shogren, Nevada Hospital Association
Dan Musgrove, US Anesthesia Partners
Blayne Osborn, Nevada Rural Hospital Partners
Jerry Matsumura, Nevada State Society of Anesthesiologists
Shane Angus, American Academy of Anesthesiologist Assistants
Erica Souza-Llamas, Records, Communications and Compliance Division, Nevada Department of Public Safety

CHAIR SPEARMAN:
I will open the hearing on Assembly Bill (A.B.) 147.

ASSEMBLY BILL 147 (1st Reprint): Revises provisions relating to dentistry. (BDR 54-74)

ASSEMBLYWOMAN ELAINE MARZOLA (Assembly District No. 21):
I had the honor of serving on the Joint Interim Standing Committee on Commerce and Labor during the 2021-2022 Interim. We heard presentations on Nevada's healthcare workforce and how we can make health care more accessible for all our residents. In particular, we learned about expanding and modernizing oral health and doctors of dentistry.

EDDIE ABLESER (Nevada Dental Association):
I have a presentation (Exhibit C) explaining the bill and the need for it. During the Interim, we had the privilege of working on this piece of legislation as well as talking about the modernization of dentistry and a variety of issues that have confronted consumers. We are struggling with access to health care throughout Nevada. Page C2 of Exhibit C shows how the Centers for Disease Control and Prevention (CDC) have ranked us in various areas. Nevada struggles in overall health care.

Doctors of dentistry, as they refer to themselves, are trained, qualified and focused on helping Nevadans live healthier lives through interprofessional collaboration and integrated health care, which is important especially in the aspects of this bill.

There are four elements in this bill that I will go through briefly. This bill increases access to health care throughout urban and rural communities for a variety of needs that individuals struggle with, particularly oral health care, which affects so much of the entire health system.

The first portion of this bill deals with provider health care. Section 1 of the bill adds dental hygienists and dental therapists into the *Nevada Revised Statutes* (NRS) as providers of health care. There is much value in doing this, particularly with regard to insurance and coordination of care and access, in the definition of what hygienists and therapists do in collaborative care for oral health.

The second part of this bill has to do with teledentistry. Telehealth is currently covered in statute, and many oral health providers are functioning under that statute. We believe we need statutes dealing specifically with teledentistry, particularly around how consumers are seen by providers.

Sections 2 through 14, 20 through 25 and 30 through 39 define that teledentistry is used to diagnose, treat, educate, manage and consult. This is a limited scope, but it is important for those who cannot access an oral health practitioner. Teledentists who practice in Nevada have to be licensed in Nevada. One of the biggest issues we have been working on is the idea of how a teledentistry relationship gets established. Many of the doctors of dentistry, hygienists and therapists have articulated that it is essential to establish an initial relationship to review the mouth, bones and gums before using

teledentistry. Practicing via teledentistry is appropriate only for procedures that are approved and necessary under the scope of care.

The bill has exceptions for emergencies, such as an individual who has an abscess or some sort of growth that needs to get checked out immediately while far away from an oral healthcare provider. We have learned about a lot of public health programs that utilize teledentistry, particularly with checkups on children in programs that do not have access to oral health care. Getting them in to be seen initially is important, and these public health programs are extremely supportive of this language.

The bill has language that ensures teledentists are seeing patients they are actually treating. The bill also includes details about emergency procedures, informed written consent, HIPAA and recordkeeping requirements for teledentists. The Board of Dental Examiners of Nevada will need to create regulations regarding teledentists and prescriptions, records and coordination of care. Much of this section mirrors the provisions of the telehealth statute, with some changes because oral health is unique and requires a view inside the mouth that is difficult to arrange via teledentistry.

The third portion of A.B. 147 covers immunizations. The Commonwealth Fund Scorecard ranks Nevada as one of the worst states for vaccine administration for every 100,000 residents. During the COVID-19 pandemic, dentists were called on to help with immunizations and vaccinations in communities across Nevada. They stepped up, and they served. However, according to statute, dentists are not allowed to give vaccinations. This bill revises that. Sections 15 through 19, 24 and 25 of the bill establish a special license from the Board to administer immunizations, with an approved course of training. Hygienists and therapists who work under the guidance of the dentist can have a special endorsement to do this as well. The immunizations must have a standing order from a doctor of dentistry, physician, physician assistant or advanced practice registered nurse.

The final portion of A.B. 147 has to do with the patient's dental home, which is a term used by the American Dental Association for a primary care physician in the oral health field. Section 19.5 of the bill says that any oral health professional who performs an initial oral health visit on a minor must refer the patient to a dental home for ongoing care. If the patient lives in a rural area that does not have access to a dentist, this can be a virtual dental home with a team

of professionals who can connect with that minor to ensure the minor is getting care. One of the situations this fixes is that in a lot of communities, children's initial checkups happen because they have toothaches or decay, and there is no ongoing care for these children. The dental home establishes a referral so families have access to ongoing care providers.

We believe that these four provisions will significantly increase the access and convenience to care through doctors of dentistry.

SENATOR STONE:
In order for subordinates of the dentist to administer immunizations, they have to work under a dentist, physician or nurse practitioner. Do you foresee dental hygienists working with a dentist who does not want to do immunizations, so immunizations are provided without a dentist actually overseeing the administration?

MR. ABLESER:
That can likely be fixed through regulation by the Board.

SENATOR STONE:
I would assume that if a dentist or hygienist is administering immunizations, there needs to be a crash cart available. Immunizations always carry the possibility of allergic reactions and possible anaphylactic shock.

MR. ABLESER:
You are right. This was a core provision of moving forward on this topic, because emergencies can happen when vaccinations are given. The emergency procedures stipulated in the bill and developed by the Board are essential.

CHAIR SPEARMAN:
I noted that the CDC ranks Nevada fiftieth for access and affordability. Can you tell me more about that?

MR. ABLESER:
Many portions of A.B. 147 are directly correlated to S.B. No. 366 of the 80th Session, which covered dental hygienists and dental therapists. We added the immunization section, which was a concept that was introduced last Session and did not get a hearing.

Nevada is such a big landmass, and we have two urban centers surrounded by a large rural area. Because of this, we struggle with access to health care in general in Nevada. I know you have all been working on it diligently to provide various ways for access. What we are concerned about is the role that oral health has in an individual's life. Decay, bone disease and gum disease can have detrimental long-term compound effects on an individual's whole physical system. Without true access to providers, these individuals are not being seen. This brings up to the need for teledentistry.

We think the teledentistry, immunization and dental home portions of A.B. 147 create greater access to health care for Nevadans.

CHAIR SPEARMAN:
Talk to me about the spectrum of teledentistry. What does that look like?

MR. ABLESER:
The way it has been explained to me is that sometimes dentists do not have someone to cover their offices when they are away. If one of their patients has an emergency while the dentists are out of town, the dentists can use teledentistry to take a quick look and express an opinion about diagnosis and treatment. Such "visits" are usually provided for free because they do not involve billing codes. Codifying this in statute allows dentists to do superficial treatments and overview via teledentistry, and its use in emergencies provides value to consumers.

At the same time, you cannot clean teeth using teledentistry. You cannot analyze gums using teledentistry, other than the color of the gums. You cannot feel the texture of the teeth or gums; you cannot touch a tooth and recognize what is going on.

CHAIR SPEARMAN:
So teledentistry gives the rural areas and frontier areas more access across the spectrum of dentistry.

MR. ABLESER:
It gives them access to ongoing care and pain treatment, yes, though it is perhaps not truly preventative. We want to ensure that people have access to their dental homes and do not have to rely on general telehealth, where they might talk to general physicians who do not necessarily understand oral health.

SENATOR STONE:
Will the dentists or dental staff who are going to be utilizing telehealth all be licensed Nevada professionals, including their subordinates? Is there any requirement that the dentist providing teledentistry has a brick-and-mortar facility in Nevada?

MR. ABLESER:
One of the provisions in this bill is that every dental professional must be licensed through the Board of Dental Examiners. Moreover, they have to go through special licensure training with the Board and subject themselves to the regulations that the Board puts forth. There are good providers who do not necessarily have brick-and-mortar offices.

SENATOR STONE:
So you need to be licensed, but you do not necessarily have to have a brick-and-mortar facility in Nevada.

MR. ABLESER:
Not necessarily, no.

SENATOR BUCK:
How would mobile dentistry play into this?

MR. ABLESER:
Mobile dentistry is something the Nevada Dental Association is proud of. We have these mobile units that go out and provide care in some of our rural communities, frontier communities and Native American colonies that are hard to reach. One of our dentists who does this is Dr. David White, who has been phenomenal in going to the really hard-to-reach communities with a mobile unit and doing cleanings, screenings and so on. He establishes that relationship with those communities.

The remote communities struggle most with ongoing care. Dr. White drives out there from Reno, but then he goes home and the people in those remote communities have no one to turn to. If we are able to establish teledentistry, it can be used to diagnose, answer questions and provide solutions in between the in-person visits.

CHAIR SPEARMAN:
How do you examine the gums in teledentistry?

MR. ABLESER:
We have had ongoing conversations about that question with other stakeholders. There are some things that cannot be done with teledentistry; a dentist needs to be there in person to see into the mouth and examine teeth and gums. That is one reason we are seeking to limit the scope of teledentistry in this bill, and why we encourage the establishment of an in-person bona fide relationship first.

CHAIR SPEARMAN:
I am reluctant to open this can of worms, but this situation reminds me of the Warby Parker discussion we had earlier this Session.

What is the nexus between seeing a dentist in a brick-and-mortar office and getting dental services via teledentistry?

MR. ABLESER:
We believe the nexus exists in the ongoing and continued care for the patient. We have found most patients see a dentist more often than they see a physician. They come in for cleanings every six months and a checkup once a year.

One advantage to teledentistry is the convenience and speed of the appointment. Most of us do not make an appointment to see a dentist for every minor pain or discomfort we experience. The trouble and inconvenience of calling the office, making an appointment and actually going to the dentist's office is more than the pain is worth. On the other hand, it is relatively quick and easy to consult with a dentist via teledentistry long enough to ask about that odd pain in a molar or when drinking hot coffee. In doing this, the patient can discover quickly if the situation warrants a full appointment or not. That is the value of teledentistry.

The other value is in an emergency situation. Teledentistry gives the remote patient the ability to consult with a trained professional to learn the best way to proceed. Is this an abscess or a canker sore? What do I do about a loose tooth? When a crown falls off, what do I do? Using teledentistry, a dentist who is

trained in the oral cavity can diagnose the problem and give guidance on the next steps to take. That is the nexus.

We do not see teledentistry replacing every in-person dentist visit in Nevada. We do not see it as a scope of practice that works in every situation.

CHAIR SPEARMAN:
Several sessions ago, we started the Adopt a Vet Dental Program here in Nevada to provide dental care to low-income veterans. How does this bill fit in with that program? I know a lot of veterans who participate in Adopt a Vet. One of the things that comes to mind is a situation where a vet was recommended to get braces or have some other type of alignment done, but that person's dentist did not do orthodontics at all.

MR. ABLESER:
Doctors of dentistry have a baseline skill and foundational understanding of the mouth. Orthodontics is a specialty of dentistry that focuses on the alignment of the teeth. When general practitioners are confronted with problems beyond their training, they refer patients to specialists for care. This results in continuity of care, a collaborative approach to ensure that patients' full physical health is coordinated and aligned. Dentists often refer patients to orthodontists to correct alignment of the teeth. Those types of relationships are pivotal for orthodontists.

With regard to veterans, the Nevada Dental Association has a homeless outreach program and provides care for hard-to-reach populations, people who generally neglect their oral health. If we can move forward with the dental home concept, they would be able to be seen, get treated and have ongoing care.

CHAIR SPEARMAN:
I am having difficulty understanding, but I will come back to this later.

SASHA SUTCLIFFE-STEPHENSON (American Association of Orthodontists):
We are fully in support of the language as it is presented in this bill. We want to thank the sponsor for working with us and working out many of the questions you are asking today.

WILLIAM HORNE (SmileDirectClub):
I have come in opposition to A.B. 147, as it limits the scope of teledentistry, particularly for my client SmileDirectClub. I have a data sheet explaining how this business operates (Exhibit D).

The work that Assemblywoman Marzola did over the Interim is appreciated. Unfortunately, SmileDirectClub was not included in those discussions. Make no mistake, those doctors who care for patients using teledentistry through SmileDirectClub and such businesses are licensed dentists in Nevada. I will repeat: they are licensed dentists, just like all the dentists who have brick-and-mortar offices. They are answerable to the Board of Dental Examiners for their scope of care and whether patients are properly being cared for. They are no different from any other dentist licensed in Nevada. SmileDirectClub has been in Nevada for years.

One thing that was missing in the presentation earlier was an endorsement from the Board of Dental Examiners. The Board is charged with overseeing licensed dental healthcare providers, and the Board should be the ones saying we have a problem we need to fix. It has not done so.

Section 10 of the bill, which deals with teledentistry, is a solution looking for a problem. The question that needs to be asked is what is the need to limit the scope of these licensed dentists.

JEFFREY SULITZER, D.M.D. (SmileDirectClub):
I am the Chief Clinical Officer of SmileDirectClub. I have been a dentist for over 38 years, and I am licensed in 6 states.

I want to make it clear that the mission of SmileDirectClub and its affiliated Nevada-licensed dentists and orthodontists is to increase access to quality care at an affordable price, which is a critical component of our model. Our model provides clear aligners, which are devices that move teeth incrementally, safely and efficiently through a teledentistry platform that provides these services at 60 percent less cost to the consumer. We can do this for $2,000 versus $6,000 to $7,000 for mild to moderate crowding. The key is that our affiliated Nevada-licensed dentists and orthodontists stay in their lanes. They manage cases, prescribe treatment and direct the care from the beginning to the end of treatment. If a case is more advanced or complicated than moderate crowding and spacing, those cases are referred to local brick-and-mortar orthodontists.

Again, access to care is critical, as the gentleman representing the Nevada Dental Association said. When you think about it, though, this bill limits access to care. It places stipulations and limitations on doctors who want to deliver a line of therapy, which is bizarre. If it is safe to deliver care through teledentistry in emergencies and for public health programs, why cannot clinical services be delivered for clear aligners to fix mild to moderate crowding and spacing through the same type of platform safely and effectively?

It is never explained why section 10 limits teledentistry to the services listed. It does not make any sense and is clearly anticompetitive. That is the Nevada Dental Association's goal.

I take issue with the suggestion from Mr. Ableser, who is not a dentist, that you cannot screen for periodontal disease, dental caries and other oral pathologies in the mouth using teledentistry. We have been doing it for over 20 years effectively and safely. There are studies that show you can diagnose and screen for certain diseases, problems, issues and concerns through our platform.

Our Nevada-licensed dentists and orthodontists refer patients to local brick-and-mortar dentists or dental specialists for follow-up. They also refer patients out for x-rays if they are indicated. X-rays are not indicated across the board, nor does the American Dental Association allow for x-rays to be taken on every case just because you want to take them. There must be a diagnostic and therapeutic advantage for taking x-rays for them to be taken. X-rays are taken if indicated and necessary.

In the end, we believe that minorities and lower income residents of Nevada are going to be hurt by the passing of this bill, given the provision in section 10 that limits the use of teledentistry. We believe it is an arbitrary, anticompetitive measure. It is unnecessary to limit this type of situation considering that there have been no adjudicated complaints to the Board against any directly affiliated dentists or orthodontists in the more than seven years we have been doing clear aligner therapy in Nevada with our affiliated dentists and orthodontists. We have treated over 19,000 people, which has created a savings of over $76 million. That is important. I do not see why we would want to see this go away just because the Nevada Dental Association and the American Association of Orthodontists want to act anticompetitively.

SENATOR BUCK:
Why would you not want an in-person initial consultation just to rule out mouth cancer or something that could potentially be underlying?

DR. SULITZER:
What happens in a teledentistry exam is that the dentist conducting the exam reviews the same clinical information that is reviewed in an in-person exam. They review the chief complaint, the informed consent, the medical history, the patient's dental history and any 3D images, photographs and x-rays that are available. It is possible to identify mouth cancers and cancerous or suspicious lesions through teledentistry. In fact, oral pathology, general pathology, dermatology and radiology exams have all been done via telehealth.

I am not suggesting that an in-person exam is not appropriate if the patient chooses to do that. In a situation where you are doing clear aligner therapy for mild to moderate crowding and spacing, an in-person exam is not always necessary. If it is indicated, an in-person exam is ordered, and no treatment is given until that in-person exam has taken place. For instance, if during the teledentistry exam, the treating doctor perceives a potential periodontal or gum disease, the patient will be placed on a periodontal clearance. That patient cannot receive any further treatment in the orthodontic environment through teledentistry until they are seen by a brick-and-mortar dentist and periodontal disease is ruled out. This process is in place already without this bill.

Section 10 does not need to be in this bill. That is our issue with this bill. There is no reason to mandate an in-person exam before a teledentistry exam. It is akin to towing a Tesla car six miles with a horse first before you turn on the engine. It does not make any sense and is not necessary.

SENATOR STONE:
People do not come to SmileClubDirect because they have a toothache or an abscess. They come to you because they have cosmetic issues with their teeth and are looking for a lower-cost alternative to orthodontics. How often do you end up having to refer patients for in-person evaluations because of other pathologies?

I think you mentioned that you have been in business for seven years. Have you had any malpractice suits against you that relate to the fact that you are doing everything by telehealth rather than in-person exams? How accessible are you if

there is a complication with the patient? How do you handle those complications?

DR. SULITZER:
There have been no malpractice suits in Nevada in those seven years.

That was a three-part question, and I am sorry, but I missed the other two parts. Could you kindly repeat your questions?

SENATOR STONE:
I mentioned that people do not come to you because they have some pathology like a toothache or an abscess. They come to you because they have some cosmetic issues with their teeth. I assume that if you discover some sort of pathology like an abscess, you then refer those patients for in-person exams to brick-and-mortar dentists.

Also, could you elaborate on why you feel this bill is purposely anticompetitive?

DR. SULITZER:
It is purposely anticompetitive because it isolates and stops the direct-to-consumer model used by SmileDirectClub, DigiBite, ResetSmile and other companies. It limits our ability to conduct business. In fact, it stops us from doing business in Nevada. I notice that the bill allows teledentistry to be used for emergencies, which is interesting. If it is safe for emergencies, why would it not be safe for clear aligner therapy? If it is safe for public health programs, why would it not be safe for any program in a private environment? It does not make sense.

SENATOR PAZINA:
What percentage of clients ask for a refund? If they ask for a refund, is there a request for a nondisclosure agreement?

DR. SULITZER:
I do not know what percentage of patients ask for refunds, but I can explain the refund policy. Patients are entitled to a full refund up to 30 days after they have received their clear aligners, no questions asked. It is an automatic full refund. If they want a refund beyond the 30 days—for example, if it is a 6-month treatment plan and in month 5 they are unhappy with the results—it is reviewed on a case-by-case basis.

Regarding nondisclosure agreements, there is no nondisclosure agreement when the refund is granted within 30 days. If a refund is granted beyond the 30 days, patients will be asked not to disclose the conditions of the refund, but it is not a nondisclosure agreement in that the patient can complain to the Board or any other regulatory group.

SENATOR PAZINA:
What percentage of patients would you say are asking for that refund?

DR. SULITZER:
Again, I do not know the exact number, but if I were to guess, I would say maybe 5 percent. I do not know for sure. In the 7-plus years we have been in existence, our affiliated dentists have treated over 2 million patients.

CHAIR SPEARMAN:
Is there a separate license for orthodontists in Nevada?

DR. SULITZER:
There are licensed orthodontists and general dentists in Nevada.

CHAIR SPEARMAN:
The American Orthodontics Association has recommended that patients have orthodontic treatment and direct and ongoing in-person supervision by a licensed orthodontist. How many orthodontists do you have here in Nevada? Is it enough to cover your patients in Nevada? I am still trying to understand the differences between traditional diagnosing and treating of dental issues and what you do.

DR. SULITZER:
There is no difference between the way SmileDirectClub-affiliated dentists and orthodontists deliver care and the way traditional brick-and-mortar orthodontists would provide clear aligner therapy. There is no Board regulation that says a dentist cannot provide clear aligner therapy for patients. If a dentist is licensed in Nevada, he or she is eligible and capable of doing clear aligner therapy without the direction or support of an orthodontist. The standard of care for patients of doctors delivering clear aligner therapy should be identical.

MR. ABLESER:
The Nevada Dental Association believes that the Board should be and must be the body that oversees, directs and guides all aspects of the profession and ensures that practitioners are acting accordingly. Section 13 of A.B. 147 contains language that says the Board shall adopt regulations regarding all aspects of teledentistry, including practice and scope. We believe all aspects of education, screening, treatment and referral should be included within the regulations provided by the Board, and we welcome the conversation with all stakeholders, from insurance to specialty practices to online and teledentistry groups.

I want to be clear. This bill does not eliminate the ability of SmileDirectClub and other organizations to serve Nevadans. If consumers want to utilize their service and product, they absolutely can, if that is their choice. The intent here is consumer protection. It is a fact that moving a person's teeth can have significant effects if it is done without fully reviewing all aspects of the oral cavity. I have heard stories of patients who attempted to move teeth, and the teeth ended up breaking and creating worse issues because there was underlying decay that had not been addressed.

CHAIR SPEARMAN:
I would like to meet with both groups after this meeting to see what we can do.

I will close the hearing on A.B. 147 and open the hearing on A.B. 153.

ASSEMBLY BILL 153 (1st Reprint): Provides for the regulation of the practice of naprapathy. (BDR 54-724)

ASSEMBLYWOMAN ELAINE MARZOLA (Assembly District No. 21):
This bill is an effort to increase access to care and provides Nevadans with another treatment option for a variety of health conditions. Naprapathy is a branch of medicine that focuses on the evaluation and treatment of neuromuscular skeletal conditions. Doctors of naprapathy are connective tissue specialists. This measure aims to protect the public from the practice of naprapathy by unqualified and unlicensed persons.

Let me give you some background. Naprapathy was founded in the early 1900s by Dr. Oakley Smith. It is different from chiropractic medicine, which focuses on the spine. Naprapathy works with the spine but emphasizes underlying

ligaments. In the U.S., doctors of naprapathy are licensed in Illinois and New Mexico and regulated in Ohio. Naprapathy schools typically involve four years of master's level study. The only accredited school of naprapathy in the U.S. is in New Mexico and is called the Southwest University of Naprapathic Medicine (SUNM).

CONNOR CAIN (HCA Healthcare):
I would like to walk you through the key provisions of A.B. 153, which we are referring to as the Naprapathic Practice Act. We are going to focus on roughly a dozen provisions.

Section 1.06 talks about the Naprapathic Practice Advisory Board, which will be overseen by the State Board of Health.

Section 1.15 defines a naprapath as a person who is approved by the Division of Public and Behavioral Health, Nevada Department of Health and Human Services, to practice naprapathy and who has been issued a license by the Division.

Section 1.18 defines the practice of naprapathy and also what the term does not include. It is important to note that the term does not include physical therapy, chiropractic or massage therapy.

Section 1.2 creates the Naprapathic Practice Advisory Board. The members of the Advisory Board, who will be appointed by the Governor, will include three licensed naprapaths and two representatives of the public. Section 1.23 outlines when the Advisory Board should meet. Section 1.26 outlines the regulations to be adopted by the Advisory Board and the State Board of Health.

Section 1.32 requires naprapaths to obtain a license by passing an examination designated by the State Board of Health.

Section 1.35 allows the Division to issue a license to a person who meets the requirements set forth in this section upon application, approval and receipt of a license fee of $500.

Section 1.49 allows for the renewal of a license if the applicant meets the requirements outlined in this section and pays the renewal fee of $500.

Section 1.58 outlines actions by a naprapath that will lead to disciplinary action.

PATRICK NUZZO, D.N. (President, Southwest University of Naprapathic Medicine and Health Sciences):
Naprapathic and chiropractic medicine started together more than 120 years ago. The philosophy and education of naprapathic and chiropractic are almost identical; the difference is in the way the two disciplines treat patients. Naprapaths are connective tissue specialists. We treat the connective tissue to bring about bony and spinal alignment, whereas a chiropractor uses a high-velocity adjustment to bring alignment.

Naprapathy offers non-pharmacological treatment for pain, which is needed in Nevada to combat the rampant opioid epidemic. The number two and three reasons people go to the doctor's office are joint pain and back pain. Naprapathy provides hands-on manual therapy that helps people get relief from pain, get back to working and return to their normal lives without the risk of taking drugs and the risk of addiction.

The Southwest University of Naprapathic Medicine is the first accredited naprapathic school in the Country. This bill will bring this profession to the citizens of Nevada. It will also bring the school to Nevada and train hundreds of naprapathic doctors over the next decades to fulfill the needs of Nevada citizens.

SENATOR LANGE:
I was the recipient of one of Dr. Nuzzo's demonstration treatments. I had partially torn my rotator cuff while fly fishing. It caused me so much pain that I could not raise my arm. By the time he finished the treatment, I was able to raise my arm all the way up and had full rotation, and it still remains healthy and free of pain to this day. I am interested in this bill, and I hope we pass it.

SENATOR DALY:
According to the bill, you will have the Advisory Board, the State Board of Health, the Division and the Department. Who is the oversight authority, and how is this hierarchy going to work? The Advisory Board is where all the expertise is, but who has the actual enforcement authority?

MR. CAIN:
The Advisory Board exists just to provide guidance and expertise. The State Board of Health is the entity that has oversight and enforcement capability, not the Advisory Board.

SENATOR DALY:
Throughout this bill, you talk about adopting regulations to do all sorts of things. I know you cannot answer the question about whether you will get the exemptions you want. I am just saying none of it will work without the regulations in place.

The bill says that a person who wants to be a naprapath has to have a bachelor's degree in order to get licensed. Why is that a requirement?

DR. NUZZO:
A bachelor's degree is on a par with the requirement for a chiropractic degree, a physical therapy degree or an acupuncture degree. The bachelor's degree is to get the prerequisites in the basic sciences. The naprapathy degree from SUNM is a full 190 credit hours past a bachelor's degree, which makes it a first professional degree and a doctoral-level program.

SENATOR STONE:
Do private insurance and Medicaid cover your services?

DR. NUZZO:
Every major medical insurance company in New Mexico and Illinois covers naprapathic treatment. Every major employer in New Mexico has naprapathic treatment as a covered benefit, and state employees have naprapathic treatment as a covered benefit. As a matter of fact, the Governor of New Mexico has made it mandatory that if state employees need musculoskeletal surgery, they must first seek consultation from a naprapath, chiropractor or acupuncturist before they have the surgery. We have saved the state numerous surgeries over the years, and we are hoping to be able to do the same thing for Nevada.

SENATOR STONE:
Assuming this passes into law in Nevada, we are going to have to jump through the hoops with private insurance and Medicaid to make Nevada specific to covering your services.

DR. NUZZO:
It is not as big an ordeal as you may think. The Current Procedural Terminology (CPT) codes and the diagnosis codes are the same for physical therapists, chiropractors, acupuncturists and osteopaths. Naprapaths would use the same CPT codes and diagnosis codes.

SENATOR STONE:
There are plenty of malpractice carriers. You have to be insured to practice, I assume.

DR. NUZZO:
Absolutely. You cannot have your license active in New Mexico without malpractice insurance. The profession of naprapathy is over 100 years old, and there has never been a malpractice case brought against a naprapath.

SENATOR BUCK:
Section 1.29 of the bill has a lot to say about unlicensed naprapaths. Who was that written for?

Also, can you contrast for me how naprapathy is different from chiropractic care?

DR. NUZZO:
Naprapathy and chiropractic start from the same philosophy—spinal manipulation and spinal alignment—and then tackle it in different ways. If you have ever been to a chiropractor, you know that a chiropractor will bring bony alignment by doing a high-velocity adjustment. A naprapath will take tension findings on the spinal column. We then design a treatment to bring that ligament and bony structure back into alignment without force. If you adjust the bony structure without taking care of the tissue that is pulling it out of alignment, it will go back out of alignment within minutes or hours after the adjustment. If you treat the connective tissue that pulls it out of alignment, it will then stay more in alignment.

MR. CAIN:
Section 1.29 relates to folks who are enrolled in a naprapathic program but not yet licensed. They may work under the supervision of a licensed naprapath. Also, instructors have a limited period of time, not more than a month, in which they can engage in those types of services. I am not sure why that is in the bill.

DR. NUZZO:
We put that into law in New Mexico so we could bring in teachers for seminars without the teachers having to get a license in New Mexico first. In New Mexico and Illinois, we need 30 hours of continuing education every year to renew our license. There were not that many naprapaths in New Mexico when we first started, so we brought them in from other parts of the Country to teach.

SENATOR BUCK:
I like the idea of this. Often, American medicine wants to give you pills, pills, pills, and I do not like taking pills. Like my colleague, I say anything that does not rely on giving pills for pain but actually fixes the root of the issue, I like very much.

CHAIR SPEARMAN:
I have seen commercials on TV for ways to treat neuropathy related to diabetes. Is this related in any way?

DR. NUZZO:
Diabetic neuropathy can be treated by naprapathy, but those commercials are nothing to do with us. Naprapathy is hands-on manual therapy and uses no pharmaceuticals of any kind.

TANYA HAGGINS:
I am in support of A.B. 153 in reference to medication-free healing practices. I am a living testimonial of the potential of these incredible practices. About six years ago, I suffered a devastating injury to my sciatic nerve during surgery that left me with severe nerve damage and intense pain. The conventional medicine approach was to prescribe narcotic medications and suggest another surgery for about $60,000. Instead, I chose to explore alternative healing practices. I traveled from Cleveland, Ohio, to Nevada to find a practitioner and underwent a comprehensive healing regime. They addressed not only the physical aspects of my injury but also tapped into the healing power of my own body.

For me, the results have been truly remarkable. I was able to avoid taking any more narcotic medications and avoid surgery. Doctors were not sure if I would ever walk again. With each session, I experienced a reduction in pain, enhanced mobility and a new sense of self and well-being. The medication-free approach

not only allowed me to avoid potential side effects, but also empowered me to take an active role in my overall healing process.

I believe these medication-free healing practices have been used for centuries in various cultures around the world. They have stood the test of time and have been refined through generations, incorporating knowledge and wisdom passed down through centuries of practice.

Nevada has the opportunity to give patients a more comprehensive and personalized approach to healing. Please pass this bill to expand the range of treatment options available and foster a more patient-centered healthcare system.

BEAU HIGHTOWER, D.C.:
I support A.B. 153.

I am a licensed chiropractor in Nevada. I am also a graduate of SUNM. I have personally found that naprapathic techniques have added to my clinical repertoire, allowing me to fix injuries that I could not with just chiropractic. I also own a business in Las Vegas. We work with mixed martial arts fighters, and our providers are helping those guys get world championships and bring belts back to Nevada.

With this bill, we are in a unique position to help with the opiate crisis by keeping patients out of emergency rooms and away from family medicine doctors' offices. Opening a school here will also bring a lot of students to Nevada.

RICK MIERA:
I am testifying in support of A.B. 153. I am a former state legislator from New Mexico. I was privileged to sponsor the naprapathy bill in New Mexico, and it has more than surpassed our expectations. Dr. Nuzzo's graduates have been able to successfully treat our population for a variety of problems up to and including pain management, which is the number one complaint in our healthcare field. As a retiree from the Department of Psychiatry at the University of New Mexico, I can state that availability to treatment is paramount in a state that is expansive in size but lacking in professional medical care. In addition, there was an economic boost to the state. Naprapathy was a welcome addition to the healthcare system and continues to provide outpatient relief for

the future with treatment for addiction and needed alternatives to therapeutic intervention.

MARY KAY PAPEN:
I am a former state senator from New Mexico. I was a strong supporter of the naprapathy bill in New Mexico. I had sciatica so bad that I asked doctors to do surgery to fix it. They said I did not need surgery and suggested I look into naprapathy. Dr. Nuzzo came to me and said, "I think I can help you." I was walking with a cane and thought I was going to have to leave the senate because I was in such pain. Dr. Nuzzo gave me treatments, and 20 years later, I am pain free and I am still walking.

I strongly support what Dr. Nuzzo is doing. To be pain-free and drug-free is to be able to live a productive life.

HARRIS SILVER, M.D.:
I am a retired ear, nose, throat, head and neck surgeon. Since 2010, I have worked as a drug policy analyst and advocate. I worked extensively with the New Mexico Legislature, helping with the scourge of addiction in New Mexico for many years. In 2018, I was chair of the New Mexico Overdose Prevention and Pain Management Advisory Council's Subcommittee on Integrative Pain Management for acute and chronic pain.

Naprapathy was one of the modalities I became most interested in. We were looking for alternatives to opioid pain management. I am sure most of you are aware that we have a scourge of opioid overdose, addiction and death in the U.S. In 2021, we set a new record for overdose deaths at 107,000, of which two-thirds were from synthetic opioids such as Vicodin, OxyContin, Percocet and especially fentanyl. When I was in the committee, we looked extensively at naprapathic medicine and found it to be an evidence-based method for reducing acute and chronic pain and eliminating the need for opioid medications. That is the key.

It should be noted that this is not alternative medicine; it is integrative medicine. The difference is integrative medicine is frontline care, not secondary. We need modalities that can be used either by themselves or with other modalities to eliminate the need for opioid medications.

It only takes one dose to start the spiral of an opioid addiction that ruins the life of a person, a family, even businesses. I want to speak out strongly for this evidence-based modality of acute and chronic pain care management.

SENATOR LANGE MOVED TO DO PASS A.B. 153.

SENATOR DALY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the hearing on A.B. 270.

ASSEMBLY BILL 270 (1st Reprint): Provides for the licensure and regulation of anesthesiologist assistants. (BDR 54-714)

ASSEMBLYWOMAN ELAINE MARZOLA (Assembly District No. 21):
Nevada has as a severe healthcare provider shortage. Our goal with A.B. 270 is to expand safe and supervised anesthesia services for Nevada residents. If this measure is passed, Nevada will join 19 other states and the District of Columbia in allowing highly trained certified anesthesiologist assistants (CAA) to work under the supervision of a certified and licensed anesthesiologist.

This bill provides for the licensure and regulation of CAAs by the Board of Medical Examiners and the State Board of Osteopathic Medicine. It includes procedures for regulating the practice of CAAs and for imposing discipline for violations of the governing statutes and regulations.

JENNIFER STEVER, C.A.A. (American Academy of Anesthesiologist Assistants):
I am a CAA who has been practicing in Atlanta, Georgia, for 18 years, with the majority of my time doing cardiothoracic anesthesia. I am also the current president of the American Academy of Anesthesiologist Assistants.

I would like to provide a brief summary of A.B. 270. Sections 2 through 18 create a license for CAAs under the Board of Medical Examiners. It provides that CAAs assist in the practice of medicine under the supervision of an anesthesiologist. It defines the word "assist" to mean that the CAA personally

performs the duties assigned to them. It defines the certification exam, which is currently administered by the National Commission for Certification of Anesthesiologist Assistants. It defines a supervising anesthesiologist as certified or eligible to be certified by the American Board of Anesthesiology. It establishes the scope of practice of a CAA, which is also regulated by the facility and the anesthesiologist. It provides for the requirements to be licensed, including graduating from an accredited CAA program, passing the national certification exam, applying for a license and meeting all requirements set by the Board. It requires a supervising anesthesiologist to be immediately available to a CAA such that the physician is able to effectively reestablish direct contact with the patient. It allows an anesthesiologist to supervise CAAs in a manner consistent with federal law.

Sections 19 through 40 amend current law to provide for CAAs to be regulated by the Board of Medical Examiners and includes CAAs in the regulations pertaining to a physician, profusionist, physician assistant and practitioner of respiratory care. This includes a process for investigating complaints and the imposition of disciplinary action.

Sections 41 through 57 create a license for CAAs under the State Board of Osteopathic Medicine.

Sections 58 through 105 provides for CAAs to be regulated by the State Board of Osteopathic Medicine in a manner consistent with regulations pertaining to an osteopathic physician and physician assistant.

For a little history, CAAs have been providing safe, cost-effective anesthesia care across the U.S. for more than 50 years using the anesthesia care team model, thus expanding access to physician-led anesthesia care, which is the safest anesthesia care for the patients of Nevada.

I have been involved with the didactic and clinical training of CAAs for over 15 years. Matriculants must complete all of the prerequisites required for admission into medical school or other physician assistant training programs.

Students often have previous clinical experience, including but not limited to respiratory therapists and pharmacists. Certified anesthesiologist assistants undergo graduate-level training encompassing the path of physiology, pharmacology and airway management necessary to become safe anesthesia

providers. Students graduate from independently accredited CAA programs with upwards of 600 anesthetics performed and more than 2,000 clinical hours of anesthesia training. Graduates of accredited CAA programs must pass a national certifying exam administered by an independent certifying organization.

Practicing CAAs must complete 50 hours of continuing medical education every 2 years along with successful completion of a continuing certification exam administered every 10 years. Certified anesthesiologist assistants are trained in all aspects of anesthesia care including general anesthesia, regional anesthesia and monitored anesthesia care. If you have had a colonoscopy, you have probably had monitored anesthesia care. Certified anesthesiologist assistants are trained to perform spinal and epidural anesthesia and peripheral nerve blocks and place invasive monitors like arterial lines and pulmonary artery catheters. These are the monitors necessary to keep you safe while having heart surgery. Certified anesthesiologist assistants are licensed and regulated by the State Board of Medical Examiners with delineation of privileges and hiring practices specific to individual facilities.

Certified anesthesiologist assistants are currently authorized to practice in 19 states, the District of Columbia and the Veterans Administration system. Certified anesthesiologist assistants are defined by the Centers for Medicare & Medicaid Services (CMS) as nonphysician anesthetists and reimbursed in the medical direction model of one physician anesthesiologist directing up to four anesthetists. Anesthesia services provided by CAAs are reimbursed by Medicare, Tricare, state Medicaid and commercial payers.

Licensure of CAAs in Nevada will increase access to physician-led anesthesia care, thus ensuring greater access to the highest quality care necessary during surgery and procedures for the residents of Nevada. Certified anesthesiologist assistants who hail from Nevada, several of whom are in the room right now, want to come home and provide care to the patients in their home State.

SHAINA RICHARDSON, M.D.:
I am a board-certified physician anesthesiologist. I have been practicing in Reno as part of the largest anesthesia group in northern Nevada for about seven years.

I would like to focus on three specific things that I think are important to this bill: safety, cost and staff shortages.

Regarding safety, CAAs function identically to nurse anesthetists within the anesthesia care team model. This equivalency in patient safety has been shown in multiple studies. This bill requires supervision of CAAs by a physician. There have been several studies in this area, but one good peer-reviewed study of some 200,000 uses of anesthetics showed that when physician anesthesiologists were specifically involved in care, there was a lower death rate in complicated cases of about 2.5 per 1,000 cases. This lower mortality rate is not insignificant.

Regarding cost, anesthesia services are reimbursed at the same rate regardless of who delivers the anesthetic. If we are paid $100 for an anesthetic and I perform it myself, I would get that entire fee. If I perform it within a supervisory model, we would split that fee. That means there is no increased cost to either the patient or to the State in involving a CAA. Insurance companies classify CAAs equally to certified registered nurse anesthetists (CRNA) in terms of risk, which means my malpractice insurance would not increase whether I practiced independently or as part of an anesthesia care team model using either CRNAs or CAAs. As it happens, CAAs also carry their own malpractice insurance.

Regarding staff shortages, as everyone on this Committee knows, Nevada has a severe shortage of healthcare providers, and anesthesia has been particularly hard hit. This is not entirely surprising, since people basically cough on us for a living, and we lost a lot of people during the COVID-19 pandemic. I personally have worked a lot more over the last several years, and I regularly work over 80 hours a week. If I did not have a very patient and understanding spouse, that would be difficult to maintain for much longer. I love my job, and I love serving this community, but I worry that these types of hours and conditions are going to drive a lot more providers to significant burnout.

Passing this bill would significantly increase the pool of providers from which we could hire. Our practice would definitely hire CAAs if A.B. 270 passes. They are competent, safe, valuable members of the anesthesia care team; they are tried and true.

I urge you to pass A.B. 270 to allow for the licensure of CAAs in Nevada.

SENATOR STONE:
When you say that the supervising anesthesiologist has to be immediately available, does that mean you have to be physically on the site, or can you be

available by Zoom? I would also like to verify that an anesthesiologist can oversee four people, so the ratio is four to one. Is that correct?

DR. RICHARDSON:
Immediately available means on site. We would not be able to supervise via Zoom. It means in the same physical location; it cannot be a hospital across town. If there is some sort of emergency, I need to be able to reach the patient very, very quickly.

Regarding the ratio, yes, it is four to one. That is in line with federal regulations via the CMS guidelines.

SENATOR DALY:
Do they have to be supervised by a physician or by an anesthesiologist, or can it be a combination?

DR. RICHARDSON:
My understanding is that it has to be a physician anesthesiologist.

CHAIR SPEARMAN:
So it cannot be just any physician; it has to be a physician anesthesiologist. Is that right?

ASSEMBLYWOMAN MARZOLA:
Yes. The supervision has to be a board-certified and licensed anesthesiologist.

SENATOR PAZINA:
Could a CAA provide the anesthesiology as a patient is going under, or are they monitoring the condition after the patient has already received the anesthetics?

DR. RICHARDSON:
They will be involved in all aspects of the patient's care. They have to be supervised under the regulations of medical direction during specific stages of anesthesia. If you think of a pilot flying a plane, the take-off and landing are the highest risk parts. In anesthesia, those are the two moments in which the anesthesiologist needs to be physically present.

STEPHANIE ZUNINI (Nevada Academy of Anesthesiologist Assistants):
I am here today to testify in support of A.B. 270. I am a CAA and the current president of the Nevada Academy of Anesthesiologist Assistants. I am a fifth-generation native Nevadan, but I currently live and practice in Denver, Colorado, because I am unable to do so in my home State.

I am a Governor Guinn Millennium scholar, just like some of the other CAAs here today, and we were paid by Nevada to earn a higher education. But right now, we are unfortunately unable to use our desperately needed skills as anesthesia providers in our home State. There is undoubtedly an anesthesia provider shortage here in Nevada.

If passed, this bill will by no means fully correct the shortage of anesthesia providers. However, it will license an additional category of advanced practice provider, a category that is currently used safely and successfully in many other states across the Country every single day. Certified anesthesiology assistants must and will always eagerly work under the direction of a physician anesthesiologist.

Passing this bill does not increase any cost to the patient or the hospital. It also does not require the use of CAAs, but it will allow for the option to use them. Please show your commitment to the expansion of the healthcare workforce and support this bill.

RACHEL MATSUMURA, C.A.A. (Nevada Academy of Anesthesiologist Assistants):
I am here to testify in support of A.B. 270. I am a CAA currently working at an Indiana University-affiliated hospital in Indianapolis. I am an advanced practice provider who would love to get back to my community and provide safe anesthesia care to the citizens of Nevada. Both of my parents, my grandmother and many close friends live in Nevada, and I would love to return to my home State to be with them. This bill would bring a new category of highly educated and safe advanced practice providers who would work in the physician-led anesthesia care team model. I hope you will support A.B. 270 because Nevada is in dire need of more safe anesthesia providers.

SUSAN FISHER (State Board of Osteopathic Medicine):
We are in full support of this bill. I would also like to add an important component of this bill is workforce development and economic development.

SARAH WATKINS (Nevada State Medical Association):
The Nevada State Medical Association supports this bill. Passage of A.B. 270 will help meet the need for supervised midlevel providers and provide more quality care in Nevada. We thank Assemblywoman Marzola for bringing this bill forward and for working with members of our Association.

JADA WABANIMKEE, C.A.A. (Nevada Academy of Anesthesiologist Assistants):
I am here in support of A.B. 270.

I am a CAA who accepted a job in Kansas City because CAAs are not licensed in my home State. I was raised in Nevada after my family was stationed at Nellis Air Force Base. I graduated from the University of Nevada, Las Vegas, with an advanced diploma in biotechnology, and then continued my education by graduating magna cum laude from the University of Nevada, Reno, with a bachelor's degree in biochemistry and molecular biology. I commissioned into the Nevada Army National Guard soon after as a lieutenant in the Medical Services Corps. Through the last three years as a master's degree student, I paid for flights to Nevada out of my own pocket each month to continue to serve my community that I grew up in, only to not have the option to work here once I graduate.

The military shares a similar stress on clinical decision-making that is required of an anesthesia provider. If I can lead Nevadans into battle, I should surely be trusted to work under the supervision of experienced anesthesiologists. My undergraduate degree was paid for by the Nevada National Guard, and I am a Millennium scholar recipient. On the Millennium scholar website, it reads, "We want to ensure Nevada's best scholars stay in Nevada." Yet here I am today to say that I cannot stay in Nevada because I cannot make a living here. We are here to change that today.

Please vote in favor of the licensure of CAAs in Nevada.

MIKAELA REZAEI (Nevada Orthopaedic Society):
We appreciate Assemblywoman Marzola bringing this bill forward. Nevada is in dire need of healthcare providers, and A.B. 270 will assist in filling that gap.

AMY SHOGREN (Nevada Hospital Association):
We are in full support of this legislation.

DAN MUSGROVE (US Anesthesia Partners):
We are probably the largest anesthesia group in Nevada with 90 doctors, and as you heard today, that is not enough. We absolutely support this bill.

CONNOR CAIN (Sunrise Hospital and Medical Center; Sunrise Children's Hospital; HCA Health Care):
We are in support of this bill.

BLAYNE OSBORN (Nevada Rural Hospital Partners):
We enthusiastically support A.B. 270.

JERRY MATSUMURA (Nevada State Society of Anesthesiologists):
I think enough has been said, so I will spare you all the material I have gathered. We are in strong support of A.B. 270.

SHANE ANGUS (American Academy of Anesthesiologist Assistants):
I am a CAA and the chair of the American Association of Anesthesiologist Assistants Education Programs, representing over 20 academic members across the U.S. For over 50 years, our member institutions have matriculated and graduated anesthesiology assistants who provide safe quality anesthesia care within the security model. All of our programs are at a graduate level and award master's degrees. All programs must be accredited by the Commission on Accreditation for Allied Health Education Programs. All programs are associated with a medical school and have a physician anesthesiologist as the medical director. All students complete a premedical curriculum, take the California Achievement Test or the Graduate Record Examination test and have highly competitive applications. All students complete a rigorous academic and clinical curriculum that is focused on clinical competency outcomes nationally. Our members have commendable retention rates, graduation rates and board passage rates, as well as employment rates.

SENATOR LANGE MOVED TO DO PASS A.B. 270.

SENATOR HAMMOND SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the hearing on A.B. 503.

ASSEMBLY BILL 503 (1st Reprint): Revises various provisions relating to background checks. (BDR 1-900)

BRADLEY WILKINSON (Chief Deputy Legislative Counsel Attorney):
I am here today in my capacity as an attorney in the Legal Division of the Legislative Counsel Bureau (LCB) to present A.B. 503 as requested by the LCB in coordination with the Records, Communication and Compliance Division (RCCD) of the Nevada Department of Public Safety, which is sometimes known as the Central Repository.

Before beginning my presentation, I need to make the disclosure that as an employee of the Legislative Counsel Bureau, I am prohibited from encouraging the passage or failure of legislation, but I may make recommendations by way of background.

In 1972, Congress authorized the FBI to conduct criminal history background checks for the purposes of licensing employment through the enactment of Public Law 92-544. Pursuant to that public law, the FBI is empowered to share Criminal History Record Information (CHRI) with officials of state and local governments if authorized by a state statute that has been approved by the attorney general. Nevada's Attorney General has delegated the authority to approve statutes to the FBI.

The policy of the FBI requires that fingerprints must be initially submitted to the RCCD for a State criminal history records check and thereafter to the FBI for a national criminal history records check. All legislation enacting or revising a statute has to be submitted to the FBI through the RCCD for the FBI's review and approval before the FBI will accept fingerprints and provide CHRI under the new revised statutes. I believe some of the statutes amended in this bill are still subject to a grace period granted by the FBI, but the grace period has already lapsed for some other statutes.

Congress first enacted this public law in 1972. In 2000, 28 years later, the FBI did its first audit of all statutes in the Country and found that many of them were not in compliance with the federal law. With respect to Nevada, the FBI

found that almost half of Nevada statutes did not comply with the federal law, and 13 of 29 were out of compliance.

Following that review, Nevada and many other states introduced legislation to fix any statutes that had been reviewed and rejected by the FBI. During the 2003 Legislative Session, the Legislature passed and Governor Kenny Guinn signed A.B. No. 155 of the 72nd Session to fix the statutes rejected by the FBI. We have fixed one or two statutes each session since then, but 2003 was the last time the Legislature made a major revision to ensure compliance with federal law.

The revisions you see today in A.B. 503 have been in the works for about four years. We began working with the RCCD in 2019 to fix the statutes that had been rejected. We were going to bring a bill last Session, but we just ran out of time. The revisions in the bill address a variety of problems the FBI found within our statutes. For example, they found that certain sections of NRS are overbroad in their applicability or description of the applicants who must submit fingerprints. Some statutes improperly authorized the release of CHRI to a private person or entity.

This bill was much larger as originally introduced, but we took out some sections relating to professional licensing boards. We are going to continue working with the RCCD on some of the issues over the Interim and come back in 2025 with a bill that will hopefully address anything remaining.

With that in mind, I will run through the sections of the bill and describe what statutes we are fixing and why. Again, please bear in mind that all of these statutes were rejected by the FBI in recent years.

Sections 7, 8 and 11 of the bill fix some statutes that exempt volunteers who are likely to have unsupervised contact with pupils from the requirement to submit fingerprints and undergo a background check if those volunteers had already had a background check conducted by another entity in the past six months. We cleaned up these statutes by clarifying that the investigation must be conducted by a public entity. We also did our best to make sure the statute meets all the other requirements set forth in the federal guidelines.

Sections 9, 12, 13 and 89 make additional changes with respect to background checks in the educational context. The FBI determined that these sections do

not meet the requirements of Public Law 92-544 because they improperly authorize the dissemination of CHRI to a private person. For that reason, those provisions are removed and conforming changes are made.

Section 10 of the bill covers a statute the FBI rejected because it believed the language "other auxiliary, nonprofessional personnel" is too broad a term for the purposes of background checks. We replaced that term with the term "paraprofessionals," which is defined in NRS.

Sections 51, 52 and 53 of the bill pertain to dental matters and relate to statutes that were considered to be overly broad. For example, there is no definition of dentistry in the chapter, so we added the definition of dentistry in section 51. Section 52 has a conforming change. In section 53, the FBI felt that the language in the current statute referring to any of the special branches of dental hygiene, dental therapy or dentistry was overly broad. We simply removed that phrase.

In section 60, the FBI determined that one sentence in the Psychology Interjurisdictional Compact improperly authorizes dissemination of CHRI to private entities. We removed that sentence and specifically stated that a compact state is prohibited from submitting to the coordinated database any CHRI obtained from a report of the Central Repository or the FBI.

Section 61 of the bill pertains to marriage and family therapists and clinical professional counselors. Currently, fingerprinting authority only exists for an expedited license by endorsement. We gave specific authorization for other types of licenses.

Section 65 of the bill pertains to the Nevada Funeral and Cemetery Services Board. That statute was not approved by the FBI because the specific applicants were not identified in the statute, so we revised that to identify each type of license certificate or permit.

Sections 81 to 84 relate to the Cannabis Compliance Board and define the terms board member, officer, owner and ownership interest for purposes of background checks of persons associated with medical cannabis establishments and adult use cannabis establishments, as the FBI has determined that those terms are overly broad.

Section 85 makes a conforming change to indicate the placement of those sections in NRS.

Section 89 repeals the statute relating to the State Board of Cosmetology that improperly authorized the sharing of CHRI between certain entities.

SENATOR DALY:
In section 13, when you talk about private schools, it seems counterintuitive that you eliminate the fingerprint requirements for those people. They can get into other databases for a background check. But I was not following the distinction that by eliminating the fingerprint requirement, they can still access the other information with background checks at private schools.

MR. WILKINSON:
That statute was rejected by the FBI because you cannot share CHRI with a private person or entity, which includes a private school or the administrator or headmaster of a private school. The bill removes that portion of the statute. The other portion of the statute has to do with the Statewide central registry for the collection of information concerning the abuse or neglect of a child. Since that is not part of the FBI's database, we kept that portion, and it remains in law.

SENATOR BUCK:
If you are an educator, you already have your fingerprints done. When you get your license renewed every few years, you have to do them again. But if you are applying to a State government agency, do you have to do it again?

MR. WILKINSON:
That is not actually addressed in the bill, but yes, you do have to do that. The FBI is careful about protecting the sharing of information, especially with private entities. You simply cannot do that. With public entities, you have a limited ability for them to share that information, and it has to be close in time. I am not sure what the outer range of time is, but anything over a year is probably too long. It also has to be for the same purpose and closely related.

With any kind of statute like that, you are just going to have to do the fingerprints over again. They have rejected other ones that have an extensive time period or are not tied to exactly the same purpose.

SENATOR PAZINA:
I was looking at existing law as it pertains to section 9. The Nevada Department of Education (NDE) maintains a list of names of people whose licenses are denied due to a conviction for a sexual offense involving a minor. They update that list monthly and provide it to the board of trustees in a school district upon request. Section 9 removes those provisions. Why is that?

MR. WILKINSON:
There are a couple of reasons for that. We created this bill in connection with the RCCD, and we took some of their suggestions. I understand they were working with the NDE as to what they wanted to do, and it was the NDE that suggested removing that provision. I suspect the reason for it is any kind of CHRI that is contained in that list cannot be shared.

ERICA SOUZA-LLAMAS (Records, Communications and Compliance Division, Nevada Department of Public Safety):
That language was removed because the FBI was concerned that those records contain CHRI. As Mr. Wilkinson said, the FBI is very particular about who the CHRI is shared with.

SENATOR PAZINA:
My concern is that those records were being shared to keep those former offenders from coming into close unsupervised contact with children. Is there still someone those records could be shared with so we can protect children in our schools?

MS. SOUZA-LLAMAS:
I am not sure I can answer that question. I will see if I can get more information for you.

CHAIR SPEARMAN:
There is no prohibition against doing another background check if needed. You just cannot share the existing information. Can they do another background check?

MS. SOUZA-LLAMAS:
Correct, if it is for a different purpose. An individual might be fingerprinted for the NDE for licensing purposes, and that is one purpose. If they go to a school district and are fingerprinted for employment with the school district, that is a

different purpose. One is for licensing, and the other is for employment follow-up.

CHAIR SPEARMAN:
I had to get a top secret clearance when I was at the Pentagon, and then they did another one when I was selected for another military assignment. If someone was gathering information for a paramilitary assignment, could that information be shared?

MS. SOUZA-LLAMAS:
It would have to be for the exact same purpose.

SENATOR DALY MOVED TO DO PASS A.B. 503.

SENATOR LANGE SECONDED THE MOTION.

THE MOTION PASSED. (SENATOR PAZINA VOTED NO.)

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CHAIR SPEARMAN:
Is there any public comment? Hearing none, we are adjourned at 11:02 a.m.

RESPECTFULLY SUBMITTED:

Lynn Hendricks,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
A.B. 147	C	3	Eddie Ableser / Nevada Dental Association	Presentation
A.B. 147	D	10	William Horne / SmileDirectClub	Data sheet