Legislative Committee on Health Care

Legislative Counsel Bureau
Bulletin No. 95-18

March 1995

REPORT OF THE
LEGISLATIVE COMMITTEE ON HEALTH CARE

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SUMMARY OF RECOMMENDATIONS

The following is a summary of the recommendations adopted by the Legislative Committee on Health Care.

1. Adopt a resolution to encourage the Welfare Administrator, in conjunction with the Commission on Substance Abuse Education, Prevention, Enforcement and Treatment and the Bureau of Alcohol and Drug Abuse (BADA), to develop a proposal to amend the Medicaid state plan to increase coverage of non-hospital-based substance abuse treatment services. The proposal should specify that state BADA funds be utilized as Medicaid matching funds. The amendment must be presented to the State Welfare Board for approval by October 1, 1996. **(BDR R-1269)**

2. Adopt a resolution to encourage the Welfare Administrator, in conjunction with the Commission on Substance Abuse Education, Prevention, Enforcement and Treatment and the BADA, to seek all necessary federal waivers and approvals to allow Medicaid coverage of substance abuse residential treatment services in a non-hospital setting through the elimination of the institutions of mental disease exclusion. **(BDR R-1269)**

3. Require, by statute, that the Commission on Substance Abuse Education, Prevention, Enforcement and Treatment and the BADA compare the cost-effectiveness of hospital-based substance abuse treatment services and residential treatment facilities. The objective of the study must be to determine the effectiveness of increasing the utilization of non-hospital-based substance abuse treatment services on the cost and the outcome of such treatments. A report must be submitted to the 1997 Legislature and the Legislative Committee on Health Care. **(BDR S-1254)**

4. Redraft Assembly Bill 277 from the 1993 Legislative Session which requires the Welfare Administrator to institute a Medicaid presumptive eligibility process for pregnant women. **(BDR 38-1237)**

5. Amend Chapter 620 (*Statutes of Nevada 1993*) and the *Nevada Revised Statutes* (NRS) to require Department of Human Resources (DHR) to begin enrollment of ADC (Aid to Dependent Children)-related Medicaid recipients in a managed care program by January 1, 1996, and begin enrollment of the Aged, Blind, and Disabled (ABD) Medicaid populations no later than January 1, 1998. **(BDR 38-1235)**

6. Amend Chapter 695C of NRS to define the terms and conditions related to health maintenance organizations (HMOs) participating in the Medicaid managed care program. **(BDR 57-1236)**

7. Adopt a resolution to urge DHR to stipulate in its contracts with all Medicaid managed care contractors that such contractors must utilize the National Practitioner Data Bank in credentialing providers. **(BDR R-1253)**

8. Include a statement in the final report that the committee recognizes the value of involving people with disabilities in planning for the implementation of Medicaid managed care. As the state prepares to design a Medicaid managed care program for aged, blind, and disabled persons, DHR should allow these individuals the choice to receive services in a manner that fosters their independence.

9. Adopt a resolution to encourage the Welfare Administrator seek all necessary waivers and approvals to establish a system which provides for the direct payment to certain disabled Medicaid recipients for the purchase of in-home personal assistant services. **(BDR R-1240)**

10. Amend NRS 632.030 to alter the representation of nurses serving on the State Board of Nursing to consist of five registered nurses and one licensed practical nurse. In addition, these board members must be appointed to represent various segments of the field of nursing, including administration, advance practice, community practice, education, and institutional practice. Furthermore, appointees must have lived and worked in Nevada for the past 2 years. **(BDR 54-1241)**

11. Amend NRS 632.075 to allow the State Board of Nursing to appoint advisory committees to consult with the board on any matters, including, but not limited to, continuing education. **(BDR 54-1242)**

12. Amend Chapter 632 of NRS to include a definition of the term "delegation." The definition should convey that delegation involves

entrusting the performance of selected nursing duties to individuals qualified and competent to perform such duties. Delegable duties are those listed in standardized policy and procedures, leading to predictable outcomes in the observation and care of clients. **(BDR 54-1239)**

13. Amend Chapter 632 of NRS to include a legislative declaration of intent regarding the regulatory power of the State Board of Nursing. The legislative declaration of intent should convey that:

> It is the policy of this state that, in order to safeguard the life, health, property, and public welfare of the people of this state and in order to protect the people of this state from the unauthorized, unqualified, and improper application of services by individuals in the practice of nursing, it is necessary that a proper regulatory authority be established. Furthermore, it is the policy of this state to regulate the practice of nursing through the State Board of Nursing with the power to enforce the provisions of this article. **(BDR 54-1243)**

14. Amend NRS 632.130 and NRS 632.260 to increase the penalty for a registered nurse and a licensed practical nurse who practices or offers to practice without a license. The penalty shall be increased from a misdemeanor to a gross misdemeanor. **(BDR 54-1243)**

15. Amend NRS to add a definition of "personal assistant," authorize a person with a disability who is not residing in a licensed facility to utilize the services of a personal assistant, and exempt personal assistants from Chapter 632 of NRS. **(BDR 54-1249)**

16. Amend NRS to increase the availability and affordability of health insurance for small employers through additional market reforms. These reforms include, but are not limited to, guaranteed issue and renewability, modified community rating, portability, and risk adjustment provisions. **(BDR 57-1238)**

17. Amend Chapters 689A, 689B, 695B, and 695C of NRS to mandate that all health insurers in the state include coverage of obstetric and prenatal care services. **(BDR 57-1245)**

18. Require the DHR to collect information on the cost, outcomes, and quality of health services. Among other responsibilities, the DHR must determine the types of providers required to participate, develop a list of data

elements to be collected from providers, and disseminate information to the public. The DHR shall coordinate its efforts with other data collection activities conducted in other state agencies which collect health-related financial, service, utilization, and health care personnel data. **(BDR 40-1251)**

19. Include a statement in the committee's final report acknowledging the need for a state health care reform plan that addresses access and coverage, individual responsibility and choice, insurance reform, payment and cost control, quality of care, and tort reform.

20. Amend Chapter 442 of NRS and provide for an appropriation to the medical malpractice premium subsidy program that provides payment of insurance premiums for physicians and mid-level providers supplying obstetrical services in rural or underserved areas of the state. **(BDR 40-1246)**

21. Amend Chapter 439A of NRS to require that DHR conduct a study of the health manpower needs in the state, including primary care physicians, mid-level practitioners, and allied health professionals as defined in the United States (U.S.) Public Health Service Act. The report must be submitted to the Legislative Committee on Health Care and the University of Nevada School of Medicine on July 1 of each even-numbered year. **(BDR 40-1247)**

22. Require, by statute, that school districts in counties whose population exceeds 35,000 establish programs to stimulate the development of allied health professionals as defined in the U.S. Public Health Service Act. The school districts must enter into necessary agreements with the University and Community College System of Nevada to accept college credit for relevant courses successfully completed by high school juniors and seniors. **(BDR 34-1248)**

23. Adopt a resolution to encourage the Board of Regents of the University and Community College System of Nevada to accept high school courses as credit towards an allied health profession degree. **(BDR R-1367)**

24. Amend Chapter 442 of NRS to require the Governor's Maternal and Child Health Advisory Board to create a subcommittee on perinatal alcohol, tobacco, and other drug use. In addition, amend Chapter 442 of NRS to establish a perinatal alcohol, tobacco, and other drug use prevention

program within the Health Division. A position of program coordinator shall be created to carry out the objectives of the program. **(BDR 40-1244)**

25. Include a statement in the committee's final report urging the Legislature to support the continuation of the Baby Your Baby project, with full implementation by the Health Division and Medicaid. Specifically, the Health Division should continue to provide toll-free telephone referral services and coordinate the recruitment of prenatal care providers for participants in rural and frontier areas. In addition, the Welfare Division should continue to receive public and private donations to fund multimedia outreach efforts to promote early entry into prenatal care.

26. Include a statement in the committee's final report endorsing continued legislative support for adequate funding of services for children with special health care needs, including the Special Children's Clinics and the Newborn Screening program.

27. Amend Chapter 439B of NRS to establish a rural health advisory subcommittee to the Legislative Committee on Health Care. The subcommittee must be comprised of various individuals appointed by the chairman for a 2-year term. All members shall serve without compensation, per diem allowances, or travel expenses. The chairman shall appoint:

    a. Not more than two representatives of federally-funded rural health clinics;
    b. Not more than two representatives of rural hospitals;
    c. Not more than two representatives of public health service providers;
    d. Not more than two representatives of rural nursing homes;
    e. Not more than two representatives of rural physicians;
    f. Not more than two representatives of rural home health providers;
    g. Not more than two representatives of rural health care providers;
    h. Not more than two representatives of rural hospital trustees;
    i. Not more than two representatives of the Center for Education and Health Services Outreach, University of Nevada School of Medicine;
    j. Not more than two representatives of consumers of rural health services; and
    k. Not more than two members of the Legislative Committee on Health Care, one of which shall serve as chair of the subcommittee. **(BDR 40-1250)**

REPORT TO THE 68TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE

INTRODUCTION

The Committee on Health Care is the Legislature's policymaking body on health care matters primarily during the interim period, with continuing duties throughout the legislative sessions. *Nevada Revised Statutes* (NRS) 439B.200 through 439B.240, the committee's enabling legislation, outlines the broad areas of oversight related to the state's health care environment that are assigned to the committee.

During the 1993-1995 interim, the Legislative Committee on Health Care primarily focused on complying with the provisions of Senate Bill 559 (Chapter 620, *Statutes of Nevada 1993*, pages 2590-2592). The 1993 Nevada Legislature enacted S.B. 559 which required the Committee on Health Care to conduct a study to evaluate and develop a mandatory, coordinated care (or managed care) system for all Medicaid recipients. The measure specified that the study must examine available medical care systems, review funding sources and provider compensation methods, assess various cost containment approaches, and evaluate the impact and replacement of any lost hospital tax revenues. See Appendix A for a copy of S.B. 559. The bill also directed the committee to submit its recommendations regarding such a system to the Governor and the Department of Human Resources (DHR) by July 1, 1994. After fulfilling its statutory obligations related to S.B. 559, the committee also considered other state health care reform measures appropriate for Nevada.

Members of the committee during the 1993-1995 interim included:

Senator Raymond D. Rawson, Chairman
Assemblywoman Vivian L. Freeman, Vice Chairman
Senator Diana M. Glomb
Senator Raymond C. Shaffer
Assemblywoman Jan Evans
Assemblywoman Sandra J. Tiffany

Legislative Counsel Bureau staff services were provided by:

Kerry Carroll Davis, Senior Research Analyst (principal staff)
H. Pepper Sturm, Chief Principal Research Analyst
Brenda J. Erdoes, Legislative Counsel
Risa L. Berger, Deputy Legislative Counsel
Debby Richards, Principal Research Secretary

The six-member committee held nine meetings between October 1993 and December 1994. During the first seven meetings, the committee examined various alternatives to establish a mandatory, managed care program for Nevada Medicaid recipients. Subsequently, the committee formulated and approved a package of recommendations outlining the general structure and characteristics of a Medicaid managed care program. These recommendations were developed in conjunction with: a consultant, the DHR and other state agencies, industry representatives, Medicaid recipients, and various interested groups and individuals. The full report entitled, "Recommendations for a Medicaid Managed Care System," is available in the Research Division of the Legislative Counsel Bureau.

At its final meeting, the committee adopted 27 recommendations covering a wide variety of issues. Some of these issues include: malpractice subsidies; mandated benefits; Medicaid; nursing; perinatal alcohol, tobacco, and other drug use; personal assistant services; rural health; and small employer health insurance market reform. Detailed descriptions of these recommendations and the committee's deliberations are provided in this report.

MEDICAID MANAGED CARE

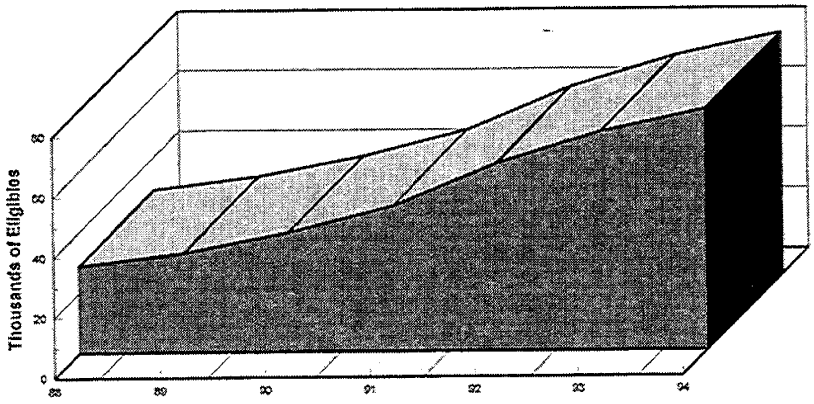
This portion of the report addresses: (1) Nevada's Medicaid program; (2) Medicaid managed care efforts in other states and Nevada; (3) Senate Bill 559, the committee's deliberations, and recommendations pertaining to Medicaid managed care; and (4) the development and current status of the 1915(b) waiver.

Nevada's Medicaid Program

Medicaid is a means-tested entitlement program financed by state and Federal Government and administered by the states. The program purchases medical services for low-income persons who meet certain eligibility criteria. Federal guidelines place requirements on states for coverage of specific groups of people and benefits. In addition to the minimum requirements, states may choose to cover other categories of persons and medical services. Federal matching payments are based on a state's per capita income and range from 50-80 percent of annual outlays. Nevada's matching rate is 50 percent.

In recent years, several factors have caused a tremendous increase in program enrollment and costs. Federal law has changed to require additional medical and related services, primarily expanding coverage to low-income pregnant women and children. The rise in spending is predominantly attributable to a combination of health care inflation, increase in state use of alternative financing mechanisms, and the rise in enrollment. As a result of these changes, population increases and the economic recession in the early 1990s, the Medicaid program has grown rapidly. In the last six fiscal years (FYs), enrollment has increased 183 percent, from an average monthly caseload of 29,032 in FY 1988 to 82,358 in FY 1994. Reimbursement for direct medical services rose 232 percent, from $90 million to $300 million over the same time period. Constructed from the "Summary of On-line Medical Expenditures for State Fiscal Years 88-94," the charts on the following page illustrate the growth in both eligibles and costs over the last six fiscal years.

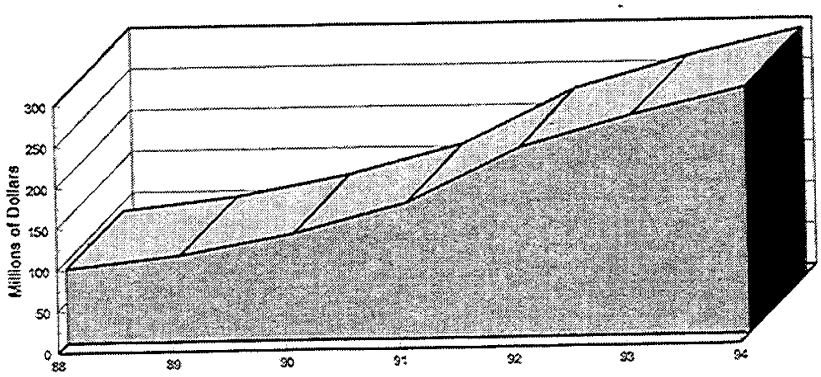
NEVADA MEDICAID
TOTAL ELIGIBLES
FISCAL YEARS 1988-1994



Source: Nevada's Welfare Division

Within the major Medicaid aid categories, the Child Health Assurance Program (CHAP) experienced the greatest percentage increase in eligibles, soaring from 146 persons to 14,926 persons--an increase in excess of 10,000 percent. This rise in recipients is primarily due to changes in federal law which requires a yearly increase in the number of individuals that must be covered under this program. The disabled and Aid to Dependent Children categories recorded the next highest growth in eligibles, with percentage increases of 140 percent and 129 percent, respectively.

NEVADA MEDICAID
TOTAL MEDICAL PAYMENTS
FISCAL YEARS 1988 - 1994



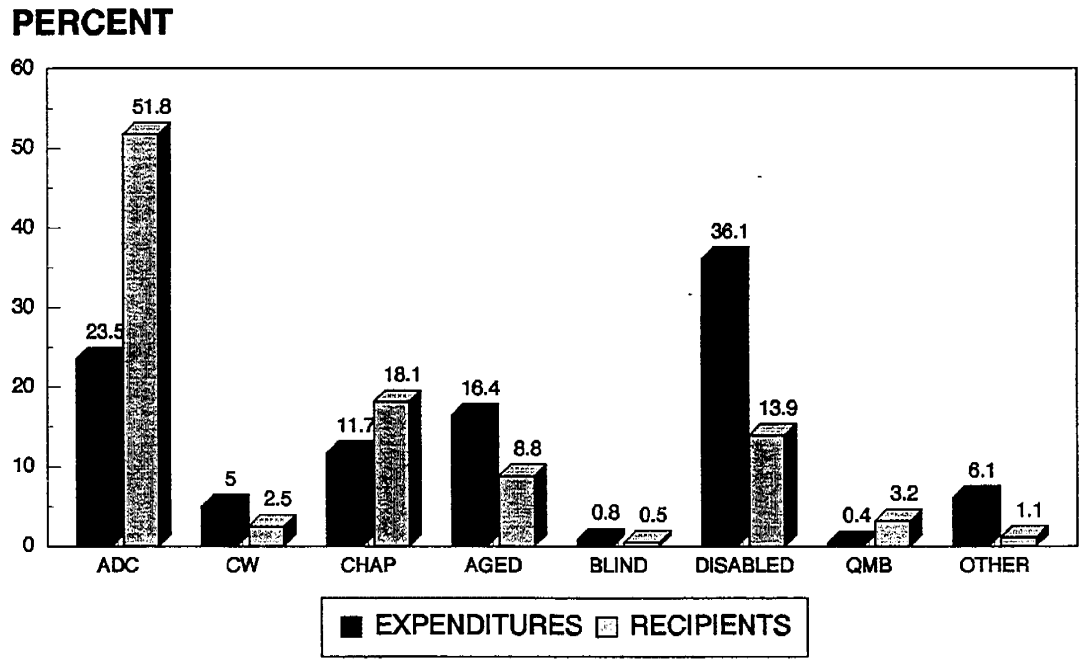
Notes: 50% State and 50% Federal Funds
FY 90-94 Includes county match program funds
FY 92-94 Does not include non-institutional provider tax or disproportionate share payments

Source: Nevada's Welfare Division

In the aggregate, Medicaid costs per eligible have risen 17 percent, from $3,110 per eligible in FY 1988 to $3,642 per eligible in FY 1994. Among the major aid categories, child welfare recipients accounted for the greatest percentage increase in cost per eligible, with costs escalating from $1,551 to $7,544 (386 percent). The rise in costs per eligible is mainly due to an expansion in the number of services available to these recipients. Aid to Dependent Children recipients posted a 52 percent increase, although costs per eligible have remained steady over the last three fiscal years. Against the trend of rising costs, CHAP recipient costs have decreased by over 50 percent since FY 1988. Lower costs have been partially the result of capitated payments for pregnancy-related services.

While adults and children in low-income families comprise nearly 75 percent of beneficiaries, they generate only 40 percent of Medicaid spending in Nevada. The elderly and disabled account for the majority of expenditures (52 percent) because of their intensive use of acute and long-term care services.

NEVADA MEDICAID
RECIPIENT POPULATIONS AND EXPENDITURES
FISCAL YEAR 1994



SOURCE: Nevada's Welfare Division

Background on Medicaid Managed Care in the States

As illustrated by Nevada's experience, states have continually struggled with the skyrocketing costs of Medicaid due to an increase in eligible persons, required services, and the cost of health care. In hopes of reining in costs and improving access, many states have begun to deliver care to their Medicaid population through managed care plans, ranging from primary care case management (PCCM) to fully capitated health maintenance organization systems. Most states, including Nevada, have instituted some form of Medicaid managed care. According to the National Health Policy Forum, every state except Wyoming anticipated implementing at least one Medicaid managed care program by 1994.

Because many of these changes are beyond the scope of the current Medicaid program, a state must obtain waivers of Medicaid law to continue to receive federal matching payments. States have sought and received two types of waivers from the U.S. Health Care Financing Administration (HCFA): (1) Section 1915(b), and (2) Section 1115. These waivers differ in intent, statutory provisions that can be waived, length of the waiver, waiver documents required, waiver approval process, and ongoing monitoring and reporting requirements. Over the term of either waiver, the total waiver program costs are not to exceed the amount the state would have spent without the waiver.

A 1915(b) waiver is referred to as a program waiver. The objective of this waiver is to allow states to take advantage of their purchasing power in the medical marketplace, as well as ensuring participants' access to providers and services. Under 1915(b) waivers, states can only disregard certain requirements of Section 1902 of the U.S. Social Security Act, including provisions regarding freedom of choice of provider, comparability, and statewideness of services. These waivers are limited to 2-year periods, but can be renewed. The state provides HCFA with standard application information, such as the purpose of the waiver; list of statutory provisions to be waived; eligible recipients; expected caseload; services to be provided; number and types of participating providers; provider qualifications; description of payment methods; and capitation rate setting process. According to law, the waiver application is deemed approved if HCFA does not respond within 90 days of the submittal.

A Section 1115 waiver is referred to as a research and demonstration waiver. To receive an 1115 waiver, states must demonstrate a significant change in the methods in which care is delivered or organized under Medicaid. With this type of waiver, HCFA essentially requires states to propose a scientifically designed research project that represents a novel or experimental approach to the

operation of the Medicaid program. Under Section 1115, a broader range of provisions may be waived than under Section 1915(b). With this authority, HCFA can waive Medicaid requirements regarding the amount, duration, eligibility, reimbursement for services, and scope of services. Specifically, a state may be allowed to waive compliance with any requirements related to Sections 1902 and 1903 of the U.S. Social Security Act. For states proposing a managed care demonstration, the ability to waive provisions of Section 1903(m) pertaining to HMOs is particularly important. Section 1115 waivers have no specific duration of time, but are typically granted for a 5-year period. In general, the 1115 waiver application must include the same material as a 1915(b) application, with one major exception. These waiver applications are required to contain a explanation of the evaluation questions to be addressed, the hypotheses for each question, and a description of how the questions will be answered. While Section 1115 waivers have no specific time frame for approval or rejection, HCFA attempts to process applications within 90 to 120 days.

Medicaid Managed Care in Nevada

In 1983, HCFA granted the state a 1915(b) waiver that allowed the University of Nevada School of Medicine (UNSoM) to introduce managed care to certain Medicaid recipients on a limited basis. While the waiver was renewed in 1985, HCFA ruled in 1987 that the state no longer needed to renew its waiver because the participation in the PCCM program was not required of recipients.

Presently, four providers offer the voluntary PCCM program through which a small number of services are provided on a partially-capitated basis. The current providers consist of UNSoM-Reno, UNSoM-Las Vegas, Nevada Care, and Community Health Centers of Southern Nevada. In a PCCM system, a single provider is responsible for locating, coordinating, and monitoring all the health care for a program member. In return, the provider receives a fixed case management fee for each member. Only ADC, aged, and institutionalized aged recipients in Clark and Washoe Counties may participate in Nevada's program. Under the program, each provider is at risk for emergency physician, pharmacy, laboratory, and radiology services; inpatient and outpatient physician services; and outpatient laboratory, pharmacy, and radiology services. The remainder of Medicaid benefits continue to be reimbursed on a fee-for-service basis.

As of January 1995, approximately 39 percent of the eligible Medicaid population (or 24,967 persons) were participating in the PCCM program. Aid to Dependent Children-related recipients comprise over 96 percent of the enrolled individuals.

Expansion of Medicaid Managed Care in Nevada: Senate Bill 559

In order to further reduce the growth in costs and improve access, the Legislature looked to build upon the experience of the state's voluntary PCCM program by **requiring** all Medicaid clients to be enrolled in a managed care plan. Legislators also intended to encourage the provision of health education as well as initiate efforts to mainstream Medicaid recipients. Furthermore, the Legislature believed that developing a statewide Medicaid managed care system would assist the state in any transition necessary under national health care reform. As a result, the 1993 Legislature enacted Senate Bill 559.

Senate Bill 559 required the Legislative Committee on Health Care to conduct a study to evaluate and develop a mandatory, coordinated care (or managed care) system for all Medicaid recipients. The bill specified that the study examine available medical care systems, review funding sources and provider compensation methods, assess various cost containment approaches, and evaluate the impact and replacement of any lost hospital tax revenues. The measure also required that the committee's recommendations regarding such a system must be submitted by July 1, 1994, to the Governor and the DHR.

In addition, the measure directed the DHR to obtain federal approval of a Section 1115 waiver to conduct a Medicaid managed care demonstration project, based on the committee's recommendations that were approved by the Governor.

The bill also required the DHR to establish this system no later than July 1, 1995. Initially, the Department was required to enroll all ADC recipients and phase in enrollment of the ABD populations by the end of the second year of the program. The measure stipulated that the UNSoM participate in the development, implementation, and service delivery aspects of the program. Furthermore, the DHR was required to assist the UnSoM in providing an adequate and diverse patient population on which to base its educational programs.

Summary of Medicaid Managed Care Committee Meetings

To fulfill the requirements of S.B. 559, the committee convened seven public meetings between October 1993 and July 1994. The first meeting focused on reviewing the requirements of S.B. 559, providing background information on the Medicaid program, and discussing the role of the DHR in the study.

Second Meeting

At the second meeting, the committee began to examine other states' initiatives in Medicaid managed care programs. A consultant to the committee explained the basic program models found in a number of states and localities, emphasizing the variety of arrangements between state agencies and health care plans/providers. The committee also received detailed information regarding the process and criterion the Federal Government utilizes to evaluate potential Medicaid managed care demonstration projects.

To assess the current service delivery system for Nevada's Medicaid recipients, the committee reviewed the provider networks presently serving the PCCM program. To aid the committee in evaluating the expansion of managed care to the entire Medicaid population, several provider networks and advocacy groups suggested changes to be incorporated into the new service delivery system.

Due to the technical aspects of the study, the committee decided to retain the consultant, Gretchen Engquist (of the Washington, D.C.-based firm Engquist, Pelrine, and Powell), to assist in determining a service delivery model that would be the most appropriate for Nevada. The consultant emphasized that the design of the model must consider several factors, including the state agency role, financial risk assumed by health plans, administrative requirements, and type of participating managed care organizations.

Third Meeting

At its third meeting, the committee discussed three potential service delivery models that could be effectively utilized under a statewide Medicaid managed care demonstration in Nevada. The three models presented by the committee's consultant included a health insuring organization (HIO), a statewide health plan, and a regional health plan design.

In an HIO model, the state Medicaid agency contracts with one insuring organization that would then contract with various health plans throughout the state. The statewide health plan design requires the state Medicaid agency to directly contract with two or more health plans that would each provide services statewide. In the regional health plan design, the state Medicaid agency directly contracts with a health plan in each region (North, South, and Rural) that would provide services regionally. In all the proposed models, the state passes the risk to either the HIO or the health plans. After deliberations with the committee's

consultant, the members stated their preference for a health insuring organization model.

Additionally, the committee examined options related to benefit package, eligibility, and enrollment issues. With regard to eligibility and enrollment functions, the consultant presented alternatives in which these functions were the responsibility of the state Medicaid agency or the contractor. Various possibilities also were discussed concerning the types of eligibility categories subject to managed care and a phase-in period related to these categories. Further, the committee reviewed the current Medicaid benefit package and the modifications that might be necessary in a managed care environment.

Fourth Meeting

During the fourth meeting, the committee continued its consideration of a service delivery model for the Medicaid managed care system. The model discussion focused primarily on various types of management structures and the assignment of risk. As a "working model," the committee chose a HIO model that would not be precluded from delivering services.

The issues of the benefit package, enrollment, and eligibility functions were also discussed. The DHR presented the committee with recommendations regarding specific services to be excluded from the managed care system and certain types of providers to be included in the system. As a result of the committee's choice of model, the department suggested that enrollment and eligibility responsibilities remain with the state Medicaid agency. With forthcoming data from the DHR, the consultant also recommended that the committee explore waiving prior quarter coverage and adding a presumptive eligibility process.

Finally, the committee examined financing options for the newly structured Medicaid program. The DHR explained the amount and sources of expected revenues and costs, and estimated the additional funding needed for the program in the next biennium. The committee's consultant proposed four possible funding schemes, including: (1) modification of the provider tax in a manner consistent with federal regulations; (2) redesignation of the provider tax to apply to the portion of the program which continues on a fee-for-service basis; (3) elimination of the provider tax and maintain the intergovernmental transfer provisions; and (4) extension of the insurance premium tax to Medicaid as a partial substitute for the provider tax. After reviewing the options, the committee considered a revised intergovernmental transfer program and an expansion of the premium tax as the most feasible funding alternatives.

Fifth Meeting

At its fifth meeting, the committee continued to explore various options related to service delivery models. As a result of these discussions, the members agreed to add a management contractor model as another possible Medicaid management structure. The management contractor model, utilized in Rhode Island's Medicaid demonstration project, had been previously described by the committee's consultant as suitable for states with limited internal resources in the area of managed care. In the management contractor model, the state would contract with an independent management firm to assume responsibility for monitoring the cost and quality aspects of the various health plans providing services. The management firm would not accept any financial risk under this arrangement.

To examine the potential pool of contractors, the Division of Insurance (Department of Business and Industry) presented an analysis of the various types of insurance-related organizations that could bid under the proposed managed care systems. The Division stated that HMOs and Third Party Administrators would be feasible candidates to bid on such a system. Regardless of the management structure, the Division recommended that capital and surplus requirements be increased for any HMO participating in a managed care plan.

Regarding the ABD populations, the DHR reported on the difficulties in collecting and analyzing data on these eligibility groups. The DHR stated that it was unable to compile specific information on the ABD population in a timely manner. Because this information is necessary for the bidding process, the Department suggested that these groups might possibly complete their phase-in period to the managed care program later than the statutory requirement of July 1, 1997. In another area, the committee heard recommendations from its rural subcommittee regarding the impact of a Medicaid managed care system on Nevada's rural areas. The committee concurred with the rural subcommittee that recommended all Medicaid services in the rural communities be exempt from a managed care program. Although, members agreed that managed care capacity should be encouraged and developed in rural Nevada.

At the conclusion of the meeting, the members voted to begin negotiations with the HCFA regarding Nevada's two proposed Medicaid managed care models: (1) a health insuring organization; and (2) a management contractor design. It was suggested that the consultant, officials from the DHR, and representatives of the committee form a team to visit federal program officers.

Meetings with the Health Care Financing Administration

In April 1994, a delegation consisting of committee members, DHR officials, and the consultant met with both regional and central office HCFA officials. The purpose of the meetings was to inform federal officials of Nevada's efforts to secure a Medicaid managed care demonstration project and to receive detailed feedback on the committee's proposals as well as the likelihood for federal approval of these proposals.

Primarily as a result of rigorous research design criteria associated with 1115 waivers, HCFA representatives contended that the state would have a much greater probability of attaining approval by pursuing its plan under another waiver authority. The HCFA suggested that Nevada could achieve all of its stated goals by utilizing a management contractor model in a 1915(b) waiver. Federal officials reiterated that 1915(b) waivers have a less stringent waiver approval process, shorter approval time, and simpler monitoring and reporting requirements.

Sixth Meeting

At its sixth meeting, the committee representatives reported on their meetings with HCFA officials regarding Nevada's proposed Medicaid waiver. Due to HCFA's suggestion that the state seek a 1915(b) waiver, the committee's consultant presented a comparative analysis of both waiver authorities.

In addition, the DHR gave an overview of various resources and time lines needed to implement the new managed care program. Because of the complexity involved in the establishment and implementation of this system, the DHR stated that it will require assistance in a variety of areas, all of which might not be available in one firm. The Department proposed that the decision on whether to maintain a function within the state or assign it to a contractor will be determined by performing a cost-benefit analysis. The areas in which the DHR intends to seek outside assistance include: (1) actuarial/financial; (2) analysis of medical trends; (3) external quality assurance; and (4) preparation of the waiver and HMO requests for proposals. Furthermore, the DHR could possibly contract for data system development and operational reviews.

The committee also discussed the advantages and disadvantages of requiring bidding organizations to be federally qualified. Finally, the committee agreed to adopt general guidelines presented by the University of Nevada School of

Medicine regarding the number of patients the school could serve and the types of services it will provide.

Seventh Meeting

The committee held its seventh meeting in which the members deliberated and voted on the final recommendations regarding the development and implementation of a Medicaid managed care system. The recommendations covered the following aspects: (1) type of Medicaid waiver; (2) management structure; (3) service delivery system; (4) eligibility; (5) enrollment; (6) benefit package; (7) criteria for the HMO bidding process; (8) the University of Nevada School of Medicine; and (9) HMO solvency. The following set of recommendations was approved by the committee on June 24, 1994.

Recommended General Structure and Characteristics of a Medicaid Managed Care System in Nevada

Type of Medicaid Waiver

1. Apply to the United States Health Care Financing Administration (HCFA) for approval of a Section 1915(b) waiver to implement a mandatory Medicaid managed care system.

Furthermore, the committee recommended that the DHR design the 1915(b) waiver application to consist of the following components:

Management Structure

2. Employ a management contractor firm(s) to assist the state Medicaid agency in managing the various health plans. The **management contractor(s)** will provide managed care expertise in various administrative function areas, including:

    - Actuarial assistance;
    - Capitation data;
    - Technical assistance in the preparation of the waiver and the HMO request for proposal (RFP);

- Assistance in the evaluation of HMO bids (in conjunction with the state);

- External quality assurance, including utilization review; and

- Analyses of medical trends for medical policy.

The state should establish a managed care unit under which the management contractor(s) would operate. Under the terms of such an arrangement, the management contractor(s) would accept no financial risk.

Subsequently, the state would contract directly with the HMOs providing services to the recipients. The financial risk would be passed to these service providers.

3. Assign the following management responsibilities to the **state**:

   - Eligibility determination;

   - Enrollment choice counseling;

   - Preparation of the HMO RFP (in conjunction with the management contractor[s]);

   - Evaluation of the HMO bids (in conjunction with the management contractor[s]);

   - Grievance appeal process;

   - Capitation rate setting (in conjunction with the actuary and the management contractor[s]); and

   - Evaluation of medical policy.

4. Designate the following responsibilities to the **HMOs**:

   - Provision or arrangement for all medical and dental services;

   - Claims payment;

- Collection of third-party liability;
- Collection and transmittal of encounter data to the state;
- Submittal of required financial, operational, and utilization reports;
- Utilization review and management;
- High-risk medical case management;
- Member health education, including prenatal education;
- Establishment of a reinsurance program and administration of reinsurance claims;
- Implementation of an internal quality review program in conformance with HCFA guidelines; and
- Adherence to required state performance criteria (e.g., 80 percent or more of all eligible children receive Early Periodic Screening, Diagnosis and Treatment [EPSDT] services).

5. Perform cost-benefit analyses regarding various remaining program responsibilities to determine whether contractual assistance would be beneficial to the state. These responsibilities relate to:
   - Enrollment and "autoassign" procedures;
   - Development of the system's data base;
   - Maintenance and analysis of encounter data;
   - Data validation; and
   - Health maintenance organization operational and financial reviews.

Service Delivery System

6. Continue to foster the growth of managed care opportunities in the rural areas and allow for participation of the rural communities.

7. Require that the service provider networks in the managed care program provide for the inclusion of the following entities:

   - Special Children's Clinics for diagnostic work only;
   - Federally Qualified Health Centers; and the
   - University of Nevada School of Medicine.

8. Provide recipients with two managed care options in southern Nevada and at least one managed care option in northern Nevada which includes multiple provider networks.

9. Suggest that all potential bidders consider developing a contractual relationship with the University Medical Center in Las Vegas.

Eligibility

10. Include the following Medicaid eligibility categories in the managed care program: (1) Aid to Dependent Children-related groups; and (2) the Aged, Blind, and Disabled populations.

11. Following program implementation, continue to review managed care opportunities for special populations initially excluded from the program.

Enrollment

12. Begin enrollment of the ADC-related groups by July 1, 1995, and enrollment of the ABD populations by July 1, 1996. All persons who become eligible for either of these eligibility groups after the commencement of enrollment will automatically be enrolled into a managed care option. Enrollment should occur at the time of scheduled eligibility redetermination or, if none is scheduled, based on contact by a Medicaid staff person. These deadlines should be

periodically reevaluated as the development and implementation of the program continues.

Benefit Package

13. Include all existing Medicaid covered services in the managed care program except:

    - Nursing facility stays over 45 days;
    - Adult day health care services;
    - Home and community-based waiver services;
    - Mental health services and other services for the severely mentally ill adult and the severely emotionally disturbed child;
    - Indian Health Services;
    - School-based health services;
    - Intermediate care facility services for the mentally retarded; and
    - Medical services for all foster children placed in out-of-state settings.

    These services will continue to be provided on a fee-for-service basis. All recipients will receive the non-excluded services through the managed care program.

14. Continue to review managed care opportunities, following program implementation, for services initially excluded from the program.

15. Encourage providers to offer additional preventative or cost-effective services to recipients if these services do not increase the cost to the state.

Criteria for HMO Bidding Process/Organizations

16. Accept bids on both a statewide and regional basis.

17. Limit the number of contracting organizations to maximize pricing advantages. Not all organizations that submit a bid within the actuarial range will be awarded a contract.

18. Award preference points to all bidders that are federally qualified by the program implementation date.

19. Award preference points to all bidders that incorporate a contractual relationship with the University Medical Center in Las Vegas in their proposal.

20. Award preference points to all bidders that provide additional preventative or cost-effective services to recipients if these services do not increase the cost to the state.

University of Nevada School of Medicine

21. Require Medicaid managed care service providers to offer an affiliation agreement with the University of Nevada School of Medicine.

HMO Solvency

22. As part of the bid review process, conduct an evaluation of the HMO's solvency. In conducting this evaluation, consider the adequacy of capital and surplus levels; reinsurance coverage; fidelity bond coverage; adequacy of the current incurred but not reported system in relationship to the anticipated Medicaid enrollment; and the overall potential impact on the organization's solvency status.

In the event a HMO terminates its affiliation with the Medicaid managed care program:

23. Specify in the HMO RFP and contracts that the state will not assume any financial responsibility for unfunded liability which exceeds the funds designated by the state for a HMO that no longer participates in the Medicaid managed care program.

24. Specify in the HMO RFP and contracts that the state divests itself of performing the duties of insurance.

25. Stipulate in the HMO RFP and contracts that the remaining HMOs must absorb the "orphaned" participants.

Other Related Issues

26. Create a subcommittee, consisting of Chairman Raymond D. Rawson, Assemblywoman Jan Evans, and Assemblywoman Sandra J. Tiffany, to continue to work with the DHR in designing and implementing the program.

27. Require the DHR to periodically report back to the full Legislative Committee on Health Care regarding the progress of the Medicaid managed care program, including the waiver process and subsequent development and implementation issues associated with the program.

Progress by the DHR Related to Implementation of Medicaid Managed Care

Once the committee and the DHR had finished developing a general structure for the program, the Department was charged with submitting a 1915(b) waiver application in compliance with the committee recommendations that were approved by the Governor. Due to the complexity of establishing such a system and applying for a federal waiver, the DHR needed to seek assistance from contractors with expertise in Medicaid managed care.

Waiver Development Process

Initially, the project required the Department to contract for actuarial services in the analysis of federal and state HMO solvency requirements, rate development, utilization review, and other related services. In March 1994, the DHR received approval from the Interim Finance Committee (IFC) to expend funds for an actuarial contractor. After a competitive bidding process, the DHR contracted with William M. Mercer, Inc., in July 1994. The contract for actuarial services to assist the DHR with the implementation of Phase I totaled approximately $187,000 for FY 1995 and $87,000 for FY 1996. In addition, the DHR received support from IFC to contract with consultants in two other areas. To implement a comprehensive managed care program, the Department requested a transfer of funds ($300,000) for an evaluation of Medicaid's current data system

capabilities and its future data system requirements. The RFP to retain a contractor for this study is still being completed. Additionally, the DHR requested a transfer of funds ($160,000) to hire a consultant for assistance in drafting the waiver, preparing the RFP to solicit HMO bids, and analyzing HMO bids. The Department has contracted with Gretchen Engquist, who previously assisted the committee, to perform these functions. Welfare Division officials have testified before IFC that more funds for consulting services will be necessary to appropriately design and implement this program.

Waiver Status

To date, a final draft of the waiver had not been submitted to HCFA. Department of Human Resources officials anticipate delivering the waiver to HCFA in March 1995. Additionally, the DHR plans to issue a Request for Information (RFI), a precursor to the RFP, to gauge the interest of potential bidders. The RFI will contain general information about the components of the waiver, including geographic areas of inclusion, eligible populations and services, and client characteristics. Depending on the feedback from the bidders, the RFP may be altered to ensure a sufficient response. In general, the absence of an administrative infrastructure to implement a complicated restructuring of the program has hampered the progress of various stages of the waiver application, particularly in the area of data development. For example, the decision to exclude various Medicaid recipients and services from managed care has lengthened the data analysis. Limitations of the data and the system have resulted in additional delays. The most critical and cumbersome portion of the waiver application is the cost-effectiveness demonstration which presents a comparison of expenditures with and without the waiver. Consequently, building an accurate and complete data base for managed care is crucial to the establishment of the capitated rates, competitive bidding process, and calculation of the estimated savings. Furthermore, the initiative has necessitated that the state procure consultant services to assist agency staff in several different areas, which has increased the time necessary to complete certain components.

ADDITIONAL HEALTH CARE-RELATED ISSUES

After fulfilling the requirements of S.B. 559, the committee held additional hearings concerning a variety of health related issues. This section provides background information and recommendations concerning these issues, including various aspects of the Medicaid program; nursing issues; the accessibility and affordability of health care; health care work force; maternal-child health matters; and rural health.

Medicaid

Substance Abuse

Medicaid reimbursement for substance abuse treatment services is primarily targeted toward hospital-based facilities. According to "The Cost of Substance Abuse to America's Health Care System, Report 1: Medicaid Hospital Costs," $1 of every $5 in Medicaid hospital costs are attributable to substance abuse. However, the state primarily funds substance abuse services that are offered in non-hospital-based facilities.

The committee received testimony on this matter from the Bureau of Alcohol and Drug Abuse (BADA), within the Rehabilitation Division, Department of Employment, Training, and Rehabilitation, and the Commission on Substance Abuse Education, Prevention, Enforcement, and Treatment. Agency representatives asserted that non-hospital-based services are more effective and cost less than hospital-based services. In fact, federal block grant funding of state alcohol and drug abuse treatment services prohibits reimbursement of hospital-based services. Consequently, the commission and the BADA suggested that state dollars for substance abuse could be used as federal matching funds for Medicaid, if Nevada could reorient its substance abuse funds to cover non-hospital-based services. As a result of the additional Medicaid funds, coverage of substance abuse services could be expanded.

The commission and the BADA reported that various barriers exist to Medicaid coverage of non-hospital-based substance abuse treatment services. Medicaid payment policies follow medical model treatments. The "medical model" correlates to services delivered within an inpatient, hospital setting. However, recent research indicates that the social model of treatment often provides a better outcome at a lower cost. The "social model" refers to services provided in an outpatient, residential, or free standing clinic setting. In addition, Medicaid classifies substance abuse as a "mental disorder" and renders recipients who

are 21-65 years of age ineligible for any Medicaid covered services, if they reside in an "institution for mental disease." This definition excludes facilities which have more than 16 beds. Finally, state funded services are not covered under Nevada Medicaid because the services are not hospital-based.

Although some states have increased their non-hospital-based Medicaid substance abuse services by obtaining a waiver, many states have opted to cover these services through an amendment to their state plan. A variety of services can be reimbursed by Medicaid under this method, including acupuncture, case management, coverage of treatment in facilities with fewer than 17 beds, day treatment, detoxification, drug-free outpatient treatment, and intensive outpatient treatment.

Therefore, the committee recommended that the 1995 Nevada Legislature:

Adopt a resolution to encourage the Welfare Administrator, in conjunction with the Commission on Substance Abuse Education, Prevention, Enforcement and Treatment and the Bureau of Alcohol and Drug Abuse (BADA), to develop a proposal to amend the Medicaid state plan to increase coverage of non-hospital-based substance abuse treatment services. The proposal should specify that state BADA funds be utilized as Medicaid matching funds. The amendment must be presented to the State Welfare Board for approval by October 1, 1996. (BDR R-1269);

Adopt a resolution to encourage the Welfare Administrator, in conjunction with the Commission on Substance Abuse Education, Prevention, Enforcement and Treatment and the BADA, to seek all necessary federal waivers and approvals to allow Medicaid coverage of substance abuse residential treatment services in a non-hospital setting through the elimination of the institutions of mental disease exclusion. (BDR R-1269); and

Require, by statute, that the Commission on Substance Abuse Education, Prevention, Enforcement and Treatment and the BADA compare the cost-effectiveness of hospital-based substance abuse treatment services and residential treatment facilities. The objective of the study must be to determine the effectiveness of increasing the utilization of non-hospital-based substance abuse treatment services on the cost and the outcome of such treatments. A report must be submitted to the 1997 Legislature and the Legislative Committee on Health Care. (BDR S-1254)

Presumptive Eligibility

Over the years, the committee has received much information regarding the benefits of presumptive Medicaid eligibility for low-income pregnant women. In general, the Welfare Division processes a Medicaid application in approximately 45 days. Presumptive eligibility is an option for state Medicaid programs which allows health care providers to immediately render services to applicants upon the completion of a preliminary application. This option guarantees reimbursement to providers for up to 45 days, even if Medicaid eligibility is ultimately denied. The objective of a presumptive eligibility option is to create expedited and early access to continuous prenatal care for potentially eligible Medicaid clients.

According to testimony received by the committee, presumptive eligibility is believed to address several issues related to prenatal care and low-income women. For example, the Medicaid application process may discourage many potential applicants. Women may lack the ability to complete the application forms, application sites may be inconveniently located, and the delays in eligibility determination may postpone medical care. In addition, Medicaid providers might be more willing to accept pregnant women as clients if a guaranteed payment source exists, rather that a possible payment source while the patient is pending eligibility. Finally, early and continuous prenatal care is correlated with a lower incidence of poor birth outcomes such as low birth weight babies, neonatal deaths, birth anomalies, and complications for the mother. These outcomes are associated with higher medical costs as well as developmental and learning disabilities that require long-term specialized services. In 1985, the Institute of Medicine concluded that direct medical care expenditures for low birth weight babies could be reduced by $3.38 for every $1 spent on prenatal care.

Depending on several assumptions, the Welfare Division developed a range of cost estimates associated with presumptive eligibility in FYs 1996 and 1997. For FY 1996, the division calculated costs ranging from $481,447 to $5,401,804. In FY 1997, the division estimated costs ranging from $577,324 to $6,363,036.

As a result, the committee proposed that the 68th Session of the Nevada Legislature:

Redraft Assembly Bill 277 from the 1993 Legislative Session which requires the Welfare Administrator to institute a Medicaid presumptive eligibility process for pregnant women. (BDR 38-1237)

Managed Care

As previously explained, Nevada's Medicaid waiver development process has been delayed for a variety of reasons. As other states are experiencing, designing and implementing any type of managed care system for a Medicaid population is a significant endeavor. The early experience of Medicaid managed care programs such as Tennessee's TennCare have focused state and federal attention on the importance of extensive preparation and planning for such an effort.

In general, the absence of an administrative infrastructure to implement a complicated restructuring of the program has hampered the progress of various stages of designing the waiver application, particularly in the area of data development. The issue of building an accurate and complete data base for managed care is crucial to the establishment of the capitated rates, competitive bidding process, and calculation of the estimated savings. Additionally, the initiative has necessitated that the DHR procure consultant services in several different areas. Furthermore, funding for the Medicaid managed care program will likely be approved late in the legislative session. If this occurs, the DHR will have difficulty completing the contracting process with the managed care providers and preparing its agencies for the new system by July 1, 1995. As a result, the committee recommended that the 68th Session of the Nevada Legislature:

Amend Chapter 620 (*Statutes of Nevada 1993*) and the NRS to require DHR to begin enrollment of ADC-related Medicaid recipients in a managed care program by January 1, 1996, and begin enrollment of the ABD Medicaid populations no later than January 1, 1998. (BDR 38-1235)

During its deliberations, the committee proposed that no new state licensed entities be created to implement the Medicaid managed care system. With information provided by the Insurance Division, the committee also concluded that HMOs would be the most appropriate licensed entity to manage the risk and delivery of services to Medicaid clients. However, the current law addressing the operation of commercial HMOs is inadequate to allow for the operation of a commercial HMO involved in the Medicaid managed care business. Among other aspects, the law must ensure that federal Medicaid requirements are met with regard to benefits, interval of organization evaluations, grievance procedures, confidentiality, et cetera. Therefore, the committee recommended that the 1995 Nevada Legislature:

Amend Chapter 695C of NRS to define the terms and conditions related to HMOs participating in the Medicaid managed care program. (BDR 57-1236)

The committee received testimony regarding the value of information contained in the National Practitioner Data Bank. Opened in 1990, the National Practitioner Data Bank is a federal repository that consists of disciplinary and malpractice reports taken against physicians and dentists. Access to this information is limited to health maintenance organizations, hospitals, licensing boards, and professional societies. Because the committee was concerned about quality of care in a managed care system, members proposed that all Medicaid managed care contractors query the data bank when credentialing their provider networks. Therefore, the committee recommended that the 68th Session of the Nevada Legislature:

Adopt a resolution to urge DHR to stipulate in its contracts with all Medicaid managed care contractors that such contractors must utilize the National Practitioner Data Bank in credentialing providers. (R-1253)

During the Medicaid managed care deliberations, the committee received valuable input from individuals with disabilities, their caregivers, and providers in developing the basic structure of the waiver. Although the committee recommended to postpone the inclusion of such individuals in the managed care program, the members agreed to acknowledge the contribution of the disabled community in the discussions and encourage their participation in the future consideration of Phase II of the program. Thus, the committee voted to:

Include a statement in the final report that the committee recognizes the value of involving people with disabilities in planning for the implementation of Medicaid managed care. As the state prepares to design a Medicaid managed care program for aged, blind, and disabled persons, DHR should allow these individuals the choice to receive services in a manner that fosters their independence.

Other Medicaid-Related Issues

The committee heard from several persons with disabilities, their caregivers, and state agency officials about the important role of personal assistance services in improving the quality and independence of the lives of disabled individuals. Personal assistance services (PAS) are defined as assistance with tasks in the home or community which disabled persons could perform themselves, if they did not have a disability. This type of assistance includes cognitive, physical,

mental and sensory tasks, i.e., balancing a checkbook, dressing, eating, housekeeping, remembering to take medications, or toileting.

In general, state and national policies tend to fund PAS in institutions, such as nursing homes, rather than in the home or community. Although Nevada Medicaid funds PAS for a limited number of people through its Home and Community-Based waiver, the state and federal requirements attached to this funding are numerous and leave the disabled person with little control in the method of PAS delivery. According to testimony from disabled individuals and providers, persons with disabilities support the users' choice, direction, and control in selecting, training, scheduling, and supervising their personal assistants. Furthermore, the disabled community advocated for the users' choice, direction, and control of administrative tasks such as determination of pay rates, withholding of taxes, and payment of benefits. Thus, the committee recommended that the 1995 Nevada Legislature:

Adopt a resolution to encourage the Welfare Administrator seek all necessary waivers and approvals to establish a system which provides for the direct payment to certain disabled Medicaid recipients for the purchase of in-home personal assistant services. (R-1240)

Nursing

Because Nevada's "Nurse Practice Act" Chapter 632 of NRS has not been completely revised since the 1940s, the State Board of Nursing created the Law and Legislative Committee (LLC) in 1992 to review the act and suggest legislative changes. This committee was comprised of 87 members from various types of nursing professionals as well as representatives of many special interest groups. In addition, the board requested that the LLC serve as a subcommittee of the Legislative Committee on Health Care to facilitate coordination of the state's response to changes in the health care environment and provide a more neutral forum for issue resolution. As a result, the State Board of Nursing presented the Legislative Committee on Health Care with the following proposals related to representation on the board, advisory committees of the board, delegation of nursing duties, and a legislative declaration of intent.

The Board of Nursing proposed that the representation on the board be altered to ensure membership from a variety of nursing fields and reflect the appropriate levels of registered nurses and licensed practical nurses currently practicing in Nevada. Therefore, the committee recommended that the 1995 Nevada Legislature:

Amend NRS 632.030 to alter the representation of nurses serving on the State Board of Nursing to consist of five registered nurses and one licensed practical nurse. In addition, these board members must be appointed to represent various segments of the field of nursing, including administration, advance practice, community practice, education, and institutional practice. Furthermore, appointees must have lived and worked in Nevada for the past 2 years. (BDR 54-1241)

The board suggested that the statutes be changed to allow for the appointment of multiple advisory committees, both ad hoc and standing. The board also supported advisory committee members serving as volunteers, with no payment for per diem or travel expenses.

Amend NRS 632.075 to allow the State Board of Nursing to appoint advisory committees to consult with the board on any matters, including, but not limited to, continuing education. (BDR 54-1242)

Although the term "delegation" is used frequently throughout Nevada's Nurse Practice Act, it is not statutorily defined. To clarify the references in the law, the board proposed to add a definition of "delegation" of nursing duties to be used a resource by the board, nursing professionals, and nursing administration.

Amend Chapter 632 of NRS to include a definition of the term "delegation." The definition should convey that delegation involves entrusting the performance of selected nursing duties to individuals qualified and competent to perform such duties. Delegable duties are those listed in standardized policy and procedures, leading to predictable outcomes in the observation and care of clients. (BDR 54-1239)

The state Board of Nursing proposed to supplement the Nurse Practice Act with a legislative declaration regarding regulatory powers of the Board of Nursing. The intent was to provide consistency with laws related to other large regulatory boards in Nevada and standardized model nurse practice acts.

Amend Chapter 632 of NRS to include a legislative declaration of intent regarding the regulatory power of the State Board of Nursing. The legislative declaration of intent should convey that:

> **It is the policy of this state that, in order to safeguard the life, health, property, and public welfare of the people of this state and in order to protect the people of this state from the unauthorized,**

unqualified, and improper application of services by individuals in the practice of nursing, it is necessary that a proper regulatory authority be established. Furthermore, it is the policy of this state to regulate the practice of nursing through the State Board of Nursing with the power to enforce the provisions of this article. (BDR 54-1243)

Nevada statutes specify that unlawful practice of nursing is a misdemeanor. Because of the overburdened criminal justice system, the committee heard testimony that the penalties for unlawful practice of nursing are not sufficient enough to cause county district attorneys to pursue prosecution of these cases. As a result, the board suggested that these offenses be associated with more severe penalties.

Amend NRS 632.130 and NRS 632.260 to increase the penalty for a registered nurse and a licensed practical nurse who practices or offers to practice without a license. The penalty shall be increased from a misdemeanor to a gross misdemeanor. (BDR 54-1243)

As discussed earlier, the committee received information on PAS and the significance of these services in the enhancement of the dignity, quality of life, and productivity of persons with disabilities.

In most program models, funding sources require PAS to be administered and/or supervised by licensed nursing personnel. According to testimony from the disabled community, this policy contributes to higher health care costs and furthers the dependence of the disabled person on medical professionals. Instead, persons with disabilities prefer to manage their own PAS without medical supervision and the costly administrative structures in which a contract agency assumes varying degrees of responsibility for managing the PAS. Because personal assistants are not licensed by the state, advocates proposed to allow personal assistants to perform non-medical services without adherence to laws and regulations of the "Nurse Practice Act."

Amend NRS to add a definition of "personal assistant," authorize a person with a disability who is not residing in a licensed facility to utilize the services of a personal assistant, and exempt personal assistants from Chapter 632 of NRS. (BDR 54-1249)

Accessibility and Affordability of Health Care

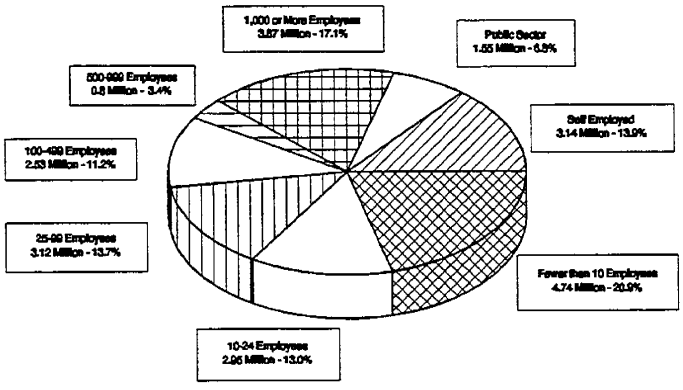
Rapid escalation of health care costs have posed serious problems for all purchasers of health insurance. However, the problems have been especially severe for small employers seeking coverage for their employees. Small firms with one or more high-risk employees or in certain occupational categories often have difficulty obtaining coverage at any price.

There are a number of factors that contribute to the disadvantage of small employers in the health insurance market. Because fixed costs are spread over fewer people, it is more expensive for insurers to market and service small groups. Small firms typically pay more for coverage because an insurer's administrative costs account for as much as 25 percent of total costs, compared with less than 10 percent for larger employers. Additionally, small employers face higher costs because they represent a minor portion of an insurer's business. As a result, these businesses are in a poor position to negotiate lower prices. Furthermore, insurers are using rating practices that increasingly segment risk. Instead of grouping many small businesses together, insurers tend to calculate each small employer's premiums based solely on its expected expenses. This practice creates a problem for small groups which must spread the cost of care over fewer people. Under this structure, one high-cost medical episode could significantly raise the group's premiums or cause coverage to be denied.

Because of the many barriers encountered in acquiring insurance, small business employees and their dependents represent a large proportion of the uninsured population. The Employee Benefit Research Institute estimates that in 1993, nearly one-half of all uninsured workers in private firms were either self-employed or working in firms with less than 25 workers.

WORKERS AGED 18-64 WITHOUT HEALTH INSURANCE BY FIRM SIZE, 1993

1993 - 22.7 Million Uninsured Workers

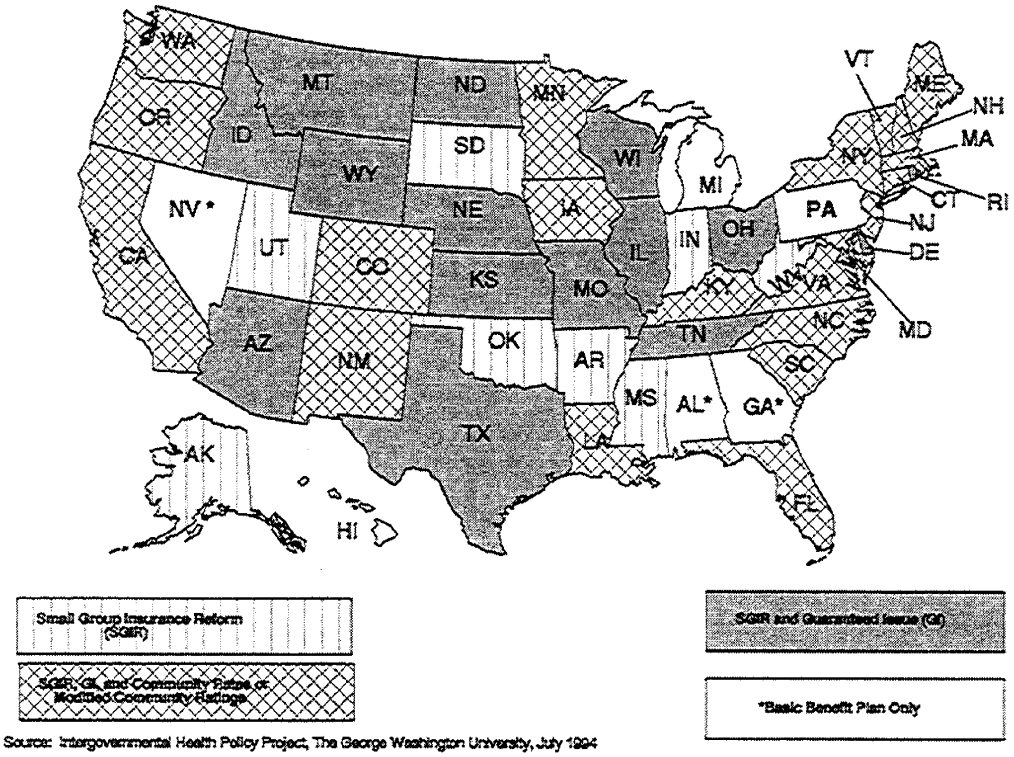


Note: Firm size distributions include private sector workers only.

Source: Employee Benefit Research Institution analysis of the March 1994 CPS

As states search for approaches to decrease the uninsured population, small group insurance reform has become a popular strategy. As reported by the Intergovernmental Health Policy Project (IHPP), 47 states, including Nevada, had enacted some form of small group reform by July 1994.

SMALL GROUP INSURANCE REFORM



Source: Intergovernmental Health Policy Project, The George Washington University, July 1994

In 1991, the Nevada Legislature passed legislation to allow insurers to issue lower cost "bare bones" health insurance policies to qualified small employers. Although bare bones policies are exempt from mandated benefits, they also offer relatively low annual and lifetime maximum payouts. Similar to other states' experience, the impact of bare bones coverage has been very limited. To date, two insurers have been approved to sell such a product; however, only one company has sold any policies. At one time, these policies covered 22 employees from six employer groups, but now insure only three employees from one employer group. Anecdotal evidence seems to indicate that the cost of the policies, which are underwritten, continued to be unaffordable for small employers.

The committee was encouraged by testimony from reform-minded state legislators in Florida, Maine, Minnesota, and Vermont to build upon Nevada's efforts in the small employer health insurance market. Many states have used or adapted model legislation developed by the National Association of Insurance Commissioners to achieve their legislative goals. Some of the most common reforms contained in the model that states have implemented include:

- Limitations on the variability of rates (rating bands or community rating);
- Standards to assure fair marketing;
- Requirements to offer coverage to all businesses during some period of the year (guaranteed issue);
- Rules regarding renewability of coverage (guaranteed renewal);
- Guarantee of continuous coverage without waiting periods for individuals moving between plans (portability);
- Limitations on the use of preexisting condition exclusions;
- Provisions for the development of "basic" and "standard" benefit plans that must be offered to all small employers; and
- Provisions for the establishment of a reinsurance program or risk adjustment mechanism.

As a result, the committee recommended that the 68th Session of the Nevada Legislature:

Amend NRS to increase the availability and affordability of health insurance for small employers through market reforms. These reforms include, but are not limited to, guaranteed issue and renewability, modified community rating, portability, and risk adjustment provisions. (BDR 57-1238)

Health insurance provides access to health care services, which is especially crucial to pregnant women. Many studies have demonstrated that prenatal and obstetrical care decrease the rates of low-birth-weight babies and infant mortality. For every low-birth-weight birth averted by earlier or more frequent prenatal care, the Office of Technology Assessment estimates that the

U.S. health care system saves between $14,000 and $30,000 in newborn hospitalization, rehospitalizations in the first year, and long-term care costs.

Private health insurance is the primary source of coverage for pregnant women. According to the March 1990 Current Population Survey, approximately 60 percent of pregnant women were covered by private insurance either as employees or as dependent spouses. Another 6 percent of pregnant women had non-group, private coverage. However, access to private health insurance benefits is threatened by the increasing cost of health care, cost shifting by providers, and insurance marketing practices that tend to deny coverage to high-risk individuals.

Thus, the committee recommended that the 1995 Nevada Legislature:

Amend Chapters 689A, 689B, 695B, and 695C of NRS to mandate that all health insurers in the state include coverage of obstetric and prenatal care services. (BDR 57-1245)

As a prerequisite to developing workable, realistic reform plans, legislators and policymakers need accurate and detailed information on the availability and utilization of services; costs by provider; methods of payment; and quality of care. To facilitate the collection of this data, several states have enacted legislation requiring hospitals, insurers, and other providers to submit information such as the type of services provided; charges; patient information and outcomes; and type of insurance coverage.

According to the National Association of Health Data Organizations, 36 states mandated the collection of information on charges, payments, and utilization in 1993. States have a variety of objectives and methods for gathering health care data. Some data bases provide information for rate-setting decisions while others measure provider supply and demand. Data collection may be centralized in one agency or allocated across several entities.

The National Association of Health Data Organizations reports that hospital discharge data is the most commonly collected health information by states. Similarly, Nevada's current collection efforts focus primarily on evaluating hospital cost containment efforts by analyzing inpatient hospital billed charges, net revenues, operating costs and profits as well as utilization statistics. As the changes in health care delivery and financing occur, policymakers require more reliable, accurate, and timely data from a greater variety of sources. Therefore, the committee recommended that the 1995 Nevada Legislature:

Require the Department of Human Resources to collect information on the cost, outcomes, and quality of health services. Among other responsibilities, the DHR must determine the types of providers required to participate, develop a list of data elements to be collected from providers, and disseminate information to the public. The DHR shall coordinate its efforts with other data collection activities conducted in other state agencies which collect health-related financial, service, utilization, and health care personnel data. (BDR 40-1251)

Although most would welcome some type of federal health reform, many states have developed and implemented their own comprehensive, statewide health care reform agendas. State governments have a major stake in the financing and delivery of health care and are reluctant to assume that federal reform will allow the states flexibility to address their unique needs. While the committee was not prepared to formulate the details of a state health care reform plan, the members agreed to express support for reform in certain broad areas of the health care environment. Therefore, the committee voted to:

Include a statement in the committee's final report acknowledging the need for a state health care reform plan that addresses access and coverage, individual responsibility and choice, insurance reform, payment and cost control, quality of care, and tort reform.

Health Care Work Force

Medical Malpractice Insurance Subsidies

The issue of diminished provider availability in underserved areas has led states to respond to concerns regarding the high cost of malpractice premiums, especially related to prenatal and obstetrical care. As of July 1994, IHPP reported that 19 states offer some form of malpractice premium relief.

Family practice physicians, nurse practitioners, and physician assistants are an important source of care in underserved communities. Malpractice insurance coverage for prenatal and obstetrics care results in a large increase in rates for providers. For example, a family practice physician practicing in southern Nevada must pay approximately $14,000 more in yearly malpractice premiums for obstetrics coverage. A 1987 survey by the American College of Obstetricians and Gynecologists indicated that nearly half of rural family practice physicians in Nevada had quit practicing obstetrics because of liability risks. Another factor linked to provider availability is the perceived threat of a lawsuit by certain

populations. Although unsubstantiated, many providers believe that caring for Medicaid and indigent patients exposes them to greater liability, particularly since those patients tend to be at a greater risk of a poor obstetric outcome. Because of these reasons, access to care has decreased, especially for low-income pregnant women in many rural and medically underserved areas.

Currently, the malpractice premium subsidy program exists in statute. However, this program has never been operational due to a lack of funding. As a result, the committee recommends that the 68th Session of the Nevada Legislature:

Amend Chapter 442 of NRS and provide for an appropriation to the medical malpractice premium subsidy program that provides payment of insurance premiums for physicians and mid-level providers supplying obstetrical services in rural or underserved areas of the state. (BDR 40-1246)

State Supply of Health Care Professionals

The Pew Health Professions Commission reports that the labor force will grow only 18.5 percent by the year 2005 while the demand for health care workers may increase nationally by 50 percent. In addition to the anticipated growth in the overall health care work force, new health care reforms and cost control initiatives will continue to increase the demand for primary care providers. For instance, most states are expanding their Medicaid managed care programs, and nearly 50 percent of privately insured employees are now enrolled in managed care plans. According to the Group Health Association of America, about 75 percent of HMOs report difficulty in recruiting primary care physicians.

While the University of Nevada's School of Medicine focuses on graduating primary care physicians, the committee concluded that current and specific data should be collected on Nevada's overall health work force to facilitate policymaking in this area. Therefore, the committee recommended that the 68th Session of the Nevada Legislature:

Amend Chapter 439A of NRS to require that DHR conduct a study of the health manpower needs in the state, including primary care physicians, mid-level practitioners, and allied health professionals as defined in the U.S. Public Health Service Act. The report must be submitted to the Legislative Committee on Health Care and the University of Nevada School of Medicine on July 1 of each even-numbered year. (BDR 40-1247)

Allied health professionals include occupations such as certified nurse anesthetists, medical laboratory technicians, occupational therapists, physical therapists, physician assistants, radiation therapy technologists, and speech pathologists. According to the Pew Health Professions Commission, more than 60 percent of the country's 10.5 million health care workers represent nearly 200 allied health groups.

The health care system is making dramatic use of allied health providers, particularly in underserved rural areas and inner cities. Currently, 50 percent of health care services are provided by people who are not physicians. These practitioners can offer significant improvements in access as well as curb the cost of health care. Despite their usefulness, the American Hospital Association has reported shortages in many of the allied health fields. To many work force experts, one solution for states is to adopt strategies designed to heighten interest in these careers by targeting high school students. Therefore, the committee recommended that the 1995 Nevada Legislature:

Require, by statute, that school districts in counties whose population exceeds 35,000 establish programs to stimulate the development of allied health professionals as defined in the U.S. Public Health Service Act. The school districts must enter into necessary agreements with the University and Community College System of Nevada to accept college credit for relevant courses successfully completed by high school juniors and seniors. (BDR 34-1248); and

Adopt a resolution to encourage the Board of Regents of the University and Community College System of Nevada to accept high school courses as credit towards an allied health profession degree. (BDR R-1367)

Other Issues

Maternal and Child Health

Although no actual figures are available in Nevada, it is estimated that between 11 and 16 percent of Nevada newborns were prenatally exposed to drugs or alcohol. In 1991, these percentages correspond to a range of 2,395 to 3,484 births. Research by the U.S. General Accounting Office concluded that the number of alcohol and drug exposed infants may be severely underestimated. As a result of substance abuse exposure, many of these newborns require 4 to 6 weeks of hospitalization at a cost of $30,000 or more.

In some instances, there are additional long-term costs for aftercare, foster care, and special education.

The problem of drug and alcohol exposed infants was studied in depth by the perinatal substance abuse subcommittee of the Governor's Commission on Substance Abuse, Education, Prevention, Enforcement and Treatment. The subcommittee documented the damaging effects of perinatal substance abuse on children and society in a July 1993 report. Because the Governor's Maternal and Child Health (MCH) Advisory Board has the authority to address perinatal substance abuse issues, the subcommittee proposed the creation of a permanent subcommittee to the MCH Advisory Board. To strengthen relevant efforts occurring in the Health Division, the proposal also included the establishment of a formal perinatal substance abuse prevention program within the Health Division. Therefore, the committee recommended that the 68th Session of the Nevada Legislature:

Amend Chapter 442 of NRS to require the Governor's Maternal and Child Health Advisory Board to create a subcommittee on perinatal alcohol, tobacco, and other drug use. In addition, amend Chapter 442 of NRS to establish a perinatal alcohol, tobacco, and other drug use prevention program within the Health Division. A position of program coordinator shall be created to carry out the objectives of the program. (BDR 40-1244)

In addition, the MCH Advisory Board presented the committee with several other recommendations affecting the maternal and child health population in Nevada. Many of the recommendations were directly related to funding of certain programs or initiatives. Although the Committee on Health Care is primarily charged with overseeing policy not funding matters, the members of the committee agreed to endorse the value of two programs of importance to the health of mothers and children in the state. Therefore, the committee voted to:

Include a statement in the committee's final report urging the Legislature to support the continuation of the Baby Your Baby project, with full implementation by the Health Division and Medicaid. Specifically, the Health Division should continue to provide toll-free telephone referral services and coordinate the recruitment of prenatal care providers for participants in rural and frontier areas. In addition, the Welfare Division should continue to receive public and private donations to fund multimedia outreach efforts to promote early entry into prenatal care; and

Include a statement in the committee's final report endorsing continued legislative support for adequate funding of services for children with special health care needs, including the Special Children's Clinics and the Newborn Screening program.

Rural Health Issues

During the committee's deliberations on Medicaid managed care, a subcommittee was formed to discuss the unique circumstances of instituting a mandatory managed care program in rural Nevada. While the subcommittee and its participants debated the feasibility of managed care in a rural environment, the group emphasized that fundamental differences existed between rural and urban areas regarding the organization, financing, and delivery of health care services. For example, the issues of provider recruitment and retention, scope of practice for nonphysician providers, and transportation profoundly impact the availability and accessibility of health care services in rural communities. To acknowledge the extraordinary challenges present in providing rural Nevadans with quality health care services, the subcommittee proposed the creation of a permanent rural health subcommittee to the Legislative Committee on Health Care. Therefore, the committee recommended that the 68th Session of the 1995 Legislature:

Amend Chapter 439B of NRS to establish a rural health advisory subcommittee to the Legislative Committee on Health Care. The subcommittee must be comprised of various individuals appointed by the chairman for a 2-year term. All members shall serve without compensation, per diem allowances, or travel expenses. The chairman shall appoint:

a. **Not more than two representatives of federally-funded rural health clinics;**
b. **Not more than two representatives of rural hospitals;**
c. **Not more than two representatives of public health service providers;**
d. **Not more than two representatives of rural nursing homes;**
e. **Not more than two representatives of rural physicians;**
f. **Not more than two representatives of rural home health providers;**
g. **Not more than two representatives of rural health care providers;**
h. **Not more than two representatives of rural hospital trustees;**

i. **Not more than two representatives of the Center for Education and Health Services Outreach, University of Nevada School of Medicine;**

j. **Not more than two representatives of consumers of rural health services; and**

k. **Not more than two members of the Legislative Committee on Health Care, one of which shall serve as chair of the subcommittee. (BDR 40-1250)**

APPENDICES

APPENDIX A

Senate Bill 559

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Senate Bill No. 559—Committee on Finance

CHAPTER 620

AN ACT relating to welfare; revising the statute governing the qualifications of members of the legislative committee on health care; requiring the legislative committee on health care to conduct a study to develop a coordinated care system for recipients of Medicaid; directing the department of human resources to establish such a program; prescribing the purposes of the program; and providing other matters properly relating thereto.

WHEREAS, The legislative committee on health care provides continuous oversight of matters relating to health care; and

WHEREAS, It is important to encourage participation on the legislative committee on health care of persons with the appropriate experience and knowledge of matters relating to health care; and

WHEREAS, The cost for medical care coverage for Medicaid-eligible patients is increasing at a rapid and unpredictable rate; and

WHEREAS, The number of Medicaid-eligible patients is also increasing at a rapid and unpredictable rate; and

WHEREAS, The need for health care reform is a national concern and the State of Nevada desires to be on the forefront of such reform; and

WHEREAS, The University of Nevada School of Medicine has 10 years of important and successful experience in a coordinated care program that currently serves 25 percent of the state's recipients of Aid to Families with Dependent Children; now, therefore,

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

Section 1. NRS 439B.200 is hereby amended to read as follows:

439B.200 1. There is hereby established a legislative committee on health care consisting of three members of the senate and three members of the assembly, appointed by the legislative commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.

2. No member of the committee may:

(a) Have a financial interest in a health facility in this state;

(b) Be a member of a board of directors or trustees of a health facility in this state;

(c) Hold a position with a health facility in this state in which the legislator exercises control over any policies established for the health facility; or

(d) Receive a salary or other compensation from a health facility in this state.

[This subsection does not prohibit]

3. The provisions of subsection 2 do not:

(a) Prohibit a member of the committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.

[3.] *(b) Prohibit a member of the legislature from serving as a member of the committee if:*

(1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and

(2) Serving on the committee would not materially affect any financial interest he has in a health facility in a manner greater than that accruing to any other person who has a similar interest.

4. The legislative commission shall select the chairman and vice chairman of the committee from among the members of the committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The chairmanship of the committee must alternate each biennium between the houses of the legislature.

[4.] *5.* Any member of the committee who does not return to the legislature continues to serve until the next session of the legislature convenes.

[5.] *6.* Vacancies on the committee must be filled in the same manner as original appointments.

[6.] *7.* The committee shall report annually to the legislative commission concerning its activities and any recommendations.

Sec. 2. 1. The legislative committee on health care shall conduct a study to evaluate and develop a mandatory coordinated care medical system for all persons covered by the State of Nevada's Medicaid program. The study must include:

(a) An evaluation of the systems available to provide medical care to recipients of Medicaid;

(b) A review of the sources of available funding for a coordinated care system and the various methods of compensating providers of health care;

(c) An evaluation of the methods of containing the costs of providing medical care to recipients of Medicaid;

(d) The impact that a coordinated care medical system may have on the revenue received from the tax on hospitals imposed pursuant to NRS 422.383 and an analysis of the methods that may be used to replace lost revenues, if any; and

(e) The committee's recommendations for establishing a mandatory coordinated care program by July 1, 1995, to serve persons participating in the state's Medicaid program.

2. The legislative committee on health care shall:

(a) Report its recommendations to the governor and the department of human resources on or before July 1, 1994; and

(b) Submit quarterly reports to the interim finance committee concerning the progress of its study, its recommendations for establishing a coordinated care program and the implementation of the demonstration project and coordinated care program established pursuant to subsection 3.

3. The department of human resources shall, with the consent of the interim finance committee:

(a) Seek all necessary approvals and waivers and establish and conduct a demonstration project pursuant to section 1115 of the Social Security Act, 42

U.S.C. § 1315, in compliance with those recommendations of the legislative committee on health care that are approved by the governor. The purposes of the demonstration project must be to:

(1) Reduce the rate of growth in the overall costs of medical care over the long term;

(2) Improve access to primary and preventative health care for the Medicaid population;

(3) Institute health education programs for the Medicaid population; and

(4) Mainstream the Medicaid population into a coordinated care program with a balance of public and private members;

(b) Establish a mandatory coordinated care program not later than July 1, 1995; and

(c) Enroll all recipients of Aid to Families with Dependent Children upon the commencement of the program, with phased-in enrollment of the Aged, Blind and Disabled populations by the end of the second year of the program.

4. The coordinated care program established pursuant to subsection 3 must include participation by the University of Nevada School of Medicine in the development and implementation of the program, as well as in the delivery of services. The department of human resources shall cooperate with the University of Nevada School of Medicine to assist in the provision of an adequate and diverse patient population on which the school can base educational programs, including programs that support the education of generalist physicians. The University of Nevada School of Medicine may establish a nonprofit organization to assist in the research necessary for the program, receive and accept gifts, grants and donations to support the program and assist in establishing educational services for patients.

5. The director of the department of human resources shall report to the interim finance committee and the legislative committee on health care quarterly concerning the demonstration project and the coordinated care program established pursuant to this section.

6. As used in this section, "Medicaid" means the program established pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

Sec. 3. This act becomes effective upon passage and approval.

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APPENDIX B

Suggested Legislation

(The bill draft requests are not available as of this publication date.)