Legislative Committee on Health Care

Legislative Counsel Bureau

Bulletin No. 97-14

January 1997

LEGISLATIVE COMMITTEE ON HEALTH CARE

BULLETIN NO. 97-14

JANUARY 1997

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SUMMARY OF RECOMMENDATIONS

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

1. **Amend Chapter 449 ("Medical and Other Related Facilities") of *Nevada Revised Statutes* (NRS) to include the following items:**

   - **Require the Health Division, Department of Human Resources, to seek criminal background information from owners and employees of residential facilities for groups;**

   - **Authorize the Health Division to charge owners and employees for the cost of the criminal background investigation;**

   - **Require owners and employees of residential facilities for groups to present their fingerprints to the Health Division for submission to the Central Repository for Nevada Records of Criminal History and the Federal Bureau of Investigation (FBI);**

   - **Direct the Health Division to notify the administrator and the owner of a residential facility for groups of any employee whom it discovers has been convicted of a felony or a crime involving moral turpitude; and**

   - **Authorize the Health Division to deny a license to an owner and to prohibit an owner from employing a person who has been convicted of a felony or a crime involving moral turpitude.**

   Furthermore, the Health Division may impose a fee upon a person investigated to offset the cost of the investigation in an amount not to exceed $50. (BDR 40-493)

2. **Include a statement in the committee's final report regarding the issue of a state agency providing ombudsman services to managed care consumers and providers.**

3. **Include a statement in the committee's final report regarding the issue of prohibiting "gag clauses" in contracts between health care providers and managed care entities.**

4. Include a statement in the committee's final report regarding the issue of requiring managed care plans to reimburse, without prior authorization, nonemergency care provided in an emergency care setting or emergency care rendered by a nonparticipating plan provider, if the individual could reasonably infer that the condition was an emergency.

5. Include a statement in the committee's final report regarding the issue of requiring managed care plans to provide to consumers, either at the time of enrollment in a health plan or upon request, information related to access to health care through primary care physicians and specialist providers; the referral and utilization review process; provider payment structures; and a description of any financial disincentives within provider agreements for referring enrollees to services.

6. Urge, by resolution, that the State Welfare Board increase Medicaid reimbursement for dental services to encourage greater provider participation. (BDR R-495)

7. Amend Chapter 397 ("Western Regional Higher Education Compact") of NRS to authorize the Nevada Western Interstate Commission for Higher Education (WICHE) to require, as a term of any loan provided to certain WICHE recipients, that the recipient perform community service to the medically underserved population for a specified period of time upon returning to practice in Nevada. The budget committees of the Legislature will determine the period of time that each recipient will be required to perform community service. In return, WICHE may forgive the loan portion of the financial support. In the event a recipient is not licensed by the state and cannot practice his or her profession, the loan period may be extended. (BDR 34-494)

8. Include a statement in the committee's final report and survey the mailing list members regarding the issues of a "Medically Needy Fund" to finance the provision of community-based, comprehensive primary care services to indigent or uninsured Nevadans. Direct patient care services covered by the fund will include: (1) counseling (family, mental health, and substance abuse); (2) dental services (preventive and restorative); (3) health education, preventive health services, and referrals; (4) outreach services; (5) pharmacy; (6) transportation services; (7) treatment of minor illnesses; (8) well-child care and immunizations; and (9) x-rays. A portion of the funds, as determined by the Department of Human Resources, may

be used to finance infrastructure and capacity building activities (e.g., equipment, health care practitioner salaries, et cetera).

The Department of Human Resources will be required to administer the fund and contract with qualified community-based health centers to provide comprehensive primary care services. Such centers shall include: (1) Federally Qualified Health Centers (FQHCs); (2) FQHC "look alikes", designated by the Federal Bureau of Primary Health Care and recognized by the U.S. Health Care Financing Administration; (3) Title V-funded Urban Indian Health Clinics; (4) Tribal Health Centers/Clinics on reservations or colonies; (5) the Primary Care Case Management program affiliated with the University of Nevada's School of Medicine; and may include, (6) community-based clinics or programs of larger organizations (hospitals, medical groups, or primary care clinics) that provide primary care services on a sliding fee schedule and at least 20 percent of the services provided are uncompensated.

9. Require, by statute, that the Department of Human Resources mandate health maintenance organizations (HMOs) participating in any Medicaid managed care program contract with a FQHC and the Primary Care Case Management program affiliated with the University of Nevada's School of Medicine to guarantee a safety net of primary care services and a continuum of care to its enrollees. (BDR 38-794)

REPORT TO THE 69TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE

INTRODUCTION

In accordance with *Nevada Revised Statutes* (NRS) 439B.200 through 439B.240, the Legislative Committee on Health Care oversees a broad spectrum of issues related to the quality, access, and cost of health care for all Nevadans.

The six-member committee held seven meetings between October 1995 and August 1996 in Carson City, Reno, and Las Vegas. All place-names are in Nevada unless otherwise noted. Over the course of the meetings, the committee discussed a wide variety of topics. At the work session, the members adopted nine recommendations covering issues such as criminal background checks for group home owners and employees; Medicaid reimbursement for dental services; community service stipulations for Western Interstate Commission for Higher Education (WICHE) recipients; and contracting requirements for Medicaid managed care Health Maintenance Organizations (HMOs).

The members of the committee during the 1995-1997 interim included:

Assemblywoman Vivian L. Freeman, Chairman
Senator Maurice E. Washington, Vice Chairman
Senator Bob Coffin
Senator Raymond D. Rawson
Assemblywoman Maureen Brower
Assemblywoman Jan F. Monaghan

Legislative Counsel Bureau staff services were provided by:

Kerry Carroll Davis, Senior Research Analyst
Marla L. McDade, Research Analyst
Risa L. Berger, Principal Deputy Legislative Counsel
Linda Chandler Law, Senior Research Secretary

BACKGROUND CHECKS FOR OWNERS AND EMPLOYEES OF RESIDENTIAL FACILITIES FOR GROUPS

In response to the growth in the senior population and concern for quality of care in the long-term care industry, the 1993 Legislature passed a measure that requires administrators of residential facilities for groups to be licensed. To apply for licensure, NRS 654.155 ("Qualifications of applicant for licensure as administrator of residential facility for groups") mandates applicants provide a set of fingerprints for submission to the Federal Bureau of Investigation (FBI) and pay a fee to cover the cost of the investigation. Through this new licensure process, the Bureau of Licensure and Certification, Health Division, reported that several investigations revealed the existence of convictions for various crimes involving physical abuse, including battery and rape. As a result, some administrators chose not to apply for licensure or left the state.

While the 1993 law covered administrators, it did not include owners and employees of these facilities. Employees are screened and hired by administrators, who are held responsible for employee actions through their licenses. No mechanism exists to investigate the criminal histories of group home owners, who may not be the same person as the administrator. Under *Nevada Administrative Code* (NAC) 449.177 and 449.2772 (both sections titled "Application for license"), the Health Division "shall conduct an investigation into the . . . qualifications of personnel . . ." upon receipt of an application for a license to operate a residential facility for groups. For facilities with less than seven residents, NAC 449.27745 ("Administrator; employees") allows the division to "request a local law enforcement agency to conduct an investigation into the background of an employee or potential employee." While these provisions permit the state to examine an individual's past to some extent, the Division has no explicit legal authority to perform state criminal or FBI background checks.

The committee received testimony from Sharon Ezell, Chief, Bureau of Licensure and Certification, Health Division, and Suzanne Ernst, former Administrator, Aging Services Division, that some owners of group homes are currently paying for criminal background checks and believe this practice is beneficial for the industry. Because the owner and the employee would be required to pay for such an investigation, committee members were concerned about the cost of the background checks. Testimony indicated that a satisfactory investigation could be conducted for $50 or less per person, which was a fee level supported by the members.

Because elderly and frail persons in group care homes are especially vulnerable to exploitation and abuse, the committee recommended that the 1997 Legislature:

Amend Chapter 449 ("Medical and Other Related Facilities") of NRS to include the following items:

- **Require the Health Division, Department of Human Resources, to seek criminal background information from owners and employees of residential facilities for groups;**

- **Authorize the Health Division to charge owners and employees for the cost of the criminal background investigation;**

- **Require owners and employees of residential facilities for groups to present their fingerprints to the Health Division for submission to the Central Repository for Nevada Records of Criminal History and the Federal Bureau of Investigation;**

- **Direct the Health Division to notify the administrator and the owner of a residential facility for groups of any employee whom it discovers has been convicted of a felony or a crime involving moral turpitude; and**

- **Authorize the Health Division to deny a license to an owner and to prohibit an owner from employing a person who has been convicted of a felony or a crime involving moral turpitude.**

Furthermore, the Health Division may impose a fee upon a person investigated to offset the cost of the investigation in an amount not to exceed $50. (BDR 40-493)

REGULATION OF THE MANAGED CARE INDUSTRY

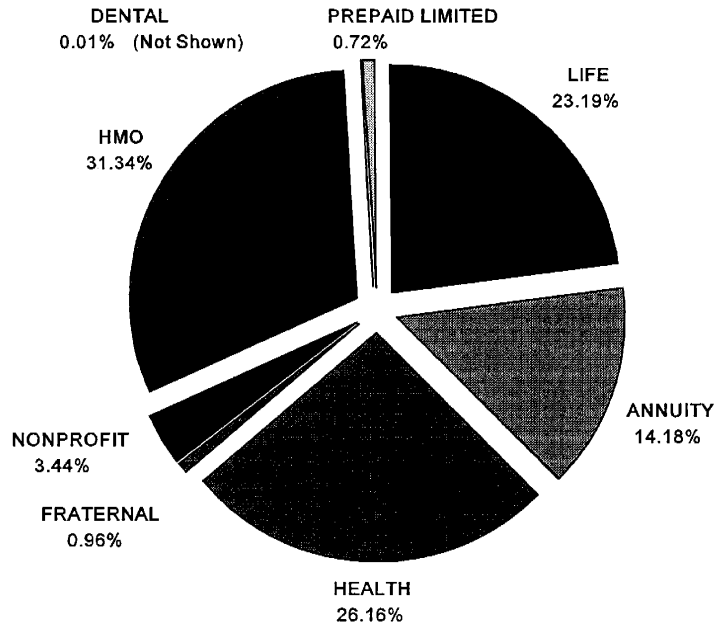
Managed care is a rapidly growing industry across the country and in Nevada. Several surrounding western states have some of the highest percentages of their state populations enrolled in HMOs. The *Interstudy Competitive Edge: HMO Industry Report 6.2* lists 1996 penetration rates for Arizona, California, Oregon, and Utah at 29.0 percent, 40.3 percent, 44.8 percent, and 30.1 percent, respectively. While Nevada's HMO penetration rate (over 18 percent) is not as high as some of its neighbors, the state has experienced significant growth in the managed care industry. During the last two years,

the number of licensed HMOs in Nevada has doubled. Currently, the state has 12 licensed HMOs, with other national companies interested in applying for licensure. In calendar year (CY) 1995, the gross direct premiums written for HMO coverage increased nearly 50 percent, from $252.7 million in CY 1994 to $499.0 million.

In addition to HMOs, managed care arrangements now encompass a wide range of other provider service networks, including independent physician associations (IPAs) and physician hospital organizations (PHOs). At this time, Nevada does not license these alternate types of managed care arrangements, therefore, it is difficult to quantify the growth in these new categories of managed care organizations.

Gross direct premium and market share data for calendar year 1995 are represented in the following chart and table.

CY 1995 GROSS DIRECT PREMIUMS WRITTEN
All Business Written
(Source: National Association of Insurance Commissioners and Company Annual Reports)



Market Share Premium Written NAIC Companies						
NRS 688A, 688B	Life Premiums				$	369,148,374
688A	Annuity Considerations				$	225,819,313
689A, 689B	Health				$	416,462,800
		Subtotal			$	1,011,430,487
695A	Fraternal Benefit Societies **	Subtotal			$	15,213,739
695B	**Nonprofit Organizations**					
	Blue Cross/Blue Shield*				$	50,097,389
	Hometown Health Providers				$	1,910,068
	Vision Service Plan				$	2,720,530
		Subtotal			$	54,727,987
695C	**Health Maintenance Organizations**			without Medicare		with Medicare
	HPN*		$	153,935,365	$	267,468,309
	FHP		$	38,634,000	$	129,250,000
	HHP*		$	42,223,602	$	46,425,874
	Nevada Health Visions		$	864,945	$	864,945
	John Alden			-		-
	Med One Health Plan		$	56,053	$	56,053
	SILMO Healthcare		$	16,601	$	16,601
	Nevadacare, Inc.			-		-
	Exclusive Health Care		$	5,493,321	$	5,493,321
	HUMANA		$	34,706,225	$	35,804,209
	HMO Colorado dba HMO Nevada		$	3,047,739	$	3,047,739
	St. Marys*		$	10,608,465	$	10,608,465
		Subtotal	$	289,586,316	$	499,035,516
695D	**Dental Care Organizations**					
	Safeguard				$	141,914
	Delta Dental				$	83,241
		Subtotal			$	225,155
695F	**Prepaid Limited Health Service Organizations**					
	Holman Mental				$	851,525
	Mutual of Omaha Preferred Dental				$	248,124
	NV. Pacific Dental				$	10,415,453
		Subtotal			$	11,515,102
		TOTAL			$	1,592,147,986

Source: National Association of Insurance Commissioners and Company Annual Reports
*Domestic companies are given a premium tax credit. **Does not pay premium tax.

The goal of managed care is to control rising health care costs without sacrificing the quality of care. With the swift proliferation of managed care arrangements, many groups are concerned that the quality of care delivered under managed care has suffered. Patients and providers have begun to pressure states for more regulation of the industry and its operations. In July 1996, the committee held two hearings that focused solely on the issues related to state oversight of the managed care industry in Nevada. While HMO representatives testified to the extensive level of regulation that governs their industry, physician and nursing groups along with consumers argued that more protections are needed to: (1) ensure access to fair and impartial procedures to address complaints; (2) prohibit plan denial of payment for nonemergency services rendered in an emergency setting, if the patient believed the condition was an emergency; (3) remove barriers to open physician-patient relationships; and (4) provide for full disclosure of information regarding health plan operations and provider compensation agreements.

At the work session, recommendations related to managed care were proposed as statutory changes requiring legislation. However, the committee heard strong opposition to instituting any new laws or regulations in this area. The opponents to new managed care legislation contended that the Insurance Commissioner currently has adequate statutory and regulatory authority to address all of the concerns raised during committee meetings. After much discussion, the committee conceded that the Legislature needs to thoroughly examine the appropriate role of the state in regulating the managed care industry in Nevada before legislation is recommended. However, the members wished to recognize that these issues are increasingly important given the growth of the industry in the state. As a result, the committee agreed that more study and analysis of managed care activities should occur during the 1997 Legislative Session.

While not recommending new legislation on these matters, the committee supported monitoring the effects of the growing managed care industry on the access to and quality of health care in the state. Therefore, the committee voted to:

Include a statement in the committee's final report regarding the issue of a state agency providing ombudsman services to managed care consumers and providers.

Include a statement in the committee's final report regarding the issue of prohibiting "gag clauses" in contracts between health care providers and managed care entities.

Include a statement in the committee's final report regarding the issue of requiring managed care plans to reimburse, without prior authorization, nonemergency care provided in an emergency care setting or emergency care rendered by a nonparticipating plan provider, if the individual could reasonably infer that the condition was an emergency.

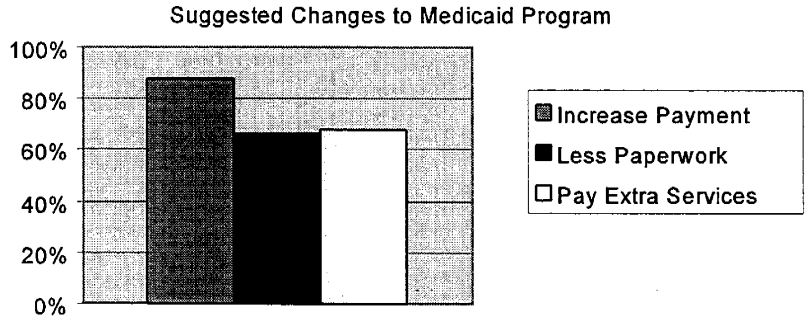
Include a statement in the committee's final report regarding the issue of requiring managed care plans to provide to consumers, either at the time of enrollment in a health plan or upon request, information related to access to health care through primary care physicians and specialist providers; the referral and utilization review process; provider payment structures; and a description of any financial disincentives within provider agreements for referring enrollees to services.

PROVIDER PARTICIPATION IN SERVING THE MEDICALLY INDIGENT

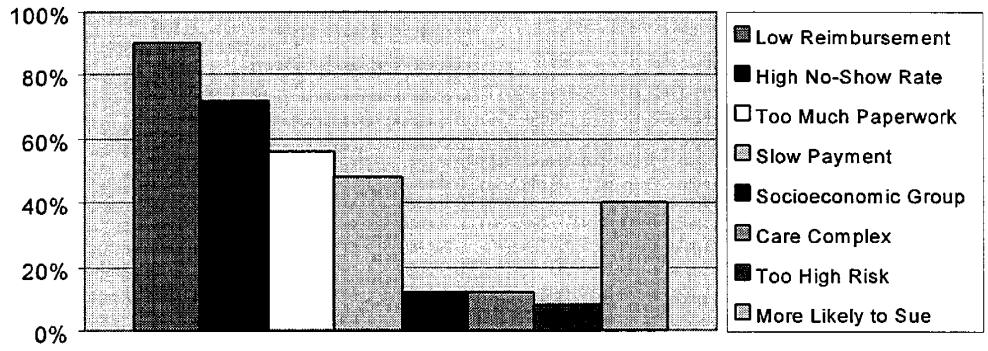
Many needy children in Nevada rely on public programs such as Medicaid to provide their health and dental care services. Most of the dental services financed by Nevada Medicaid are provided to children. However, access to preventive or emergency dental care for low-income children and adolescents is severely restricted by a lack of dental care providers willing to routinely serve this population.

In 1992, a youth oral health needs assessment was conducted for the Department of Human Resources by Cristman Associates. Among other issues, the study examined the reasons for the lack of dentists serving Medicaid and other low-income patients. According to a survey conducted by Cristman Associates for the assessment, 70 percent of dentists did not accept Medicaid patients, and the remaining 25 percent that accept Medicaid patients limit the numbers of these clients in their practices. More importantly, Cristman Associates found that 90 percent of respondents cited low reimbursement as the main deterrent to their participation with Medicaid. Correspondingly, nearly 90 percent of the responding dentists suggested that Medicaid reimbursement rates should be increased. These dentists submitted data to substantiate that Medicaid reimbursement rates were as low as one-third to one-half of usual and customary charges. Furthermore, approximately 70 percent of dentists advised that Medicaid should provide additional reimbursement for extra services.

Survey of Nevada Dentists



Obstacles to Dentists Participating in Medicaid



Source: Cristman Associates, 1992

In addition to the information in the Cristman report, Gary Mouden, Executive Director, Nevada Dental Association (NDA) and Yvonne Sylva, Administrator, Health Division, told the committee that low reimbursement rates are a primary reason that dentists are reluctant to serve Medicaid patients. For several years, the Health Division has operated a children's dental program for low-income children. In 1989, the Division switched its payment methodology from fee-for-service to Medicaid reimbursement levels. At that time, approximately 47 dentists were participating in the program; however, in 1996, only 28 dentists are serving children through the Division.

According to Nevada Medicaid, dentists have received general percentage increases in reimbursement rates along with other providers over the years. Most recently, Nevada Medicaid providers received a 5 percent increase in rates effective November 1, 1994, and a 2.5 percent increase effective October 1, 1996. However, dental rates have not been specifically targeted for raises to address the concerns of the dental community. As a result, the committee voted to encourage the 1997 Legislature to:

> **Urge, by resolution, that the State Welfare Board increase Medicaid reimbursement for dental services to encourage greater provider participation. (BDR R-495)**

In discussing the lack of access to dental care for low income children, Ron Sparks II, Director, Nevada office of Western Regional Higher Education Compact (WICHE), commented that he believed his office was being underutilized in addressing health and dental care access problems. He noted that WICHE operates a voluntary pro bono program for dentists, but it suffers from poor participation due to the low Medicaid reimbursement rates used to offset the dentists' student loans. Although three dentists presently are offering their services to the program, as many as ten dentists participated in the past.

Mr. Mouden from NDA also stressed that the financial difficulties faced by new dentists created a reluctance to serve Medicaid and other low income patients. He contrasted the profitability requirements of dentists with physicians. Given the student loan obligations and costs to establish a practice, Mr. Mouden explained that dentists require a greater level of reimbursement to cover their business expenses. He concluded that the trend for dentists providing services to the working poor and others who do not qualify for services under existing programs is to serve them through volunteer programs outside of their own practices where costs are lower.

In order to utilize WICHE to alleviate the problem of reaching medically underserved populations, Mr. Sparks suggested that the program require all students supported by WICHE to satisfy a community service obligation once they return to practice in Nevada. In return for their service, the loan portion of WICHE financial assistance will be forgiven. During the committee's deliberations, members discussed the need to encourage other health professionals to offer their services to medically indigent and uninsured persons. Because WICHE assists students pursuing a variety of health-related degrees, the members agreed that the recommendation should be broadened beyond dentistry to include all types of students supported by WICHE.

To facilitate that more providers serve medically indigent and uninsured persons, the committee proposed that the 69th Session of the Nevada Legislature:

> **Amend Chapter 397 ("Western Regional Higher Education Compact") of NRS to authorize the Nevada Western Interstate Commission for Higher Education (WICHE) to require, as a term of any loan provided to certain WICHE recipients, that the recipient perform community service to the medically underserved population for a specified period of time upon returning to practice in Nevada. The budget committees of the Legislature will determine the period of time that each recipient will be required to perform community service. In return, WICHE may forgive the loan portion of the financial support. In the event a recipient is not licensed by the state and cannot practice his or her profession, the loan period may be extended. (BDR 4-494)**

FUND FOR PRIMARY CARE SERVICES

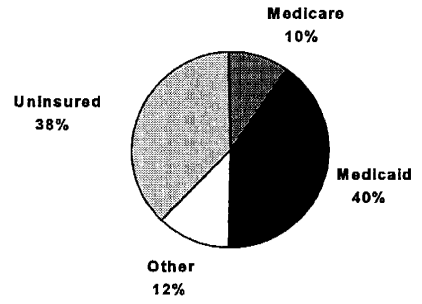
The changes taking place in the financing and delivery of medical care are having an enormous impact on "safety net" providers. Although no formal definition exists, Sara Rosenbaum, Director, Center for Health Policy Research, describes safety net providers as those who have a legal obligation to provide free or reduced rate health care to persons. The "safety net" consists of elements such as public hospitals; community, migrant and rural health centers; family planning clinics; the federal Ryan White AIDS program; the federal health care for the homeless program; public health departments; and

the joint federal-state Medicaid program. Many of these organizations or programs provide a comprehensive array of primary care and other services in locations where health care can be difficult to obtain.

Foremost among the pressures on these providers is the diminished level of federal, state, and local funding. Safety net providers such as community health centers (CHCs) rely heavily on Medicaid reimbursement.

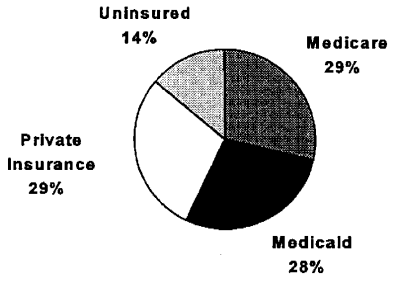
According to information provided to the committee, Medicaid provides 45 percent of revenue for the Community Health Centers of Southern Nevada and pays for approximately 41 percent of patients served by the Health Access Washoe County Community Health Center. Oftentimes, Medicaid is the only source of stable funding for safety net providers. Many believe Congressional proposals to replace the current Medicaid program with a modified block grant would result in the loss of coverage for many individuals.

Health Insurance Coverage among Patients at Community and Migrant Health Centers



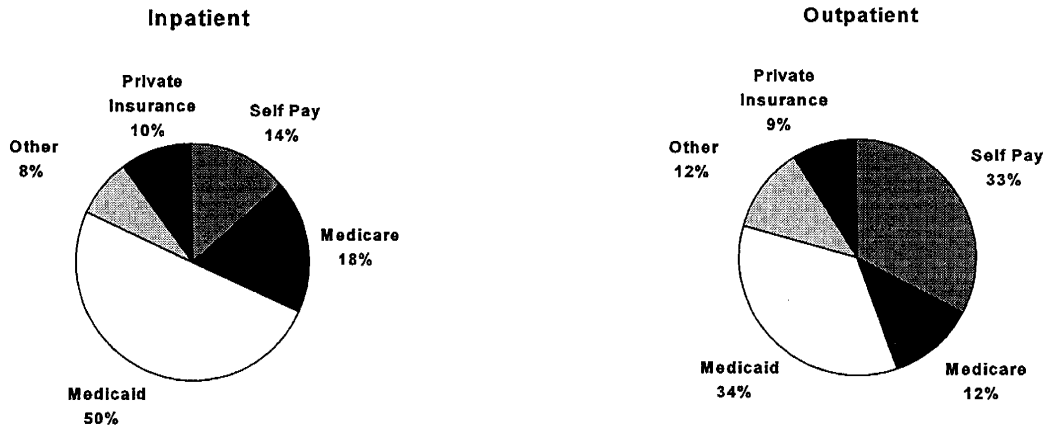
Source: Alliance for Health Reform Sourcebook, Fiscal 1994

Health Insurance Coverage among Patients at Rural Health Clinics



Source: U.S. Office of Rural Health Policy, Fiscal 1994

Public Hospitals: Sources of Revenue



Source: NAPH Report: *America's Essential Providers*, 1991

Compounding the problem of dwindling resources is an increase in the number of uninsured people. The *New England Journal of Medicine* reports that the trend is for less employer-based health insurance, which will not be compensated by an expansion of Medicaid as it was between 1988 and 1994. In addition, less charity care will be provided because of the fiscal difficulties of public health providers as well as the supplanting of nonprofit facilities by for-profit organizations. Uninsured people often have complex health problems such as AIDS and drug-resistant tuberculosis. For the uninsured or those with inadequate insurance, safety net providers are among the few places in the community to receive health care. These providers have little ability to tap other resources and cover losses due to low Medicaid rates or uninsured patients.

Furthermore, managed care plans represent a large and growing part of the public health system. According to The Robert Wood Johnson Foundation, a key problem for safety net providers is gaining access to managed care networks, which are rapidly becoming the choice of private and public payors. Public agencies and nonprofit organizations that serve large numbers of poor and special needs people often compete at a disadvantage with private health companies to offer managed care under Medicaid and other programs.

As a result of the committee's discussion regarding the role of community health centers, Dr. John Yacenda, Executive Director, Great Basin Primary Care Association, submitted a proposal to create a fund to finance primary care services for the indigent and uninsured populations. Although concerned about the suggested funding mechanism (a portion of

existing gaming revenues and an increase in the cigarette excise tax), the committee voiced support for such a fund. Because the concept of the fund was not fully reviewed at any meeting, the committee voted to survey interested persons, represented by those whose names appear on the mailing list, to seek further comments on the proposal. Therefore, the committee agreed to:

Include a statement in the committee's final report and survey the mailing list members regarding the issues of a "Medically Needy Fund" to finance the provision of community-based, comprehensive primary care services to indigent or uninsured Nevadans. Direct patient care services covered by the fund will include: (1) counseling (family, mental health, and substance abuse); (2) dental services (preventive and restorative); (3) health education, preventive health services, and referrals; (4) outreach services; (5) pharmacy; (6) transportation services; (7) treatment of minor illnesses; (8) well-child care and immunizations; and (9) x-rays. A portion of the funds, as determined by the Department of Human Resources, may be used to finance infrastructure and capacity building activities (e.g., equipment, health care practitioner salaries, et cetera).

The Department of Human Resources will be required to administer the fund and contract with qualified community-based health centers to provide comprehensive primary care services. Such centers shall include: (1) Federally Qualified Health Centers (FQHCs); (2) FQHC "look alikes", designated by the Federal Bureau of Primary Health Care and recognized by the U.S. Health Care Financing Administration; (3) Title V-funded Urban Indian Health Clinics; (4) Tribal Health Centers/Clinics on reservations or colonies; (5) the Primary Care Case Management program affiliated with the University of Nevada's School of Medicine; and may include, (6) community-based clinics or programs of larger organizations (hospitals, medical groups, or primary care clinics) that provide primary care services on a sliding fee schedule and at least 20 percent of the services provided are uncompensated.

Survey Results

In total, the committee received 26 survey responses. Overall, the concept of a medically needy fund was supported by the respondents; however, respondents expressed concern regarding adequate financing mechanisms for the fund. The responses covered a wide range of issues, but most comments focused on broad policy or funding aspects of the proposal. The survey responses are briefly summarized below.

Policy Recommendations

Although not specifically mentioned in the proposal, several responses suggested other services that should be eligible for payment from the fund. Examples of such services were alcohol and drug rehabilitation services, cognitive pharmaceutical care, emergency services, home health care, laboratory, prosthetic devices, and reproductive care. It was also proposed that the fund support treatment for minor illnesses of children, including impetigo, middle ear and throat infections, and pink eye. However, other respondents indicated a preference that the fund not finance too many services because they believed the additional expense would render the program ineffective.

Another respondent also suggested that the program should promote access to the fund for all Nevada health care providers who currently offer medical care to indigent and uninsured populations. Alternatively, one respondent advocated the adoption of insurance reforms that would decrease the number of uninsured Nevadans and reduce the need for the fund.

Funding Recommendations

In terms of methods to finance this fund, four respondents recommended either increasing cigarette taxes or using existing cigarette taxes. Gaming revenues were cited as a possible source of taxation, including taxing one tenth of one percent of gross gaming revenue or earmarking 2 to 3 percent of current General Fund gaming taxes. One respondent proposed a 50-cent per person transient lodging tax. Another recommendation was to earmark some of the state's surplus funds to provide infrastructure monies to existing safety net providers, thereby lowering their overhead expenses. Other suggestions involved a surtax on health care providers or facilities that accept state funds and do not provide at least 20 percent of their services as uncompensated care; a tax on out-of-state providers; and a ban on HMOs that are not based in the state.

Language Recommendations

Three respondents made detailed recommendations to reword the proposal's language. The comments are identified in the summary table in Appendix B.

Miscellaneous Comments

Following are some of the more specific comments that were submitted regarding the concept of the proposal:

- Certain health care professionals, such as hospital chief financial officers, were requested to participate directly in the decision making process for the medically needy fund;

- The program should be tied to a comprehensive study of the current and future Medicaid program as well as county medical services funding;

- Such a fund requires an in-depth analysis of the needs of the population to be served in comparison to existing funds and programs currently available at the federal, state, and local levels;

- Nevada's Medicaid program should be expanded to access available federal matching dollars; and

- Any new program that is established must be able to ensure accountability.

For additional information, Appendix B contains a copy of the survey that was sent to the mailing list members; a table summarizing all of the survey responses; and copies of each complete response submitted to the committee. Also attached are responses not included in the summary, which were received after the deadline for inclusion.

CONTRACTING REQUIREMENTS FOR MEDICAID MANAGED CARE

In the past three years, Nevada has attempted to expand its voluntary Medicaid managed care program through legislation and collaboration with the Department of Human Resources. The process began in 1993 when the Legislature passed Senate Bill 559 (Chapter 620, *Statutes of Nevada 1995*, pages 2590-2592). This measure required the Legislative Committee on Health Care to evaluate and develop a mandatory managed care system for all of Nevada's Medicaid recipients. The measure specified that the program be established in two phases. The first phase involved the enrollment of Aid to Families with Dependent Children (AFDC) recipients followed by the enrollment of the aged, blind, and disabled populations in the second phase. In addition, the DHR was directed to apply to the Federal Government for a Medicaid waiver to implement the plan. The intention of the legislation was to build upon the experience of the state's voluntary primary care case

management (PCCM) program by requiring Medicaid clients to be enrolled in a managed care plan. Furthermore, the Legislature considered that developing a statewide Medicaid managed care system would assist the state in any transition necessary under national health care reform initiatives.

The Committee on Health Care began its analysis in October 1993 and concluded its study with the adoption of several recommendations for establishing and implementing a comprehensive Medicaid managed care system. The recommendations were submitted to the Governor in July 1994 for consideration during the biennial budget process. The Governor's proposed Medicaid budget for the 1995-1997 biennium included most of the Health Care Committee's recommendations. The 1995 Legislature passed the Governor's proposed Medicaid budget and approved a General Fund appropriation of $12.8 million for the projected one-time costs associated with converting to a managed care delivery model. Shortly before the close of the session, federal officials approved Nevada's 1915(b) waiver application. The Department began the contracting process in anticipation of a January 1996 implementation date for phase one of the program.

However, in the fall of 1995, the DHR postponed and subsequently abandoned the waiver and its implementation deadlines due to the uncertainties of federal Medicaid funding, the potential for block grants, and the possibility of significant Congressional reform to Medicaid law. Given the unpredictable outcome of the federal Medicaid debate, the Department also had expressed uncertainty that there were an insufficient number of HMOs to provide competitive bids on the waiver contract.

During this interim (1995-1996), a subcommittee to the Nevada Legislature's Interim Finance Committee (IFC) evaluated and monitored the progress of the implementation of a Medicaid managed care system. As a result of further analysis and discussion with DHR, the subcommittee approved a remedial measure which would allow for the establishment of an "aggressive" voluntary managed care program for the AFDC population. This program would enable all willing providers (including HMOs) that bid within actuarially established capitated rate ranges to serve participants in Clark and Washoe Counties. The IFC approval was contingent on the understanding that the new voluntary program was an intermediate step towards the larger goal of implementing a mandatory program in the upcoming biennial budget process.

While the reasons for a delay in implementation were acknowledged by legislative members, the committee expressed its disappointment that the proposed voluntary program does not include some of the elements present in the federally approved 1915(b) waiver. The members commented on the efforts undertaken by last interim's Legislative Committee on Health Care as well as the 1995 Legislature to work diligently with DHR in crafting a waiver application that appealed to all parties. If an expanded Medicaid managed care program is going to be implemented, the committee contended that certain

tenets from the original agreement should be present in the new program. In particular, the members were interested in mandating contracted HMOs to include in their networks a FQHC and the PCCM program affiliated with the University of Nevada's School of Medicine to protect the patient bases of these organizations. Additionally, the committee voiced its concern that the state was not requiring all bidders to adhere to the "75/25" federal rule, which encourages contractors to mainstream Medicaid clients with their commercial patient base. Therefore, the committee recommended that the 1997 Legislature:

Require, by statute, that the Department of Human Resources mandate health maintenance organizations (HMOs) participating in any Medicaid managed care program contract with a FQHC and the Primary Care Case Management program affiliated with the University of Nevada's School of Medicine to guarantee a safety net of primary care services and a continuum of care to its enrollees. (BDR 38-794)

APPENDICES

APPENDIX A

Nevada Revised Statutes 439B.200-439B.240

LEGISLATIVE COMMITTEE ON HEALTH CARE

439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.

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.

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.

(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.

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

6. Vacancies on the committee must be filled in the same manner as original appointments.

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

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333; 1993, 2590)

REVISER'S NOTE.

Ch. 620, Stats. 1993, the source of paragraph (b) of subsection 3 of this section, contains the following preamble and provisions not included in NRS:

"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,"

"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."

WEST PUBLISHING CO.

Health and Environment ⇐ 3.
Officers and Public Employees ⇐ 30.3.
WESTLAW Topic Nos. 199, 283.
C.J.S. Health and Environment §§ 9, 10.
C.J.S. Officers and Public Employees § 29.

439B.210 Meetings; quorum; compensation.

1. The members of the committee shall meet throughout each year at the times and places specified by a call of the chairman or a majority of the committee. The director of the legislative counsel bureau or a person he has designated shall act as

the nonvoting recording secretary. The committee shall prescribe regulations for its own management and government. Four members of the committee constitute a quorum, and a quorum may exercise all the powers conferred on the committee.

2. Except during a regular or special session of the legislature, members of the committee are entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the committee or is otherwise engaged in the business of the committee plus the per diem allowance provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207.

3. The salaries and expenses of the committee must be paid from the legislative fund.

(Added to NRS by 1987, 864; A 1987, 1629; 1989, 1221)

NRS CROSS REFERENCES.
Fee imposed on health insurers for support of committee, NRS 449.465.

439B.220 Powers. The committee may:

1. Review and evaluate the quality and effectiveness of programs for the prevention of illness.

2. Review and compare the costs of medical care among communities in Nevada with similar communities in other states.

3. Analyze the overall system of medical care in the state to determine ways to coordinate the providing of services to all members of society, avoid the duplication of services and achieve the most efficient use of all available resources.

4. Examine the business of providing insurance, including the development of cooperation with health maintenance organizations and organizations which restrict the performance of medical services to certain physicians and hospitals, and procedures to contain the costs of these services.

5. Examine hospitals to:

(a) Increase cooperation among hospitals;

(b) Increase the use of regional medical centers; and

(c) Encourage hospitals to use medical procedures which do not require the patient to be admitted to the hospital and to use the resulting extra space in alternative ways.

6. Examine medical malpractice.

7. Examine the system of education to coordinate:

(a) Programs in health education, including those for the prevention of illness and those which teach the best use of available medical services; and

(b) The education of those who provide medical care.

8. Review competitive mechanisms to aid in the reduction of the costs of medical care.

9. Examine the problem of providing and paying for medical care for indigent and medically indigent persons, including medical care provided by physicians.

10. Examine the effectiveness of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services, and its effect on the subjects listed in subsections 1 to 9, inclusive.

11. Determine whether regulation by the state will be necessary in the future by examining hospitals for evidence of:

360

(a) Degradation or discontinuation of services previously offered, including without limitation, neonatal care, pulmonary services and pathology services; or

(b) A change in the policy of the hospital concerning contracts,

as a result of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services.

12. Study the effect of the acuity of the care provided by a hospital upon the revenues of hospital and upon limitations upon that revenue.

13. Review the actions of the director in administering the provisions of this chapter and adopting regulations pursuant to those provisions. The director shall report to the committee concerning any regulations proposed or adopted pursuant to this chapter.

14. Conduct investigations and hold hearings in connection with its review and analysis.

15. Apply for any available grants and accept any gifts, grants or donations to aid the committee in carrying out its duties pursuant to this chapter.

16. Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.

17. Recommend to the legislature as a result of its review any appropriate legislation.

(Added to NRS by 1987, 864)

NRS CROSS REFERENCES.
"Physician" defined, NRS 0.040.

WEST PUBLISHING CO.
Health and Environment ⇐ 6.
WESTLAW Topic No. 199.
C.J.S. Health and Environment § 13.

439B.225 Committee to review certain regulations proposed or adopted by licensing boards; recommendations to legislature.

1. As used in this section, "licensing board" means any board empowered to adopt standards for licensing or for the renewal of licenses pursuant to chapter 449, 630, 631, 632, 633, 637B, 639, 640, 641, 641B, 652 or 654 of NRS.

2. The committee shall review each regulation that a licensing board proposes or adopts that relates to standards for licensing or to the renewal of a license issued to a person or facility regulated by the board, giving consideration to:

(a) Any oral or written comment made or submitted to it by members of the public or by persons or facilities affected by the regulation;

(b) The effect of the regulation on the cost of health care in this state;

(c) The effect of the regulation on the number of licensed persons and facilities available to provide services in this state; and

(d) Any other related factor the committee deems appropriate.

3. After reviewing a proposed regulation, the committee shall notify the agency of the opinion of the committee regarding the advisability of adopting or revising the proposed regulation.

4. The committee shall recommend to the legislature as a result of its review of regulations pursuant to this section any appropriate legislation.

(Added to NRS by 1991, 940)

NRS CROSS REFERENCES.
Administrators of facilities for long-term care, NRS chapter 654.
Audiologists and speech pathologists, NRS chapter 637B.
Dentistry and dental hygiene, NRS chapter 631.

Medical and other related facilities, NRS chapter 449.
Medical laboratories, NRS chapter 652.
Nursing, NRS chapter 632.
Osteopathic medicine, NRS chapter 633.
Pharmacists and pharmacy, NRS chapter 639.
Physical therapists, NRS chapter 640.
Physicians and assistants, NRS chapter 630.
Psychologists, NRS chapter 641.
Social workers, NRS chapter 641B.

439B.230 Investigations and hearings: Depositions; subpoenas.

1. In conducting the investigations and hearings of the committee:

(a) The secretary of the committee, or in his absence any member of the committee, may administer oaths.

(b) The secretary or chairman of the committee may cause the deposition of witnesses, residing either within or outside of the state, to be taken in the manner prescribed by rule of court for taking depositions in civil actions in the district courts.

(c) The chairman of the committee may issue subpoenas to compel the attendance of witnesses and the production of books and papers.

2. If any witness refuses to attend or testify or produce any books and papers as required by the subpoena, the chairman of the committee may report to the district court by petition, setting forth that:

(a) Due notice has been given of the time and place of attendance of the witness or the production of the books and papers;

(b) The witness has been subpoenaed by the committee pursuant to this section; and

(c) The witness has failed or refused to attend or produce the books and papers required by the subpoena before the committee which is named in the subpoena, or has refused to answer questions propounded to him,

and asking for an order of the court compelling the witness to attend and testify or produce the books and papers before the committee.

3. Upon such petition, the court shall enter an order directing the witness to appear before the court at a time and place to be fixed by the court in its order, the time to be not more than 10 days from the date of the order, and to show cause why he has not attended or testified or produced the books or papers before the committee. A certified copy of the order must be served upon the witness.

4. If it appears to the court that the subpoena was regularly issued by the committee, the court shall enter an order that the witness appear before the committee at the time and place fixed in the order and testify or produce the required books or papers. Failure to obey the order constitutes contempt of court.

(Added to NRS by 1987, 866; A 1987, 1630)

439B.240 Investigations and hearings: Fees and mileage for witnesses. Each witness who appears before the committee by its order, except a state officer or employee, is entitled to receive for his attendance the fees and mileage provided for witnesses in civil cases in the courts of record of this state. The fees and mileage must be audited and paid upon the presentation of proper claims sworn to by the witness and approved by the secretary and chairman of the committee.

(Added to NRS by 1987, 866)

APPENDIX B

Request for Response to a Survey on the "Medically Needy Fund" Proposal,
Table Compiled from Responses to Survey, and
Actual Response Letters to Survey

STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
LEGISLATIVE BUILDING
CAPITOL COMPLEX
CARSON CITY, NEVADA 89710
Fax No.: (702) 687-5962

LORNE J. MALKIEWICH, *Director*
(702) 687-6800

LEGISLATIVE COMMISSION (702) 687-6800
RANDOLPH J. TOWNSEND, *Senator, Chairman*
Lorne J. Malkiewich, *Director, Secretary*

INTERIM FINANCE COMMITTEE (702) 687-6821
JOHN W. MARVEL, *Assemblyman, Chairman*
MORSE ARBERRY, JR., *Assemblyman, Chairman*
Daniel G. Miles, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

Wm. GARY CREWS, *Legislative Auditor* (702) 687-6815
ROBERT E. ERICKSON, *Research Director* (702) 687-6825
BRENDA J. ERDOES, *Legislative Counsel* (702) 687-6830

September 12, 1996

To: Persons on the **LEGISLATIVE COMMITTEE ON HEALTH CARE, (*Nevada Revised Statutes* [NRS] 439B.200 through 439B.240)** mailing list

Subject: REQUEST FOR RESPONSE TO A SURVEY ON THE "MEDICALLY NEEDY FUND" PROPOSAL

At its work session on August 26, 1996, the Legislative Committee on Health Care discussed a proposal to create a fund to finance primary care services for the indigent and uninsured populations. Although concerned about the suggested funding mechanism (a portion of existing gaming revenues and an increase in the cigarette excise tax), the committee voiced support for such a fund. Because the concept of the fund was not fully reviewed at any meeting, the committee voted to survey interested persons, represented by those whose names appear on the mailing list, to seek further comments on the proposal.

If you are interested in providing feedback to the committee on this issue, please submit your written comments regarding the establishment of a "Medically Needy Fund" by October 15, 1996, to:

Kerry Carroll Davis, Sr. Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

The committee approved the following text to describe the "Medically Needy Fund" proposal. Please comment on all aspects of the proposal, including possible revenue sources for such a fund.

As part of addressing the problem of the uninsured and underserved persons in the State of Nevada, the state may create, by statute, a "Medically Needy Fund" to finance the provision of community-based, comprehensive primary care services to indigent or uninsured Nevadans. Direct patient care services covered by the fund will include: (1) counseling (family, mental health, and substance abuse); (2) dental services (preventive and restorative); (3) health education, preventive health services, and referrals; (4) outreach services; (5) pharmacy; (6) transportation services; (7) treatment of minor illnesses; (8) well-child care and immunizations; and (9) x-ray. A portion the funds, as determined by the Department of Human Resources, may be used to finance infrastructure and capacity building activities (e.g., equipment, health care practitioner salaries, et cetera). The proposal must be coordinated with the other existing programs for the uninsured and the insured, including Medicaid and Medicare.

The Department of Human Resources will be required to administer the fund and contract with qualified community-based health centers to provide comprehensive, primary care services. Such centers shall include: (1) Federally Qualified Health Centers (FQHCs); (2) FQHC "look alikes", designated by the federal Bureau of Primary Health Care and recognized by the U.S. Health Care Financing Administration; (3) Title V-funded Urban Indian Health Clinics; (4) Tribal Health Centers/Clinics on reservations or colonies; 5) the Primary Care Case Management (PCCM) Program affiliated with the University of Nevada's School of Medicine; and may include, (6) community-based clinics or programs of larger organizations (hospitals, medical groups, or primary care clinics) that provide primary care services on a sliding fee schedule and at least 20 percent of the services provided are uncompensated.

Medically Needy Fund
Summary of Comments
October 1996

The following 6-page table is a summary representation of comments solicited from persons on the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200 through 439B.240) mailing list regarding a medically needy fund for Nevada.

RESPONSE	POLICY	FUNDING	LANGUAGE	OTHER COMMENTS
1	It is essential that reproductive care be part of any safety net which includes preventive health screening, family planning, and pregnancy related care—including abortion.	General Fund monies; cigarette taxes.	Paragraph 2: a. Add a **comma** to clarify that these groups include community clinics such as Planned Parenthood, and b. Delete the "**may include**" which precedes (6).	Support a program that offers the opportunity to avoid a major health care crisis in Nevada by early preventive action. The program should fill the existing gap in health care services which will grow as welfare reforms reach Nevada and as sliding-scale clinics lose fee-paying clients to managed care.
2	The plan must have well established benefit parameters, the recipient population must have a distinct needs standard describing medical indigence, and the funding sources ample for medical need demands which are always advocated to be greater than the available resources.	The concept of using gaming revenues and cigarette excise taxes is reasonable, but a broader base may be needed.		This process should be closely tied to a comprehensive study of current and future Medicaid and county medical services funding.
3				Representation on the committee designing this fund should be composed of Hospital Chief Financial Officers who are familiar with reimbursement methodologies in the state.
4	Consider emergency services; dental and vision care; not restricting prescription drugs to generics; the provision of wheel chairs, walkers, crutches, or prostheses.			Must consider that the poor do not deserve less consideration than individuals who are able to pay for their own care through insurance plans. Must have a system that uses qualified physicians, therapists, and nurses. Would like to see "our best physicians donate one day a week to the indigent, either in their own offices or in a clinic providing care to the indigent."

Medically Needy Fund
Summary of Comments
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RESPONSE	POLICY	FUNDING	LANGUAGE	OTHER COMMENTS
5		A flat $.50 per person transient lodging tax; one tenth of one percent of gross gaming revenue.		The cost for the care of the medically indigent should not be borne by other users whose resources may be limited. The gaming/resort industry is the primary benefactor of a low-wage service force. Apply the lodging tax to all except those using transient lodging facilities as primary residences. "Comp" rooms should not be exempt from the fee.
6	Direct patient care services should include the cost of diagnostic medical laboratory services			Without lab coverage, it is impossible to diagnose and treat many of the problems which will be presented for comprehensive primary care services.
7	Include home health care.			People who are not eligible for Medicare/Medicaid and county welfare, and who have no health insurance, are about 1 percent of the home health care population.
8		Tax the sale of tobacco products and gaming.		We cannot look the other way as untreated and under treated individuals create significant public health problems for all of Nevada's citizens, serve to increase the costs of hospitalization for all patients, and indirectly contribute to fiscal pressures on counties in the state.
9	Include care for alcohol and drug rehabilitation centers.			
10	The qualification for compensation from the fund should be a sliding fee schedule, and programs/clinics in which 10 to 15 percent of the services provided are uncompensated. Add primary care services delivered at home as a category that is compensable.	A 15-cent per pack increase in the cigarette excise tax (on 20-cigarette packs), and an appropriation of 2 to 3 percent of current General Fund gaming tax revenues deposited in the General Fund.		Envision that the fund would be developed parallel to Medicaid and Medicare, and would not be used to offset less than customary charges. The fund is not intended to supplant existing indigent care funds or resources. Propose a variety of funding mechanisms including grants-in-aid; competitively bid contracts; targeted program initiatives; and local consortium awards. Each mechanism would be allocated a percentage of the annual fund based on documented need. The following are proposed as accountability standards: quarterly projections of uncompensated care with annual reconciliations; records of sliding fee scale usage, charges, and services rendered; detailed demographic reports; and evidence of follow-up and case management coordination.

Medically Needy Fund
Summary of Comments
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RESPONSE	POLICY	FUNDING	LANGUAGE	OTHER COMMENTS
11	Include services to the senior homebound population including nutritional dietary supplements, personal care items, cleaning materials, immunization, eye care, transportation services, and senior abuse counseling.			The Federal Government is leading the way with the realization that nutritional well-being keeps seniors healthy and independent, and it does so with lower overall health costs. State programs should support these mandates with funding.
12	Look at creating the fund to increase community-based primary medical care to more uninsured on a sliding fee basis, rather than create another class of entitlements or commit to providing services for which we have no cost estimates.	Earmark state's surplus dollars for one-time investments in the infrastructure of the safety net providers. Also consider a surtax on health care providers or facilities.	Limit Item (1) counseling, to substance abuse; (2) dental services; to emergency cases. Clarify (4) outreach services. Add Item (10) to include laboratory tests.	Do not include any provider as a contractor unless their services are available on a sliding fee schedule to anyone in need of care, regardless of their ability to pay, and at least 20 percent of services provided are uncompensated as either bad debt write-off, sliding fee scale, or charitable contributions. Earmarked state surplus funds could be used to allocate funds to purchase equipment, land, or build new facilities to increase safety net capacity while lowering overhead of providers. A surtax may be applied against providers who accept state funds and do not contribute at least 20 percent to uncompensated care. May also consider a tax on out-of-state providers, or a ban on HMOs who are not based in Nevada.
13	Include provision of cognitive pharmaceutical care services.			Clearly assess other proposals which will request funding from an increase in cigarette excise tax and appropriation of General Fund gaming tax revenues to determine whether this pool is a feasible source of funding.
14	Designate highest priority recipients as the youngest, most vulnerable population (infants, children, adolescents, and mothers).			
15	Rather than fund a proliferation of new providers, resources would be better used by supporting existing providers.			Preventive care appears to be the focus of the proposal, yet target population tends to underutilize resources already available. Would incentives be a part of the plan so that preventive services are more readily used by this population?
16		Earmark a portion of cigarette tax revenue.		Earmarked funds may be used to establish a statewide tobacco resistance youth education component.

Medically Needy Fund
Summary of Comments
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RESPONSE	POLICY	FUNDING	LANGUAGE	OTHER COMMENTS
17		Support a broad-based funding approach which would address the statewide nature of the need.		The nature and types of services which would be most effectively and efficiently provided through this fund require an in-depth analysis of the needs of the population to be served (i.e., age, health status, geographic location, et cetera).
18	Serve this population by expansion of the Medicaid program.	Matching federal dollars available through the Medicaid program.		If Medicaid block grant legislation passes Congress within the next few years, a base year is likely to be established. If that base year were FY 96, Nevada would be at a large disadvantage because it offers little to no optional Medicaid coverage. On the other hand, 37 states have a Medicaid Medically Needy program. If Nevada were to get its program into place by FY 97, it would potentially become a part of our base year for a future Medicaid block grant.
19	Recommend not creating another bureaucracy within the Department of Human Resources. Create a medically needy Medicaid program by expanding the number of disabled persons eligible for home and community based services and by providing resources to the counties for expansion of the county medical indigent programs.	By expanding eligibility for Medicaid, the state is eligible for federal matching funds.		For a state to have a medically needy program, it must cover a certain segment of the population as identified in federal law. The population in this group could be expected to comprise about 70 percent of medically needy pregnant women and children, but would generate only about 30 percent of increased Medicaid expenditures.
20		The fund should be supported by currently available revenue.		The necessity of establishing an additional fund to finance primary care for indigent and uninsured residents of Nevada is less certain in light of the existing funds and programs currently available at the local, state, and federal levels.
21				Must consider the continued protection of the public and avoid any compromise on quality of dental care.

Medically Needy Fund
Summary of Comments
October 1996

RESPONSE	POLICY	FUNDING	LANGUAGE	OTHER COMMENTS
22			*In last paragraph:* Such centers ...may include, (6) community-based clinics or programs of larger organizations (hospitals, medical groups, [or] primary care clinics, or county and district health departments) that provide primary care services on a sliding fee schedule and at least 20 percent of the services provided are uncompensated.	
23	Believe that the program should promote access to all Nevada health care providers currently providing medical care to the indigent and uninsured populations of Nevada.	Oppose the development of a special tax on a select group of industries.		The proposal gives the impression of being self-serving to a limited number of providers who, in respect to the total number of patients falling into this category, provide a small percentage of the medical services this total population receives.
24	Must ensure accountability.			Would like to see clinics rotate their services to uninsured patients—possibly through provision of a mobile unit.

Medically Needy Fund
Summary of Comments
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RESPONSE	POLICY	FUNDING	LANGUAGE	OTHER COMMENTS
25	Nevada must adopt significant small group health insurance reforms to assure that uninsured working Nevadans have access to coverage. Should also consider: encouraging the creation of voluntary small employer purchasing groups; elimination of mandated insurance benefits and replace with basic benefits package; permit portability of insurance; provide for guaranteed renewability of people who have insurance and develop an illness or condition; provide for a risk pool to assure coverage of certain categories of medically uninsurable Nevadans; encourage MSAs.	Access matching funds from county indigent programs; also increase tobacco taxes.		Support the expansion of the state's Medicaid program to include care for the indigent populations, currently subsidized by county indigent programs or whose care is simply uncompensated. Local funds currently used for county indigent programs could be used as matching funds to supplement an expanded Nevada Medicaid program. Also, advocate significant increases in tobacco taxes to decrease easy availability of tobacco products to youth and decrease the incidence of tobacco related illness.
26	Include dental care for uninsured children. Also, support treatment for minor illnesses (i.e., pink eye, impetigo, middle ear and throat infections).			

MLM/lcl:W61652-1.16

Sept. 16,1996

Kerry Carroll Davis, Sr.
Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau

Capitol Complex

Carson City,Nv 89710

Dear Kerry Carroll Davis:
The "Medically Needy Fund" is an excellent idea. One of the main things needed is alchol and drug rehabilitation centers. These people need help.

Sincerely,
Judith Warner

Judith Warner
AARP State Leg. Committee
2000 E Bonanza
Las Vegas, Nevada 89101

AARP

Bringing lifetimes of experience and leadership to serve all generations.

NEVADA STATE LEGISLATIVE COMMITTEE

CHAIR
Joseph E. Fisher
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Las Vegas, NV 89101-3329
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7201 Blue Falls Cir.
Reno, NV 89511-1016
(702) 852-5993

Kerry Carroll Davis, Sr. Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Dear Ms. Davis,

I greatly appreciate the opportunity to comment on the "Medically Needy Fund" Proposal. I would like to strongly support the concept described in your letter and presented briefly at the last meeting of the LEGISLATIVE COMMITTEE ON HEALTH CARE in Carson City recently.

As the committee must be aware, Nevada leads the country in the percentage of citizens who lack health care insurance. This fact, the cost of medical care in Nevada and the high number of personal bankruptcies in our state all suggest a need to deal more effectively with our increasing population of medically indigent citizens . We cannot look the other way as untreated and undertreated individuals create significant public health problems for all of our citizens, serve to increase the costs of hospitalization for all patients and indirectly contribute to fiscal pressures on our counties.

As with all issues of health care, someone has to pay the costs. Our state is limited in its sources of revenue. In view of the fact that smoking, which is a well documented contributor to our high level of morbidity, is practiced by a very high proportion of Nevadans, it is quite appropriate to tax the sale of tobacco products. Our casinos, who employ many of the indigent and near-indigent workers in the state, many of whom work as part-time employees and thus are uninsured, should also accept some of the fiscal responsibility for this needed program.

On behalf of the AARP State Legislative Committee I would strongly encourage support for this important legislation.

Sincerely yours,

William Hausman, M.D.

Home Health Services of Nevada, Inc.

Roberta K. Skelton, RN, Administrator

Offices Throughout Nevada

Phone: (702) 738-7178

FAX: (702) 738-7850

P.O. Box 1359
1810 Pinion Road
Elko, Nevada 89803

September 17, 1996

Kerry Carrol Davis
Senior Research Analyst
Nevada Legislative Counsel Bureau
Legislative Building - Capitol Complex
Carson City, NV 89710

RE: Legislative Committee on Health Care
Survey Response on the "Medically Needy Fund" Proposal

I read with interest the areas where direct patient care could be provided via a variety of public funded programs from taxes derived from gaming and cigarettes.

The one large component I saw missing was home care. I run a not-for-profit. free standing home health agency in rural Nevada. Our corporation provides care in twelve of Nevada's rural counties.

As of this date people who are not eligible for Medicare/Medicaid and county welfare and, have no health insurance are about 1% of our population. We service these people and work with infusion companies and others to provide home care at cost or free. I certainly would like to see home health care represented in the total scheme of things.

I would be most interested in working with your staff toward that end.

Sincerely,

Roberta K. Skelton, RN
Administrator/CEO

cc: John Busse, Elective Director
Home Health Care Association of Nevada

"Bringing health care home..."

HAMMOND FINANCIAL SERVICES, INC.

Employee Benefit Plans
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President

**Variable Life and Annuities*
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September 18, 1996

Kerry Carroll Davis
Sr. Research Analyst
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Re: Survey On the "Medically Needy Fund" Proposal

Dear Mr. Davis:

Please forgive me if you are woman, as I wasn't sure. I am writing regarding the Medically Needy Fund, as requested in the September 12, 1996, letter.

My only comment is that direct patient care services covered by the fund should also include the cost of diagnostic medical laboratory services, which I presume is an oversight. Without lab coverage, it is impossible to diagnose and treat many of the problems which will be presented for comprehensive primary care services.

Please have my mailing address on your mailing list changed to indicate my recent move.

Respectfully submitted,

F.G. Rusty Hammond, CLU ChFC

(702) 699-5569 2949 East Desert Inn Road, Suite 2, Las Vegas, NV 89121 FAX 699-5650

ORLAND T OUTLAND
2675 Valmar Place, Reno, Nevada, 89503-213075, Phone (702) 747-3163

September 23, 1996

Kerry Carroll Davis, Sr. Research Analyst
ATTN: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson, City, NV 89710

re: REQUEST FOR RESPONSE TO A SURVEY ON THE "MEDICALLY NEEDY FUND" PROPOSAL

As it stands now, the brunt of the cost on uncompensated care is loaded onto the charges of other users in the provider system. The cost for the care of the medically indigent should not be borne by other users whose resources may be limited. It is illogical to have the sick pay for others who are sick.

There can be no question but that a "Medically Needy Fund" of some sort is a necessity and a overall societal problem.

It does not seem prudent to divert existing revenue from existing programs to respond to the societal responsibility. Rather, additional revenue should be sought from those contributing to the problem.

The gaming/resort industry is the primary benefactor of a low-wage service force and the shunting of the burden of sustaining that low-wage population in the social service arena off to the general population.

The gaming industry should be viewed as a franchise operation of the State and the franchise fee structure needs to be re-addressed. Gaming is willing to pay 20 percent of its gross income in other States to operate in those States, but does not pay even half of that to operate in this State.

There should be a flat $.50 per person transient lodging tax on all except those using transient lodging facilities as primary residences to partially fund a "Medically Needy Fund"; an additional source could be one/tenth of one percent of gross gaming revenue. "Comp" rooms should not be exempted from the $.50 fee.

Orland T Outland

NEVADA ASSOCIATION OF MANUFACTURED HOMEOWNERS

1928 Western, Suite #4
Las Vegas, Nevada 89102
Telephone (702) 384-8428

'A Non-Profit Organization'

September 23, 1996

Kerry Carroll Davis, Senior Research Analyst
Legislative Counsel Bureau
Capitol Complex
Carson City Nevada 89710

ATTENTION: Medically Needy Fund

Dear Ms. Davis:

The fund proposal being studied is, in my opinion, a most worthwhile and vital concern, particularly in view of the changes in Welfare laws.

My concerns are 1.) adequate services. We already have clinics, doctors and nurses who provide inadequate care under some insurance plans, as well as existing welfare and Social Security programs.2.) Emergency services only? Broken bones, Pneumonia, heart attacks, etc.?

3.) There is presently a dire need for dental and vision care not covered under a lot of insurance plans. Will these be included? Should they be? Teeth do often need to be treated in order to clear infections that can infiltrate other organs. Without proper glasses, many, many of the indigent can not function in what is already a deplorable condition for them. 4.) Prescriptions are often necessary; generic only? This cannot be a rule because some problems require more. (My cardiologist, for example, adamantly states, "no generics"). Do the indigent deserve less consideration? 5.) How would wheel chairs, walkers, crutches, protheses be paid for? 6.) Would there be care for ongoing needs?

All issues are worthy of study, but the most important is to make qualified physicians, therapists and nurses available. There is very little of that considered in treating the poor.

I'm greatly concerned about this issue, having seen the results too often of care given by staff who cannot get into offices and hospitals because they are unqualified. It has even been reported to me by members of this association that some of the clinics are not even manned by one physician.

I would like to see our best physicians donate one day a week to the indigent, either in their own offices or in a clinic providing care to the indigent. Is this too much of a pipe dream?

Derry Carroll Davis, Sr. Research Analyst (con't)
Carson City Nv. 89710

Thank you for including me in your survey and please feel free to contact me if I can be of any help in furthering this project.

Sincerely,

Jeannie Deeg

Jeannie Deeg, State President
s/

DESERT SPRINGS
HOSPITAL

2075 East Flamingo Road
Las Vegas, Nevada 89119
(702) 733-8800
Affiliated with Universal Health Group, Inc.

September 26, 1996

Kerry Carroll Davis
Sr. Research Analyst
Attn: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV. 89710

re: Response on the Medically Needy Fund Proposal

Dear Ms. Davis:

Having met with the Data and Finance Committee of the Nevada Association of Hospitals and Health Systems recently, I was made aware that this particular fund was being created. I feel that representation on the committee designing this fund should be composed of Hospital Chief Financial Officers who are familiar with reimbursement methodologies in the State of Nevada. There was a lot of interest among the Chief Financial Officers present at the Data and Finance Committee to participate and their collective experience and expertise would benefit the development of the fund design.

I appreciate your solicitation of comments. If there are any questions, or if I can be of any help please feel free to call me at (702) 369-7609.

Sincerely,

David C. Chapman
Chief Financial Officer

DCC/scb

Nevada State Board of Pharmacy

1201 TERMINAL WAY • SUITE 212 • RENO, NEVADA 89502-3257
(702) 322-0691 • 1-800-364-2081 • FAX (702) 322-0895

October 2, 1996

Kerry Carroll Davis
Senior Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, Nevada 89710

Dear Analyst Davis:

This letter is to provide response to the legislative committee on Healthcare regarding a "Medically Needy Fund".

The concept of providing primary medical health services to Nevada's indigent or uninsured Nevadans has merit. An acknowledged significant percentage of the population is without financial resources for basic health care. Of the nine direct patient care services listed in your memo, several while unquestionably beneficial can become an insatiable demand if certain limitations are not established. Medical technology and corresponding costs rise exponentially compared to the general economy.

An area of familiarity for me is pharmacy. The newest and effective new treatment for HIV patients is combination antiviral therapy. Recommended are two nucleosides and a protease inhibitor. This highly effective medication costs at least $12,000 per year for each patient. Many senior citizen maintenance drug therapies are $200 to $300 per month. Ongoing expenditures become virtually spontaneous, as the most seriously ill persons will qualify as medically needy.

The concept of using gaming revenues and cigarette excise taxes is reasonable. Possibly other tax revenues need to be explored, rather than expansion of taxing services we believe come primarily from tourism or "sin" taxation. A broader base may be needed, considering the impact Medicaid funding may create as a result of recent congressional action.

In summary, a medically needy health care plan must have well established benefit parameters, the recipient population must have a distinct needs standard describing medical indigence, and the funding sources ample for medical need demands which are always advocated to be greater than the available resources. This process should be closely tied to a comprehensive study of current and future Medicaid and county medical services funding.

Sincerely,

Keith W. Macdonald

Keith W. Macdonald
Executive Secretary

KWM:ljh

NEVADA WOMEN'S LOBBY

Medically Needy Fund

The Nevada Women's Lobby urges the support of the Legislative Committee on Health Care for the proposed Medically Needy Fund. This proposal offers the opportunity to avoid a major health care crisis in Nevada by early preventive action. Not only does the already existing gap in health care services for Nevada's neediest families need attention, but this gap will grow as welfare reforms reach Nevada, and as sliding-scale clinics lose fee-paying clients to managed care.

In addition to addressing current and growing unmet health care needs, it is critical to Nevada's public health that its existing health care safety net be maintained. The income of both public and private providers of low income health care is being eroded as paying clients who previously could choose these clinics under their health insurance now must choose doctors within their new managed care plans. As these clients depart, the percentage of unreimbursed care in these clinics goes up, and the number of indigent/uninsured clients who can be served goes down.

The Nevada Women's Lobby is especially concerned with women's health care, the majority of which is reproductive health care. It is essential that reproductive care be a part of any safety net, and that this care include preventive health screening, midlife services, family planning, and pregnancy related care--including abortion.

The Nevada Women's Lobby supports the proposed funding through general fund monies and cigarette tax. The following minor changes are suggested.

Suggestions for Clarification of Wording:

Paragraph 2:

a. Add a **comma** to clarify that these groups include community clinics such as Planned Parenthood, and

b. Delete the "**may include**" which precedes (6):

> "...and (6) community-based clinics, or programs of larger organizations ..., that provide primary care services on a sliding fee schedule and at least 20 percent of the services provided are uncompensated."

10/5/96

NorthernDivision: P.O. Box 5565 - Reno, Nevada 89513 - (702) 972-5447 - (702)831-8318
Southern Division: P.O. Box 46292 - Las Vegas, Nevada 89114-6292 - (702) 658-5965

HEALTH ACCESS WASHOE COUNTY

October 11, 1996

Ms. Kerry Carroll Davis, Sr. Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Dear Ms. Davis:

Thank you for the opportunity to comment upon the establishment of a Medically Needy Fund.

I am not so concerned with documenting the need for the fund as I am with providing information about practical ways of supporting its implementation. I do not believe the committee needs more information to justify setting up such a fund as its does in finding realistic and practical solutions. Even the Governor's Office, according to Ms. Andreini, is well aware of the needs of the working uninsured. Ms. Andreini has stated that the governor's aids are all in agreement that something needs to be done, yet, does not have a solution to the problem.

While there are many good reasons to establish the Fund, nevertheless, it seems painfully true that there are at least seven issues already threatening the Medically Needy Fund as drafted;

1) New Federal welfare reforms will create even more working poor (uninsured),
2) There is little doubt that the Federal share to take care of the Medicaid eligible will shrink,
3) That the percentage of working uninsured, already at nearly twice the national average, may climb as high as 30% of the working population,
4) There is no doubt that there is little support to increase taxes, or earmark existing tax revenues to make up the lost federal dollars,
5) The Medically Needy Fund, as drafted, includes so many services (and therefore potential cost), it could die of its own weight (cost),
6) There would be little support to pay for so many services, and
7) There would be little support to create another entitlement program for such a large percent of the population,

Again, however, assuming there is wide spread support for creating access for the working uninsured, who are also paying for the indigent care of others, I would propose that the committee consider supporting a "bare bone" approach that does not directly pay for services or create another entitlement, yet creates additional capacity with the existing "safety net" providers to do more, for more working uninsured.

For example, instead of earmarking gaming revenues, which seems highly unlikely, perhaps some of the State's surplus could be earmarked for one-time investments in the infrastructure of the safety net providers. Perhaps, funds could be allocated to purchase equipment, land, or too build new facilities to increase safety net capacity while lowering their overhead. Perhaps, there could be grant support from the cigarette excise tax revenues for safety net providers (i.e., The Arizona Plan), that offer medical services on a sliding fee scale. This would provide a means to take care of the uninsured while also maintaining strict budget controls. Since we are assuming there is no appetite for additional taxes, unlimited services, or creating another class of entitlements; the State would be providing for additional capacity to care for the uninsured by paying to support the community-based providers who already provide services partially paid for by the recipient. For example, seed money to hire needed providers (ob-gyn, dentists, counselors, etc.) who would eventually pay for themselves would be very helpful.

Specifically, for now, I would suggest limiting item (1) counseling, to substance abuse; limiting (2) dental services, to emergency cases; eliminating (4) outreach services, unless it is better defined; and adding a number (10) to include laboratory tests. Additionally, I would suggest that the committee not include any provider as a contractor unless their services are available on a sliding fee schedule to **anyone** in need of care, regardless of their ability to pay, and at least 20% of services provided are uncompensated as either bad debt write-off, sliding fee scale, or charitable contributions.

Other sources of revenue could include a request to the AG's office to join the suits against tobacco companies. After all, the complications caused by cigarette smoking are the largest contributors to health problems that utilize the state's contribution of tax dollars to the Medicaid program. The committee could also consider a surtax on health care providers or facilities who accept state funds and do not contribute at least 20% to uncompensated care, or a tax on out-of-state providers, or even ban HMO's who are not based in Nevada. Every effort should be made to keep Nevada's health care tax dollars circulating in Nevada. Switching to mandatory managed care to save 1% to 3%, and then sending 5% to 10% in profits to out of state corporations makes little sense.

In summary, I am suggesting that the committee, in the short-term, look at creating a Medically Needy Fund to increase community-based the safety net providers' ability to furnish comprehensive primary medical care too more uninsured on a sliding fee basis, rather than create another class of entitlements or commit to providing services for which we have no-cost estimates. This approach, while only a start, would allow that State to get started on a program for the uninsured, while it reviews other long-term comprehensive approaches. Second, I am suggesting that the committee consider widening its view of potential funding sources and finding ways to keep Nevada's health care tax dollars in Nevada.

Again, thank you for the opportunity to comment.

Sincerely,

Michael Rodolico, Ed.D., MPH
Executive Director

NEVADA SOCIETY OF HOSPITAL PHARMACISTS

October 11, 1996

Kerry Carroll Davis, Sr. Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Dear Mr. Davis,

The Nevada Pharmacists Association (NPhA) and the Nevada Society of Health-System (formerly Hospital) Pharmacists (NSHP) have been made aware of the Medically Needy Fund Proposal. Both organizations feel this is an important proposal to assist the uninsured and underserved patients in the State of Nevada. The document addresses many significant aspects of patient care, and we would like to further support the role of pharmacy.

Our organizations know how necessary it is for patients to receive pharmaceutical products, but it is equally important that patients receive the proper counseling and pharmaceutical interventions to avoid drug-related morbidity and mortality. In a recent study it is estimated that in the United States, approximately $76 billion annually is spent on drug-related morbidity and mortality. Examples of drug-related morbidity and mortality include non-compliance with medications, polypharmacy, and adverse drug events. Providing cognitive pharmaceutical care services has been shown to reduce drug-related morbidity and mortality and our organizations may provide you with numerous studies and examples of current practice settings which exemplify improved patient outcomes and decreased costs to the healthcare system. If the Legislative Committee on Health Care requests more information or professional expertise regarding cognitive pharmaceutical care services, you may contact myself or Kenneth Searles, Pharm.D. at the following:

Kenneth E. Searles, Pharm.D.
NPhA, President
P.O. Box 68
Pahrump, NV 89041
(702) 727-5775

Kari A. Wieland, Pharm.D.
NSHP, President
1910 Sierra Highlands Drive
Reno, NV 89523
(702) 746-1302

Our organizations believe this proposal has great potential to help the uninsured and underserved persons in the State of Nevada. We would support the incorporation of cognitive pharmaceutical care services in the proposal. If we may be of assistance or provide information, please contact us or our organizations.

Sincerely,

Kari A. Wieland, Pharm.D.
NSHP, President

3006 S. Maryland Pkwy. Ste. 101 Las Vegas, NV 89109 702/732-4610 Fax 702/369-3490

Nevada State Medical Association

PAUL E. DIERINGER, M.D., President
WILLIAM A. SCHRADER, President-Elect
FRANK J. NEMEC, M.D., Immed. Past President
MARIETTA NELSON, M.D., Secretary
JOHN G. SCOTT, M.D., Treasurer
MICHAEL J. FISCHER, M.D., AMA Delegate
ROBERT W. SHRECK, M.D., AMA Delegate
JAMES D. BARGER, M.D., AMA Alternate Delegate
MARJORIE L. UHALDE, Ph.D., M.D., AMA Alternate Delegate
LAWRENCE P. MATHEIS, Executive Director

October 11, 1996

Kerry Carroll Davis, Senior Research Analyst
Attention Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, Nevada 89710

Dear Ms. Davis:

On behalf of the Nevada State Medical Association (NSMA), I appreciate the opportunity provided by the Legislative Committee on Health Care to address the issues related to a "Medically Needy Fund".

The Great Basin Primary Care Association has raised an important set of issues and has proposed an interesting approach to some of them. As I understand it, the proposal attempts to link at least three sets of issues together. It seeks to address the cost of providing for the primary care medical needs of the non-Medicaid indigent and the uninsured populations through the establishment of a segregated State "Medically Needy Fund". The proposal is that there should be an increase in tobacco taxes and a reallocation of some of the current gaming taxes.

This is certainly one approach to these issues, but it may present some difficult political and logistical problems. It might be possible to reconceptualize the problems and possible solutions.

It is NSMA's position that the absence of a "medically needy" portion of the State Medicaid program has had significant negative consequences for Nevada. As part of any State Medicaid "reform", NSMA has supported the expansion of the State's Medicaid program to include care for the indigent populations, currently subsidized by County Indigent programs or whose care is simply uncompensated. The data also indicate that this large non-Medicaid indigent population has increased the number of Nevada's uninsured population, which is composed primarily of working Nevadans and their families or those who are "medically uninsurable" because of pre-existing medical conditions.

We think that the Legislature should consider increasing the State's Medicaid program to include all or part of the "Medically Needy" population as a more direct approach to dealing with non-Medicaid indigent care. This basic approach has a significant financial incentive when compared to funding any new State program since local public funds used for indigent care could then be applied to Federal matching funds as part of the Nevada Medicaid program.

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2590 Russell Road • Las Vegas, NV 89120 • (702) 798-6711 • FAX (702) 739-6345
NVSTMEDA@aol.com

The growing number of uninsured Nevadans is an issue to which NSMA has addressed itself for several years. Much of the "Health Access Nevada" proposal, which NSMA made two years ago, is meant to address the causes of this issue. It should be possible without creating a significant state program to provide for reforms of the health insurance markets to resolve some of the problems resulting in the group health insurance market. Some of these were finally addressed in the recent Federal action on insurance portability.

There has been considerable Legislative and consumer support for the principles of "Health Access Nevada" which was proposed by NSMA in 1995. NSMA policy continues to be that Nevada must adopt significant small group health insurance reforms to assure that uninsured working Nevadans have access to coverage. The legislation passed in 1995, i.e. SB 538 (which allows employer purchasing groups to be established) and AB 592 (which permits Medical Savings Accounts to be offered as a health benefit package), were a start on these reforms.

The following summarizes some additional actions which the Legislature could take to reduce the number of uninsured Nevadans:

a. Encourage the creation of voluntary small employer purchasing groups.
b. Eliminate mandated insurance benefits and replace with basic benefits package.
c. Permit portability of insurance
d. Provide for guaranteed renewability of people who have insurance and develop an illness or condition.
e. Provide for a risk pool to assure coverage of certain categories of medically uninsurable Nevadans.
f. Encourage "Medical Savings Accounts".

Again, these or similar changes would not require commitment of additional State funds and should generate revenue, since new insurance premiums would be generated.

The final issue raised by the "Medically Needy Fund" proposal is that of appropriate funding of the medical services provided for the indigent and uninsured. Of course, medical services which must be provided are either paid for directly or indirectly. Underfunded public programs simply add costs to others using the services. While our comments indicate that new sources of revenue may not be needed to deal with the issues of the non-Medicaid indigent and the uninsured, NSMA has long recommended significant increases in tobacco taxes as desirable public policy. Data indicate that price is a significant issue for youth purchasers of tobacco products. Higher taxes do decrease easy availability of tobacco products to youngsters, which is a desirable public policy. It is certainly true that tobacco related illnesses cost public programs, including Medicaid. A number of states are currently litigating that issue in various courts around the

country. An additional tobacco tax for support of providing Medicaid or indigent care is certainly worth considering by the Legislature.

I appreciate the Committee's request for comments and encourage further exploration of these important issues.

Sincerely,

Lawrence P. Matheis
Executive Director

cc: Paul E. Dieringer, MD, President
Frank J. Nemec, MD, Immediate Past-President
William A. Schrader, MD, President-Elect

10-13-96

Kathy Brown
Member MS Society
964 Alpine Drive
Elko NV 89801
(702) 753-3968

October 12, 1996.

Kerry Carroll Davis, Sr. Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capital Complex
Carson City, NV 89710

Dear Ms. Davis and Legislative Healthcare Committee

This letter is in regards to the "Medically Needy Fund." I ask first off that you consider such a fund as I, myself, don't have proper insurance coverage due to a diagnosis of Multiple Sclerosis. There are many others with similar situations. Many are even able to purchase the insurance but denied the coverage due to

"pre-existing" conditions. That particular dilema is where a problem lies as we don't qualify for Medicare or Medicaid. My feeling is that this particular group of people are where the system "cracks" lies.

Some of the program ideas could well come from places like the MS Society, Centers for Independent Living and the Cancer Society so I'd encourage a contact with them.

One concern I have is in both the funding and the proper overseeing of these funds. It would be imperative to have a strong accountability set up. Could funding be available through alcohol or cigarette tax? Areas of "bad health" seem logical to a "good" health program. Maybe percentages from the MS Society, Cancer Society etc. I mentioned earlier, would be possible or even locations for the clinics on a

rotating bases. In fact, would Mobile Units traveling through counties or outlying areas be more cost efficient and practical? What I don't want to see, is health care providers taking advantage of the program without a true concern for the patient.

Please contact some of the groups I mentioned earlier as you will discover a wealth of ideas and talent in the group of volunteers, who, many, themselves are in need of the program. Ray Bothell or June Swanson are two excellent contacts through the Reno Great Basin Sierra Chapter MS Society.

I appreciate the continued interest and involvement of people like myself you all have had in our healthcare delima. Thank you for your diligent work.

Sincerely,
Kathy Brown

10-13-96

Dear Kerry,

I am writing in support of the proposed Medically Needy Fund. I am particularly excited about the prospect of dental care for the uninsured. I work as a school nurse and see the need for dental care daily. Students with dental pain or infection are unable to concentrate in school until we can find resources to help these students which creates a very frustrating situation.

Treatment for minor illness would also be extremely valuable as I see many students without a primary care physician who are in need of immediate treatment for diseases such as pink eye, impetigo, middle ear and throat infections to name a few. Resources to meet these needs are sometimes limited.

Again, I am extremely excited about the idea of an easily accessible resource to meet student health and dental needs.

Sincerely,
Kim Garrison, RN
School Nurse

Cristman
Associates

101 S. Rainbow, Ste. 28-14 • Las Vegas, NV 89128 • (702) 255-9541 • FAX (702) 228-8442

October 14, 1996

Kerry Carroll Davis, Senior Research Analyst
Attention: Medically Needy Fund
Legislative Council Bureau
Capitol Complex
Carson City, NV 89710

FAX: (702) 687-3048

Dear Ms. Davis:

Cristman Associates has been conducting health needs assessments in Nevada for eight years, at both state and local community levels. These comprehensive needs assessments have gathered information relative to both medical and dental care access, and certainly support the necessity of developing a Medically Needy Fund.

Without exception, our research indicates that inability to pay for care is the single greatest barrier that Nevada's vulnerable populations experience. This has been demonstrated time and again through our surveys and interviews of patients, providers, community nurses and agency administrators. Neglecting to ensure healthcare access for already compromised populations causes unnecessary great cost to Nevadans in terms of the resulting medical and social complications, lost productivity and human suffering.

In the event a Medically Needy Fund is established, Cristman Associates suggests that the highest priority in funding be given to our youngest and most vulnerable populations, including infants, children, adolescents and mothers.

Sincerely,

Cherrill Cristman

October 14, 1996

Kerry Carol Davis, Sr. Research Analyst
Legislative Counsel Bureau
Capitol Complex
Carson City, Nevada 89710

Dear Kerry (and Chairwoman Vivian Freeman and Committee Members):

Re: Comments on the Medically Needy Fund

In response to a number of inquiries, the Great Basin Primary Care Association distributed a "Q/A Briefing" on our conceptualization of the "Medically Needy Fund," as presented in your mailing, to a number of persons on your mailing list, and to the interested public. By way of public comment on the Medically Needy Fund, I am submitting our "Briefing" for the legislative record. Readers were informed that our "Briefing" was "framed solely from the Association's conceptualization of how a 'Medically Needy Fund' could work for Nevada."

Although we are still committed to financing the Fund with a 15 cent increase in the excise tax on cigarette 20-packs, and 2-3% of existing gaming tax revenues, we are committed to working with the Committee and Legislature on exploring all financing opportunities and packages. Bottom line: Nevada needs a Medically Needy Fund, and now more than ever is the time to seize the momentum to ensure (not insure, as in insurance) that we create greater access to primary care services for Nevadans. The Fund, as conceptualized, would encourage providers to establish sliding fee schedules (allowing more access to care for working Nevadans who are currently uninsured and living in our urban counties), and would help support the urban and rural care-provider infrastructure to guarantee these providers remain in our communities, very often as the only source of care for individuals and families.

I hope you find this information useful in framing your views on the Medically Needy Fund. I look forward to the Committee's "Work Session" -- would that be scheduled soon after the November election? Again, thanks for all your assistance and support.

Q: WHAT IS THE GOAL OF THE FUND?
A: The Fund is to stabilize the economic underpinnings of a statewide "safety net" of providers of primary care services to the medically needy -- who, as a population of consumers, cannot otherwise obtain services through existing insurance or fee for service programs.

P.O. Box 584 / 300 So. Curry St., Ste 6 / Carson City, Nv 89703 / tel. (702) 887-0417, fax 887-3562

Q: IS THIS AN INSURANCE FUND?
A: No. The Fund is a categorical account in the state treasury set aside to meet the Fund's proposed statutory requirements to provide fiscal resources to the broad category of community-based primary care providers who: 1) serve indigent and uninsured Nevadans on a published sliding fee: and 2) who care for persons regardless of their ability to pay, often resulting in their providing uncompensated care (i.e., no revenues are collected for services provided. or revenues collected do not equal the costs to provide the services).

The Fund would be developed parallel to, yet independent and cognizant of Medicaid and Medicare programs. as well as other funds that serve the indigent and uninsured. As you know, Medicaid is a federally and state funded insurance program for poor women and children/families. the disabled. blind. and the aged. and Medicare is a federally funded insurance program for the aged and disabled on Social Security.

Q: CAN THIS FUND BE USED TO OFFSET LESS THAN CUSTOMARY CHARGES?
A: The Fund is not to be used to compensate providers for lower than desired private or public insurance fees for services, or to enhance capitated payments for persons enrolled in managed care programs. The Fund is not intended to supplant existing indigent care funds or resources.

Q. WHO ARE THE INDIGENT AND UNINSURED?
A: They represent the 18-23% of Nevadans determined by the State Health Division to be without health insurance. Carson City, Clark. and Washoe Counties report higher percentages of uninsured (26.45%. 24.64%. and 25.42%. respectively -- Nevada Primary Care Access Plan. January 1995).

Q: WHO ELSE QUALIFIES AS PRIMARY CARE PROVIDERS?
A: As described in the statement from the Committee. clearly identified as qualified community-based health centers are: 1) Federally Qualified Health Centers (FQHCs); 2) FQHC "look alikes." designated by the Federal Bureau of Primary Health Care and recognized by the U.S. Health Care Financing Administration; 3) Title V-funded Urban Indian Health Clinics; 4) Tribal Health Centers/Clinics on reservations or colonies; and 5) the Primary Care Case Management Program affiliated with the University of Nevada's School of Medicine.

The sixth category of qualified providers is designed to capture other professionals and professional groups who meet the "indigent/uninsured" care criteria as noted in answers to earlier questions. Our original proposal suggested providers must have programs in which 20% of the services provided are uncompensated. After more thoroughly assessing the broad pool of primary care service providers who serve the indigent and uninsured. our recommendation is that this base percentage float somewhere between 10-15%. Thus, the qualification for compensation from the "Medically Needy Fund" for providers of primary care services would be a sliding fee schedule. and programs/clinics in which 10-15% of the services provided were uncompensated. The legislation and administrative guidelines of

the Fund would more clearly stipulate uncompensated care percentages, and when and if they might be variably applied to different communities and care settings.

Q: MUST ELIGIBLE PRIMARY CARE PROVIDERS IN THE SIXTH CATEGORY BE FREE-STANDING AGENCIES?

A: No. As long as the basic criteria are met, these "providers" could be an outreach program of a hospital, a special mobile primary care services program of a hospital, clinic or medical group, or any number of other "care providing entities" who may include private practices in remote parts of the state, and heavily-impacted rural or urban group practices. The critical question -- Do these providers meet the basic criteria for the "Medically Needy Fund" as noted above? These must be the standards to level the playing field for all in this category of eligible providers.

Q. HOW BROAD ARE THE CATEGORIES OF THE COMPREHENSIVE PRIMARY CARE SERVICES IN THE PROPOSED FUND?

A: As listed in the "Statement" -- 1) counseling (family, mental health, and substance abuse) -- includes counseling as it relates to ongoing case management needs; 2) dental services (preventive and restorative) -- general exams and cleanings, dental exams, pre-emergency restorative services that prevent further complications; 3) health education, preventive health services, and referrals -- includes a variety of health education topics to promote health and prevent illness or accident, family planning counseling and services (not abortion services), and referrals to specialists and other providers; 4) outreach services -- community-based outreach to indigent and uninsured persons to prevent the spread of communicable diseases and increase the level of community health; 5) pharmacy -- to cover prescription drugs; 6) transportation services -- to assist persons' access to primary care services and follow-up appointments that are part of an ongoing case management program; 7) treatment of minor illnesses -- primary care medical services typically delivered in community-based health centers; 8) well-child care and immunizations; and 9) x-ray -- appropriate to complement medical care. We would add, 10) primary care services delivered at home.

Q. WHAT ARE THE INFRASTRUCTURE AND CAPACITY BUILDING SET ASIDE FUNDS SUGGESTED IN THE "STATEMENT" MEANT TO ACCOMPLISH?

A: These funds are targeted to assist individual health centers, and community groups and primary care providers, to create the infrastructure and programs to meet community needs for comprehensive primary care services. This may mean opening new clinics, expanding existing clinics, recruiting providers, the acquisition of equipment, etc., but would not include the construction of any buildings or facilities.

Q. MUST ORGANIZATIONS OR INDIVIDUALS WHO MEET THE BASIC CRITERIA OF AN ELIGIBLE PROVIDER (I.E., SLIDING FEE SCHEDULE, AND AT LEAST 10-15% OF DOCUMENTED UNCOMPENSATED CARE), PROVIDE THE FULL RANGE OF PRIMARY CARE SERVICES LISTED IN THE "STATEMENT" TO BE ELIGIBLE FOR COMPENSATION FROM THE "FUND?"
A: No. Organizations or individuals would be eligible for compensation from the Fund if they provided any one or more of the listed services under the guidelines of eligibility.

Q. CAN ELIGIBLE PROVIDERS SUBCONTRACT WITH OTHER AGENCIES TO PROVIDE FUND-COVERED SERVICES?
A: Yes, as long as the services are for the indigent and uninsured. In many communities, these partnerships would be encouraged to provide an opportunity for eligible providers to offer a wider range of services to indigent and uninsured populations. Thus, subcontracts with providers of more specialized services (e.g., home health, education and outreach, transportation, etc.) would encourage broader participation in the Fund, and a more diverse and durable "safety net."

Q. WOULD THIS FUND BE AFFECTED BY THE NEWLY PASSED PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 (WELFARE REFORM)?
A: It's likely Welfare Reform will create more of a need for the Fund. Under the new legislation, Medicaid coverage for persons on Welfare is no longer a guaranteed "benefit," and with the removal of other previously qualified persons from the Welfare rolls, it appears likely that the demand for uncompensated primary care services will increase. Similarly, as Welfare reform works to assist some persons in getting off Welfare and becoming employed, it's fair to assume that many of these persons and their families will have continuing needs for primary care services that they can afford only if made available to them on a sliding fee.

Q. WHO WILL ADMINISTER THE "MEDICALLY NEEDY FUND," AND HOW WILL FUNDS BE MADE AVAILABLE?
A: It is proposed the Department of Human Resources be the administrator of the Fund. Patterning the Fund after the successful aspects of other states' programs, and limiting the pitfalls that others have discovered, it is proposed funds be awarded in more than one way, depending on demonstrated need. Different funding mechanisms could include: grants-in-aid; competitively bid contracts; targeted program initiatives; and local consortium awards. Each mechanism would be allocated a percentage of the annual Fund based on documented need.

As envisioned, there would be a "start-up" period during which all currently eligible providers would use a standardized procedure to document their level of uncompensated services. This level of uncompensated care would be factored into their base funding, with additional funds awarded competitively to eligible providers for programs to address infrastructure and capacity-building initiatives, and a host of other prevention-oriented primary care initiatives.

Providers not currently eligible, could established a sliding fee schedule, after which they would have a "start-up" period of at least six months to use the standardized procedure to document their level of uncompensated services. In other words, to participate in the Fund, providers must not only meet the basic criteria, but must document the degree to which they have done so.

Q: WHAT KIND OF ACCOUNTABILITY STANDARDS ARE PROPOSED?
A: High fiscal accountability to the Legislature is essential. Thus, accountability would be shared by the Department, related State agencies, and providers. Other than actual fiscal expenditures, other information would be required: a) quarterly projections of uncompensated care, with annual reconciliations; b) records of sliding fee scale usage, charges and services rendered; c) detailed demographic reports on persons served, services provided, and referrals made; and d) evidence of follow-up and case management coordination with other public and private providers and insurance programs. Of interest to the Legislature and health planners would be comparisons of demographic data collected by providers with area-wide and regional surveys of disease morbidity rates and trends, behavioral risk factor surveys, youth risk factor surveys, mortality rates, birthrates, communicable disease rates, and other associated rates and tracking statistics on service-related conditions (dysfunctional family issues, mental illness, dental decay, etc.).

These studies, used to identify plausible causal relationships or positive health correlations, would be a collaborative effort among relevant State agencies, the Department, and providers.

Q: WHAT IS THE PROJECTED ADMINISTRATIVE COST OF THIS FUND?
A: It's not certain, but a fund of the magnitude proposed would require administrative oversight. Other states have limited administrative costs, some severely so. This question cannot be answered until the legislative and administrative guidelines are developed, but it will be held to a minimum with the accountability an essential function to be staffed.

FUNDING

The "Medically Needy Fund" shall be established in the State Treasury -- the Fund to receive its resources from general revenue funds raised through two sources: 1) a 15 cent per pack increase in the cigarette excise tax (on only 20-cigarette packs). Based on FY96 net distribution, less the 3% discount provided to wholesalers for stamping the packs, this would yield $20,727,179.22. The second revenue source would be an appropriation of 2-3% of current general fund gaming tax revenues deposited in the State's general fund, which in FY96 totaled $513,519,669.54. Two-three percent would yield $10,270,393.40 to $15,405,590.10. This increase in the cigarette excise tax shall not affect the Intergovernmental Agreements currently in place between Tribal Governments and the State of Nevada.

Tobacco tax revenues have been used to address primary care needs in states like Arizona, California, and Massachusetts, for example. Numbers of gaming industry workers who are fully employed, yet uninsured (during probation), or underinsured relative to limits of their personal and family coverage, are frequent users of federally qualified health centers who render care to these individuals on a sliding fee scale or at no charge if means are not available. A share of current gaming tax revenues (with no increase to the gaming industry) seems entirely appropriate given the health benefits to the gaming industry. The "Medically Needy Fund" would be permanent and exempt from laws relating to the lapsing of appropriations.

We stand at an important crossroads in taking a stand on the creation of a system that will ensure comprehensive primary care to the medically needy indigent and uninsured. I am grateful to The Legislative Committee on Health Care for affording the interested public an opportunity to respond to the "Statement" that came out of committee. The Committee's gesture did, I trust, elicit a range of sentiments on this proposal -- you now have ours. Again, thank you, Kerry. If I can be of any further assistance to the Committee or the Legislative Counsel Bureau in the furtherance of the Medically Needy Fund, please let me know.

Sincerely,

John Yacenda, MPH, PhD
Director

CC: Kenneth McBain, President
Dr. Richard Skelskey, Vice President
Dr. Michael Rodolico, Secretary/Treasurer
Edward Martinez, Chairman, Legislative Committee

DISTRICT HEALTH DEPARTMENT

October 14, 1996

Kerry Carroll Davis, Sr. Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

The preservation and enhancement of our ability to secure a health care "safety net" in Nevada may well be enhanced by the "medically needy fund." While the possibilities are being explored, some of the issues we'd like to see addressed include:

1. Rather than funding a proliferation of new providers, resources would be better utilized by supporting existing providers.
2. Who will assume the responsibility for quality assurance?
3. How this proposal would mesh with managed care and existing funding needs to be very clearly presented to Legislators.
4. Would this fund exist in Clark and Washoe Counties as well as Rural Nevada?
5. How would medical care be provided after diagnosis of a problem? The provision of a mammogram would presumably be included under this proposal, but how would that woman access resources for surgery, if indicated, and follow-up care?
6. Preventive care appears to be the focus of the proposal, yet we know that the target population tends to underutilize those resources already available. Would incentives be a part of the plan?
7. A clear assessment of other proposals which will request funding from an increase in cigarette excise tax and appropriation of current general fund gaming tax revenues needs to be an ongoing priority.

Please keep us informed as this proposal proceeds through the legislative process.

Sincerely,

David E. Rice, M.P.H.
District Health Officer

DER/bh

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NEVADA
RURAL
HOSPITAL
PROJECT
An alliance of rural healthcare providers

4600 Kietzke Lane
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Reno, Nevada 89502
702/827-4770
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Bill M. Welch
President

October 15, 1996

Ms. Kerry Caroll Davis, Senior Research Analyst
Attention Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, Nevada 89710

Dear Ms. Davis:

On behalf of the Nevada Rural Hospital Project (NRHP) members, I would like to thank you for the opportunity to communicate our thoughts on the proposed "Medically Needy Fund" program being considered to address the financing of primary care services for the indigent and uninsured populations.

The members of NRHP facilitate the majority of all primary care, which includes the primary physicians, emergency care, outpatient diagnostic and hospital services, to the citizens of rural Nevada. With that in mind, NRHP members support a program which would provide funding for primary medical services to the indigent and uninsured populations of Nevada through a Medically Needy Fund program supported by a broad-based revenue source. Further, we believe the program should promote access to all Nevada health care providers currently providing medical care to these patients.

Regarding the proposal you presented us to review, NRHP members believe it to be vague and felt it promoted more questions than answers. However, there are two points which do seem clear. It appears to be limited in scope regarding a funding mechanism and it seems exclusive to a small number of primary health care providers who facilitate only a small percentage of health care services to the population being considered.

The proposal gives the impression of being self-serving to a limited number of providers who, in respect to the total number of patients falling into this category, provide a small percentage of the medical services this total population receives. The eligibility criteria for an eligible provider requires having at least 10-15% of documented uncompensated care. While the percentage of indigent and uninsured may be less than 10-15% of NRHP members' total revenue, the amount of services we provide clearly represents the majority of care this population receives in rural Nevada. According to state of Nevada figures, this amount is more than $9,000,000 per year.

We are also concerned with the proposed funding mechanism to support such a program. While we certainly could support the state of Nevada in the development of a broad-based funding mechanism, we oppose the development of a special tax for a select group of industries. The NRHP members see the problem of meeting the primary medical needs of the indigent and uninsured populations as a statewide social issue and can not be successfully dealt with unless it is addressed as such.

In closing, NRHP members support the state of Nevada in its efforts to find a solution to this social problem and would be interested in working in conjunction with the state to develop a program. Once again, we appreciate the opportunity to provide input on such matters. If we can be of any other assistance, please advise.

Sincerely,

Bill M. Welch
President
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BMW/mhn

Nevada State Board of Dental Examiners

Susan S. Jancar, D.D.S.
President

Dennis Anastassatos, D.M.D.
Secretary-Treasurer

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October 15, 1996

Assemblywoman Vivian L. Freeman, Chairman
Legislative Committee on Health Care
Legislative Counsel Bureau
Capitol Complex
Carson City, Nevada 89710

Attention: Kerry Carroll Davis, Sr. Research Analyst
"Medically Needy Fund"

Dear Assemblywoman Freeman:

Thank you for the opportunity to comment on the proposed establishment of a "Medically Needy Fund" to finance primary care services for the indigent and uninsured populations. As the state agency responsible for the licensure and regulation of the dental and dental hygiene professions, our comments are focused on the aspect of the proposal regarding preventive and restorative dental services.

As indicated in earlier correspondence, the State Dental Board's major function is the protection of the dental-treatment interests of Nevada's citizens. Under current statute, this protection is extended to all sectors of the population regardless of social or economic status. Establishment of a "Medical Needy Fund" may well be the first step toward resolving the issues involved in providing dental services to indigent and/or uninsured persons. However, the steps which follow funding in actually implementing a program of patient care services must consider the continued protection of the public and avoid any compromise on quality of dental care.

As you know, Dr. Jancar and other members of the Board are available to provide information as requested by the Committee. If we can assist you, please let me know.

Sincerely,

VaLonne Harmon

VaLonne S. Harmon
Executive Director

cc: Members, Nevada State Board of Dental Examiners

Catholic Charities of Southern Nevada

Senior Nutrition & Meals-on-Wheels

531 N. 30th Street • Las Vegas, NV 89101 • 385-3351 • FAX: 385-3206

27 E. Texas Street • Henderson, NV 89015 • 565-7980 • FAX: 565-4224

ADVOCATE

Research

October 15, 1996

Kerry Carroll Davis, Sr. Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Re:"MEDICALLY NEEDY FUND" PROPOSAL

In response to your letter of September 12, 1996, I see a segment of the population that has been neglected. The Senior Homebound population lacks all of the services that are included plus additional services. Services to be included:

Nutritional Dietary Supplements
Vitamins
Personal Care Items: adult diapers, denture cleaning materials, etc.
Immunization: Flu and Pneumonia
Eye care: Examinations, Glasses & Surgical Treatment
Transportation Services that allow health professionals to go into the homes to provide these services.
Counseling: Senior Abuse (including self induced abuse and neglect)

The federal government is leading the way with the realization that nutritional well-being keeps seniors healthy,

independent and does so with over-all lower health costs. It is now structuring all senior programs to include nutritional needs as a basis for service. All programs such as ours are mandated to educate in nutritional health as well as health of teeth, gums and eyesight along with senior abuse (including self abuse and neglect).

It is now up to Nevada to guarantee such services to our homebound population that are uninsured and/or underinsured though covered through existing programs inclusive of Medicaid and Medicare.

I will be glad to provide you with statistical information regarding the 1000 clients we serve daily as well as the 300 that we have on our waiting list for our Meals-on-Wheels Program.

Please include me as an active member of this public forum through this committee to continue to deliberate with you as to the formation of the "MEDICALLY NEEDY FUND." I will make myself and my staff available to attend any meetings, provide any presentations and speak with interested members of the committee at your request.

Respectfully,

Myra J. Davis
Senior Advocate
Manager, Social Services

Nevada Association of Hospitals and Health Systems
4600 Kietzke Lane, Suite A-108 ■ Reno, Nevada 89502 ■ (702) 827-0184 ■ FAX 702/827-0190

October 15, 1996 **HAND DELIVERED**

Ms. Kerry Carroll Davis
Senior Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, Nevada 89710

Dear Ms. Davis:

On behalf of the Nevada Association of Hospitals and Health Systems (NAHHS), I would like to express my appreciation for the opportunity to provide feedback regarding the creation of a fund to finance primary care services for the indigent and uninsured populations.

For the twelve month period ending June 30, 1996, the amount of free care provided, and bad debt written off, by Nevada's hospitals amounted to over $224 million. Of that total, almost $9 million was borne by rural facilities and the remainder was provided in urban areas. With the recent passage of a federal welfare reform bill and the pending changes in federal funding of Medicaid and other social programs, the number of indigents and uninsured in the state of Nevada is surely to increase. A recent study released by the Senator Alan Bible Center for Applied Research reported that in 1994, 17.4% of adult Nevadans do not have health care coverage. The findings also show that poor and less educated are at disproportionate risk for gaps in health insurance.

Clearly these statistics point out the importance of a fund to cover the medically needy. However, the nature and types of services which would be most effectively and efficiently provided through a medically needy fund would require an in-depth analysis of the needs of the population to be served (ie. age, health status, geographic location etc). The brief proposal provided with your request for comment outlines a conceptual framework for a fund; however, it does not address the details. The NAHHS membership would be very interested in participating in further discussions at a more detailed level.

The concept of funding a program to cover the health needs of the indigent and underinsured is a social policy issue. In light of this observation, NAHHS would be in support of a broad-based funding approach which would address the statewide nature of the need as well as of the solution. The extent of the funding required to develop and maintain a fund would need to be determined in conjunction with the analysis referred to above.

Once again, we appreciate the opportunity to provide our comments regarding a medically needy fund to the Legislative Committee on Health Care. Please feel free to contact me should you have any questions or need further information.

Sincerely,

Jeanette K. Belz
President/CEO

JKB/dfm
Enclosure
d:jeanette.board.medneedy.ltr

cc: Michael Callahan, Chair, NAHHS Board of Directors

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*ADMITTED IN CALIFORNIA ONLY

October 15, 1996

WRITER'S DIRECT DIAL NUMBER:
(702) 788-8690

Kerry Carroll Davis, Sr. Research Analyst
Attn: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Re: Medically Needy Fund Proposal

Dear Ms. Davis:

Thank you for the opportunity to submit comments on the establishment and funding of a "Medically Needy Fund" (the "Fund") in Nevada. The need for programs to assist medically indigent and uninsured individuals is apparent; however, the necessity of establishing an additional fund to finance primary care for indigent and uninsured residents of Nevada is less certain in light of the existing funds and programs currently available at the local, state, and federal levels. Until additional details regarding the specific needs of the residents of Nevada are identified and until further details of the establishment and administration of the Fund are available, Lionel Sawyer & Collins ("LS&C") is unable to assess and comment upon the specific aspects of the proposal.

While unable to offer specific input regarding the scope of the services to be provided by the the Fund, we would like to offer general information regarding the proposed funding mechanism. Any legislation establishing a medically needy fund should ensure that the Fund is supported by currently available revenue and should not seek to support the Fund through a tax increase or a tax directed at specific industries. Attempts to fund specific programs with product specific taxes have potential to result in a loss of revenue derived from that source despite the increased tax rate. Because increasing the cigarette excise tax has been specifically mentioned as a possible funding source, these comments focus specifically on the consequences of imposition of such an increase.

When other states have raised the cigarette excise tax, the states have experienced an increase in cross-border sales and decrease in sales and tax collections. Nevada is particularly susceptible to cross-border sales because of its geographic proximity to a number of states currently imposing taxes which are lower or only slightly higher than those currently imposed by Nevada. An increase in the excise tax will make Nevada less competitive than neighboring states and provide incentive for residents to make cross-border purchases to avoid Nevada taxes. In addition to cross-border state sales, Nevada's proximity to California provides easy access to illegal imports from Mexico and other central American countries.

Nevada may also lose revenue because of tax free purchases made at smoke shops on Native American tribal lands. Purchasers of cigarettes currently pay an average of $18.30 for a carton of cigarettes with all excise taxes paid; a consumer can pay an average of $14.80 at Native American smoke shops. Again, Nevada faces significant risk of lost revenue from redirected sales. The number of Native American operated smoke shops in Nevada will provide residents accessibility to tax free cigarettes resulting in a decrease in sales at privately owned stores which must collect the excise taxes. Not only will Nevadan's have access to tribal smoke shops in Nevada, a number of Nevada's neighboring states have a significant number of smoke shops where tax free cigarettes can be purchased and brought over the boarder into Nevada, further decreasing contributions to the State treasury.

Because purchasers of cigarettes in Nevada can expect to pay $18.30 per carton and a purchaser of cigarettes smuggled from tax-free locations will pay between $8.00 and $11.00, an increase in the excise tax will create an atmosphere that will foster expansion of underground markets for those seeking to evade the law and purchase tax free cigarettes. An increase in the cigarette excise tax in Michigan, Arizona, and Canada resulted in a significant increase in the underground markets and a significant decrease in legitimate sales. Forcing development of an underground market will increase crime, decrease sales, and result in a net loss to the Nevada treasury because of lost tax revenue due to lost sales and an increase in allocation of resources necessary to combat the crime associated with an expanded underground market.

Based on the experience of other states that have raised the excise tax on cigarettes, it is apparent that the threat of decreased revenue and other negative repercussions is more than a possibility. Not only will the State suffer a decrease in revenue, but the sixteen Nevada counties, Carson City, and the local governments therein will experience a decrease in the revenue received from collection of the excise tax. A decrease in the cigarette excise tax by these entities will compel Nevada's local governments to make budget cuts to compensate for the loss of revenue from the excise tax. If forced to make budget cuts, discretionary local government programs will be the first target. Many of these discretionary programs are programs which assist the indigent and uninsured. The inability to continue operation of these programs or decrease services provided by these programs will result in a loss of services for those most in need. As the possible consequences of

increasing the cigarette excise tax are examined, it becomes evident that institution of such measures will create more problems than solved; therefore, alternative financing sources must be scrutinized.

While we agree there is a need to review the needs of the medically indigent and uninsured, we do not agree that an increase in the cigarette excise tax or any excise tax increase is an appropriate manner by which to fund such programs. As the direction of the proposal becomes more defined and other funding mechanisms are explored, we welcome the opportunity to participate in the process. If we may offer further information or assistance, please do not hesitate to contact us.

Best Regards,

Morgan Baumgartner

MRB/tbl
cc: Henry Stokes, R.J. Reynolds Tobacco Company
Harvey Whittemore

LEGAL SERVICES STATEWIDE ADVOCACY OFFICE

111 West Telegraph Street, Suite 202
Carson City, Nevada 89703
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FAX 702-883-1872

Jon L. Sasser
State Advocacy Coordinator

October 15, 1996

Kerry Carroll Davis
Senior Research Analyst
Research Division
State of Nevada
Legislative Counsel Bureau
401 S. Carson Street
Carson City, NV 89710

Dear Ms. Davis:

I am writing in response to your request for comments on the concept of creating a Nevada fund for the medically needy. I have urged the creation of a medically needy program in Nevada in various legislative forums going back to the mid-1980s and certainly continue to strongly support such a proposal.

In terms of the specifics, I would concur in the priorities contained in the letter to you today from my colleague, Mary Ellen McCarthy. I share Ms. McCarthy's view that so long as a matching federal dollar is available to Nevada, that we should serve the medically needy through the Medicaid program.

Although it is impossible to engage in completely accurate crystal ball-gazing regarding federal Medicaid reform, there may well be an additional incentive at the present time for Nevada to utilize the Medicaid program for any expansion of services. If Medicaid block grant legislation passes Congress within the next few years, a "base year" is likely to be established. If that base year were FY 96, Nevada would be at a large disadvantage because it offers little to no optional Medicaid coverage. On the other hand, 37 states have a Medicaid Medically Needy program. If Nevada were to get its program into place by FY 97, it would potentially become a part of our base year for a future Medicaid block grant.

Nevada continues to have one of the highest percentages of our population without insurance. A primary cause is our restricted eligibility for Medicaid. I continue to believe that an extension of Medicaid is the wisest first step toward providing medical coverage to the uninsured.

Sincerely,

Jon L. Sasser
State Advocacy Coordinator

JLS:or

NEVADA INDIAN RURAL LEGAL SERVICES

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October 15, 1996

Kerry Carroll Davis
Senior Research Analyst
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Re: Medically Needy Fund

Dear Ms. Davis:

This letter is in response to your request for comments on the proposed medically needy fund. As a long time advocate of a medically needy program, I strongly support any efforts to improve the health care of Nevada's residents. I have some concern, however as to a proposal which would require another bureaucracy within the Department of Human Resources to administer such a program. I am also concerned that the proposal, as I understand it, is not designed in such a manner as to provide for the utilization of currently available federal dollars to match local expenditures.

These comments are based upon my experience over the past seven years in trying to assist low-income Nevada residents with the cost of health care. Sadly in a number of cases, I must advise Nevadans that the only way they can obtain medically necessary health care is to uproot their families and move to another state or country. At the present time, three separate sets of governmental agencies assist some portion of the population with he cost of medical care. These programs are the extremely limited Medicaid program, the County Medical Assistance programs and the Indigent Accident Fund. The latter two programs receive no federal matching dollars.

I believe that many of the objectives of the proposal could be addressed by providing for a "medically needy" Medicaid program for some portion of the population, by expanding the number of disabled persons eligible for home and community based services and by providing funds to the counties for expansion of the county medical indigent programs.

These policies would address the health care needs of several groups within the uninsured population. The first group of persons are pregnant women and children whose income and or resources exceed the current Medicaid amounts under present policy.

The second group of persons are those whom I have found to be most adversely affected by Nevada's current health care policies. These are disabled persons who receive Social Security benefits, but whose income exceeds the SSI limit by as little as one cent and who have not received Social Security disability benefits for the two years necessary in order for them to become eligible for Medicare. This population is most at risk for adverse health consequences, including death, if they are unable to obtain necessary medications and health care.

The third group of persons I have seen are those disabled persons who can be adequately cared for at home with home and community based services, but who are placed on a waiting list for the home and community based waiver program. This waiting list is several years long. Unfortunately, I must advise such clients that they must enter a nursing home, at a higher cost to the state's Medicaid program in order to obtain necessary health care.

The fourth group of persons are those residents who suffer from a severe short term disability, but who are not expected to be disabled for the twelve month period in order to qualify for Social Security or SSI disability benefits.

A medically needy program under the state Medicaid plan could be developed to address the needs of the first two populations described above. The third group could be helped by an expansion of the current waiver program. The final group can only be assisted at the present time under a state or county funded program. A Medicaid medically needy program is not required to include all segments of the population or all of the services provided to regular Medicaid recipients. I would strongly encourage the development of a program which includes all relevant populations. However if funding is insufficient for a full medically needy program, a more modest program could be initiated.

A medically needy Medicaid program provides that after a person has spent a certain amount of his or her income toward the cost of his or her care, the balance is paid by Medicaid. Medically needy time periods can be established on a monthly or other basis up to a "spend down period" of six months. The use of such a program has the effect of a sliding fee scale, but may be administratively simpler to administer than a sliding fee scale involving multiple providers.

In addition to other advantages, a medically needy program for the TANF (formerly called AFDC) related population would alleviate one of the problems identified with the proposal for Medicaid managed care. Providers have expressed concern about the inability of a Medicaid managed care program to "lock in" patients for more than a one month period. A major problem with lack of continuity for Medicaid recipients is not the Medicaid patients are choosing to disenroll from a plan on a frequent basis. Rather the severely limited nature of the present Medicaid program, eliminates Medicaid coverage for persons whose income exceeds the income limits of the various programs by as little as one cent. thus, a family may be eligible for one month, ineligible for the next month and eligible again the following month. The establishment of a medically needy program would enhance the ability of managed care organizations to provide continuity of care.

In order for a state to have a medically needy program, the state is required to cover certain groups of people and certain services. The population which must be included in any medically needy program under Medicaid are:

1. individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as a mandatory Medicaid recipient: and

2. pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance under mandatory and optional Medicaid categories.

3. for one year, the newborn children of a woman receiving medically needy Medicaid on the date of the child's birth.

4. for sixty (60) days after the end of pregnancy for women who received medically needy Medicaid.

See, 42 U.S.C. §1396a(a) (10)(C) (ii), and 42 C.F.R. § 435.301(b)(1).

The population in this group could be expected to comprise about 70% of medically needy pregnant women and children, but would generate only about 30% of increased Medicaid expenditures. This estimate is based upon current Medicaid ratios of population to cost. Under present law, 50% of the cost of this program would be paid by the federal government. The expansion of the Medicaid program to cover this group could provide for all of the care needs identified in the proposal for this population at one-half the cost of a state only program. Since this population represents only a small portion of the Medicaid budget, I would recommend that full Medicaid services be provided to this population.

The state could also establish a medically needy program for disabled persons who do not receive Medicaid as SSI recipients. This population includes only persons who meet the disability requirements of the Social Security Act. Since this population would be time limited for full Medicaid coverage (all Social Security disabled beneficiaries are eligible for Medicare after receiving cash benefits for two years), the cost would likewise be limited. The cost limitation of this program was noted in Georgia when the disabled were added to that state's Medicaid program.

In addition, the state could expand the Medicaid waiver program for the disabled population. It is my understanding a request could be made to double the number of disabled persons eligible for services under this waiver program.

Finally additional funding could be made available to the counties for assistance with the short term medical needs of the disabled population for out-patient treatment and prescription drugs. Hospital care and emergency care are presently provided to this population under NRS 428.015. It would also be advisable to increase the income eligibility criteria for this program to the poverty level.

I would also support the use of a dedicated tax source to fund these programs. I hope that this information if of assistance to the committee in improving the health care of some of Nevada's most vulnerable residents. Kindly advise if I may provide any additional information or assistance to the committee.

Very truly yours,

Mary Ellen McCarthy

Mary Ellen McCarthy
Executive Director

MEM:or

AMERICAN CANCER SOCIETY Southwest Division, Inc.

Kerry Carroll Davis, Sr. Research Analyst
Attn: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, Nevada 89710

Oct.15, 1996

To: Persons on the Legislative Committee On Health Care
[NRS] 439B.200 through 439B.240

Re: Response for a Survey on the "Medically Needy Fund" Proposal

The **American Cancer Society**, Southwest Division Nevada is pleased to provide you with the enclosed feedback information regarding a proposed tobacco tax increase in Nevada to fund "medically needy" care. The enclosed **Health and Revenue Gains From a Tobacco Tax Increase In Nevada**, was compiled using published tobacco industry numbers and applying an accepted scientific formula to arrive at the **Revenue Gained** as well as the lives saved. As you will see the proposed tax increase is graduated from ten cents, to a dollar per pack.

According to a recent Tobacco Tax Survey conducted in Nevada by **The Marketing Workshop Inc.**: "The majority of Nevada adults agree a cigarette tax increase wouldn't bother me like a property or sales tax increase would. It's different." The report goes on to state: "A tobacco tax increase (of between thirty-five to sixty cents per pack) if put to a vote at the ballot box would probably pass because it is supported by a majority of registered voters."

It is also important to note that in every state that a tobacco tax increase has been successful, great public support and approval was achieved through ear marking a portion of revenues gained for a **tobacco resistance youth education** component to be used throughout the state. In order to save lives in this area as well as help reduce youth access to tobacco, the **American Cancer Society Nevada**, would be pleased to help implement that public education component in any way possible.

If you have any further questions or comments please don't hesitate to contact me.

Cordially,

Mark Savage
Legislative Affairs
American Cancer Society, Nevada

HEALTH AND REVENUE GAINS FROM A TOBACCO TAX INCREASE IN NEVADA[1]

Tax Increase	Adult Reduction[2]	Youth Reduction[3]	Revenue Gained	Lives Saved[4]
$0.10	2 %	5.1%	$ 14 Million	1,085
$0.25	5.1%	12.8%	$ 34 Million	2,754
$0.50	8.7%	20.4%	$ 65 Million	4,799
$0.75	12.2%	27.8%	$ 94 Million	6,752
$1.00	15.3%	33.9%	$121 Million	8,475

1 Assumes an average price of $1.95 per pack of 20 cigarettes in Nevada based on the Tax Burden on Tobacco Vol.30 1995 published by the Tobacco Institute, Washington, D.C.

2 The adult reduction estimate assumes a constant price elasticity of demand for cigarettes of -0.4, a midpoint derived from a report by an expert panel of economists who agreed that the price elasticity is between -0.3 and -0.5. National Cancer Institute. The Impact of cigarette Excise Taxes on Smoking among children and Adults. Rockville, MD: Division of Cancer Prevention and Control, National Cancer Institute, 1993.

3 The youth reduction estimate assumes a conservative price elasticity of -1.0. The two most highly regarded studies of price elasticity of demand for minors found it to be about -1.4. Lewit, E.M., Coate, D. Grossman, M. "The Effects of Government Regulation on Teenage Smoking." Journal of Law and Economics 24:545-569, December 1981; Chaloupka, F. J., Wechsler, H. "Price Control Policies and Smoking Among Young Adults." Working Paper No. 5012, Cambridge, MA: National Bureau of Economic Research, February, 1995.

4 The estimates of lives saved conservatively assumes a -0.26 price elasticity for smoking participation and that 1 in 4 of these discouraged from smoking avoids dying prematurely as a result. The estimates are a cumulative total of lives that would be saved among today's population in response to a given tobacco tax increase, assuming that the tax increase is maintained in real terms over time. Lewit, E.M., Coate, D. "The Potential for Using Excise Taxes to Reduce Smoking." Journal of Health Economics,1(2):121-145. 1982

Prepared By: Mark Savage, American Cancer Society Southwest Division Inc.

BOB MILLER
Governor

CHARLOTTE CRAWFORD
Director

STATE OF NEVADA

YVONNE SYLVA
Administrator

DONALD S. KWALICK, MD, MPH
State Health Officer

DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
505 E. King Street, Room 201
Carson City, Nevada 89710
Telephone: (702) 687-4740 • Fax: (702) 687-3859

October 16, 1996

MEMORANDUM

To: Kerry Carroll-Davis, Sr. Research Analyst
Legislative Counsel Bureau

From: Donald S. Kwalick, MD, MPH, State Health Officer
Health Division

Re: Medically-Needy Fund

I suggest the following additional language to the August 26, 1996, approved text in the last paragraph:

> Such centers...may include, (6) community-based clinics or programs of larger organizations (hospitals, medical groups, [or] primary care clinics, or county and district health departments) that provide primary care services on a sliding fee schedule and at least 20 percent of the services provided are uncompensated.

Note: [brackets] = deletions
underline = additions

Please call me if you have any questions.

DSK/ll

Additional Response Letters to "Medically Needy Fund" Survey
Received after Deadline and
Not Included in "Summary of Comments" Table

BOB MILLER
Governor

STATE OF NEVADA

CAROL A. JACKSON
Director

DEPARTMENT OF EMPLOYMENT, TRAINING AND REHABILITATION
DIRECTOR'S OFFICE
1830 E. Sahara Avenue, Suite 208
Las Vegas, Nevada 89104
Telephone (702) 486-7923 • Fax (702) 486-7924

MEMORANDUM

TO: Kerry Carrol Davis, Senior Research Analyst
Legislative Counsel Bureau

FROM: Carol A. Jackson, Director

DATE: October 16, 1996

RE: Response to Survey on the "Medically Needy Fund" Proposal

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This letter is in response to the survey requested by the Legislative Committee on Health Care with respect to the Medically Needy Proposal.

ANALYSIS OF PROPOSAL RELATIVE TO SUBSTANCE ABUSE FIELD:

Paragraph one of the proposal, number one (1) counseling... includes substance abuse counseling. This could potentially improve funding opportunities for substance abuse service providers and counselors. However, there are no data estimates provided with respect to the number of such persons needing this category of services, nor an estimated break-out of the number of persons who might access substance abuse counseling services to provide any clear impact on monetary values.

Paragraph two of the proposal which states: "Such centers shall include:... (4) Tribal Health Centers/Clinics on reservations or colonies;...(6) community-based clinics or programs of larger organizations (hospitals, medical groups, or primary care clinics) that provide primary care services on a sliding fee schedule and at least 20 percent of the services provided are uncompensated," may provide more funding opportunities for substance abuse service providers and counselors by **inference** of the terms "comprehensive primary care services" and "programs of larger organizations" to include substance abuse services. This application would be contingent upon clarification or further delineation of the terms espoused above to clearly include "community-based counseling services." Number four (4) of this paragraph could potentially apply to two (2) substance abuse programs on Indian Reservations funded by the Bureau in Owyhee and in Las Vegas. The proposed "Medically Needy" program may provide more funding

sources for these entities.

However, there are concerns that are not addressed in this proposal that could be of vital importance to this agency. These concerns include the following:

1.) Who will be responsible for the administration of the Medically Needy Program;
2.) Who will define and develop the criteria for eligibility under this category;
3.) How will clients and agencies access funds?
4.) How will confidentiality be addressed?
5.) How will emergency medical care related to accidental DUI be handled?
6.) How would emergency medical detox be handled? What about seizures or overdose related to chemical dependency and abuse?
7.) Would this program be coordinated through a community assessment triage center?
8.) Would the funding mechanism for this program be based on a capitated basis?
9.) Would pregnant, post partum women and drug-exposed infants be included in this program?

POSSIBLE REVENUE SOURCES:

The agency is unable to identify any revenue sources.

CAJ/rm

cc: Liz Breshears, Administrator-Rehabilitation Division
File

Churchill Council on Alcohol and Other Drugs
A Non-Profit Corporation

EXECUTIVE OFFICES
90 North Maine Street
Fallon, Nevada 89406
(702)423-1412
FAX(702)423-5778

COMMUNITY
SERVICE CLINIC
(702)423-4644

EMPLOYEE
ASSISTANCE PROGRAM
(702)423-1412

YOUTH SERVICES
(702)423-4644

NEW FRONTIER
TREATMENT CENTER
165 North Carson Street
Fallon, Nevada 89406
(702)423-6048

FERNLEY
COUNSELING SERVICE
200 E. Main
Fernley, NV 89408
(702)575-6191

LOVELOCK
COUNSELING CLINIC
P.O. Box 1612
Lovelock, NV 89419
(702)273-2022

TONOPAH
COUNSELING SERVICE
1100 Erie Main
P.O. Box 3995
Tonopah, NV 89049
(702)482-5250

GATEWAY
COUNSELING SERVICE
P.O. Box 248
Schultz Trailer Park #32
Beatty, NV 89003
(702)553-9154

October 17, 1996

Kerry Carroll Davis, Senior Research Analyst
Attention: Medically Needy Fund
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Dear Ms. Davis:

I wish to write in response to the proposal for a "Medically Needy Fund." Because many of Nevada's citizens are medically uninsured and, hence, underserved, I support the creation of a medically needy fund.

Due to the work that I do, I would like to briefly address the need to include substance abuse counseling services. The agency I work for is partially funded by the Bureau of Alcohol and Drug Abuse (BADA). Most of the people that BADA funded programs serve are uninsured and unable to pay for the cost of services. BADA funded programs do not receive enough money to pay for the full cost for treatment, so our programs have to charge clients something. Charges are based on a sliding fee scale.

Even though we charge our impoverished clients very little, some people are unable to pay even that minimal amount. We never turn anyone down for lack of ability to pay, but many people still don't access services because they feel that being charged or paying any amount, no matter how small, is a burden.

The point of all of this is to explain that I believe the Medically Needy Fund could be used, in part, to help needy people access services by paying their portion of the sliding fee scale. This would tear down one major barrier to access for some of our prospective clients.

In addition, since we know that so many medical problems are either caused or exacerbated by substance abuse, making substance abuse services more accessible will certainly lead to an overall lower utilization of medical services among those that come to us for help.

If you need more information or would like to talk more about the ideas I've put forth in this letter, I'd be happy to talk with you or anyone on the committee. Thanks for considering my views.

Sincerely,

Kevin Quint
Executive Director

cc: file

ELY SHOSHONE TRIBE

16 SHOSHONE CIRCLE Fax. 702 - 289 - 3156 ELY, NEVADA 89301
702 - 289 - 3013

October 17, 1996

Kerry Carroll Davis, Sr.
Research Analyst, Legislative Counsel Bureau
Capitol Complex, Carson City, NV 89710

Dear Mr. Davis:

The Ely Shoshone Tribe supports the proposal of the Legislative Committee on Health Care for a "Medically Needy Fund" for Nevada's indigent and uninsured populations.

The funding mechanisms proposed make sense. We would suggest looking at a liquor tax as well. Considering the health cost of both cigarettes and alcohol, "sin" taxes become a sensible method of recovering at least a share of the millions of dollars in uncompensated medical care that abuse of these drugs costs our health care system.

We find the range of primary care services in the proposed fund to be adequate, provided primary care services delivered at home are included in the mix.

The proposal brings up more questions than answers for us as to how our Newe Clinic, staffed by Indian Health Service personnel, could work with the fund. We are presently working on the general question of state-tribal cooperation and interaction as members of the Great Basin Primary Care Association. We would welcome an opportunity to enter a dialogue with the Nevada Legislature on ways we might both - Tribe and State - use our resources to serve the broadest range of Nevadans. Perhaps as this proposal goes forward, we might begin that dialogue.

Sincerely,

Sally Marques

Sally Marques
Tribal Chairman

October, 1996

District III of the Nevada Nurses Association has members throughout Clark County, and we support efforts to establish a Medically Needy Fund in Nevada. Although our population growth cuts across all income levels, many families of the working poor find themselves with wages but no medical benefits. This impacts on adults and children, who find themselves without community based, comprehensive health services.

We support funding to provide health services to indigent or uninsured Nevadans. We support the plan to fund the program with money raised through a cigarette tax and an appropriation from the general fund gaming tax revenues, and to place the money in the State Treasury, to be administered by the Department of Human Resources.

Sincerely,

Donna S. MacDonald RN

Donna S. MacDonald, R.N.

October 1996

Clark County school nurses support the establishment of a Medically Needy Fund to provide community based, comprehensive primary health services to indigent or uninsured Nevadans.

In many of our schools, we see children who have medical, mental, or dental health needs and have no resources for care. Many of these students are from intact families with hard working parents. Parents with jobs often have not met the time eligibility requirements for insurance coverage, or have benefits as an employee but cannot afford the coverage for the rest of the family. Working adults may be terminated from a job before they reach the magic 90 day limit, thus never becoming eligible for benefits. Pre-existing conditions often have a waiting period that puts people at greater health risk. Some have limited benefits with a deductible so high that it is the same as being uninsured.

We support the efforts to establish a medically needy fund, and we support the plan to fund this with money raised through a cigarette tax and an appropriation from the general fund gaming tax revenues.

We support establishing the fund in the State Treasury to be administered by the Department of Human Resources.

Patricia Van Betten RN
Tamara Asson RN
[illegible]
Deborah Cole RN
[illegible] RN
Roweena P. Dial RN
[illegible]
Karen Dawson, RN
Elizabeth Sirotz RN
Patricia Freeman RN
[illegible] RN
Sandra Gordon, RN
Sheila Sullivan RN
Mary Ann Sorensen RN
Renee Ball RN

Pg 1 of 2

Patti Roberts RN
Jennifer Quelley RN
[illegible] RN
Gail B. Tomao, RN
Sandra J. Lackey RN
[illegible] RN
Georgiana DeHaven
[illegible] RN
Pat Westmoreland, RN
[illegible] RN
Colleen Van Swearingen, RN
Pauline Gallego RN
Mary Weston RN
Sharon Gordon RN
[illegible] RN
Mary Bettle

Medically Needy Fund

Linda Cannarozzo RN
Linda Lowe RN
Joyce M. Palmer RN
Julia Wagner RN
Lois Houghton RN
Kim Nakamura RN
Diane Shestino RN

Janet O. Conrad RN
Julie Bolton RN
Marie Benninger RN
Yvonne Chanel RN
Darlie Mabin RN
Colleen McElhenie RN
Sharon Dalessio RN
Karen M. Klein RN
Felicia Wagner RN
Judy Kopple RN
Janice Menshaw RN

MEMO

LCB, Research Division

DATE: 11/1/96

TO: Pepper Sturm

FROM: Dale Caguiro 687-4588

SUBJECT: Attached Survey for Dentists

Keri Davis suggested I send this to you when mailed to dentists. Here it is.

BOB MILLER
Governor

STATE OF NEVADA

CHARLOTTE CRAWFORD
Director

MYLA C. FLORENCE
Administrator

DEPARTMENT OF HUMAN RESOURCES
WELFARE DIVISION – NEVADA MEDICAID
Capitol Complex • 2527 N. Carson Street
Carson City, Nevada 89710
(702) 687-4775

October 30, 1996

Dear Doctor:

You have been selected to represent Nevada's licensed dentists by completing the attached survey on the potential effectiveness of proposed changes to Nevada Medicaid's dental program.

Our decision to adopt the enclosed fee schedule and other changes depends on the honest feedback we receive from you and other surveyed dentists. We look to the survey results to justify our committing additional funding for dental services.

Written suggestions and questions are welcome. Mail the survey in the enclosed self-addressed stamped envelope. or write to the following address:

Attention: V.R.
Dale Capurro
Dental Program Manager
Nevada Medicaid
2527 North Carson Street
Carson City, NV 89710

Thank you in advance for taking the time to review the enclosed materials and complete the survey form. We value your input.

Sincerely,

Matthew Bayan
Chief, Medicaid Program Services

dhc:(C: . . .\rates\surv969c)

MEDICAID DENTAL SURVEY RESPONSE FORM - NOVEMBER 1996

I. Mark each item to show if the program change encourages you to treat Medicaid clients.

1._Yes _ No Except for codes 5150 and 9899, all codes on the attached fee schedule are from the American Dental Association's CDT-2 code list. Will Medicaid's adoption of the fee schedule make participation more attractive to you?

2._Yes _ No For clients less than 21 years of age, dental providers may perform services and bill without authorization from Medicaid. However, Medicaid requires documentation and/or x-ray verification for payment of emergency and prior authorized services for clients 21 years or older. We propose eliminating many of these prepayment verification and authorization requirements for older clients. Instead, Medicaid dental consultants would occasionally audit your records. You would have less paperwork, and we would process your payments faster than the current 20 day turnarounds. Would you consider this a very welcomed change?

3._Yes _ No With the exception of about 20 codes to be paid at a higher rate, the fee schedule reflects a 35% aggregate payment increase for Nevada Medicaid. Except for the 20 higher paid codes, fees were established according to relative values reported by Relative Value Studies, Inc., a national research company based in Denver, Colorado. Will adoption of these fees on or before January 1, 1997 make Medicaid participation more attractive to you?

II. Indicate if knowing the following information makes you more likely to accept Medicaid clients.

1._Yes _ No Nevada may have the nation's most aggressive program for combating fraud and abuse issues? Each month more than 800 investigations are completed. Approximately fifty-five percent (55%) of these investigations result in finding clients ineligible and penalizing them. The penalties include collection of incorrectly paid benefits, program lockout and criminal prosecution. In addition, Nevada collects previously paid benefits from the estates of deceased recipients. Welfare clients believed to be erroneously receiving benefits should be reported to the Nevada State Welfare Division Investigations and Recovery Unit by dialing the Welfare Fraud "hot line" number published in each local telephone directory, or by dialing Carson City at 687-5903.

2._Yes _ No Medicaid allows providers 120 days to submit a billing. The starting time for this period is the date of service or the date of the client's eligibility, whichever is latest. When insurance companies or other payers must be billed, the claim is accepted within one year. Many dentist office staffs accustomed to dealing with Medicaid say the third-party billing requirements are no more cumbersome than billing for clients covered by private insurance. Dial 829-4020 in Reno for a consultation or on-site visit with the field representative.

3._Yes _ No Signing a Medicaid provider agreement places the dentist under no obligation to treat any Medicaid client. However, Medicaid clients are protected by federal law prohibiting discrimination on the basis of race, religion, ethnicity or handicap. Questions on this issue may be directed to Dale Capurro at 687-4588 in Carson City. (Continued on reverse side.)

Some dentists require their Medicaid clients to sign written understandings including statements such as the following: "Considering the heavy care needs of Medicaid covered patients, and considering this office's limited number of appointment slots for meeting those needs, you may jeopardize future treatment for yourself and your family if you miss any appointment without prior 24 hour notice."

III. Indicate your degree of interest in the Medicaid program.

1. Circle the number of Medicaid clients you currently treat per month: 0, 1-5, 6-10, 11-20, 21-30, 31+

2. Circle the number of Medicaid clients you will treat each month if all of the indicated program changes are made: 0, 1-5, 6-10, 11-20, 21-30, 31-50, 51+

3. If applicable, explain why the indicated Medicaid program changes would not encourage you to treat Medicaid clients: _____

_____

Medicaid plans to pursue electronic billing capabilities in 1997. If electronic billing would be important to you, or if you have other recommended changes for Medicaid, please comment here: _____

IV. To insure responses are not duplicated, please print or type your name, telephone number and address below.

Dentist's Name: _____ Telephone #: _____

Address: _____

\# Street, City, State Zip Code

V. **(Optional)**

Signing below will authorize Nevada Medicaid to add your name to a provider referral list after January 1, 1997. Your local Nevada State Welfare Division office will use the list to limit new-client referrals to you according to the number you designate at III-2 above. You may contact the local office at any time to change the number of referrals to you.

Dentist's Signature: _____ Date: _____

Signing dentists who need to enroll as a Medicaid providers will be mailed a partially completed agreement as the indicated program changes are implemented. (Dentists may enroll without signing here by telephoning [702] 687-4769 or requesting an application packet from the address below.)

Mail this survey page in the enclosed stamped self-addressed envelope or send it to, "Attention: V.R., Dale Capurro, Dental Program Manager, State of Nevada, Welfare Division-Nevada Medicaid, Capitol Complex, 2527 North Carson Street, Carson City, Nevada 89710-9989." **Medicaid needs to receive your response by November 17, 1996.**

dhc:(C: . . . \rates\surv969a)

CDT-2 CODES	CDT-2 SHORT DESCRIPTIONS	PROPOSED RATES EFFECTIVE 01/01/97
120	Periodic oral evaluation	10.00
140	Limited oral evaluation -- problem focused (*replaces emerg. eval.)	20.35
150	Comprehensive oral evaluation (*replaces initial exams)	28.28
160	Detailed and extensive oral evaluation -- problem focused, by report	By Report
210	Intraoral -- complete series (including bitewings)	50.35
220	Intraoral -- periapical -- first film	16.21
230	Intraoral -- periapical -- each additional film (*Not to exceed 5 films)	5.00
240	Intraoral -- occlusal film (*per film)	12.00
270	Bitewing -- single film	10.00
272	Bitewings -- two films	15.10
274	Bitewings -- four films	20.00
275	Bitewings -- each additional film	5.00
290	Posterior -- anterior or lateral skull and facial bone survey film	50.00
320	Temporomandibular joint arthrogram, including injection (*prior authorization required)	200.00
321	Other temporomandibular joint films, by report (*prior authorization required)	By Report
330	Panoramic film	45.00
332	Tomographic survey (*by report)	150.00
340	Cephalometric film	40.00
415	Bacteriologic studies for determination of pathologic agents (*by report)	By Report
430	Biopsy and examination of oral tissue, hard	64.00
440	Biopsy and examination of oral tissue, soft	60.00
460	Pulp vitality tests	10.00
470	Diagnostic casts	25.00
471	Diagnostic photographs	20.00
501	Histopathologic examinations (*by report)	60.00
502	Other oral pathology procedures, by report	By Report
999	Unspecified diagnostic procedure, by report	By Report
1110	Prophylaxis -- adult	40.00
1120	Prophylaxis -- child (*ages 7 through 20 years)	35.00
1125	Prophylaxis -- child, age 0-6	15.00
1201	Topical application of fluoride (including prophylaxis) -- child	45.00
1203	Topical application of fluoride (prophylaxis not included) -- child	10.00
1310	Nutritional counseling for the control of dental disease	24.00
1330	Oral hygiene instructions	10.00
1351	Sealant -- per tooth (*permanent, once per life of tooth)	30.00
1510	Space maintainer -- fixed (unilateral)	118.30
1515	Space maintainer -- fixed (bilateral)	236.60
1520	Space maintainer -- removable (unilateral)	100.00
1525	Space maintainer -- removable (bilateral)	140.00
1550	Recementation of space maintainer	21.87
2110	Amalgam -- one surface, primary	43.80
2120	Amalgam -- two surfaces, primary	55.88
2130	Amalgam -- three surfaces, primary	62.77
2131	Amalgam -- four or more surfaces, primary	75.02
2140	Amalgam -- one surface, permanent	50.35
2150	Amalgam -- two surfaces, permanent	68.28
2160	Amalgam -- three surfaces, permanent	78.10
2161	Amalgam -- four or more surfaces, permanent	100.00
2330	Resin -- one surface, anterior	54.53
2331	Resin -- two surfaces, anterior	74.36

* NV Medicaid requirement/stipulation
** NV Medicaid code

CDT-2 CODES	CDT-2 SHORT DESCRIPTIONS	PROPOSED RATES EFFECTIVE 01/01/97
2332	Resin -- three surfaces, anterior	81.38
2335	Resin -- four or more surfaces or involving incisal angle anterior	91.71
2336	Composite resin crown, anterior, primary	40.00
2380	Resin -- one surface, posterior - primary	20.00
2381	Resin -- two surfaces, posterior - primary	30.00
2382	Resin -- three surfaces, posterior - primary	40.00
2385	Resin -- one surface, posterior - permanent	73.12
2386	Resin -- two surfaces, posterior - permanent	91.38
2387	Resin -- three surfaces, posterior - primary	100.00
2721	Crown -- resin with predominantly base metal	300.00
2722	Crown -- resin with noble metal	340.00
2740	Crown -- porcelain/ceramic substrate	400.00
2751	Crown -- porcelain fused to predominantly base metal	320.00
2752	Crown -- porcelain fused to noble metal	360.00
2792	Crown -- full cast noble metal	320.00
2910	Recement inlay	30.00
2920	Recement crown	30.00
2930	Prefabricated stainless steel crown -- primary tooth	80.00
2931	Prefabricated stainless steel crown -- permanent tooth	120.00
2932	Prefabricated resin crown	60.00
2933	Prefabricated stainless steel crown with resin window	90.00
2940	Sedative filling	30.00
2950	Core buildup, including any pins	120.00
2951	Pin retention -- per tooth, in addition to restoration	20.00
2952	Cast post and core in addition to crown	160.00
2954	Prefabricated post and core in addition to crown	100.00
2955	Post removal (not in conjunction with endodontic therapy), (*by report)	By Report
2960	Labial veneer (laminate) -- chairside	120.00
2961	Labial veneer (resin laminate) -- laboratory	200.00
2962	Labial veneer (porcelain laminate) -- laboratory	200.00
2970	Temporary crown (fractured tooth)	80.00
2980	Crown repair, by report	By Report
2999	Unspecified restorative procedure, by report	By Report
3110	Pulp cap -- direct (excluding final restoration)	25.00
3120	Pulp cap -- indirect (excluding final restoration)	20.00
3220	Therapeutic pulpotomy (excluding final restoration)	60.00
3310	Anterior (excluding final restoration)	160.00
3320	Bicuspid (excluding final restoration)	200.00
3330	Molar (excluding final restoration)	280.00
3351	Apexification/recalcification -- initial visit (apical closure/calcific repair of perforations, root resorption,	80.00
3352	Apexification/recalcification -- interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	80.00
3353	Apexification/recalcification -- final visit (includes completed root canal therapy --apical closure/calcifi repair of perforations, root resorption, etc.)	160.00
3410	Apicoectomy/Periradicular surgery -- anterior	140.00
3421	Apicoectomy/Periradicular surgery -- bicuspid (first root)	150.00
3425	Apicoectomy/Periradicular surgery -- molar (first root)	160.00
3426	Apicoectomy/Periradicular surgery -- (each additional root)	60.00
3430	Retrograde filling -- per root	60.00
3450	Root amputation -- per root	100.00

* NV Medicaid requirement/stipulation
** NV Medicaid code

CDT-2 CODES	CDT-2 SHORT DESCRIPTIONS	PROPOSED RATES EFFECTIVE 01/01/97
3460	Endodontic endosseous implant (*by report)	By Report
3920	Hemisection (including any root removal, not including root canal therapy	80.00
3940	Recalcifications of repair (perforations, root resorption, etc.)	60.00
3950	Canal preparation and fitting of preformed dowel or post	60.00
3999	Unspecified endodontic procedure, by report	By Report
4110	Periodontal exam	40.00
4210	Gingivectomy or gingivoplasty -- per quadrant	120.00
4211	Gingivectomy or gingivoplasty -- per tooth(*to maximum of 2 teeth before using quadrant code)	40.00
4220	Gingival curettage, surgical, per quadrant, by report	By Report
4240	Gingival flap procedure, including root planing -- per quadrant	120.00
4249	Clinical crown lengthening -- hard tissue	By Report
4250	Mucogingival surgery -- per quadrant	160.00
4251	Mucogingival surgery -- per tooth(*maximum of 2 teeth before using quadrant code)	100.00
4260	Osseous surgery (including flap entry and closure) -- per quadrant	200.00
4263	Bone replacement graft -- first site in quadrant(*by report to include x-rays)	By Report
4264	Bone replacement graft -- each additional site in quadrant(by report to include x-rays)	By Report
4266	Guided tissue regeneration -- resorbable barrier, per site, per tooth	By Report
4267	Guided tissue regeneration -- nonresorbable barrier, per site, per tooth (includes membrane removal)	By Report
4270	Pedicle soft tissue graft procedure	120.00
4271	Free soft tissue graft procedure (including donor site surgery)	160.00
4273	Subepithelial connective tissue graft procedure (including donor site surgery)	By Report
4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	By Report
4320	Provisional splinting -- intracoronal	20.00
4321	Provisional splinting -- extracoronal	20.00
4341	Periodontal scaling and root planing -- per quadrant	100.00
4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicul tissue, per tooth, by report (*payable without authorization when Medicare covers a Qualified Medicar Beneficiary)	By Report
4910	Periodontal maintenance procedures (following active therapy)	40.00
4999	Unspecified periodontal procedure, by report	By Report
5110	Complete denture -- maxillary	500.00
5120	Complete denture -- mandibular	500.00
5130	Immediate denture -- maxillary	550.00
5140	Immediate denture -- mandibular	550.00
5150	** Identification Imbedding, must be performed/billed with every denture/partial -- unless the dentist can explain why the prosthetic structure doesn't allow imbedding	14.94
5211	Maxillary partial denture -- resin base (including any conventional clasps, rests, and teeth)	200.00
5212	Mandibular partial denture --resin base (including any conventional clasps, rests, and teeth)	200.00
5213	Maxillary partial denture -- cast metal framework with resin denture bases (including any conventiona clasps, rests, and teeth) (*includes flexite II)	600.00
5214	Mandibular partial denture -- cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) (includes flexite II)	600.00
5281	Removable unilateral partial denture -- one piece cast metal (including clasps and teeth)	400.00
5410	Adjust complete denture -- maxillary (*maximum of 3 in 6 mos.)	40.00
5411	Adjust complete denture -- mandibular (maximum of 3 in 6 mos.)	40.00
5421	Adjust partial denture -- maxillary (maximum of 3 in 6 mos.)	40.00
5422	Adjust partial denture -- mandibular	40.00
5510	Repair broken complete denture base (*considered emergency procedure, no authorization required)	60.00
5520	Replace missing or broken teeth -- complete denture (each tooth)(*considered emergency procedure	40.00

* NV Medicaid requirement/stipulation
** NV Medicaid code

CDT-2 CODES	CDT-2 SHORT DESCRIPTIONS	PROPOSED RATES EFFECTIVE 01/01/97
	no authorization required)	
5610	Repair resin denture base(*considered emergency procedure, no authorization required)	60.00
5620	Repair cast framework	120.00
5630	Repair or replace broken clasp	120.00
5640	Replace broken teeth -- per tooth(*two or more teeth paid at twice allowed amount)	60.00
5650	Add tooth to existing partial denture	60.00
5660	Add clasp to existing partial denture	100.00
5730	Reline complete maxillary denture (chairside)	120.00
5731	Reline complete mandibular denture (chairside)	120.00
5740	Reline maxillary partial denture (chairside)	100.00
5741	Reline mandibular partial denture (chairside)	100.00
5750	Reline complete maxillary denture (laboratory)	160.00
5751	Reline complete mandibular denture (laboratory)	160.00
5760	Reline maxillary partial denture (laboratory)	160.00
5761	Reline mandibular partial denture (laboratory)	160.00
5810	Interim complete denture (maxillary)	240.00
5811	Interim complete denture (mandibular)	240.00
5820	Interim partial denture (maxillary)	200.00
5821	Interim partial denture (mandibular)	200.00
5850	Tissue conditioning, maxillary	40.00
5851	Tissue conditioning, mandibular	40.00
5862	Precision attachment, by report	By Report
5899	Unspecified removable prosthodontic procedure, by report	By Report
5931	Obturator prosthesis, surgical	640.00
5932	Obturator prosthesis, definitive	1,500.00
5933	Obturator prosthesis, modification	300.00
5936	Obturator prosthesis, interim	550.00
5983	Radiation carrier (*payable without authorization when Medicare covers a Qualified Medicare Beneficiary)	By Report
5984	Radiation shield(*payable only when Medicare covered for qualified clients)	By Report
5985	Radiation cone locator(*payable only when Medicare covered for qualified clients)	560.00
5988	Surgical splint	By Report
5999	Unspecified maxillofacial prosthesis, by report	By Report
6930	Recement fixed partial denture	40.00
7110	Single tooth	40.00
7120	Each additional tooth	40.00
7130	Root removal -- exposed roots	40.00
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and /or section of tooth	80.00
7220	Removal of impacted tooth -- soft tissue	160.00
7230	Removal of impacted tooth -- partially bony	200.00
7240	Removal of impacted tooth -- completely bony	200.00
7241	Removal of impacted tooth -- completely bony, with unusual surgical complications	200.00
7250	Surgical removal of residual tooth roots (cutting procedure)	80.00
7260	Oroantral fistula closure	240.00
7261	Antrotomy, radical, unilateral (Caldwell-Luc)	280.00
7262	Antrotomy, radical, bilateral (Caldwell-Luc)	480.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	100.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	120.00

* NV Medicaid requirement/stipulation
** NV Medicaid code

CDT-2 CODES	CDT-2 SHORT DESCRIPTIONS	PROPOSED RATES EFFECTIVE 01/01/97
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	80.00
7285	Biopsy of oral tissue -- hard	80.00
7286	Biopsy of oral tissue -- soft	80.00
7290	Surgical repositioning of teeth	240.00
7291	Transseptal fiberotomy, by report	40.00
7310	Alveoloplasty in conjunction with extractions -- per quadrant	84.00
7320	Alveoloplasty not in conjunction with extractions -- per quadrant	106.00
7360	Tuberosity, reduction	80.00
7430	Excision of benign tumor -- lesion diameter up to 1.25 cm	130.00
7431	Excision of benign tumor -- lesion diameter greater than 1.25 cm	200.00
7440	Excision of malignant tumor -- lesion diameter up to 1.25 cm	640.00
7441	Excision of malignant tumor -- lesion diameter greater than 1.25 cm	By Report
7450	Removal of odontogenic cyst or tumor -- lesion diameter up to 1.25 cm	200.00
7451	Removal of odontogenic cyst or tumor -- lesion diameter greater than 1.25 cm	320.00
7460	Removal of nonodontogenic cyst or tumor -- lesion diameter up to 1.25 cm	200.00
7461	Removal of nonodontogenic cyst or tumor -- lesion diameter greater than 1.25 cm	320.00
7465	Destruction of lesion(s) by physical or chemical method, by report	By Report
7470	Removal of exostosis -- maxilla or mandible	150.00
7490	Radical resection of mandible with bone graft (*payable without authorization when Medicare covers a Qualified Medicare Beneficiary)	4,000.00
7510	Incision and drainage of abscess -- intraoral soft tissue	80.00
7520	Incision and drainage of abscess -- extraoral sort tissue	120.00
7530	Removal of foreign body, skin, or subcutaneous areolar tissue	By Report
7540	Removal of reaction - producing foreign bodies -- musculoskeletal system (*by report)	120.00
7550	Sequestrectomy for osteomyelitis (*by report)	350.00
7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	260.00
7480	Partial ostectomy (guttering or saucerization) (*by report)	310.00
7610	Maxilla -- open reduction (teeth immobilized, if present) (*simple)	800.00
7620	Maxilla -- closed reduction (teeth immobilized, if present) (*simple)	700.00
7630	Mandible -- open reduction (teeth immobilized, if present) (*simple)	900.00
7640	Mandible -- closed reduction (teeth immobilized, if present) (*simple)	800.00
7650	Malar and/or zygomatic arch -- open reduction (*simple)	500.00
7660	Malar and/or zygomatic arch -- closed reduction (*simple)	400.00
7670	Alveolus -- stabilization of teeth, open reduction splinting (*simple)	400.00
7680	Facial bones -- complicated reduction with fixation and multiple surgical approaches (*simple)	1,000.00
7710	Maxilla -- open reduction (*compound)	1,000.00
7720	Maxilla -- closed reduction (*compound)	880.00
7730	Mandible -- open reduction (*compound)	1,140.00
7740	Mandible -- closed reduction (*compound)	900.00
7750	Malar and/or zygomatic arch -- open reduction (*compound)	630.00
7760	Malar and/or zygomatic arch -- closed reduction (*compound)	520.00
7770	Alveolus -- stabilization of teeth, open reduction, splinting (*compound)	520.00
7780	Facial bones -- complicated reduction with fixation and multiple surgical approaches (*compound)	By Report
7810	Open reduction of dislocation (*TMJ related procedure)	1,260.00
7820	Closed reduction of dislocation (*TMJ related procedure)	190.00
7830	Manipulation under anesthesia (*TMJ related procedure)	100.00
7840	Condylectomy (*TMJ related procedure)	1,200.00
7850	Surgical discectomy, with/without implant (*TMJ related procedure)	600.00
7852	Disc repair (*TMJ related procedure)	720.00
7854	Synovectomy (*TMJ related procedure)	560.00

CDT-2 CODES	CDT-2 SHORT DESCRIPTIONS	PROPOSED RATES EFFECTIVE 01/01/97
7856	Myotomy (*TMJ related procedure)	By Report
7858	Joint reconstruction (*TMJ related procedure)	2,240.00
7860	Arthrotomy (*TMJ related procedure)	600.00
7865	Arthroplasty (*TMJ related procedure)	1,680.00
7870	Arthrocentesis (*TMJ related procedure)	80.00
7872	Arthroscopy -- diagnosis, with or without biopsy (*TMJ related procedure)	520.00
7873	Arthroscopy -- surgical: lavage and lysis of adhesions (*TMJ related procedure)	570.00
7874	Arthroscopy -- surgical: disc repositioning and stabilization (*TMJ related procedure)	720.00
7875	Arthroscopy -- surgical: synovectomy (*TMJ related procedure)	770.00
7876	Arthroscopy -- surgical: discectomy (*TMJ related procedure)	800.00
7877	Arthroscopy -- surgical: debridement (*TMJ related procedure)	740.00
7880	Occlusal orthotic device, by report (*TMJ related procedure)	By Report
7899	Unspecified TMD therapy, by report (*TMJ related procedure)	By Report
7910	Suture of recent small wounds up to 5 cm	26.00
7911	Complicated suture -- up to 5 cm	52.00
7912	Complicated suture -- (*add for each centimeter) greater than 5 cm	10.00
7940	Osteoplasty -- for orthognathic deformities	1,200.00
7941	Osteoplasty -- ramus, closed	800.00
7942	Osteoplasty -- ramus, open	1,200.00
7943	Osteoplasty -- ramus, open with bone graft	1,500.00
7944	Osteoplasty -- segmented or subapical -- per sextant or quadrant	1,000.00
7945	Osteoplasty -- body of mandible	1,000.00
7946	LeFort I (maxilla -- total)	2,500.00
7947	LeFort I (maxilla -- segmented)	2,500.00
7948	LeFort II or LeFort III (osteoplasty of facial bone for midface hypoplasia or retrusion) -- without bone g	2,800.00
7949	LeFort II of LeFort III -- with bone graft	By Report
7955	Repair of maxillofacial soft and hard tissue defect	By Report
7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	120.00
7970	Excision of hyperplastic tissue -- per arch	240.00
7971	Excision of pericoronal gingiva	120.00
7980	Sialolithotomy	240.00
7981	Excision of salivary gland, by report	400.00
7982	Sialodochoplasty	570.00
7983	Closure of salivary fistula	240.00
7990	Emergency tracheotomy	500.00
7991	Coronoidectomy	800.00
7996	Implant -- mandible for augmentation purposes (excluding alveolar ridge), by report	By Report
7999	Unspecified oral surgery procedure, by report	By Report
8010	Limited orthodontic treatment of the primary dentition (* includes control of harmful habit; excludes any billing for Phase I treatment plan which should include this.)	By Report
8020	Limited orthodontic treatment of the transitional dentition (* Considered Phase I treatment; 12 mos. treatment max.; recognized by Nev. Medicaid in lieu of CDT-2 codes 8030 and 8040)	By Report
8040	Limited orthodontic treatment of the adult dentition (* includes control of harmful habit; excludes any billing for Phase I treatment plan which should include this; less than 20 years old)	450.00
8080	Comprehensive orthodontic treatment of the adolescent dentition (*treatment more than 24 mos. but less than 30 mos.; inclusive payment of all services except 8660)	By Report
8090	Comprehensive orthodontic treatment of the adult dentition (*18-19 yrs only; treatment lasting more than 24 mos.;this code used for inclusive payment of all services except 8660)	By Report
8210	Removable appliance therapy	374.99
8220	Fixed appliance therapy (*upper or lower band)	374.99

* NV Medicaid requirement/stipulation
** NV Medicaid code

CDT-2 CODES	CDT-2 SHORT DESCRIPTIONS	PROPOSED RATES EFFECTIVE 01/01/97
8660	Pre-orthodontic treatment visit (*includes exam, diagnosis, two dx models)	47.59
8670	Periodic orthodontic treatment visit (as part of control)(*per visit)	77.69
8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) (*upper or lower retainer)	115.04
8690	Orthodontic treatment, (alternative billing to a contract fee) (*Not a benefit?)	By Report
8999	Unspecified orthodontic procedure, by report	By Report
9110	Palliative (emergency) treatment of dental pain -- minor procedure (*description of patient condition/ need required)	40.00
9210	Local anesthesia not in conjunction with operative or surgical procedures	10.00
9212	Trigeminal division block anesthesia	10.00
9215	Local anesthesia	6.00
9220	General anesthesia -- first 30 minutes	110.00
9221	General anesthesia -- each additional 15 minutes	40.00
9230	Analgesia	18.00
9240	Intravenous sedation	40.00
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	60.00
9410	House call (*includes travel)	60.00
9420	Hospital call (*Includes travel and excludes any examination charge. Travel not allowed when examination billed in lieu of 9420.)	40.00
9430	Office visit for observation (during regularly scheduled hours) -- no other services performed (*requir description of client need justifying charge)	24.00
9440	Office visit – after regularly scheduled hours (*must indicate time services were performed)	60.00
9610	Therapeutic drug injection, by report	20.00
9630	Other drugs and/or medicaments, by report (*requires name of any drug given)	By Report
9899	** Admission to hospital or surgical center, not to be billed in addition to 9420	50.00
9930	Treatment of complications (post-surgical) -- unusual	By Report
9940	Occlusal guard, by report	200.00
9950	Occlusion analysis -- mounted case	164.00
9951	Occlusal adjustment -- limited (*$10/tooth to max of $100)	10.00
9952	Occlusal adjustment -- complete	160.00
9999	Unspecified adjunctive procedure, by report	By Report

NOTE: "By Report" in the rate column means the payment amount is to be decided by the dentist's report and/or Medicaid's evaluation of the report and other variables.

* NV Medicaid requirement/stipulation
** NV Medicaid code

APPENDIX C

Suggested Legislation

SUMMARY—Requires check of any criminal history of applicant for license to operate residential facility for groups and employee of residential facility for groups. (BDR 40-493)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to residential facilities for groups; requiring the health division of the department of human resources to check the criminal history of each applicant for a license to operate a residential facility for groups and employee of a residential facility for groups; authorizing the health division to deny or revoke a license if an applicant for a license to operate a residential facility for groups or his employee has been convicted of a certain crime; requiring the administrator of or person licensed to operate a residential facility for groups to terminate the employment of an employee who has been convicted of a certain crime; and providing other matters properly relating thereto.

WHEREAS, Residential facilities for groups provide food, shelter and assistance to some of the most vulnerable residents of this state, including aged, infirm, mentally retarded and handicapped persons; and

WHEREAS, There have been many reports of abuse of and stealing from these vulnerable residents by employees of residential facilities for groups; and

WHEREAS, The legislature recognizes that it is necessary for the state to exercise its police powers to protect the health, safety and welfare of persons who reside in residential facilities for groups; now, therefore,

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

Section 1. Chapter 449 of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. *1. Each applicant for a license to operate a residential facility for groups and each employee of a residential facility for groups shall submit to the health division a complete set of fingerprints and a written authorization for the division or its designee to forward the fingerprints to the central repository for Nevada records of criminal history for submission to the Federal Bureau of Investigation for its report.*

2. The health division shall secure from each appropriate law enforcement agency information regarding the criminal history of each applicant for a license to operate a residential facility for groups and each employee of a residential facility for groups.

3. The health division may impose a fee upon a person investigated pursuant to this section for the cost of the investigation in an amount not to exceed $50.

Sec. 3. *1. If the health division determines that a person who is employed at a residential facility for groups has been convicted of a crime listed in section 4 of this act, the health division shall immediately notify the administrator and the person licensed to operate the residential facility for groups where the person is employed.*

2. Upon receipt of notice from the health division pursuant to subsection 1, or evidence from any other source, that a person who is employed at a residential facility for groups has been convicted of a crime listed in section 4 of this act, the administrator of or the person licensed to operate the residential facility for groups shall terminate the employment of that person. If the notice is obtained from a source other than the health division, the administrator or the person licensed to operate the residential facility for groups shall verify the conviction before he terminates the employment of the person.

Sec. 4. *In addition to the grounds listed in NRS 449.160, the health division may deny a license to operate a residential facility for groups to an applicant or may suspend or revoke the license of a licensee to operate a residential facility for groups if:*

1. The applicant or licensee has been convicted of:

(a) A felony;

(b) A crime involving moral turpitude; or

(c) Any other crime committed against a person who is 60 years of age or older; or

2. The licensee has continued to employ a person who has been convicted of a crime listed in subsection 1.

Sec. 5. NRS 449.030 is hereby amended to read as follows:

449.030 1. No person, state or local government or agency thereof may operate or maintain in this state any medical facility or facility for the dependent without first obtaining a license therefor as provided in NRS 449.001 to 449.240, inclusive [.] , *and sections 2, 3 and 4 of this act.*

2. Unless licensed as a freestanding facility for hospice care, a person, state or local government or agency thereof shall not operate a program of hospice care without first obtaining a license for the program from the board.

Sec. 6. Each person who is licensed to operate a residential facility for groups, applicant for a license to operate a residential facility for groups or employee at a residential facility for groups on or before October 1, 1997, shall provide the health division of the department of human resources with a complete set of fingerprints not later than November 1, 1997.

SUMMARY—Urges state welfare administrator to increase reimbursement to providers of dental care who serve recipients of Medicaid. (BDR R-495)

_____ CONCURRENT RESOLUTION—Urging the state welfare administrator to increase reimbursement to providers of dental care who serve recipients of Medicaid.

WHEREAS, Many low-income families in the State of Nevada rely on public programs such as Medicaid to provide for their dental care; and

WHEREAS, Access to dental care for low-income families is severely restricted by a lack of providers of dental care who are willing to serve them; and

WHEREAS, The headaches and pain associated with dental problems have been linked to poor performance by children in school; and

WHEREAS, Approximately 90 percent of all dentists who responded to a survey conducted in the State of Nevada during the year of 1992 identified low reimbursement from Medicaid as the primary reason for denying dental care to recipients of Medicaid; now, therefore, be it

RESOLVED BY THE _____ OF THE STATE OF NEVADA, THE _____ CONCURRING, That the members of the 69th session of the Nevada Legislature do hereby urge the state welfare administrator to increase reimbursement for dental care provided to

recipients of Medicaid as set forth in the state plan adopted pursuant to NRS 422.237 to encourage more providers of dental care to offer services to recipients of Medicaid.

RESOLVED, That the _____ of the _____ prepare and transmit a copy of this resolution to the state welfare administrator.

SUMMARY—Authorizes commissioners of Western Interstate Commission for Higher Education from State of Nevada to require certain students to perform community service as term of receiving support fee. (BDR 34-494)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to the Western Regional Higher Education Compact; authorizing the commissioners of the Western Interstate Commission for Higher Education from the State of Nevada to require certain students to perform community service as a condition to receiving a support fee; extending the time for making the first installment of the loan of a student under certain circumstances; and providing other matters properly relating thereto.

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

Section 1. Chapter 397 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The provisions of this section apply only to support fees received by a student on or after July 1, 1997.

2. The three commissioners from the State of Nevada, acting jointly, may require a student who is certified to study to practice in a profession which could benefit a medically underserved area of this state, as that term is defined by the officer of rural health of the University of Nevada School of Medicine, to practice in such an area as a condition to receiving a support fee for a period of time determined pursuant to subsection 4.

3. If a person agrees to practice in a medically underserved area of this state pursuant to subsection 2, the three commissioners from the State of Nevada, acting jointly, may forgive the portion of the support fee designated as the loan of the person.

4. The senate standing committee on finance and the assembly standing committee on ways and means, or their successor, shall determine during each legislative session the period of time that a student may be required to practice in a medically underserved area of this state pursuant to subsection 2 as a condition to receiving any support fee awarded to such a student during the next biennium.

5. As used in this section, a "profession which could benefit a medically underserved area of this state" includes, without limitation, dentistry, physical therapy, pharmacy and practicing as a physicians' assistant.

Sec. 2. NRS 397.0615 is hereby amended to read as follows:

397.0615 Financial support provided to a student who is chosen by the three commissioners from the State of Nevada to receive such support from the Western Interstate Commission for Higher Education must be provided in the form of a support fee. [Twenty-five] *Except as otherwise provided in section 1 of this act, 25* percent of the support fee is a loan that the student must repay with interest pursuant to NRS 397.063 or

397.064, as appropriate. Seventy-five percent of the support fee is a stipend that the student is not required to repay, except as otherwise provided in NRS 397.0653.

Sec. 3. NRS 397.064 is hereby amended to read as follows:

397.064 Loans, from the Western Interstate Commission for Higher Education's fund for student loans, to students who enter the program on or after July 1, 1985, must be made upon the following terms:

1. All loans must bear interest at 8 percent per annum from the first day of the academic term for which the student received the loan.

2. [Each] *Except as otherwise provided in section 1 of this act, each* student receiving a loan must repay the loan with interest following the termination of his education or completion of his internship for which the loan is made.

3. The loan must be repaid in monthly installments over the period allowed, *as set forth in subsection 4,* with the first installment due *:*

(a) If he becomes licensed to practice in this state in the profession for which he was certified to study within 1 year after the date of the termination of his education or the completion of his internship for which the loan is made [.] *, 1 year after the date of termination or completion; or*

(b) If he does not become licensed to practice in this state in the profession for which he was certified to study within 1 year after the date of the termination of his education or the completion of his internship for which the loan is made, 2 years after the date of termination or completion.

The amounts of the installments may not be less than $50 and may be calculated to allow a smaller payment at the beginning of the repayment period, with each succeeding payment gradually increasing so that the total amount due will have been paid within the period allowed for repayment.

4. The three commissioners from the State of Nevada, acting jointly, shall, or shall delegate to the director of the Western Interstate Commission for Higher Education the power to, schedule the repayment within the following periods:

(a) Five years for loans which total less than $10,000.

(b) Eight years for loans which total $10,000 or more but less than $20,000.

(c) Ten years for loans which total $20,000 or more.

[3.] *5.* A student loan may not exceed 50 percent of the student fees for any academic year.

[4.] *6.* A delinquency charge may be assessed on any installment delinquent 10 days or more in the amount of 8 percent of the installment or $4, whichever is greater, but not more than $15.

[5.] *7.* The reasonable costs of collection and an attorney's fee may be recovered in the event of delinquency.

Sec. 4. NRS 397.0645 is hereby amended to read as follows:

397.0645 1. A student who receives from the Western Interstate Commission for Higher Education a stipend governed by the provisions of NRS 397.065 or 397.0653 must repay all state contributions for the stipend unless he practices, in *the State of* Nevada, the profession *for* which he was certified to study:

(a) For 3 years, if he entered the program before July 1, 1985;

(b) For 1 year for each academic year he receives a stipend, if he enters the program after June 30, 1985; [or]

(c) For 1 year for each 9 months he receives a stipend, if he enters the program after June 30, 1985, and is enrolled in an accelerated program that provides more than 1 academic year of graduate and professional education in 9 months [,] *; or*

(d) For the period specified by the legislature pursuant to section 1 of this act, if he agrees to practice in a medically underserved area of this state as a condition to receiving his support fee,

within 5 years after the completion or termination of his education, internship or residency for which he receives the stipend.

2. The three commissioners from the State of Nevada, acting jointly, may adopt regulations which:

(a) Reduce the period of required practice for a person who practices his profession in a rural area of this state or as an employee of this state.

(b) Extend the time for completing the required practice beyond 5 years for a person who is granted an extension because of hardship.

3. If the period for the required practice is only partially completed, the commission may give credit towards repayment of the stipend for the time the person practiced his profession as required.

Sec. 5. This act becomes effective on July 1, 1997.

SUMMARY—Makes various changes related to Medicaid. (BDR 38-794)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to state welfare administration; requiring the department of human resources to contract only with a health maintenance organization that contracts with a federally-qualified health center to provide Medicaid managed care; requiring the department of human resources to include the University of Nevada School of Medicine in the development, implementation and delivery of any Medicaid managed care program; making a technical change replacing the term "assistance to the medically indigent" with "Medicaid" to make the references to Medicaid consistent throughout the Nevada Revised Statutes; and providing other matters properly relating thereto.

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

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

Sec. 2. *"Medicaid" has the meaning ascribed to it in NRS 439B.120.*

Sec. 3. *1. For any Medicaid managed care program established in the State of Nevada, the department shall:*

(a) Contract only with a health maintenance organization that contracts with a federally-qualified health center.

(b) Include participation by the University of Nevada School of Medicine in:

(1) The development and implementation of the program; and

(2) The delivery of services for the program.

2. The department shall cooperate with the University of Nevada School of Medicine, in the development of any Medicaid managed care program, to assist in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

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

4. For the purposes of this section:

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

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

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

422.001 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 422.005 to 422.055, inclusive, *and section 2 of this act,* have the meanings ascribed to them in those sections.

Sec. 5. NRS 422.050 is hereby amended to read as follows:

422.050 "Public assistance" includes:

1. State supplementary assistance;

2. Aid to families with dependent children;

3. [Assistance to the medically indigent;] *Medicaid;*

4. Food stamp assistance;

5. Low-income home energy assistance;

6. Low-income weatherization assistance; and

7. Benefits provided pursuant to any other public welfare program administered by the welfare division pursuant to such additional federal legislation as is not inconsistent with the purposes of this chapter.

Sec. 6. NRS 422.054 is hereby amended to read as follows:

422.054 "Undivided estate" means all assets included in the estate of a deceased recipient of [assistance to the medically indigent] *Medicaid* and any other assets in or to which he had an interest or legal title at the time of his death, to the extent of that interest or

title. The term includes assets passing by reason of joint tenancy, reserved life estate, survivorship or trust, and any of the decedent's separate property and his interest in community property that was transferred to a community spouse pursuant to NRS 123.259 or pursuant to an order of a district court under any other provision of law.

Sec. 7. NRS 422.153 is hereby amended to read as follows:

422.153 1. The medical care advisory group consists of the state health officer and:

(a) A person who:

(1) Holds a license to practice medicine in this state; and

(2) Is certified by the board of medical examiners in a medical specialty.

(b) A person who holds a license to practice dentistry in this state.

(c) A person who holds a certificate of registration as a pharmacist in this state.

(d) A member of a profession in the field of health care who is familiar with the needs of persons of low income, the resources required for their care and the availability of those resources.

(e) An administrator of a hospital or a clinic for health care.

(f) An administrator of a facility for intermediate care or a facility for skilled nursing.

(g) A member of an organized group that provides assistance, representation or other support to recipients of [assistance to the medically indigent.] *Medicaid.*

(h) A recipient of [assistance to the medically indigent.] *Medicaid.*

2. The director shall appoint each member required by paragraphs (a) to (h), inclusive, of subsection 1 to serve for a term of 1 year.

3. Members of the medical care advisory group serve without compensation, except that while engaged in the business of the advisory group, each member is entitled to receive the per diem allowance and travel expenses provided for state officers and employees generally.

Sec. 8. NRS 422.215 is hereby amended to read as follows:

422.215 1. The administrator or his designated representative may administer oaths and take testimony thereunder and issue subpoenas requiring the attendance of witnesses before the welfare division at a designated time and place and the production of books, papers and records relative to:

(a) Eligibility or continued eligibility for public assistance; and

(b) Verification of treatment and payments to a provider of medical care, remedial care or other services pursuant to the state plan for [assistance to the medically indigent.] *Medicaid.*

2. If a witness fails to appear or refuses to give testimony or to produce books, papers and records as required by the subpoena, the district court of the county in which the investigation is being conducted may compel the attendance of witnesses, the giving of testimony and the production of books, papers and records as required by the subpoena.

Sec. 9. NRS 422.2345 is hereby amended to read as follows:

422.2345 1. The administrator shall:

(a) Promptly comply with a request from the unit for access to and free copies of any records or other information in the possession of the welfare division regarding a provider;

(b) Refer to the unit all cases in which he suspects that a provider has committed an offense under NRS 422.540, 422.550, 422.560 or 422.570; and

(c) Suspend or exclude a provider who he determines has committed an offense under NRS 422.540, 422.550, 422.560 or 422.570 from participation as a provider or an employee of a provider, for a minimum of 3 years. A criminal action need not be brought against the provider before suspension or exclusion pursuant to this subsection.

2. As used in this section:

(a) "Provider" means a person who has applied to participate or who participates in the state plan for [assistance to the medically indigent] *Medicaid* as the provider of goods or services.

(b) "Unit" means the Medicaid fraud control unit established in the office of the attorney general pursuant to NRS 228.410.

Sec. 10. NRS 422.236 is hereby amended to read as follows:

422.236 1. As part of the health and welfare programs of this state, the welfare division may provide prenatal care to pregnant women who are indigent, or may contract for the provision of that care, at public or nonprofit hospitals in this state.

2. The welfare division shall provide to each person licensed to engage in social work pursuant to chapter 641B of NRS, each applicant for [assistance to the medically indigent] *Medicaid* and any other interested person, information concerning the prenatal care available pursuant to this section.

3. The welfare division shall adopt regulations setting forth criteria of eligibility and rates of payment for prenatal care provided pursuant to the provisions of this section, and such other provisions relating to the development and administration of the program for prenatal care as the administrator and the board deem necessary.

Sec. 11. NRS 422.270 is hereby amended to read as follows:

422.270 The department through the welfare division shall:

1. Except as otherwise provided in NRS 432.010 to 432.085, inclusive, administer all public welfare programs of this state, including:

(a) State supplementary assistance;

(b) Aid to families with dependent children;

(c) [Assistance to the medically indigent;] *Medicaid;*

(d) Food stamp assistance;

(e) Low-income home energy assistance;

(f) Low-income weatherization assistance;

(g) The program for the enforcement of child support; and

(h) Other welfare activities and services provided for by the laws of this state.

2. Act as the single state agency of the State of Nevada and its political subdivisions in the administration of any federal money granted to the state to aid in the furtherance of any of the services and activities set forth in subsection 1.

3. Cooperate with the Federal Government in adopting state plans, in all matters of mutual concern, including adoption of methods of administration found by the Federal

Government to be necessary for the efficient operation of welfare programs, and in increasing the efficiency of welfare programs by prompt and judicious use of new federal grants which will assist the welfare division in carrying out the provisions of NRS 422.070 to 422.410, inclusive.

4. Observe and study the changing nature and extent of welfare needs and develop through tests and demonstrations effective ways of meeting those needs and employ or contract for personnel and services supported by legislative appropriations from the state general fund or money from federal or other sources.

5. Enter into reciprocal agreements with other states relative to public assistance, welfare services and institutional care, when deemed necessary or convenient by the administrator.

6. Make such agreements with the Federal Government as may be necessary to carry out the supplemental security income program.

Sec. 12. NRS 422.285 is hereby amended to read as follows:

422.285 The department , [of human resources,] through the welfare division, may reimburse directly, under the state plan for [assistance to the medically indigent,] *Medicaid,* any registered nurse who is authorized pursuant to chapter 632 of NRS to perform additional acts in an emergency or under other special conditions as prescribed by the state board of nursing, for such services rendered under the authorized scope of his practice to persons eligible to receive that assistance if another provider of health care would be reimbursed for providing those same services.

Sec. 13. NRS 422.293 is hereby amended to read as follows:

422.293 1. When a recipient of [assistance to the medically indigent] *Medicaid* incurs an illness or injury for which medical services are payable under the state plan and which is incurred under circumstances creating a legal liability in some person other than the recipient or the welfare division to pay all or part of the costs of such services, the division is subrogated to the right of the recipient to the extent of all such costs and may join or intervene in any action by the recipient or his successors in interest to enforce such legal liability.

2. If a recipient or his successors in interest fail or refuse to commence an action to enforce the legal liability, the welfare division may commence an independent action, after notice to the recipient or his successors in interest, to recover all costs to which it is entitled. In any such action by the division, the recipient or his successors in interest may be joined as third-party defendants.

3. In any case where the welfare division is subrogated to the rights of the recipient or his successors in interest as provided in subsection 1, the division has a lien upon the proceeds of any recovery from the persons liable, whether the proceeds of the recovery are by way of judgment, settlement or otherwise. Such a lien must be satisfied in full, unless reduced pursuant to subsection 5, at such time as:

(a) The proceeds of any recovery or settlement are distributed to or on behalf of the recipient, his successors in interest or his attorney; and

(b) A dismissal by any court of any action brought to enforce the legal liability established by subsection 1.

No such lien is enforceable unless written notice is first given to the person against whom the lien is asserted.

4. The recipient or his successors in interest shall notify the welfare division in writing before entering any settlement agreement or commencing any action to enforce the legal liability referred to in subsection 1. Except if extraordinary circumstances exist, a person who fails to comply with the provisions of this subsection shall be deemed to have waived any consideration by the administrator of a reduction of the amount of the lien pursuant to subsection 5 and shall pay to the division all costs to which it is entitled and its court costs and attorney's fees.

5. If the welfare division receives notice pursuant to subsection 4, the administrator may, in consideration of the legal services provided by an attorney to procure a recovery for the recipient, reduce the lien on the proceeds of any recovery.

6. The attorney of a recipient:

(a) Shall not condition the amount of attorney's fees or impose additional attorney's fees based on whether a reduction of the lien is authorized by the administrator pursuant to subsection 5.

(b) Shall reduce the amount of the fees charged the recipient for services provided by the amount the attorney receives from the reduction of a lien authorized by the administrator pursuant to subsection 5.

Sec. 14. NRS 422.2935 is hereby amended to read as follows:

422.2935 1. Except as otherwise provided in this section, the welfare division shall, to the extent it is not prohibited by federal law and when circumstances allow:

(a) Recover benefits correctly paid for [assistance to the medically indigent] *Medicaid* from:

(1) The undivided estate of the person who received those benefits; and

(2) Any recipient of money or property from the undivided estate of the person who received those benefits.

(b) Recover from the recipient of [assistance to the medically indigent] *Medicaid* or the person who signed the application for [assistance to the medically indigent] *Medicaid* on behalf of the recipient an amount not to exceed the benefits incorrectly paid to the recipient if the person who signed the application:

(1) Failed to report any required information to the welfare division which he knew at the time he signed the application; or

(2) Failed within the period allowed by the welfare division to report any required information to the welfare division which he obtained after he filed the application.

2. The welfare division shall not recover benefits pursuant to paragraph (a) of subsection 1, except from a person who is neither a surviving spouse nor a child, until after the death of the surviving spouse, if any, and only at a time when the person who received the benefits has no surviving child who is under 21 years of age or is blind or permanently and totally disabled.

3. Except as otherwise provided by federal law, if a transfer of real or personal property by a recipient of [assistance to the medically indigent] *Medicaid* is made for less than fair market value, the welfare division may pursue any remedy available pursuant to chapter 112 of NRS with respect to the transfer.

4. The amount of [assistance to the medically indigent] *Medicaid* paid to or on behalf of a person is a claim against the estate in any probate proceeding only at a time when there is no surviving spouse or surviving child who is under 21 years of age or is blind or permanently and totally disabled.

5. The administrator may elect not to file a claim against the estate of a recipient of [assistance to the medically indigent] *Medicaid* or his spouse if he determines that the filing of the claim will cause an undue hardship for the spouse or other survivors of the recipient. The board shall adopt regulations defining the circumstances that constitute an undue hardship.

6. Any recovery of money obtained pursuant to this section must be applied first to the cost of recovering the money. Any remaining money must be divided among the Federal Government, the department and the county in the proportion that the amount of assistance each contributed to the recipient bears to the total amount of the assistance contributed.

7. An action to recover money owed to the department of human resources as a result of the payment of benefits for [assistance to the medically indigent] *Medicaid* must be commenced within 6 months after the cause of action accrues. A cause of action accrues after all of the following events have occurred:

(a) The death of the recipient of [the assistance to the medically indigent;] *Medicaid;*

(b) The death of the surviving spouse of the recipient of [the assistance to the medically indigent;] *Medicaid;*

(c) The death of all children of the recipient of [the assistance to the medically indigent] *Medicaid* who are blind or permanently and totally disabled as determined in accordance with 42 U.S.C. § 1382c; and

(d) The arrival of all other children of the recipient of [the assistance to the medically indigent] *Medicaid* at the age of 21 years.

Sec. 15. NRS 422.29355 is hereby amended to read as follows:

422.29355 1. The welfare division may, to the extent not prohibited by federal law, petition for the imposition of a lien pursuant to the provisions of NRS 108.850 against real or personal property of a recipient of [assistance to the medically indigent] *Medicaid* as follows:

(a) The welfare division may obtain a lien against a recipient's property, both real or personal, before or after his death in the amount of assistance paid or to be paid on his behalf if the court determines that assistance was incorrectly paid for the recipient.

(b) The welfare division may seek a lien against the real property of a recipient at any age before his death in the amount of assistance paid or to be paid for him if he is an inpatient in a nursing facility, intermediate care facility for the mentally retarded or other medical institution and the welfare division determines, after notice and opportunity for a

hearing in accordance with its regulations, that he cannot reasonably be expected to be discharged and return home.

2. No lien may be placed on a recipient's home for assistance correctly paid if:

(a) His spouse;

(b) His child who is under 21 years of age or blind or permanently and totally disabled as determined in accordance with 42 U.S.C. § 1382c; or

(c) His brother or sister who is an owner or part owner of the home and who was residing in the home for at least 1 year immediately before the date the recipient was admitted to the medical institution,

is lawfully residing in the home.

3. Upon the death of a recipient the welfare division may seek a lien upon his undivided estate as defined in NRS 422.054.

4. The state welfare administrator shall release a lien pursuant to this section:

(a) Upon notice by the recipient or his representative to the administrator that the recipient has been discharged from the medical institution and has returned home;

(b) If the lien was incorrectly determined; or

(c) Upon satisfaction of the welfare division's claim.

Sec. 16. NRS 422.2936 is hereby amended to read as follows:

422.2936 Each application for [assistance to the medically indigent] *Medicaid* must include:

1. A statement that any assistance paid to a recipient may be recovered in an action filed against the estate of the recipient or his spouse; and

2. A statement that any person who signs an application for [assistance to the medically indigent] *Medicaid* and fails to report:

(a) Any required information to the welfare division which he knew at the time he signed the application; or

(b) Within the period allowed by the welfare division, any required information to the welfare division which he obtained after he filed the application,

may be personally liable for any money incorrectly paid to the recipient.

Sec. 17. NRS 422.2993 is hereby amended to read as follows:

422.2993 1. Except as otherwise provided in NRS 228.410 and 422.2345 and subsection 2 of this section, any information obtained by the welfare division in an investigation of a provider of services under the *state* plan for [assistance to the medically indigent] *Medicaid* is confidential.

2. The information presented as evidence at a hearing:

(a) To enforce the provisions of NRS 422.450 to 422.580, inclusive; or

(b) To review an action by the welfare division against a provider of services under the *state* plan for [assistance to the medically indigent,] *Medicaid,*

is not confidential, except for the identity of any recipient of the assistance.

Sec. 18. NRS 422.2997 is hereby amended to read as follows:

422.2997 1. Upon receipt of a request for a hearing from a provider of services under the *state* plan for [assistance to the medically indigent,] *Medicaid,* the welfare division shall appoint a hearing officer to conduct the hearing. Any employee or other representative of the welfare division who investigated or made the initial decision regarding the action taken against a provider of services may not be appointed as the hearing officer or participate in the making of any decision pursuant to the hearing.

2. The welfare division shall adopt regulations prescribing the procedures to be followed at the hearing.

3. The decision of the hearing officer is a final decision. Any party, including the welfare division, who is aggrieved by the decision of the hearing officer may appeal that decision to the district court. The review of the court must be confined to the record. The court shall not substitute its judgment for that of the hearing officer as to the weight of the evidence on questions of fact. The court may affirm the decision of the hearing officer or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:

(a) In violation of constitutional or statutory provisions;

(b) In excess of the statutory authority of the welfare division;

(c) Made upon unlawful procedure;

(d) Affected by other error of law;

(e) Clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or

(f) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Sec. 19. NRS 422.364 is hereby amended to read as follows:

422.364 "Plan" means the state plan for [the medically indigent] *Medicaid* established pursuant to NRS 422.237.

Sec. 20. NRS 422.380 is hereby amended to read as follows:

422.380 As used in NRS 422.380 to 422.390, inclusive, unless the context otherwise requires:

1. "Hospital" has the meaning ascribed to it in NRS 439B.110 and includes public and private hospitals.

2. ["Medicaid" has the meaning ascribed to it in NRS 439B.120.

3.] "Public hospital" means:

(a) A hospital owned by a state or local government, including, without limitation, a hospital district; or

(b) A hospital that is supported in whole or in part by tax revenue, other than tax revenue received for medical care which is provided to Medicaid patients, indigent patients or other low-income patients.

Sec. 21. NRS 422.385 is hereby amended to read as follows:

422.385 1. The allocations and payments required pursuant to NRS 422.387 must be made, to the extent allowed by the state plan for [assistance to the medically indigent,] *Medicaid,* from the Medicaid budget account.

2. The money in the intergovernmental transfer account must be transferred from that account to the Medicaid budget account to the extent that money is available from the Federal Government for proposed expenditures, including expenditures for administrative costs. If the amount in the account exceeds the amount authorized for expenditure by the department for the purposes specified in NRS 422.387, the department is authorized to expend the additional revenue in accordance with the provisions of the state plan for [assistance to the medically indigent.] *Medicaid.*

Sec. 22. NRS 422.387 is hereby amended to read as follows:

422.387 1. Before making the payments required or authorized by this section, the department shall allocate money for the administrative costs necessary to carry out the provisions of NRS 422.380 to 422.390, inclusive. The amount allocated for administrative costs must not exceed the amount authorized for expenditure by the legislature for this purpose in a fiscal year. The interim finance committee may adjust the amount allowed for administrative costs.

2. The state plan for [assistance to the medically indigent] *Medicaid* must provide:

(a) For the payment of the maximum amount allowable under federal law and regulations after making a payment, if any, pursuant to paragraph (b), to public hospitals for treating a disproportionate share of Medicaid patients, indigent patients or other low-

income patients, unless such payments are subsequently limited by federal law or regulation.

(b) For a payment in an amount approved by the legislature to the private hospital that provides the largest volume of medical care to Medicaid patients, indigent patients or other low-income patients in a county that does not have a public hospital.

The plan must be consistent with the provisions of NRS 422.380 to 422.390, inclusive, and Title XIX of the Social Security Act (42 U.S.C. §§ 1396, et seq.), and the regulations adopted pursuant to those provisions.

3. The department may amend the state plan for [assistance to the medically indigent] *Medicaid* to modify the methodology for establishing the rates of payment to public hospitals for inpatient services, except that such amendments must not reduce the total reimbursements to public hospitals for such services.

Sec. 23. NRS 422.480 is hereby amended to read as follows:

422.480 "Plan" means the state plan for [assistance to the medically indigent] *Medicaid* established pursuant to NRS 422.237.

Sec. 24. NRS 426A.060 is hereby amended to read as follows:

426A.060 1. The advisory committee on traumatic brain injuries, consisting of 11 members, is hereby created.

2. The director shall appoint to the committee:

(a) One member who is an employee of the rehabilitation division of the department.

(b) One member who is an employee of the welfare division of the department of human resources and participates in the administration of the state program providing [assistance to the medically indigent.] *Medicaid.*

(c) One member who is a licensed insurer in this state.

(d) One member who represents the interests of educators in this state.

(e) One member who is a person professionally qualified in the field of psychiatric mental health.

(f) Two members who are employees of private providers of rehabilitative health care located in this state.

(g) One member who represents persons who operate community-based programs for head injuries in this state.

(h) One member who represents hospitals in this state.

(i) Two members who represent the recipients of health care in this state.

3. After the initial appointments, each member of the committee serves a term of 3 years.

4. The committee shall elect one of its members to serve as chairman.

5. Members of the committee serve without compensation and are not entitled to receive the per diem allowance or travel expenses provided for state officers and employees generally.

6. The committee may:

(a) Make recommendations to the director relating to the establishment and operation of any program for persons with traumatic brain injuries.

(b) Make recommendations to the director concerning proposed legislation relating to traumatic brain injuries.

(c) Collect information relating to traumatic brain injuries.

7. The committee shall prepare a report of its activities and recommendations each year and submit a copy to the:

(a) Director;

(b) Legislative committee on health care; and

(c) Legislative commission.

8. As used in this section:

(a) "Director" means the director of the department.

(b) "Person professionally qualified in the field of psychiatric mental health" has the meaning ascribed to it in NRS 433.209.

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

Sec. 25. NRS 428.030 is hereby amended to read as follows:

428.030 1. When any person meets the uniform standards of eligibility established by the board of county commissioners or by NRS 439B.310, if applicable, and complies with any requirements imposed pursuant to NRS 428.040, he is entitled to receive such relief as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of the money which may be lawfully

appropriated pursuant to NRS 428.050, 428.285 and 450.425 for this purpose.

2. The board of county commissioners of the county of residence of indigent inpatients shall pay hospitals for the costs of treating those indigent inpatients and any nonresident indigent inpatients who fall sick in the county an amount which is not less than the payment required for providing the same treatment to patients pursuant to the state plan for [assistance to the medically indigent,] *Medicaid* within the limits of money which may be lawfully appropriated pursuant to NRS 428.050, 428.285 and 450.425 for this purpose.

3. The board of county commissioners may:

(a) Make contracts for the necessary maintenance of indigent persons;

(b) Appoint such agents as the board deems necessary to oversee and provide the necessary maintenance of indigent persons;

(c) Authorize the payment of cash grants directly to indigent persons for their necessary maintenance; or

(d) Provide for the necessary maintenance of indigent persons by the exercise of the combination of one or more of the powers specified in paragraphs (a), (b) and (c).

4. A hospital may contract with the department of human resources to obtain the services of a state employee to be assigned to the hospital to evaluate the eligibility of patients applying for indigent status. Payment for those services must be made by the hospital.

Sec. 26. NRS 428.090 is hereby amended to read as follows:

428.090 1. When a nonresident or any other person who meets the uniform standards of eligibility prescribed by the board of county commissioners or by NRS 439B.310, if applicable, falls sick in the county, not having money or property to pay his board, nursing or medical aid, the board of county commissioners of the proper county shall, on complaint being made, give or order to be given such assistance to the poor person as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of money which may be lawfully appropriated for this purpose pursuant to NRS 428.050, 428.285 and 450.425.

2. If the sick person dies, the board of county commissioners shall give or order to be given to the person a decent burial or cremation.

3. Except as otherwise provided in NRS 422.382, the board of county commissioners shall make such allowance for the person's board, nursing, medical aid, burial or cremation as the board deems just and equitable, and order it paid out of the county treasury.

4. The responsibility of the board of county commissioners to provide medical aid or any other type of remedial aid under this section is relieved to the extent provided in NRS 422.382 and to the extent of the amount of money or the value of services provided by:

(a) The welfare division of the department of human resources to or for such persons for medical care or any type of remedial care under the state plan for [assistance to the medically indigent;] *Medicaid;* and

(b) The fund for hospital care to indigent persons under the provisions of NRS 428.115 to 428.255, inclusive.

Sec. 27. NRS 108.850 is hereby amended to read as follows:

108.850 1. A petition to the district court for the imposition of a lien as described and limited in NRS 422.29355 to recover money owed to the department of human resources as a result of payment of benefits for [assistance to the medically indigent] *Medicaid* must set forth:

(a) The facts concerning the giving of assistance;

(b) The name and address of the person who is receiving or who received the benefits for [assistance to the medically indigent;] *Medicaid;*

(c) A description of the property, sufficient for identification, and its estimated value;

(d) The names, ages, residences and relationship of all persons who are claiming an interest in the property or who are listed as having any interest in the property, so far as known to the petitioner; and

(e) An itemized list of the amount owed to the department of human resources as a result of payment of benefits for [assistance to the medically indigent.] *Medicaid.*

2. No defect of form or in the statement of facts actually existing voids the petition for the lien.

Sec. 28. NRS 108.860 is hereby amended to read as follows:

108.860 1. A petition for the imposition of a lien must be signed by or on behalf of the state welfare administrator or the attorney general and filed with the clerk of the court, who shall set the petition for hearing.

2. Notice of a petition for the imposition of a lien must be given by registered or certified mail, postage prepaid, at least 10 days before the date set for hearing or other action by the court. Each such notice must be addressed to the intended recipient at his last address known to the administrator, receipt for delivery requested. The administrator shall cause the notice to be published, at least once a week for 3 successive weeks, in one newspaper published in the county, and if there is no newspaper published in the county, then in such mode as the court may determine, notifying all persons claiming any interest in the property of the filing of the petition, the object and the location, date and time of the hearing.

3. Notice of a petition for the imposition of a lien must be given to:

(a) Each person who has requested notice;

(b) The person who is receiving or has received benefits for [assistance to the medically indigent;] *Medicaid;*

(c) The legal guardian or representative of a person who is receiving or has received [benefits for assistance to the medically indigent,] *Medicaid,* if any;

(d) Each executor, administrator or trustee of the estate of a decedent who received benefits for [assistance to the medically indigent,] *Medicaid,* if any;

(e) The heirs of such a decedent known to the administrator; and

(f) Each person who is claiming any interest in the property or who is listed as having any interest in the subject property,

and must state the filing of the petition, the object, and the time set for hearing.

4. At the time appointed, or at any other time to which the hearing may be continued, upon proof being made by affidavit or otherwise to the satisfaction of the court that notice has been given as required by this chapter, the court shall proceed to hear the testimony in support of the petition. Each witness who appears and is sworn shall testify orally.

5. The court shall make findings as to the appropriateness of the lien and the amount of the lien.

6. At the time of the filing of the petition for imposition of a lien the administrator shall file a notice of pendency of the action in the manner provided in NRS 14.010.

7. Upon imposition of the lien by the court, the administrator shall serve the notice of lien upon the owner by certified or registered mail and file it with the office of the county recorder of each county where real property subject to the lien is located.

8. The notice of lien must contain:

(a) The amount due;

(b) The name of the owner of record of the property; and

(c) A description of the property sufficient for identification.

9. If the amount due as stated in the notice of lien is reduced by a payment, the administrator shall amend the notice of lien, stating the amount then due, within 20 days after receiving the payment.

Sec. 29. NRS 108.870 is hereby amended to read as follows:

108.870 The state welfare administrator may, to the extent not prohibited by 42 U.S.C. § 1396p(b), foreclose upon a lien for money owed to the department of human resources as a result of the payment of benefits for [assistance to the medically indigent] *Medicaid* by action in the district court in the same manner as for foreclosure of any other lien.

Sec. 30. NRS 123.259 is hereby amended to read as follows:

123.259 1. Except as otherwise provided in subsection 2, a court of competent jurisdiction may, upon a proper petition filed by a spouse or the guardian of a spouse, enter a decree dividing the income and resources of a husband and wife pursuant to this section if one spouse is an institutionalized spouse and the other spouse is a community spouse.

2. The court shall not enter such a decree if the division is contrary to a premarital agreement between the spouses which is enforceable pursuant to chapter 123A of NRS.

3. Unless modified pursuant to subsection 4 or 5, the court may divide the income and resources:

(a) Equally between the spouses; or

(b) By protecting income for the community spouse through application of the maximum federal minimum monthly maintenance needs allowance set forth in 42 U.S.C. § 1396r-5(d)(3)(C) and by permitting a transfer of resources to the community spouse an amount which does not exceed the amount set forth in 42 U.S.C. § 1396r-5(f)(2)(A)(ii).

4. If either spouse establishes that the community spouse needs income greater than that otherwise provided under paragraph (b) of subsection 3, upon finding exceptional circumstances resulting in significant financial duress and setting forth in writing the

reasons for that finding, the court may enter an order for support against the institutionalized spouse for the support of the community spouse in an amount adequate to provide such additional income as is necessary.

5. If either spouse establishes that a transfer of resources to the community spouse pursuant to paragraph (b) of subsection 3, in relation to the amount of income generated by such a transfer, is inadequate to raise the income of the community spouse to the amount allowed under paragraph (b) of subsection 3 or an order for support issued pursuant to subsection 4, the court may substitute an amount of resources adequate to provide income to fund the amount so allowed or to fund the order for support.

6. A copy of a petition for relief under subsection 4 or 5 and any court order issued pursuant to such a petition must be served on the state welfare administrator when any application for medical assistance is made by or on behalf of an institutionalized spouse. He may intervene no later than 45 days after receipt by the welfare division of the department of human resources of an application for medical assistance and a copy of the petition and any order entered pursuant to subsection 4 or 5, and may move to modify the order.

7. A person may enter into a written agreement with his spouse dividing their community income, assets and obligations into equal shares of separate income, assets and obligations of the spouses. Such an agreement is effective only if one spouse is an institutionalized spouse and the other spouse is a community spouse or a division of the

income or resources would allow one spouse to qualify for services under NRS 427A.250 to 427A.280, inclusive.

8. An agreement entered into or decree entered pursuant to this section may not be binding on the welfare division of the department of human resources in making determinations under the state plan for [assistance to the medically indigent.] *Medicaid.*

9. As used in this section, "community spouse" and "institutionalized spouse" have the meanings respectively ascribed to them in 42 U.S.C. § 1396r-5(h).

Sec. 31. NRS 146.070 is hereby amended to read as follows:

146.070 1. When a person dies leaving an estate, the gross value of which after deducting any encumbrances does not exceed $25,000, and there is a surviving spouse or minor child or minor children of the deceased, the estate must not be administered upon, but the whole thereof, after directing such payments as may be deemed just, must be, by an order for that purpose, assigned and set apart for the support of the surviving spouse or minor children, or for the support of the minor child or minor children, if there is no surviving spouse. Even though there is a surviving spouse, the court may, after directing such payments, set aside the whole of the estate to the minor child or minor children, if it is in their best interests.

2. When there is no surviving spouse or minor child of the deceased and the gross value of a decedent's estate, after deducting any encumbrances, does not exceed $25,000, upon good cause shown therefor, the judge may order that the estate must not be administered upon but the whole thereof must be assigned and set apart:

First: To the payment of funeral expenses, expenses of last illness, money owed to the department of human resources as a result of payment of benefits for [assistance to the medically indigent,] *Medicaid,* and creditors, if there are any; and

Second: Any balance remaining to the claimant or claimants entitled thereto.

3. All proceedings taken under this section, whether or not the decedent left a will, must be originated by a verified petition containing:

(a) A specific description of all of the decedent's property.

(b) A list of all the liens, encumbrances of record at the date of his death.

(c) An estimate of the value of the property.

(d) A statement of the debts of the decedent so far as known to the petitioner.

(e) The names, ages and residences of the decedent's heirs, devisees and legatees.

The petition may include a prayer that if the court finds the gross value of the estate, less encumbrances, does not exceed $25,000, the estate be set aside as provided in this section.

4. The petitioner shall give notice of the petition and hearing in the manner provided in NRS 155.010 to the decedent's heirs, devisees and legatees and to the welfare division of the department of human resources. The notice must include a statement that a prayer for setting aside the estate to the spouse, or minor child or minor children, as the case may be, is included in the petition.

5. No court or clerk's fees may be charged for the filing of any petition in, or order of court thereon, or for any certified copy of the petition or order in an estate not exceeding $1,000 in value.

6. If the court finds that the gross value of the estate, less encumbrances, does not exceed the sum of $25,000, the court may direct that the estate be distributed to the father or mother of any minor heir or legatee, with or without the filing of any bond, or may require that a general guardian be appointed and that the estate be distributed to the guardian, with or without bond as in the discretion of the court seems to be in the best interests of the minor. The court may direct the manner in which the money may be used for the benefit of the minor.

Sec. 32. NRS 146.080 is hereby amended to read as follows:

146.080 1. When a decedent leaves no real property, nor interest therein nor lien thereon, in this state, and the gross value of the decedent's property in this state, over and above any amounts due to the decedent for services in the Armed Forces of the United States, does not exceed $10,000, the surviving spouse, the children, lawful issue of deceased children, the parent, the brother or sister of the decedent, or the guardian of the estate of any minor or insane or incompetent person bearing that relationship to the decedent, if that person has a right to succeed to the property of the decedent or is the sole beneficiary under the last will and testament of the decedent, or the welfare division of the department of human resources, may, 40 days after the death of the decedent, without procuring letters of administration or awaiting the probate of the will, collect any money due the decedent, receive the property of the decedent, and have any evidences of interest, indebtedness or right transferred to him upon furnishing the person, representative, corporation, officer or body owing the money, having custody of the property or acting as

registrar or transfer agent of the evidences of interest, indebtedness or right, with an affidavit showing the right of the affiant or affiants to receive the money or property or to have the evidences transferred.

2. An affidavit made pursuant to this section must state:

(a) The affiant's name and address, and that the affiant is entitled by law to succeed to the property claimed;

(b) That the decedent was a resident of Nevada at the time of his death;

(c) That the gross value of the decedent's property in this state, except amounts due to the decedent for services in the Armed Forces of the United States, does not exceed $10,000, and that the property does not include any real property nor interest therein nor lien thereon;

(d) That at least 40 days have elapsed since the death of the decedent;

(e) That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction;

(f) That all debts of the decedent, including funeral and burial expenses and money owed to the department of human resources as a result of the payment of benefits for [assistance to the medically indigent,] *Medicaid* have been paid or provided for;

(g) A description of the personal property and the portion claimed;

(h) That the affiant has given written notice, by personal service or by certified mail, identifying his claim and describing the property claimed, to every person whose right to

succeed to the decedent's property is equal or superior to that of the affiant, and that at least 10 days have elapsed since the notice was served or mailed; and

(i) That the affiant is personally entitled, or the department of human resources is entitled, to full payment or delivery of the property claimed or is entitled to payment or delivery on behalf of and with the written authority of all other successors who have an interest in the property.

3. If the affiant:

(a) Submits an affidavit which does not meet the requirements of subsection 2 or which contains statements which are not entirely true, any money or property he receives is subject to all debts of the decedent.

(b) Fails to give notice to other successors as required by subsection 2, any money or property he receives is held by him in trust for all other successors who have an interest in the property.

4. A person who receives an affidavit containing the information required by subsection 2 is entitled to rely upon such information, and if he relies in good faith, he is immune from civil liability for actions based on that reliance.

5. Upon receiving proof of the death of the decedent and an affidavit containing the information required by this section:

(a) A transfer agent of any security shall change the registered ownership of the security claimed from the decedent to the person claiming to succeed to ownership of that security.

(b) A governmental agency required to issue certificates of ownership or registration to personal property shall issue a new certificate of ownership or registration to the person claiming to succeed to ownership of the property.

6. If any property of the estate not exceeding $10,000 is located in a state which requires an order of a court for the transfer of the property, or if it consists of stocks or bonds which must be transferred by an agent outside this state, any person qualified under the provisions of subsection 1 to have the stocks or bonds or other property transferred to him may do so by obtaining a court order directing the transfer. The person desiring the transfer must file a verified petition in a court of competent jurisdiction containing:

(a) A specific description of all of the property of the decedent.

(b) A list of all the liens and encumbrances of record at the date of the decedent's death.

(c) An estimate of the value of the property of the decedent.

(d) The names, ages and residences of the decedent's heirs and legatees.

(e) A prayer requesting the court to issue an order directing the transfer of the stocks or bonds or other property if the court finds the gross value of the estate does not exceed $10,000.

If the court finds that the gross value of the estate does not exceed $10,000 and the person requesting the transfer is entitled to it, the court may issue an order directing the transfer.

Sec. 33. NRS 150.220 is hereby amended to read as follows:

150.220 The debts and charges of the estate must be paid in the following order:

1. Funeral expenses.

2. The expenses of the last sickness.

3. Family allowance.

4. Debts having preference by laws of the United States.

5. Money owed to the department of human resources as a result of the payment of benefits for [assistance to the medically indigent.] *Medicaid.*

6. Wages to the extent of $600, of each employee of the decedent, for work done or personal services rendered within 3 months before the death of the employer. If there is not sufficient money with which to pay all such labor claims in full, the money available must be distributed among the claimants in accordance with the amounts of their respective claims.

7. Judgments rendered against the deceased in his lifetime, and mortgages in order of their date. The preference given to a mortgage must only extend to the proceeds of the property mortgaged. If the proceeds of such property are insufficient to pay the mortgage, the part remaining unsatisfied must be classed with other demands against the estate.

8. All other demands against the estate.

Sec. 34. NRS 150.230 is hereby amended to read as follows:

150.230 1. The executor or administrator shall, as soon as he has sufficient funds in his hands, upon receipt of a sworn statement of the amount due and without any formal action upon creditors' claims, pay the funeral expenses, the expenses of the last sickness, the allowance made to the family of the deceased, money owed to the department of human

resources as a result of payment of benefits for [assistance to the medically indigent] *Medicaid* and wage claims to the extent of $600 of each employee of the decedent for work done or personal services rendered within 3 months before the death of the employer; but he may retain in his hands the necessary expenses of administration.

2. He is not obliged to pay any other debt or any legacy until the payment is ordered by the court.

3. He may, before court approval or order, pay any of the decedent's debts amounting to $100 or less if:

(a) Claims for payment thereof are properly filed in the proceedings;

(b) The debts are justly due; and

(c) The estate is solvent.

In settling the account of the estate, the court shall allow any such payment if the conditions of paragraphs (a), (b) and (c) have been met; otherwise, the executor or administrator is personally liable to any person sustaining loss or damage as a result of such payment.

4. Funeral expenses and expenses of a last sickness are debts payable out of the estate of the deceased spouse and must not be charged to the community share of a surviving spouse, whether or not the surviving spouse is financially able to pay such expenses and whether or not the surviving spouse or any other person is also liable therefor.

Sec. 35. NRS 228.410 is hereby amended to read as follows:

228.410 1. The attorney general has primary jurisdiction to investigate and prosecute violations of NRS 422.540 to 422.570, inclusive, and any fraud in the administration of the plan or in the provision of medical assistance. The provisions of this section notwithstanding, the welfare division of the department of human resources shall enforce the plan and any administrative regulations adopted pursuant thereto.

2. For this purpose, he shall establish within his office the Medicaid fraud control unit. The unit must consist of a group of qualified persons, including, without limitation, an attorney, an auditor and an investigator who, to the extent practicable, has expertise in nursing, medicine and the administration of medical facilities.

3. The attorney general, acting through the unit established pursuant to subsection 2:

(a) Is the single state agency responsible for the investigation and prosecution of violations of NRS 422.540 to 422.570, inclusive;

(b) Shall review reports of abuse or criminal neglect of patients in medical facilities which receive payments under the plan and, when appropriate, investigate and prosecute the persons responsible;

(c) May review and investigate reports of misappropriation of money from the personal resources of patients in medical facilities which receive payments under the plan and, when appropriate, prosecute the persons responsible;

(d) Shall cooperate with federal investigators and prosecutors in coordinating state and federal investigations and prosecutions involving fraud in the provision or administration of

medical assistance pursuant to the plan, and provide those federal officers with any information in his possession regarding such an investigation or prosecution; and

(e) Shall protect the privacy of patients and establish procedures to prevent the misuse of information obtained in carrying out this section.

4. When acting pursuant to NRS 228.175 or this section, the attorney general may commence his investigation and file a criminal action without leave of court, and he has exclusive charge of the conduct of the prosecution.

5. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Plan" means the state plan for [the medically indigent] *Medicaid* established pursuant to NRS 422.237.

Sec. 36. NRS 441A.220 is hereby amended to read as follows:

441A.220 All information of a personal nature about any person provided by any other person reporting a case or suspected case of a communicable disease, or by any person who has a communicable disease, or as determined by investigation of the health authority, is confidential medical information and must not be disclosed to any person under any circumstances, including pursuant to any subpoena, search warrant or discovery proceeding, except as follows:

1. For statistical purposes, provided that the identity of the person is not discernible from the information disclosed.

2. In a prosecution for a violation of this chapter.

3. In a proceeding for an injunction brought pursuant to this chapter.

4. In reporting the actual or suspected abuse or neglect of a child or elderly person.

5. To any person who has a medical need to know the information for his own protection or for the well-being of a patient or dependent person, as determined by the health authority in accordance with regulations of the board.

6. If the person who is the subject of the information consents in writing to the disclosure.

7. Pursuant to subsection 2 of NRS 441A.320.

8. If the disclosure is made to the welfare division of the department of human resources and the person about whom the disclosure is made has been diagnosed as having acquired immunodeficiency syndrome or an illness related to the human immunodeficiency virus and is a recipient of or an applicant for [assistance to the medically indigent.] *Medicaid.*

9. To a fireman, police officer or person providing emergency medical services if the board has determined that the information relates to a communicable disease significantly related to that occupation. The information must be disclosed in the manner prescribed by the board.

10. If the disclosure is authorized or required by specific statute.

Sec. 37. NRS 442.1192 is hereby amended to read as follows:

442.1192 1. A health officer in a county or community that lacks services for prenatal care may submit an application to the University of Nevada School of Medicine for a grant to subsidize a portion of the malpractice insurance of a provider of prenatal care who provides services to pregnant women in the county or community.

2. A county or community lacks services for prenatal care if at least one of the following conditions is present:

(a) A provider of prenatal care does not offer services to pregnant women within the county or the community.

(b) Fifty percent or more of the live births to women who are residents of the county occur outside the county.

(c) The percentage of live births to women in the county or community who received no prenatal care exceeds the percentage of live births to women in the state who received no prenatal care.

(d) The percentage of live births of babies with low birthweight to women in the county or community is higher than the percentage of live births of babies with low birthweight to women in the state.

3. If the applicant is a county or district health officer, he must provide proof of the financial contribution by the county or district for the provision of prenatal services for women who do not qualify for reimbursement pursuant to the state plan for [assistance to the medically indigent.] *Medicaid.*

Sec. 38. NRS 422.008 is hereby repealed.

Sec. 39. This act becomes effective on July 1, 1997.

TEXT OF REPEALED SECTION

422.008 "Assistance to the medically indigent" defined. "Assistance to the medically indigent" means the program established to provide assistance for part or all of the cost of medical or remedial care rendered on behalf of indigent persons pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) and other provisions of that act relating to medical assistance to indigent persons.