MINUTES OF THE MEETING
OF THE
LEGISLATIVE COMMITTEE ON HEALTH CARE
(*Nevada Revised Statutes* 439B.200 through 439B.240)
December 5, 2000
Las Vegas, Nevada

The seventh meeting of Nevada's Legislative Committee on Health Care for the 1999-2000 Interim was held on Tuesday, December 5, 2000, at 10 a.m., in Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. This meeting was videoconferenced to Room 3138 of the Legislative Building in Carson City, Nevada. Pages 2 and 3 contain the "Meeting Notice and Agenda" for this meeting.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Ellen M. Koivisto, Chairman
Senator Raymond D. Rawson, Vice Chair

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Maurice E. Washington

COMMITTEE MEMBERS ABSENT:

Senator Bernice Mathews
Assemblywoman Merle Berman
Assemblywoman Vivian L. Freeman

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Marla McDade Williams, Senior Research Analyst, Research Division
Risa B. Lang, Principal Deputy Legislative Counsel, Legal Division
Leslie K. Hamner, Senior Deputy Legislative Counsel, Legal Division
Kennedy, Senior Research Secretary, Research Division

MEETING NOTICE AND AGENDA

Name of Organization:	Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200)
Date and Time of Meeting:	December 5, 2000 10 a.m.
Place of Meeting:	Grant Sawyer State Office Building Room 4401 555 East Washington Avenue Las Vegas, Nevada

Note: Some members of the committee may be attending the meeting and other persons may observe the meeting and provide testimony, through a simultaneous video conference conducted at the following location:

Legislative Building
Room 3138
401 South Carson Street
Carson City, Nevada

f you cannot attend the meeting, you can listen to it live over the Internet. The address for the Legislative Veb site is http://www.leg.state.nv.us. For audio broadcasts, click on the link "Listen to Meetings Live on he Internet."

A G E N D A

. Opening Remarks
Assemblywoman Ellen M. Koivisto, Chair

II. Report Concerning Activities of the Office for Consumer Health Assistance, Governor's Office
Laurie England, Director

III. Discussion of Issues Related to Hospital Emergency Rooms That May be Unable to Accept Patients When They Are Transferred by Ambulance to Area Hospitals
A. Jim Spinello, Franchise Services Manager, Franchise/Legislative Services Division, Clark County Administrative Services

B. Trace Skeen, Chief Executive Officer, Southern Nevada Regional Office, American Medical Response

C. John Wilson, Executive Partner, Southwest Ambulance

D. Representative, Las Vegas Fire Services, City of Las Vegas

E. Jackie Taylor, University Medical Center of Southern Nevada

IV. Presentation of Recommendation Concerning a Proposal to Improve Rural Health Care in Nevada
A. Steve Tognoli, District Chief, Mason Valley Fire Protection District

B. Robin Keith, President, Nevada Rural Hospital Project

C. Carolyn Ford, M.P.H., Assistant Dean/Director, Center for Education and Health Services Outreach, University of Nevada School of Medicine

V. Update Concerning Payment Issues for Skilled Nursing Facilities in Nevada
A. Charles Perry, Executive Director, Nevada Health Care Association

B. Charles Duarte, Administrator, Division of Health Care Financing and Policy, Nevada's Department of Human Resources (DHR)

VI. Discussion Concerning Previously Adopted Recommendation of the Committee for Legislation to Allow Persons Who Are Disabled to Receive Income From Employment and to Retain Their Eligibility for Medicaid

VII. Discussion Concerning Cost Estimates to Offer "Presumptive Eligibility" for Pregnant Women and Children as Part of the Medicaid Program
Charles Duarte, Administrator, Division of Health Care Financing and Policy, DHR

/III. Public Testimony

X. Adjournment

Denotes items on which the committee may take action.

lote: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call Kennedy at (775) 684-6825 as soon as possible.

lotice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, asement, Capitol Building; City Hall, 201 North Carson Street; Legislative Building, 401 South Carson Street; and Nevada State Library, 00 Stewart Street. Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations: Clark County Office, 500 South rand Central Parkway; and Grant Sawyer State Office Building, 555 East Washington Avenue.

OPENING REMARKS

Chairman Ellen M. Koivisto called the meeting to order at 10:27 a.m. and announced that the committee will hear testimony and updates on health issues.

REPORT CONCERNING ACTIVITIES OF THE OFFICE FOR CONSUMER HEALTH ASSISTANCE, GOVERNOR'S OFFICE

Laurie England

Laurie England, Director, Office for Consumer Health Assistance (CHA), Las Vegas, Nevada, updated the committee on progress made at CHA during the past year. She said CHA is a telephone assistance center offering resource referrals to the public on a range of topics including health care, medical insurance, and worker's compensation. There is an office in Carson City and in Las Vegas, Nevada, as well as an Internet site at http://cha.state.nv.us. Online information is presented in English and Spanish, and CHA is responsible for performing statewide outreach efforts.

Continuing, Ms. England said the majority of telephone calls received by CHA include: (1) appeals; (2) complaints; (3) explanation of benefit entitlements; and (4) other information including education, counseling, et cetera, and all callers are categorized by payer source. CHA asks for documentation and a signed legal release in return for acting as a third-party arbitrator on behalf of citizens in certain cases. In response to a question, Ms. England noted that five percent of consumers do not sign release forms.

Concluding, Ms. England said CHA practices fair treatment for all callers. Data about each caller is collected and analyzed by elected officials, the Legislative Counsel Bureau (LCB), and others. In her opinion, she said data collected in the past year will end the "ambiguity" regarding the number of uninsured or non-insured individuals in Nevada. Consumers are also asked to participate in a survey, and results show a 40 percent return with a positive rating for CHA's customer service performance. Ms. England stated that another requirement of the office is outreach.

Chairman Koivisto commended the efforts of CHA and said she has received positive feedback from constituent referrals.

Responding to a question on procedure from Chairman Koivisto, Ms. England said most telephone calls regarding Medicaid involve fee-for-service practices, delays or perceived delays in prior authorization approvals, and provider payment issues. Ms. England said CHA does not have any recommendations for legislation at this time.

DISCUSSION OF ISSUES RELATED TO HOSPITAL EMERGENCY ROOMS THAT MAY BE UNABLE TO ACCEPT PATIENTS WHEN THEY ARE TRANSFERRED BY AMBULANCE TO AREA HOSPITALS

Jim Spinello

Jim Spinello, Assistant Director, Administration Services, Clark County; former member of the Nevada State Assembly; and private citizen, Las Vegas, explained that "divert" is a procedure used by hospital emergency rooms (ERs) to redirect ambulances and emergency medical services (EMS) respondents to alternate facilities equipped with staff and resources to handle emergencies. Typically, high occurrences of influenza cases during winter months cause ERs to fill up. He said that divert is no longer a seasonal phenomenon and has become the "norm." Furthermore, Mr. Spinello said the divert status of ERs jeopardizes required response time guidelines for ambulance franchises. However, an ambulance service is not held accountable when the ER system is "overloaded." It is his opinion that no one benefits during divert situations.

Continuing, Mr. Spinello said this raises local community issues such as the capacity of services delivered, the multifaceted reasons why ERs are overcrowded, and an identification of the types of patients paralleling a divert situation. The symptomology of these patients include alcohol/drug detoxification, and mental illness, as well as uninsured individuals utilizing ERs in the manner of a primary health care provider. He said these types of cases belong in an alternative medical facility and not in an ER, which is designed to provide care for critical emergencies. However, to deny medical clearance to an individual suffering from mental illness is in direct conflict with current State law, which requires a medical screening prior to involuntary commitment for these types of patients.

Concluding, Mr. Spinello asked the members to review Nevada's entire health care structure with respect to population growth and an overloaded provider system. He cautioned that frequent "casualties" of stressed health care systems include persons suffering from mental illness and this population will not simply vanish. In his opinion, members of Nevada's mentally ill population are divided, confused, and easy to ignore because of lack of representation. He recommended the creation of a program including: (1) staffing and facilities; (2) both community- and facility-based programs; (3) support services from private and public sectors; and (4) out-placement services to ensure that persons suffering from mental illness are not released into communities with undeveloped infrastructures for the needs of this population. He said that unprepared communities have disproportionately high numbers of persons with mental illness living in homeless shelters or jails, and inappropriately receiving treatment in ERs. He said this is just one contributing element to the problem of bed shortages in ERs.

Trace Skeen

Trace Skeen, Chief Executive Officer, American Medical Response, Southern Nevada Regional Office, Las Vegas, said the EMS community appreciated Mr. Spinello's input and efforts in addressing a community crisis. He cautioned that health care crisis discussions not dissolve into panic like the phenomenon experienced with Year 2000 (Y2K), which resulted in excessive and unused resources. However, Mr. Skeen said those supply inventories continued to deplete even after the winter phenomena of cold and influenza season ended, indicating a volume of services so great that it is now categorized by the EMS community as a "crisis."

Continuing, Mr. Skeen said the American Medical Response Company took specific steps to address two situations:

- The divert situation could be handled by policy instead of delaying care. Patients experience delays in receiving treatment, whether the ambulance was diverted to another hospital miles away, or by having to wait for a bed upon arrival at the closest hospital. There are cases of individuals calling 911 from a pay telephone outside of the emergency room in an attempt to receive care sooner. Unfortunately, some patients walk out against medical advice.

- Impacts to the provider organizations include: (1) fines and penalties are imposed for inferior response times, and cost approximately $24,000 per month; (2) additional ambulances and staff are needed because of the fleet of engaged units sitting in hospital emergency parking lots waiting to deliver clients into hospital custody and care; and (3) patient care may be compromised.

Mr. Skeen reported that the American Medical Response team collaborated with the California-based Aberas Group to determine patient flow through a hospital system. The Aberas Group conducted interviews with hospital staff and citizens, and in August 2000, a community summit was held for 80 health care professionals to openly discuss these issues. Several proposed solutions derived from the summit include:

- Eliminating the divert status protocol so ERs discontinue the practice of refusing patients.

- Expediting patient transfers from the ambulance to the ER.

- Requiring hospitals to pay ambulance franchises for wait times. The standard "drop time" is 23 minutes. When a hospital makes an ambulance wait, the staff on board must provide care for the patient in transit.

- Incorporating paramedics into a more aggressive role in transferring patients upon arrival at an ER. An army cot could accompany each patient into the ER to ensure that EMS staff can deliver the patient and leave to continue serving the community instead of waiting for an ER bed to become available. This concept is called an "auto transfer."

- Expanding the facilities that are authorized to accept emergencies to include "urgent care centers."

- Modifying nursing plans to allow registered nurses to work with physician assistants or other authorized hospital staff to complete physical evaluations. This will liberate ER physicians to attend to medical emergencies; however, the shortage of registered nurses in Clark County also needs to be addressed.

Concluding, Mr. Skeen said 70 percent of ambulance transports are exceeding the standard drop time of 23 minutes and ERs operate on divert status an average of 70 percent to 85 percent of the time. He said that the local nursing staffs are experiencing critical stress levels in response to the shortage.

John Wilson

John Wilson, Executive Partner, Southwest Ambulance, Las Vegas, discussed payment reimbursement and transportation authority conflicts:

Mr. Wilson noted that the mental health transport situation operates under the authority of *Nevada Revised Statutes* (NRS) 433A.165, **"**Examination required before transportation of person to mental health facility; payment of cost." Accordingly, this NRS mandates that a patient receive a physical exam by a licensed physician prior to admittance into a mental health facility. Hospital emergency departments receive compensation for the examination, but the transport company frequently does not because many of these patients are not suffering from any life threatening conditions. Further, the health insurance company denies payment twice, because the patient also requires a second transport to a mental health facility after medical clearance is granted from the ER. Mr. Wilson asserted that this issue should be addressed from a legislative standpoint.

Continuing, Mr. Wilson discussed a related mental health transport mandate issue in NRS 433A.330, **"**Transportation to mental health facility." He stated that this statute has been interpreted to require that a person suffering from mental illness, who will be involuntarily ordered to a mental health facility, be transported there by the ambulance that initially took him to the ER. Although the statute requires that the individual ". . . shall be delivered to the sheriff of the county who shall convey the person to the appropriate public or private mental health facility," the Las Vegas Metropolitan Police Department (Metro) does not transport this population to the ER or to the mental health facility. The responsibility has been delegated to the ambulance providers and now raises serious questions regarding liability and under what authority the ambulance providers are acting. Mr. Wilson noted that it is not the desire of any ambulance provider to be "deputized" by the Metro in order to legally provide these transports.

Mr. Wilson also discussed The Chronic Inebriant Program that has been established at Westcare, a private mental health facility, to medically evaluate intoxicated individuals and to allow for their detoxification, if necessary, which is in a facility, not an ER. Further legislation is needed to expand facilities of this type to liberate beds in acute medical facilities to reserve resources needed for life threatening intervention. Additionally, an updated screening protocol will streamline the process of where to transport a person needing detoxification.

Further, Mr. Wilson testified that legislation is needed to allow local ambulance services, under the guidance of the governing health district, to transport certain individuals into urgent care centers. Previously, ambulances from Sierra Health Services would transport their patients to Sierra's urgent health center. This stopped upon closer examination of the current language in the NRS, which does not permit ambulances to transport patients to urgent care centers from the scene of an emergency. Proper due diligence from the heath care community and providers can

create a plan with greater options for transport services.

Concluding, Mr. Wilson said that it was his opinion the State Board of Nursing would benefit from a streamlined recruitment process to attract nursing professionals to Nevada. He asked that the Legislative Committee on Health Care consider alternatives to address the shortage of registered nurses.

Kenneth Riddle

Kenneth Riddle, Deputy Fire Chief, Las Vegas Fire and Rescue; Vice President, Southern Nevada Fire Chiefs; and representative, International Association of Fire Chiefs, EMS Section, Las Vegas, explained that the divert issue is a nationwide problem and is not unique to Clark County. He discussed the impact on the fire departments in the southern Nevada area and said the current situation requires trained fire units to respond to routine public calls. Trained fire fighters are routinely called to assist senior citizens in nonemergency situations.

Pointing out the differences between EMS professions, Deputy Riddle explained that fire departments are geographically based whereas private ambulance providers are not. Fire trucks contain cross-trained staff with paramedic training, but do not transport patients. The impact divert has had on fire departments has resulted in units being out of position, which leaves portions of the city unprotected. Impacts on response time create a "domino effect," where other units must respond to calls outside of their designated area because the primary truck is elsewhere.

Concluding, Deputy Riddle commended local officials, hospital representatives, and private ambulance providers for bringing the divert issue before the committee, and he said he is encouraged by the community's renewed interest and partnership in finding a resolution. He suggested the creation of a "911 gatekeeper concept" that would allow operators to direct patients to appropriate facilities.

Jackie Taylor

Jackie Taylor, representative, University Medical Center of Southern Nevada (UMC), Las Vegas, distributed divert statistics for critical care and emergencies (Exhibit A) and described UMC's capacity for treating emergency situations. She stated the following points: (1) the trauma center has 11 beds; (2) the pediatric emergency department has 23 beds; and (3) the emergency room has 40 beds. She reported that a new emergency department will open at the UMC in the beginning of 2001 and is designated as the only trauma center in the community that does not incorporate divert procedures.

Ms. Taylor explained UMC's policy for extreme circumstances and said the ER converts to the intensive care unit (ICU) when the critical care areas, which are coronary, intermediate, and intensive care units, become full. She said ten to twenty-five ICU patients in the ER would cause the system to backup — stalling patients in the waiting room and ambulances in the parking lot.

Ms. Taylor said divert status activation typically occurs when ERs cannot discharge patients due to pending medical clearances and laboratory work analyses; and when the ten available beds at the mental health facility are full. In her opinion, the current process of discharging and placing mental patients into an appropriate facility is cumbersome. Additionally, inebriant patients present a problem for the ER because Westcare's detoxification facility needs funding and medically trained staff. Ms. Taylor said staffing is a problem throughout the community and until a permanent solution is found, approximately 100 traveling registered nurses meet the current need.

Concluding, Ms. Taylor expressed support for UNSOM's proposed psychiatric residency program in southern Nevada, which she said may alleviate the pressure on ER physicians created by admitting and discharging people with mental illness. She updated committee members on a "Blue Ribbon Committee" meeting schedule and said newly formed subcommittees reflect a spirit of cooperation and information sharing. The Blue Ribbon Committee is a mechanism for providers to work together in reducing divert hours as the medical community braces for the seasonal influenza problem.

Senator Rawson said the committee could address the mental health issue and suggested that the recommendations be condensed for a bill draft request (BDR). He asked Ms. Taylor to list the areas where immediate assistance is needed. She responded with the need for a "screening" position, additional staffing, and schedule enhancement for

the vulnerable time for system delays, which is early evenings and nights.

Mr. Skeen added that public awareness of 911 services has increased in the last two decades and residents know this is the first access point into the health care system. Citizens are confident that a call to 911 will result in action by EMS staff. He said studies demonstrate that approximately 50 percent of individuals accessing health care through the 911 system do not need emergency vehicles to respond. The majority of these cases can use an alternate venue to access health care. The proposed screening program would direct potential patients to a pathway to receive care, for example, through advice nurse programs. Mr. Skeen said that medical communities are aware of the tedious process encumbered by changing entire systems, however, the current situation demands that solutions are bold and creative.

James Goobles

James Goobles, Vice President, Regional Ambulance Service, Washoe County, Reno, Nevada, said that a group of local emergency care professionals formed a consortium in 1998 and defined a community diversion plan. This plan offers the capabilities for an acute care hospital to divert, but the volume of patients does not support continual utilization in northern Nevada.

Continuing, Mr. Goobles reported that the new Nevada Mental Health Institute (NMHI) facility has ten fewer beds. Additionally, there are procedural and policy conflicts adding to the current situation. The consortium developed several solutions to improve overall service to mental health patients statewide, including: (1) employing additional staff; (2) subcontracting with other mental health facilities to cover overloaded resources; (3) requiring local ambulance franchise companies to commit to transporting persons with mental illness twice and plan transportation resources accordingly; and (4) restructuring the current policy and allowing mental health centers to perform physical health screenings thereby eliminating the dual ambulance transport requirement.

Jack D. Campbell, Esq.

Jack D. Campbell, Esq., Jack D. Campbell and Associates, Reno, stated he provides legal counsel for acute medical and psychiatric facilities in the Reno and greater northern Nevada area. He provided a scenario faced by local ERs when the NMHI is full. Basically, NMHI cannot admit an emergency psychiatric patient by law until the patient is initially taken to an ER for a medical clearance. If it is determined that NMHI cannot admit, then the patient stays in the ER inappropriately using limited acute emergency resources and bed space. However, based on licensing requirements, it is against the law for medical facilities to retain inappropriate clients on site. These facilities are in violation and are subject to federal, state, and civil liabilities. Mr. Campbell recommended that medical emergency facilities have the option to discharge psychiatric patients who have received a medical clearance, because it is not appropriate for this type of client to remain in an ER.

Continuing, Mr. Campbell said the solution must allow psychiatric medical clearances to be facilitated outside of the ER, due to the fact that this non-life threatening procedure takes up valuable resources better directed toward the treatment of acute medical problems. Additionally, he asserted that psychiatric patients need to be moved through the facilities quicker when medical clearances are performed.

Concluding, Mr. Campbell suggested that the NMHI open at full staffing; that the Legislature fund additional areas for medical clearances such as nurse practitioners, physician assistants, or other appropriately supervised medical care personnel; and that the appropriate statutes be amended to eliminate the requirement that psychiatric medical clearances be performed in ERs.

Senator Rawson proposed that the Senate Committee on Human Resources and Facilities request a bill draft to address the funding and staffing of mental health issues. Further, he suggested that Chairman Koivisto request a bill draft addressing the issues of changing the law to allow transport to various types of medical facilities. Chairman Koivisto agreed.

PRESENTATION OF RECOMMENDATION CONCERNING A PROPOSAL TO IMPROVE RURAL HEALTH CARE IN NEVADA

Carolyn Ford, M.P.H.

Carolyn Ford, M.P.H., Assistant Dean/Director, Center for Education and Health Services Outreach, UNSOM, Reno, presented committee members with a document titled "The Frontier and Rural Health Care Improvement Act of 2001" (Exhibit B). She explained the current proposal has been revised from when it was presented to members of the Legislative Committee on Health Care at the March 7, 2000, and June 6, 2000, meetings. She presented four general areas of refinements in the new proposal, including:

- An education and training program to establish: (1) an EMS Training Academy; and (2) a physician assistant (PA) training program through the UNSOM.

- A special population health care needs unit to: (1) establish a rural mental health telemedicine network; and (2) provide enhanced perinatal health care services;

- A health services delivery program to: (1) expand the Nevada Health Service Corporation loan repayment program; and (2) augment the Capital Loan Pool to provide financial access to rural health facilities and service; and

- A financing department to provide support for incremental adjustments in Medicaid reimbursement for rural primary health care practitioners.

Continuing, Ms. Ford said new changes in the proposal's budget include: (1) the EMS Training Academy will offer 16 weeks of instruction during the first year of operation with full implementation by the second year; (2) the PA training program will locate a physical site in the first year; (3) the special population needs section has reduced the equipment budget category from $195,000 to $13,000; (4) the perinatal program budget is adjusted from three nurse practitioners to two; and (5) the proposed budget reexamines an incremental adjustment towards a reasonable cost-basis for primary health care and dental practitioners.

Concluding, Ms. Ford requested that the proposal and its mission statement be introduced into the 2001 Legislative Session and enrolled as a NRS chapter called "Frontier and Rural Health Care."

Steve Tognoli

Steve Tognoli, District Chief, Mason Valley Fire Protection District, Mason Valley, Nevada, said that rural areas struggle to meet the increased demands on recruitment and retention of career and volunteer EMS staff. He said that Nevada's EMS system consists mainly of volunteers providing continuous service and are subject to inconsistencies in both training and funding. He said the stress created from these working conditions might explain why the longevity of volunteer EMS staff has been reduced by half.

Concluding, Mr. Tognoli said the following steps have been taken to address the situation: (1) the development of the Nevada Emergency Medical Association; and (2) the formation of the Nevada Emergency Medical Directors Association. He said an infusion of additional funding could further the development of an EMS infrastructure, self-support billing systems, and training with compressed videotapes distributed statewide.

Gerald Ackerman

Gerald Ackerman, Director, Rural Programs, Center for Education and Health Services Outreach, UNSOM; and Director, Elko Officer Operations, Elko, Nevada, commented briefly on the proposed EMS Training Academy and said that a compressed video for the EMT-II training course is available for students. The Nevada community of Austin has doubled its EMS volunteer force and this success is attributed to the training video. He said that EMS is the safety net of Nevada's rural health care system.

Ms. Ford added the proposed EMS Training Academy is stationed in Elko because it is the geographical center of the rural volunteer force. The proposed curriculum and applicant pool will be chosen with the focus on primary care, including geriatrics. Additionally, workforce diversity, tribal health, and the prison system are emphasized in the proposal. For a complete record of Ms. Ford's testimony, see Exhibit B.

Robin Keith

Robin Keith, President, Nevada Rural Hospital Project (NRHP), Reno, said the proposed "Frontier and Rural Health Care Improvement Act of 2001" contains an appropriation to the State Office of Rural Health to fund additional categories of eligibility for the existing NRHP Foundation Loan Pool. She said the current loan pool balance is $1.34 million, and since its inception, 15 loans have been made that directly impact patient care or the financial liability of rural hospitals. She said the NRHP has been a careful steward of these funds, and she requested a one-time supplement of $500,000 to this fund in the State Office of Rural Health because the loan pool balance will drop to $600,000 after the Robert Wood Foundation loan of $740,000 is repaid in October 2001.

Concluding, Ms. Keith said the loan pool is accessible to hospitals and rural providers. The Robert Wood Foundation may forgive the $600,000 principal and interest on the loan if the State approves replenishment of the pool. She said augmenting the loan pool is an efficient way to support rural health because it builds on the success of an existing program, is self-sustaining, and matching funds could increase the loan pool to $1.75 million.

Responding to questions by Senator Rawson, Ms. Ford agreed that the proposed act takes into consideration increased Medicaid reimbursements for a variety of providers including primary health care practitioners and dental physicians. She said the $1.5 million ongoing future cost of the proposal could be offset by tuition from the EMS Training Academy and PA training programs.

Senator Rawson noted that at a meeting of the Task Force for the Fund for a Healthy Nevada, the committee was asked to consider awarding $300,000 to place cardiac monitors and Automatic External Defibrillation (AED) machines throughout rural Nevada. He asked Ms. Ford if she had any objections to enhancing her proposal by adding these requirements. Ms. Ford stated no objection and suggested that the proposed EMS Training Academy request two EMS faculty positions to monitor all granting programs.

Steve Tognoli said it is his opinion that law enforcement staffs require AED training.

Senator Rawson recommended including $300,000 per year in the "Frontier and Rural Health Care Improvement Act of 2001" for the purchase of, and training in the use of, AEDs until the state is fully equipped after which time a "phase-out" would begin. He also recommended that the Senate Committee on Human Resources and Facilities draft a BDR and include sponsorship from the Legislative Committee on Health Care or any of its members. He directed staff of the LCB to draft a bill incorporating Ms. Ford's proposals including the $300,000 addition to fund the AEDs for the 2001 Session.

Both Senator Washington and Chairman Koivisto agreed to support Senator Rawson's suggestion.

Senator Rawson further directed staff of the LCB to prepare a BDR for joint sponsorship between both houses, and include participating committee members' names. He asked the presenters to organize rural leadership for co-sponsorship signatures on the BDR.

Carl Heard, M.D.

Carl Heard, M.D., Chief Medical Officer, Nevada Rural Health Centers; and Chairman, Nevada Emergency Medical Directors Association, Carson City, Nevada, spoke in favor of the proposed rural health initiative within the context of public testimony on this agenda item. He noted that the committee appeared to be moving forward on this initiative and offered his services for future information sharing.

UPDATE CONCERNING PAYMENT ISSUES FOR SKILLED NURSING FACILITIES IN NEVADA

Charles Perry

Charles Perry, Executive Director, Nevada Health Care Association, Las Vegas, said he represents the majority of skilled nursing facilities and intermediate care providers in Nevada and submitted a copy of his testimony (Exhibit C). He commented on developments affecting Nevada's long-term care providers since the June 6, 2000, meeting of the Legislative Committee on Health Care. He noted the following points:

- Medicaid will make retroactive payments to long-term providers from July 1, 1999, to reflect a 7.64 percent increase in reimbursement payments;

- Despite the 7.64 percent retroactive payment, long-term providers continue to experience uncertain financial viability due to increased costs in benefits, food, liability insurance, medical equipment/supplies, salaries, and utilities; and

- Governor Guinn has indicated an understanding that the retroactive reimbursement represents approximately 50 percent of what is needed. His office has also indicated the need for a reimbursement policy that recognizes current business conditions and eliminates the necessity of retroactive increases or emergency appropriations as a way of paying for the care of Nevada's residents.

Furthermore, Mr. Perry said that the Nevada Health Care Association agrees that Medicaid has an obligation to pay for the high level of long-term care that it demands from Nevada's long-term care providers.

Continuing, Mr. Perry reported that the Administrator of the Division of Health Care Financing and Policy (DHCFP), Nevada's Department of Human Resources (DHR), invited members of the provider communities to participate in a comprehensive revision of the Medicaid program. He reported that several studies are in development and there is an atmosphere of opportunity for resolution as discussions open up the possibility of consensus. He expressed appreciation for the responses of Michael Willden, Administrator, Welfare Division, DHR, and his staff.

Concluding, Mr. Perry addressed the problems in delivering care to Nevada nursing home residents, including difficulties experienced throughout the Medicaid assistance eligibility process. He spoke to a variety of topics including the difficulties in receiving payment for services, "unfunded mandates," and current use of the "outdated" *Medicaid Services Manual* from 1993. He said the domino effect created by policymakers began with the Balanced Budget Act of 1997 and changes in Medicare reimbursement. The changes created obstacles in reimbursing providers, which then caused financial risk to the facility, and ultimately threatened access to citizens requiring institutional care. Mr. Perry said it is his opinion that the provider community is anxious to contribute to the creation of a fair and adequate reimbursement methodology.

Responding to a question by Senator Rawson, Mr. Perry said that the effect of liability on insurance premiums in long-term care is dramatic. He said he was impressed with the efforts and attitude of willingness from Charles Duarte, Administrator of the DHCFP.

Responding to a question by Chairman Koivisto, Mr. Perry said a disparity exists between local building code enforcement and the Health Care Financing Administration's (HCFA), U.S. Department of Health and Human Services, ability to issue citations. He said HCFA safety codes utilize different components whereas Clark County adopts building codes from different periods of time. In his opinion, he said that HCFA is a licensing agency and should yield to the local authority that administers building code citations. At Chairman Koivisto's request, Mr. Perry agreed to provide additional information concerning these issues.

Charles Duarte

Charles Duarte, Administrator, DHCFP, DHR, Carson City, thanked Mr. Perry for his "straightforward representation" of the current situation with Medicaid reimbursements to long-term care providers. He acknowledged that further investigation is needed with respect to reimbursement rates for intermediate care and skilled nursing facilities. He said the DHCFP is committed to working directly with industry representatives to resolve long-term care issues. He updated committee members on activities of a long-term care task force, which include:

- The submission of a request for proposal (RFP) to hire a consultant to assist in evaluating rate methodologies for acute hospital reimbursements, medical equipment, and graduate medical education. The scope of the proposed comprehensive contract will include numerous smaller studies. The consultant will work directly with representatives from the health care industry, including the long-term care association and the hospital association;

- At the initial meeting of the long-term care task force on October 2, 2000, Mr. Perry and other representatives of the long-term care community met to determine a variety of recommendations, the most important being an examination of rate methodology for long-term care, and also the possible restructuring of DHCFP administrative practices. The concept of a continuum of care is also under consideration;

- The submission of a second RFP to study rate methodology in a variety of service areas, including comparison to other states. Other topics for study include: (1) rate setting policies for long-term and acute care beds; (2) rate setting policies for recipients requiring specialized services due to age, behavioral issues, and diagnosis; and (3) determining levels of care and their relationship to reimbursement;

- The DHCFP is considering condensing the current six-level structure of reimbursement into a more streamlined version. Other states, however, are expanding levels in response to an industry trend to adopt "multitiered" levels of reimbursement. For example, New York has 46 levels of care;

- The DHCFP is revising the nursing facilities chapter in the *Medicaid Services Manual*, and the anticipated changes will be "substantial";

- The process conducted by the Medical Review Team will be withdrawn because the results duplicate the work of the Bureau of Licensure and Certification. The overall workload for DHCFP staff will be lessened with regard to monitoring; and

- The DHCFP has requested that its fiscal agent, Blue Cross Blue Shield, develop electronic billing methods for long-term care and recommendations are anticipated by January 2001.

Responding to a question from Chairman Koivisto, Mr. Duarte said the electronic billing system will be developed to decrease data entry and user errors. "Up front edits" will be built-in to bar certain user errors. There are some claims that will not be converted to the electronic format, such as medical validation forms in long-term care, but the majority of forms can be improved to match current technology.

DISCUSSION CONCERNING PREVIOUSLY ADOPTED RECOMMENDATION OF THE COMMITTEE FOR LEGISLATION TO ALLOW PERSONS WHO ARE DISABLED TO RECEIVE INCOME FROM EMPLOYMENT AND TO RETAIN THEIR ELIGIBILITY FOR MEDICAID

Marla McDade Williams

Marla McDade Williams, Senior Research Analyst, Research Division, LCB, Carson City, said the committee adopted a recommendation for legislation to allow persons who are disabled to receive income from employment and still retain Medicaid eligibility. The committee moved forward with this recommendation without the inclusion of a fiscal appropriation, but requested that the Director of the DHR submit this at a later date. Ms. McDade Williams announced that the committee will not receive an estimate on the costs of implementation because the director of the DHR has indicated that she does not have enough information to develop such an estimate. Ms. McDade Williams stated her understanding that the DHR and the DHCFP will benefit from the recent award of a grant to study this issue, however.

Charles Duarte

Charles Duarte, previously identified in these minutes, reported that the DHR accepted the terms and conditions of a HCFA Medicaid Infrastructure Grant authorized by the Ticket to Work and Work Incentives Improvement Act of 1999. He said this act enhanced eligibility options for states to allow disabled persons to continue to receive Medicaid benefits despite changes in income. The act also affects individuals by:

1. Authorizing more people the opportunity to "buy into" Medicaid;

2. Allowing states to remove the upper income limit of 250 percent of poverty (or $21,000) and set higher limits

on income, unearned income, and resources;

3. Permitting people with disabilities to retain Medicaid coverage even though their medical conditions have improved to where they are no longer eligible for Supplemental Security Income insurance; and

4. Extending Medicare Part A Premium Coverage for people on Social Security disability insurance who return to work and provides this for the next 6.5 years.

Continuing, Mr. Duarte said Nevada received a grant from HCFA to develop the infrastructure for addressing changes in newly adopted Medicaid options. The State will receive $625,000 during the first year of the grant, $500,000 during the second year, and $500,000 for the next two years thereafter. The implementation of the grant will be the responsibility of the DHCFP in collaboration with multiple divisions within the DHR.

Concluding, Mr. Duarte said disabled individuals will be involved in meaningful discussion and decision-making processes throughout the duration of the grant. The grant funds will be used for a comprehensive analysis of the existing infrastructure relating to the competitive employment of persons with disabilities, consumer education, development and implementation of a proposed Medicaid "buy-in" program, eligibility determination, enrollment functions, demographic data collection, third-party liability collection, and other fiscal activities. Additionally, the fiscal agent in charge of the claims system will be examined, and other activities associated with the implementation of the grant.

John Liveratti

Responding to concerns of the members of the committee, John Liveratti, Program Specialist, Welfare Division, DHR, Carson City, said the decision-making process will proceed immediately even though the HCFA grant offered funding for four years.

Senator Rawson expressed concerns for the production of substantial results weighed against the timeline of the HCFA grant. He said the grant should not impede or interfere with the need to make systematic progress on this issue.

Mr. Duarte added that the timelines associated with the grant will be examined with the intent of providing the Legislature with substantive information for action. He said the grant offers the ability to plan, and he anticipates flexibility with the timeline.

Senator Washington and Chairman Koivisto both agreed with Senator Rawson that it is unacceptable to ask the disabled community to wait for measurable outcomes after the grant and subsequent legislative timeline are completed (a worst case scenario of six years). Due to exhaustive research on the topic already in place, the committee recommended implementing the Ticket to Work Program rather than waiting for the outcome of the grant. Chairman Koivisto suggested that implementation occur concurrently with a study.

Jon L. Sasser, Esq.

Jon L. Sasser, Esq., Washoe Legal Services, Reno, updated members of the Legislative Committee on Health Care on the recommendation adopted in June 2000. He said that the HCFA grant offers an opportunity to assist disabled people. However, it is his opinion that the real issue is to remove the eligibility barriers for those individuals wanting to return to work but are prevented from doing so by the cost of health insurance once Medicaid is withdrawn. He asked that the DHCFP consider allowing these cases to return to work without losing Medicaid benefits.

H. Jill Smith, Esq.

H. Jill Smith, Esq., Nevada Disability Advocacy and Law Center, Las Vegas, presented members with a document regarding the proposed Medicaid buy-in program (Exhibit D) and said that Nevada Medicaid is exhibiting a "typical stalling tactic." She opined that the law authorizing the HCFA grant contains specific language to fund a Medicaid buy-in program and to develop demonstration projects. She also submitted a document regarding the requirements of "The *Olmstead* Decision" (Exhibit E).

Responding to Ms. Smith's comments, Mr. Duarte said the best way to determine costs and estimates associated with the implementation of the Medicaid buy-in program is through the development of a model of service as determined through community involvement. He said the HCFA grant will assist in providing that information, but it will not prevent or usurp the legislative intent that has been previously established. He reiterated the purpose of the grant as funding the development of infrastructures and models of service. Furthermore, Mr. Duarte stated that Governor Guinn and the Nevada State Legislature will be informed as to the program costs. He said it is difficult to determine other costs associated with projects that the community wants the DHCFP to engage in, but Ms. Smith should not feel that anything is being precluded from happening.

DISCUSSION CONCERNING COST ESTIMATES TO OFFER "PRESUMPTIVE ELIGIBILITY" FOR PREGNANT WOMEN AND CHILDREN AS PART OF THE MEDICAID PROGRAM

Marla McDade Williams

Marla McDade Williams, previously identified in these minutes, provided background information concerning presumptive eligibility to committee members. She said that as a result of meetings in October 1999 between the DHCFP and the Welfare Division, the Chairman forwarded a request to Michael Willden, Administrator, Welfare Division, for the following data:

- The annual number of births reimbursed by Medicaid;
- The geographic distribution of where births occur;
- The number of physicians providing prenatal care for Medicaid eligible pregnant women;
- The annual number of low weight Medicaid births and the associated cost; and
- All relevant data for access to prenatal care in relation to presumptive eligibility.

Ms. McDade Williams indicated that Mr. Duarte may be able to respond to this data request.

Mr. Duarte referred to a memorandum (Exhibit F) and said the DHCFP continues to gather information on several of the topics listed by Ms. McDade Williams, specifically low birth weight data. He listed the key points contained in Exhibit F:

- Medicaid reimbursed 8,884 births in Fiscal Year (FY) 1999, the majority of which occurred in Clark County;
- Medicaid obstetrics and gynecological (OB/GYN) staff numbers are listed by county; and
- There were 405 low birth weight babies born in FY 2000, and more accurate cost data is needed. The cost for 130 of the 405 low birth weight babies is approximately $3.5 million, or $26,700 per baby.

Concluding, Mr. Duarte said this information is available upon request, and listed his Carson City office telephone number as 775-687-4176.

Senator Rawson noted that the limited statistics might not reflect an accurate range of costs for low birth weight babies. Mr. Duarte explained the difficulties in collecting this type of data, most of which was contributed by the staff of the Maternal Obstetrical Management Service, which is the MOMS Program. He said the capacity to produce special reports does exist, but most of the data involves "stubby pencils and check-off lists."

Responding to Senator Rawson's comment that this data is critical in decision-making, Mr. Duarte said that the Nevada Operations Multi-Automated Data Systems will provide eligibility information after a computer system conflict is resolved. He explained that the Nevada Medicaid Program has a lack of systems functionality, which prevent this type of information from being collected. This issue will be included in the development of a new

program that complies with the federally certified system for reporting. The estimated cost of developing a new system is $2.3 million with some costs carrying over into the next biennium.

Senator Rawson referenced correspondence he received from Dr. Feldman stating that Medicaid managed care may be preventing the proper medical treatment of some clients, and the suggestion is to isolate the OB/GYN unit. He asked Mr. Duarte to respond to the potential to document any savings from presumptive eligibility for pregnant women.

Mr. Duarte said he met recently with 46 obstetricians, including Dr. Feldman, at Sunrise Hospital, to discuss Medicaid concerns. The recommendations as a result of that meeting include: (1) identify the elements included in the managed care contract by Medicaid with respect to obstetrical care; and (2) establish a medical advisory committee to develop medical policy.

Additionally, Mr. Duarte said the proposed draft managed care contract has been changed to include a requirement that health plans consider an OB/GYN as a primary care physician and language that prior authorization policies do not present a barrier to care. Members of the provider community have been notified of these recommendations.

Mr. Sasser said the committee members adopted recommendations on June 6, 2000, to enact presumptive eligibility for three different populations, one of which is pregnant women. The fiscal note for presumptive eligibility for pregnant women is $1.6 million in annual state funds. The assumptions of the fiscal note continue to be evaluated and data will determine if there are cost savings as a result of presumptive eligibility.

Concluding, Mr. Sasser reported that Mr. Duarte and Mr. Willden have an amiable working relationship and there is a spirit of cooperation toward achieving progress on this issue.

Responding to a comment by Senator Rawson, Mr. Duarte said that eligibility must be determined for pregnant women as soon as possible due to the nine-month time constraint. Access to prenatal care needs to occur early in these cases. The Medicaid eligibility issue is an incentive to have the provider community involved to assure prompt payment when a pregnant mother visits the office. He said the DHCFP is supportive of early access to prenatal care.

Explaining further, Mr. Duarte said there are costs associated with both recommendations of earlier access to care or the presumptive eligibility program, including significant administrative expenses. Given the constraints of the current budget, it is not financially feasible because of the difficulty in correlating "non events" with process changes. Speculating on the success of any proposed changes is premature as well. Mr. Duarte said that DHCFP will require staff, system changes, and extra benefit funds, in order to launch either program.

PUBLIC TESTIMONY

Brian Lahren, Ph.D.

Brian Lahren, Ph.D., Executive Director, Washoe Association for Retarded Citizens (WARC); and member, Nevada Forum on Disabilities, Reno, submitted a copy of his testimony (Exhibit G), and presented an overview of efforts to raise awareness of the DHR's critical lack of services to the disabled community in Nevada. In Dr. Lahren's opinion, the DHR has selectively provided services to only the "squeaky wheels" of the disabled community.

Continuing, Dr. Lahren gave statistics comparing the service records of other states to Nevada. He said the DHR does not recognize the crisis of not providing services to deserving citizens. During the last two years, WARC pressured the DHR to address these issues but failed because the DHR does not perceive a "crisis" situation and therefore, will not act. As a result of basic service deficiencies, WARC is considering pursuing two avenues of litigation:

1. The Nevada Forum on Disabilities is reviewing the possibility of litigating on behalf of people with physical disabilities; and

2. The Nevada Disability and Advocacy Law Center is preparing litigation on behalf of children with developmental disabilities.

Furthermore, Dr. Lahren said that should the State lose either of these cases, it could potentially relinquish control of provision of the services offered to the federal courts. The courts would take over the role of determining what services should be provided and at what cost. He estimated the fiscal impacts as significant.

Concluding, Dr. Lahren said the disabled community needs a rate commission to: (1) offer providers with competitive rate increases to recruit and retain staff at residential programs; and (2) objectively review the costs of providing adequate service to providers. The current system is on the verge of collapse if it is not stabilized. He said WARC will provide examples of administrative failures of Nevada's Division of Mental Health and Developmental Services, DHR, and will pursue Legislative assistance after two years of unproductive dialogue with the DHR. He noted that three Legislative sessions have passed over this issue, but expressed appreciation to Senator Raggio for his "quick and decisive interest to protect the state and provide adequate services." Dr. Lahren asked members of the committee to take the necessary action during the 2001 Session to correct Nevada's status as "the worst state in the nation for special citizens with disabilities," and to join WARC's effort to establish a dialogue with the Executive Branch of State Government.

Senator Rawson requested an original copy of Dr. Lahren's exhibit and noted that the attempts in the past four years to procure a disability waiver failed because of the variables of unlimited participants and unknown funds. However, under court order, Nevada will lose control of its budget process. He suggested that funds be held in the Senate Finance Committee and an interim study formed to develop an action plan that includes input from the disabled community. He said these actions can be initiated by the Legislative Branch and ultimately, the Executive Branch would be directed to comply with a recommended direction. He said he is committed to finding a solution to this issue and asked Dr. Lahren to be available in the future. Senator Rawson then instructed staff of the LCB to draft a bill to direct this effort.

Dr. Lahren thanked Senator Rawson and said he was encouraged by the Legislative interest.

ADJOURNMENT

Chairman Koivisto thanked committee and staff members for the time and efforts expended on behalf of this interim work. There being no further business to come before the committee, Chairman Koivisto adjourned the meeting at 2:25 p.m.

Exhibit H is the "Attendance Record" for this meeting.

Respectfully submitted,

Kennedy
Senior Research Secretary

Marla McDade Williams
Senior Research Analyst

APPROVED BY:

_____
Assemblywoman Ellen M. Koivisto, Chairman

Date: _____

LIST OF EXHIBITS

Exhibit A is a document titled "Divert Stats – Critical Care," distributed by Jackie Taylor, representative, University Medical Center of Southern Nevada, Las Vegas, Nevada.

Exhibit B is a bound document dated December 5, 2000, and titled "The Frontier and Rural Health Care Improvement Act of 2001," submitted by Carolyn Ford, M.P.H., Assistant Dean/Director, Center for Education and Health Services Outreach, University of Nevada School of Medicine, Las Vegas, Nevada.

Exhibit C is a document dated December 5, 2000, and titled "Nevada Health Care Association," submitted by Charles Perry, Executive Director, Nevada Health Care Association, Las Vegas, Nevada.

Exhibit D is a document dated December 5, 2000, and titled "Comment Presented to the Legislative Committee on Health Care Regarding the Medicaid Buy-in Program - Prepared by Jack Mayes, Executive Director and H. Jill Smith, Esq., Legal Director, Nevada Disability Advocacy and Law Center," and submitted by H. Jill Smith, Esq., Legal Services Director, Nevada Disability Advocacy and Law Center, Las Vegas, Nevada.

Exhibit E is a packet of information dated December 5, 2000, and titled "Comment Presented to the Legislative Committee on Health Care Regarding the Requirements of The *Olmstead* Decision, Service Provider Rate increases, And The Waiting Lists For Services, Prepared by Jack Mayes, Executive Director and H. Jill Smith, Esq., Legal Services Director, Nevada Disability Advocacy and Law Center," and submitted by H. Jill Smith, Esq., Legal Services Director, Nevada Disability Advocacy and Law Center, Las Vegas, Nevada.

Exhibit F is a memorandum dated December 4, 2000, to Assemblywoman Ellen M. Koivisto from Charles Duarte, Administrator, Division of Health Care Financing and Policy, Carson City, Nevada, regarding requested data and estimates on presumptive eligibility.

Exhibit G is a packet of information including a copy of testimony given by Brian Lahren, Ph.D., Executive Director, Washoe Association for Retarded Citizens; and member, Nevada Forum on Disabilities, Reno, Nevada.

Exhibit H is the "Attendance Record" for this meeting.

Copies of the exhibits are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. You may contact the library at (775) 684-6827.