MINUTES OF THE MEETING
OF THE
LEGISLATIVE COMMITTEE ON HEALTH CARE
(*Nevada Revised Statutes* 439B.200 through 439B.240)
June 6, 2000
Carson City, Nevada

The sixth meeting of Nevada's Legislative Committee on Health Care for the 1999-2000 Interim was held on Tuesday, June 6, 2000, at 9:30 a.m., in Room 3138 of the Legislative Building in Carson City, Nevada. This meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Pages 2 and 3 contain the "Meeting Notice and Agenda" for this meeting.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Assemblywoman Ellen M. Koivisto, Chairman
Senator Raymond D. Rawson, Vice Chair
Senator Bernice Mathews
Senator Maurice E. Washington
Assemblywoman Vivian L. Freeman

COMMITTEE MEMBER PRESENT IN LAS VEGAS:

Assemblywoman Merle A. Berman

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:	Tuesday, June 6, 2000 9:30 a.m.
Place of Meeting:	Legislative Building Room 3138 401 South Carson Street Carson City, 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:

Grant Sawyer State Office Building
Room 4401
555 East Washington Avenue
Las Vegas, Nevada

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

A G E N D A

I. Opening Remarks
Assemblywoman Ellen M. Koivisto, Chairman

*II. Approval of Minutes of Meetings Held on March 7, 2000, and April 18, 2000

*III. Presentation Concerning the Proposed Establishment of a School of Pharmacy at the University of Nevada School of Medicine (UNSOM)
Dr. David Westfall, Vice President of Academic Affairs and Professor of Pharmacology, UNSOM

*IV. Update Concerning the Nevada Check-Up Program
John Yacenda, M.P.H., Ph.D., Deputy Director, Department of Human Resources (DHR)

*V. Presentation Concerning Work Place Safety, Particularly as it Relates to "Needle Sticks," for Nurses and Other Health Care Workers
Lisa M. Black, R.N., B.S.N., American Nurses Association Delegate, and Member, Nevada Nurses Association

*VI. Presentations Concerning Efforts to Prevent a Person's Loss of Medicaid Coverage As it Relates to the Temporary Assistance for Needy Families Program, and Activities Concerning Placing Eligibility Workers at Locations other than Welfare District Offices
Michael J. Willden, Administrator, Welfare Division, DHR
Roger Volker, Executive Director, Great Basin Primary Care Association

*VII. Presentation and Consideration of Proposed Funding for the Treatment of Breast and Cervical Cancer for Women in Underserved Areas of Nevada, and Proposed Funding for Federally Qualified Health Centers That Provide Services to Persons Who Do Not Have Health Insurance
Dr. Michael Rodolico, Executive Director, Health Access Washoe County, and President, Great Basin Primary Care Association
Roger Volker, Executive Director, Great Basin Primary Care Association

*VIII. Presentation and Recommendations Concerning Medicaid Billing, Reimbursement, and Enforcement Issues and Costs As They Affect Certain Nursing Home Facilities In Nevada
Daniel Kearns, Regional Vice President, Integrated Health Systems, Inc.
Tom Hathaway, Administrator, Washoe Care Center, Reno

IX. Public Testimony, Including Testimony Related to Items on the Agenda and Recommendations for Consideration in the Work Session Document

*X. Work Session – Discussion and Action on Final Recommendations
1. Pediatric Diabetes and Endocrinology Center, University of Nevada School of Medicine
2. Medicaid Enhancements and New Programs:
   A. Diabetes care
   B. Presumptive eligibility
   C. Ticket to Work and Work Incentives Improvement Act of 1999
   D. Cost-based reimbursement
   E. Assets test
3. Medicaid Services and Other Issues
   A. Waiting lists
   B. Personal care assistance
4. Nevada Check-Up Program
5. Medicaid and the Temporary Assistance for Needy Families Program

6. Institutionalization of Persons Who Are Disabled
7. Kids Count Project
8. Autism
9. Medical Errors

XI. Adjournment

*Denotes items on which the committee may take action.

Note: 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.

Notice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, Basement, Capitol Building; City Hall, 201 North Carson Street; Legislative Building, 401 South Carson Street; and Nevada State Library, 100 Stewart Street. Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations: Clark County Office, 500 South Grand Central Parkway; and Grant Sawyer State Office Building, 555 East Washington Avenue.

OPENING REMARKS

Chairman Ellen M. Koivisto called the meeting to order at 9:50 a.m. and directed the secretary to call roll. She introduced staff from the Legislative Counsel Bureau (LCB), Carson City, Nevada, and announced that this is the last scheduled meeting of the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200). She said testimony was presented to the committee from a variety of groups during the interim, demonstrating that Nevada is not taking care of its weakest and most vulnerable citizens. As a result, recommendations made to the committee in previous sessions are likely to be heard again because it is key to the legislative process that multiple attempts achieve results.

APPROVAL OF MINUTES OF MEETINGS HELD ON MARCH 7, 2000, AND APRIL 18, 2000

The Chairman called for approval of the minutes of the committee's fourth and fifth meetings.

SENATOR RAWSON MOVED FOR APPROVAL OF THE MINUTES OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE FOR THE MARCH 7, 2000, MEETING IN CARSON CITY, NEVADA, AND THE APRIL 18, 2000, MEETING IN LAS VEGAS, NEVADA. THE MOTION WAS SECONDED BY SENATOR WASHINGTON AND CARRIED UNANIMOUSLY.

PRESENTATION CONCERNING THE PROPOSED ESTABLISHMENT OF A SCHOOL OF PHARMACY AT THE UNIVERSITY OF NEVADA SCHOOL OF MEDICINE

Dr. David Westfall

Dr. David Westfall, Vice President of Academic Affairs, Professor of Pharmacology, University of Nevada School of Medicine (UNSOM), Reno, Nevada, gave a slide presentation on the proposed school of pharmacy (Exhibit A). He said a statewide effort will be achieved through the participation of task force and steering committee members representative of Nevada's pharmacy and university communities. The conception of the proposed school of pharmacy in Nevada began one and a half years ago to address the need for more pharmacists due to: (1) rapid senior citizen growth; (2) projections for 1,815 additional pharmacists needed by the year 2006; (3) the evolving role of the pharmacist to disseminate vital information to patients; and (4) the rate of expanding health maintenance organizations (HMO), tertiary, and private practice settings.

Dr. Westfall stated that the vast majority of schools of pharmacy in the United States are university affiliated. There are schools of pharmacy located in 14 western states but none in Nevada. He reported that the proposed school of pharmacy for Nevada will offer a doctorate program and noted that pharmacy schools are offering masters graduate programs. The enrollment of women and minorities is increasing, as is the popularity of pharmacy as a profession. He said that 65 percent of pharmacy students are female and 12.3 percent are minorities.

Continuing, Dr. Westfall said the proposed school of pharmacy requires six years for completion and offers multiple points of entry for new or returning students because the program design is flexible, unique, and integrated. The

three-part curriculum includes: (1) English, mathematics, history, et cetera; (2) fundamental science, pharmacology, and microbiology basics; and (3) clinical practice. A returning student who has completed the appropriate prerequisites could graduate from the proposed school of pharmacy in four years with a doctorate of pharmacy degree. Students who already have a Bachelor of Science degree in an appropriate field could complete the program within several years. Dr. Westfall said the proposed school does not have a specific location but will encompass the entire Nevada University System by offering the option of a joint degree between universities and community colleges. For example, the two year pre-pharmacy curriculum may be offered by community colleges, the two year basic sciences program achieved at the University of Nevada, Reno, and the two year clinical practice program completed at the University of Nevada, Las Vegas.

Dr. Westfall listed the benefits of the proposed school of pharmacy: (1) students in Nevada will be provided with an opportunity for an education in pharmacy, which matches curriculum and career potential with existing programs in medicinal chemistry, pharmacology, toxicology, pharmacokinetics, and pharmaceutics; (2) pharmaceutical and biotechnology firms will be attracted to Nevada thereby increasing research and sponsored projects funding; and (3) there will be enhanced statewide health care planning and delivery of services.

Continuing, Dr. Westfall listed current goals for the proposed school of pharmacy: (1) develop doctorate program curriculum; (2) examine existing strengths; (3) determine multiple entry points into the program; (4) design a community-based and multi-campus program; (5) explore financial implications and realities; and (6) establish timelines and implementation strategies, including the appointment of a dean. The proposed school of pharmacy costs include: (1) $6,500 for in-state tuition compared to $7,000 billed by surrounding states; and (2) $13,000 for out of state tuition compared to $16,000 billed by surrounding states. He noted that these costs are less than the average cost of private school tuition, which ranges from $20,000 to $30,000.

Concluding, Dr. Westfall stated that the first graduates of the proposed school of pharmacy may be recognized in the spring of 2007. He asked the committee to help create legislative interest and urged members to realize the importance of approving the proposal prior to the 2001 Legislative Session in order to resolve funding issues. He stated the proposed school of pharmacy will cost $2.5 million per year, and the school will need $1,410,000 to cover expenses not offset by tuition. He said that U.S. Senator Harry Reid and Nevada Governor Kenny Guinn have both expressed interest in the proposed school of pharmacy.

Senator Mathews expressed concern for small class-sizes and asked for more financial information. She said the fiscal structure of the proposed school of pharmacy needs to be examined in terms of costs to the State because tuition does not pay for programs.

Senator Rawson suggested that larger class-sizes could be achieved by attracting more out-of-state students as evidenced by enrollment figures at dental schools. He noted that dental students leave the state because local educational opportunities do not exist. This migration of students seeking professional schools keeps Nevada communities from maturing. He said there are strong arguments for the proposed school of pharmacy that are in line with the mission of the university in providing educational opportunities to the citizens of the State. Senator Rawson urged the committee to support the proposed school of pharmacy.

Dr. Westfall said that the proposed school is a good opportunity but could disappear as private pharmacy schools consider Nevada as a new site. He said these private schools will result in higher tuition costs for Nevada students. The proposed school of pharmacy is a cost-effective solution to education that offers easier access for Nevadans by utilizing statewide university participation.

Responding to questions by Assemblywoman Berman, Dr. Westfall said it was not possible to suggest a date when the proposed school of pharmacy might be self-supporting, if ever. He said the proposal will use current faculty of the university system as a measure to keep requests for state funding minimal.

Senator Rawson said that Dr. Westfall is actually very close to being able to fund the proposed school of pharmacy through closer examination of the "student formula." He urged Dr. Westfall to participate in a dialogue with the Board of Regents to suggest policy changes for the specialized program.

Chairman Koivisto noted that the use of existing medical school labs for the students of the proposed school of pharmacy is another cost saving measure.

SENATOR RAWSON MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE DRAFT A LETTER TO UNITED STATES SENATOR HARRY REID AND TO THE BOARD OF REGENTS SHOWING SUPPORT FOR THE PROPOSED SCHOOL OF PHARMACY. SENATOR MATHEWS SECONDED AND THE MOTION CARRIED WITH ASSEMBLYWOMAN FREEMAN VOTING NAY AND ASSEMBLYWOMEN BERMAN ABSTAINING.

Senator Rawson and Chairman Koivisto disclosed that they both are employees of the Nevada University System and would not be affected by the outcome of the motion. Assemblywoman Freeman said that she could not add her support to the proposed school of pharmacy because of many challenges facing the current university system in Nevada. Assemblywoman Berman abstained from the vote and requested additional financial information from Dr. Westfall.

UPDATE CONCERNING THE NEVADA CHECK-UP PROGRAM

John Yacenda, M.P.H., Ph.D.

Dr. John Yacenda, M.P.H., Deputy Director, Nevada's Department of Human Resources (DHR), Carson City, referred to his written testimony (Exhibit B, Tab IV). He updated committee members on the Nevada Check-Up Program by listing the following issues and accomplishments:

- Reorganization within the program includes strong support from the DHR for: (1) staffing; (2) application tracking and processing; (3) marketing and outreach; and (4) increased partnerships with public and private agencies serving low-income families and children.

- A newly designed flyer features a toll free telephone number and logo.

- Outcome-based marketing and outreach includes a planned intervention event called the "Golden Opportunity." An outcome-based plan identifies: (1) the appropriate population eligible for the Check-Up Program; (2) logistics needed to facilitate the event; (3) materials to be utilized and distributed; (4) intervention and collaboration required, requested, or sought; and (5) outcomes of intervention. The outcome does not always involve the enrollment of additional children into the Check-Up Program.

- A review of enrollment and program data (Exhibit B, Tab IV).

- The Federal Fiscal Year (FFY) 2000 award for the Nevada Check-Up Program is $30,526,393. Nevada's unused federal allocation from FFY 1998 is $21,263,053. The National Governor's Association is investigating methods to allow states greater access to unspent allocated money for their children's programs.

- The method used to ascertain the "number of children" used in the formula for calculating the Title XXI state allocation for FFY 2000 was different from the formula used in FFYs 1998 and 1999. The "number of children" is equal to the sum of 75 percent of the uninsured children in Nevada under 19 years of age under 200 percent of the Federal Poverty Level and 25 percent of the number of low-income children in Nevada. The changed formula focuses less on children who are uninsured and includes low-income children. In FFY 2001, the formula will be adjusted further to reflect a 50 percent to 50 percent ratio instead of the 75 percent to 25 percent ratio in the current formula.

Continuing, Dr. Yacenda said the enrollment trend for the Check-Up Program is stabilizing and an investigation is underway to find the reasons why applicants do not respond to redetermination, which results in disenrollment. He explained that disenrollment refers to those children who were enrolled and have been terminated. An additional cause for concern is loss of client contact. The redetermination process has been amended to allow for determination 12 months from the last enrollment date instead of at each FFY, resulting in a "rolling eligibility."

Concluding, Dr. Yacenda listed the top reasons why clients are denied entry or re-entry into the Check-Up Program: (1) lack of information due to partially completed forms; (2) non responsive to enrollment; (3) gross income too high; and (4) current enrollment in Medicaid.

Responding to questions by Assemblywoman Freeman, Dr. Yacenda stated that his position oversees the transition and redirection of the Check-Up Program. The program offices are under the jurisdiction of the Division of Health Care Financing and Policy of DHR. He said the state funding source for the Check-Up Program is federally matched and has not changed. Rural communities have a history of the highest number of applicants for the Check-Up Program and minority enrollment is disproportionately high compared to the rural population in general. Dr. Yacenda stated that Nevada ranks "medium" in comparison to other states for "reversion" or unspent funds allocated for a three-year funding cycle because the Check-Up Program began in FFY 1998 and did not take enrollments until FFY 1999. The funding carries over for three years after which unspent funds revert. Assemblywoman Freeman suggested that the committee communicate with Nevada's Congressional Delegation regarding these concerns.

Responding to a question from Senator Washington, Dr. Yacenda stated the Check-Up Program will continue to be funded at the federal level. He said the program is increasing in popularity for communities because of the benefits that each "dollar of care" generates. He added that the outreach budget should be increased from the current 10 percent cap.

PRESENTATION CONCERNING WORK PLACE SAFETY, PARTICULARLY AS IT RELATES TO "NEEDLE STICKS," FOR NURSES AND OTHER HEALTH CARE WORKERS

Lisa M. Black, R.N., B.S.N.

Lisa M. Black, R.N., B.S.N., American Nurses Association Delegate, Member, Nevada Nurses Association, Reno, Nevada, presented a proposal for legislation, to be sponsored by Assemblywoman Sheila Leslie, to protect health care workers from avoidable injury (Exhibit B, Tab V). She demonstrated for committee members several medical devices that decrease the possibility of needlestick wounds. She urged committee members to follow the example of other states with the creation of preventative needlestick legislation to protect Nevada's 17,000 health care workers. She provided committee members with a summary of needlestick protection bills legislated to date and the individual bill numbers for states currently addressing this issue. Ms. Black offered statistics affecting the Nevada Nurses Association and explained that bedside nurses sustain a majority of the 787,000 accidental exposures to blood and body fluids.

Ms. Black stated that safer needle devices have been available since the late 1970s but one-third of hospitals in the nation currently do not use them. She said that a device costing 28 cents more than the standard device would have changed her life or even saved her life because she contracted HIV in 1997 as a result of a contaminated needlestick while caring for a patient. The Centers for Disease Control (CDC) estimates that more than 80 percent of needlestick injuries can be prevented with the consistent use of safer needle alternatives.

Ms. Black said the cost for treating one high-risk needlestick without infection is nearly $3,000. There is no ceiling to the cost of treatment if a health care worker is infected with a blood-borne illness. She said she is in the latter category and her prescriptions cost approximately $5,000 per month.

Continuing, Ms. Black said the legislative bill currently being drafted on behalf of Assemblywoman Leslie would protect health care workers from contaminated needlestick injuries and subsequent infections by:

- Amending the Nevada blood-borne pathogen standard to require that within 12 months of enactment, every medical care facility licensed in the state that employs 25 or more health care workers will be required to have evaluated potential injury-causing "sharps" present in their facilities and have replaced them with devices incorporating Food and Drug Administration (FDA) approved safety features.

- Requiring health care employers to maintain a record of all exposure incidents in a log with annual reports

submitted to the Occupational Safety and Health Administration.

- Including a presumptive eligibility clause stating that if a health worker, who has regular and significant exposure to blood and body fluids of a potentially infectious nature, is found to have become infected with a blood borne illness, that it would be assumed the infection stemmed from the employee's work environment. The affected employee will then be eligible to seek coverage under the employer's workers' compensation policy.

Concluding, Ms. Black stated that representatives from the medical association, the dental association, and the Nevada Hospital Association are willing to work collaboratively with the Nevada Nurses Association on the proposed draft bill. She asked members of the committee for consideration of this proposal in the 2001 Legislative Session.

Responding to a question by Chairman Koivisto, Ms. Black reported that the workers' compensation carrier of a hospital is responsible for the costs associated with needlestick follow-up care.

Senator Rawson expressed his regrets for the needlestick injury sustained by Ms. Black. He said that the medical profession is concerned about legislation that imposes unwieldy, ineffective, and/or more dangerous techniques for recapping devices. He said he suffered several needlestick injuries as a result of implementing new devices required for the dental community. He stressed the importance of a collaborative effort between various medical groups in order to draft effective and meaningful legislation. He said he supported the proposed preventative needlestick legislation.

Assemblywoman Freeman pointed out the ease with using a safety device and expressed concern for quality control to ensure that the device is effective. Ms. Black said that the proposed legislation would implement a process through which bedside nursing professionals share input in the selection of safety devices. Assemblywoman Freeman suggested that the proposed legislation require the reporting of procedures and safety measures. She asked to be included in the process of drafting the bill and expressed her support. Ms. Black said that the bill will address insurance and fiscal considerations. A committee of medical professionals will make the final device selection instead of a non-medical entity, such as a purchasing department. Assemblywoman Freeman directed legal staff to investigate specifics of Ms. Black's testimony with regard to presumptive eligibility during her needlestick follow-up care and subsequent litigation with her employer.

Responding to a question from Assemblywoman Berman, Ms. Black said the proposed bill will stipulate that the chosen safety devices will either eliminate needle use, or render the needle harmless by incorporating a retracting feature. Assemblywoman Berman offered her support to Ms. Black.

PRESENTATIONS CONCERNING EFFORTS TO PREVENT A PERSON'S LOSS OF MEDICAID COVERAGE AS IT RELATES TO THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM, AND ACTIVITIES CONCERNING PLACING ELIGIBILITY WORKERS AT LOCATIONS OTHER THAN WELFARE DISTRICT OFFICES

Michael J. Willden

Michael J. Willden, Administrator, Welfare Division, DHR, Carson City, spoke about the division's efforts to prevent certain applicants/recipients of the Temporary Assistance for Needy Families (TANF) program from losing Medicaid coverage and provided an update on how children are reinstated who lost Medicaid eligibility as a result of the Welfare Reform Act (Exhibit B, Tab VI). He listed the following updates:

- The division's efforts to determine whether individuals and families lost Medicaid coverage without proper notice, or without a proper Medicaid redetermination, when their TANF case was closed or when their Transitional Medical Assistance coverage ended include:

  1. A notice of decision explaining the reason for termination is routinely sent to the family at least 13 days prior to the termination date. The notice also provides the opportunity for a hearing and continued benefits should the family disagree with the reason for termination.

2. The division's new automated management information system called Nevada Operations Multi Automated Data Systems (NOMADS) is programmed to search through all Medicaid eligibility categories using the latest case data to determine a person's Medicaid eligibility when he does not meet the requirements for assistance. In the event that a family is scheduled to be terminated from TANF cash assistance, the system determines each person's eligibility for other programs. He said some families were inadvertently missed in the eligibility testing and subsequently are not included in the 25-month coverage group. These include a small percentage of women who were not pregnant and older children. The division is taking the necessary steps to reenroll these individuals into the Medicaid program. Within the next week a final determination will be made as to whether the division can identify specific families that were affected or whether a range of people will be acknowledged as needing reenrollment.

- The method used by the division to identify and reinstate children who: (1) became ineligible for Supplemental Security Income (SSI) due to the 1996 change in the SSI disability rules and who were terminated from Medicaid without consideration of their eligibility pursuant to provisions of the Balanced Budget Act; or (2) were terminated without a proper redetermination including an ex parte review includes:

  1. The Social Security Administration provided a list to the division of children in Nevada who lost their Medicaid eligibility. The list was forwarded to the division's field staff with instructions to restore Medicaid eligibility retroactive to the termination date for each individual named.

  2. Use of a less stringent disability standard as a result of a recent finding from a "federal certification visit."

- Federal regulations require the placement of outstationed eligibility workers in disproportionate share hospitals and Federally Qualified Health Centers (FQHC) to encourage the taking of applications of persons who may be eligible for Medicaid. It appears that the division does not take full advantage of placing workers in locations other than district offices. Corrective measures include:

  1. Staffing of eligibility workers in two high-volume disproportionate share hospitals: (1) the University Medical Center (UMC); and (2) Washoe Medical Center. The eligibility workers approve 75 percent of applications taken at UMC and 90 percent taken at Washoe Medical Center.

  2. There is currently no staff at FQHCs because the volume does not warrant it. However, the division provides applications and brochures to these locations and works closely with the staff to ensure timely acceptance and processing of applications. It is not a requirement of outstationing to have a full-time staff at disproportionate share hospitals or FQHCs.

Responding to questions from Chairman Koivisto, Mr. Willden reported that health care centers without an outstationed eligibility worker process five to ten applications per month. An alternative to having an outstationed worker on-site includes the training of other staff. He stressed the importance of having applications completed correctly in order for eligibility determinations to be made in a timely manner.

Chairman Koivisto suggested the use of facsimile transmission technology to facilitate the application process in locations without an outstationed eligibility worker. Mr. Willden agreed and said an electronic application process is currently being examined but an interactive Web site application is not yet available. An additional method for consideration called "itinerant runs" will collect applications from remote parts of Nevada.

Responding to a question by Assemblywoman Freeman, Mr. Willden said NOMADS converted approximately 90 percent of the division's cases and will conclude within three weeks. Receipt of child support payments account for an influx of $8 million into the system as a result of being routinely processed through NOMADS. The division is preparing for a "federal certification visit" scheduled for Fall 2000.

Roger Volker

Roger Volker, Executive Director, Great Basin Primary Care Association, Carson City, said that the association represents the majority of the FQHCs throughout Nevada, including the community health centers and the majority of

tribal clinics. He introduced Dr. Michael Rodolico, Executive Director, Health Access Washoe County (HAWC), and identified HAWC as a FQHC. He said the association works jointly with the staff of the Welfare Division and finds them highly creative and motivated toward enrolling children. Mr. Volker continued with the following points:

- It is the law that outstationed workers be placed in FQHCs. There are two community health center organizations in Nevada operating 15 sites. The demographics of Nevada create a significant and distinctive difference between sites.

- To stay compliant with federal mandates, 35 outstationed workers need to be placed in Nevada, but he asserted that this may be an impractical use of staff and current resources might not support this policy. There are provisions in the statutes giving the State of Nevada several options for complying with the law without placing 35 staff: (1) a FQHC can be compensated for utilizing their own employees to process applications; and (2) "job sharing" between states. For example, the Utah Division of Welfare offered to place an outstationed worker at the Nevada Rural Health Centers office in Wendover, Nevada. Wendover is a border town divided by the Nevada/Utah state line.

- The use of technology, the Internet, and other innovative electronic methods will be used to meet the standard of law for eligibility determination, to shorten application-processing time, and to facilitate personal interviews. Models used by other states will be explored, and the association would like to investigate and report the findings back to the committee at a later date.

Dr. Michael Rodolico

Dr. Michael Rodolico, Executive Director, HAWC, Carson City, reported that obeying federal mandates as they apply to eligibility workers has been an ongoing project for the past five years. He said he was past the point of "anger and frustration" and viewed the situation as ". . . almost comical." Dr. Rodolico expressed his enthusiasm in working with a new administration to accomplish eligibility worker goals. He said that the FQHCs are offering flexibility and a willingness to cooperate with the State to hire staff to sign up Nevadans for health programs. He added that State workers need to be flexible when enrolling citizens for the variety of programs currently available.

Responding to a question by Assemblywoman Freeman, Dr. Rodolico stated that border communities like Utah are examining licensing and certification differences for workers as well as eligibility requirements between the states. He said that Nevada and Utah do not currently have uniform standards and suggested a meeting between the governors of both states to address this issue. The concept of "health free zones" for communities divided by state boundaries has been discussed with the Welfare Division administrator and there is currently a dialogue in process between Nevada and Utah.

Responding to a transportation question by Assemblywoman Freeman, Mr. Volker introduced Dr. Carl Heard, Chief Medical Officer, Nevada Rural Health Centers, which is comprised of 13 clinics. Dr. Heard said that it is his understanding that state workers use their private vehicles for transportation to job sites in rural Nevada. He said there are no specific state or federal funds available for travel expense reimbursements.

In response to a request for specific recommendations, Mr. Volker stated that it was the intention of his association to appear before the committee and report ongoing progress. He said that collaborative efforts between the Welfare Division and the FQHCs need to be allowed to find creative ways to meet the "spirit of the law" and to look at the uniqueness of Nevada and return with joint proposals. Mr. Volker said there were no specific recommendations at this time because the placement of eligibility workers in every possible location is already a law. He said that while the FQHCs encourage that goal, there were also economic realities to be considered.

PRESENTATION AND CONSIDERATION OF PROPOSED FUNDING FOR THE TREATMENT OF BREAST AND CERVICAL CANCER FOR WOMEN IN UNDERSERVED AREAS OF NEVADA, AND PROPOSED FUNDING FOR FEDERALLY QUALIFIED HEALTH CENTERS THAT PROVIDE SERVICES TO PERSONS WHO DO NOT HAVE HEALTH INSURANCE

Roger Volker

Mr. Volker, Executive Director, Great Basin Primary Care Association, spoke about the success of a "mammovan," which moves throughout urban and rural Nevada communities to provide a mammography service to the underserved. The service also includes breast cancer screening and other diagnostic tests. He said the problem is the absence of follow-up care for citizens who test positive. Mr. Volker referred to cancer statistics (Exhibit B, Tab VIII) and he discussed two different but equally effective approaches to providing treatment money for Nevada women who are diagnosed with breast or cervical cancers.

Mr. Volker indicated that the Women's Health Connection program is funded by a grant from the CDC to provide breast and cervical cancer screening and diagnostics to women who have an income at or below 250 percent of the Federal Poverty Level and who are uninsured or underinsured. The CDC screening program does not pay for breast and cervical cancer treatment yet it requires participating states to provide such services. Results from a study show that while treatment is eventually found for almost all of the women screened, some do not receive treatment at all, some refuse care, and some experience delays. While the Women's Health Connection staff and participant providers have been diligent and creative in finding treatment services for these women, the system is overloaded. The study also found that the sources of treatment funding are uncertain, tenuous, and fragmented and the burden of finding treatment often becomes the responsibility of the providers. Seeking charity care from public hospitals adds to hospitals' uncompensated care costs.

As a result of this problem, Mr. Volker's first proposal asks for approximately $4 million to cover the estimated cases projected by the Nevada's Women's Health Connection statistics. The funding would be used for treatment of women who have been diagnosed with breast or cervical cancer.

Mr. Volker went on to discuss United States Senate Bill 662, (Sections 1 and 1920B), which seeks "to amend Title XIX of the Social Security Act to provide medical assistance for certain women screened and found to have breast or cervical cancer under a federally funded screening program." He stated that this measure is expected to be approved by the U.S. Senate during the 106th Congressional Session. This bill will allow all states to participate in Medicaid funding, which is matched 75 percent with federal funds and 25 percent with state funds.

As a result of this measure, he proposes that the Legislative Committee on Health Care sponsor a bill to compliment S.B. 662 and grant the state's Medicaid Program the authority to: (1) finance treatment for diagnosed women; and (2) allocate increased funding for the program.

Continuing, Mr. Volker said the cost to treat Nevada's 212 diagnosed cancer cases would be approximately $4 million utilizing Medicare rates through a self-funded program or $1 million through a CDC/Medicaid Program.

Senator Rawson inquired to the process after an individual is diagnosed with cancer. Dr. Heard responded that a few cancer patients are sent elsewhere for diagnostics and management. The "mammovan" program has been in operation for five months and screens an average of 10 to 15 patients per day. Dr. Heard said that securing financial assistance for women who have been diagnosed with breast cancer is part of Great Basin Primary Care Association's proposal, which would establish a state-only funded program for patients, or the second proposal, which involves proportional state funding

Senator Rawson expressed his dismay that Nevada does not have mechanisms in place to care for patients who screen positive for cancer. He said the committee would study the proposals.

Mr. Volker clarified that the proposals are intended to address the availability of resources for treatment of breast and cervical cancer patients who do not have coverage or financial assets. Senator Rawson pointed out that this is a county responsibility and asked if the proposals were suggesting a fundamental shift from county to state? Mr. Volker responded that the proposals asked for the creation of a fund using state resources to compensate providers and include additional resources for counties. Senator Rawson suggested that Mr. Volker discuss this issue with the committee that is currently addressing disproportionate share.

Dr. Heard said that Nevada First Lady Dema Guinn is generating a fund for urgent medical needs of the breast cancer patients identified through the "mammovan" program. He stated that there are currently no funds available to treat patients with cervical cancer.

Assemblywoman Berman commented that Nevada should be prepared on this issue regardless of the outcome of federal bills.

Responding to a question from Assemblywoman Freeman, Dr. Heard said Nevada Rural Health Centers receives a substantial portion of support from the counties through underwriting operational costs of facilities. He said that the counties also support contracts for other services. Currently, there is no dialogue regarding a fiscal study in taxation and indigent care. He expressed his willingness to discuss these issues further. Dr. Heard expressed his opinion that there is a need for comprehensive health planning for counties because the most pressing issue is the lack of consistent and global consideration of health care needs in rural areas. Assemblywoman Freeman suggested that Dr. Heard meet with county commissioners to get local level support.

Senator Rawson said that he is aware of a number of committees and proposals in motion to address this issue. He noted that while rural health care initiatives is not an agenda item, it should be given full consideration and asked the committee to meet again to discuss it.

Chairman Koivisto indicated that she would have the committee staff look into these issues.

Dr. Michael Rodolico

Dr. Michael Rodolico, Executive Director, HAWC, and President, Great Basin Primary Care Association, presented testimony and offered suggestions for Nevada's uninsured population. He proposed a "Health Care Fund for Uninsured Nevadans" (HCFUN) to address the increased financial burden managed by Nevada's safety-net providers. The safety-net providers allow access to health care services on a sliding fee basis to a growing population of underserved/uninsured Nevadans, and the purpose of the proposed HCFUN is to increase financial support to those providers. Dr. Rodolico stated that Nevada has one of the largest uninsured groups in the country by percentage. It is his opinion that this phenomenon is due to:

- The large gaming and tourism industry that traditionally does not provide health insurance benefits;
- The difficulty in qualifying for Medicaid;
- The lack of a medically needy Medicaid program; and
- The lack of mandated eligibility workers in the safety-net agencies.

He identified three examples to address the financial inequity in Nevada's health care safety-net provider system (Exhibit B, Tab VII): (1) allocate $3 million, annually, for program start-up and expansion of existing programs directed towards the delivery of health care services to Nevada's uninsured population; (2) allocate $3 million to a fund to reimburse Nevada's safety-net providers for services they provide to uninsured Nevadans on a sliding fee scale; or (3) allocate $3 million annually and combine examples 1 and 2.

Dr. Rodolico listed the benefits to Nevadans in creating and funding one or more of the proposed examples: (1) increased sustainability of programs; (2) increased programs and services; (3) continuity of care provided; (4) identification of new sites; (5) comprehensive health care services delivered to more Nevadans; (6) increased employment opportunities; (7) increased productivity; (8) increased learning ability for healthy children; and (9) less funds spent for catastrophic illness.

Chairman Koivisto recommended Dr. Rodolico present these proposals to the Task Force on Access to Public Health Services (Senate Bill 556, Chapter 598, *Statutes of Nevada 1999),* which "creates a task force on policy of State of Nevada concerning access to public health services," because of the similar work and direction taken by that committee. Chairman Koivisto further recommended that Mr. Volker work with Assemblywoman Berman on the breast and cervical cancer issue because of her previous request for legislation specific to that issue.

Responding to comments by Assemblywoman Freeman, Dr. Rodolico said he sought feedback and advice from the Legislative Committee on Health Care regarding these proposals.

Senator Rawson indicated that the 2001 Legislative Session will engage in a prioritization venue, and he urged Dr. Rodolico to present his issues in a broader context to other committees in order to obtain more legislative support. He said that individually drafted bills will be lost in the next session and that there was a better chance for Dr. Rodolico's proposals to be considered if they are part of a comprehensive prioritized package. Senator Rawson stated his opinion that Nevada has not taken advantage of the "matching funds capabilities" and this is a challenge for creativity and leadership in legislation design.

Chairman Koivisto advised Dr. Rodolico to contact John Yacenda, a staff member on S.B. 556 to make a presentation. Mr. Volker said that a presentation was scheduled before the S.B. 556 Task Force on June 19, 2000.

Senator Rawson urged Mr. Volker and Dr. Rodolico to point out to the S.B. 556 members that there are specific needs in Nevada that are not met. One of those needs is that Nevada is able to screen for breast cancer but cannot offer treatment for positive diagnoses. They must also be made aware of an erosion of the safety-net providers while the number of uninsured Nevadans increases.

PRESENTATION AND RECOMMENDATIONS CONCERNING MEDICAID BILLING, REIMBURSEMENT, AND ENFORCEMENT ISSUES AND COSTS AS THEY AFFECT CERTAIN NURSING HOME FACILITIES IN NEVADA

Tammy Supchak

Tammy Supchak, staff, Integrated Health Services, Incorporated (IHS, Inc.), and Administrator, Cheyenne Care Center, North Las Vegas, Nevada, informed committee members that Daniel Kearns, Regional Vice President, IHS, Inc., was unable to attend due to international travel schedule conflicts. Ms. Supchak stated that IHS, Inc., operated 15 nursing facilities in Nevada and over 500 facilities nationwide. She explained that IHS, Inc., recently filed for Chapter 11 bankruptcy protection in Nevada.

Dallas Adams

Dallas Adams, Regional County Manager, IHS, Inc., Las Vegas, stated that up to 80 percent of the patients in IHS, Inc., facilities are covered by the state's Medicaid program. Further, he announced that accounts receivable owed to IHS, Inc., from the Nevada Medicaid program are approximately $14 million of which "stale" Medicaid claims are approximately $5.5 million.

The IHS, Inc., will ultimately write-off most of the stale dated accounts receivable, effectively receiving zero payment for services appropriately rendered.

Continuing, Mr. Adams listed the causes of stale dating:

- Nevada's billing cycle is only 120 days compared to one year for other Medicaid programs in the nation (Exhibit C). Because Nevada's Medicaid system is not automated, the process is paperwork intensive and prone to human errors and delays. A direct result of the short billing cycle is that neither the State nor the provider has enough time to correct forms that are found to be incomplete or inaccurate. The IHS, Inc., believes that more than 50 percent of the delays that result in stale dated claims are a result of administrative delays at the State level.

- First time claims become the largest percentage of stale dated claims due to the cumbersome approval and authorization process. Most of these stale date claims are caused by paperwork not processed in a timely manner by the State.

- The "two-strike rule" punishes providers when the problem is the lack of communication between Medicaid and Blue Cross Blue Shield. The burden of proving another entity's error falls on IHS, Inc., forcing the use of the appeals process, which exceeds the 120-day billing cycle limit. The appeal process does not address the stale date problem equitably.

Mr. Adams offered the following suggestions as resolution to stale dated Medicaid claims:

- Extend the billing cycle to one year.

- Eliminate the "two-strike rule."

- Consolidate the paperwork for the initial approval and authorization to bill and begin the stale date clock when the State is no longer the main consumer of the stale date window.

- Place parameters on the State's portion of the review cycle. For example, if a submitted Medicaid claim has not been reviewed within a specific time frame, it should be paid automatically. A subsequent audit on claims paid in this manner will verify payment accuracy.

Mr. Adams also discussed the impacts that the "no payor source" patient has on IHS, Inc., in the State of Nevada. The IHS, Inc., has filed for bankruptcy and will be downsizing operations by eliminating buildings that are not financially viable. The buildings scheduled for elimination provide care primarily for Medicaid patients. The problem stems from the fact that provided care is not reimbursed. For example, in the six buildings the IHS, Inc., operates in northern Nevada, there have been eight long-term patients in the past year with no payor source. The State would not allow their discharge, Medicaid will not reimburse for their care, and it resulted in a $36,000 loss of revenue to the IHS, Inc.

Continuing, Mr. Adams discussed the causes of no payer source saying that patients are admitted as Medicaid "pendings" without Medicaid eligibility ever being awarded. The State takes no responsibility in attempting to resolve the issue, even if the patient is clearly Medicaid eligible. In these situations, the facility gives a 30-day notice of eviction if there is no payment or assistance in getting eligibility established. The State Ombudsman then intervenes and denies discharge because the patient cannot be released to a safe place. This often occurs when the family refuses to take the patient home and when other facilities decline the patient due to the no payor source issue. The facility is then forced by law to render all care for this patient with no reimbursement for costs including pharmaceuticals, intravenous drug therapies, transportation, wound care, nursing labor, dietary needs, et cetera.

Mr. Adams listed solutions to the no payor source issue:

- The State should take a more active role in establishing the Medicaid eligibility when a family demonstrates an uncooperative attitude.

- If the State forces the nursing home to care for the patient, it should be the State's responsibility to pay for that care or transfer the patient to a county facility.

- When a patient is an established resident of a facility and refuses discharge and the State refuses the facility the right to discharge, the State should grant the facilities the right to attach property, bank accounts, and any other assets owned by the resident or responsible party in order for the facility to be reimbursed for services rendered.

- When the facility is established as the patient's caretaker without a payor source, and discharge is denied by the State, then the facility or a State appointed third party, should be awarded the right to act as the patient's legal guardian. This action will: (1) facilitate the settling of the patient's financial affairs; (2) reduce the possibility of abuse of the resident's funds by family members, friends, roommates, et cetera; and (3) facilitate payment for care given by the facility.

- After it has been determined that the facility is the caretaker, there is no payor source, and the State has denied discharge, the facility should be granted the right to become "representative payee" on any and all income for the patient.

- Facilities should have the right to become a representative payee when a patient has been awarded Medicaid eligibility and the family or guardian is refusing to pay any portion of the State mandated private portion.

Concluding his remarks, Mr. Adams summarized that the current stale-date policy creates substantial revenue losses for IHS, Inc. As an industry, the unfairness of the stale-date policy was demonstrated to Medicaid representatives at several public meetings, and the policy was subsequently appealed in November 1999, which was announced in a public forum by the Administrator of the Division of Health Care Financing and Policy. At that time, the division agreed to extend the period to one year, but the director of the Department of Human Resources, Charlotte Crawford, vetoed this change. He said it is unfair that Ms. Crawford has the power to change a process in which she did not participate. The no payor source issue will involve less than 1 percent of admissions, yet it is the major contributor to loss of revenue. The one or two patients a year without a payor source can be the difference between a facility losing money or being profitable. Mr. Adams stressed that the changes suggested in his presentation will result in a zero dollar impact to the State budget. The proposed changes will result in a fairer system and will give facilities rights in collecting from residents and family members who are now taking advantage of the current rules. He concluded by stating that the proposed changes will allow nursing facilities in the State of Nevada to remain operational and to provide a high quality of care.

Responding to a question by Chairman Koivisto, Ms. Supchak reported that when a facility closes, the fate of the clients is dependant upon the leaseholder. The leaseholder could: (1) continue to provide service for the clients, if licensed to do so; (2) lease the facility to a different provider; or (3) make other arrangements for use of the facility. Ms. Supchak added IHS, Inc., discusses these options prior to the leaseholder's determination.

Assemblywoman Freeman asked Senator Washington for recommendations. Senator Washington stated that the recommendations have been previously forwarded to the committee. The main issue for discussion is the ability of the department to facilitate reimbursements. He stressed that a "middle ground" be found to allow Nevada to provide quality care for its senior citizens while giving nursing homes the ability to operate at a profitable margin.

Senator Rawson commented that there is a basic rule of fairness involved with this issue and an example of unfairness is a system designed with all of the parameters favoring one side. He said that the State essentially has the authority in this case and is able to create major problems through tardiness. He said this is a dishonest way for the State of Nevada to conduct business, and it should be changed. If the agency does not come forward with a solution, then the committee should pursue its own solution.

Members of the committee discussed the issue of "profit" for nursing homes, and they concluded that the State needs very clear guidelines under which nursing homes should operate. Regulating profits, however, was a sensitive issue and one that members chose not to address at this time.

Senator Rawson reported that the courts have determined that nursing homes must be reimbursed at a rate that permits them to meet their expenses. If the nursing homes cannot meet their expenses, then the system is clearly unfair. If a large proportion of Nevada's long-term care facilities are in receivership, the courts may find the opportunity to administer their operations. Senator Rawson said he was in opposition to the courts administering this because Nevada can do it by making a few adjustments.

Responding to a question from Assemblywoman Berman, Ms. Supchak stated that the closing of IHS, Inc., will displace 800 Nevada clients; 600 residents in northern Nevada and 200 in southern Nevada.

Senator Washington requested that Charlotte Crawford, Director, DHR, address these issues and explain: (1) her philosophy and policies regarding governing and reimbursing providers; (2) her role with the Health Care Financing Administration, United States Department of Health and Human Services, with regard to compliance issues; and (3) her direction in addressing these concerns. He pointed out that the Legislative Committee on Health Care could suggest legislation but the issue spoke to fiscal policy, which might be better addressed by the money committees. Senator Washington recommended that if it were determined after Ms. Crawford's testimony that she has taken an adversarial direction with providers, then the committee should attempt to reestablish balance for the quality protection of patients and for providers to sustain and maintain their businesses.

Senator Rawson commented that a $5 million write-off by IHS, Inc., warrants an explanation from the State as well as an examination of the evidence of specific wrongdoing by the provider. He said that it is unreasonable to expect a provider doing business with the State to write off that amount regardless of the state's policy.

Responding to a question from Assemblywoman Berman, Ms. Supchak stated that IHS, Inc., anticipated the closure

of facilities within 90 days to six months. Assemblywoman Berman urged the committee to resolve the stale billing issue to avoid losing services.

Assemblywoman Freeman responded to Senator Rawson and Assemblywoman Berman's comments saying the State is "no stranger" to litigation regarding fiscal irresponsibility. She said that the State has not adopted the concept that it must spend money in order to save money. She suggested drafting a letter to the Executive Branch of Nevada State Government which details the committee's concerns and requests assistance from the Director of DHR.

Chairman Koivisto agreed that a letter be drafted to Nevada Governor Kenny Guinn expressing the committee's concerns.

Senator Washington said he opposed the drafting of a letter to the Governor's Office because it was "not enough" to wait for a response. He agreed with Senator Rawson that Ms. Crawford be called before the committee to answer questions because of the urgency of IHS, Inc.'s situation. The State will be directly impacted by facility closures by assuming financial responsibility for the cost of the facilities, staffing, medications, et cetera.

Chairman Koivisto directed a member of the audience, Janice A. Wright, Administrator, Division of Health Care Financing, DHR, to deliver a verbal request to Ms. Crawford to appear before the committee within 30 minutes.

Tom Hathaway

Tom Hathaway, Administrator, Washoe Care Center, identified his participation before the committee as that of a Nevada citizen. He informed committee members of the impending crisis regarding displaced elderly citizens. He said the companies who operate nursing home facilities under Medicaid reimbursement programs are paid $30 to $100 a day less than it costs to provide care for a resident. A nursing home company cannot subsidize the State of Nevada's Medicaid system. He reported that 50 percent of Nevada nursing homes are bankrupt. National corporations are folding as well because the regulatory environment is "harsh" and the reimbursement rates under the Balanced Budget Amendment are too low. He said that if Nevada wants to provide care for frail elderly citizens, then it must be prepared to pay for that care. Staffing levels are difficult to meet, and directors of nursing are impossible to recruit because the environment is difficult in which to work. Further, the staff are underpaid and the regulatory climate is so harsh that no registered nurse would "want that job." He said that in the nursing home facility that he operates, there have been four directors of nursing in a two-year span.

Responding to question from Chairman Koivisto, Mr. Hathaway said that the crisis is nationwide but it has exacerbated in Nevada. There are only 49 nursing homes in the State yet it is currently ranked third for substandard quality of care facilities. He said his nursing home recently received a $10,000 per day penalty while simultaneously receiving high marks for being ". . .the best it has ever been."

Responding to a question from Assemblywoman Freeman, Mr. Hathaway said the nursing home facility that employs him is located in Sparks, Nevada, and HCFA authors the governing regulations. The HCFA contracts with the Bureau of Licensure and Certification, Health Division, DHR, to perform the surveys. The federal and state regulations are so complex that licensed nurses report spending up to one and one-half hours with a patient and the remaining seven hours are spent on paperwork to meet federal and state requirements. Mr. Hathaway reported documentation requirements are extensive. He said it is difficult to understand the intent of the regulations and to implement them on a day-to-day basis.

Assemblywoman Freeman agreed that charting is time consuming but expressed dissatisfaction with explanations blaming regulations. Mr. Hathaway agreed to meet with her in private for further discussion on the regulatory environment in nursing home facilities.

Ms. Supchak presented a final recommendation concerning Medicaid billing, reimbursement, enforcement issues, and costs as they affect certain nursing home facilities in Nevada (Exhibit D). She recommended a new reimbursement system for nursing and the creation of a committee comprised of consumers, providers, elected officials, governmental health care agency representatives, and other experts in health care financing. This committee is not intended to study the issue, but rather, to develop an alternative financing system for the State of Nevada. This proposed committee would meet immediately and conclude its work within two years.

Chairman Koivisto suggested that Ms. Supchak make these recommendations before the Interim Study for Long-Term Care in Nevada (Senate Concurrent Resolution No. 4, File No. 143, *Statutes of Nevada 1999*).

Michael Clark

Michael Clark, Executive Director, Nevada Health Care Association, Las Vegas, Nevada, stated that the association's recommendations were made to the Interim Study for Long-Term Care in Nevada (S.C.R. 4), and they are currently under consideration.

Senator Mathews commented that an issue more immediate than IHS, Inc., is for Medicaid to reimburse back pay. If Medicaid is unable to comply, then an explanation is due. She was concerned that the committee was hearing one side of this issue and Medicaid must have a compelling reason for not paying.

Mr. Hathaway responded to the remarks of Senator Mathews by saying Nevada is not paying its bills. He said the processes of application, eligibility, and meeting regulatory conditions are causing delays in paperwork, which leads to claims being denied. He said the paperwork process is complex because it is a manual one. He stated that he has a resident in his nursing home with a total unpaid bill of over $33,000 because of the resident's Medicaid pending status for the past 13 and a half months. Mr. Hathaway said, "I have completed all the paperwork on this resident and where is my money?"

Mr. Clark referred to a statement provided to committee members (Exhibit B, Tab IX) and said that in the last two years, the Nevada Health Care Association has experienced a 25 percent decrease in the number of licensed administrators in the State of Nevada. He listed the reasons being: (1) financial; (2) rigorous enforcement from regulatory agencies; and (3) poor facility surveys resulting in damaged careers.

Mr. Clark said that the DHR is responsible for creating the current policy and has received a presentation from the Nevada Health Care Association asking reasonable questions as to why the State is delinquent in reimbursing nursing care facilities. The division that administers Medicaid reports that the division has not received a new computer in the last 20 years but this is a poor excuse for not paying for services rendered.

Chairman Koivisto directed Ms. Supchak to provide committee members with background material regarding the reasons for the creation of a new system. Ms. Supchak noted that in prior years Medicare funds balanced fiscal inequities within State programs. In accordance with the Balanced Budget Act, Medicare cut funding and figures suggest that the actual cuts are three times the amount of initial projections.

Senator Washington asked Mr. Hathaway to clarify a point in his proposal regarding the change in the regulatory climate between 1992 and 1999. Mr. Hathaway responded penalties imposed in 1999 are due to a new rule issued by HCFA and enforced by the Bureau of Licensure and Certification. He pointed out that the President of the United States, William Clinton, promotes increased regulatory enforcement in nursing home facilities by using civil money penalties as a tool to ensure compliance. Mr. Hathaway said that nursing home facilities cannot improve wages and care when they are "financially broken." He said the Clinton administration is instructing HCFA to "turn up the heat" and HCFA is instructing the Bureau of Licensure and Certification to "turn up the heat," which translates into a dramatic increase in civil penalties in each survey conducted in nursing home facilities.

Chairman Koivisto urged Senator Washington to talk to U.S. Congressman Jim Gibbons regarding these issues.

Upon Ms. Crawford's arrival at the meeting, Chairman Koivisto asked her to respond to Senator Washington and Senator Rawson's remarks regarding why the State is stalling provider reimbursements causing IHS, Inc., to accrue $14 million in stale date claims, $5.5 million of which will be written off. The Chairman explained that IHS, Inc., indicated that the stale claims are caused by complicated paperwork and subsequent errors cause stalls, which lead to missed deadlines and denials of reimbursement.

Ms. Crawford explained the current claim process and stated that she has no knowledge of any agency losing $14 million without having more details as to the time period in which it occurred.

Responding to a question by Senator Mathews, Ms. Crawford clarified that 120 days is the time period that the vendor has to bill, not the time period that the State takes to reimburse. Senator Mathews asked for the timeframe in

which the State reimburses once a bill is received. Ms. Crawford stated that she did not know and would call on Ms. Wright for comment.

Ms. Crawford explained, however, that she chose not to extend the 120 day claiming period to a 365 day period and it has not been incorporated into the budgets for the State or Medicaid because of the need to assess the financial impact. Preliminary analysis shows a cost of $6 million for the Medicaid program. Ms. Crawford explained that making that type of a change outside of the budget is not authorized and has an extraordinary impact. The DHR is searching for solutions within the existing budget based on sound policy. Ms. Crawford reported that no decisions have been made.

To address specific stale-dating claims, Ms. Crawford deferred to Ms. Wright. Ms. Wright stated that DHR contracts with Blue Cross Blue Shield as the State fiscal agent to process all claims. At this point in time, Blue Cross Blue Shield is reimbursing 99 percent of providers in less than 30 days from the time the initial request is received. She listed the situations causing delays in reimbursement: (1) client cases requiring provider research; (2) the possibility of identifying third party liability; (3) alternate payor sources emerge including private insurance or Medicare; or (4) pending slip status is temporarily assigned to a client. Commenting on Mr. Hathaway's example of stalled reimbursement she explained that clients in "pending slip status" still receive services from the provider and ". . .nobody is on the hook."

Commenting on Mr. Adams's remarks, Ms. Wright agreed that lack of a payor source presents a great challenge for the long-term health care industry. She acknowledged there are a variety of very complicated issues impacting the State agencies and the providers.

Responding to a question from Senator Mathews, Ms. Wright said Nevada's Medicaid did not offer presumptive eligibility for the elderly.

Senator Rawson reminded witnesses that when IHS, Inc., closes facilities within the next 90 days it will displace 800 people for which the State of Nevada will become financially responsible. He said that there is a concern on the part of the committee that this be forestalled. Ms. Wright responded that a representative of IHS, Inc., presented that figure at a meeting in the fall of 1999, with Senator Washington in attendance; however, the issue today is whether the $14 million is a long-standing stale-date issue or if it is something current. She said that she needed to meet with Mr. Adams to review the claims listed in the $14 million issue before making that determination.

Continuing, Ms. Wright offered additional detail on Ms. Crawford's earlier testimony regarding the State's attempt to resolve stale date claims in 1999. She said that an internal process called the CRSH ("Crash") Program was used. This is a process utilizing a Claims Reconciliation Special Handling program to address each individual outstanding claim.

Ms. Wright said that a stale dated claim is automatically overridden if Medicaid or Blue Cross Blue Shield creates the problem. Testimony on this topic was given by DHR to the Legislative Commission's Audit Subcommittee in April 2000 in response to an audit by the LCB and to address concerns regarding the point at which stale date claims were overridden. She said a mechanism called the "special reconsideration request" is available to any facility or provider regardless of the enactment of the stale date claim policy. The special reconsideration request program has been in place for two years, but because Medicaid providers continue to provide service on a daily basis, this is something that can only be viewed as a "snapshot in time."

Chairman Koivisto said that testimony was given saying that a claim submitted twice with errors cost the provider its entitled reimbursement, even though the State is still responsible for payment. Ms. Wright responded that the "two strikes rule" is a long-standing policy and explained that the first time an error is found, the claim is returned to the provider and "the clock is stopped," which allows the provider an additional 120 days to rectify the claim. The third time an error is discovered, the claim is not paid. She explained this is the policy, and it is not unusual for Medicaid or other insurance programs to incorporate it. She said that during discussions with Mr. Adams and members of the long-term health care industry, with Senator Washington as a witness, these various policies were examined to find ways to simplify it for the provider community while allowing Medicaid the ability to enforce the mechanisms.

Ms. Crawford stated that DHR's intent in the Medicaid program is not to evade payment but to attempt to run an orderly business. She pointed out that apart from the claiming period issue, the division has worked very diligently

with the industry as evidenced by the substantial effort put forth to resolve any stale dated claims two years ago. She said that $14 million in stale date claims against a total payment of approximately $75 million annually for long-term care is evidence of a substantial percentage of claims that were submitted after the 120-day period. Ms. Crawford said DHR would "look into that," but she said the industry has always had the opportunity to be trained on claim processing if they would just "come forward."

Mr. Adams refuted Ms. Wright's testimony saying a survey of 26 states' Medicaid programs determined that only one state, Pennsylvania, utilized the "two strikes rule." He reported that Medicare does not operate with a "two strikes rule" nor does any insurance agency interviewed. Mr. Adams clarified a fiscal point saying that $14 million is the total amount owed to IHS, Inc., at any one time. The stale date amount is $5.5 million accrued from January 1997 to present, or during a three year time period. He said the 120-day billing cycle is the time a provider is allowed to bill from the time the division authorizes a person for Medicaid. Medicaid is consistently responsible for causing paperwork delays with technical errors. Attempts by the provider to correct technical errors result in the form ". . . sitting on a desk at the Medicaid office for 45 days each try." The provider loses payment on the claim as a result of the form being stalled at Medicaid for the majority of the 120-day window of billing opportunity. Medicaid was responsible for 90 days of that 120 days. He referred to Ms. Crawford's testimony regarding the projected budgetary impact caused by increasing the stale date window from 120 to 365 days saying that $6 million is care provided that is not reimbursed. Chairman Koivisto directed Mr. Adams to submit his recommendations in writing to the committee

Responding to a question from Assemblywoman Freeman, Ms. Crawford stated that Nevada has the only Medicaid system in the country without a Medicaid management information system (MMIS). Ms. Wright verified that the 1999 Legislative Session granted the division the authority to proceed with development of a MMIS at a cost of $2.5 million. It will take an estimated five to seven years to complete.

Senator Washington made a recommendation that the committee meet again to examine the relationship between the State of Nevada, HCFA, and the providers, requesting that representatives from each entity be present. He suggested that a representative from the Executive Branch, possibly from the Governor's office, also be invited. He said resolution will not be reached during the meeting.

Chairman Koivisto directed Mr. Adams to work with the Interim Study of Long-Term Care in Nevada (S.C.R. 4) and said the committee would meet at a later date to hear further discussion. She thanked Ms. Crawford for attending on short notice and reiterated the committee's concern for the 80 percent of nursing home facilities that have closures pending.

Ms. Crawford told committee members that the providers have not brought this information to the attention of the division. She said that the division is willing to work with them if specific information is shared. The division is aware that 37 percent of Nevada long-term care facilities are currently in Chapter 11 bankruptcy. She said the division is also aware of Medicare's interface in this issue, and it is considered serious. She suggested that the division could facilitate addressing specific claims if the providers would be forthcoming with more information.

Senator Mathews asked whether the division was aware of the debt owed to IHS, Inc. Ms. Crawford responded that Ms. Wright reported that the providers have not brought any information forward regarding an unresolved, substantially large stale dated claim. Ms. Crawford said that at this point in time, the division was unaware of the disposition of the stale date claim from IHS, Inc., specifically, who was at fault. She said it was difficult to work with the industry without information on specific claims. Senator Mathews stated that the heart of the issue involved real lives and was less about the owners of the facilities.

Senator Washington stated that he was present at a meeting in which providers reported specific information regarding outdated claims to division representatives.

PUBLIC TESTIMONY, INCLUDING TESTIMONY RELATED TO ITEMS ON THE AGENDA AND RECOMMENDATIONS FOR CONSIDERATION IN THE WORK SESSION DOCUMENT

Jan Gilbert

Jan Gilbert, member, Nevada Progressive Leadership Alliance, urged the committee to create recommendations that

could be accomplished in the 2001 Legislative Session. The alliance supported the following recommendations: (1) presumptive eligibility; (2) the Ticket to Work and Work Incentives Act of 1999; and (3) enactment of the Medicaid Disabled Waiver Act of 1997. Ms. Gilbert concluded her remarks by stating recommendations should be limited to several realistic items and letters from the committee are more effective than resolutions.

Florence Laroy

Florence Laroy, Training Services Coordinator, Nevada Parents Encouraging Parents Inc., addressed the proposal to establish a commission on autism (Exhibit E, Tab D) and said autism is the most severe childhood disorder and the third most common developmental disability.

Ms. Laroy said early identification followed by behavioral and educational intervention has significantly changed the prognosis of autism. Intense intervention has even resulted in children attending regular education classes and being indistinguishable from their peers. Many individuals with autism spectrum disorder are contributing members of society who work and live independently. The purpose of this proposal is to give Nevada families the opportunities to obtain the needed services so that they too may achieve this outcome.

Continuing, Ms. Laroy said establishing a commission on autism and centers are critical to the future of 1 in 500 children that will be born with autism in Nevada and for the many individuals who are currently in need of services. The issues and concerns include early identification, intensive early behavioral and educational services specific to autism, a continuum of services for all ages, and specific training for individuals and families who attend to their needs. Currently children are often undiagnosed, receive a late diagnosis, or receive a diagnosis other than autism. These delays in identification and early intervention lead to more pronounced behaviors and a greater effort to establish communication with the child. Waiting lists for services can further exacerbate the problems resulting in more intensive and long-term intervention with a significant disruption in the lives of families. Autism centers would provide the needed expertise to the community to ensure an early diagnosis and the beginning of early intervention services.

Ms. Laroy reported that although the regional centers of Nevada have provided services to 111 adults and children with autism, until the recent Parry versus Crawford lawsuit, individuals without mental retardation were not eligible for services despite the fact that 75 percent of children with autism have mental retardation ranging from mild to severe.

Ms. Laroy concluded that services for individuals with or without mental retardation need to specifically address the characteristics of autism. Autism centers would provide information and training specific to autism thereby enhancing and increasing appropriate service delivery for the estimated 3,618 people with autism in Nevada.

Susan Pacult

Susan Pacult, staff member, Clark County Social Services, North Las Vegas, introduced Marcia Holmberg, representative, University Medical Center of Southern Nevada (UMC), and referred to a proposed outstationed enrollment program (Exhibit F). Ms. Pacult said that the proposed presumptive eligibility pilot program will compliment the committee's recommendation and implementation can begin immediately because both Social Services and UMC have the expertise and computer equipment to perform this function.

Marcia Holmberg

Marcia Holmberg, representative, UMC, expressed support for the presumptive eligibility recommendation and expressed enthusiasm in working with both the State and Clark County Social Services.

R. Keith Schwer

R. Keith Schwer, Ph. D., Director, Center for Business and Economic Research, University of Nevada, Las Vegas (UNLV), introduced Marlys Marton, Director, Nevada Kids Count Project. He offered an overview of the Nevada Kids Count Project:

- The Annie E. Casey Foundation initially instituted this project with matching funds from the State of Nevada.

- The project is part of a nationwide network to collect and distribute information on the status of children. It is a continuation of an ongoing effort in Nevada for the past three years.

- A data book will be an end product. Nevada-specific information will be generated which will be useful to policymakers and those interested in the status of children.

- Children's health care is a key policy issue.

Concluding, Dr. Schwer said the project seeks to upgrade the federal data sets, which are not adequate for Nevada.

WORK SESSION – DISCUSSION AND ACTION ON FINAL RECOMMENDATIONS (SEE ATTACHED "WORK SESSION DOCUMENT" FOR A SUMMARY OF PROPOSALS)

Chairman Koivisto referred to the committee's "Work Session Document" (Exhibit E). The recommendations contained in the "Work Session Document" are listed below in italics and precede the actions of the committee.

PEDIATRIC DIABETES AND ENDOCRINOLOGY CENTER,
UNIVERSITY OF NEVADA SCHOOL OF MEDICINE:

It is recommended that:

1. *Appropriate from the State General Fund to the University of Nevada School of Medicine the following amounts for the continued operations of the program administered by the Pediatric Diabetes and Endocrinology Center:*

   For the fiscal year 2001-2002: $379,500
   For the fiscal year 2002-2003: $379,500

   The sums appropriated should be available for either fiscal year. Any balance of those sums must not be committed for expenditure after June 30, 2003, and reverts to the State General Fund as soon as all payments of money committed have been made.

   The proposed language may be:

   The money appropriated by this measure must be used to: (a) pay the salaries of professional and support personnel on the multidisciplinary team of the Pediatric Diabetes and Endocrinology Center, including, without limitation, pediatric endocrinologists, licensed clinical social workers, exercise physiologists, psychologists, health analysts, biostatisticians, nurse practitioners, registered nurses, and registered dietitians; (b) purchase equipment; and (c) fund general operational costs, including travel expenses.

   The Center must continue the activities of the advisory board, which consists of eight members of the executive committee of the Nevada Diabetes Council and three additional members who are medical and allied health professionals in the field of diabetes to provide advice to the Pediatric Diabetes and Endocrinology Center regarding the collaboration between the various state agencies, focusing primarily on the care and treatment of children with diabetes.

   The Center must ensure that a data analysis is conducted to evaluate the financial situation of the program administered by the center and the medical results of patients who receive care under the program. The advisory board shall monitor and review the data analysis and provide advice based on the results of the analysis.

It is recommended that:

2. *<u>Diabetes care</u>: Require the Division of Health Care Financing and Policy, Department of Human Resources, to*

establish podiatry services as a Medicaid benefit. Further, require the division to pay for insulin pump therapy for patients whose physicians have indicated that such treatment is medically necessary for the patient.

Appropriate $412,857 to the division for the initial establishment of this requirement.

Senator Rawson commented that he received letters of approval and support for the service and support that they are receiving as a result of these two programs. He recommended that the committee authorize a bill draft request (BDR) for both recommendations and also send a letter to the Governor asking that these programs be included in the Executive Budget recommendations.

SENATOR RAWSON MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE ADOPT THE RECOMMENDATIONS TO: (1) REQUIRE THE UNIVERSITY OF NEVADA SCHOOL OF MEDICINE (UNSOM) TO ESTABLISH THE PEDIATRIC DIABETES AND ENDOCRINOLOGY CENTER (PDEC) AND REQUIRE THE DIVISION OF HEALTH CARE FINANCING AND POLICY, DEPARTMENT OF HUMAN RESOURCES, TO PROVIDE PODIATRY SERVICES AND INSULIN PUMP THERAPY IN MEDICAID FOR PERSONS WHO ARE ELIGIBLE FOR THIS DIABETES TREATMENT MINUS 25 PERCENT; (2) APPROPRIATE $284,625 FOR EACH YEAR OF THE BIENNIUM TO THE UNSOM FOR THE PDEC; (3) APPROPRIATE $412,857 FOR EACH YEAR OF THE BIENNIUM TO THE DIVISION TO PROVIDE PODIATRY SERVICES AND INSULIN PUMP THERAPY; AND (4) DRAFT A LETTER TO THE BOARD OF REGENTS AND THE GOVERNOR INDICATING THAT THE PDEC SHOULD BE PART OF THE BASE BUDGET OF THE UNIVERSITY SYSTEM'S MEDICAL SCHOOL. THE MOTION WAS SECONDED BY SENATOR WASHINGTON.

Discussion on the motion heard Assemblywoman Freeman's comment to add to the motion a document submitted by Mylan Hawkins, Executive Director, NDACA, to the Division of Health Care Financing and Policy, DHR. She said Ms. Hawkins' document would provide additional information to policymakers.

Ms. McDade Williams explained that the Division of Health Care Financing and Policy, DHR, responded to Ms. Hawkins' document with a memorandum determining the cost to include both podiatry and insulin pump services (Exhibit G). This amount is $412,857.

Senator Rawson disclosed that his son is a podiatrist and that he has not contributed to any programs with this fact in mind. He stated that his son is not participating in Medicaid podiatry at this point in time.

SENATOR MATHEWS AMENDED THE MOTION BY CALLING FOR THE ADDITION OF FINANCIAL INFORMATION AS WELL AS MS. HAWKINS' MATERIAL. UPON THE CALL OF THE MOTION AND A SECOND, THE MOTION CARRIED UNANIMOUSLY.

Senator Rawson noted that the creator of this program in 1997, Dr. David Donaldson, recently departed from Nevada.

MEDICAID ENHANCEMENTS AND NEW PROGRAMS CONTINUED:

It is recommended that:

3. *Presumptive eligibility: Require the Division of Health Care Financing and Policy and the Welfare Division of the Department of Human Resources, to allow for presumptive eligibility determinations by eligible health care providers for the Medicaid and the Nevada Check-Up Programs. Such funding shall be used for administrative and medical costs associated with these determinations. Administrative costs include the expenses that are associated with training eligible health care providers to make presumptive eligibility determinations. Medical costs shall include expenses that are incurred for services provided to persons who were subsequently determined to be ineligible for these programs.*

Appropriate $31,831,730 to the division for the initial establishment of this requirement.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE ADOPT THE RECOMMENDATION TO DRAFT A BILL TO: (1) REQUIRE THE DIVISION OF HEALTH CARE FINANCING AND POLICY, DEPARTMENT OF HUMAN RESOURCES, TO ADOPT PRESUMPTIVE ELIGIBILITY IN THE MEDICAID PROGRAM FOR WOMEN AND CHILDREN AND FOR THE NEVADA CHECK-UP PROGRAM; (2) APPROPRIATE $31,831,730 FOR EACH YEAR OF THE BIENNIUM TO THE DIVISION TO IMPLEMENT PRESUMPTIVE ELIGIBILITY ($1,650,000 FOR PREGNANT WOMEN IN MEDICAID; $29,500,000 FOR CHILDREN IN MEDICAID; AND $681,730 FOR CHILDREN IN NEVADA CHECK-UP). SENATOR MATHEWS SECONDED THE MOTION.

Discussion on the motion was heard and Ms. McDade Williams referred members to the memorandum from the Division of Health Care Financing and Policy, DHR (Exhibit G), which provides cost estimates for presumptive eligibility. She said the cost of the recommendation before the committee would be relatively identical to the costs that were developed for the measure considered by the 1999 Legislature.

Ms. Wright updated committee members with the following cost estimates: (1) the Nevada Check-Up Program totals $1.95 million, 35 percent of which will belong to the State General Fund; (2) the total for pregnant women is $3.3 million, 50 percent of which will belong to the State General Fund; and (3) the total for children in Medicaid is $59 million, 50 percent of which will belong to the State General Fund. Ms. Wright listed components not built into the current caseload include the cost of: (1) individuals who will only be eligible for a 45-day period or who will not follow through with, or be found eligible by Medicaid; (2) individuals who follow through and will be found eligible; and (3) individuals initially determined presumptively eligible for Medicaid and who are later found not to be eligible.

Senator Rawson suggested that two of the programs, one for pregnant women and Nevada Check-Up, be considered because of affordability. Several year's worth of real data could be analyzed prior to a decision on a large amount of funding being made. He added that the legislative session has an amendment process for any changes.

Assemblywoman Freeman said that hospitals are in a similar situation to the nursing home facilities, which regard to having to write off uncompensated care. She noted that hospitals have traditionally become responsible for costs for Medicaid patients who were deemed ineligible.

UPON THE CALL OF THE MOTION AND A SECOND, THE MOTION CARRIED WITH A NAY VOTE FROM SENATOR WASHINGTON.

It is recommended that:

4. *Ticket to Work and Work Incentives Improvement Act of 1999: Require the Division of Health Care Financing and Policy, Department of Human Resources, to establish the Ticket to Work and Work Incentives Improvement Act to allow disabled Nevadans who receive Medicaid services to be employed.*

   Appropriate $(not available) to the division for the initial establishment of this requirement.

Ms. Wright reported that the division did not have cost estimates available for this recommendation, but she said a task force is working jointly between DHR and the Department of Employment, Training and Rehabilitation to present an analysis on June 26, 2000. The purpose of the task force is to determine implementation of the Ticket to Work and Work Incentives Improvement Act of 1999. She said that HCFA has new policies, regulations, and funding options in reference to the Act but that information has not been communicated to the states at this time. Ms. Wright said that further comment on this recommendation would be premature. She noted that the Act is an optional program that Nevada is actively pursuing.

Chairman Koivisto informed committee members that costs could be developed in the future.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE ADOPT THE RECOMMENDATION TO REQUIRE THE DIVISION OF HEALTH CARE FINANCING AND POLICY, DEPARTMENT OF HUMAN RESOURCES,

TO ALLOW DISABLED PERSONS WHO ARE ELIGIBLE FOR MEDICAID TO RECEIVE INCOME FROM EMPLOYMENT AND STILL RETAIN THEIR MEDICAID ELIGIBILITY. THE MOTION WAS SECONDED BY SENATOR RAWSON AND CARRIED UNANIMOUSLY.

It is recommended that:

5. *Cost-based reimbursement: Require the Division of Health Care Financing and Policy, Department of Human Resources, to allow the division to pay rural hospitals at their cost for providing care to Medicaid patients.*

Appropriate $700,000 to the division for the initial establishment of this requirement.

Ms. Wright told committee members that the division does not have a mechanism in place to track provider costs for rural practitioners and viewed this recommendation in two parts: (1) provider reimbursements with no cost estimates available; and (2) rural hospital reimbursements which would not cost the state anything because the division is already paying the hospitals at their cost.

Chairman Koivisto said rural hospital representatives disagreed with the division's view on reimbursements.

Senator Rawson explained that the committee was provided with a response saying there is a routine cost limitation specified in Title 42. The information from rural hospitals notes that this specification belonged to a policy that was phased out by the Federal Government although Nevada is still adhering to it. Senator Rawson said that Nevada now has the option of enforcing those limitations.

Ms. McDade Williams directed committee members' attention to a discrepancy regarding reimbursement of rural hospitals. She said that it was her understanding that the program needs an infusion of $700,000 to accommodate rural hospitals.

Grant Asay, President, Nevada Rural Hospital Project, said that reimbursement in rural hospitals is for Medicaid long-term health care. Currently, the Medicaid system follows the Medicare reimbursement pattern that applies a routine cost limit, or imposed cap, against cost reports submitted by providers. Similarly, the State Medicaid system applies the same formula to allow reimbursements within a cap. Mr. Asay explained that in the last year, Medicare broadened the reimbursement formula for Medicaid long-term care patients to address costs associated with stroke, physical therapy, rehabilitation, et cetera. He said a published routine cost limit is no longer in existence. The recommendation before the committee returns to an older system prior to 1993 in which hospitals received reimbursements for Medicaid long-term care services based on their costs. He said the recommendation will assist rural hospitals facing financial disasters because of large Medicaid and Medicare patient populations. The $700,000 will translate to $1.4 million with federally matched funding. He added that rural hospitals support the economy of communities they serve because they are the largest employers in their areas.

After additional discussion:

ASSEMBLYWOMAN FREEMAN MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE ADOPT THE RECOMMENDATION TO: (1) REQUIRE THE DIVISION OF HEALTH CARE FINANCING AND POLICY, DEPARTMENT OF HUMAN RESOURCES, TO PAY RURAL HOSPITALS AT THEIR COST FOR PROVIDING CARE FOR LONG-TERM CARE SERVICES PROVIDED TO MEDICAID PATIENTS; AND (2) APPROPRIATE $700,000 TO THE DIVISION FOR EACH YEAR OF THE BIENNIUM TO IMPLEMENT THIS PROVISION. THE MOTION DIED FOR LACK OF A SECOND.

ASSEMBLYWOMAN FREEMAN RENEWED HER MOTION ASKING FOR A BILL DRAFT REQUEST FOR COST-BASED REIMBURSEMENT TO RURAL HOSPITALS FOR THEIR COSTS IN PROVIDING LONG-TERM CARE TO MEDICAID PATIENTS. THE MOTION WAS SECONDED BY SENATOR WASHINGTON AND CARRIED UNANIMOUSLY.

Senator Rawson suggested that Chairman Koivisto direct LCB staff to schedule a meeting of the committee in

December 2000 to address the rural health issues in detail. The Chairman agreed.

Chairman Koivisto informed committee members that resolutions require the same amount of staff and members' resources as a BDR. She said that a resolution does not have the force of law, and she then directed Ms. McDade Williams to include the recommendations concerning the drafting of resolutions in the final report of the committee.

It is recommended that:

6. *Assets test: Require the Division of Health Care Financing and Policy, Department of Human Resources, to eliminate the assets test as a requirement for eligibility for pregnant women and children in the Medicaid Program.*

   Appropriate $3,530,387 to the division for the initial establishment of this requirement.

Michael J. Willden, Administrator, Welfare Division, DHR, said that Assembly Bill 4, from the 1999 Legislative Session, which sought to prohibit the DHR from considering assets of a child or pregnant woman or their families to determine eligibility for the Child Health Assurance Program, did not pass. The bill, however, had a fiscal note, and the current estimates would be similar to the original fiscal note. He reported the estimated costs at $3.1 million for the first year of operation for Fiscal Year (FY) 2000, and $3.5 million in FY 2001. He said he could provide exact figures at Ms. McDade William's request. He added that these figures were in "total dollars" with 50 percent being Nevada's cost and 50 percent provided by HCFA.

SENATOR RAWSON MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE ADOPT THE RECOMMENDATION TO AUTHORIZE A BILL DRAFT TO REQUIRE THE WELFARE DIVISION, DEPARTMENT OF HUMAN RESOURCES, TO ELIMINATE THE ASSETS TEST AS A REQUIREMENT FOR ELIGIBILITY FOR PREGNANT WOMEN AND CHILDREN IN THE MEDICAID PROGRAM. FURTHER, APPROPRIATE $3,530,387 FOR EACH YEAR OF THE BIENNIUM TO THE DIVISION OF HEALTH CARE FINANCING AND POLICY, DEPARTMENT OF HUMAN RESOURCES, TO IMPLEMENT THIS PROVISION. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND CARRIED UNANIMOUSLY.

MEDICAID SERVICES AND OTHER ISSUES:

It is recommended that:

7. *Waiting lists: Encourage, by resolution, the Division of Health Care Financing and Policy, Department of Human Resources, to eliminate the waiting lists for existing Medicaid waiver programs, including the Community Home-based Initiatives Program, the Physically Disabled Waiver Program, and the Intermediate Care Facilities for the Mentally Retarded Waiver, by seeking funding from the Nevada Legislature for the 2003-2004 biennium.*

Discussion of this resolution will be included in the final report of the committee.

It is recommended that:

8. *Personal care assistance: Encourage, by resolution, the Division of Health Care Financing and Policy, Department of Human Resources, to provide effective personal care assistant services and personal care assistant for the disabled services pursuant to suggestions that have been provided to the division during the course of public hearings concerning regulations that govern these services.*

Discussion of this resolution will be included in the final report of the committee.

NEVADA CHECK-UP PROGRAM:

It is recommended that:

9. *Encourage, by resolution, the Division of Health Care Financing and Policy, Department of Human Resources, to access the total amount of federal funding that is available to the state to provide health insurance coverage to children through the Nevada Check-Up Program by: (a) hiring a sufficient number of personnel to process applications for the Nevada Check-Up Program; (b) revising the division's existing outreach efforts for the program; (c) expanding the division's marketing campaign; and (d) eliminating the six-month waiting period between a child's loss of health insurance coverage and eligibility for coverage by the Nevada Check-Up Program.*

Discussion of this resolution will be included in the final report of the committee.

MEDICAID AND THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM:

It is recommended that:

10. *Encourage, by resolution, the Welfare Division, Department of Human Resources, to comply with federal directives to ensure that persons who lose cash assistance, pursuant to the Temporary Assistance for Needy Families Program, do not lose Medicaid coverage. Further, encourage the division to locate and assist persons who have lost such coverage for the purpose of reestablishing the coverage.*

Discussion of this resolution will be included in the final report of the committee.

INSTITUTIONALIZATION OF PERSONS WHO ARE DISABLED:

11. *Encourage, by resolution, the Department of Human Resources, to take all reasonable steps to comply with the Olmstead v. L.C. ex rel. Zimring, 119 S.Ct. 2176 (1999), court decision for the purpose of ensuring that a person who is disabled is not institutionalized if his physician specifies that his condition does not require institutional placement.*

Discussion of this resolution will be included in the final report of the committee.

KIDS COUNT PROJECT:

It is recommended that:

12. *Require the Center for Business and Economic Research, University of Nevada, Las Vegas, to compile primary data concerning the number of children in Nevada who do not have health insurance coverage and to publish the Kids Count Databook. If feasible, data in the book should reflect whether programs that currently provide services to children in Nevada are able to serve all children who are eligible for such services. For those programs that are not able to provide services to all children who are eligible for such services, data reported in the book should illustrate the number of children who are in this category.*

    Appropriate $150,000 for each year of the biennium to the Center for Business and Economic Research for salaries, research, and publication costs.

Senator Rawson commented that the information received as a result of this recommendation is fundamental to a policy and funding decision. He said the recommendation was appropriate.

SENATOR RAWSON MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE ADOPT THE RECOMMENDATION TO REQUIRE THE CENTER FOR BUSINESS AND ECONOMIC RESEARCH (CBER), UNIVERSITY OF NEVADA, LAS VEGAS, TO: (1) COMPILE PRIMARY DATA CONCERNING THE NUMBER OF CHILDREN IN

NEVADA WHO DO NOT HAVE HEALTH INSURANCE COVERAGE; (2) PREPARE AN ANALYSIS OF THE NUMBER OF CHILDREN WHO ARE UNABLE TO ACCESS SERVICES FROM GOVERNMENT SPONSORED PROGRAMS; AND (3) PUBLISH THE KIDS COUNT DATABOOK. FURTHER, APPROPRIATE $150,000 TO THE CBER FOR EACH YEAR OF THE BIENNIUM TO CONDUCT THE RESEARCH AND PUBLISH THE BOOK; AND SEND A LETTER TO THE BOARD OF REGENTS AND THE GOVERNOR TO INCLUDE THIS CONCEPT IN THE CBER'S BASE BUDGET. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND CARRIED WITH ASSEMBLYWOMAN BERMAN OUT OF THE ROOM.

AUTISM:

It is recommended that:

13. *Establish the Commission on Autism within the Division of Mental Health and Developmental Services, Department of Human Resources. The commission will establish two Autism Centers for Excellence, and it will assess current services relating to the treatment of autism in Nevada. The commission will have the authority to make programmatic changes in the delivery of current programs that are administered by the Departments of Education and Human Resources. The commission will have the authority to request the drafting of bills to each session of the Nevada Legislature for purposes of establishing new services or restructuring existing programs.*

    Appropriate $700,000 to the division for the establishment of the Commission and the two centers.

SENATOR WASHINGTON MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE ADOPT A RECOMMENDATION TO INCLUDE THE ESTABLISHMENT OF TWO AUTISM CENTERS FOR EXCELLENCE, AND APPROPRIATE $700,000 FOR THE ESTABLISHMENT OF A COMMISSION ON AUTISM. THE MOTION WAS SECONDED BY SENATOR RAWSON AND CARRIED UNANIMOUSLY.

MEDICAL ERRORS:

It is recommended that:

14. *The Nevada Legislature must establish an interim committee to develop a "mandatory health care errors reporting system." The committee will be authorized to request one bill draft request, which seeks to establish the reporting system. The work of the subcommittee shall be completed by June 30, 2002.*

Senator Rawson suggested that this recommendation be proposed as a legislative study or as a standing committee issue. He said that there will be an equal number of interim studies from each house and this issue may become one.

Chairman Koivisto reminded committee members of previous testimony regarding medical errors. She said that federal legislation is forthcoming to develop a reporting system and suggested that Nevada become involved in this issue. She advised the formation of a subcommittee. After clarification by Ms. McDade Williams regarding the language of the original recommendation, Chairman Koivisto agreed to hear a motion.

SENATOR RAWSON MOVED THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE ADOPT THE RECOMMENDATION TO REQUIRE THE LEGISLATIVE COMMITTEE ON HEALTH CARE TO APPOINT A SUBCOMMITTEE TO DEVELOP A MANDATORY HEALTH CARE ERRORS REPORTING SYSTEM. THE STUDY WILL USE THE PARAMETERS OUTLINED IN THE WORDING THAT WAS PROVIDED TO COMMITTEE MEMBERS, BUT THE CHAIRMAN OF THE HEALTH CARE COMMITTEE WILL BE GIVEN THE AUTHORITY TO SELECT THE MEMBERS OF THE SUBCOMMITTEE. THE MOTION WAS SECONDED BY SENATOR WASHINGTON AND CARRIED UNANIMOUSLY.

Chairman Koivisto directed the following individuals to be contact people to assist with the construction of approved

bill draft requests: (1) Florence Laroy for autism; (2) Grant Asay for cost-based reimbursement; and (3) John Chambers for Ticket to Work.

ADJOURNMENT

Chairman Koivisto advised committee members that an additional Legislative Committee on Health Care meeting will be held after the General Election in the fall of 2000. There being no further business to come before the committee, Chairman Koivisto adjourned the meeting at 3:30 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 13-page copy of a slide presentation titled, "University of Nevada proposed School of Pharmacy presentation to Legislative Committee on Health Care, June 6, 2000," submitted by Dr. David Westfall, Vice President of Academic Affairs and Professor of Pharmacology, University of Nevada School of Medicine, Reno, Nevada.

Exhibit B contains a one-volume set of documents that provide background information on selected agenda items. Arranged to correspond with the items on the meeting agenda, this document was prepared by Marla McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau, Carson City, Nevada, for members' reference. Specifically:

- Materials provided by John Yacenda, M.P.H., Ph.D., Deputy Director, Nevada's Department of Human Resources, Carson City, Nevada.
- Materials provided by Lisa M. Black, R.N., B.S.N., American Nurses Association Delegate, and Member, Nevada Nurses Association, Reno, Nevada.
- A 5-page copy of testimony submitted by Michael J. Willden, Administrator, Welfare Division, Nevada's Department of Human Resources, Carson City, Nevada, including a 6-page document titled, "Outstationed Medicaid Enrollment: Policy Implications for Welfare Reform and CHIP."
- A 13-page document dated March 20, 2000, titled, "NACHC'S Recommendations to HCFA for Updating and Revising Its Guidance on Outstationing Requirements," submitted by Roger Volker, Executive Director, Great Basin Primary Care Association, Carson City, Nevada.

- A 3-page document titled, "Nevada's Cervical and Breast Cancer Treatment Fund, June 6, 2000," provided by Roger Volker, Executive Director, Great Basin Primary Care Association, Carson City, Nevada.

- A 7-page copy of testimony titled, "The Health Care Fund for Uninsured Nevadans," submitted by Dr. Michael Rodolico, Executive Director, Health Access Washoe County, and President, Great Basin Primary Care Association, Carson City, Nevada.

- A 3-page copy of testimony submitted by Michael Clark, Executive Director, Nevada Health Care Association, Las Vegas, Nevada.

- A 2-page letter dated May 5, 2000, from Jon L. Sasser, Esq., Legal Services Statewide Advocacy Coordinator, Reno, Nevada, to Chairwoman Ellen Koivisto, regarding proposed legislation.

- A 2-page letter dated May 12, 2000, from Bobbie Gang, Lobbyist, Nevada Women's Lobby, Incline Village, Nevada, to Chairwoman Ellen Koivisto regarding recommendations for legislation.

- A 2-page letter dated May 14, 2000, from Lisa M. Black, R.N., American Nurses Association, Reno, Nevada, and Cynthia Bunch, R.N. State Legislative Coordinator, Henderson, Nevada, to Assemblywoman Koivisto regarding proposed legislation.

- A 2-page letter dated May 15, 2000, from Jack Mayes, Executive Director, Nevada Disability Advocacy and Law Center, Inc., Reno, Nevada, to Chairwoman Ellen Koivisto regarding recommendations for consideration.

Exhibit C is a 6-page document titled "Integrated Health Services, Inc. (IHS) Nevada Medicaid – Stale Dating," submitted by Dallas Adams, Regional County Manager, IHS, Inc., Las Vegas, Nevada.

Exhibit D is a 4-page document titled "Nevada Health Care Association, Integrated Health Services, Creation of a New Reimbursement System for Nursing Facilities in the State of Nevada – The Time is Now," submitted by Tammy Supchak, staff, IHS, Inc., and Administrator, Cheyenne Care Center, North Las Vegas, Nevada.

Exhibit E contains a one-volume set of documents that provide background information on selected Work Session items. Arranged to correspond with the items for the Work Session on the meeting agenda, this document was prepared by Marla McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau, Carson City, Nevada, for members' reference.

Exhibit F is a 2-page document titled "Out-Stationed Enrollment Program," submitted by Susan Pacult, staff member, Clark County Social Services, North Las Vegas, Nevada.

Exhibit G is a 21-page memorandum with attachments dated June 5, 2000, from Janice A. Wright, Administrator, Division of Health Care Financing and Policy, Carson City, Nevada, to Assemblywoman Ellen M. Koivisto regarding cost estimates.

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.