MINUTES OF THE MEETING

OF THE

LEGISLATIVE COMMITTEE ON HEALTH CARE

(*Nevada Revised Statutes* 439B.200 through 439B.240)

December 14, 1999

Carson City, Nevada

The second meeting of the Nevada Legislature's Committee on Health Care for the 1999-2000 interim was held on Tuesday, December 14, 1999, at 9:50 a.m., in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. This meeting was simultaneously video conferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Pages 2 and 4 contain the "Meeting Notice and Agenda."

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Assemblywoman Ellen M. Koivisto, Chairman

Senator Maurice E. Washington

Assemblywoman Vivian L. Freeman

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Raymond D. Rawson, Vice Chairman

COMMITTEE MEMBERS EXCUSED:

Senator Bernice Mathews

Assemblywoman Merle A. Berman

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT IN CARSON CITY:

Marla McDade Williams, Senior Research Analyst

Risa B. Lang, Principal Deputy Legislative Counsel

Leslie Hamner, Senior Deputy Legislative Counsel

Linda Chandler Law, Senior Research Secretary

All place names mentioned in these minutes are in Nevada unless otherwise noted.

MEETING NOTICE AND AGENDA

Name of Organization: Legislative Committee on Health Care

(*Nevada Revised Statutes* 439B.200)

Date and Time of Meeting: Tuesday, December 14, 1999

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

A G E N D A

I. Opening Remarks by the Chairman

Assemblywoman Ellen M. Koivisto

*II. Presentation Concerning Suicide Hotline and Prevention Services in Nevada

Nora Brashear, Administrative Coordinator, Crisis Call Center, Reno, Nevada

*III. Discussion Concerning Residential Care Placements at Devereux Cleo Wallace Centers

Debra McEwan, Director, Social Services Program, Moapa Paiute Band, Moapa, Nevada

Steve Shaw, Administrator, Division of Child and Family Services, Nevada's Department of Human Resources (DHR)

Janice Wright, Administrator, Division of Health Care Financing and Policy, DHR

Michael Montgomery, Executive Director, Devereux Cleo Wallace, Denver, Colorado

Robert Kreider, Chairman of the Board of Devereux Cleo Wallace, Villanova, Pennsylvania

*IV. Discussion Concerning the Cost of Health Insurance Premiums for Small- and Medium-sized Employers

Jeanette K. Belz, Director, Government Relations, Wadhams & Akridge, Las Vegas

*V. Follow-up Report Concerning Nevada's Immunization Program

Yvonne Sylva, Administrator, Health Division, DHR

*VI. Presentation Concerning the Implementation of Senate Bill 519 (Chapter 531, *Statutes of Nevada 1999*) [This measure authorizes certain persons to possess and administer controlled substances and dangerous drugs.]

Keith W. Macdonald, Executive Secretary, State Board of Pharmacy

*VII. Report Concerning "Pill Splitting"

Keith W. Macdonald, Executive Secretary, State Board of Pharmacy

Alice A. Molasky-Arman, Commissioner of Insurance, Division of Insurance, Nevada's Department of Business and Industry

*VIII. Follow-up Report Concerning Nevada Check-Up Program (Children's Health Insurance Program), Including a Discussion of the Number of Uninsured Children in the State

Janice A. Wright, Administrator, Division of Health Care Financing and Policy

*IX. Informational Presentation Concerning Medicaid Issues Affecting Persons who are Aged and Disabled in Nevada

Paul Gowins, Rehabilitation Specialist, Office of Community Based Services, Rehabilitation Division, Department of Employment, Training and Rehabilitation

*X. Informational Presentation Concerning Legislative and Regulatory Reforms to Increase Access to Health Insurance for Small- and Medium-sized Employers

Alice A. Molasky-Arman, Commissioner of Insurance

*XI. Discussion of Proposed Federal Regulations Concerning Medical Records Privacy

XII. Informational Report Describing the National Conference of State Legislatures Health Care Conference

Marla L. McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau

XIII. Discussion of Future Topics

XIV. Public Testimony

XV. Scheduling of Next Meeting

XVI. 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 Linda Chandler Law, 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: Grant Sawyer State Office Building, 555 East Washington Avenue; and Clark County Office, 500 South Grand Central Parkway.

OPENING REMARKS BY THE CHAIRMAN

Chairman, Assemblywoman Ellen M. Koivisto

Chairman Koivisto called the meeting to order at 9:45 a.m. She introduced the members and support staff present and welcomed those in the audience, both in Carson City and Las Vegas. Roll was called. A quorum was not present; therefore, she and Assemblywoman Freeman formed a subcommittee to hear testimony, until such time as a quorum was present. Ms. Koivisto explained that:

- •Due to length of the agenda, those testifying should keep their remarks brief and as unrepetitive as possible.
- •Members of the public, representing the interests of autistic children and their parents, would be allowed to offer testimony first, prior to hearing the agenda items.

Exhibit A contains a two-volume set of documents that provide background information on selected agenda items. Arranged to correspond with the items on the meeting agenda, those documents were provided by Marla McDade Williams for members' reference.

Senator Rawson requested those wishing to testify to come forward to speak. The following parents testified from Las Vegas.

PUBLIC TESTIMONY

Shannan Michalsky

Shannan Michalsky, mother of an autistic son, explained that:

- •Although her son has done well in the past, as he has gotten older, his behavior has become more difficult and he has developed some psychoses;
- •In seeking assistance for him, she has been shuffled from agency to agency;
- •Desert Regional Center and Desert Willow have both avoided providing services for him and have suggested that she send him out of state for long-term residential care;

- •Removing him from his family would require him to give up all he has been familiar with that is secure; and

- •Nevada, especially with Las Vegas's population now exceeding one million people, should have more to offer these children.

Michele Tombari

Michele Tombari, mother of a four-year-old autistic son, noted that:

- •Her son is doing well currently; however, the program is very expensive;

- •She would like to see more health care for autistic children, similar to that of other states;

- •In her view, current care levels in Nevada are inadequate;

- •Families for Effective Autism Treatment, a parent-support organization, is working to increase awareness of this condition; and

- •Currently, autism affects one in 500 children, and it is the third most common developmental disability in the nation.

Ms. Tombari referred to an item contained in the materials provided by Paul Gowins (see Exhibit A, Item IX, page IX-1), which indicated a need to "develop alternate resources for children with chronic and disabling conditions who have a need for services beyond those offered in Nevada Check-Up." She noted the proposed outcome in his materials of "no action" is, in her view, unacceptable.

She requested the committee to address this issue and to immediately find funding, as other states have, to provide services to autistic children so that they can lead productive lives. She also questioned why Nevada has no developmental specialists or diagnostic centers that would be able to provide services to these children and eliminate the need to diagnose them elsewhere.

Florence LaRoy

Florence LaRoy, speaking from prepared remarks (see Exhibit B), noted that she is the mother of a 15-year-old autistic son for whom:

- •Services are not available either in the community or elsewhere in Nevada; and
- •Obtaining out-of-state services is prohibitively expensive for most parents, even when covered by insurance.

Due to the shortage of services and affordable interventions in Nevada, many autistic children and their families experience:

- •Financial hardship, which results in further stress on their familial relationships;
- •A lack of respite from the demands of raising an exceptional child; and
- •Unusually high rates of divorce and custody abdication.

In her view, Nevada needs to profoundly change its system for serving children with special needs to:

- •Prevent families with special-needs children from leaving the state;
- •Enable families to obtain necessary services;
- •Provide autistic and other children with services that will lead to their becoming more productive citizens; and
- •Ensure that in-state services are developed and provided to Nevada's special children.

Answering questions from the panel, Ms. LaRoy explained that the numbers of autistic children in the state have been "greatly underestimated." Nationally, 15 in 10,000 births is the incidence rate for autism. In her role as an advocate, she receives calls from people who are desperate to obtain services for their children. She notes that the challenges being

faced by families today are unchanged from those she has faced in the past with her child.

In conclusion, Ms. LaRoy said she would forward accurate statistical information on autism to the members of this committee.

Barbara Ames

Barbara Ames, said that her daughter, who was born and is being raised in Las Vegas, is profoundly deaf and has behavioral problems. Ms. Ames explained that she has:

- •Had to seek services for her daughter out of state because services do not exist in Nevada;
- •Been unsuccessful in obtaining help from Medicaid for the residential care needed for her daughter; and
- •Been unable to locate appropriate therapy, sign language training, or group home services.

In her view, something needs to be done, and she requested that the Legislature establish programs to assist these families.

Jan Crandy

Jan Crandy, member of the Governor's Independent Living Council, director of Families for Effective Autism Treatment (FEAT), and mother of an autistic child, testified that she and her husband have:

- •Obtained funding for and begun in-home programs for families, through Independent Living Skills, that teach independent living skills;
- •Become aware that there are approximately 150 autistic children in the Clark County School District (CCSD);

- •More than 300 families on the FEAT mailing list that are affected by autism spectrum disorder;
- •Come to believe that this population has been overlooked by the state;
- •Provided, at great personal expense, 30 to 40 hours of therapy per week for her own child; and
- •Realized the importance of keeping autistic children in their homes; however, without appropriate interventions, many of these children will end up institutionalized at a great cost to taxpayers.

In conclusion, Ms. Crandy said that, with appropriate training, many autistic people and their families can adapt to various social situations and take advantage of the public school system. It is disappointing to see how many people with disabilities have been overlooked and how scarce funding has been from the Legislature.

Chairman Koivisto requested those in Las Vegas, who would like to be either notified of the committee's next meeting or included on a future agenda to discuss this issue, submit their names and telephone numbers to staff. To accommodate a scheduling conflict, she called next for an update on Nevada's immunization program.

Unless so noted, all ensuing witnesses testified in Carson City.

FOLLOW-UP REPORT CONCERNING

NEVADA'S IMMUNIZATION PROGRAM

Yvonne Sylva

Yvonne Sylva, Administrator, Health Division, DHR, explained that:

- •A request was made to the Interim Finance Committee (IFC) for funds to offset the shortfall that is anticipated to continue the immunization program at current levels;

- •At its meeting on November 17, 1999,the IFC approved up to $1.2 million to pay for the childhood immunization program at those levels; and

- •Information has been provided (see Exhibit A, Section V, pages V-3 through V-6) describing the cost of adult immunizations and the implementation of Senate Bill 519 (Chapter 531, *Statutes of Nevada 1999*), which will have no impact on federal or state funding for vaccines.

Chairman Koivisto and others asked Ms. Sylva to comment on the cost, efficacy, and cost/benefit ratios of the varicella (chicken pox) vaccine.

Ms. Sylva explained that the vaccine:

- •Is more expensive than most others;

- •Cost/benefit information will be provided to staff;

- •Has no known, significant adverse reactions to the vaccine; and

- •May be paid for through federal funds, and information on the level and purpose of federal funding should be made public and disseminated in January 2000.

Senator Rawson noted that the varicella vaccine provides not only protection against chicken pox but also against herpes zoster, shingles, and other related diseases that have long-term effects. Although cost may be an issue, its overall benefit and safety should be considered when deciding whether the varicella vaccination program should be continued.

PRESENTATION CONCERNING

SUICIDE HOTLINE AND PREVENTION SERVICES IN NEVADA

Nora Brashear

Nora Brashear, Administrative Coordinator, Crisis Call Center, Reno, Nevada, described suicide and hotline service in Nevada. She said that the program that operates the crisis call lines in the state:

- •Has been in effect since 1966;
- •Has handled a number of statewide services, including emergency after-hours calls for rural mental health clinics, elder abuse and neglect reporting, and child abuse and neglect reporting after hours (except for Clark County); and
- •Received a grant recently to provide a statewide suicide hotline that specifically focuses on advertising and providing service in the Las Vegas area, where many calls have originated in the past.

She provided results from the telephone survey conducted on behalf of the Crisis Call Center by R&R Partners (see Exhibit C). She also outlined Nevada's suicide statistics, including:

- •The state's long-term standing as the state with the highest number of suicides per capita -- almost double the national average, which is 12 suicides per 100,000 population; and
- •Most suicides in Nevada occur among non-Hispanic white males, representing the fifth leading cause of death.

Ms. Brashear introduced Misty Allen to further explain the new statewide hotline.

Misty Allen

Misty Allen, Crisis Line Coordinator, Crisis Call Center, Reno, Nevada, explained that:

- •Her duties include the recruitment and training of volunteer operators for the 24-hour hotlines;
- •Currently, there are two statewide, toll-free lines in operation -- 800/992-5757, which has been in service for many years, and 877/885-4673 (HOPE), which is a new number with two lines;

- •The number of volunteers chosen thus far is 62, for whom training will begin in January 2000;
- •Other volunteers are being sought;
- •The telephone numbers will be listed in the new Las Vegas telephone books that will be distributed in January 2000; and
- •The numbers are now available through directory assistance.

Referring to the survey mentioned in Exhibit C, Ms. Allen noted that complete results would be forthcoming soon, at which time the public awareness campaign would be initiated in southern Nevada and the rural counties.

Responding to questions from the members, Ms. Allen explained the volunteer training, which is approximately 55 hours:

- •Is intensive and focuses on various suicide statistics, interview assessments, techniques, and interventions, together with aspects of sexual assault, child and elder abuse and neglect, and domestic violence;
- •Includes training related to depression, mental health crises, substance abuse, and other information and referral services;
- •Provides direction to the volunteers about when to ask for assistance from senior staff during a call and when to call for emergency medical or police intervention; and
- •Describes the procedures to be followed when the person calling indicates there is no family or other support system to turn to during the crisis.

A brief discussion regarding suicide assessment and the related protocols followed.

Ms. Brashear noted that:

- •Although up to 80 percent of suicides in Nevada involve young to middle-aged men, there is an increase in the

rate of suicide among seniors; however the senior rate is no higher than in other parts of the nation.

- •The funding provided during the 1999 Session ($98,000 for each year of the biennium) will allow the center to hire additional staff, will pay for the recent survey (see Exhibit C), and about one-third will be spent on a public awareness campaign in the Las Vegas area.

- •The University of Nevada, Reno (UNR), School of Medicine, through a research group located at the Las Vegas campus, is doing a five-state, long-term study of people who have survived suicide attempts, in an effort to determine the causes of suicide. A Crisis Call Center board member assisted in obtaining the funding for that project and is participating in related committees.
- •The Crisis Call Center is closely linked to UNR. The university provides the building and pays utilities and other expenses, in exchange for center personnel teaching a course on campus.

Ms. Allen, responding to further questions of the members, stated that:

- •The center is not involved in follow-up activities with those who call in.

- •The $200,000 grant for the statewide suicide hotline has two purposes. It provides funding for: (1) the new toll-free telephone number that serves the Las Vegas area, which is and will be kept separate from those services provided previously; and (2) hiring additional support staff and volunteers, if needed.

- •A Community Computer Services Network (CCSN) is also being developed, and at some time the CCSN may join with the Silver Link in Las Vegas to provide referrals for callers.

- •Although some work is currently underway, the full public awareness program for eastern and southern Nevada is scheduled to begin in January 2000.

Ms. Brashear noted that about half of the center's budget of approximately $422,000 comes from federal pass-through money, as a result of 13 separate grants.

Senator Washington pointed out that one of the strongest advocates for suicide prevention money during the 1999 Session was Senator Ann O'Connell from Las Vegas. He wanted to publicly thank her for her efforts in this regard.

Responding to a request from Chairman Koivisto, Ms. Brashear said that she would provide copies of the final survey report, referred to in Exhibit C, to the committee members. In addition, she will also submit copies of the monthly reports to the Mental Health Planning Commission and the reports due to that body in July 2000, January 2001, and July 2001.

DISCUSSION CONCERNING RESIDENTIAL CARE PLACEMENTS AT DEVEREUX CLEO WALLACE CENTERS

Debra McEwan, Director, Social Services Program, Moapa Paiute Band, Moapa, Nevada, was not present to testify at this meeting.

Janice A. Wright

Janice A. Wright, Administrator, Division of Health Care Financing and Policy, Nevada's Department of Human Resources (DHR), provided a brief history of the issues and activities concerning the relationship between the state's Medicaid provider program and the two Cleo Wallace Centers in Colorado Springs (a satellite facility) and Westminster (the main hospital), Colorado. These facilities are licensed as one facility that recently became the "Devereux Cleo Wallace Centers."

She noted that the facilities:

- •Have been an approved provider since 1992 and, since that time, have had between three and five Nevada children housed there at any particular time;
- •Have served as a primary out-of-state, in-patient psychiatric service that providers use for Medicaid eligible clients, and they are also used by the Division of Child and Family Services (DCFS), DHR, for children and adolescents who are in DCFS custody or in parental custody;
- •Are considered by Medicaid as "one of the better and more comprehensive" mental health facilities used for children who are suffering from emotional, mental, and psychological pathologies and disorders; and
- •Have been used for Nevada's most difficult and hard-to-place children, particularly those who are a threat to themselves or others.

Ms. Wright noted that two issues surround the centers. First, whether children have been approved to be served there and whether they have received the appropriate level of care in the appropriate unit of the facility. Those issues have been investigated by the Medicaid Fraud Control Unit of the Colorado Attorney General's Office. Second, whether the children have been approved for services at the Cleo Wallace Centers and whether they have been safe (are not in danger of any kind) and are receiving adequate treatment. This also has been investigated by Colorado's Division of Child Care Licensing.

With respect to the first issue, most commonly, in a psychiatric hospital for children, one acute unit is designated for the treatment of patients who have severe psychiatric conditions, i.e., being homicidal, suicidal, and so forth. The residential treatment center (RTC) unit is for patients who no longer exhibit those behaviors or who may have been stabilized through medication or therapy, but who still require intensive, long-term care and treatment.

As a result of a claim filed by an ex-administrator of the Cleo Wallace Centers approximately two years ago, the Colorado Medicaid Fraud Control Unit investigated and rendered a decision on whether the clients treated at the centers, regardless of payment source, were receiving authorized services. Prior to 1998, some patients were placed in the acute unit when beds were not available in the RTC and after verbal approval was received from the state of Colorado. In that state, acute units, which must be locked or secured, are licensed separately from RTC units, which cannot be locked. Therefore, even though the center alleged that children received appropriate care in the acute unit, the state's Medicaid Fraud Control Unit ruled that Cleo Wallace violated some patients' rights between 1995 and 1998 because they were placed in a secured acute unit rather than in an RTC environment. In Nevada, however, there is no separate licensing requirement for psychiatric acute and RTC units; consequently, this would be a nonissue since they all have to be locked.

Subsequent to Colorado's Attorney General determining that the center violated patients' rights, Nevada's Attorney General found no justification for terminating this state's contract with Cleo Wallace or to remove its children from the facility. Medicaid's sister agency, the DCFS, agreed, and it is the contention of both entities that in the event the center is ever charged with and convicted of criminal wrong doing, Medicaid would terminate its contractual relationship with the Cleo Wallace Centers. If that were to occur, all Medicaid-eligible children would be removed from the facility.

With respect to the second issue, Ms. Wright commented that she was sorry that Ms. McEwan was not present. She explained that Ms. McEwan, in her capacity as director of social services for the Moapa Paiute Band, removed three of the band's Medicaid-eligible children from the Cleo Wallace Centers on February 19, 1998. She immediately placed those children in Cedar Springs Center (also in Colorado), a non-Nevada psychiatric facility that had not been approved as a Medicaid provider. Subsequently, when the band sought reimbursement of the costs of care for these three children, Medicaid refused payment pursuant to existing regulation. That refusal was based on the grounds that Ms. McEwan unilaterally made the decision to remove the children without prior authorization by Medicaid.

Although Medicaid was under no obligation to reimburse either a non-Medicaid contracted service provider or services that were prior authorized, Medicaid did agree to research the case. In the event its findings were consistent with Ms.

McEwan's claim that the children were in danger at the time they were removed from the facility, then Medicaid would have deemed the removal "an emergency," and under those circumstances would have reimbursed Cedar Springs Center.

In an attempt to verify Ms. McEwan's claim, Nevada Medicaid contacted Marilyn Bernier, supervisor of the Colorado Division of Emergency Care, who was unable to substantiate the claim that the facility was unsafe or that the children were in life-threatening danger. Ms. McEwan then filed a formal complaint against Cleo Wallace Centers that alleged 16 deficiencies. The state of Colorado investigated the complaint and found that 15 of the alleged Cleo Wallace deficiencies were unfounded or unsubstantiated. For the one deficiency that was found valid, Cleo Wallace submitted a plan of corrective action to Ms. Bernier, which was accepted and approved by that state.

Respecting the fact that the Moapa Paiute Band was not satisfied with Cleo Wallace and had not had any contact with the center for almost two years, Nevada Medicaid worked to locate, contract with, and train on Medicaid policy and requirements, a native American RTC program. That program is called VistaCare, which is located in Arizona. When VistaCare was made a Medicaid provider, Medicaid staff advised Ms. McEwan that this facility was a qualified replacement for the Cleo Wallace Centers.

Ms. Wright reiterated that, as a matter of policy, if at any time, Nevada Medicaid were to receive notice from Colorado's state Division of Child Care Licensing that it has removed, revoked, suspended, or terminated Cleo Wallace Centers' license, or in any way determined that the children placed in that facility are in danger, Nevada Medicaid will terminate its contract with Cleo Wallace and remove any children placed there.

Ms. Wright concluded that Medicaid recognizes the seriousness of these issues. Nevada Medicaid has conveyed to the facility its concerns and its expectations as to the safety of Nevada's children.

Steve Shaw

Steve Shaw, Administrator, DCFS, DHR, speaking from prepared remarks (see Exhibit D) explained that Nevada:

- •Has contracted with Cleo Wallace, not Devereux Cleo Wallace, since April 1991;
- •Placed a total of 37 children at Cleo Wallace from April 1991 until today;
- •Has decreased its out-of-state commitments in the last three to four years, from a high of 150 to 19 today;

- •As a matter of policy, tries to treat Nevada's children in state;
- •Has been very successful at bringing many children back into Nevada and developing appropriate resources for them; and
- •Semi-annually monitors the care and treatment of children who are in out-of-state facilities, through face-to-face visits at the treatment program site.

Mr. Shaw noted that reviews ordinarily include an examination of the patient's treatment, discharge plans, living conditions, and treatment methodologies. Further, it includes reviews of contract compliance, face-to-face interviews with the child, the child's therapist, child-care workers, program managers, and program administrators, a paper review of the provider's most recent licensing visit, and any national accreditation reports that may exist. He indicated that the most recent review or visit was:

- •Not the result of a committee or other outside request;
- •The result of routine, on-site monitoring requirements; and
- •Conducted within the last two weeks.

According to Devereux Cleo Wallace's internal reports, there had been an excessive number of physical management interventions or "takedowns." It was not too high according to any licensing standards or any joint accreditation standards; it was too high according to facility guidelines or goals, and the facility has planned extensive training to reduce the incidence of these interventions.

Mr. Shaw noted that no Nevada child has ever suffered an injury as a result of intervention practices at Cleo Wallace. He also explained that:

- •The Devereux Foundation, which in September 1999 affiliated with Cleo Wallace Center, is the oldest and most experienced provider of residential treatment for children.
- •The foundation has provided significant, in-house training program evaluation that is designed to decrease the physical management and interventions to acceptable levels.

- •The physical management of seriously emotionally disturbed children is a necessary tool of last resort for the effective and safe treatment of those children, which is used in Nevada's own programs, hopefully at acceptable levels.

- •A strength of any program is self criticism.

- •The division's experience with Devereux Cleo Wallace centers has been and is "very positive."

- •The continuing care that is provided to the division's children at Cleo Wallace is a valuable clinical resource that would be difficult to replace.

Responding to questions from the members, Mr. Shaw said:

- •Placing children who are supposed to receive RTC services into an acute unit does not coincide with our state's current policy and best-practices goal of placing kids in the least restrictive, appropriate environment.

- •Cleo Wallace admitted that deficiency, which happened a few years ago; however, in Nevada facilities, they are jointly licensed. At the same time, Nevada does not place a child in an acute building unless it is needed.

Ms. Wright, further discussing Ms. McEwan's actions, explained that, according to agency files, Ms. McEwan:

- •Indicated she was concerned about the children's safety;

- •Removed them in the middle of the night, without contacting Nevada Medicaid in advance; and
- •Placed them in a facility that was not an approved Medicaid provider facility.

Further, the proper protocol for moving children from an approved Medicaid facility includes:

- •The individual who has any concern contacting the Nevada Medicaid office to explain the circumstances and situation.

- •If it is determined that an emergency situation exists, the office will "prior authorize" immediate (same day) removal of the children and placement in a Nevada Medicaid approved facility.

Ms. Wright added that:

- •In her view, Nevada Medicaid would have worked with Ms. McEwan had she contacted the office; however, that information was not forthcoming until after the children were removed and placed in a different facility. No written notice was received, and Ms. McEwan telephoned the office to complain about the Cleo Wallace Center after the incident occurred. Nevada Medicaid did not have the opportunity to know about her concerns in advance. She promised to provide a chronology of the incident to members of the committee.

- •Cedar Springs is now a Nevada Medicaid approved facility, she added, and it provides current billing claims, and Nevada pays for appropriate Medicaid approved services. At the time Ms. McEwan placed those children in that facility, however, it had not been certified by Nevada Medicaid as an approved facility and payment could not be authorized. The division explained to Ms. McEwan that Cedar Springs was not under contract as a Nevada Medicaid provider. Therefore, there was no ability to provide reimbursement to a facility that had no contractual relationship with Nevada Medicaid.

- •Nevada immediately started to work with Cedar Springs Center to make sure that it would become a Nevada Medicaid facility. Cedar Springs is currently under contract and being paid as a Nevada Medicaid provider. During the period in question, however, the facility did not have an agreement with Nevada Medicaid, and the program was prohibited from reimbursing it for services that were not authorized under a contractual agreement.

- •Whether or not Cedar Springs was ever reimbursed by the Moapa Paiute Band is unknown.

Senator Washington asked Ms. Wright to provide the total amount of Cedar Springs Center's claim for services for those three children. Chairman Koivisto explained that, in her view, that is not an issue for the committee to deal with, it is between the Moapa Paiute Band and Cedar Springs. Ms. Wright explained that Nevada Medicaid cannot reimburse Cedar Springs for a period of time when it was not a Medicaid provider. Ms. Wright noted that she is not familiar with any discussion of this topic in legislative money committees during the last session. Chairman Koivisto asked staff to contact Ms. McEwan to obtain more specific information.

Senator Rawson pointed out that:

- •The Legislature established some of the Medicaid rules in question because a state cannot afford to have every person who has a disagreement with a provider pull patients out, make their own arrangements, and then expect Medicaid to pay for those services.

- •Some kind of order must be maintained by the responsible oversight agency.

- •An agency must have rules, Nevada Medicaid has made its ruling, and it seems like it stops there.

- •Nevada had procedures in place to be able to deal with such situations, but the agency was never consulted in the matter.

In his view, Nevada Medicaid has no obligation, legally or morally, to pay Cedar Springs Center for services that were unauthorized in this instance.

Jerry Clark

Jerry Clark, inspector for Nevada Medicaid, DCFS, explained that he performed an audit of Devereux Cleo Wallace Centers in Colorado on November 23, 1999. That visit included:

- •Talking with each child, as the consumer, asking the child how he was treated; ensuring that the child knows what his treatment plan is, and discussing how staff treats him;

- •Examining each child's treatment plan by having a therapist justify each treatment plan as being appropriate for the child, and assessing whether the child's discharge plan is appropriate;

- •Speaking to program managers about their program structure, i.e., determining the types of techniques that are used to control the children;

- •Talking to administrators about policy and procedure and how those are working, discussing contract stipulations that they have with us, and determining their compliance with the stipulations;

- •Looking at the restraint record for the facility as a whole and for each DCFS child in placement, to determine if a child has been restrained. If a child has been restrained, determining the cause, the outcome, and its appropriateness; and

- •Examining how often children are restrained. If those numbers go up, more questions are asked to find out why that is happening.

Mr. Clark noted that Cleo Wallace has always been open about providing information during these inspections, disclosing its statistics, and instituting corrective action plans when necessary.

In addition to the above, the following are also a part of the review process:

- •Looking at the licensing reports from Colorado to see what concerns they have; and
- •Reviewing any Joint Commission on Accreditation of Healthcare Organizations (JCAHO) report received during the previous six months, including following up on correction plans.

Mr. Clark said that during the process of this review, between April 1991 and December 14, 1999, 37 children have been place at Cleo Wallace. During that time, some of Nevada's children have been physically restrained at the facility; however, none have suffered any serious injuries. Therefore, the issue of how we manage children physically is an issue for Cleo Wallace, but it has not resulted in any consequences for the children Nevada has placed there.

Responding to questions posed by Mr. Shaw, Mr. Clark explained that Cleo Wallace:

- •Has treated Nevada's children well;
- •Was, in fact, one of the first contractors to accept Nevada's contract stipulation that requires Cleo Wallace to fly, at its own expense, the families of the children to the Denver campus once each quarter to participate in treatment so long as their children are there;
- •Has spent more money on those family visits than any other contractor, and the visits have worked well to keep kids in touch with their families;
- •Has two campuses, which include a hospital that may be used if a child needs acute care, and an RTC that treats a wide variety of children;
- •Is an easy organization with which to work;
- •Is always child centered and family focused, which is not the case with every program; and
- •Utilizes locks on the doors of the acute unit at Cleo Wallace that are delayed locks, which open within 15 seconds of a person pushing the bar and, therefore, they are not really what "you would classify or define as restraints."

Mr. Clark added that, in his opinion, if Nevada were no longer able to send its children to Cleo Wallace for treatment, it would be a serious loss because of the scope and quality of the actual care it provides. He said he has been pleased with patient outcomes. To disturb that working relationship would be a loss for the children and the treatment that they can receive at Cleo Wallace.

Senator Washington explained that he is not concerned about the competency of Cleo Wallace Centers because its record speaks for itself. Apparently, Ms. McEwan made a decision, based on her own information and at her own recourse, to move these children without notifying Nevada Medicaid or DCFS. The issue, therefore, is whether the state or the Moapa Paiute Band should pay for unauthorized placement and the resulting services.

Chairman Koivisto noted her concern about using restraints, particularly in view of legislation adopted in the last legislative session that addressed the use of aversive techniques. She suggested including this item on a future agenda to keep the committee members up to date on this topic.

Robert Kreider

Robert Kreider, Chairman of the Board of Devereux Cleo Wallace and Chief Financial Officer of the Devereux Foundation, Villanova, Pennsylvania, speaking from his prepared remarks (see Exhibit E), noted that the Devereux Foundation:

- •Is an 88-year-old organization, which is the largest nonprofit provider of mental health and mental retardation services in the country;
- •Cares for more than 2,500 people of all ages in residential facilities in 13 states and the District of Columbia;
- •Cares for more than 15,000 individuals in outpatient, day treatment, and school programs at any one time;
- •Serves a wide range of ages, more than half of whom are children and adolescents with significant mental health problems; and
- •Is a national leader in the care of autistic children and is currently working in conjunction with the University of California at Davis to develop a comprehensive program for autism.

Referring to Devereux's most recent annual report, which is titled "Devereux, Creating Communities of Hope" (see Exhibit F), Mr. Kreider explained that additional corporate information is available on the company's web site www.devereux.org. In addition, he described:

- •Devereux's desire to merge with Cleo Wallace, which was influenced by Cleo Wallace's "tremendous reputation among customers across the country";

- •The due diligence efforts undertaken to investigate the feasibility of that merger, including among other things the review of a pending "qui tam" suit, in which the Federal Government declined to join and which Devereux had perceived as a "nuisance suit"; and

- •The completion of the acquisition on September 1, 1999, at which time Devereux became the controlling member of the newly formed corporation and instituted its quality management structure.

Mr. Kreider comprehensively described that management structure, which encompasses:

- •Research and training divisions;

- •Enhanced standards of care;

- •Technical support;

- •Systems of accountability and ethical assessment; and

- •A best-practice service bureau, which recognizes outstanding programs and practices across the organization.

He described the duties of the regional quality improvement director for the facilities. He further indicated that Helene Bartlett, who is responsible for evaluating these Cleo Wallace Centers, has been pleased with the eagerness displayed by Cleo Wallace employees to adapt to Devereux's more structured quality management and training programs.

During an annual analysis of all locations, the performance of each center is evaluated against Devereux's standards for:

- •Clinical service delivery;

- •Educational and vocational programs;

- •Operations and administration;
- •Training; and
- •Incorporation of best practices.

If gaps in performance are identified, a plan of correction is required and results are checked during subsequent self-assessment visits to ensure high-quality service. He concluded that such due diligence activities were an integral part of Devereux's decision making process when the purchase of Cleo Wallace was considered.

Michael Montgomery

Michael Montgomery, Executive Director, Devereux Cleo Wallace, Denver, Colorado, noted that he is a clinical social worker with 20 years' experience in Colorado. Responding to questions from the members, he explained that Cleo Wallace Centers:

- •Made a voluntary agreement with the state of Nebraska, based on that state's requested nighttime staffing ratios, which were more stringent than company policy and other states' requirements, to remove Nebraska's patients from the facility;
- •Will determine whether it is possible, from a financial and policy perspective, to establish a special unit that can accommodate Nebraska's needs and revised standards; and
- •Anticipates that such an accommodation may provide for renewed services sometime in early 2000.

Commenting on the issue of client restraint, Mr. Montgomery said that "restraint" is typically defined in three ways:

- •Chemical, through the administration of medications;
- •Physical, hands-on activities; or
- •Mechanical procedures, such as tie-downs or locking devices.

Neither Devereux nor Cleo Wallace use chemical restraints in their facilities. Mechanical procedures are employed when patients are dangerous to themselves or others, and that method is used most infrequently because it is an extremely aggressive intervention that they try to avoid. Therefore, the issue being discussed today is physical management. Physical management, as it is used by Cleo Wallace Center staff:

- •Is applied in accordance with a 21-hour, nationally certified training method to manage behavior that is dangerous to the patient or someone else; and

- •Is specific in its application, i.e., how many people are used, and how and where to hold the patient in a way that is as safe and therapeutic as possible under the given circumstances.

In addition, most children being served at the centers are never restrained. Statistically, a very small percentage of children, usually those who suffer from aggression or self-destructive behaviors as part of their clinical profile, account for the vast majority of the physical managements that occur. The staff would prefer never to use hands-on procedures because they can be dangerous for all concerned; however, there are circumstances under which such methods are unavoidable. As previously noted by Mr. Shaw and Mr. Clark, Nevada refers children to the center for whom no other provider is appropriate, and some of those children display behavior that is dangerous to themselves and others. For those few children, physical restraint is appropriate under certain circumstances.

Cleo Wallace recognizes that the number of physical restraint incidents that have occurred is higher than it would prefer, and it has a number of options:

- •It can change its admission criteria and not admit children for whom those interventions are occasionally necessary; or

- •It can adopt innovative training programs, which Mr. Montgomery asserted is part of the reason it chose to merge with Devereux, in an effort to avoid the situations where staff members (70 percent of whom are female) have historically been compelled to use a hands-on procedure.

In those programs, staff can learn the difference between issues of compliance and safety. Hands-on procedures should not be used to elicit compliance with a directive or order from staff. They should only be used to protect a child's safety.

Regarding the removal of the three children by Ms. McEwan, Mr. Montgomery said that, according to his recollection, approximately two months prior to the removal of those children, the former administrator of the Colorado Springs campus, who had been Ms. McEwan's primary contact with the facility, resigned his position and subsequently filed the

qui tam action against the company. In his view, that relationship had been important to both the administrator and Ms. McEwan. His resignation caused her some measure of concern and, although Cleo Wallace thought those concerns were being addressed at the time, staff was surprised when Ms. McEwan showed up late one evening with a reporter and removed the children. She indicated to Mr. Montgomery that she was angry that the administrator was no longer with Cleo Wallace, even though she had been satisfied with the care provided to that time. Mr. Montgomery said that although Cedar Springs is a competitive facility nearby, both providers share some employees and some patients on occasion. In conclusion, he assured the members that Devereux Cleo Wallace Centers would work to ensure that Nevada's children that are referred to their facilities would receive the best care that can be delivered in light of the complexity of these cases.

Chairman Koivisto requested staff to contact Ms. McEwan and ask her to appear at a future meeting.

DISCUSSION CONCERNING THE

COST OF HEALTH INSURANCE PREMIUMS

FOR SMALL- AND MEDIUM-SIZED EMPLOYERS

Jeanette K. Belz

Jeanette K. Belz, Director, Government Relations, Wadhams & Akridge, representing the Nevada Association of Health Underwriters, introduced witnesses who discussed the challenges of providing health care coverage for their employees.

Jeff Paine

Jeff Paine, owner of the Gold 'N Silver Inn, Reno, provided written remarks (see Exhibit G), which emphasized the following points:

- •The Gold 'N Silver has been in business for more than 40 years and employs approximately 50 people, for whom health insurance has been provided by the company for the last 20 years;

•Providing health insurance for employees and making it available for dependents has been an incentive to attract and keep long-term, loyal workers;

- •Recent changes in the law, which have caused the company to be viewed by the state as a "small employer," have drastically affected the employees that qualify for these benefits, and the cost of providing insurance has increased dramatically;

- •Large employers are not mandated to cover employees based on the same criteria as small employers, and they enjoy lower premiums overall, which results in "a gross injustice to small- and medium-sized employers . . . if not . . . outright discrimination" against smaller companies;

- •Health insurance premiums for his company have increased approximately 20 percent over the past three years, and the company estimates that many employees will drop health insurance coverage if they are required to pay 50 percent of the premium;

- •Those employees who have indicated that they would choose not to carry insurance if they were required to pay a portion of their premiums have indicated that they would rather go to the hospital, which must serve them in an emergency, and let the facility "write off" the bill; and

- •Legislation that would, perhaps, require all employers to "provide" insurance, rather than "pay for" health insurance coverage for their employees, might be a possible solution.

Mr. Paine believes that if his employees choose not to purchase the health insurance he offers, it will lead to increased costs of care for everyone. He spoke in opposition to government mandated policies for private businesses, especially those that do not provide for business to be treated the same. He concluded that making policies impinge on specific types and sizes of business will have a serious impact on both the business community and on society in general.

Marc Avila

Marc Avila, insurance broker for the Gold 'N Silver, explained that the recent statutory change requires "small employers" to insure all employees who work 30 or more hours per week. On the other hand, some of the company's direct competitors who employ more than 50 people have only to insure those who work 40 hours or more. Therefore, companies that have "just under" 50 employees, like the Gold 'N Silver, are forced to carry a more expensive benefit package, thereby being unfairly disadvantaged. Mr. Avila further explained that:

- •Many carriers have found it more difficult to participate in Nevada due to these legislative mandates;

- •The number of carriers available to a "small company"in this state 15 years ago was about 30, and that number currently stands at no more than seven insurers; and

- •One of the reasons that carriers have cited for leaving Nevada's market is the rising number of mandated benefits with which they must comply.

A brief discussion followed regarding Mr. Paine's fluctuating personnel levels, his interaction with the state's Division of Insurance, Department of Business and Industry, and the difficulty that he has experienced in getting insurers to bid on his health insurance needs. Ms. Belz noted that the Division of Insurance had been trying to assist in clarifying the definition of "small employer," but it seems difficult to do. Chairman Koivisto asked Mr. Paine to provide staff with copies of correspondence related to his experience.

Doug Moir

Doug Moir, Controller, Sportif USA, speaking from written testimony (see Exhibit H), explained that Sportif:

- •Employs approximately 50 people, who manufacture outdoor clothing, most of whom receive a full benefit package;

- •Is involved in a highly competitive, low-profit industry that does not allow for passing increased costs on to the public in the form of higher wholesale or retail prices;

- •Has found it difficult to grow and achieve its goal as its profits are constrained;

- •Has developed a progressive benefits package in an attempt to attract and keep talented employees; and

- •Despite implementing innovative efforts, has struggled to contain costs related to health insurance benefits, which is the largest personnel cost component outside of wages.

Mr. Moir described the company's experience with health insurance costs, including:

- •An average premium increase of 16 percent annually over the last five years, which would have been even higher had employees not agreed to reductions in coverage;

- •A 40 percent increase in premiums for the most recent renewal, and most employees were not happy with the provider or the level of services purchased;
- •Double-digit annual increases precluding consideration of coverage for spouses or dependents;
- •Sacrifices by employees in terms of increased co-payments and deductibles and reduced pharmaceutical coverage;
- •The company agreeing to pay for some out-of-pocket medical expenses and eliminating its plan to enhance its 401K matching plan; and
- •Mandated coverage has removed the company's flexibility to meet employee needs at a reasonable cost.

Mr. Moir said that, because of increasing health insurance costs, Sportif is "struggling" to attract good employees and attain its corporate goals. Likewise, if Nevada's corporate citizens continue to struggle economically, so will the state.

Gaylord Rodeman

Gaylord Rodeman, owner of J&M Windows in Reno, agreeing with many of the difficulties faced by Mr. Paine and Mr. Moir, said that he had reduced benefits to his employees. Many of his employees indicated that they dropped health insurance coverage when the choice was either to "buy insurance or feed the family."

Chairman Koivisto questioned whether small companies had considered forming cooperatives to negotiate with insurers for health care insurance. Ms. Belz said that had been discussed but it is still a fledgling process. Also being reviewed is how other states are addressing this challenge. The issue of access is also being discussed in other legislative committees this interim.

A brief discussion of the number of insurance policy mandates followed.

Misty Grimmer

Misty Grimmer, on behalf of Robert Ostrovsky, who represents Nevadans for Affordable Health Care (NAHC), read Mr. Ostrovsky's testimony (see Exhibit I). Ms. Grimmer noted:

- •NAHC is an organization dedicated to the belief that health care should be affordable, accessible, and of high quality.
- •Greater flexibility and innovation should be encouraged and government intervention should be minimized.

Referring to Exhibit I, she also reviewed the potential costs and effects of proposed changes in health care delivery, including:

- •An exacerbation of the number of uninsured individuals nationwide;
- •The anticipated number of additional uninsured individuals in Nevada that might result from premium increases;
- •The change in wages, which may be reduced to offset premium increases due to mandated benefits and coverage;
- •Anticipated increases in health insurance costs brought about by rising medical and pharmaceutical inflationary trends;
- •The correlation between higher incomes and a higher rate of health insurance coverage;
- •The expansion, between World War II and the 1980s, of not only the scope of coverage but also the number of people who benefitted from employment-based health insurance;
- •The shift triggered by inflated health care costs, i.e., from expansion of coverage toward cost containment and the choice by some employers not to offer health care coverage as a benefit; and
- •The forecast that by 2008, 55 million Americans will be uninsured, or approximately 22 percent of the non-elderly.

Ms. Grimmer also reviewed the factors that affect an individual's health insurance coverage choices and those that affect an employer's decision to provide coverage. She noted that, while medium- and small- sized employers' premiums rose between 4.7 percent and 6.95 percent, respectively, larger employers' premiums rose between 3.1 percent and 4.2 percent, and self-insured employers' rose between 3.1 percent and 5.1 percent, depending on the type of insurer, e.g., conventional, preferred provider organization (PPO), or heath maintenance organization (HMO). At the same time:

- •The number of employers who fully pay workers' premiums has diminished;

- •Fewer employees elect to be insured when they earn less than $20,000 annually and when they are required to pay a portion or all of the premium; and

- •The percentage of workers in service sector and other lower-paying positions who are covered by health insurance may be higher in Nevada than in some other states, however, due to union-sponsored plans being mandatory; and

- • Premiums in the year 2000 are expected to increase as much as 20 percent, which may cause the number of uninsured persons in Nevada to increase.

Responding to questions from the members, Ms. Grimmer noted that when faced with paying minor out-of-pocket health insurance premiums, a significant number of employees choose not to participate in health care plans offered by their employers. Further, if workers decline the benefit, thereby theoretically saving the employer, the amount of money that would have been paid for the insurance premium is not passed through directly to the worker in the form of higher wages. According to some members of NAHC, if premium savings were passed through to employees, it is likely that they would see the money as "just a raise," rather than using that money to purchase private health care coverage. Chairman Koivisto noted that, whether an employer paid the premiums or passed the savings through to employees, in either case, the employer would be responsible for increased costs.

PRESENTATION CONCERNING

THE IMPLEMENTATION OF SENATE BILL 519

(CHAPTER 531, *STATUTES OF NEVADA 1999*)

[THIS MEASURE AUTHORIZES CERTAIN PERSONS TO POSSESS AND ADMINISTER CONTROLLED SUBSTANCES AND DANGEROUS DRUGS.]

Keith W. Macdonald

Keith W. Macdonald, Executive Secretary, State Board of Pharmacy, provided a copy of *Nevada Administrative Code* (NAC) Chapter 639, "Immunizations or Vaccinations", draft regulations (see Exhibit J), which was developed and approved by the board. He noted that the development of these proposed regulations, pursuant to S.B. 519 (Chapter 531,

Statutes of Nevada 1999) has been slow and deliberate.

He explained that the new regulations include:

- •Certain requirements for pharmacist certification, noting that 10 to 12 pharmacists have been certified in Las Vegas so far, and it is expected that those people will train others who will become certified within ensuing months;
- •Requirements for notification and record keeping procedures that will keep county and state health officers abreast of immunization activities; and
- •Protocols and oversight for pharmacists who provide immunizations allowed by the new law, which were drafted in cooperation with the Nevada State Board of Medical Examiners.

REPORT CONCERNING "PILL SPLITTING"

Keith W. Macdonald also provided correspondence and other information on pill splitting. A number of letters and other information that describe the difficulties faced and efficacy concerns related to pill splitting are included in Exhibit K, which contains letters from Joel Davidson, M.D.; Joseph P. Hardy, M.D.; Tom LaMure; Sandra Sherlock; Patricia van Betten; Arnold Wax, M.D.; and Bea Webb. Articles submitted were "Pill-splitting," *Pharmacist's Letter*, October 1999; and "Oral Solid Dosage Forms That Should Not Be Crushed: 1996, Revision," by John F. Mitchell, PharmD, as reported in *Hospital Pharmacy*, 1996. Also see Exhibit A, pages VII-3 and VII-4, for a newspaper article on this issue. Mr. Macdonald, referring to Exhibit K, explained that:

- •Some HMOs, in an effort to contain the cost of pharmaceuticals, have directed pharmacies to split pills when filling prescriptions issued by authorized providers, regardless of the directions written;
- •If insurers' directions for dispensing medications are not followed by a pharmacist, often payment is withheld;
- •Concern has been voiced by health care professionals, hospitals, and the public regarding the arbitrary requirement of pharmacies to provide doses of less than a full tablet;
- •Many people who are physically disabled or elderly experience difficulty when trying to split medications;

- •Although some HMOs and other insurance providers allow for a patient to request exact dosage administration, obtaining approval can be a time-consuming undertaking that can delay the prompt dispensing of medication;

- •The consistency, formulation, shape, and titration characteristics of some drugs make them especially subject to improper dosage when split;

- •The board has expressed its concern regarding pill splitting; however, it has no regulatory control or effect on insurance companies nor can it request they change their policies on the issue; and

- •The board requested that these concerns be expressed to this committee and the Legislature because pharmacists are faced with a serious dilemma.

Mr. Macdonald asked for further discussion of this issue on its merits, either in this or a legislative forum. He noted that the board would have unanimously passed a regulation to address pill-splitting practices (see Exhibit A, page VII-1); however, members of the board recognized that such a regulation would have had no force or effect against the industries that are paying for drugs or the practitioners who are prescribing them.

Chairman Koivisto suggested that pharmacists, physicians, and insurance providers work together to bring a workable solution to this committee. Mr. Macdonald concurred with this suggestion. He noted that there must be a reasonable basis for the splitting of medications, and questions regarding shelf life and the efficacy of pharmacological care must be an integral part of the discussion.

Chairman Koivisto also requested that information regarding other states' practices in this area be submitted to the members. Mr. Macdonald stated he would attempt to compile that information with the assistance of some national sources.

Guy Perkins

Guy Perkins, Chief Insurance Examiner for the Life and Health Section, Division of Insurance, Nevada's Department of Business and Industry, representing Alice A. Molasky-Arman, Commissioner of Insurance, prior to his discussion of this agenda item, provided the "Calendar Year 1998 Gross Direct Premiums Written" report. See Exhibit L.

Mr. Perkins explained that the Division of Insurance:

- •Would approach a complaint about pill splitting by referencing NRS 695G.240, which currently prohibits a managed care organization (MCO) from interfering with the communications between a medical provider and a patient;
- •Regards pill splitting as a matter between the provider and patient, unless interference occurs; and
- •Has not otherwise taken a position on this matter.

Based on his conversations with the division's seven consumer officers, no complaints have been received by the division on this issue, nor has the consumer assistance representative at the Governor's office. Of the HMOs doing business in Nevada, only one has an official pill-splitting policy, and it understands that if its policy interferes with the wishes of the provider under NRS 695G.240, the providers choice must be honored and prior authorization granted.

Tom Wood

Tom Wood, representing the Pharmaceutical Research Manufacturers of America and Wyeth/Ayerst Laboratories, noted that manufacturers are concerned about the liability aspect of pill splitting and its potential impact on efficacy and titration. In his view:

- •The State Board of Pharmacy is not so much concerned about liability but, rather, the welfare of patients.
- •This issue is not limited to Nevada but also has been experienced elsewhere.
- •Although most HMOs, managed care organizations, and other insurers are not trying to compromise the patient on these issues, there should be some legislative policy forthcoming on this topic, as suggested by Mr. Macdonald.

Mr. Macdonald interjected that, if the state were to limit or otherwise set policy on pill splitting, there are other agencies that engage in the practice over which the state has no control, e.g., the Veterans Administration and American Health Care, which is located in Sacramento, California.

Jim Wadhams

Jim Wadhams, representing Health Plan of Nevada, one of the entities that has a program that allows for pill splitting, noted that, in review of the pharmacy laws, pharmacists are required to fill prescriptions as presented to them by authorized prescribing practitioners. Under current law, if a pharmacist has questions regarding a written prescription, he is required to contact the practitioner. Those practitioners should be represented in any discussion of a solution to the debate on this issue.

To his knowledge, none of the prescriptions that have generated questions have come from anyone other than an authorized practitioner. When medication comes in a form that lends itself to obtaining two doses for the price of one, there is an economic benefit that has been taken advantage of over the years. The details of titration and chemical composition should probably be examined on a larger basis, perhaps in concert with the State Board of Health, on which a broad base of practitioners serve.

For those activities that violate current state law, there are already bodies to mete out appropriate sanctions. To the extent the state wants to review pill splitting from a policy perspective, the idea of bringing the stakeholders together is an appropriate approach to ensure that the public safety is not compromised. In conclusion, Mr. Wadhams said that he would provide whatever information he obtains on this issue to committee staff for inclusion in a future meeting.

Chairman Koivisto said pill splitting would be revisited during a future meeting of the committee. Mr. Macdonald noted that whoever is asked to lead the effort to resolve this issue should have statewide authority, e.g., the State Board of Health. The pharmacy board has limited authority, he concluded. Ms. Koivisto mentioned that recently a news piece was done that recommended that, as a cost-saving measure, senior citizens consider splitting pills.

FOLLOW-UP REPORT CONCERNING

NEVADA CHECK-UP PROGRAM

(CHILDREN'S HEALTH INSURANCE PROGRAM),

INCLUDING A DISCUSSION OF THE NUMBER OF

UNINSURED CHILDREN IN THE STATE

Janice A. Wright, Administrator, DHCFP, provided follow-up information requested by the committee. See Exhibit A, pages VIII-1 through VIII-5 and pages VIII-9 through VIII-174, for a detailed discussion of:

- •The elapsed time between application (or request for information) and a response being generated by Nevada Check-Up Program staff, which was 5 days on average when complete applications were submitted, compared with 30 days for the Free/Reduced Lunch Program;

- •Eligibility determinations, which are usually completed within 15 days and within 30 days when additional information is required due to incomplete applications;

- •The source and number of Check-Up applications received between October 1, 1998, and October 1, 1999, of which there were more than 200,000 in total;

- •The application process, which has forms available in English and Spanish and requires copies of the applicant's two most recent tax returns;

- •Grievance procedures, including copies of the applicable sections of Chapter XXXI of the Medicaid Services Manual, which are identical to any other Medicaid complaint process;

- •Coordination of efforts with the tribal health clinics and the Native American community to enroll children, of which 170 have been signed up, and the test pilot project that is being developed in conjunction with the Yerington Paiute Tribe; and

- •The waiver of Check-Up premium cost-sharing for Native American children eligible for the program.

Nevada Check-Up's enrollment has been extremely successful, reflecting a higher percentage of participation, when compared with other states' experiences. She also noted that a series of the reports included in Exhibit A relate to uninsured populations in the state, and she said members could review that section at their convenience.

INFORMATIONAL PRESENTATION CONCERNING

MEDICAID ISSUES AFFECTING PERSONS WHO ARE

AGED AND DISABLED IN NEVADA

Chairman Koivisto asked Ms. Wright to comment on the Personal Care Assistant (PCA) issue as it relates to the disabled and elderly.

Ms. Wright explained that she was able to provide an update on this topic to the Workers' Compensation interim committee that met in Las Vegas in November 1999. She commented that at that meeting:

- •Concerns were expressed with respect to PCAs and their ability to obtain private insurance. When Employers Insurance Company of Nevada (EICON) privatized, it increased the premium amount, which made it more difficult for PCAs to obtain coverage. Since that time, her office has been successful in working with the Insurance Commissioner to ensure that PCAs have a relatively low-cost method to secure workers' compensation coverage.

- •It was anticipated that privatization by EICON would have a negative impact on the ability of a PCA to purchase the necessary workers' compensation insurance. Currently, however, PCAs can, for $50 down and $50 a month for the ensuing nine months, obtain affordable insurance that will cover work-related injury.

The DHCFP has also been working with the Division of Insurance on a method to demonstrate, after some PCA history is built up, that the actual claims of these workers are "extremely low." If there are few claims, premiums are expected to further decline. The DHCFP appreciates the cooperation of the other state agencies and the private insurers in providing an opportunity to get low-cost insurance for the PCAs. It is possible, that, as the insurance industry recognizes the experience and sees that the PCAs really do not have very many claims, a risk assessment can be done, which could potentially reduce premiums

Ms. Wright, at the request of Chairman Koivisto, also discussed PCA wage changes that will take effect on July 1, 2000. She noted that the current wage rate approved by Medicaid is $9.48 per hour, which will increase to $14.50 in July 2000, when State General Fund money becomes available to fund that increase. The DHCFP is hopeful that such an increase will attract Medicaid PCA provider agencies, which might provide PCA services to those recipients, rather than contracting with individual PCAs for services. The benefit of having a provider agreement with an agency for those services is that such an arrangement ensures backup service in the event an assistant is ill and so forth. Two provider agencies have indicated an interest in entering Nevada's market in July 2000.

Responding to questions from members, Ms. Wright noted that:

- •Medicaid does not now allow family members to be paid for providing PCA services;

- •To pay family members for furnishing PCA services to Medicaid recipients, the Legislature would have to authorize funding for that purpose;

- •The DHCFP will issue requests for proposals that will specify the various conditions necessary to be granted a contract to provide PCA services, including a plan for standby or backup personnel;

- •There may also be provision made for PCAs who do not wish to be employed by such agencies to continue to contract with the division individually; and

- •The solicitation and contract process should be completed before July 1, 2000, so that PCAs may provide services pursuant to those new contracts at the new rate on that date.

Ms. Wright also noted that she has met on three occasions with staff of the Centers for Independent Living and has attended other public hearings and meetings to clarify the needs of those using PCA services. The prime concern voiced in those meeting was a need for backup services. The difficulty faced by Medicaid now is that alternative personnel cannot be paid from federal funds to be on standby duty; therefore, state dollars must be available in a fund to pay for that backup pool. The agency provider arrangements will provide that backup. Expansion of the program, to provide additional services, is being considered within the constraints of current regulations and funding.

During the 2001 Legislative Session, several requests for expansion of programs will be submitted, she said. It will be up to that body to provide additional services, if it sees fit to do so. In the meantime, Ms. Wright said that she is committed to providing the best services allowable under the existing authority granted. In conclusion, she noted that following a December 20, 1999, regulatory hearing on the proposed expansion (as approved during the 1999 Session) of the physically disabled waiver, she anticipates that the waiver application will be submitted to the Health Care Financing Administration (HCFA), United States Department of Health and Human Services, by year's end. Further, representatives of HCFA have assured her that there will be no resistance to the expansion of services, and she anticipates timely approval of the waiver application. Approval by HCFA will allow Nevada to serve approximately 30 additional individuals in the first year of the biennium and 30 more in the second year.

Ms. Wright, in conclusion, noted that during this application process, she has worked with representatives of the disabled community to ensure that only those services that are of use to the community are requested.

Paul Gowins

Paul Gowins, who is a Rehabilitation Specialist with the Office of Community Based Services, Rehabilitation Division, Department of Employment, Training and Rehabilitation, noted that he was not speaking in his official capacity but on behalf of himself and other disabled citizens. Referring to written remarks dated December 14, 1999, and included in Exhibit A, Section IX, pages IX-1 through IX-15, inclusive, and other statistical information titled "HR, HCF&P, Nevada Medicaid, Title XIX," "Provider payments Calender Year 98, Provided by Center for Health Information Analysis," and an untitled chart depicting "Waiver Services" (see Exhibit M) Mr. Gowins explained:

- •The desire to establish a Medicaid Buy-in program that has an income eligibility level of up to 250 percent of the poverty level, as discussed during the 1999 Session and at other hearings of this committee;

•The Massachusetts Medicaid Buy-in program that is described in Exhibit A, Section IX, pages IX-33 through IX-42, has proven to be cost-neutral over its 10-year history in that state;

- •His preference that Nevada "needs" to look at programs that work; and

- •The provisions of the federal Work Incentives Improvement Act (WIIA) of 1999, passed on November 18, 1999, which is included in Exhibit A, Section IX, pages IX-43 through IX-46.

He noted that the United States Congress did not pass WIIA because they were "nice guys." He asserted that it was passed because Congress recognized that the primary obstacle for people with disabilities going to work is the fear of losing their Medicaid insurance. In the Balanced Budget Act of 1997, there was a provision to allow the Medicaid Buy-in to be developed at the state level with a 250 percent of poverty cap on the amount that an individual could earn. Oregon currently is utilizing such a concept. In WIIA, however:

- •The cap has been eliminated;

- •The upper limit is left to the discretion of the states, which in his view, is a major improvement;

- •Funding is provided to states over a period of five years to develop the necessary health care infrastructure for these individuals; and.

- •States are allowed access to demonstration projects.

Therefore, from the federal perspective, there is a lot of ability and flexibility to provide such programs while leaving it up to the states to determine what is most workable for them.

He noted that, in the past, it has been suggested that:

- •Programs be limited to those persons already on the Medicaid roll, so that there would be no unknown burden on the "system"; and

- •For persons who are already receiving benefits, allowing them to go to work would provide an avenue through which they could begin to earn a living and pay something back into the "system."

Mr. Gowins said that the Governor's Office has been approached by the disabled community, and he has demonstrated some interest in such a program being developed. Interest and dollars, however, are not the same thing. Taking

advantage of the provisions of the WIIA will, in his view:

- •Allow disabled Nevadans to go to work, while retaining medical coverage;
- •Provide for the cautious development of programs that will have long-term benefits in the state by accommodating the expansion of the buy-in program; and
- •Enhance vocational rehabilitation programs.

He solicited the committee's support for establishing the Medicaid Buy-in program, including:

- •Enhancing the Nevada Medicaid staff to accommodate the changes; and
- •Recognizing the beneficial, long-term impact on Nevada's disabled community.

The next issue discussed by Mr. Gowins was the development of a Medicaid waiver program that would work for the residents of the state. He outlined some of the fundamental problems that were encountered in that development:

- •The original estimated budget for the pilot project was $500,000, which was funded in the 1997 Session; however, during the latter part of the following biennium, a fiscal "crunch" occurred and the money was reverted because the program had not be implemented;
- •Replacement of the funding was not forthcoming in 1999 in Governor Guinn's Executive Budget;
- •The effectiveness of such a waiver program for people with disabilities cannot be demonstrated without being funded; and
- •When the DHCFP made its cost projections for the project, it estimated the cost would be $2.9 million, which effectively barred the pilot program from consideration.

Subsequently, the DHCFP moved the expanded waiver pilot program higher on its list of priorities, and DHCFP staff has been most cooperative and has made substantial effort to accommodate issues within the parameters given. Several issues remain, however, when comparing the services offered under the proposed Physically Disabled Waiver Amendment (PDWA), which is based on the old waiver, with what would exist under an Independent Choices Waiver

(ICW). Referring to Exhibit M, Mr. Gowins pointed out the differences in scope, which are a function of budgetary constraints, reflected in the two options. The more inclusive ICW would provide services such as skilled nursing assessment, family training, behavioral and cognitive therapies, and physical, occupational, speech, hearing, and language therapies that are necessary for the more severely disabled individuals. He asserted that the PDWA would probably not be able to provide any of those services because of budgetary constraints. In the event the expanded PDWA is adopted, the disabled community will still pursue the ICW program.

Mr. Gowins briefly discussed the numbers of persons and costs to remove disabled individuals from waiver waiting lists.

The three standing issues that apply to the waiver program, in his view, are:

- •The need to amend the assessment tools used for providing services;
- •The services offered, preferably through the ICW; and
- •The cost-neutral requirement.

Referring to the performance indicators set forth in Exhibit M, he discussed the effectiveness of various classes of waivers and related provider payments from the perspective of the disabled community. Further, he reiterated that the Governor has agreed to review some of the aforementioned issues.

Finally, Mr. Gowins, addressed PCA services, which, in his view:

- •Are a key topic of concern for this committee;
- •Make things "work" for disabled individuals in the community; and
- •Will be improved by the use of service provider agencies or organizations by providing backup staff and other benefits.

With the revised premium structure for workers' compensation insurance for PCAs, one issue has yet to be adequately

addressed. The benefits of this insurance include the replacement of wages, in addition to the payment of medical costs related to that injury, for the worker when he or she is injured on the job. The new premium structure affords only limited disability coverage. Since wages are deemed at $300 per month wage, when a PCA who is fully employed as an attendant gets hurt, his disability payment is based on that deemed wage rather than actual average income, which might be as much as $1,200 per month. Most PCAs do not understand this concept until they are hurt on the job. To attain parity with other employees, that coverage would have to be "at least doubled."

Mr. Gowins also suggested that the federal definition of "family" be adopted in Nevada regulation in place of this state's current definition, which was taken from welfare regulations. In rural areas, it can be difficult to find PCAs to provide services to the disabled. If family members could be paid for providing those services, which is allowable according to federal definitions, that might be a good concept to pursue since it would increase the resources available in the state. He did not estimate what such a change might cost but noted that Ms. Wright had declined to make such a change without legislative action.

In conclusion, Mr. Gowins discussed the personal care assistance for the disabled (PCAD) program, which will be discussed at the December 20, 1999, meeting that Ms. Wright mentioned. He explained that:

- •The legislation authorizing the PCAD program was passed in 1995;
- •The original measure set forth a structure for allowing lay people to provide services to persons with disabilities that would normally be provided by nurses; and
- •The structure has worked effectively since it was instituted, and currently under Medicaid that structure is being developed into a program to which the disability community is opposed.

The reason for that opposition is, in his view, that the changes are unduly punitive and that the disabled are being required to give up rights that are granted to others who use PCA services, such as payment for mileage. See Exhibit A, Section IX, pages IX-49 through IX-148 for details.

Responding to questions from the panel, Mr. Gowins explained that:

- •Until accurate and reliable data and cost forecasts are available, it will continue to be difficult for the disability community to bring its case before the IFC to request funding for new programs or the expansion of existing services; and

- •Although some changes can be accomplished through the DHCFP, other issues, especially those that relate to setting policy and providing increased funding, are more appropriately dealt with in legislative hearings.

Following a general discussion of related issues, Senator Rawson asked Mr. Gowins to provide recommendations for specific actions and committee bill drafts to staff for consideration at the committee's work session. Chairman Koivisto underscored that, in her view, it is essential for regulations to be promulgated in a manner that will pertain directly to the needs of the disabled community, rather than what will "look good" on the bottom line.

Mr. Gowins noted that many people have been involved in the various aspects of service delivery to the physically disabled. The goal is to convince enough people of the benefits of providing expanded services to this community, as those services are now provided to the mentally disabled, so that funding will be approved. There has been a lack of concerted planning for the physically disabled, which has led to the suggestion of establishing an Office of Disability Services, fashioned after the Oregon plan. In his view, withholding funds from this segment of the disabled community has not been done maliciously; however, the lack of long-term planning by an office dedicated to that population has resulted in the money going to other programs. Part of the difficulty in realizing the desired policy outcomes for the physically disabled has been a result of the division going through four administrative changes during the past few years. Each time a new administrator is chosen, the process seems to have to start over again.

In conclusion, he explained that the Federal Government has earmarked more than $500 million to fund the WIIA plan because, as the nation's population ages, so does the disabled population. Policies and services will need to be in place to serve that growing segment of the population.

Jon Sasser

Jon Sasser, Washoe Legal Services, noted that having served as a lay member on this committee during the 1997-1998 interim, he was aware that:

- •Several recommendations came out of that committee and were forwarded for consideration during the 1999 Session;
- •Few of those bills were passed;
- •Historically, a bill that carried with it a "price tag" has rarely been considered favorably by the Legislature, partly because its cost was not included in the Executive Budget and because no fiscal note accompanied it out of this committee; and

- •Often, bills that are heard are derailed due to a lack of consensus on either the numbers of people to be served or the cost of providing that service, consequently, the numbers are debated rather than the needs of the population or the policy issues.

During the ensuing discussion, it was suggested that fiscal information might be requested from either the DHCFP or the LCB. Senator Rawson pointed out that the compilation of departmental budgets has already begun. Therefore, it might be appropriate for the committee to send a letter to the Governor and his staff to advise them of the committee's priorities. In that way, perhaps funding for these programs might be included in the preliminary budgetary considerations. In the past, the Legislature has only changed the Executive Budget by less than 4 percent; therefore, if a program is not included initially, there is very little chance of incorporating it into the final budget.

ASSEMBLYWOMAN FREEMAN MOVED TO SEND A LETTER TO THE GOVERNOR REQUESTING THAT HE MAKE, AS ONE OF HIS BUDGET PRIORITIES, FUNDING FOR CERTAIN PROGRAMS FOR THE DISABLED COMMUNITY. SENATOR WASHINGTON SECONDED THE MOTION.

Following discussion on the motion, Ms. Freeman suggested that the language of the letter be drafted by staff.

UPON THE CALL OF THE MOTION AND A SECOND, THE MOTION PASSED UNANIMOUSLY.

Mary Jean Thomsen

Mary Jean Thomsen, Community Advocacy Coordinator, Northern Nevada Center for Independent Living, provided written testimony (see Exhibit N) regarding the delay in implementing expanded services under the physically disabled waiver. According to Ms. Thomsen, during the 1999 Session, the money committees approved funding the existing Medicaid waiver program based on testimony from Ms. Wright.

After reviewing excerpts from legislative meetings at which Ms. Wright addressed this issue, Ms. Thomsen further explained that, in her view:

- •Although it was promised that the expanded waiver program could provide the same services as the ICW, and that some additional aid would be immediate, services are yet to be available to the disabled;

- •The process has taken seven months so far and is yet to receive HCFA approval, which may take an additional 90 days, and that will result in at least a 10-month delay;

- •Such a delay indicates that the disabled and their needs do not constitute a priority to the Legislature or to Nevada Medicaid;

- •There should be some accountability, and the delay in the approval of the expanded waiver should be investigated along with the infrastructure that is in place for delivery, based on the testimony provided by Ms. Wright; and

- •Members should stay informed on these issues to ensure that these expanded services to the physically disabled can be provided in the most efficient and timely manner.

Ms. Thomsen added that:

- •When she attempted to obtain current Nevada Medicaid information, local offices in Carson City and Reno were unable to supply information that she sought and the booklet she received from LCB staff was two years old. In her view, these materials should be readily available to the public.

- •When the PCA provider agencies are available, after July 1, 2000, there should be some provision made for disabled individuals to choose whether to use a provider agency or an independent contractor.

A discussion of these issues followed, and Senator Rawson commented that this committee is consumer driven; however, the financial issues must be considered during economically lean times in Nevada. The state's budget must be balanced. During the last 12 years, Nevada's Medicaid budget has grown substantially. There has been a significant effort made on the part of the Legislature and the executive branch agencies to address the needs of the residents of the state. It is frustrating for everyone to see how much has been invested and yet realize that certain goals are not being accomplished. Much of that shortfall is growth driven, in his view.

Ms. Koivisto concurred and noted that advising the Governor of the committee's priorities may help alleviate some conflicts during the next session. In addition, she reminded the committee that Ms. Wright and other agency heads are bound to act within narrowly defined guidelines that, are in large part, set by the Legislature; therefore, making change often takes time even when everyone is working together toward the desired goals.

INFORMATIONAL PRESENTATION CONCERNING

LEGISLATIVE AND REGULATORY REFORMS TO

INCREASE ACCESS TO HEALTH INSURANCE FOR

SMALL- AND MEDIUM-SIZED EMPLOYERS

Sharen Weaver, Manager, Health Insurance Portability and Accountability Act (HIPAA) Section, Division of Insurance, Department of Business and Industry, introduced Van Mouradian, Actuary for the HIPAA Section. She discussed the passage of Assembly Bill 521 (Chapter 586, *Statutes of Nevada 1997*), which created HIPAA. She explained Nevada's efforts during the past 15 years to actively and consistently address health care issues by referring to information provided by Alice Molasky-Arman, Commissioner of Insurance (see Exhibit A, Section X, pages X-1 through X-17 for policy synopses).

Ms. Weaver noted that:

- •Those efforts began in 1985, when the law (NRS 689B.026) was amended to enable insurance companies to market to discretionary groups;
- •Today, discretionary groups are generally referred to federally as a fully insured, multiple employer welfare arrangements (MEWA) or Multiple Employer Trusts (MET) that are backed and fully underwritten by insurance companies; as contrasted with uninsured MEWAs, which are unauthorized activity;
- •In 1991, Nevada made a further effort to provide additional, larger markets to the small employers by developing the "bare bones policy" in Senate Bill 503 (Chapter 648, *Statutes of Nevada 1991*), which was unsuccessful in the marketplace;
- •Again, in 1995, the Legislature responded to small employers by passing A.B. 299 (Chapter 395, *Statutes of Nevada 1995*) that provided basic medical and hospital care coverage; however these were not guaranteed issue policies; and
- •When A.B. 521 was passed in 1997, it provided that HIPAA guarantee the issue of a policy of health insurance to small employers; the measure made other significant changes to health care insurance for small employers.

Ms. Weaver further informed the committee that:

- •The health insurance market is fragile;
- •Of the 868 insurance companies licensed to sell health insurance in the state, only about 68 offer health insurance products to small employers;
- •Of those 68, only about 20 companies are active in Nevada's marketplace; and
- •Since May 1998, seven insurance companies have exited the small group health insurance market nationally due to the small volume of business written in this area; however, they will continue to write policies for large groups and individuals.

She also reviewed the charts and tables (see Exhibit A, Section X, pages X-11 through X-17 for details) that describe and illustrate the premium components and HMO medical costs related to various HIPAA Section data.

Van Mouradian

Van Mouradian, actuary for HIPAA, provided further insight regarding the establishment of premiums for small employers. He explained that:

- •For HMOs, rate filings are calculated by taking the historical data, projecting the future year's claims, arranging the premium structure to contemplate the realization of a certain amount of revenue to pay the actual claims, and allowing for administration costs and a profit.
- •An index rate is also used to address the experience variation that can occur within a class of insureds.
- •Increases are also calculated to take into consideration, among other things, guaranteed issue provisions to protect the insurance companies' solvency.
- •The loss ratio for most HMOs runs between 70 percent and 85 percent, generally, which leaves an administration, premium tax, and profit ratio of between 15 percent and 30 percent, depending on the company.
- •Some companies are more successful than others in forecasting their premium rates and some are currently operating at a loss.

- •Indemnity companies that provide health care insurance, on the other hand, usually base their premiums on 55 percent for claims and 45 percent for administration, tax, and profit.

- •Preferred provider organizations generally estimate 65 percent to 75 percent for claims payments, in comparison.

He also discussed the actuarial basis for and technicalities of implementing the legislative directives since 1985 and the effects such changes have had on the consumers, employers, and insurers in Nevada. Further, he noted that a report from the United States General Accounting Office, on employer health insurance issues, may be presented at a future meeting.

At this point, Ms. Koivisto noted that a quorum was no longer present and the remaining members would continue to hear testimony as a subcommittee, but no action would be taken on any other items.

DISCUSSION OF PROPOSED FEDERAL REGULATIONS CONCERNING

MEDICAL RECORDS PRIVACY

Chairman Koivisto explained that, due to time constraints, Ms. Williams would not formally present Exhibit O, which includes a "Summary of a Proposed Regulation of the United States Department of Health and Human Services for 'Standards for Privacy of Individually Identifiable Health Information,'" an "Executive Summary, Proposed Department of Health and Human Services, Health Information Privacy Regulation," and a copy of the *Federal Register*, Vol. 64, No. 212, Proposed Rules 45 CFR, Parts 160 through 164, which could be reviewed individually by members at a later time. That document will also be available to the public on request. She noted, too, that the comment deadline on the proposed regulations has been extended to February 2000.

INFORMATIONAL REPORT DESCRIBING

THE NATIONAL CONFERENCE OF STATE LEGISLATURES (NCSL)

HEALTH CARE CONFERENCE

Ms. Williams, committee policy analyst, stated that Exhibit A, Section XII, pages XII-1 through XII-14, includes the agenda for and a full report on her attendance at the National Health Care Conference, sponsored by the NCSL. The

primary topics covered at that conference included:

- •"After Olmstead: Community Care for People with Disabilities";
- •"Pharmaceutical Benefits Under Medicaid";
- •"Seal of Approval: Managing Health Care Quality";
- •"Growing Financial Troubles of Hospitals: Myth or Reality?"; and
- •"New Thinking on Coverage of the Uninsured."

She invited members to contact her if, after reviewing the materials, she could answer any questions regarding the conference. In addition, Exhibit A, Section XII, pages XII-15 through XII-23, contains information on a conference, "Prescription Drug Coverage: What Can We Afford? How Do We Decide?" to be held in Atlanta, Georgia, on January 10 through 12, 2000.

Senator Washington indicated a desire to attend the conference in Atlanta, Georgia, and Chairman Koivisto agreed that he could represent the committee there. Senator Rawson concurred.

DISCUSSION OF FUTURE TOPICS

The following items were suggested to be placed on a future agenda:

- •The effects of the Olmstead decision on Nevada's on-going programs;
- •The overall impact of health insurance mandates on employees and on employers' ability to provide insurance to workers;

- •An update on the work of the long-term care committee; and

- •The effect of the disproportionate share (DSH) program and how indigent services are provided.

Ms. Wright noted that during the last legislative session the DHR was directed to study DSH and a number of goals were outlined. The task force that was formed, which has members representing interests across the state, will have its first meeting in Las Vegas on December 21, 1999, and the meeting will be videoconferenced to Carson City. At that meeting, the task force will look at the federal DSH program, the statutory requirements of the state, the flow of funds between the federal and the state programs, and how hospitals and the state receive benefits that are utilized to fund the Medicaid and Nevada Check-Up programs, and, finally, at how allocations are made to rural hospitals. It is anticipated that there will be a series of meetings between December 1999 and June 2000 that will result in recommendations being given to DHR for forwarding to the IFC, the legislative health care committee, and the Governor's Office by July 2000.

PUBLIC TESTIMONY

Glen Martin

Glen Martin, resident of Carson City and a volunteer in the exercise programs for the Division of Aging Services, DHR, the Retired Senior Volunteer Program, and the American Association of Retired Persons testified that there is significant information available:

- •From the Mayo Clinic, Rochester, Minnesota, on the long-term health benefits of exercise for seniors, including reductions in the incidence of coronary artery disease, diabetes, high blood pressure, obesity, osteoporosis, senility, and stroke, among others (see Exhibit P); and

- •About the decrease in complications of illness such as influenza and pneumonia for seniors who participate in immunization programs.

He suggested that these types of programs are sound and proven. They also carry with them anti-aging benefits that can reduce the costs of health care services for the aged population in Nevada.

Theresa Morrow

Theresa Morrow, R.N., chairman of the Health Care Oversight Committee for the Nevada Services Employees Union, speaking from Las Vegas, asked Chairman Koivisto to include a report from her organization on an agenda for a future meeting. Specifically, she requested an opportunity to update this committee on hospital staffing, patient outcome, and "whistle blower" issues. Chairman Koivisto agreed to hear testimony on those issues during a future hearing.

SCHEDULING OF NEXT MEETING AND DIRECTIONS TO STAFF

Ms. McDade Williams provided a list of suggested meeting dates. See Exhibit H. Those meetings are tentatively set for January 26, 2000, in Las Vegas; March 7, 2000, in Carson City; April 18, 2000, in Las Vegas; and June 6, 2000, in Carson City.

Exhibit Q is the Attendance Roster for this meeting.

ADJOURNMENT

There being no further business, the meeting was adjourned at 3:50 p.m.

Respectfully submitted,

Linda Chandler Law

Senior Research Secretary

Marla McDade Williams

Senior Research Analyst

Approved by:

_____

Assemblywoman Ellen M. Koivisto

Chairman

Date: _____

LIST OF EXHIBITS

Exhibit A contains a two-volume set of documents that provide background information on selected agenda items. Arranged to correspond with the items on the meeting agenda, those documents were provided by Marla McDade Williams, committee staff advisor, for members' reference.

Exhibit B is a copy of prepared remarks submitted by Florence LaRoy, the mother of an autistic son.

Exhibit C includes the preliminary results from a telephone survey conducted by R&R Partners on behalf of the Crisis Call Center, which was provided by Nora Brashear, Administrative Coordinator, Crisis Call Center.

Exhibit D is a copy of the prepared remarks submitted by Steve Shaw, Administrator, Division of Child and Family Services, Department of Human Resources (DHR).

Exhibit E includes the prepared testimony of Robert Kreider, Chairman of the Board of Devereux Cleo Wallace and Chief Financial Officer of the Devereux Foundation, Villanova, Pennsylvania.

Exhibit F includes Devereux's most recent annual report, titled "Devereux, Creating Communities of Hope," also submitted by Mr. Kreider.

Exhibit G includes the written remarks provided by Jeff Paine, owner of the Gold 'N Silver Inn, located in Reno.

Exhibit H is the written testimony of Doug Moir, Controller, Sportif USA, located in Reno.

Exhibit I is the testimony of Robert Ostrovsky, representing Nevadans for Affordable Health Care, submitted by Misty Grimmer.

Exhibit J is a copy of *Nevada Administrative Code* (NAC), Chapter 639, "Immunizations or Vaccinations" draft regulations, submitted by Keith W. Macdonald, Executive Secretary, State Board of Pharmacy.

Exhibit K contains letters from Joel Davidson, M.D.; Joseph P. Hardy, M.D.; Tom LaMure; Sandra Sherlock; Patricia van Betten; Arnold Wax, M.D.; and Bea Webb. Articles submitted were "Pill-splitting," *Pharmacist's Letter*, October 1999; and "Oral Solid Dosage Forms That Should Not Be Crushed: 1996, Revision," by John F. Mitchell, PharmD, as reported in *Hospital Pharmacy*, 1996, which were provided by Keith W. Macdonald.

Exhibit L is a report, titled "Calendar Year 1998 Gross Direct Premiums Written," submitted by Guy Perkins, Chief Insurance Examiner for the Life and Health Section, Division of Insurance, Nevada's Department of Business and

Industry, who represented Alice A. Molasky-Arman, Commissioner of Insurance.

Exhibit M includes other statistical information titled "HR, HCF&P, Nevada Medicaid, Title XIX," "Provider payments Calender Year 98, provided by Center for Health Information Analysis," and an untitled chart depicting "Waiver Services," submitted by Paul Gowins.

Exhibit N is a copy of the written testimony provided by Mary Jean Thomsen, Community Advocacy Coordinator, Northern Nevada Center for Independent Living.

Exhibit O includes a "Summary of a Proposed Regulation of the United States Department of Health and Human Services for 'Standards for Privacy of Individually Identifiable Health Information,'" an "Executive Summary, Proposed Department of Health and Human Services, Health Information Privacy Regulation," and a copy of the *Federal Register*, Vol. 64, No. 212, Proposed Rules 45 CFR, Parts 160 through 164, submitted by Ms. McDade Williams.

Exhibit P includes information provided by Glen Martin, a volunteer in the exercise programs for the Division of Aging Services, DHR, the Retired Senior Volunteer Program, and the American Association of Retired Persons, regarding senior exercise programs.

Exhibit Q is a copy of the Attendance Roster 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.