MINUTES OF THE MEETING

OF THE

TASK FORCE ON TH EPOLICY OF THE STATE OF NEVADA CONCERNING

ACCESS TO PUBLIC HEALTH SERVICES

(SB 556)

March 1, 2000

Carson City, Nevada

The third meeting of The Task Force on the Policy of the State of Nevada Concerning Access to Public Health Services was held on Wednesday, March 1, 2000, at 10:30 a.m., in Room 1214 of the Legislative Counsel Building, 401 South Carson Street, Carson City, Nevada. This meeting was video conferenced to Room 4412 of the Grant Sawyer State Office Building, 555 E. Washington Avenue, Las Vegas, Nevada. The "Meeting Notice and Agenda" is attached to these Minutes.

TASK FORCE MEMBERS PRESENT IN CARSON CITY:

Dr. Javaid Anwar, Chairman

Senator Mark Amodei, Vice Chairman

Keith Beagle, Nevada Association of Health Plans

Bobbette Bond, Culinary Union

Charlotte Crawford, Director, Department of Human Resources

Larry Matheis, Nevada State Medical Association

Bob Ostrovsky, Nevadans for Affordable Health Care

Scott Craigie, Nevada Public Health Foundation

Senator Terry Care

Assemblywoman Sheila Leslie

TASK FORCE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Merle Berman

Assemblywoman Ellen Koivisto

Randy Capuro, Private Health Insurance

DEPARTMENT OF HUMAN RESOURCES STAFF PRESENT IN CARSON CITY:

John Yacenda, Deputy Director, Department of Human Resources

Rachel Rogers, Management Assistant III

NEVADA DIVISION OF INSURANCE STAFF PRESENT IN CARSON CITY:

Guy Perkins, Supervisor, Life & Health Section

OFFICE OF THE ATTORNEY GENERAL STAFF PRESENT IN CARSON CITY:

Nancy Angres, Deputy Attorney General

TASK FORCE MEMBERS WITH AN EXCUSED ABSENCE:

Anne Cory, Nevada Women's Lobby

Senator Randolph Townsend

APPROVAL OF MINUTES

Larry Matheis motioned to approve, seconded by Assemblywoman Sheila Leslie.

Unanimously approved.

OPENING REMARKS

Chairman Dr. Javaid Anwar welcomed the members present in Carson City and Las Vegas, and acknowledged the public in attendance at each location.

PRESENTATION MADE BY DIVISION OF HEALTH CARE FINANCING & POLICY

Janice Wright, Administrator, Division of Health Care Financing and Policy (DHCFP), opened the meeting with a slide presentation (Exhibit A) that began with the explanation of what Medicaid is and who it served. The current enrollment is approximately 100,000 with half of those being children. Nevada's program is a 50/50 match of state/federal funds. It is estimated that the Medicaid enrollment will increase 331% over the next 30 years, meaning a 10% increase each year. A handout (Exhibit B) detailing the multiple presentations from staff of the DHCFP was provided members of the Task Force.

Dale Capurro, DHCFP staff, gave an overview of Nevada Medicaid programs and told the Task Force that the third party intermediary processes 30,000 claims each week. Mr. Capurro indicated most Medicaid dollars are spent on federally required benefits and not on state options.

Questions (and/or explanation) from respective Task Force members (with answers as provided by respective speakers:

Senator Terry Care: What is the current expenditure on long term care? Most of his district falls under this category and he is curious to know what the recipients are currently receiving.

Assemblywoman Sheila Leslie: Where does the State of Nevada Medicaid program fall nationally? And how do we relate to other states?

Ms. Wright indicated she would provide follow-up information to answer these questions.

Bob Ostrovsky: What is the current tracking system for required and optional services? Currently there isn't a tracking system and Janice is to obtain the information and provide it to the Task Force.

# # #

Dave Caloiaro, DHCFP staff, provided the committee with descriptive over view of the Nevada Medicaid Inpatient Hospital Services. The five types of services that are covered are:

Medical/Surgical Hospitals (basic general)

Psychiatric Hospitals (general hospitals with psychiatric units and freestanding psychiatric hospitals)

Rehabilitation Hospitals (head and spinal cord injuries)
Specialty (or long term care acute) Hospitals (ventilator dependent, wound management, strokes, etc.).

Psychiatric Residential Treatment Centers (RTC) (medical model treatment programs, most of which are out-of-state, for children and adolescents with behavioral, emotional and psychological problems). Primarily out-of-state programs.

Medicaid contracts with HealthInsight for conducting inpatient hospital and residential treatment center prior authorizations, concurrent and retro-eligibility reviews, and certifications. HealthInsight qualifies for a 75% federal match.

The Medicaid program contracts with other divisions with the state to meet some of the needs of the clients. The Division of Child and Family Services and Mental Health and Developmental Services provide the services that are reimbursed by Medicaid. The program currently has 38 children in out-of-state programs.

Questions:

Assemblywoman Leslie: What percentage of the 38 children in the out-of-state programs are sex offenders?

A high percentage is sex offenders and the percentage for female offenders is increasing. Currently the only facility, which is owned and operated by the Division of Child and Family Services, (Dessert Willows) is in Las Vegas and is for male offenders. Currently looking at a step down program for the sex offenders and those with multiple failed placements.

Assemblywoman Leslie: What is our Medicaid plan for outpatient mental health?

Bobbette Bond raised issues about custodial care asking if this could be provided to patients who are no longer progressing in a rehabilitation setting and who are no longer on ventilators. They still need care, adding, but they don't need to be institutionalized. Pediatric facilities are out-of-state and none of them will take pediatric long-term, acute patients. There are very few facilities that will take the long-term care patients that need to be in an institution but that don't need nursing care.

# # #

Marti Searcy, DHCFP staff, presented preventative care programs. These programs included family planning services with the goal of preventing unwanted or poorly timed pregnancies, as well as, STD's. The MOMS

program provides case management services for all Medicaid eligible or pending eligible pregnant women. Since the inception of the MOMS program the drop-in delivery rate dropped 98% in the first year at Carson-Tahoe Hospital and 16% at University Medical Center in Las Vegas.

Nevada's version of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program is entitled Healthy Kids. The goals of this program is to provide early, preventive health care to Medicaid eligibles less than 21 years of age and to reach a participation rate of 80% set by the Health Care Financing Administration (HCFA). Currently there are 57,574 individuals enrolled.

Ms. Searcy reported that an estimated 43,000 Nevadans receiving Medicare might be eligible for Medicaid benefits. Applying for these benefits could help them pay for prescriptions and other needed health care.

Dr. Javaid Anwar asked why the figures in the Northern portion of the state are much higher (i.e., better) than those in the Southern portion of the state.

Ms. Searcy replied explained that their (DHCFP's) figures are provided to the program by hospitals. One of the reasons that the number is so high for Carson is because the MOMS program has a clinic in conjunction with Carson-Tahoe Hospital that makes access easier. They have yet to be able to replicate the program elsewhere in the state. Whether it is due to transportation or other dynamics.

Larry Matheis posited that ESPDT should be looked at more closely by the Task Force, and evaluated as what public health services should be put on the high list of accessibility to everybody. This particular program provides early prevention, screenings, and early treatment of problems. This looks to be a database that is already set up and available for the Task Force to look at when the time is right.

Dr. Javaid Anwar asked that more information about Southern Nevada be provided, particularly as it ties in with the emergency drop-in delivery rate.

Ms. Wright was asked to provide additional information. She indicated the screening cost incurred for this program is about $2 million, but the cost of referral is about $20 million. The Task Force requested more detailed EPSDT information from Ms. Wright.

Larry Matheis: The purpose of this program is more than screening. It is to prevent the amount of emergency room drop-ins then in turn lowering some of the costs incurred. There should be a cost for this if you are screening for something that people occasionally get then you should find it which means then you should do something about it. Not merely to screen for a problem but to treat the problem you find. You are not doing prevention if you only find problems and don't treat them.

Scott Craigie: There are real advantages to hearing from those that have worked with the clientele on the front lines and have run into the institutional barriers. Those that don't have access to family physicians so they don't get introduced to the programs until it's urgent, or many of the facilities that are designed to provided indigent care aren't located in areas where the indigent live and those that are, like Community Health Centers of Southern Nevada, are struggling to survive. We need to look at what other states are doing to more aggressively bring people in and look more importantly at the conditions that exist and determine whether or not some of our money can increase the number of people that go through screening programs. We must hear from those that really know what those barriers are.

Dr. John Yacenda, Principal Staff to the Task Force, asked Ms. Wright for clarification on what type of information the members could expect in regards to the EPSDT program.

Ms. Wright indicated she would provide actual expenses from the EPSDT screening and the number of people that benefit from the different provider types.

Larry Matheis further clarified the Task Force's need to have a listing of what the screening tests are, and the kind of services provided, and where these are provided in terms of geography and location in the State.

Scott Craigie: We need to identify those areas geographically within the main urban areas as well as in the rural areas, where the concentration of those living below the poverty level live. We should be able to do this without researching it and using the documentation we already have. Then we have to ask what services are available for either drop in care, quick access to a physician, or federally qualified health clinic facilities.

# # #

Valerie Cain, R.N., DHCFP staff, spoke about Skilled Nursing Facilities, Long term Care and Hospice Care. The state of Nevada has 42 Medicaid certified, Long Term Care facilities with 4,972 beds. Of those facilities, 40 are skilled nursing facilities, 2 are intermediate care facilities. With 2,597 beds occupied making that a 74% occupancy rate of Nevada Medicaid recipients. There has been a 38% increase in the last 24 months of nursing home beds. In 1999 there were 7 new facilities that opened and in the year 2000 there have been 5 new facilities that are either under construction, have put in plans or have made applications to the licensure and certification. With 456 new beds available. Medicaid reimburses with 6 levels of care that reflect the individual resident's level of care. Medical reviews are conducted monthly and annually. Several improvements have been made to the system, which include revising of forms, increased contact with the facility, and training to the billing staff.

Hospice has been a Nevada Medicaid covered benefit since October 1, 1997. Recognition of impending death – going from curative to palliative. The benefits are approved if the recipient has less than 6 months to live and the recipient can revoke at any time. Hospice is run with the Medicare guidelines and Medicaid regulations being followed. The average stay for a Medicaid recipient is 45 days with 36% lasting a week or less.

There are 9 hospice providers and the 2 in Las Vegas are inpatient care facilities. They expect a 10-20% annual increase.

Questions:

Larry Matheis observed that an increasing portion of long-term care patients is Medicaid patients. Nevada's infrastructure for long-term care is thin, and the growth of major corporations as the providers makes it more possible that Nevada could go from having adequate arrangements to having crisis. We have to monitor the financial conditions of the operators with the thin long-term care system that we have.

Charlotte Crawford added that there are three national companies that own facilities in Nevada, which are in the process of filing chapter 11 proceedings. The Department of Human Resources is seeing indications of financial hardship with the Long Term Care Systems and Home Health Care. 60% of LTC and Home Health Care are paid for my Medicaid.

# # #

Sharon Willans, DHCFP staff, explained that Nevada currently has four waiver programs, two of which are run by the Division for Aging Services (i.e., Aging Services Group and Aging Services CHIP). The services provided through these waivers are presented in Exhibit B. The other two waivers are Home Community Based Waiver for Persons with Mental Retardation and Related Conditions, and Medicaid Physically Disabled. A comparison of the costs with the waiver versus institutionalization was presented.

Home Community Based Waiver for Persons with Mental Retardation and Related Conditions

Served 754 persons last year

$13,342 – waiver cost

$81,532 - Institution

Home and Community Based Waiver for Elderly at Home (CHIP)

There is a waiting list of 500+ with majority being in Clark County

997 last waiver period

$ 4,312 – waiver cost

$18,481 - institution

Home and Community Based waiver for Elderly in Group Care

SSI only – facility receives a subsidy payment from the Welfare Division

$ 2,553 – waiver cost

$18,481 - institution

Home and Community Based Waiver for Persons with Physical Disability

120 persons served last year - 180 are currently on a waiting list

$ 875 – waiver

$18,212 – Nursing facility

Most of the waivers are in the renewal process. The renewal process must done during the 3rd year of a new waiver program and every five years from that point on.

Home Health Services must be physician prescribed. Personal care assistants – not nursing. This is a non-nursing services program. The intermediate care served 264 persons in Nevada with 15 being served out-of-state.

Questions:

Scott Craigie: How long are the waiting lists in Nevada? How long can a person be on a waiting list? Do those that are in critical stages on the waiting lists and are unable to receive benefits from one of the other waivers, can they be put in an institution?

Ms. Willans responded that three of the waivers have waiting lists. Ms. Willans was asked to provide information with exact figures for each waiver.

Bobbette Bond: What is the average time on a waiting list?

Ms. Willans responded it depends on which waiver the individual is seeking assistance from and where the individual lives. Ms. Wiliness was asked to provide additional information.

Senator Care: Can a person be on more than one list at a time?

Ms. Willans responded it's not possible to be served by three programs. The intake process determines the

best program for the individual. But it is possible to be on three waiting lists.

# # #

Dale Capuro provided information on Dental and Medical Transportation, and indicated that Federal guidelines state that each state must make sure that individuals can make it to appointments. Then it is determined what is the best method for the individual. Whether it be bus, taxi, walking distance if the person is able to do so. The best and most cost effective option is utilized. The needs for transportation is verified and scheduled by the Medicaid offices. Washoe and Clark counties are in the process of looking at a partnership to make this easier.

Dental is optional for adults 21 and over and covers emergency only and dentures every 5 years. The dental option is mandatory for those under the age of 21 except and no prior authorization is needed. The dentist bills the Medicaid program directly. The program does not cover orthodontist procedures. The program is still having problems finding dentists to take the Medicaid patients, but Washoe and Clark Counties are working in conjunction with the state to help alleviate this situation. Rural counties are still having the hardest problem in finding services. Dental school is currently looking at accepting Medicaid patients.

Questions:

Bobbette Bond: What percentage of the dentists enrolled provides services to the Medicaid enrollees?

Mr. Capurro responded there are a large number of dentists enrolled in the program but only a handful provide services. Last year there were 50 dentists providing services and this year there are 59 dentists providing services.

# # #

Laurie Squartsoff, DHCFP staff, presented information on Pharmacy Benefits. It is an optional coverage of the Medicaid program. Which means that prior authorization is needed and then the diagnosis must be considered to be medically necessary to be covered.

Currently 423 pharmacies are Medicaid providers. Clients can receive 3 prescriptions a month with the addition of an antibiotic. Drug rebates ($7 million) were earned and are reallocated to medical services so access to these drugs can continue. Education is used to make sure that the medications are being used correctly.

There are 500 durable medical equipment providers in the state, which allows the rural counties to have access.

The vision portion covers eyeglasses and exams every two years for adults and children are covered as often as needed whenever the prescription changes.

Questions:

Keith Beagle: With drug price inflation being in double digits, how has Medicaid prepared for this? Is there a generic mandatory in effect?

Ms. Squartsoff responded there is an increased concern in the increasing price of prescriptions. They continue to work with drug manufacturers for the rebates dollars. Generic mandatory law in effect for all persons.

Bob Ostrovsky: Do we have any contracts with pharmacy benefits managers? Are we using any? What about

contracted rebates?

Ms. Squartsoff responded all pharmacies have chosen to be providers. There is a preferred network of providers and with the over 90 program and rebates the Medicaid utilizes the best prices available.

Bobbette Bond: Does the state work with formularies?

Ms. Squartsoff responded the formularies that are primarily for those in managed care. Fee for service doesn't have a closed formulary. Don't pay for obesity or cosmetic services. Federal regulations require that the patients have access to all medications.

# # #

Carol Tilstra, DHCFP staff, presented information on Outpatient Services offered to the Medicaid beneficiaries. Medically necessary services for treatment of disease or injury that requires hospitalization less than 24 hours is covered. Medicaid will reimburse services provided by Indian Tribal Health Centers and Special Children's Clinics.

Medicaid will pay for emergency services with an emergency diagnosis and proper documentation.

There is a program for weight reduction in children to prevent chronic illness now and later in life.

# # #

Phil Nowak, Deputy Administrator, DHCFP, provided an overview of the Nevada Check-Up Program. The CHIP program is designed to health insurance to children 0-18 who are from families that are uninsured or that are ineligible for Medicaid. States were given the option of offering CHIP as separate program or as an expansion of Medicaid and Nevada chose to separate and received approval for the Nevada Check-up program August 13, 1998.

Currently 5 million of the 10 million uninsured children in the nation are covered by some form Medicaid or expansion program.

21 states are Medicaid

16 states including Nevada are an expansion program (50/50 match for Medicaid and 65% for CHIP)

13 states are using a combination of Medicaid and expansion program

*48 billion authorization that would offer more flexibility to insure more children.

As of March 1, 2000, the Nevada Check-up program is covering 9,000 children. Those that are eligible are children birth to 18 years of age and that are not eligible for Medicaid, meet the 200% of poverty level, and have not been insured for the past six months. The application is one page, two-sided in length and the applicant must provide 2 check stubs. There is no co-pay for the office visit, and the premiums are paid quarterly for the entire household (not per child).

Primarily one staff member does the marketing for the program. Persons may download an application from the Internet, file a paper application, and use the 800-phone number to get an application, or use 850 other locations at which an application can be obtained. This has been a learning experience for the marketing of this program, with the schools being the single most effective way to inform the public of the program. The Medicaid program would like to see Nevada Check-up be as recognizable as is the Baby your Baby program.

They are currently looking at using broadcast media, public service announcement or a video to distribute to provide more information and to reach the people that may not be reached otherwise.

The question has been raised, more than once, is this a capped program? The program is no where near being capped.

Questions:

Dr. Javaid Anwar: How involved are Check Up staff in working with doctor's offices, clinics, and patients?

Assemblywoman Sheila Leslie: 1) How many staff members are actually marketing this program? 2) The issue of crowd out never really materialized did it? Nevada has a six-month waiting period; some states have no prior insurance requirement. 3) Why don't we have presumptive eligibility? What is the cost to expand the program with presumptive eligibility added?

Ms. Wright responded that at the beginning of the program there was a major concern that people would drop their private insurance for the coverage provided by the Nevada Check-up program. It doesn't appear to have happened. The DHCFP is looking at possibly lowering or dropping the crowd out waiting period. Ms. Wright also noted that HCFA has ruled that Native Americans do not have cost sharing responsibilities with the children's health insurance program. Further, Ms. Wright noted that the issues of presumptive eligibility and crowd out are decisions the Legislature may need to address.

Scott Craigie: According to the charts (Exhibit C) there is $92 million available for Nevada Check Up. Why have we spent only $13 million? I understand being fiscally conservative, but there's more money than people.

Ms. Wright responded the program is funded by an appropriation of federal money to states with a state match. Nevada's match is 35% -- that is, 65% in federal funds requires 35% in state funds. The program has yet to spend the first year's appropriation of the federal funding. The way the CHIP program is set up, states are able to carry forward unspent funds for several years.

Dr. Javaid Anwar commented that we must maximize our use of resources and leverage all available federal dollars.

Scott Craigie commented that Washington and New Mexico provide tax benefits for participation in their programs and Nevada currently advertises for free money with the Pre-paid tuition program. He asked: What is the hold-up with the advertising of the Check-Up program? We need to jump-start this program.

Larry Matheis commented too few kids are enrolled, leaving us with unexpended funds. We need to increase media efforts to increase the number of children enrolled. We need to leverage the resources of the "Covering Kids" coalition more effectively and integrate them with state efforts.

Keith Beagle commented that we have a lack of marketing for this product, and we lack physicians' support. We need to more directly involve providers in the promotion of Nevada Check Up. What I'm hearing from the public is that the "Covering Kids" coalition is not doing its job; it's failing and the public is concerned.

Bob Ostrovsky: Agreeing with Assemblywoman Sheila Leslie regarding comments made about presumptive eligibility, he asked if some of the money could be used to hire more staff to be present at special events that are held across the state and in the rural areas?

Scott Craigie: Are there ways we can identify what kinds of health care services persons will need as they leave Medicaid because they have jobs and have incomes that no longer qualify them for Medicaid? Can we take this information and use it to factor in the potential of moving these people into public health services?

Keith Beagle asked if we could look at expanding Nevada Check Up and Medicaid and what that would mean in terms of costs and coverage

Presentation made by Dr. Larry Weiss, Sanford Center for Aging

Dr. Larry Weiss, Director, Sanford Center for Aging – Medicare in Nevada

The presentation (Exhibit D) covered what Medicare is and what it covers and doesn't cover.

Questions:

Charlotte Crawford: Is there any segment of the 65+ population in Nevada that isn't covered by Medicare?

Dr. Weiss responded 90% are covered.

Charlotte Crawford: How many have coverage for outpatient pharmacy?

Dr. Weiss responded that we don't know for sure, but we have estimates in our report (Exhibit D) about these pharmacy costs.

Charlotte Crawford: Do you have any idea what the Medicare pharmacy package coming out of Washington, D.C. will look like?

Dr. Weiss responded he wasn't sure.

Keith Beagle raised several questions and made observations about information presented by Dr. Weiss on pages 3,7,10 & 12 of Exhibit D.

Assemblywoman Sheila Leslie: Why doesn't Medicare cover preventive services like dental, vision, and audio.

Dr. Weiss responded that these services are not generally considered acute services and persons themselves are responsible for the costs of these services.

Dr. Javaid Anwar asked in response to Dr. Weiss' statistics on the use by African Americans on Medicare of more costly hospital care instead of primary care physicians, what could be done to reverse this occurrence.

Dr. Weiss responded education at the community level with an emphasis on these Medicare beneficiaries establishing relationships with primary care physicians.

Sub-committee Reports

Senator Terry Care – Chairman's Question Sub-committee -- Announced the subcommittee is scheduled to meet on April 4th, in Las Vegas, the day prior to the next Task Force Meeting. He indicated he is open to ideas and suggestions from other members on the tasks faced by his subcommittee.

Larry Matheis – Health Insurance Sub-committee is looking to meet either the 16th or 23rd of March. There

are nine questions that need to be answered by the sub-committee.

Scott Craigie recommended the sub-committees utilize LCB resources, appropriate state divisions and heads of state agencies.

Technical Advisory Committee

Dr. John Yacenda reported the members of the technical advisory committee have been contacted and have agreed to serve in that capacity. They are aware that their role has not yet been defined but they are ready to go when the functions have been identified.

Dr. Javaid Anwar – Reminded everyone that the TAC is not limited to a specific number of members.

Nancy Angres indicated there needed to be a formal motion made to approve the TAC members as they stand. So moved by Larry Matheis; seconded by Senator Terry Care.

Discussion of April 5, 2000 Meeting

Dr. John Yacenda reported that the next meeting will be held in Las Vegas and will contain the third piece to the picture of serving the uninsured. It will have an 8:30 start time and will have presentations from a wide array of public and private agencies.

Copies of the presentations have been requested to be sent to Dr. Yacenda by the 23rd of March to make sure that all members have the prior to the meeting. There is the possibility that there will be time allocations and set times for the presenters.

Larry Matheis recommended the Task Force hear from Medicaid and Nevada Check-up advocates, perhaps in a panel discussion format.

Dr. Javaid Anwar indicated he has received calls, written information and suggestions from people as to what could be or should be accomplished by the Task Force, suggesting there is great expectation for this Task Force to succeed.

Open for Comments

Keith Beagle mentioned the reading materials sent out to members by staff are appreciated and have been very applicable to the work of the Task Force.

Bob Ostrovsky noted that the Task Force has to come up with a basic agreement as to what benefits should be mandatory for health insurance policies. He asked that this be added to the agenda for the May meeting. He also asked if there should be work groups that meet prior to the beginning of the meetings to accomplish some of these items.

Dr. Javaid Anwar took the members comments under consideration and thanked the members for their ideas.

Senator Terry Care recommended members re-read Senate Bill 556 to find out what the Task Force should accomplishing.

Public Comment

Laurie England, Director of the Governor's Office of Consumer Health Assistance, noted that any outcome to alleviate some of the frustrations for the people that call her office seeking assistance for health coverage would be welcomed.

Adjournment (3:00 p.m.)

Scott Craigie motioned to adjourn; seconded by Senator Terry Care.