MINUTES OF THE MEETING
OF THE
TASK FORCE ON THE POLICY OF THE STATE OF NEVADA CONCERNING
ACCESS TO PUBLIC HEALTH SERVICES
(SB 556)
June 19, 2000
Carson City, Nevada

The sixth meeting of The Task Force on the Policy of the State of Nevada Concerning Access to Public Health Services was held on Monday, June 19, 2000, at 9:30 a.m., in Room 1214 of the Legislative Counsel Building, 401 S. Carson Street, Carson City, Nevada. The meeting was video conferenced to Room 4401of the Grant Sawyer Office Building, 555 E. Washington Avenue, Las Vegas, Nevada.

TASK FORCE MEMBERS PRESENT IN CARSON CITY:

Dr. Javaid Anwar, Chairman
Bobbette Bond, Culinary Union
Larry Matheis, Nevada State Medical Association
Bob Ostrovsky, Nevadans for Affordable Health Care
Anne Cory, Nevada Women's Lobby
Assemblywoman Sheila Leslie
Senator Terry Care
Senator Mark Amodei

TASK FORCE MEMBERS PRESENT IN LAS VEGAS:

Randy Capuro, Private Health Insurance Senator Mark Amodei, Vice Chairman
Assemblywoman Ellen Koivisto
Assemblywoman Merle Berman

TASK FORCE MEMBERS WITH AN EXCUSED ABSENCE:

Charlotte Crawford, Director, Department of Human Resources
Senator Randolph Townsend
Scott Craigie, Nevada Public Health Foundation
Keith Beagle, Nevada Association of Health Plans

DEPARTMENT OF HUMAN RESOURCES STAFF PRESENT IN CARSON CITY:

John Yacenda, Deputy Director, Department of Human Resources
Pat McInnis, Management Assistant I

APPROVAL OF MINUTES

Approval of minutes was postponed until the next meeting because not all members had adequate time to review them before the meeting.

Chairman Javaid Anwar noted in his opening remarks that he had read about the Vermont Health Plan and its rural focus and was looking forward to the breadth of material before the Task Force this day.

Dr. John Yacenda led the Task Force through a numbering of the items to be considered for BDR. In all, there were 39

recommendations from Task Force subcommittees and from testimony presented during hearings.

RECOMMENDATIONS FROM HEALTH INSURANCE SUBCOMMITTEE

Larry Matheis, Chairman of the subcommittee, reported on their comparison of seven plans (Exhibit A). We looked at the most common Nevada plans, PPO, HMO, Union Health Plan, the model comprehensive health insurance and health cost containment model that the National Association of Insurance Commissioners had developed and the subcommittee felt that for the purposes of the task force to make a recommendation for a basic benefits plan for Nevada.

The subcommittee recommends that the task force uses the following health plans as the potential Nevada Basic Nevada Benefits Plan to generate public comment and accurate analysis of the premium costs associated with the inclusion and exclusion of specific benefits and those are the HIPPA standard plan, and the composite of the most common preferred provider organization and health maintenance organization plans available in Nevada. That excludes the ERISA Taft Hartley trust plans. That's our first recommendation and that's so we've got something that we are working from when we are talking about what we will be recommending as the basic benefits plan that everybody will be covered for.

Anne Cory had a question on the lack of coverage for family planning services under most of these plans.

Larry Mathei added they weren't saying this shouldn't be in the basic benefits plan. We discussed in the subcommittee the absence of dental coverage. All this is so there is a working document before us. The task force will be soliciting comments and at some point will be making a final set of recommendation about what should be included. This is what is provided in Nevada to conform to the HIPPA requirements and the most commonly available HMO and PPO plans. The subcommittee was not endorsing any of the plans that are on the table; rather, that we have something to work from.

Dr. Anwar- Is there a motion to accept this bill draft? Motion made by Larry Matheis; seconded by Assemblywoman Leslie. Passed unanimously.

Move to recommendation #2-Larry Matheis -- One of the reasons so many of the debates about mandated benefits occurs is because of the problems created by those people who have conditions which make them medically uninsurable. That also, a very small number of people, has a disapportionate impact on premium costs depending on whether or not those things are covered. Twenty-eight states currently, not including Nevada, have high risk pools to deal with the issues of the medically uninsurable. What we are recommending is that as we proceed, the task force looks at recommending to the legislature the adoption of a high-risk pool program. At this point, without making any recommendations about which of the twenty-eight state plans that currently exist. Four or five models are the best. They have been around for a number of years and have taken a lot of pressure off of the uninsured numbers by taking out of those pools that have to be covered by small employer insurance. Those few people who have chronic conditions or have a specific condition that either raised the premium cost or make a group uninsurable. As we consider making a basic plan, we also should consider recommending to the legislature developing a high-risk pool on one of those models. Basically the second recommendation is to approve in principle the development of a proposal for a high-risk pool to provide coverage for a limited number of conditions or persons to compliment the development of the basic coverage plan.

Motion made by Larry Matheis; seconded by Assemblywoman Leslie. Passed unanimously.

A PROPOSED STUDY TO FIND OUT WHAT MOTIVATES EMPLOYERS ABOUT BUYING INSURANCE

Bob Ostrovsky presented a proposal for an independent study. We've had a study done by UNLV regarding how employees or employers are covered as individuals. We never talked to the employers directly. I am asking for financial support from the committee's budget and if I can get any funds for this. I would do two things. First, I would go to the private community and raise the remaining funds needed to conduct this study. Second, the committee could put together a subcommittee. If we want to do a study, we have to look at the current availability of the budget, how much of that you might allocate to me and then I will try and raise the rest of the money privately to do that study. The request is substantial, almost $25,000, which I think is probably too much for the budget in this committee. Any portion

that could be paid would be helpful.

Dr. Yacenda explained the budget constraints of the task force, and indicated that until the actuarial work was completed there was no discretionary money for a study.

CHAIRMAN QUESTION'S SUBCOMMITTEE REPORT

Senator Care, Chairman, reported the subcommittee looked at other states, web sites, legislative council materials, and heard testimony from Laura Tobler who is a expert on the subject. We looked at sources that we already work with and at the suggestion of Charlotte Crawford, we broke it down into demographics. Example: Anne Cory looked at what other states have for women; especially women who are head of household-working women. Sen Amodei was to look at disabled who are not currently covered. Out of that, we came up with these recommendations and when we met the last time, we all agreed to unanimously adopt all of the recommendations even if some of the members from the subcommittee might oppose some of these. The idea was not to stifle creativity. We were interested in concepts. I'm not sure what to do with the 28; that is too many bill draft requests. Sen Amodei is still waiting for materials. We will try and tie the threads together. What I would like to see is the members look at all twenty eight and take it from there.

Dr. Anwar-We'll go through our number list; #4 would be the Tenn Care and this is important.

Anne Cory commented that a resolution creates the same amount of work for the bill drafters, committees, and everyone as a regular bill. A resolution carries no weight.

Dr. Anwar: We need to have a motion or move along.

Anne Cory-Perhaps the legislative members of the task force can suggest the best process for us to follow. Recommend some long term policies for dealing with health care access. Is there something to let us do long term planning?

Senator Care echoed Anne's comments as to the value of a resolution. Laura Tobler said to go slowly, don't try and change too much to soon. It is a long-term process.

Assemblywoman Leslie asked if this is something that could be referred to the Interim Health Committee and agreed a resolution doesn't solve anything.

Assemblywoman Kovisto-It could be handled that way or a separate study group to keep this issue alive and keep people working on it. I don't think we should let the issue go. A resolution might throw it away. To request a continuing study group or to refer it to the health care committee for continued study would work.

Dr. Anwar-We could have a request for a BDR for a study by the legislature.

Assemblywoman Leslie-I would support that and motion to request a BDR for this purpose. Seconded by Assemblywoman Koivisto. Passed unanimously.

Dr. Anwar-#5 and #6 have been acted on by the Legislative Committee on Health Care so we don't need to take action on those.

The school based health center or clinics. A part of #7, #14, #26, and a portion of recommendation of #31. We can formulate one out of these.

Bob Ostrovsky-Are we going to make a motion that says that this committee supports school based clinics or would you like one that is more specific to create a bill draft to raise that issue with the legislature.

Dr. Anwar-We want to make a bill draft.

Assemblywoman Leslie-I concur. I would like to see some money attached to it. I prefer #7, initiate a pilot program so

it has a better chance. We would have money set aside and have school districts compete for who would want to do the pilot project.

Dr. Anwar-How would we ask for money?

Assemblywoman Leslie-In bill draft, you just ask for money.

Anne Cory-Would the committee need to specify how much money would be necessary to accomplish this pilot program?

Dr. Anwar-And for that we would need to know the scope of the pilot project. Duration of time, how big it's going to be.

Anne Cory-I would be happy to work with a subcommittee or part of the Chairman's Question Subcommittee whichever would work better to development that information.

John Yacenda-The reason we selected the bill drafts, we have ten for the task force. Notification needs to go to legal division and LCB about our areas of interest as soon as possible to claim our space.

Dr. Anwar-Suggest bill draft conceptually on the subject of school based clinic along with appropriations needed for the pilot project. Moved by Assemblywoman Leslie; seconded by Larry Matheis. Passed unanimously.

Dr. Anwar-#8 extend family planning benefits to those as part of Medicaid and Nevada Check up issues and I don't know if we need to take any action on this. Are there any comments?

Anne Cory-This was one of my proposals and there have been some states. It is a Medicaid suggestion, with heads of household women who are turning into the work force. It is a very cost-effective measure for coverage to continue coverage of family planning benefits after the woman has lost eligibility for financial reasons for other Medicaid services. It's an excellent way of preventing a subsequent pregnancy.

Bobbette Bond-Anne Would there be a way to limit family planning service more to birth control services. Because when you get into family planning, then you're also talking about fertility treatment and that might be a different issue.

Anne Cory-The coverage would be currently available under Medicaid which does not include fertility treatment. So, it would be the same benefits package. It would include cancer screening, contraceptives, annual exams.

Anne Cory-Because it is a suggestion for the Medicaid program; are you assuming we do not need committee action or legislative action if the committee were so inclined? I believe it is an expansion of the Medicaid program that could not be done without legislative approval for expansion.

Dr. Anwar-I think you are right in your comments but I think it beyond the scope of our task force and our mandate.

Anne Cory-It seemed to me that in the Chairman's Question Subcommittee, we were looking at Medicaid coverage in other states to find innovative ways that we keep people insured any Medicaid expansion would probably be within the scope of our task force job. I would be interested in hearing from other task force members on their response.

Senator Care-We looked at between 25 and 30 states on this and I agree with Anne's interpretation of what this subcommittee was charged with.

Dr. Anwar-There is 10, 11, 12, 13, 15 and 16, which are similar. They are important issues but are they part of the mandate of our task force. We could, even the things that we feel are beyond the mandate of this task force, make recommendations in our report. We can vote on the ones, which we want to formulate a BDR.

Anne Cory-I wonder if the Medicaid questions could be put into one BDR to be dealt with together. They are

addressing Medicaid eligibily and access to health care through Medicaid.

Assemblywoman Leslie-I like that idea for now. Can we keep track of the Medicaid program ones and then put them in one BDR.

Dr. Anwar-Moving to #17 which is eliminate mandates and moratorium on mandates as #18. #19, #20 and #23. Those I thought were not part of the mandate of this task force.

Bob Ostrovsky-#17 should be withdrawn. #18 is part of the charge of this committee to make recommendations about how to control future costs. #19 is part of Larry Mathias's committee and that should be pulled until we decide what we are going to do in that area. #20 should be pulled. They are getting commissioned now and so that is unnecessary. #23 is an issue. This might get mixed in with the Medicaid. This is how to spend existing dollars. I might point out in #16, seek a federal waiver, for employers to participate in CHIP funding, similar to Massachusetts. Really is something I am suggesting in #23 which is creative ways to find partnership between government and business to see that the working poor are insured. How do you want to approach that? Do you want to throw that into the Medicaid issues you just talked about? That would be fine. I'd hate to see these not addressed in some way. I would be happy to discuss any of these items.

Dr. Anwar-Some sort of agency or board or organization to be an intermediator between the Government and private sector. I think it is important conceptually and I want to include something in our final report.

Anne Cory-It could be a part of our proposal on a study.

Dr. Anwar-Could we have a motion? Anne-motion would be to include #23 (funding of a quasi-governmental agency to grant funds to innovative employer programs) in the request for a BDR asking for an on going study of innovative models of health insurance and health care access for low income and uninsured people. Seconded by Assemblywoman Leslie. Passed unanimously.

Bob Ostrovsky-We skipped around. What did we do with #11 through #16 and the others?

Dr. Anwar-That's all a part of Medicaid and Nevada 3Check up.

Bob Ostrovsky-Those will be included in our discussion of Medicaid at a later time?

Dr. Anwar-The school based clinics; we have already taken action. Any of the others, we have left out, would be a part of Medicaid.

Bob Ostrovsky-The only other issue is #18. Is that not a subject that you think this committee should address?

Dr. Anwar-Are you talking about the moratorium?

Bob Ostrovsky-Yes, #18. We have discussed some of this before. After considerable discussion and study at the subcommittee level, I think we've agreed that we can create the plans, no one will buy them. No employers or individuals. Keep mandates so we don't take away any benefits. Some agreement that we cannot continue the cost of health insurance to increase. We should ask the legislature to allow this thing to level out. This increasing cost continues to create more uninsured. It's going up way faster than the current cost of inflation. I think the committee should recommend that. We need to get some control of future costs if we're ever going to ask employers to continue to invest money in these plans on behalf on their employees. I would be happy to hear from anyone else on the committee.

Bobbette Bond-I'm not convinced, based on the presentation at the last meeting, that the reason insurance costs are increasing is employer mandates. We are seeing increases in industries that don't even need to pay attention to those mandates. I'm concerned that this committee would go ahead and issue a recommendation for no more mandates and the legislature when we don't know what might be coming and when I don't think that there has been any direct link to the cost of these mandates.

Larry Matheis-I think the issue is what is the trade off. If there is a sense that the legislature should not consider future proposals for mandated benefits. There is a reason that the public has demanded those benefits and its because they can't get the coverage that they want or need through the way we have allowed the system to develop. We can be part of the overall recommendation related to the adoption of a basic benefits plan and process for future changes in the basic benefits plan that removes the extra need for the public to go to the legislature to get a benefit mandated because the basic benefits plan will have considered overall, the cost and benefits associated with including any particular coverage. That's also why the subcommittee on insurance recommended looking at the high risk pool to take that added pressure off of the need for mandates. Without a basic benefits plan being adopted, without something to address the medically uninsurable, a process that would prohibit the legislature or would say that this committee says it is a good idea for the legislature not to consider public requests for additional requirements that insurance cover X Y or Z, would be unfair. I think it would not move anything further except to allow further exclusions from basic coverage of things that people need. It can't stand alone but part of an overall package that assures that the concerns which cause the proposals for mandated benefits is addressed: then, I think I could look at it positively.

Bob Ostrovsky commented to Bobbette -- I'm not suggesting that mandates are the only things that are increasing the cost of health insurance. They are just one of the items that are involved in increasing the costs. Many states have asked for mandate moratoriums and have gotten them. We have got on the books now a requirement that certain steps be taken before mandates are adopted by the legislature that is ignored by the legislature. I suggest that you speak with fork and tongue if you want to make health care more affordable yet you don't want to give up anything. I would urge you to support this. We need a basic benefit plan.

Senator Mark Amodei - Bob, I'm concerned about the cost of providing insurance and want it to be as affordable as possible for the business people, some of who you represent, to continue to provide that. A mandate doesn't make the big leagues in this state and what generates to cost of coverage. I'm dismayed that no pharmaceutical folks saw fit to stop by when I was in attendance at any meeting. That's a huge number in the overall cost. Life style was a huge cost. I'm not saying that we need to continue to be able to do what your asking us not to. But as a member of the legislature I'm not going to toss in the only chip that we have got until some of the other folks, competition amongst providers, until some of those chips are on the table tossed in to. This is not to be interpreted as a lets continue to legislate benefits but it probably should clearly be interpreted to say at least for myself; that I'm not going to toss in the legislatures ability to be involved in health care in that sense without the pharmacy people at the table, without doctors at the table talking about competitive issues and some of those other things that according to the objective cold facts folks that have spoken to this committee are the major drivers of medical care costs in this state. For what that's worth, that's where I'm at as a result of being on the committee.

Randy Capuro - It seems logical that you have to close the door on the barn if you don't want to let the horses out. We're not going to be able to change what the legislature thinks and what they do but I think it's a philosophical point that we have got to say. We've got to slow down on some of these things till we go ahead. I don't believe that we can tell a legislature what to do. They're going to do what they're going to do. It's just a general idea what we've got here to slow things down to get things where we think they should be. That's my comment.

Dr. Anwar-No further comments. It's seems that there isn't much appetite to vote on this right now. What we can do is as we go along, when we're ready to formulate some response, put some information together, the things that this task force feels strongly about we could include as a part of our report later on if things change. But at this point in time, it doesn't seem like much muscle on this. We'll keep moving down the list. #24 is reciprocity in doctor and dentist licensing.

Bob Ostrovsky-I think relates to another one. Does the medical school have one here. Someone had one, is it Great Basin that's got one relative to the Western Regional Dental Board licensure process and so on? Should we combine those? #35 and #24?

It seems to me #34 and #35 which talk about access to health care as a consideration of licensing, and the use of the Western Regional Dental Board licensing procedure and so on, are all related to this same issue and that's permitting more doctors and dentists to practice in this state or encouraging them to come here. I asking Dr. Yacenda whether or

not we should look at these together or individually.

Dr. Anwar-Bob, are you talking about #34 and #24?

Bob Ostrovsky-Yes.

Dr. Anwar-Yes, we have those combined together. I think we can look at both of those together because they are complementary.

Bob Ostrovsky-I certainly encourage you to look at ways to permit more doctors to come into the community and more dentists. I don't believe I'm expert enough to talk about doctors. We have people here that might be able to respond to that. Clearly we've been having problems in finding enough dentists to serve Medicaid and Check Up patients and I would encourage you to look at either allowing licensees from other states to come in or the Western Regional Dental Board licensure process to be used; or both. To try to permit more dentists to enter and serve in this community.

Larry Matheis-I don't think we had any testimony or information that this is a problem when it comes to M.D.'s or D.O.'s. I think it was about dentists. In fact, there are a number of specific statutory provisions that do allow the Board of Medical Examiners to waive some of the requirements in order to assure location of physicians in under served areas that is used considerably. There are also ones on waiving, or the reciprocity issue, with low-income tenants that are almost never used. I think that the testimony that there are problems with the number of physician in certain specialty categories. I don't it has anything to do with licensing or with the ease of licensure. It really has to do with the geographic distribution of specialties around the country. I think we have heard as a task force, and many of us have been involved in a number of meetings over the years that there are problems related to the number of dentists particularly dealing with Medicaid population, the indigent population and at least a part of that has to do with the licensing and the reciprocity issues. I'm not sure that I've heard anything that there is a specific problem regarding physicians but I think we have heard the other.

Terry Care-The testimony that I recall from Laura Tobler was that in some states there are civil immunity laws that have been acted on to encourage volunteers to come in from other states. I think we are talking both about dentists and doctors. I may be wrong. As I recall, in those states where those programs exist, the number of people being treated, had demonstrably increased.

Larry Matheis-I wasn't aware that this was talking about the volunteer program. I think the Board of Medical Examiners is going to be proposing legislation that will allow them to create a special category for licensing retired physicians who move into Nevada to be able to offer their services free in these areas. If that's what this is talking about, I thought this was addressing the licensing issue and reciprocity issue. I think I'm right on that. This was more about the dental professional shortages.

John Yacenda-The subcommittee chairman that Sen. Care was is referring to the program in Tennessee. A volunteer program where the physicians can come to the state of Tennessee unlicensed and practice in voluntary clinics for a certain amount of time for part of their rural outreach. They found that program very successful. The sub committee heard some testimony, which led to Mr. Ostrovsky's recommendation on this. It was documented in the sub committee to bring this to a level of a recommendation and I believe the intention here is to request a BDR which includes both recommendations from Mr. Ostrovsky and Great Basin Primary Care Association. This is to get the BDR space and then develop the thoughts that are appropriate to that afterward.

Bob Ostrovsky-To request draft asking for some ease in the reciprocal arrangement we make with other states and to introduce the joining of Western Regional Dental Board licensure process. It means the state would still have its own licensing procedure; but, someone could take a practical examination and it covers a number of western states in one exam rather than have to take the practical exam in many different locations. The Board would still have the licensing policies it does. It applies to the practical test and I believe that would help insure better access in the future.

Motion made by Bob Ostrovsky; seconded by Anne Cory. Passed by full Task Force with a "no" vote from Assemblywoman Koivisto.

Anwar-#25, #26, #27, #28, and #29 are already a part of 38, which is the office of minority health.

Bob Ostrovsky-I agree on #25, #27, and #28. They are issues all relative to addressing minority populations in the state. One comment on #29. The idea here was not only minority services but I think these kinds of issues used in other states can help address the issue in the rural areas also. Other states have given special funds set ups to repay doctors school loans or make other kinds of financial incentives to get health care professionals to either locate an office in a minority community or a rural community. That requires dollars. Some fund would have to be created to say it is so important to get health care to rural areas, Native American reservations. It is important to get into areas of the communities, which are substantially minority in population. I don't know if this committee wants to consider that or we can do it in the minority health issues of setting aside some money. It effectively worked in other states. That is where I got this idea. This idea came from other states Chairman's Question Committee.

Dr. Larson from the School of Medicine-I wanted to inform the task force that there's actually within the office of Rural Health, which is housed in the University Medical School, a number of programs that provide scholarships and pay backs for both physicians and P.A.'s who come back to rural communities and I would suggest that perhaps a short paper from the Office of Rural Health would be of great benefit in actually outlining what other programs are currently available to recruit and retain health professionals in the rural areas.

Dr. Anwar-#30. Dr. Larson-I'm a professor of pediatrics and associate dean at the University of Nevada School of Medicine. I previously spoke before this committee and described the network of services that are currently provided by school of medicine faculty and residents to citizens in both Reno and Las Vegas. We already do a fair amount of uncompensated care covering a lot uninsured and under insured through the auspices of University Medical Center and their affiliated clinics and Washoe Medical Center and their affiliated clinic. It's a very complicated system that pays for this. Both Washoe Medical Center and University Medical Center who are the designated hospitals for the two counties for uninsured and under insured folks. They receive money to support their residency programs through Medicare. They are allowed an additional payment on top of their Medicare funds to support residency programs. This money for the residency salaries and part of the faculty salaries comes from the hospital this money comes from Medicare reimbursements. It's been difficult to get a handle on how much money that is but we suspect it more than pays for the cost of residency programs. Washoe Medical Center is under contract to Washoe County to take care of their indigent patients. Carried out by the School of Medicine through contracts with Washoe Medical Center. In Las Vegas, at the University Medical Center, their clinics serve whoever walks through the door and they consider the residents to be the primary source of that care in the offices. Faculty does have to be available to supervise. There is a strict regulation on faculty supervision for residencies. That's the basic way this is identified. Much of the indigent care is paid through Medicare. Part of our recommendation today really has to do with how do you increase the ability to serve folks who are uninsured or under insured. Number one recommendation has to do with creating a pool of money. I am not a money person. You don't get something for nothing, no matter who is providing the services. A pool of money is the most continence part of any program to really serve this group of patients if you're looking for a more comprehensive program. I think there are some minor ways to increase access, look for innovation in the delivery of services that might bring in a few more people into the system or even people who would already qualify for some of the programs but clearly a pool of money is the only way to be able to address some of the major issues of the uninsured. They are the ones who do not get preventive care. Who suffer from a number of life style issues? I brought up the issues of tax. I hate to say that. Some sort of fee schedule that would allow this to happen in addition to state funds. We have tobacco fund that has been designated for primary care. That needs to be looked at as part of the pool of funds to fund this particular issue. I've read through the packet and I'm particularly taken by how and if it would be possible to combine a number of programs for low-income folks. You have the Tenn Care project that you looked at which includes Medicaid, the indigent, the uninsured all in one large package. That would require a big overhaul of existing systems. I don't know if that's feasible or possible and I don't know how broadly you want to look. This is going to be difficult without additional funds.

Dr. Anwar-How big a pool of money are you looking at? A pond, a river?

Dr. Larson-If you're saying that the uninsured and the under insured should have the same basic coverage as those that are insured. This is a large lake. If you are looking at some other programs to increase access, to start the trickle of people, perhaps those who are qualified for other programs that are already funded to begin to get them into the system. It's not the big fix; it's the slow fix. I think then we are talking about a pond. It's absolutely critical that the folks you look at to serve and what you want to serve them with guides any sort of allocation that's being looked at.

Dr. Anwar-One of the mandates of this task force is that if you're going to come up with a program that requires a decent funding, we have to come up with a source of that funding also. Do you have any thoughts; you were looking at tobacco dollars. What are you're thoughts?

Dr. Larson-I agree that it could be one of the sources. It's been designated for primary care, this would be a very important way to begin to address the health issues of those who are uninsured and they do include life style issues like smoking. That's one place that needs to be looked at that cannot fund a big program. I don't know how much of interest this is to businesses. Do they suffer from absenteeism from their part time employees who don't have insurance coverage? Do they have to stay home with their children who are uninsured? There's many other issues for the working poor that beg a question should there be another source of funding for that as part of looking at how do you keep people healthy and a work force growing and healthy. I think that need to be looked at. That's not my area but it seems evident that if you have some benefit for these dollars, then you push programs for those benefits. One of the issues is that you pay a lot of money for insurance and do you see what you want to see from that insurance money. Insurance companies are in it for the profit and do we look at looking at insurance companies and their profits, same as HMO's and their profits, or do you look at actually creating a new system that is government run that may be less an overhead. Those are some fundamental for the long term about how you might look at really funding more care at maybe the same price.

Anne Cory-The Chairman's Question Subcommittee talked a little bit about this issue and how to most effectively increase access to uninsured and under insured individuals. Our discussion centered around the fact that most insurance provided in our society through employers and that when we have a large number of working uninsured that we do have in our state, it might be most effective to target some of the funding at paying or subsidizing insurance through employers rather than creating a separate system. Particularly in a state like Nevada, where politically creating government programs is not always the most popular way to go about things. There are some models that we can look at of using government money to subsidize private insurance for employers for uninsured individuals.

Dr. Larson-There are already systems developed. There are many systems already in place to begin to serve the uninsured and under insured. What might be effective is to network them more fully. We have counties with systems paid for by county revenues and those are big systems; particularly in Clark County. There are systems in Washoe County that are funded through county funds. Can we enhance existing networks a little bit and how much will that cost or benefit or is it necessary to go after insurance premiums to do that? I don't have the answer but I think it is a fundamental question when you are looking at cost effectiveness.

Dr. Anwar-Do we have a motion? To formulate this as a BDR?

Assemblywoman Leslie-So motion that we adopt what the chairman said. Aren't you listening? I thought the chairman was asking for a BDR. I'm wondering how this relates back to one of the first ones. I'm losing track of our bill drafts. I'm open to supporting this.

Assemblywoman Leslie-Mr. Chairman we have an idea. Because this is overwhelming, does it make since to put this issue into our study that we are calling for and have a look at how the funding for the tobacco settlement relates to this and what are the different options because there is more options that what Dr. Larson happened to raise today and I think it's worth considering if you feel that it fits within the scope of the proposed study.

Dr. Anwar-I think we could make it a part of that study. We don't need a separate BDR for this. That will open up if we need it for something else. Yes, we could make it a part of that study. We could specify that this is to be looked at also as a part of that study.

Assemblywoman Leslie-Then I would make that motion, Mr. Chair that we include this as part of the proposed study of this topic; seconded by Anne Cory.

Bob Ostrovsky-I have a question? What I think we just did was something the legislature has done already. Clearly the legislature has addressed issued relative to the combination of indigent funds at the county level and rejected that as a proposal. Somehow it has been incorporated into state funds. What I hear now is seeking out a revenue source; I guess I'm not even willing to vote to study this matter. It's going to result in a property tax increase or tax upon insurers I hear again that insurers are making a lot of money in this state. I disagree. Whether we're going to put some taxes back to the employer. This is not the solution to the problem. There was some discussion made that we have in one of my proposals was to look at the state of Massachusetts where we do have a partnership between employers and government to try and use existing dollars to stretch them as far as they can but I can't support a motion to seek out new revenue sources.

Dr. Yacenda-Mr. Ostrovsky according to my records, the intention of the motion is to include this concept in our continuing study which is looking at what is going on in other states and how those programs can fit into what some of our ideas are. That would include the Massachuetts model as well as the other models. The context the mood of the chairman is not to have anything come out of this task force that talks about raising taxes or creating new revenues outside of existing revenues. Only if I'm speaking correctly for the chairman. Only reapportioning current revenues is acceptable to him. I think you can be certain that whatever language will come out of here will reflect that. There will not be an intention to create new revenues and that it will only be to look at best practices to what's going on and how we can apply those to Nevada.

Dr. Anwar-What Assemblywoman Leslie has done in her motion is include this as part of that study.

Assemblywoman Leslie-If I can clarify, I think and maybe Doctor Larson could help us here, I'm willing to include in this study the idea of looking at existing revenue sources such as the tobacco settlement which was supposed to be spent on health care in the study of what other states are doing and whether we can create a model for health care for Nevada that actually works for our citizens so I'm looking at the broader scope and I would like this concept from Dr. Larson and the medical school to be considered as part of that study. Dr. Larson, can you elaborate or clarify a little bit?

Dr. Larson-Actually this was meant to be a provocative statement rather than an absolute recommendation because it is very difficult to say how you're going to increase coverage's and the ability to serve people without having a funding source and so I think if it can be done with existing funds and reallocations looking at some best business practices as far as clinical guidelines, ways HMO's use to cut their costs, then I think that is useful. This was meant to be more provocative as how do you pay for this. It's not going to come through the existing systems without change.

Bob Ostrovsky-I going to vote against this motion.

Assemblywoman Koivisto-Maybe this is already being taking care of in a study that being done during this interim of the tobacco funds by the AB474 Task Force for a Healthy Nevada that's co-chaired by Assemblywoman Buckley and Assemblywoman Freeman.

Terry Care-Just to follow up. When our subcommittee met last time, I raised the issue of the tobacco settlement funds and task force for a healthy Nevada is looking at this. I think some of that money might be available if that's what this vote would be about to inquire into that. I think it's maybe 20% of the 50% of the funds that the tobacco settlement money is earmarked possibly could include. It's supposed to go to people with disabilities and for children. Programs for those two demographic groups. I'm interpreting the motion to mean that the recommendation would be to look into seeing if those funds that that task force is mulling over would be available. Certainly not an increase in any existing taxes.

Nancy Angres-The task force for Fund for a Healthy Nevada at it's next meeting on 29th of June will be setting up a grant application process. Certainly anybody who wants to try and access that money can put in their request for proposal as allocated by that task force when that happens. I want to point out that that money is in the process of being

considered and allocated and you don't want to miss out on that by having this task force study the issue.

Dr. Anwar: Do you want to withdraw the motion?

Assemblywoman Leslie-I'll withdraw the motion because I think we have much more important things to use our debating time on today and I guess I was using it as a forum to say that rather than go through an RFP process to try and get some money out of that poor committee that's going to be deluged with requests. I wish we had appropriated money from the tobacco tax settlement or consider looking at future tobacco tax settlement monies to fund health care. I am getting outraged at the state of health care in Nevada. We've heard over and over at these committee meetings how important it is to fund the uninsured, the underinsured and we know it costs a lot of money. We know costs are going up and yet it seems we keep dancing around the fact that Dr. Larson was correctly pointing out that it costs money to do that. I will withdraw the motion at this time.

Dr. Anwar-Moving down to #31. Portion related to school based clinics. Dr. Larson, how do you feel about that? We have combined that with #7, #14, and #26. We thought that it would include this.

Dr. Larson-Within this recommendation, it just acknowledges that there is already a system of care in place that uses residents and faculty that already begins to serve the needs of the indigent and the under insured. One potential is to put in money to the budget for the School of Medicine for faculty and residents to enhance the ability to serve more people. I gave you a number of options here. Since we're part of the University budget that's starting to get beat up that may be difficult. That's one way to be able to fund providers. I think you recognize the fact that the School of Medicine through their residency program is a fairly inexpensive provider of care with the way they are set up. The other part of this had to look at new sites. I've been looking at starting this in Washoe County for five years. There are a number of barriers. A bill draft that states you want this to happen would be the greatest thing that could happen. Right now the school boards and the school districts are frightened of getting into this because for them school based clinics mean birth control. This needs a lot of education and its one of the reasons we could not get this started in Washoe County schools because there was nobody willing to take on a pilot program. This is the best way to reach the un and under insured to provide primary and preventive health care. This establishes sites within neighbors that are familiar and comfortable. It allows health professionals to rotate because this would not be available everyday. They are set up with a rotation. It utilizes health professionals effectively. This should be a program that utilizes public health, health professionals, as well as social services or health aides that can actually address the other wrap around issues. What happens with these is you identify people who are able to access other programs and need other assistance with housing, food. You provide a way to raise their whole level of living by having wrap around services. Usually the social services that co locate with medical services. It's effective, it's been shown in a number of programs federally to enhance retention and recruitment for programs. My proposal as a secondary part of this would be through funding and allocation actually a pilot program in Las Vegas and in Reno in conjunction with the health department and with the school districts. I think the only way that would be started would be through a bill. I would support that because I know how difficult it will be at the local level.

Dr. Anwar-Comment. We as physicians we understand when the work clinic is used as to what it means to lay public. A thing that is common among physicians may be taken in a totaling different context so I wonder if the language of that should be changed from clinics to something else maybe school based health care or something to make it softer and easier to promote. Second, you may solicit your parties spacing? and drafting of the bill.

Dr. Larson-I'd very happy to help. I've had experience in looking at the barriers to the provision of health care in schools and I'm a proponent of it. I think it will serve the neighborhoods we want to serve in the best fashion.

Assemblywoman Koivisto-Is this an enhancement of the school based health clinics that we already requested the BDR for?

Dr. Anwar-It's part of the same.

Assemblywoman Koivisto-I don't want to use another bill draft for something we have already done.

Dr. Anwar- No, that's a part of it.

Roger Volker-Executive Director of Great Basin Primary Care Association. We appreciate the opportunity to come before you this morning at your invitation to present some recommendations from our members. Our association represents all of Nevada as community health center sites. Most of the tribal clinics throughout the state and other safety net providers. The clinics serve nearly 100,000 under served citizens in Nevada. As per request, we solicited the membership of our organization as to the recommendations which they would make to the committee based on Access to Health Care and we are presenting this morning seven of those which you have numbered 32 through 39. I've also invited Loren Ellery, President of Great Basin Primary Care Association and the health director of the Reno Sparks Indian Colony along with Dr. Carl Heard who is clinical representative to Great Basin and also medical director of Nevada Rural Health Centers and we have presented along with those seven recommendations some background information. It is not intention this morning to go through all that information for you. Particularly since it appears that a number of our recommendations are now becoming involved with roll-up. Roll-up process with the task force. I would like to make a brief comment on each one Mr. Chairman and I wonder if you would like for me to go over in total or take them one at a time.

Dr. Anwar-Let's do Office of Minority Health first.

Roger Volker- This one probably not near the top of the list although it remains an important agenda item for our association and that is we would establish a Nevada office of minority health and that we would recommend that it would be located within the priority care development center of the Health Division of the Department of Human Resources. We've given you some language in terms of what we think that would do and we're also recommending that perhaps that it could be done of reprioritizing some of the tasks of personnel within that division so that there would be a person in Nevada who would be able to focus the dialog around minority health issues. I heard an earlier testimony that minority health issues might also include those who are living in parts of rural Nevada given that they also have extreme barriers to accessing health care as do minorities that are based because of ethnic necessity or other sorts of barriers. It would be important to us that you might look at that list and basically it would be to increase access for particular populations to build coalitions with local communities to work with service providers to see to it that we have providers that are culturally competent or are geographically dispersed in various areas where we can raise the access issue.

Dr. Anwar-I think from our task force point of view, it seems like it is an important issue and come out of two committees already.

Larry Matheis-It is an important issue. I'm not sure that I would want to limit the Office of Minority Health to primary care issues. It seems to me that there is a significant ongoing problem in the state that there is no ongoing advocacy of the range of issued faced by the various minority populations of the state in primary care but in special problems of access to care, access to coverage, the uninsured rates are high, there secondary. I support the intent of the various proposals that came out of Senator Care's sub committee on this. I would like to see us recommend to the legislature and to the Governor to create an Office of Minority Health Affairs and to give it prominence not to lose it somewhere in the third or fourth levels of the bureaucracy and squeeze it into shape because of whatever bureaucracy office that it is put in but rather to say that it is time to recognize theirs a very special set of health problems related to Nevada minority groups. We have done a very poor job of addressing them as communities as a state and that we want to make that a priority and to raise that visibility and to raise that commitment as high as possible in the Division of Health or in the Department of Human Resources or in the Office of the Governor. As long as we are recommending the creation of an office. What we should do is to recommend that the issue and the cluster of issues about it are elevated at the same time. We say that this is a significant oversight in Nevada's history and one that we really see addressed.

Dr. Anwar-I think we can keep the language of that bill draft broad enough so that it is inclusive rather than exclusive.

Dr. Anwar-Would anyone like to make a motion?

Larry Matheis-So moved; seconded by Anne Cory. Approved unanimously.

Dr. Anwar-#36, we don't need to take action. It is part of #5 and #6 as you can see. Action has been taken by the Interim Legislative Committee on Health Care.

Roger Volker-I would like to add one point to that. When we are discussing the out stationing of the eligibility workers. That's the one we are referring to

Dr. Anwar-#36?

Roger Volker-Yes. We would include Tribal Health Clinics under the definition of Federally Qualified Health Centers and ask that there be legislation that would enforce the federal mandate to out station eligibility workers. We are cognizant of the enormous cost of doing of that and are willing to work representing the health centers with people throughout the administration in finding creative ways to do that but we don't want to de-emphasize that the mandate calls for those workers to be spread thoughout Nevada in the Federally Qualified Health Centers.

Bobbette Bond-Can you tell me how you anticipate the community health center here in Las Vegas being affected by this kind of program? I've struggled through this committee to figure out what exactly to do about the Community Health Center. It seems to have enormous potential to serve a lot the uninsured and the under insured but I know it's always struggled.

Dr. Carl Heard-If you're speaking of community health centers of southern Nevada, there no longer a Federally qualified health center. We as a community health center are interim grant recipients and are in the process of opening up four clinical sites in Las Vegas. These sites would qualify for out station worker or its equivalent. We would look forward to that cooperative effort. We will be moving into the new faculty that community health centers had initially been slated to go into and that will be in an cooperative effort with University Medical Center and a variety of other community supporters or safety net providers.

Dr. Anwar-We can go back to #32 and you can continue.

Roger Volker-The establishment of the Health Care Fund for Uninsured Nevadans is very complimentary of the testimony that Dr. Larson gave and also others that you have heard as a committee. I would like to add several comments. One is that in a study that Great Basin Primary Care Association has completed and which will be published on June 30. It indicates that there are over 350,000 uninsured Nevadans and that number seems to be growing. We have made two proposals as part of our presentation to you today on which we have put some number. If we use formulas to determine how many of these people access the primary care delivery sites which they do at about two and half times a year, the cost for the uncompensated comes to about $3,000,000 in our estimation and so that's why under our example #1, we've put that number. I heard the committee speak earlier about it's desire not to seek new taxes to provide funding and also you are aware of Dr. Larson's testimony that funding is necessary so what are we going to do about that? I might also share with you that the legislature in the state of Colorado just recently created a fund of $6,000,000 for citizens of Colorado and they took the money from the tobacco settlement. So in your study you might want to look at what Colorado has recently done. We also are aware of the Governor's budget projections for years to come and the view of how a deficit may be in our future. We are also aware that we may be facing some short-term surplus opportunities and so we are calling for the possibility here of making an investment. If we were to make an investment in the short term, in the infrastructure that we have a place here in Nevada to serve the uninsured. Those clinics spread out throughout the state might then have the ability to sustain themselves and provide services when we as a state might not have the resources to put into such a fund. We are suggesting that that fund could be used for capital improvement, for equipment purchases, for matching funds to support the development of new safety net provider sites. Once those are established; then, perhaps they will be capable of providing services in out years. In our other example, we were suggesting that you perhaps create some short-term compensation out of the fund to match costs that patients are paying in order to reduce the burden on the safety net providers today or some combination thereof. You can read the examples in the testimony.

Anne Cory-I think that this proposal strikes to the heart of what this task force was established to examine. When we look at the issues of the uninsured and the quality of life issues in our state that targeting the uninsured for health care services and finding ways to invest in the organizations that will be able to serve them is absolutely critical.

Dr. Anwar-#32, #33, #34, #35. These are all access issues. We have considered some of them already in #14, #24, #25, and #26. I think they are important enough that since it's a part of our main work that require some extra funding or some sort of funding source unless we whatever we recommend if that requires funding We have to come up with the source of that funding is going to be. However, short of that, we can always include them in our report that these are the things that the task force found to be important and worth looking into and addressing if it requires the legislative at least a look if not action. Some of these things if you can learn from the Vermont experience, repeated before that I reviewed this morning, that we cannot have our wish list, it is implementable because the forces of resistance tremulously rise in direct proportion to the number on our wish list. Their experience has been to make insured palatable chunks that can be swallowed and digested easily. I think that everybody can learn from that and people who serve on the legislature in Nevada know that very well much more than I know or some of our other colleges know. I think these are important enough issues that they should be apart of our report. We are on #32 still.

Anne Cory-I actually believe that #32 is important enough that I would like to move that we request a BDR to establish a health care fund for uninsured Nevadans seconded by Assemblywoman Leslie.

Dr. Anwar-My question on that would be that where would we look at the source for that funding?

Anne Cory-As we discussed earlier in response to Dr. Larson's presentation, I think there probably a number of issues we can examine in proposing a financial structure to support this. I think Great Basin has information on some short term funding opportunities that may disappear but they could be used as an initial investment. At this point, I would propose we reserve one of our BDR's for this issue and do some further research to identify the potential sources of funding and be able to present in the proposed legislation not only the initial sources of funding but some of the cost savings that we would accrue over time to our state.

Dr. Anwar-Any other comments or questions? We will take a five minute recess before voting on the measure.

Dr. Anwar (after the recess) - My personal feelings on all these is that anything that requires funding I'm basically in favor of some innovative way of reapportioning funds or coming up with services, as Dr. Larson pointed earlier that nothing comes for free. All the good things-the gooder it gets the more it costs. We do have a motion that has been seconded and any further discussion on that? If not, I'll call for a vote.

Assemblywoman Koivisto-I'd like a little more specifics on funding source?

Anne Cory-I guess the answer that I would have to give right now is, I'm not exactly sure if Great Basin in making this proposal has some specific suggestions. We could certainly consider that but I would say that in draft that that..I'm making the motion at this time to kind of reserve the BDR space and I'm perfectly willing to put some research time into looking at the potential sources of funding for this and what can be reallocated versus new sources of revenue and if there are new sources of revenue that acquired we'll put that into the proposal and if at that point the committee for the task force doesn't choose to move the legislation forward so be it. I think we need more time to establish what the sources of revenue would be but I believe that this issue is critical to the mission of this task force and I think we need an opportunity to make a proposal like this. But, also need more time to put the details together.

Dr. Anwar-Call for question? All those in favor. Passed unanimously.

#33-Establish Cervical and Breast Cancer Fund. A report?

Assemblywoman Berman?-We discussed this in our regular health care interim committee meeting and we had decided both Senator Rawson and myself would be bringing this bill forward as I worked on this very same bill in the last legislative session and got nowhere with it.

Roger Volker-This does call for and establishment of a fund but this one we would like to separate from the fund for the uninsured and talk about this particular issue and perhaps Dr. Hurd will share us with a little information on this particular one. Cancer is the leading cause of death among all women and Nevada is no exception to that. We have

good news and bad news. The good news is that we have dramatically increased our ability to do screening and early detection. The mammovan that is a part of the Nevada rural health centers operation which travels throughout rural and urban parts of our state in providing screening to particularly to low income women is a an asset that we have in this state. The bad news is that there are no dollars available in many cases to provide treatment for the women that are diagnosed. The reason we bring this before you is that if you look at the examples, the proposals, it's estimated that at least 212 women or more this year will be diagnosis with breast cancer who are unable to pay for those services and that probably could cost the state about $4,000,000. In some way or another it's going to be paid for out of indigent funds or in hospitals as they draw on their particular capacities and we would like to present you with an opportunity here as you can see in proposal #2 that working its way through the United States Senate today. Senate Bill 662 which is supported by both Senators Reid and Bryan could give us an opportunity to leverage the funds that are going to be spent in Nevada and we would ask that this committee and other related health committees in the state public support this activity. There could be new provisions under Medicaid which would then pay for this treatment services and instead of $4,000,000 it might only cost us $1,000,000. Here's an opportunity where the uninsured could be cared for if we were to join with our delegation in supporting that and perhaps, Dr. Hurd you have something to add.

Dr. Heard-I also oversee the mammovan project. It's now completing its fifth month of services in Las Vegas and it will be coming up north in the first part of July to travel throughout the rest of the state and continue to work with women's health connection in a pro active basis to try and detect cancer at its earliest stages. The interesting thing that I've read in my preparation for my testimony today is that this is another one of those cases where I think the state has accepted a grant and there is a requirement that the state set aside funds for the treatment and management of patients that are diagnosed as having cancer in that womens health connection program. At this juncture, there is not money available. There is some very generous efforts being undertaken by the first lady. This will not even begin to touch on the financial impact that is going to be found in this screening project. The mammovan will also be screening for breast and cervical cancer including cervical cancer, prostate cancer, and a variety of other health programs. That is simply a corollary to our request for funding for treatment for the women who are diagnosed with breast and cervical cancer. We are not requesting money specifically in this for support of a mammogram.

Larry Matheis-The issue is that a bill draft has been requested by Assemblywoman Berman and Senator Rawson to do this and there is certainly unanimous support for the item. It's just that it doesn't seem that it really needs to be a bill draft that we need to request as a task force.

I would suggest that the Great Basin Primary Care Association might want to work with Assemblywoman Berman and Senator Rawson to make sure the bill gets somewhere this next time.

Dr. Anwar-#34 is commission to monitor consistency and regulatory boards. Part of #24 that we have looked at earlier. Is there any additional comment on this.

Roger Volker-As we heard before and in #24 we were talking in particular about the provision of dentists in rural or underserved parts of the state. We've come today to recommend that a commission be established which will monitor consistency among the regulatory boards that license health professions in this state. Insuring that access to health care is a consideration in a licensing process and we realize that it takes a work group to define access to health care much as you have been doing but that the issues presented to us and the dental situation was a fine example. If you live in Yerington, Nevada which is not in the most remote part of the state and you have insurance provided by Medicaid or Nevada Check Up. You must go 160 miles round trip in order to access a dentist. Our studies show that 75% of all children who access public school lunch program in this state are in immediate needs of oral health if you speak any nurse at a school. She'll tell you that the #1 problem that he or she faces is children coming to school in pain and unable to learn. We believe that while some professions may have solved these problems to an adequate degree that across the licensing spectrum in Nevada that there are number of issues in terms of applying some sort of criteria that we could establish as a state that says; as part of your licensing procedure, you will look at the issues that have to do with access as a part of that. We've made a recommendation of what membership might look on that commission. The commission would be able to make recommendations to the legislature for action to be housed within the Department of Human Resources that would staff the commission. It would look for areas of consistency. Parody is a consistency issue. Are we're applying the very things that you are talking about as a task force to the process that is looking at practitioners and so definitely every heath profession should be represented on this commission so that we get a good sense of

consistency. That would be our proposal to you.

Dr. Carl Heard-It has been my experience in the five years that I've been medical director at Nevada Rural Health Centers that there is a great deal of variably from the way one board manages it professionals to the next board. There are some exceptional efforts being made on all boards cases and they have found some innovative solutions to certain access issues. It should be so much more difficult to recruit certain professionals into this state then other professionals and these are relatively easy to get into the state using the waiver program, using the H1B program, using a variety of other innovative solutions that the Board of Medical Examiners has found. But, when you look at other boards and every profession in this state is in a state of crisis now in the under maning of its needs. What we are asking for is perhaps one of those innovative almost no cost types of approaches that I think this task force seems to be searching for in that we could encourage and require each of these boards to get together, discuss their differences, review systematically their differences, look at how other states reach conclusions that are sometimes much more conducive to the public health need or the access to care needs and do all of this in a way that is essentially not duplicating services, we're not trying to create a super board, we're not trying to create one board that would have authority over any other board. We trying to say that if the innovations that are found both within the state and outside the state could be generalized to all boards then we could perhaps open the door wide enough to qualified high quality physicians and all other professions. Pharmacists, dentists, the variety of nursing staffs that would be needed for this state that we could probably avoid perhaps some other more costly ways to bring professionals into this state.

Anne Cory-I think it's an excellent goal and the process of getting from where we are now to the ultimate goal of having coordination among licensing boards is a reach for this task force and legislatively probably a very difficult proposal to move through. I'm wandering if mentioning this in our report and maybe working with someone from Senate commerce, perhaps asking Senator Townsend if he would be willing to discuss this issue.

Anne Cory-We've handled most of the proposals at this point except all of those issues that relate to Medicaid and Nevada Check Up. I wonder if we might discuss how we can address some of those issues that are in fact very important in insuring access and increasing access but are separate in terms of how we approach them.

Dr. Anwar-We're going to get down to that at the end I was hoping. On number 37 did you have anything specific to say about settlement dollars that haven't been discussed already or that you want to bring to the attention of this task force.

Roger Volker-I do not Mr. Chairman. I might add that all of the members of our association are willing to work with members of the task force in any part of this process to help move these recommendations forward.

Fergus Laughridge-Supervisor, Emergency Medical Services, Bureau of Licensure and Certification, State Health Division. Thank you for allowing us to talk with you today. When originally presented with this task our focus was not clear. After spending the last three hours hearing the focus of the task force, my focus can be applied to your scope of what you are trying to achieve. Just a brief history on emergency medical services in Nevada is one of areas that is strictly general funded. But it has a very big responsibility in the state. Within every community there are emergency medical service units. The original scope of this agency was to be the regulatory agency to oversee that and to make sure those provisions were there. The scope of practice has changed now for emergency medical services across the country. We are concerned that our demographic change in Nevada that scope also changes. It must stay in line with that. We find that some of the concerns that you have from the other presenters and recommendations today are very in line with those of where emergency medical services are at. And even more so because emergency medical services in our communities do not have the mechanisms in place because they have never been integrated into our overall health care program in Nevada. It is probably the biggest things that we would like to see achieve is that as we talk these issues that we do integrate EMS into those areas. We should look at establishing that the state office of emergency medical services be the designated lead agency for all of these activities across our state. We have issues revolving around medical direction, the scope of practice of our EMT's, intermediates and paramedics, and what they can and cannot do at any particular time that all need to be incorporated into that. One of the areas is of interest to us or that we would like possible direction on is the licensure as we have it now, you must be licensed to provide care on an ambulance, certified and licensed to provide care. The person is allowed to provide that level of care with the service that's permitted at that level. I could have a paramedic that's working with a basic ambulance service and he or she can

only provide basic care up to that level.

There's a movement in other states where this has been expanded to where they incorporate with the state medical director, which we do not have one right now, that we could incorporate in allowing this paramedic to function at that level if it were approved by this agency and by the medical director and with the proper training and oversight. That would allow the other communities to have an expanded services out there. As we move along and the services wain with our hospital, with closures that are on the forefront and we're talking about these issues, it's the emergency medical services in each one of those communities that's going to be the true safety net provider. We have problems with vehicle replacement, there are programs that we should be looking at outside of Nevada where we could have some alternate funding sources for that or just education for the ambulance provider, the community directors to assist them with that. One that is coming out of Oklahoma that we are starting to look at a little bit. Overall, our biggest problem is that we the state agency don't have the latitude in regulation and statute. I have identified some areas and the big one within the packet was the medical direction and needing a physician. Our physicians in the communities can converse with on the issues revolving around emergency medical services and I've outlined that there. This item has been looked at many times.

We have an aged communication system that we could possibly join some partnerships with some other private entities to work through also.

Education, we working with the University School of Medicine in trying to develop a program of outreach, telecommunications, with compressed video and other things like that. Our biggest one coming up in the provision of emergency medical services will that of financing. DHCFP is establishing a fee structure for ambulances. It will be a set fee structure that every ambulance in the state will then be under that. It's unsure how that will filter out. It will take effect January 1, 2001. Then we will see the impact of that. We need to be proactive to this because this could be a very big impact to our rural service providers that we have out there now. I look for direction from the task force on how to proceed with that.

Dr. Heard-I can speak as the chairman of the Nevada Emergency Medical Directors Association. We've been around for about two years and we are attempting to bring all state medical directors which are all volunteer positions except for two paid positions in the state.

Dr. Heard-We recently at the statewide EMS conference in Elko, our second annual meeting of the emergency medical association, and as our platform we are firmly behind the concept of having a statewide medical director in the Bureau of Licensure and Certification for EMS. The importance of this cannot be stressed enough. Right now there are significant threats in the quality of services and consistencies of services for emergency medical services throughout the state. I personally used to supervise seven EMS in central Nye and Esmeralda counties. The very ability of those services to be able to meet the emergency medical needs that are presented to them by traffic and by tourists is remarkable. It's based on the fate of the county as to whether that program will run well or not. I think that's a statement that there has been such an attrition of funding for the Bureau of Licensure and Certification for OEMs over the years that their ability to do there most important job which is assuring consistency and quality of services in OEMs has been eroded because of that fiduciary challenge. The other aspect of this is whether we can have a statewide medical director. At one time this was a funded position, some years back. I think that due to recruiting efforts and recruiting problems some five or six years ago, they were unable to fill that position in a timely manner that they lost that funding. That roll is probable more important now than it ever has been because of the challenges that there now facing in the intermediate level of training which is now a 300 hour training program which requires a great deal of EMS not only Bureau of Licensure and Certification but their medical directors input. If we had a statewide medical director, I think we could move more rapidly towards consistent protocols for the management of emergency medical cases. We could also move very quickly forward in the administrative responsibilities of each of these services have and are highly variable based on county influences.

Anne Cory-I think this is another one of the issues that is incredibly important to the quality of the care being provided throughout the state but isn't necessarily an access issue as it relates to what our mission is in this task force. I don't know where exactly where this would go within the legislative system but it seems a bit out of the scope of what we're doing. The one proposal that really directly relates to access, I think in the material presented, was the scope of practice

issue with the paramedics and being able to practice in health centers; and that I would see as an access issue. I'd be interested in hearing more about weather that's something that's been. You mentioned one project in New Mexico. If that has been tried elsewhere or how that could fit into the system that we have.

Fergus Laughridge-That system does work in New Mexico but they did have to enable legislation to get that through. Right now a pre hospital care provider can only provide care outside of a facility. We have to address many issues within legislation but it is very valuable. In Green River, New Mexico, they are able to help with community immunizations, that's one of our folks that has been in Nevada is our children immunization program. It's waning throughout the counties and the counties abilities to support that and the state to be able to support that. The access to the folks not getting to the clinics or to a medical facility for routine follow up care. That is another provision of this where they are in contact with maybe Dr. HUD at his office which is a rotation that he is in Las Vegas that day. But, I'm in a rural community of Nevada, I can consult with him via the telephone or via other mechanisms out there that other states are looking at with actual video language between and identify what's going on and we can take care of that individual right there that day. They don't have to wait another two weeks or week before they are back on that rotation to that community. That can help with that. These people are trained. It might take a little additional training but it is a workable plan.

Dr. Heard-The first and foremost in insuring quality is access. If you have no access to medical care, there is not quality. My statements in favor of augmenting the funding of the Bureau of Licensure and Certification to help them do their primary job which is assure quality. They are going to devise ways of assisting these programs to continue to exist. Many of these programs are threatened by attrition in their staff and training issues and the variety of burn out factors that the Bureau of Licensure and Certification is ideally situated to assure that they continue to offer the access to pre hospital systems and so perhaps I'm not understanding if there is another definition of access perhaps I don't understand that.

Dr. Anwar-Can we call for a motion for BDR on this question?

Larry Matheis-I wonder if this one is really appropriate for us? This strikes me as an executive branch funding augmentation which I'm not sure we've had anything like that requested. It really should be part of the administrative budget process. It's an important issue but I don't see it in a task force charge, directly or indirectly; as far as a BDR, I'm sure even if an executive agency are supposed to be asking for this kind of funding support.

Anne Cory-I would move that we request a BDR to change the statute so that intermediate and advanced paramedic level providers could provide care in a facility setting to augment the resources to create access; seconded by Senator Amodei.

John Yacenda-Let's clarify the motion because Larry said one thing and Anne came back with a motion that was unrelated. I wanted to make sure what the motion was in Las Vegas. The motion is not to ask for any funding, not to support any particular office or direction. The issue is a BDR to address #39 in our packet which is one item in the EMS presentation not the whole EMS presentation. Just the one item relative to the scope of practice enabling the EMS workers to be able to assist primary physicians in immunization clinics, things like that are community clinic based activities. That's what the motion is about. It's not about any of the funding issues.

Dr. Anwar-Anne, does that reflect your motion accurately?

Anne Cory-Yes.

Assemblywoman Berman-We've had no testimony to any of this. This is all new to me. I'm not comfortable with the scope of this new proposal. I'm not going to be able to support it. Thank you.

Dr. Anwar called for question. Passed: yes votes from B. Bond, T. Care, M. Amodei, A. Cory, J. Anwar. No votes: L. Matheis, E. Koivisto, M. Berman.

Anne Cory-I would like to clarify which of the proposals we are folding into these two. We may need to separate or in

some cases put them in both. #8 on family plan benefits for Medicaid, #9, #10, #11, #13, #15, #16, and #36. Am I correct that these are the Medicaid and CHIP related issues that we have not addressed? Long pause. In our chairman' subcommittee meeting, Charlotte Crawford made a statement that although some changes to Medicaid or the Check-Up program would appear to be just administrative changes and not requiring legislative action. Then, in fact, traditionally in Nevada administrative changes of any magnitude do require legislative approval before they occur because they do have fiscal impact. Some of these items do not appear to be requiring legislative action in order to happen. That's the process we need to follow.

Assemblywoman Koivisto-I'm not sure which piece of paper we're looking at here.

Dr. Anwar-This is our discussion from the morning till now, we were putting aside anything that would pertain to Medicaid or changes in Medicaid as far as delivery of care of the funding that may be needed to be expanded or increased services. We were putting all of those things aside to take them at the end. Putting them together as one BDR.

Anne Cory-There are three pieces of paper that include recommendations that impact Medicaid or Check-Up. The first is my recommendations, the one labeled Governor's Task Force on access recommended legislation women #8, #9, and #10 are on that page. Bob Ostrovsky's recommendations under Chairman's Questions Subcommittee #11, #13, #15, and #16 are on that. The Great Basin recommendation #36 is in that packet.

Larry Matheis-I'll move that we ask for a bill omnibus bill draft on Medicaid Children's Health Insurance reform items to include each of those items that were just listed; seconded by Senator Care.

Dr. Anwar-Moving to H on the agenda is the establishment of public forum and consumer input subcommittee and assignments. We would like to formulate a subcommittee for that to let the public know as to what this task force has been asked to do, what it has done so far and get input on those things. I like to offer my serves to chair that subcommittee. I'd like to have volunteers for that. How about the two subcommittee chairs. Five people volunteered. We will have a schedule for those meetings.

John Yacenda reviewed the nine BDR's passed by the Task Force:

1) Basic benefits for insurance.
2) High risk pool insurance.
3) Continuing study group for the innovative state programs.
4) School based health centers (Study and pilot program which carries appropriation).
5) Licensure issues and commission issues. The merger of those.
6) Office of Minority Health.
7) Health Care Fund.
8) EMS scope of practice.
9) Omnibus Medicaid Check Up reform bill of 2001.

Gave a brief report on the conference attended in Salt Lake City at the request of the Chairman. The conference was on Improving Health Through the Expanded Use of Clinical Preventative Services.

Dr. Anwar-Moved to item J on the agenda which is public comment. No public comment.

Meeting adjourned at 1:35 p.m.