MINUTES OF THE MEETING

OF THE

LEGISLATIVE COMMITTEE ON HEALTH CARE

(*Nevada Revised Statutes* 439B.200)

November 30, 1998

Carson City, Nevada

The twelfth meeting of the Nevada Legislature's Committee on Health Care for the 1997-1998 interim was held on Monday, November 30, 1998, at 9:30 a.m., in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. This meeting was video conferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Pages 2 through 5 contain the "Meeting Notice and Agenda."

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Raymond D. Rawson, Chairman

Assemblywoman Vivian L. Freeman, Vice Chairman

Senator Bernice Mathews

Senator Maurice E. Washington

Former Assemblyman Jack D. Close, P.T.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Barbara E. Buckley

OTHER LEGISLATORS PRESENT IN LAS VEGAS:

Assemblywoman Kathy McClain

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

H. Pepper Sturm, Chief Principal Research Analyst

Marla McDade Williams, Senior Research Analyst

Risa B. Lang, Principal Deputy Legislative Counsel

Leslie Hamner, Senior Deputy Legislative Counsel

Roxanne Duer, Senior Research Secretary

-

MEETING NOTICE AND AGENDA

Name of Organization: Legislative Committee on Health Care

(Nevada Revised Statutes 439B.200)

Date and Time of Meeting: Monday, November 30, 1998

9:30 a.m.

Place of Meeting: Legislative Building

Room 4100

401 South Carson Street

Carson City, Nevada

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

Grant Sawyer State Office Building

Room 4412

555 East Washington Avenue

Las Vegas, Nevada

A G E N D A

1. Opening Remarks by the Chairman

Senator Raymond D. Rawson

*II. Approval of Minutes for the Committee's Meeting on September 11, 1998, in Las Vegas, Nevada

*III. Approval of Final Report of the "Study of Uninsured Persons in Nevada"

IV. Presentation of Report for the Subcommittee to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled

V. Follow-Up Report Concerning Issues from Meetings of the Subcommittee to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled

Charlotte Crawford, Director, Nevada's Department of Human Resources (DHR)

Christopher Thompson, Administrator, Division of Health Care Financing and Policy, DHR

A. Feasibility of Establishing a Medicaid "Buy-In" Program

B. Feasibility of Changing the Eligibility Level of Medicaid to 250 Percent of the Federal Poverty Level

3. Results of Meeting Regarding Personal Care Attendants

4. Feasibility of Considering Assisted Living Facilities as Placements for Individuals Who Receive Medicaid Medical and Waiver Services

VI. Discussion of Proposals to Promote "Aging in Place" for Nevada's Elderly Citizens

John Busse, Executive Director, Home Health Care Association of Nevada

Mike Gerard, Director, Washoe Home Care

1. Implement a Model in Nevada that Parallels the Program for All Inclusive Care for the Elderly, Which is a Program Administered by the Health Care Financing Administration, United States Department of Health and Human Services

2. Evaluate the Adequacy of Payment Rates for Medicaid Home Health Services

3. Include Medical Social Services as a Medicaid Home Health Benefit

VII. Follow-Up Report Relating to Transportation for the Aged and Disabled (Paratransit) Issues from October 5, 1998, Subcommittee Meeting

VIII. Informational Presentation of "Quality Care Act of 1999"

Theresa Morrow, R.N., Co-Chair, Service Employees International Union, Health Care Oversight Committee

IX. Status Report Concerning Nevada Check-Up, the Children's Health Insurance Program in Nevada

Charlotte Crawford, Director, DHR

Christopher Thompson, Administrator, Division of Health Care Financing and Policy, DHR

*X. "Covering Kids" Status Report and Presentation and Discussion Concerning Outreach and Enrollment Issues for Nevada Check-Up

John Yacenda, M.P.H., Ph.D., Executive Director, Great Basin Primary Care Association

XI. Informational Presentation Concerning the Minority Health Initiative

Carla Freeman, Facilitator, Clark County Minority Health Steering Committee

XII. Update Regarding the Mandatory Medicaid Managed Care Program

XIII. Public Testimony

*XIV. **WORK SESSION:** Review and Discussion of Proposed Recommendations of the Legislative Committee on Health Care for the 1999 Legislative Session

1. Long-Term Care Insurance
2. Tobacco Issues
    1. Local Versus State Regulation of Smoking
    2. Increase the Cigarette Tax
1. Issues Affecting Persons Who Are Aged or Disabled and the Medicaid Program
    1. Evaluating Quality of Care and Satisfaction of Services in Medicaid
    2. Personal Care Services
    3. Increasing Access to Medicaid Waiver Services
    4. Changing the Eligibility Level of Medicaid to 250 Percent of the Federal Poverty Level
1. Establishing a Medicaid "Buy-In" Program
2. Alternative Living Arrangements
3. Aging in Place Issues

NOTE: Recommendations under consideration by the committee are presented in the attached "Work Session Document," Legislative Committee on Health Care, November 30, 1998. A revised copy of this document may be provided at the meeting. Additional copies of this document may be obtained from Roxanne Duer, Research Division, Legislative Counsel Bureau, 684-6825, Capitol Complex, Carson City, Nevada.

XV. Adjournment

*Denotes items on which the committee may take action.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, Capitol Complex, Carson City, Nevada 89701-4747, or call Roxanne Duer, at 684-6825, as soon as possible.

Notice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, Basement, Capitol Building; Carson City Courthouse, 198 North Carson Street; Legislative Building, Room 1214, 401 South Carson Street; and Nevada State Library, 100 Stewart Street. Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations: Clark County Office, 500 South Grand Central Parkway; Grant Sawyer State Office Building, 555 East Washington

Avenue.

OPENING REMARKS BY THE CHAIRMAN

Chairman Raymond D. Rawson called the meeting to order and roll was called. With reference to the "Work Session Document," Chairman Rawson explained that in order to comply with the directives established for the 120-day session, all bill draft requests (BDRs) must be complete by December 15, 1998. If there are issues to be addressed during the bill drafting process, he asked that he and staff be allowed to deal with any concerns that may arise.

APPROVAL OF MINUTES FOR THE COMMITTEE'S MEETING ON SEPTEMBER 11, 1998, IN LAS VEGAS, NEVADA

ASSEMBLYWOMAN FREEMAN MOVED FOR APPROVAL OF THE MINUTES OF THE SEPTEMBER 11, 1998, MEETING OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE IN LAS VEGAS. THE MOTION WAS SECONDED BY MR. CLOSE AND PASSED UNANIMOUSLY BY THOSE WHO WERE PRESENT. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

APPROVAL OF FINAL REPORT OF THE "STUDY OF UNINSURED PERSONS IN NEVADA"

Chairman Rawson noted that the final report of the study of uninsured Nevadans is complete; however, there are some technical points that need to be addressed. Based on the executive summary "Health Insurance Coverage of Nevadans, 1997" that was presented to the committee, Chairman Rawson called for a motion for approval of the final report (please refer to Exhibit A).

ASSEMBLYWOMAN FREEMAN MOVED FOR APPROVAL OF THE FINAL REPORT "HEALTH INSURANCE COVERAGE OF NEVADANS, 1997." THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY BY THOSE WHO WERE PRESENT. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

Assemblywoman Buckley asked if staff was able to ascertain if the collaborating data for the survey that was mailed to the low income populations is included in the final report, and noted that nationwide results for these groups are oftentimes "skewed" due to a lack of response.

Marla McDade Williams

Ms. Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau, stated that she reviewed the final document and discussed the report with Dr. Keith Schwer, Executive Director, Center for Business and Economic Research, University of Nevada, Las Vegas, and was of the opinion that the majority of the items discussed at the September 11, 1998, health care committee meeting have been addressed.

PRESENTATION OF REPORT FOR THE SUBCOMMITTEE TO ADDRESS MEDICAID AND OTHER ISSUES FOR PERSONS WHO ARE AGED OR DISABLED

Mr. Close, Chairman of the Subcommittee of the Legislative Committee on Health Care (*Nevada Revised Statutes* [NRS] 439B.200) to Address Medicaid and Other Issues for Persons Who are Aged or Disabled, referenced the subcommittee's final report (please refer to Exhibit B). The three major areas of concern that the subcommittee dealt with were: (1) the paratransit system in Clark and Washoe Counties (Nevada); (2) a proposal for a Medicaid buy-in program; and (3) the evaluation of appropriate levels of care for Medicaid recipients. Mr. Close referred to a document from Bruce Turner, Principal Planner, Regional Transportation Commission (RTC), Clark County. A brief review of the document indicates that the RTC perceives the transportation problems differently than those identified by the disabled community. It is

anticipated that after a thorough review of the report, these concerns will be addressed. Although no formal recommendation was made, the subcommittee would encourage the health care committee to continue assessing this matter. Mr. Close stated that legislation was not required at this time, but stressed that it is essential that the disabled community have access to transportation in both the northern and southern areas of the state. The lack of transportation for the disabled between Carson City and Reno, Nevada, was also brought to the attention of the committee members.

Responding to Mrs. Freeman's question about transportation monitoring requirements, Mr. Close suggested that a periodic report could be submitted to the Senate Committee on Human Resources and Facilities and the Assembly Committee on Health and Human Services to address the concerns expressed by the health care committee as well as the disabled community.

Chairman Rawson noted that the Legislative Committee on Health Care is an ongoing statutory committee and has the ability to work through the legislative session. He suggested that the committee assume the responsibility of monitoring and report to the Senate Committee on Human Resources and Facilities and the Assembly Committee on Health and Human Services. He also requested that this issue become an ongoing agenda item of the health care committee.

Continuing, Mr. Close focused on Medicaid issues and, specifically, the feasibility of increasing the income eligibility level for Medicaid applicants to 250 percent of the federal poverty level. He stated that the subcommittee was reluctant to make any type of recommendation until Christopher Thompson, identified on page 3, could present a report identifying budget costs and the overall impact on the Division of Health Care Financing and Policy. Discussion continued regarding home health care and ensuring that the appropriate "level of care" is provided to dependent persons and utilization of personal care assistants in the home health care industry.

In conclusion, Mr. Close thanked Chairman Rawson for creating the subcommittee and allowing the members to address the issues that the disabled population encounters. He encouraged the future committee chairman to view the disabled community as an integral component of the health care committee.

FOLLOW-UP REPORT CONCERNING ISSUES FROM

MEETINGS OF THE SUBCOMMITTEE TO ADDRESS MEDICAID

AND OTHER ISSUES FOR PERSONS WHO ARE AGED OR DISABLED

Christopher Thompson

Mr. Thompson, Administrator, Division of Health Care Financing and Policy (DHCFP), DHR, outlined the results of a November 20, 1998, meeting between the division and disabled persons regarding personal care needs. Following are the major areas of concern that evolved from the meeting:

- Respite care;
- Recruitment and retention of personal care assistants (PCAs);
- Compensation rates; and
- Implementation of a client-driven approach.

Addressing a proposal to increase the hourly rate for payment of PCAs by 40 percent, Mr. Thompson explained that the budget impact to the DHCFP would be an increase of 10 to 15 percent. He indicated that percentage would equate to an additional $250,000 annually, which is not a significant increase in the Medicaid program.

In response to Chairman Rawson, Mr. Thompson stated that the DHCFP has requested funding in its budget proposal to address the anticipated rate increase.

In answer to Senator Mathews' question regarding the disparity in the duties of a certified nursing assistant (CNA) and a PCA, Mr. Thompson replied that there is not a great deal of disparity in duties. He commented that there are areas of treatment when a CNA is required to carry out direct medical applications; however, of the work currently performed by CNAs in Medicaid, at least 75 percent of those duties could be accomplished at the PCA-D level.

Senator Mathews requested that a job description of PCA duties be provided to the committee since this topic will be addressed during the 1999 Legislative Session. Mr. Thompson replied that a job description would be provided to the committee members.

Kathy Apple, M.S., R.N

Ms. Apple, Executive Director, Nevada's State Board of Nursing, explained that under the provisions of NRS 632.340, "Exemptions from required licensing or certification," a PCA is exempt from licensure or certification when performing services for a person with a physical disability pursuant to NRS 629.091, "Personal assistant authorized to perform certain services for person with physical disability if approved by provider of health care; requirements."

Mr. Close stated that the role of a PCA was discussed at some length during the meetings of the subcommittee to determine what qualifications are required to perform personal care services and to define their realm of responsibility. He noted that PCAs play a major role in the disabled community and should be compensated equitably for their services.

Ms. Buckley informed the committee that during discussions with individuals representing the disabled community, it was explained that they are not attempting to expand the duties that are covered by CNAs, but rather to ensure that the procedure is more user-friendly. As for the issue of PCA certification, there was general concern that the state was imposing additional criteria than that set forth in NRS 629.091.

Continuing, Mr. Thompson presented the dollar limitations for individuals covered by Medicaid and explained that if the hourly rate is increased, the number of hours an individual is entitled to will decrease. Currently, services for eight hours of personal care is provided at $80 per day; however, if the PCA rate is increased to $12 per hour, the number of care hours would be decreased to six hours, which would be the equivalent expense of a long-term care facility.

Chairman Rawson asked for clarification as to whether PCA services are a Medicaid benefit, or if they are considered a waiver service.

According to Mr. Thompson, the PCA benefit is a Medicaid service, but is subject to the limitations of the least costly alternative. Under the waiver service, however, there is the possibility of providing additional care in the area of personal care homemaker respite, which is generally not covered under Medicaid. The Community Home-Based Initiatives Program for the elderly, Nevada's primary homemaker service, is a Medicaid waiver program.

Discussion continued focusing on the Balanced Budget Act of 1997 and its effect on Medicare home health services. Mr. Thompson indicated that because of the changes in Medicare regulations, home health care agencies can no longer subsidize services provided by the DHCFP. To compensate for the funding deficit, the Division has requested an additional $300,000 to $500,000 annually to ensure continuity of home health service providers.

With regard to establishing a Medicaid buy-in program and the feasibility of increasing the eligibility level of Medicaid to 250 percent of the federal poverty level, Mr. Thompson said that these programs were not economically viable for the state at the present time. However, he stated that with the forthcoming tobacco settlement there may be options for providing some of these services. He also suggested that waiver services be considered as an alternative program since funding has been requested for expansion of Medicaid waiver services.

Additionally, the issue of assisted living facilities as placements for individuals receiving Medicaid medical and waiver services was discussed. Mr. Thompson indicated that there is an adult group care facility waiver in place that receives an amount equal to the Supplemental Security Income payment that an individual receives, as well as a state supplement. The basis for the split is that Medicaid is not intended to cover room and board costs, thus assisted living essentially becomes a bridge between group care and nursing facilities. Negotiations between the federal government and the State of Nevada are needed to determine the expenses incurred for room and board, which are non-Medicaid, and the medical costs, which are Medicaid, to allow for expansion of waiver services.

Jon Sasser

Mr. Sasser, representing Washoe Legal Services, referred to the previously discussed items regarding changing the Medicaid eligibility level to 250 percent of the federal poverty level, and the establishment of a Medicaid buy-in program. He noted that both items were extensively discussed before the Subcommittee to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled and, because of the fiscal aspects involved, should be considered as separate programs. If a Medicaid buy-in program were established, individuals currently receiving services would be able to return to work while maintaining status in the Medicaid program by paying a premium or "buying-in" into the program.

With respect to expanding Medicaid eligibility, Mr. Sasser explained that a large number of disabled individuals may qualify for this program, but they face a two-year waiting period before Medicare benefits take effect. By changing the Medicaid eligibility level, coverage could be provided to those individuals during the transition period. Mr. Sasser asked that the committee recommend submitting BDRs to the 1999 Legislature that provide an in-depth cost analysis review of the two programs in question.

Ms. Buckley indicated that at the October 5, 1998, meeting of the subcommittee there was considerable discussion about these two programs. At that meeting, the subcommittee members requested that the DHCFP develop cost projections for the Medicaid buy-in program to determine if the program could be cost-neutral. Ms. Buckley wondered when a preliminary cost analysis of the two programs would be provided to the committee members.

Responding, Mr. Thompson stated that a report would be provided to the committee within the next few weeks.

DISCUSSION OF PROPOSALS TO PROMOTE "AGING IN PLACE"

FOR NEVADA'S ELDERLY CITIZENS

Mike Gerard

Mr. Gerard, Director, Washoe Home Care, addressed the inadequacy of Medicaid payments for home health care. He stated that the situation is one of growing concern because of the inability of home health agencies to financially afford to admit and care for Medicaid clients. He explained that the Interim Payment System, a program imposed at the federal level, has reduced reimbursement to Washoe Home Care by 30 percent. This system bases its payment to home health agencies on an "episode" as well as a "per visit" limit. The episode is predicated upon the profile of utilization the agency experienced in 1993. The problem is that the complexity of the patients and the acuity level of a home care patient in 1998 bears little resemblance to the patient that was served in 1993. Washoe Home Care will lose approximately $80,000 for the Medicaid population it serves and, as a hospital-based agency, has a greater imperative to enter into this type of loss scenario because it assists the hospital's ability to discharge at an appropriate time and transfer the patient into home care since the losses are less than the losses to the hospital. If an agency is not hospital-based, there is no incentive to take the Medicaid patient. In fact, the Medicaid patient may imperil the essential viability of the agency overall.

Discussion continued about the increased costs per visit brought about by federal regulations. Some of the effects of these regulations are:

- Interpretation of federal codes is becoming more stringent;
- The amount of documentation that was required with previous surveys is a fraction of what the documentation is with current surveys;
- Retraining of Nevada's surveyors by representatives of the Health Care Financing Administration, United States Department of Health and Human Services, which entails meeting higher standards. If an admission time increases from two to three hours because of the extra documentation to achieve the new standards, then the cost of an admission visit goes up in the same proportion; and
- In the past, the average documentation time per visit was approximately 20 minutes. It is not unusual to have 30 to 40 minutes of documentation time in addition to the visit.

Summarizing, Mr. Gerard stressed the effect these financial impacts have on Nevada's home health agencies and their ability to accept Medicaid home health referrals. This is an issue that deserves close scrutiny in determining the impact of a patient's access to Medicaid, he said.

Discussion continued with Mr. Gerard focusing on the following topics:

- There is a definite need for Medicaid coverage that will allow for a home care medical-social worker. Oftentimes, a Medicaid patient needs the assistance of a medical-social worker to arrange for available community services allowing a patient to remain in their home. If community services are not available, it falls upon family and other care givers to provide the needed assistance.

Establish equal job requirements for CNAs and PCAs in Nevada. Along with the mandatory federal standards a CNA must meet, the state requires completion of at least 400 hours of work a year. This can create additional expenses as well as an access problem in the rural areas where the scale of economy is such that maintaining 400 hours is often difficult.

- Explore federal programs similar to the HCFA Program for All Inclusive Care for the Elderly (PACE), to enable the State of Nevada to provide all inclusive care of the elderly and allow for aging in place at a reduced cost.

-

FOLLOW-UP REPORT RELATING TO TRANSPORTATION FOR THE AGED AND DISABLED (PARATRANSIT) ISSUES FROM OCTOBER 5, 1998, SUBCOMMITTEE MEETING

Chairman Rawson stated that a report from Kurt Weinrich, Director of the Regional Transportation Commission in Las Vegas was presented to the committee (please refer to Exhibit C). The report responds to transportation issues for the aged and disabled (paratransit system). He noted that the Commission's report has been assigned to staff and asked that this particular issue be included as a permanent item on the health care committee's agenda to ensure that the issues brought forth at the subcommittee's October 5, 1998, meeting are responded to.

-

INFORMATIONAL PRESENTATION OF "QUALITY CARE ACT OF 1999"

Chairman Rawson explained to the committee that a panel of four individuals representing the Service Employees International Union, the Nevada Nurses Association, the Philippine Nurses Association, and the medical community were present in Las Vegas and would speak on the Quality Care Act of 1999.

Patricia Van Betten, R.N.

Ms. Van Betten, representing the Nevada Nurses Association, referred to her presentation entitled "The Quality of Care Act of 1999" (please refer to Exhibit D). She noted that the Quality of Care Act would ensure that patients receive the services they are paying for by providing access to information about quality of care. Further, the proposal would protect the ability of front line care givers to heal, care, and advocate for patients.

Additionally, the Quality of Care Act is built on the following key principles:

1. Title I. Community Right to Know — provides for the collection and disclosure of vital consumer information regarding staffing, patient census, and patient incidents and outcomes.

2. Title II. Whistleblower Protection — ensures that health care professionals who advocate for their patients will not have to fear for loss of their jobs.

3. Title III. Staffing standards — assures that there are adequate staff to provide quality patient care.

4. Title IV. Enforcement — sanctions against institutions that fail to respect their patients' right to quality of care.

Belen Gabato, R.N.

Ms. Gabato, representing the Philippine Nurses Association, discussed the importance of the public's "right to know" about patient care incidents and outcomes so that patients can make informed decisions regarding health care options in the future. Ms. Gabato noted, however, that there are some critics who oppose this legislation because:

- The public will not be able to comprehend the information provided. It is proposed that the information to be released will consist of relevant health care information as well as statistical data;

- It is unfair to hospitals that "house" patients who require extensive levels of care. The proposed legislation specifies that reports shall be published that include information about the "case mix" of each facility; and

- It is not possible to collect this information. It was noted that the University of Nevada, Las Vegas, and the Division of Health Care Financing and Policy have implemented a joint program where information regarding patient discharges is collected. Incorporating this data with additional patient census data will improve the quality of available information.

General discussion continued regarding the importance of the "Whistleblower Protection" program. Ms. Gabato stated that nurses have an inherent duty to report patient abuse and to disclose unsafe hospital conditions; however, the law currently does not guarantee anonymity, and oftentimes they fear retaliation or are faced with job termination.

Theresa Morrow, R.N.

Ms. Morrow, Co-Chair of Nevada's Service Employees International Union, Local 1107, Health Care Oversight Committee, spoke on staffing standards required by the Quality Care Act of 1999. Such standards would require the State Board of Health to establish guidelines to ensure quality of care in health care facilities. For example, the bill would adopt a minimum ratio of two patients to one registered nurse in intensive care units. More nurses would be assigned as patient needs demand them. Minimum standards are needed to prevent the worst abuses and beyond those minimums, facilities need flexibility to respond to constantly changing circumstances. Ms. Morrow asserted that the Quality Care Act will provide both.

Concluding, Ms. Morrow focused her comments on enforcement standards. The Quality Care Act of 1999 would require tough enforcement standards to protect the quality of patient care. Civil penalties shall be subject to $10,000 per violation, with the fine appropriate to the gravity of the offense. Criminal penalties for willful and repeated serious offences would impose a fine, imprisonment for not more than one year, or both.

Mitch Keany, M.D.

Dr. Keany, President, Clark County Medical Society, stated that physicians are particularly concerned about quality of care in hospitals. Over the years, there are three ways in which inadequate staff has manifested:

- Simple care acts being omitted;
- As a consequence of inadequate staffing, initial therapy for patients being admitted to the hospital is delayed; and
- The problem of the unknown patient. With increased workloads, nurses are busy performing "accountable care acts" leaving no time to get to know the person they are taking care of in a meaningful way medically.

In Dr. Keany's opinion, hospitals are "prey" to the competitive environment that exists in the health care field today. He expressed the need for a "level playing field" so no one single entity in the marketplace has a competitive edge.

In conclusion, Ms. Morrow thanked the committee for the opportunity to present the key principles of the Quality of Care Act of 1999 and asked for support of the act in concept.

-

STATUS REPORT CONCERNING NEVADA CHECK-UP,

THE CHILDREN'S HEALTH INSURANCE PROGRAM IN NEVADA

Mr. Thompson, identified previously, informed the committee that since the inception of Nevada Check-Up, 1,500 children were enrolled in the program as of October 1998, with 2,500 participants covered in November, and an anticipated 2,800 children registered as of December 1998. Approximately 20 applications are received daily, which equates to 1,200 children per month. However, numerous telephone inquiries have been received from individuals in rural areas who are not covered by managed care asking how to access the program. The DHCFP is working with providers in the rural areas to encourage their active participation in the program by providing a link between the providers and the recipients.

In conclusion, Mr. Thompson stated that he is concerned about the following issues as they affect the Nevada Check-Up program:

1. Under HCFA regulations, applicants approved for Nevada Check-Up will be disenrolled if an additional application for Medicaid is not filed. The DHCFP is in the process of contacting individuals who have not filed a Medicaid application to inform them of the consequences of not submitting such a form.

2. To determine income eligibility, applicants must submit pay stubs along with their most recent tax return. At the present time, there are 1,000 children who have been categorized as "pending" because a tax return has not been received. The Division will accept a written explanation stating that a tax return was not filed.

"COVERING KIDS" STATUS REPORT AND PRESENTATION AND DISCUSSION CONCERNING OUTREACH AND ENROLLMENT ISSUES

FOR NEVADA CHECK-UP

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

Dr. Yacenda, Executive Director, Great Basin Primary Care Association, presented the committee with an update of the Robert Wood Johnson Foundation's "Covering Kids" initiative (please refer to Exhibit E). He outlined the following information:

- The "Covering Kids" statewide coalition has met repeatedly over the past five months. Local coalitions in Clark and Washoe Counties have also met on numerous occasions;
- Collectively, the group has refined work plans and time lines to reflect the later than expected start date of Nevada Check-Up; and
- Preparations for the Robert Wood Johnson Foundation site visit in Reno on December 11, 1998, are currently underway.

Discussion focusing on children's enrollment in Nevada Check-Up continued. Dr. Yacenda stated that since HCFA approved the Nevada Check-Up program, and it is more closely linked to Medicaid, the challenge will be to ensure that both programs achieve optimal success in terms of fiscal management and enrollment of the maximum number of eligible impoverished and low-income children.

Enrollment estimates in Nevada counties indicate that:

- In Clark County, 31,975 children could be eligible for Nevada Check-Up; 12,009 are Medicaid eligible, but have not enrolled;
- Carson City and Washoe Counties combined have an estimated 16,043 children eligible for Nevada Check-Up; 5,389 are eligible for Medicaid, but not enrolled; and
- It appears that in other rural counties 2,587 children may be eligible for Nevada Check-Up, with 862 Medicaid eligible.

Low-income individuals are reluctant to access Nevada Check-Up because of the following "barriers":

- They do not understand the program or its benefits;
- They do not have a reliable income source; and
- They do not trust the government.

Because of these social obstacles, development of an outreach program that is unique to the lifestyle, language, and culture of the low-income population is critical for the program to succeed.

Dr. Yacenda then focused his comments on the "linkage" of Nevada Check-Up to Medicaid eligibility, and outlined the

three areas of action the committee could take to ensure that children are enrolled in the Nevada Check-Up and Medicaid programs:

1. Direct the Department of Human Resources (DHR) to ensure full- or part-time Medicaid eligibility workers are outstationed at all federally qualified health centers (FQHCs) and Disproportionate Share Hospitals (DSHs). Or, instruct the department to ensure eligibility staff at FQHCs and DSHs are both trained to do Medicaid intake and that these agencies are, in accordance with federal Medicaid law, compensated by the DHR for the amount of time spent and resources used to conduct eligibility intake for Medicaid.

2. Approximately eight quarters are left in which Nevada can receive an enhanced 90 percent federal financial participation rate for outreach and enrollment assistance activities with persons who have lost cash assistance under welfare reform. The committee may direct the DHR to "draw down" these one-time welfare reform dollars and grant the dollars directly to community-based organizations which submit outreach plans that are likely to reach these post-cash assistance persons. Further, the assistance may be used for persons in properly maintaining Medicaid coverage for themselves and their children.

3. Direct the DHR to create a Nevada Check-Up contracting and incentives program with community-based organizations and providers who, as essential community providers, have established trusting relationships with low-income families.

In conclusion, Dr. Yacenda encouraged the committee to direct the DHR to ensure the full application of federal Medicaid law as it applies to FQHCs and DSHs and to assess the effective use of modern technology to facilitate eligibility determination and enrollment from community-based sites. Since federal Medicaid law does not require face-to-face interviews, investigate the use of computerized on-line enrollment and acceptance of Medicaid applications and telephone or video conference interviews.

Responding to a question from Mrs. Freeman pertaining to the amount of funding allotted for the outreach program, Dr. Yacenda stated that he would "welcome the opportunity" to discuss this issue with the Senate Committee on Finance and the Assembly Committee on Ways and Means. The program currently authorizes the state an expenditure of 10 percent of the money that is used for insuring children. As an example, if $30 million was spent on premiums, then $3 million could be disbursed to administration, which would include the outreach program. Dr. Yacenda reiterated the fact that the state should be more of a records custodian, while the function of public outreach should be located within the communities.

-

INFORMATIONAL PRESENTATION CONCERNING THE

MINORITY HEALTH INITIATIVE

Carla Freeman

Ms. Freeman, Facilitator, Clark County Minority Health Steering Committee, referred to a fact sheet about minority health in Nevada (please refer to Exhibit F). She pointed out that statistically:

- Minorities in Nevada are more unhealthy than their white counterparts;
- Native Americans are more likely to commit suicide than any other group in Nevada;
- African Americans have the highest death rates and reported AIDS cases of any other group;
- Hispanics have the highest teen pregnancy rate;
- Chinese Americans have the highest rate of nasopharyngeal cancer compared to all other racial and ethnic groups;
- Liver cancer among Vietnamese Americans is 11.3 times higher than in the white population, while the incident rate of cervical cancer among Vietnamese women is five times higher than the rate among white women; and
- Minorities account for 23.1 percent of Nevada's population.

According to Ms. Freeman, the United States Surgeon General has focused on the disparity of health incidents among minorities and compared it to a national epidemic. As Nevada's minority population increases, it is more important than

ever to join the other 35 states that have developed state level offices or commissions to focus on minority health issues. In conclusion, Ms. Freeman thanked the committee for its support toward establishing a division of minority health.

UPDATE REGARDING THE MANDATORY MEDICAID MANAGED CARE PROGRAM

Chairman Rawson referred to a report submitted by Christopher Thompson, Administrator, Division of Health Care Financing and Policy, Department of Human Resources, titled "Overview of Mandatory Managed Care," and requested that the report be included as a part of the record for this meeting (please refer to Exhibit G).

PUBLIC TESTIMONY

Paul Gowins

Mr. Gowins, Developmental Disabilities Council, stated that the public hearings of the Subcommittee to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled provided an arena in which to develop communication between the disabled community and Medicaid providers. Through these discussions there is now a great deal of support to retain various Medicaid options since no one particular option will work for the entire disabled population. There have been changes made in some of the waivers resulting in better options and utilization; however, even with these changes, if an individual is considered eligible for an option, there are no available "slots." It was suggested that if the committee would review the numbers so that the Medicaid waivers can be fully utilized, it would be of great benefit to the disabled community.

Additionally, Mr. Gowins commented that he supports establishing a Medicaid "buy-in" program and the feasibility of changing Medicaid eligibility to 250 percent of the federal poverty level. He encouraged the committee to consider a bill draft request addressing these items. For future reference, Mr. Gowins asked that the disabled community be referred to as "disabled" and not "handicapped."

In conclusion, Mr. Gowins submitted a copy of literature review about health care coverage and employment of people with disabilities, as well as an abstract summarizing recent data on the relationship between disability and employment (please refer to Exhibit H).

Susan Pacult

Ms. Pacult, Clark County Social Services, testifying on behalf of Ruth Mills, President of the Nevada Health Care Reform Project, referred to a letter sent to the Legislative Committee on Health Care, dated October 29, 1998 (please refer to Exhibit I). The letter stated that the Nevada Health Care Reform Projected voted unanimously to endorse a bill draft request for the following two items:

- Expand Medicaid eligibility by adopting the state option to provide coverage to disabled individuals in families whose incomes do not exceed 250 percent of the federal poverty level; and
- Seek a Medicaid waiver to allow disabled Medicaid recipients to "buy-in" to Medicaid coverage, if they return to the work force.

Mary Jean Thompson

Ms. Thompson, Northern Nevada Center for Independent Living, questioned the status of a July 1997 approval that

authorized the creation of a waiver for people with disabilities.

Donny L. Loux

Ms. Loux, Chief, Office of Community Based Services, Nevada's Department of Employment, Training and Rehabilitation, indicated that the waiver is complete except for minor cost revisions. It has been reviewed in draft form by the National and Regional HCFA offices and is pending final review from the DHCFP. Submittal to the Interim Finance Committee is anticipated for December 1998 approval.

Responding to Ms. Loux's comments, Chairman Rawson stated that the next meeting of the Interim Finance Committee will be held on December 14, 1998, and suggested that Ms. Thompson review the meeting agenda to see if this item is noticed.

Continuing, Ms. Loux, speaking on behalf of the Nevada Forum on Disability and the State Councils on Independent Living and Developmental Disabilities, thanked Mr. Close for his leadership and service to the disabled community in his role as Chairman of the Subcommittee to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled.

Jon Sasser

Mr. Sasser, Washoe Legal Services, said that he strongly supports all of the recommendations listed on the "Work Session Document" that emanated from the Subcommittee to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled. Referring to Recommendation Nos. 7 and 9, Mr. Sasser stated that these were drafted in a much "broader" form than the committee may have intended. Specifically, Recommendation No. 7 speaks to increasing Medicaid eligibility for all applicants up to 250 percent of the federal poverty level. The committee proposed that Nevada adopt, as part of its state plan, the option offered by the Balanced Budget Act of 1997, which covers only disabled individuals. The committee's intent on Recommendation No. 9 was not to design a Medicaid buy-in program exactly like the Massachusetts program. To assure a cost-neutral program, Nevada's program would be limited to individuals who are currently on Medicaid.

Bob Johnston

Mr. Johnston, Chairman, Legislative and Insurance Committee of Retired Public Employees of Nevada (RPEN), informed the committee that RPEN "wholeheartedly" supports providing long-term health care for Nevada's retired public employees. The proposal to fund the program for state and active retirees is worthwhile and an important first step toward that goal. Of real concern to retired public employees who are on moderate-fixed incomes, is affordable long-term care. If retirees cannot afford to purchase long-term care coverage and become indigent, they quite often require extensive care which adds to the state's indigent expenses.

With reference to Recommendation No. 1, Mr. Johnson addressed the following issues:

- Is it possible to include an option that would enable other public employees to obtain coverage at their own expense even if their employer chose not to participate in the program? The theory being, that the larger the number of employees enrolled in the program, the better the rates for all employees;

- In addition to the base plan, RPEN supports an option for expanded benefits available to plan participants wherein the individual would bear the additional expense;

- A request that additional information about the role of care advisors, type of equipment covered in the policy, informal care and what it involves be provided; and

- Is this an initial offering of insurance and would future employees and retirees be eligible for benefits?

In summary, he stated that the cost of nursing homes or home health care can rapidly erode savings and threaten the financial plans and investments that a person has worked toward to provide for future generations. The RPEN commends this committee for taking an active role toward providing this "critical" benefit.

Chairman Rawson explained that the recommendation would be drafted as a one-time appropriation and then would go to the Committee on Benefits which could invite other public employees (e.g., county and city workers, school teachers, et cetera) throughout the state to participate in this initiative; however, the state would not pay for their coverage. If the appropriation does not pass, the fallback position would be to allow for aggressive recruitment or solicit people throughout the state.

Peter D. Krueger

Mr. Krueger, representing the Nevada Petroleum Marketers and Convenience Store Association, addressed Recommendation Nos. 2 and 3, which relate to tobacco. He urged the committee to "think long and hard" before considering adoption of Recommendation No. 2 and imposing more stringent regulations. According to figures compiled by Nevada's Office of the Attorney General, the "buy rate" of over-the-counter tobacco products has declined from over 60 percent approximately two years ago to less than 12 percent in 1998. The reason for this decline is that Nevada has a uniform state law that allows tobacco retailers to train and prepare for one set of standards. This proposal could allow agencies or the smallest board or commission to adopt more stringent regulations which could destroy the ability of the tobacco retailers to train, prepare, and continue to further reduce youth access to tobacco. Mr. Krueger remarked that a primary complaint from retail sales associates is that they are prohibited from selling tobacco products to youth under 18 years of age, however, it is not illegal for these youngsters to buy, posses, or use such items. He questioned the effectiveness of current state law concerning youth access to and use of tobacco products.

Commenting about the cigarette tax increase, Mr. Krueger referenced the recent tobacco settlement that will yield the State of Nevada at least $50 million over the biennium. He asked that the Legislature consider allocating that money toward the reduction and cessation of tobacco usage.

-

WORK SESSION

REVIEW AND DISCUSSION OF PROPOSED RECOMMENDATIONS OF THE

LEGISLATIVE COMMITTEE ON HEALTH CARE FOR THE

1999 LEGISLATIVE SESSION

Chairman Rawson referred to the committee's "Work Session Document" which appears as Exhibit J. The recommendations contained in the "Work Session Document" are listed below in italics and precede the actions of the committee.

This Work Session Document was prepared by the staff of the Legislative Committee on Health Care. It contains a summary of major proposals that have been presented to the committee in public hearings and correspondence since August 3, 1998.

LONG-TERM CARE INSURANCE

The committee heard testimony that long-term care insurance policies will help to prevent individuals and families from losing assets and financial resources when they need long-term care. Further, Medicare does not pay for long-term care; Medicaid does, however, only for individuals who meet certain disability or income criteria.

It is recommended that:

> ***1. A "one-time" appropriation be made to purchase a long-term care insurance product for state employees and retirees. Other political bodies may participate in the pool at their own expense subject to negotiations with the Committee on Benefits, Risk Management Division, Department of Administration.***

The proposed language may be to:

Appropriate funds to the Committee on Benefits, Risk Management Division, Department of Administration, and amend Nevada Revised Statutes 287.043, "Committee on benefits: Powers and duties," for long-term care insurance coverage for current and retired state employees. Such coverage should include the benefits listed in the Attachment. Further, such coverage shall qualify as a long-term care insurance product that enables a consumer to benefit from the tax implications contained in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). This will be a one-time appropriation after which time the Committee on Benefits must establish the level of participation required by active and retired state employees, and employees of participating public agencies.

NOTE: *Pursuant to Section 1 of NRS 287.043, group life, accident, health coverage, or any combination of*

these, may be provided for the benefit of "state officers and employees and other persons who participate in the state's program of group insurance." And, pursuant to Section 2 of NRS 287.043, the committee is authorized to ***negotiate and contract*** *with the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other public agency of the State of Nevada "which is desirous of obtaining group insurance for its officers, employees and retired employees."*

Assemblywoman Freeman noted that since this recommendation would be subject to the regulations of the Committee on Benefits, she asked Chairman Rawson if the membership of the committee would change and, if so, the dollar amount that would be allocated toward the reorganization.

Chairman Rawson responded that at this point there is discussion of a request for $14 million dollars to address budget issues as well as committee reorganization; a specific plan has not been proposed.

Vincent Stark

Mr. Stark, District Manager, Long-Term Care Division, GE Capital Assurance, inquired about the coverages being considered for long-term care and asked Chairman Rawson how the committee arrived at these benefits.

The Chairman explained that the NYLIFE Administration presented a proposal for long-term care insurance to the committee at its September 11, 1998, meeting in Las Vegas. He noted that this item is simply a recommendation to be considered during the 1999 Legislative Session. If it is considered, this item will be noticed as a public hearing item and any company or individual who is interested in presenting a product or addressing the issue can do so at that time.

ASSEMBLYWOMAN BUCKLEY MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 1. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

Chairman Rawson stated that he would work with the appropriate staff of the Legislative Counsel Bureau in preparing a bill draft request for a one-time appropriation to purchase a long-term care insurance product for state employees and retirees. He indicated that the concerns presented by RPEN as well as the issues brought forth about the Committee on Benefits would be taken into consideration when drafting the BDR.

TOBACCO ISSUES

Representatives of the American Cancer Society made two recommendations for the committee. The first recommendation relates to the regulation of smoking in Nevada, and the second recommendation relates to the cigarette tax in the State.

Local Versus State Regulation of Smoking

Mr. Mark Savage testified that existing statutes prohibit local governments from imposing more stringent restrictions governing smoking than those provided in State law.

Therefore, it is recommended that the Legislature:

2. Amend the current statute regarding state regulation of smoking to allow local municipalities to develop their own policies governing the sale of, marketing of, distribution of, and display of tobacco products.

   The proposed language might be to:

   Amend Nevada Revised Statutes 202.249, "Smoking tobacco: Declaration of public policy; enforcement," to allow an agency, board, commission, or political subdivision of this state, including any agency, board, commission, or governing body of a local government to impose more stringent restrictions on the smoking, use, sale, distribution, marketing, display, or promotion of tobacco or products made from tobacco than are addressed by NRS 202.2491, "Smoking tobacco: Unlawful in certain public places; posting signs; designation of areas for smoking"; NRS 202.2492, "Smoking tobacco: Penalty; issuance of citations"; NRS 202.2493, "Cigarettes and smokeless products made from tobacco to be sold in unopened package only; sale and distribution of cigarettes and other products made from tobacco to minor prohibited; penalties"; and NRS 202.2494, "Cigarette vending machines unlawful in certain public areas; restrictions on coin-operated machines."

***NOTE**: Assembly Bill 313 of the 1997 Legislative Session sought to amend these statutes, however this measure failed to be adopted.*

Chairman Rawson noted that since the committee heard previous discussions regarding tobacco issues, there has been a national settlement with the tobacco industry. He indicated that Nevada will receive $1.2 billion over the next 25 years, with $18 million appropriated the first year. Chairman Rawson felt that the recent decision may have an impact on how the committee votes on Recommendation Nos. 2 and 3.

Assemblywoman Freeman stated that in light of the settlement, it would be best not to vote for adoption of these items until the committee has an opportunity to determine the recommendation of Nevada's Attorney General.

The committee did not take action on Recommendation No. 2.

Increase the Cigarette Tax

The committee heard testimony that indicated health care costs related to tobacco use and smoking are a significant burden to society. Further, according to Mr. Savage, in recent elections, the per pack tax in the State of California was increased by 50 cents, and surrounding states have a per pack tax that is significantly higher than Nevada's cigarette tax. According to a representative in Nevada's Department of Taxation, when Arizona increased its cigarette tax, Nevada realized an increase in revenue in areas that share a border with Arizona. It is likely that Nevada will realize an increase in cigarette sales in areas that share a border with California due to that state's increase, if the current tax remains unchanged.

Discussion before the committee indicated that an increase in cigarette taxes generally results in a decrease in smoking. Therefore, it is likely that the State may realize a decrease in tax revenue, which would ultimately affect the State General Fund.

It is recommended that the Legislature:

3. Amend the current statute to increase the existing cigarette tax by 50 cents per pack, which would equate to a tax of 42.5 mills per cigarette. The revenue will be used for substance abuse grants, supplemental funding for Nevada Check-Up, and grants to educate the public about the effects of tobacco use.

   If the committee supports this proposal, suggested language may be to:

   Amend Nevada Revised Statutes 370.350, "Levy; amount; exemptions," to increase the tax on cigarettes to 42.5 mills per cigarette. Proceeds from the tax will be subject to budget considerations by the Legislature and will be used for: (1) grant funding for substance abuse treatment programs; (2) supplemental funding for the children's health insurance program; and (3) grant funding for organizations whose mission it is to educate the public about the effects of tobacco use. The Department of Employment, Training and Rehabilitation and the Department of Human Resources will administer the grant funds, and each department will adopt regulations governing the criteria for the use and dispersal of available funds. Not more than 10 percent of the proceeds may be used for administrative expenses by agencies that administer the funds.

***NOTE:** The current tax on cigarettes is 17.5 mills per cigarette, which results in a tax of 35 cents on an average 20-cigarette pack. According to a representative in the Administrative Services Division of Nevada's Department of Taxation, at current levels, increasing the tax by 50 cents may result in $86 million in revenue.*

***NOTE:** In accordance with NRS 370.450, "Levy, rate and collection of tax; exemptions; retention of portion by dealer; penalty," a levy of 30 percent is assessed on the wholesale price of products made from tobacco.*

The proposal above is a 143 percent increase from the existing cigarette tax. If a similar increase was applied to the wholesale price of products made from tobacco, it would result in the retailer paying more in taxes than the price of the product that was purchased.

The committee did not take action on Recommendation No. 3.

ISSUES AFFECTING PERSONS WHO ARE AGED OR DISABLED

AND THE MEDICAID PROGRAM

A subcommittee to address Medicaid and other issues for persons who are aged or disabled met three times and considered a number of issues. The items that warrant further consideration by the committee follow.

Evaluating Quality of Care and Satisfaction of Services in Medicaid

The subcommittee determined that there is a need to evaluate the treatment of persons who are aged or disabled and who receive services from the Medicaid program. Because these persons will not be required to enroll in a managed care program, and in some cases are prohibited from enrolling in a managed care program, their satisfaction with Medicaid services may not be evaluated.

Therefore, the subcommittee recommended that the Legislature:

4. Appropriate funds to the Legislative Committee on Health Care for a consultant to conduct a feasibility study to determine whether Nevada's Department of Human Resources could implement a cost-efficient evaluation of the quality of care it delivers to Medicaid recipients who are not in a managed care program. The study would: (1) assess methods that would produce regular evaluations of quality assurance; (2) consider available evaluation tools in both the public and private sectors to assess the satisfaction of services delivered in Medicaid to persons who are aged and/or disabled; (3) consider existing data requirements of health care providers, licensed health care facilities, and managed care organizations in the current delivery system; and (4) make recommendations that would improve the ability of the department to conduct regular evaluations. The consultant shall report his progress in both a verbal and written report at each meeting of the Legislative Committee on Health Care, and he shall complete his findings by June 1, 2000.

Mr. Close stated that this item came out of the Subcommittee to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled. The reason that this item was brought forth was the fact that the committee continuously heard comments about the efficiency and effectiveness of the Medicaid program, and yet the process had not been thoroughly evaluated. This recommendation would provide "real data" to substantiate how effective the program is and to evaluate the quality of care Medicaid recipients are receiving.

MR. CLOSE MOVED THAT THE COMMITTEE DIRECT THE LEGAL DIVISION OF THE LEGISLATIVE COUNSEL BUREAU TO PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 4. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

Senator Mathews commented that she would support this item as a bill draft request, but may not be supportive when it is introduced as a bill since there are some concerns that remain to be answered.

Chairman Rawson said that was understood with all the recommendations, and that no one is under any obligation to "follow their vote" in the 1999 Legislative Session. He reiterated that the concerns of the committee members would be taken under consideration as the BDRs were prepared.

Ms. Buckley made reference to Recommendation No. 4 as well as the other BDRs that the committee approves that include a fiscal note. She suggested there should be a means of providing guidance to the Senate Committee on Finance and the Assembly Committee on Ways and Means in which issues could be ranked in terms of health care policy when there is a fiscal impact.

The following items may be considered as BDRs based on testimony presented during the November 30, 1998, meeting. Some of these recommendations would expand Medicaid eligibility to certain individuals who meet the

criteria for these program options.

Personal Care Services

Personal care services are essential for a person who is disabled because they enable the person to remain at home and they allow him to remain self-sufficient. Although personal care services are a Medicaid benefit, individuals who would benefit from these services have had difficulty accessing them. The subcommittee has expressed its support for personal care services.

Therefore, the health care committee may wish to ask the Legislature to:

5. Adopt a resolution that directs Nevada's Department of Human Resources to fully utilize personal care services for persons who receive Medicaid services, including the disabled. The resolution should: (1) stress the importance of providing services to a person in his home and in the community; (2) direct the department to develop a "client driven" approach to care for individuals who are disabled and using Medicaid services; (3) strongly encourage the department to promote personal care services for individuals as an alternative to hospitals and nursing homes, whenever feasible; (4) direct the department to develop solutions for the industrial insurance problem for individuals who act as personal care attendants; (5) encourage the department to develop contract penalties for individuals and agencies that provide personal care attendant services and who fail to uphold the terms of their contracts; (6) direct the department to equalize the care and payment rates provided by personal care attendants and other noncertified or nonlicensed personnel with that of certified nursing assistants, including homemakers, to encourage private sector provision of such home delivered services; (7) encourage the department to decrease its reliance on providing state supported staff to provide any type of home delivered service for individuals in the State; (8) direct the department to use the criteria established in Nevada Revised Statutes 629.091 to recognize when a person is capable of providing personal assistant services and prohibit the department from establishing more stringent qualifications for a person to perform such services; and (9) direct the department to submit a budget to the following session of the Nevada Legislature that supports personal care services. The department should report its progress quarterly in a written report to the chairman of the Legislative Committee on Health Care beginning September 1, 1999.

Marla McDade Williams

Ms. Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau, noted that this is another item from the Subcommittee to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled and deals extensively with personal care services.

MR. CLOSE MOVED THAT THE COMMITTEE DIRECT THE LEGAL DIVISION OF THE LEGISLATIVE COUNSEL BUREAU TO PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 5. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

Increasing Access to Medicaid Waiver Services

Waiver services in the Medicaid program are those services that are not medical benefits. They include such items as case management, homemaker, personal care, and other things that prevent a person from being placed in a nursing home. The subcommittee heard testimony that indicated that most people on waiting lists for Medicaid waiver services have not been evaluated to determine whether they are in fact eligible for waiver services. Further, to qualify for the services from a waiver, an individual must have an income that is not more than 100 percent of the federal poverty level (FPL), if he is not in a long-term care facility. If he is in a long-term care facility, his income may be up to 300 percent of the FPL. Finally, the subcommittee heard testimony that some problems in the waiver programs are due to a limited number of case managers to process applicants, and some problems are due to the "system."

Therefore, the health care committee may wish to ask the Legislature to:

6. Adopt a resolution that directs Nevada's Department of Human Resources to increase access to its Medicaid waiver programs. The department should: (1) take efforts to eliminate waiting lists in waiver programs; (2) streamline the process of determining eligibility for waiver services; (3) increase flexibility in waiver programs; and (4) conduct regular evaluations to assess the satisfaction of clients who apply to waiver programs and who receive waiver services. The department should report its progress quarterly in a written report to the chairman of the Legislative Committee on Health Care beginning September 1, 1999.

Ms. Williams, stated that this recommendation would direct Nevada's Department of Human Resources to increase access to Medicaid waiver programs and lists the methods that should be considered.

MR. CLOSE MOVED THAT THE COMMITTEE DIRECT THE LEGAL DIVISION OF THE LEGISLATIVE COUNSEL BUREAU TO PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 6. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

Changing the Eligibility Level of Medicaid to 250 Percent of the Federal Poverty Level

Testimony indicated that there is a gap in eligibility levels in Nevada for people who may be eligible for Medicaid and Medicare. If a person is eligible for Medicare due to his disability, he must wait two years before accessing Medicare benefits.

Therefore, the committee recommends that the Legislature:

7. Adopt a measure that would increase the income eligibility level for Medicaid applicants to 250 percent of the federal poverty level.

Ms. Williams referred to previous testimony regarding Recommendation No. 7, and the request that the recommendation be limited to the option available in the Balanced Budget Act of 1997, which covers only disabled individuals.

MR. CLOSE MOVED THAT THE COMMITTEE DIRECT THE LEGAL DIVISION OF THE LEGISLATIVE COUNSEL BUREAU TO PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 7. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

Alternative Living Arrangements

The subcommittee determined a need to permit individuals who are eligible for Medicaid and Medicaid waiver services to be placed in assisted living facilities if this arrangement proves to be cost-effective for the Medicaid program. Such facilities are likely to be licensed as residential facilities for groups and are regulated by the State of Nevada; however, if they are not, it may be necessary for the Bureau of Licensure and Certification, Health Division, DHR, to develop regulations to ensure that individuals who receive publicly funded assistance from programs administered by the department and live in these facilities are kept in a healthy, safe environment.

Therefore, the health care committee may wish to ask the Legislature to:

8. Adopt a resolution that directs the Department of Human Resources to permit an individual who is eligible for Medicaid and Medicaid waiver services to be placed in an assisted living facility when circumstances warrant such a placement. Further, the department should develop regulations to allow a facility that is not currently regulated in the State to participate as a Medicaid provider within the parameters of available options to do so as developed by the Health Care Financing Administration, United States Department of Health and Human Services.

Ms. Williams commented that this recommendation relates to whether or not assisted living facilities should be considered as placements for individuals on Medicaid and seeks preparation of a bill draft request for adoption of a resolution.

Mr. Close noted that this subject responds to placing the disabled community in the least restrictive environment at the most cost-effective means. The subcommittee heard considerable debate and discussion regarding this issue and agreed that this is an area that can be improved without too much effort.

MR. CLOSE MOVED THAT THE COMMITTEE DIRECT THE LEGAL DIVISION OF THE LEGISLATIVE COUNSEL BUREAU TO PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 8. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

Establishing a Medicaid "Buy-In" Program

It appears that the eligibility requirements of Medicaid for persons who are disabled may serve as a disincentive for them to become employed because they may lose their Medicaid benefits if their income increases.

Therefore, the committee recommends that the Legislature:

9. Adopt a measure to establish a Medicaid buy-in program in Nevada as the program was presented by Mr. Charles Cook, Massachusetts Common Health.

Ms. Williams noted that during previous testimony at this meeting, it was suggested that this recommendation be limited to people who are currently on Medicaid, rather than those individuals who currently do not have Medicaid eligibility.

MR. CLOSE MOVED THAT THE COMMITTEE DIRECT THE LEGAL DIVISION OF THE LEGISLATIVE COUNSEL BUREAU TO PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 9. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

"Aging in Place" Issues

The committee received three recommendations in written correspondence from John Busse, Executive Director, Home Health Care Association of Nevada. Mr. Busse indicates a need for a comprehensive evaluation of home health services in the scope of Medicaid. The three items that will be considered here include: (1) promoting "aging in place" for persons who are elderly; (2) evaluating the adequacy of payment rates for Medicaid home health services; and (3) evaluating the feasibility of including medical social services as a Medicaid home health benefit.

Mr. Busse asserts that, although Medicaid waiver programs have demonstrated the ability to promote aging in place at a cost that is equal to or less than institutional care, these programs are limited in their scope. Whereas a federal program known as the Program for All Inclusive Care for the Elderly, or PACE, which is administered by the Health Care Financing Administration, U.S. Department of Health and Human Services, is a comprehensive model to promote aging in place. This program has tremendous individual benefit for persons who are elderly, but it is feasible only for areas that are largely metropolitan.

Further, home health services are an integral component of an individual's care plan to prevent him from being institutionalized. However, in Nevada, while the Medicaid benefit mirrors the same operational requirements as are required in the Medicare program, the reimbursement rate for these services is much less than the Medicare rate. This inequity may result in payments to home health care agencies that are less than the agency's cost for "fringe benefits of an employee."

Finally, Mr. Busse states:

Medicare and most commercial insurance products cover the cost of medical-social work as part of their home health benefit. The cost is covered because of the recognition that addressing patient care giver medical social work issues is cost-effective. Leaving these issues unaddressed results in higher cost associated with premature institutionalization.

Based on this discussion, it is recommended that the health care committee ask the Legislature to:

10. Adopt a resolution directing Nevada's Department of Human Resources to conduct a comprehensive evaluation of programs to promote aging in place for persons who are aged or disabled in Nevada. The evaluation should: (1) analyze the model that is the Program for All Inclusive Care of the Elderly and establish a system that incorporates its principles for care of the elderly in the State. This recommendation does not require the department to pursue the PACE demonstration program administered by the Health Care Financing Administration; (2) require the department to equalize the payment structure for home health services between the Medicaid and Medicare programs to decrease any disincentive to provide home health services to the Medicaid population; and (3) direct the department to include medical social work as a Medicaid benefit. The department should report its progress quarterly in a written report to the chairman of the Legislative Committee on Health Care beginning September 1, 1999.

Ms. Williams summarized that this item requests a BDR that directs the Department of Human Resources to conduct a comprehensive evaluation of programs to promote aging in place and to explore methods to establish a program similar to the PACE program. It also requires the department to equalize the payment structure for home health

services between Medicaid and Medicare programs to decrease any disincentives for home health services to the Medicaid population, and directs the DHR to include medical social work as a Medicaid benefit.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE DIRECT THE LEGAL DIVISION OF THE LEGISLATIVE COUNSEL BUREAU TO PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 10. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

11. Adopt a resolution directing the Department of Human Resources to: (1) ensure full- or part-time Medicaid eligibility workers are outstationed at all federally qualified health centers (FQHCs) and Disproportionate Share Hospitals (DSHs); or instruct the Department to ensure eligibility staff at FQHCs and DSHs are both trained to do Medicaid intake, and that these agencies are, in accordance with federal Medicaid law, compensated by the DHR for the amount of time spent and resources used to conduct eligibility intake for Medicaid; (2) draw down the one-time welfare reform dollars, and grant the dollars directly to community-based organizations who submit outreach plans likely to reach these post-cash assistance persons, and who are capable of assisting these persons in properly maintaining Medicaid coverage for themselves and their children; and (3) create a Nevada Check-up contracting and incentives program with community-based organizations and providers who, as essential community providers, have established trusting relationships with low-income families.

Mr. Thompson, identified previously, replied to Chairman Rawson's inquiry, stating that the division's main concern regarding this issue would be the "seeding" of the limited federal dollars allocated for administrative purposes to outside organizations.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE DIRECT THE LEGAL DIVISION OF THE LEGISLATIVE COUNSEL BUREAU TO PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 11. THE MOTION WAS SECONDED BY MR. CLOSE AND PASSED UNANIMOUSLY.

ATTACHMENT

RECOMMENDATION NO. 1

The following benefits are recommended for inclusion in a long-term care insurance product:

- *Adult day care;*
- *Alzheimer's disease and other organic brain disorders;*
- *Bed holds for individuals in nursing homes (subject to limitation);*
- *Care advisor coordination (subject to limitation);*
- *Consumer choice of waiting periods;*
- *Daily benefit amounts and policy maximums that are flexible;*
- *Durable medical equipment (subject to limitation);*
- *Home and community-based care that includes all levels of care;*
- *Hospice care (subject to limitation);*
- *Hospitalization not required to access benefits;*

- *Inflation protection;*
- *Informal care (subject to limitation);*
- *No waiting periods or exclusions for preexisting conditions;*
- *Nursing home coverage that includes all levels of care;*
- *Policies that are guaranteed renewable for life;*
- *Premiums that are waived under certain circumstances; and*
- *Respite care (subject to limitation).*

Plan for Active Employees

For active employees, the plan will:

- *Meet expenses up to $100 per day for nursing home, assisted living, or home care with no policy lifetime maximum and an elimination period of 90 days; and*
- *Be guaranteed issue at standard rates for employees under age 65.*

Plan for Retired Employees and Certain Active Employees

For retired employees between the ages of 65 and 85, the plan will:

- *Meet expenses incurred for nursing home or assisted living for up to $100 per day; for home care, the plan will pay up to $60 per day;*
- *Have a policy lifetime maximum benefit of $109,500 with an elimination period of 90 days; and*
- *For both active and retired employees 65 years of age and older or affiliated persons, be issued subject to underwriting approval at the appropriate rate class (preferred standard or two substandard classes).*

ADJOURNMENT

Chairman Rawson thanked the committee and the members of the expanded committee for their time and dedication in dealing with some difficult health care issues.

There being no further committee business, the Chairman adjourned the meeting at 1:30 p.m.

Respectfully submitted,

Roxanne Duer

Senior Research Secretary

APPROVED:

_____

Senator Raymond D. Rawson, Chairman

_____

Date

LIST OF EXHIBITS

Exhibit A is an executive summary submitted by Keith Schwer, Ph.D., Executive Director, Center for Business and Economic Research, University of Nevada, Las Vegas, titled "Health Insurance Coverage of Nevadans, 1997," dated November 30, 1998.

Exhibit B is a report presented by Jack D. Close, P.T., titled "Report of the Subcommittee of the Legislative Committee on Health Care (Nevada Revised Statutes 439B.200) to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled."

Exhibit C is correspondence to Marla McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau, from Kurt Weinrich, Director, Regional Transportation Commission, Las Vegas, titled "Materials in Response to Subcommittee Questions," dated November 24, 1998.

Exhibit D is a fact sheet submitted by Patricia Van Betten, R.N., Nevada Nurses Association, from the Nevada Service Employees Union, Local 1107, AFL-CIO, titled "The Quality of Care Act of 1999," dated November 29, 1998.

Exhibit E is a copy of the testimony of John Yacenda, M.P.H., Ph.D., Executive Director, Great Basin Primary Care Association, dated November 30, 1998.

Exhibit F is a fact sheet submitted by Carla Freeman, Facilitator, Clark County Minority Health Steering Committee, titled "Minority Health Facts for Nevada," dated November 1998.

Exhibit G is a Memorandum to Marla McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau, from Christopher Thompson, Administrator, Division of Health Care Financing and Policy, Department of Human Resources, titled "Overview of Mandatory Managed Care," dated November 23, 1998.

Exhibit H was submitted by Paul Gowins, Developmental Disabilities Council, and contains the following items:

1. *A report titled "Exploratory Study of Health Care Coverage and Employment of People with Disabilities: Literature Review," dated October 27, 1997.*

2. *An abstract titled "Disability and Employment — #11," dated September 8, 1997.*

Exhibit I is a copy of a letter to Senator Raymond D. Rawson, Chair, Legislative Committee on Health Care, dated October 29, 1998, from Ruth Mills, President, Nevada Health Care Reform Project, titled "Legislative Committee on Health Care."

Exhibit J is the "Work Session Document," dated November 30, 1998

Exhibit K is the Attendance Record for this meeting.

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