

**MINUTES OF THE MEETING
OF THE
LEGISLATIVE COMMITTEE ON HEALTH CARE**

(Nevada Revised Statutes 439B.200)

August 3, 1998

Carson City, Nevada

The tenth meeting of the Nevada Legislature's Committee on Health Care for the 1997-1998 interim was held on Monday, August 3, 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 4412A, B, and C of the Grant Sawyer State Office Building, Las Vegas, Nevada. Pages 3 through 4 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

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblyman Jack D. Close

Assemblywoman Barbara E. Buckley

COMMITTEE MEMBERS ABSENT:

Senator Maurice E. Washington

OTHERS PRESENT IN CARSON CITY:

Jeanette K. Belz, President and Chief Executive Officer, Nevada Association of
Hospitals and Health Systems

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

Winthrop Cashdollar, Executive Director, Nevada Health Care Association

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

Fred Hillerby, Hillerby & Associates

Elena Lopez-Bowlan

Donny L. Loux, Chief, Office of Community Based Services, Department of
Employment Training and Rehabilitation

Larry Matheis, Executive Director, Nevada State Medical Association

Georgia McGuire, HealthInsight

Gary Milliken, Gem Consulting

Robert A. Ostrovsky, President, Ostrovsky & Associates

Guy Perkins, Division of Insurance, Nevada's Department of Business and
Industry

Jon L. Sasser, Washoe Legal Services

Carla Sloan, Administrator, Aging Services Division, DHR

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

John Yacenda, MPH, Ph.D., Executive Director, Great Basin Primary Care
Association

OTHERS PRESENT IN LAS VEGAS:

Bernard H. Feldman, M.D., MPH, Vice Chair, Department of Pediatrics, University of Nevada School of Medicine

James Kinard, D.D.S., Nevada Dental Association

Dr. Donald S. Kwalick, Assistant Health Officer, Clark County District Health
Department

Marie H. Soldo, Vice President, Government Affairs, Sierra Health Services, Inc.

Patricia van Betten, Nevada Healthcare Reform Project

Jim Wadhams, Esq., representing interests in insurance and health care

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

H. Pepper Sturm, Chief Principal Research Analyst

Marla L. McDade, Senior Research Analyst

Risa L. Lang, Principal Deputy Legislative Counsel

Leslie Hamner, Deputy Legislative Counsel

Jo Greenslate, 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, August 3, 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 4412A, B, and C
555 East Washington Avenue

A G E N D A

1. Opening Remarks by the Chairman

Senator Raymond D. Rawson

*II. Approval of Minutes from May 29, 1998, Meeting

III. Presentation Regarding Hunger and its Effect in Nevada

Cherie Jamason, Corporate Executive Officer, Food Bank of Northern Nevada

IV. Presentation and Proposal for Mental Health Parity in Health Insurance Policies in Nevada

Rosetta Johnson, President, Alliance for the Mentally Ill of Nevada

V. Proposal to Create a County Organized Health System in Nevada

William R. Hale, Chief Executive Officer, University Medical Center

*VI. Discussion and Recommendations for a Study of Managed Care Programs Administered by Nevada's DHR

*VII. Report of the July 14, 1998, Meeting of the Subcommittee of the Legislative Committee on Health Care to Address Medicaid Managed Care Issues for Persons With Disabilities

VIII. Public Testimony

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

Some recommendations will be voted on and others will be presented to determine whether the committee wishes to develop the ideas further for a future work session. The possible topics that may be covered are listed below.

1. Long-Term Care Issues
2. Hospice and Pain Management Issues
3. Physical Fitness Training Program for Senior Citizens
4. Individuals with Chronic or Life-threatening Illnesses
5. Licensure for Physical Therapists in Nevada
6. Steroid Warning Labeling
7. Diabetes Issues
8. Nevada Medicaid Issues
9. Minority Health Issues
10. Children's Health Insurance Plan Issues

NOTE: Recommendations under consideration by the committee are presented in the attached "Work Session Document, Legislative Committee on Health Care, August 3, 1998." A revised copy of this document may be provided at the meeting. Additional copies of this document may be obtained from Jo Greenslate, Research Division, Legislative Counsel Bureau, 684-6825, Capitol Complex, Carson City, Nevada.

X. 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 Jo Greenslate, 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. The Chairman noted that a quorum was present. He mentioned that this would be the final meeting at which members of the expanded committee would participate, and thanked them for their participation.

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APPROVAL OF MINUTES FROM

MAY 29, 1998, MEETING

ASSEMBLYWOMAN FREEMAN MOVED FOR APPROVAL OF THE MINUTES OF THE MAY 29, 1998, MEETING OF

THE LEGISLATIVE COMMITTEE ON HEALTH CARE IN LAS VEGAS. THE MOTION WAS SECONDED BY ASSEMBLYMAN CLOSE AND PASSED UNANIMOUSLY BY THOSE WHO WERE PRESENT. SENATOR MATHEWS WAS ABSENT FOR THE VOTE.

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PRESENTATION REGARDING HUNGER AND ITS EFFECT IN NEVADA

Paula Berkley representing the Food Bank introduced Cherie Jamason, Corporate Executive Officer, Food Bank of Northern Nevada.

Cherie Jamason

Ms. Jamason explained that a food bank is like the "United Way" of food, in that food is gathered from many different resources and provided to agencies that serve the ill, needy, elderly and children. She enumerated the following facts regarding the food bank:

- It serves 83 agencies in northern Nevada.
- There is a similar food bank in southern Nevada serving Clark, Lincoln, and Nye counties.
- The Food Bank of Northern Nevada serves the 13 northern counties and approximately 15 small communities near the areas of Bridgeport, Susanville, and Lake Tahoe.
- Thirty-five of the 83 agencies are emergency food programs, which acquire all or most of what they distribute from the food bank.
- Forty-eight of the 83 agencies provide services such as senior nutrition programs, day care centers for low-income families, substance abuse treatment, soup kitchens, and domestic violence shelters.

According to Ms. Jamason, the food bank is a support system for these agencies, providing food and grocery products to them. She advised that they raise approximately \$250,000 a year to purchase food, and Title XX contributes approximately \$27,000 of that funding.

Ms. Jamason noted that the food bank participated with Second Harvest, the national food bank network, to assess food needs in its service area (see Exhibit A).

Also, Ms. Jamason stated that the purpose of her presentation was to obtain feedback from the committee regarding its areas of interest in regard to food issues faced by people who have low incomes. She asked the committee to consider how increasing food security might impact the programs that are funded through the Legislature, or Community Services Block Grants, from Nevada's Department of Human Resources (DHR).

Ms. Jamason continued to highlight points made in her handouts (see Exhibit A), and urged the committee to support the efforts of the food bank, which is to end the problem of hunger.

Ms. Berkeley invited the committee members to an upcoming Food Summit, and welcomed information and ideas from the members. She said the interests and ideas from attendees would be used to organize relevant workshops at the summit.

Chairman Rawson called attention to the fact that everything in the handouts was presented in percentages and inquired what the actual numbers of people requiring food assistance are. Ms. Jamason replied that there are about 128,000 people being served in northern Nevada, mostly in emergency food programs.

According to Ms. Berkeley, one of the goals of the Food Summit is to narrow the food bank's survey more specifically to Washoe and Clark counties and develop questions that can provide better data and answers.

In response to Chairman Rawson's observation that Nevada's number of disabled persons needing food assistance is higher than the national average, Ms. Jamason affirmed a need to address that problem. She said that is a perfect area for a partnership with the Aging Services Division, DHR, since the division already studies the problem for disabled persons over a certain age.

Fred Hillerby (identified on page 1) questioned the figure of 128,000 people in northern Nevada requiring food assistance. He mentioned that in gathering statistics for the children's health insurance program, an estimate of 60,000 dropped to 27,000 uninsured children; yet the food bank estimates there are approximately 40,000 children under 17 years of age, and 85 percent of the families are under the poverty level. Mr. Hillerby asserted those numbers do not work with only 27,000 children in need statewide.

Ms. Jamason clarified that the 128,000 figure includes duplicated numbers of people. She continued the unduplicated emergency food program clients are in the neighborhood of 40,000, but the instances of service is over 128,000.

Jon L. Sasser (previously identified on page 2) asked if the food bank could, in future statistics, keep track specifically of those people who have come off programs such as Temporary Assistance to Needy Families (TANF), food stamps, and Supplemental Security Income (SSI) to see if they are going from those programs to the food bank rather than gaining employment and becoming self-sufficient.

In response to a question from the committee, Ms. Jamason stated that data extrapolated from a study conducted in 1992, the Community Childhood Hunger Identification Project, indicated that about 75,000 children in Nevada are at risk of suffering from adverse affects on brain development and cognitive development due to inadequate nutrition.

Discussion ensued regarding including members of the Hispanic community in the summit and statistical differences in the numbers of people being served from different racial and ethnic groups. It was pointed out that not all minorities go to traditional places which offer assistance, and that the income levels of minorities may be lower, which may create a corresponding higher percentage of food bank users among these groups.

PUBLIC TESTIMONY

Upon conclusion of this agenda item, Chairman Rawson invited two committee members to provide public testimony, out of order, due to travel contingencies.

John Busse

John Busse, Executive Director, Home Health Care Association of Nevada (HHCAN), invited Mike Girard, Director of Washoe Home Care and a member of HHCAN, to join him at the witness table. Mr. Busse referred to his handout, a letter addressed to Senator Raymond D. Rawson dated July 31, 1998, Re: Recommendations of Home Health Care Issues for Consideration during the 1999 Nevada Legislative Session (see Exhibit B), and said Mr. Gerard would speak on the first item. Continuing Mr. Busse remarked that home care is an integral part of long-term care.

Mr. Girard read from "Consideration of Demonstration or Waiver Programs Promoting Aging in Place," the first item of Exhibit B.

In response to Senator Mathew's questions, Mr. Busse replied:

- Duties differ between a certified nurse assistant (CNA) and a personal care assistant (PCA) in terms of licensing. The PCAs are not licensed and are expected to provide non-medical services and care. A CNA can do everything a PCA does including limited medical services that are overseen by nurses, registered nurses, and licensed practical nurses.
- He suggests elevating PCAs to the same level as CNAs, particularly in the rural areas where PCAs disburse medication, change dressings, and so forth.
- Although CNAs are regulated by the State Board of Nursing, PCAs are not regulated at all.
- Since the demand for PCAs has increased dramatically, there is a greater possibility for PCAs to make undetected mistakes, which could possibly endanger patients.

Donny L. Loux (previously identified on page 1) suggested that perhaps Mr. Busse was addressing statutes that allow a personal assistant to perform services for a person who is disabled. She said her office worked with the State Board of Nursing to establish guidelines for such people to be tested by either a registered nurse or the person's physician to ensure their ability to carry out those tasks. Ms. Loux stated the primary reason for adopting such a practice was to keep costs down and ensure that people covered by Medicaid are not exceeding their institutional care costs and are able to remain in their own homes.

Mr. Busse expressed his appreciation and mentioned he should perhaps work with Ms. Loux to delineate some of the concerns about PCAs in the rural areas and who is responsible for supervising them. Ms. Loux informed Mr. Busse that her office contracts with community based agencies for PCAs, and those agencies supervise the PCAs as well as pay their benefits.

Mr. Sasser referenced the first item Mr. Gerard mentioned, the Program for All Inclusive Care for the Elderly (PACE), which allows for aging in place as an alternative to long-term care. He asked if HHCAN would support his Recommendation No. 29 on the Work Session Document, which calls for an interim study by the Legislative Commission to look at a range of alternatives to long-term care. Mr. Gerard answered affirmatively.

In response to questions by Mr. Thompson, Messrs. Busse and Gerard answered as follows:

- Mr. Busse concurred with the observation that the cost of providing care would be approximately \$50 an hour under a Medicare situation. Therefore, only two hours of home care would be comparable to the care that would be paid for in an institution.
- Mr. Gerard indicated that under Medicare, a patient generally receives one or two visits from a medical social worker to coordinate all other community services and deal with various family and other caregiver issues that are beyond the scope of the home health agency. These initial services prevent the need for high cost medical care at a later date.
- Regarding the cost of Medicare versus Medicaid, the mandate that Medicaid must use a Medicare certified agency, which charges a rate higher than its reimbursement, coupled with the fact that the hourly cost of the nurse is not covered, is a disincentive to serve the Medicaid population.
- The current federal cutbacks in Medicare home health services since passage of the Balanced Budget Act of 1997 has slashed reimbursement rates between 15 and 20 percent, and one out of ten home health agencies in the country has gone out of business.

Carla Sloan (identified on page 2) clarified that PCAs are not regulated by the Division for Aging Services. She said the division's home and community based care program utilizes homemakers, and is a non-medical program coordinated by her agency.

Chairman Rawson invited Larry Matheis to present his public testimony before continuing to the next agenda item.

Larry Matheis

Larry Matheis, Executive Director, Nevada State Medical Association, suggested items for future agendas. He asked for the following presentations:

- Electronic data interchange (EDI). The Health Insurance Portability and Accountability Act of 1997 includes a requirement for the establishment of standardized electronic claims management. According to Mr. Matheis, a number of states are taking advantage of this opportunity to look at community health information networks to find ways to maximize use of the standardized information. Mr. Matheis recommended a briefing by an EDI group, which consists of purchasers, providers, and users and generators of health claims data that have been studying this issue.
- A presentation by the Nevada Tobacco Prevention Coalition to update the committee on the status of health issues related to tobacco, both at the state and national levels.

PRESENTATION AND PROPOSAL FOR MENTAL HEALTH PARITY IN HEALTH INSURANCE POLICIES IN NEVADA

Chairman Rawson held discussion of this issue later in the meeting.

PROPOSAL TO CREATE A COUNTY ORGANIZED HEALTH SYSTEM IN NEVADA

William R. Hale

William R. Hale, Chief Executive Officer, University Medical Center of Southern Nevada (UMC), distributed a proposal titled, "Formation of a County Organized Health System — An Innovative Approach to the Healthcare Needs of Nevada's Uninsured," (see Exhibit D). He testified that UMC has developed a plan that would shift responsibility for the care of patients requiring social programs to local county governments.

Mr. Hale explained that this proposal consolidates the Children's Health Insurance Program, county programs for social service patients, and the Medicaid program into one program administered by a county agency. It also establishes a new program for the medically needy and those persons who are uninsured. He maintained this proposal would result in the following benefits:

- An end to much of the confusion and fragmentation of existing services.
- A seamless delivery system that would maximize the use of federal dollars.
- Improved access to services by the uninsured population.
- Improved efficiency by removing the duplication of administrative services.
- More efficient utilization of state and local dollars.
- One source for individuals or families who are uninsured and in need of health care.

Responding to a question from Chairman Rawson, Mr. Hale replied that there are many other models of plans similar to this proposal. He said the proposed format is being used in California, Minnesota, and other states. He advised that the plan includes setting up a committee, which is a separate entity, that would be a nonprofit organization. Mr. Hale made the following additional points:

- The committee would be appointed by the board of county commissioners of each county, consisting of seven members plus two members from the Governor's Office.
- Committee members would include people from the private sector who are not health care providers or those with a vested interest in any of the programs that provide services.
- The health plan would include all providers willing to participate, and they would be required to provide care to all persons in need, including uninsured persons.
- Washoe County and Nevada's rural areas would be included in the system, and each county or area would have the option of running its own program or requesting that the State administer its program.

Presently, Mr. Hale asserted that Nevada is losing federal matching dollars for the medically needy population. He estimates that in Clark County alone, 35 percent of the patients covered by the county's social service programs would be eligible for a medically needy program. According to

Mr. Hale, those patients are currently being covered 100 percent by local tax dollars. In conclusion, he stressed that this plan will enable Nevada to receive a 50 percent match from the Federal Government for these costs.

In response to questions by Mrs. Freeman, Mr. Hale remarked:

- The Clark County commissioners voted 7-0 in favor of the proposal.
- To allay concerns of the financial committees, the plan has been crafted in such a way that increases in state dollars would only be proportionate to population increases in the needs of the various categorically linked programs now being provided through state funding. New money would come from the counties to help make the matching dollars for the medically needy program.

Responding to Chairman Rawson's question regarding the bill draft language, Mr. Hale advised that it has been redrafted and is open for discussion. He added that once he meets with representatives from the rural areas and determines whether they want to be included, he will change the first sentence under Section 3 of the bill draft, striking the statement, "In a county with a population greater than 400,000."

In response to further questions from the committee, Mr. Hale stated:

- The development of this system is compatible with the concept of HMOs providing an insurance package for children enrolled in the Nevada Check-Up program with some adjustments. Under this plan, HMOs would be involved in the process as well as other providers.
- The new commission would contract with tribal governments and work through the various tribal health clinic provider networks that have been set up.
- Each county would determine its own eligibility criteria.
- Nevada Check-Up, Medicaid, and the medically needy program would have to follow federal guidelines for eligibility.
- All providers participating will accept uninsured persons. The additional funding received by hospitals and doctors through a medically needy program will entice private physicians and other providers to participate in the programs.
- The advisory group will include the disability community, minorities, consumers — the people that actually receive the services, as well as experts from businesses.

Responding to issues raised by Mr. Thompson, Mr. Hale pointed out:

- Administrative costs of the committee would have to be shared. Federal money is available for administrative costs at certain levels. Additionally there would be some state and county costs. Ideally, duplicate services would be removed, resulting in administrative cost savings in the long run.
- It is the intent of the bill draft to place most of the liability on the separate entity. If the program was to go bankrupt, it has been crafted in a way to minimize cost to the counties.

PRESENTATION AND PROPOSAL FOR MENTAL HEALTH PARITY IN HEALTH INSURANCE POLICIES IN NEVADA

Upon the arrival of Rosetta Johnson, President, Alliance for the Mentally Ill of Nevada, the Chairman appointed Assemblywoman Freeman to work with Ms. Johnson in a subcommittee to draft specific proposals for a hearing of the full committee.

REPORT OF THE JULY 14, 1998, MEETING OF THE SUBCOMMITTEE OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE TO ADDRESS MEDICAID MANAGED CARE ISSUES FOR PERSONS WITH DISABILITIES

Assemblyman Jack D. Close referred to his memorandum addressed to Senator Ray Rawson, Subject: "Summary of results from the first meeting of the subcommittee created to address Medicaid Managed Care Issues for Persons with Disabilities," dated July 31, 1998, (see Exhibit E).

Mr. Close testified that, in general, the meeting went well, and there was a lively discussion regarding the problems that face the disabled community. He added that this meeting was one of the few forums for disabled persons to be able to provide direct testimony to the Legislature. His handout summarizes the main points of the meeting. Mr. Close reported there was a consensus of opinion at the end of the meeting that the issues raised need further investigation along with other areas which are identified in his report (see page 2 of Exhibit E).

Chairman Rawson directed the subcommittee to meet another time to create an agenda of specific items to take to the 1999 Legislative Session.

Mr. Sasser requested permission for members of the expanded committee involved with the subcommittee to continue their involvement with the subcommittee. Chairman Rawson concurred.

DISCUSSION AND RECOMMENDATIONS FOR A STUDY OF MANAGED CARE PROGRAMS ADMINISTERED BY NEVADA'S DHR

Regarding Nevada Check-Up, Mr. Thompson advised that his office has submitted a revised state plan which reflects changes in the program over the course of the past six weeks. These changes include:

- The same set of benefits to the Nevada Check-Up population as are being offered to the Medicaid managed care population.
- In locations where there are no managed care providers, the individuals under the program will receive services on a fee-for-service basis.
- With regard to specific eligibility issues, a question will be added to the application form regarding assets.

Mr. Thompson made the following points regarding the managed care program:

- The mandatory managed care program is on track to be in effect as of December 1, 1998.
- A "Request for Contract" has been released to managed care organizations (MCOs).
- The state plan amendment has been filed with the Health Care Financing Administration (HCFA), United States Department of Health and Human Services (DHHS), as of July 31, 1998.
- In October 1998, the program will begin providing Medicaid-eligible individuals their choice of MCOs under Medicaid managed care, and recipients will begin receiving services on December 1, 1998.

In response to Chairman Rawson's query as to whether a simplified eligibility determination has been proposed, Mr. Thompson provided the following information:

- The state plan proposed to HCFA that individuals who apply for Nevada Check-Up will be provisionally enrolled in this program while a full Medicaid determination is being made.
- The HCFA requires that individuals who are potentially eligible for Medicaid based on income and the additional assets question, will have to file a full Medicaid application.
- Individuals will be informed of their obligation to file a full Medicaid application, and if they do not comply within one month, they will be informed that they will be disenrolled from Nevada Check-Up.

Mr. Thompson suggested moving forward with this program to determine how many individuals will be directly affected (i.e., How many individuals are presumably eligible for Medicaid but choose not to apply?). He reasoned that changes could be made pursuant to the established need to make such changes.

Discussion ensued regarding eligibility, disenrollment, and one application versus two. Mr. Thompson made the following points in response to the committee's comments and questions:

- If a child is provisionally enrolled in the program, and it is subsequently determined that he is Medicaid eligible, the Medicaid program would pay back Nevada Check-Up for the difference, at the lower 50-50 match for those costs as opposed to the 65-35 match.
- A child that is provisionally enrolled but does not follow through on Medicaid eligibility would get the full 65 percent federal match and would be considered eligible for Nevada Check-Up at that time.
- The eligibility problem would not be solved by dropping the assets test in Medicaid. Practical consideration of the state's entire eligibility system within Welfare and the work being done on Nevada Operations Multi Automated Data Systems (NOMADS), necessitates maintenance of a separate eligibility determination process of Nevada Check-Up.

In response to Ms. Buckley's comments regarding dropping the assets test, Charlotte Crawford (identified on page 1) explained that in her discussion with the Legislature's Interim Finance Committee (IFC), she believed that the IFC did not express an interest in directing the DHR to drop the assets test at this time. However, she advised that the DHR is preparing its legislative budget to include a number of different Medicaid options, which includes elimination of the assets test.

Responding to additional questions from the committee, Mr. Thompson made the following points:

- Originally his office had projected a cost that was roughly comparable to Medicaid patients.
- In discussions with the MCOs, particularly since there were significantly lower than projected sign-ups, the MCOs raised the issue that there would be substantially greater adverse selection among those families and individuals that actually chose to sign up.

- With regard to the amount of adverse selection, the program will provide a percentage increase over the cost per Medicaid patient that will be reviewed after six months to compare actual utilization of Nevada Check-Up clients with Medicaid clients. This will give both sides data as to what a true adverse selection adjustment should be.
- Essentially there is a guaranteed amount that the MCOs will receive for that six-month period, but if the adverse selection amount is more than 10 percent above the projection, they will get an additional retroactive adjustment.
- It was determined that a separate benefits package tailored to the individuals who would be covered would be costly to administer. Therefore, it would be easier to build on the existing Medicaid population.
- The change that was made is cost efficient even though it provides a broader benefits package.
- Nevada Check-Up applications that are determined to be potentially eligible for Medicaid will be routed to Welfare, and a similar procedure will be implemented for ineligible Medicaid applicants, to Nevada Check-Up.
- Additional information will be requested in the form of a more complete application.
- Routing of applications is also being considered of individuals who initially applied for Medicaid but are determined ineligible. The possibility of using the Medicaid application as a Nevada Check-Up application is being explored.
- The HCFA will be consulted about these proposals.

Responding to questions from Ms. Buckley, Chairman Rawson remarked:

- That he would have staff of the Fiscal Analysis Division of the Legislative Counsel Bureau either correspond or telephone Ms. Buckley regarding IFC's decision to have two application processes.
- That the dental portion of Nevada Check-Up and Medicaid managed care is ready to proceed once the program is approved.

Adding to Chairman Rawson's comments, Mr. Thompson iterated that the dental program: (1) will be treated in the same manner for Nevada Check-Up as it would for the Medicaid managed care program, (2) will be a service outside of the managed care contract, and (3) will no longer require a copayment. Additionally, no copayment will be required for prescription drugs, hearing and vision services.

In response to Chairman Rawson's inquiry as to when a final determination is expected from the HCFA, Mr. Thompson remarked that he anticipates hearing from HCFA by today, August 3, 1998, or by Wednesday, August 5, 1998.

Mr. Thompson responded to questions from Senator Mathews as follows:

- Of the states whose children's health insurance programs have been approved, most have gone with a full Medicaid add-on, but there are a few separate children's programs which have already been approved.
- Approximately 5,400 children have applied for Nevada Check-Up to date; Native American children are included in that figure.
- A survey from Keith Schwer, Ph.D., Center for Business and Economic Research, University of Nevada, Las Vegas (UNLV), will provide information regarding individuals who appear to be eligible for Nevada Check-Up but have not applied.
- The original figure of 60,000 uninsured children under 200 percent of poverty included about 15,000 to 20,000 kids that were potentially eligible for Medicaid. Under federal law and federal interpretation, those 15,000 to 20,000 would not be eligible for Nevada Check-Up, but beyond that there is a study that has been made available to the committee that indicates the total number of children who may be eligible in Nevada for Nevada Check-Up may be as few as 17,000 children.

Mr. Thompson maintained that once he receives the information from UNLV, his office will be in a better position to determine the quality of outreach to date and what other services his office can provide.

In response to an inquiry as to when the survey information is expected from UNLV, Chairman Rawson advised he was told the committee might get information at its September meeting. He requested staff to send an urgent memorandum to UNLV expressing the critical nature of the survey information to the committee.

Responding to Mr. Sasser's comment regarding his estimates that 80 to 90 percent of families whose income falls below 200 percent of poverty might be potentially eligible for Medicaid, Mr. Thompson pointed out that based on the information acquired from the Nevada Check-Up applications that were filed, it appears closer to 50 percent. He said that is based on net income determined by adjusting a family's gross income to allow for unknown child care expenses.

In response to additional questions from the committee, Mr. Thompson explained:

- The 5,400 figure he referred to represents the total number of applicants. Enrollment forms will not be distributed until all of the issues are resolved with HCFA. A letter was mailed to applicants in early July 1998 advising of the change in the program and that the change would

cause a delay. It also mentioned that certain individuals who had been determined to be eligible for Medicaid may be required to file a full Medicaid application.

- Of the 5,400 applicants, just under 2,000 were determined eligible for Nevada Check-Up and not eligible for Medicaid.
- A slightly lower number were determined to be potentially eligible for Medicaid and, therefore, provisionally eligible for Nevada Check-Up.
- The remaining applicants were either denied at a rate slightly over 10 percent or are still pending due to a lack of information on their application.
- The children who have applied for Nevada Check-Up, who appear eligible for Medicaid (almost half the applicants), have been sent Medicaid applications.

Larry Matheis (identified on page 2) spoke on the benefits of expanding Medicaid. He concurred with Ms. Buckley's suggestion of setting up the program now as close to correct as possible rather than letting the Legislature try to restructure and repackage it thereby delaying implementation into the year 2000. He asserted that Nevada has triggered the HCFA's close analysis by proposing to use unexpended Medicaid funds as the state's portion of the payment for its new program. Mr. Matheis urged the committee to "clear the air, move on, and look at the same problem it started with." In conclusion, Mr. Matheis said there is "cheap" federal money available to help Nevada construct or reconstruct coverage of the indigent and uninsured children, and the State should do what it can to see that as many of them as possible are covered by health insurance.

Following the remarks of Mr. Matheis, Mrs. Freeman expressed her frustration that the Legislative Committee on Health Care decides policy, but the Interim Finance Committee, the Senate Committee on Finance, and the Assembly Committee on Ways and Means, make decisions that have a major impact on decisions being made in the policy committees without including members of the policy committees in the discussions regarding those decisions.

Ms. Buckley concurred with Ms. Freeman's comments regarding the policy issues. She asserted, for example, the issue is not just whether the assets test should be eliminated prior to commencement of the 1999 Legislature, but its impact on the application system by having dual applications. It was her opinion that the IFC has not had the opportunity to discuss this issue in the amount of detail the committee has from a policy point of view. She asserted that without this essential review the program no longer makes sense.

PUBLIC TESTIMONY

Helen Gallardo

Helen Gallardo, Nevadans Acting for Welfare Reform, mentioned attending the task force meeting in the interim session prior to the Governor signing the block grant. She said the issues raised at that meeting were tabled due to a breach of confidentiality, but it was addressed in the 1997 Legislative Session on October 31, 1997, as part of the inter-local agreement between the Employment Security Division, Department of Employment, Training and Rehabilitation; Clark County Social Services; and Nevada State Welfare. She advised that since they have an inter-local agreement and are coming up to the next Legislative Session, the October 31, 1997, decision should be amended to make it a universal application for both Nevada Check-Up and Medicaid. Ms. Gallardo referred to a draft of the proposed application (see Exhibit F), and suggested adding a routing block to the top and following the existing format. Continuing, she stressed the importance of adding the confidentiality statement to the bottom of the form, and recommended having a "Part A" and "Part B," with questions one through ten, with the majority of duplicated questions as Part A. Ms. Gallardo concluded by suggesting that Part B could be optional depending on which program was being applied for. She reminded the committee that federal guidelines prohibit a duplication of efforts.

Mary Jean Thomsen

Mary Jean Thomsen, Northern Nevada Center for Independent Living, advised that Rick Cline, who attended the Subcommittee to Address Medicaid Managed Care Issues for Persons with Disabilities held on July 14, 1998, requested she read a statement. Ms. Thomsen noted Mr. Cline's concerns and suggestions for improving the personal care assistant for the disabled (PCA-D) program (see pages 4 and 5 of Exhibit G). Ms. Thomsen also noted she had called the person in charge of the PCA-D program approximately three days prior to the meeting and learned that the program is on hold due to legislative information which she has been unable to obtain.

Chairman Rawson mentioned that there was a subcommittee meeting on this issue chaired by Assemblyman Jack Close, and there will be another meeting of the subcommittee. He said Mr. Cline's questions will be forwarded to Mr. Close, and he requested staff to gather background information on the PCA-D program prior to the next subcommittee meeting.

Ken Richardson

Ken Richardson, Health Director, Walker River Paiute Tribe, stated that he attended the meeting to present information regarding the Native American tribes of Nevada. He made the following points regarding the Native American population:

- There are two Indian Health Service units that provide health care services for 23 tribes within the state.
- Roughly 25,000 Native Americans in Nevada use these health services.

- Another 12,000 to 14,000 Native Americans cannot receive services in the Las Vegas area.
- Currently, there are approximately 9,800 Native American children under the age of 19 years; about 2,200 are on Medicaid; the remainder are under Native American health services care.

Mr. Richardson indicated that Native Americans are supportive of Nevada Check-Up and would like to be involved with the program, and he requested receiving a status report on the program's progress. Mr. Richardson concluded by informing the committee that the last report he received reflected that there were only 11 people signed up from Mineral County, but added that travel logistics are often a problem for tribal members.

Chairman Rawson informed Mr. Richardson that there is a federal requirement that the State reach out to the Native American community, and requested he leave his name and address so that he could be added to the mailing list.

Winthrop Cashdollar

Winthrop Cashdollar requested clarification that those who have proposed recommendations would have an opportunity to discuss them later in the meeting when questions arise. Chairman Rawson affirmed that they would. Mr. Cashdollar expressed his support for Recommendation No. 17 regarding licensure of physical therapists, Recommendation No. 29 regarding long-term care alternatives, and Recommendation No. 31 regarding establishment of a statutory subcommittee to consider health care and medical needs of people with chronic and disabling conditions, including the elderly.

John Yacenda

John Yacenda, MPH, Ph.D., Executive Director, Great Basin Primary Care Association, stated there were several items he recommended in the Work Session Document. One in particular that he testified on at length in the committee and for which he prepared bill draft language, is Recommendation No. 45, establishment of a Division of Minority Health. He mentioned the following points raised about that recommendation:

- Based on input from several interested parties, it was decided an entity was needed that would be able to serve all state agencies that were participating in and delivering health care and social services program to minorities.
- The proposal explains a creative way of funding the division, utilizing a method of sharing the costs among a broad range of agencies.
- An advisory committee would be established for this new office, which would include members from the major minorities in Nevada.
- Four basic assumptions were used in requesting a division:
 1. The health and social service programs that currently target minorities are housed in a number of different state agencies;
 2. Effective input, dialog, and technical assistance across the board must be ensured and readily accessible among entities that provide services to minorities;
 3. Technical assistance in program design that focuses on the internal and external forces influenced by culture are essential to state programs; and
 4. The division is established not to create a special class of Nevada citizenry, but to hone efforts to improve the overall health of Nevada by appropriately focusing programs to address the disparities experienced more frequently by minorities.

Dr. Yacenda also referenced Recommendations Nos. 46 through 49, which relate to Nevada Check-Up; having contracts directly with the provider to the persons most likely eligible for Nevada Check-Up; to automatically enroll children who are enrolled in the Women, Infants & Children program, which is (WIC), United States Department of Agriculture Special Supplemental Food Program; and to maximize the use of all federal dollars for outreach relative to the TANF program as well as the Nevada Check-Up program, with a special emphasis on enrolling Native American children.

Elena Lopez-Bowlan

Ms. Lopez-Bowlan (previously identified on page 1) offered her support for Recommendation No. 45, and claimed there are many federal reports that affect the Hispanic community that never reach Nevada. She distributed copies of an initiative titled, "Hispanic Agenda for Action: Improving Services to Hispanic Americans," (please see Exhibit H) which was submitted to Donna E. Shalala, Secretary of the DHHS. Ms. Lopez-Bowlan advised that Ms. Shalala approved the formation of a committee to study Hispanic health issues throughout the country, but Ms. Lopez-Bowlan has never heard anyone in Nevada discuss this report that is guiding the department in its funding and program planning. She stressed the importance of forming a coordinating agency that will study Hispanic health issues.

Donny Loux

Ms. Loux (identified earlier) advised that one of her proposals is to continue the work of the Subcommittee of the Legislative Committee on Health Care to Address Medicaid Managed Care Issues for Persons with Disabilities. She commended Assemblyman Close for his admirable chairmanship of the subcommittee. Ms. Loux noted that the disabled and elderly are most vulnerable to being removed from their homes and

placed into nursing homes and other institutions, and it is the most costly population for which to provide care to the taxpayers, the State, and Federal Government.

Regarding the Medicaid buy-in proposal, Ms. Loux read from congressional findings regarding why proposals to maintain health care for people with disabilities are so important. She revealed the following statistics:

- Currently, less than one-half of one percent of Social Security Disability Insurance (SSDI) and SSI beneficiaries cease to receive SSDI and SSI benefits as the result of employment.
- If only an additional one-half of one percent of the current SSDI beneficiaries were to cease receiving these benefits because of employment, the savings in cash benefits and public assistance would be nearly \$4 billion.

Ms. Loux also mentioned the difference in the cost of living for people with disabilities who work versus those without disabilities. She noted the out-of-pocket costs for a working disabled person with excellent insurance, are around \$5,000 to \$8,000 per year. Ms. Loux supports Recommendation Nos. 3 and 6 regarding reimbursement costs for nursing home care. She is also in support of Recommendation No. 25, for expansion of Medicaid to the medically needy.

Jon Sasser

Mr. Sasser commented on the proposals that he submitted, Recommendation Nos. 23 through 29. He remarked that Recommendation Nos. 23, 24, 26, and 27, offer the opportunity to propose legislation that would put some of the eligibility rules into statute and, therefore, bind the finance committees to policies set by the policy committees. Mr. Sasser advised that he put the medically needy option into Recommendation No. 25, which expands Medicaid eligibility because, of the proposals being considered to expand eligibility, No. 25 is the broadest. Continuing, he mentioned that Recommendation No. 28 proposes to eliminate current waiting lists for the various Medicaid waiver programs that serve people who do not go into nursing homes. Finally, Mr. Sasser explained that Recommendation No. 29 is a study to find alternatives to long-term care which would enhance the quality of life at less cost.

Helen Gallardo

Ms. Gallardo told of awaiting a SSDI ruling for the last seven months, during which time her case worker pressured her to work because he interpreted the law under the block grant to read that if a 100 percent disability was not approved through Social Security, the claimant is required to work even if the claimant's physician advises against working. Ms. Gallardo pointed out that not all disabilities are 100 percent, and she recommended that the 1999 Legislature spell out the work requirements in more detail, especially while claimants' cases are pending.

Chairman Rawson requested that Mr. Close address the issue raised by Ms. Gallardo in the next Subcommittee of the Legislative Committee on Health Care to Address Medicaid Managed Care Issues for Persons with Disabilities meeting.

The Chairman excused the expanded committee members in preparation for the work session.

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WORK SESSION

LEGISLATIVE COMMITTEE ON HEALTH CARE

(Nevada Revised Statutes 439B.200)

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 through May 29, 1998. A citation concerning the source of each recommendation is noted, where available.

Supporting documentation for concepts listed in this paper will be available for committee members and the public at the August 3, 1998, meeting of the committee.

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**NOTE: Starred items indicate issues that the committee has not addressed during its hearings.*

\$\$: Indicates items that may require funding to the agency to carry out the designated concept. Cost estimates may be provided at a later date.

PROPOSALS FOR ACTION BY THE

LEGISLATIVE COMMITTEE ON HEALTH CARE

Long-term Care Issues

(Items 1 through 9 were proposed by Winthrop Cashdollar, Executive Director, Nevada Health Care Association. See the July 10, 1998, memorandum, which is included as Attachment A. Please see Exhibit I.)

1. a. A proposal was made to compel the Welfare Division, Department of Human Resources (DHR), to provide for the training of recipients of the division's Temporary Assistance for Needy Families (TANF) program as certified nursing assistants (CNAs) for purposes of providing long-term care to nursing home residents in Nevada. Further, the proposal suggests that the division develop a program that recruits and retains CNAs in long-term care facilities. Additionally, an objective of the retention program should be to provide child care in nursing home facilities for all such personnel to ensure that workers are offered affordable child care. The program should be operational by July 1, 1999. \$\$

(According to Mr. Cashdollar, this proposal would serve two purposes: (1) alleviate a potential shortage of CNAs in nursing homes in Nevada; and (2) assist the division to accomplish the "welfare-to-work" goals of welfare reform.)

OR

b. An alternative proposal might be to ask the Welfare Division to conduct an agency study of the feasibility of developing a CNA training program for recipients of TANF benefits. The study, in cooperation with the Nevada Health Care Association, would assess the number of CNA slots needed in Nevada and whether TANF recipients had the skills to appropriately meet the CNA need for nursing homes. Further, the study would identify the necessity of child care for these CNA trainees, and it would identify methods to encourage nursing homes to provide child care for their personnel. The results of this study should be reported to the Legislative Committee on Health Care by July 1, 2000, at which time the committee may review the study's findings and report its recommendation regarding this proposal to the Interim Finance Committee.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST WHICH INCLUDES THE CONCEPT OF RECOMMENDATION NO. 1(b).

ADDITIONALLY, THE BILL DRAFT REQUEST SHOULD DIRECT THE WELFARE DIVISION TO INCLUDE IN ITS STUDY AN ASSESSMENT OF OTHER PERSONNEL NEEDS OF NURSING HOMES THAT MIGHT BE FILLED BY APPROPRIATELY TRAINED RECIPIENTS OF THE PROGRAM FOR TEMPORARY ASSISTANCE TO NEEDY FAMILIES. THE MOTION WAS SECONDED BY ASSEMBLYMAN CLOSE AND PASSED UNANIMOUSLY.

*2. A proposal was made to compel the Division of Health Care Financing and Policy, DHR, to conduct an agency study of nursing facility staffing and reimbursement in relation to the federal "Resource Utilization Groups III" system and its effect on long-term care facilities that are affected by this system. The results of the study should be reported to the Legislative Committee on Health Care by July 1, 2000, at which time the committee may review the findings of the study and report its recommendation regarding this proposal to the Interim Finance Committee. * §§*

(According to written comments submitted by Mr. Cashdollar, Nevada's Medicaid nursing facility reimbursement system was designed to meet the minimum requirements of the new repealed federal "Boren Amendment." This amendment set a standard of "adequate and reasonable" reimbursement that protected states from lawsuits. Upon repeal of this amendment, the rationale for the current reimbursement system in Nevada no longer applies. Further, this system creates a disincentive for nursing home facilities to hire additional nursing staff or pay existing staff higher wages.)

Mr. Cashdollar advised that the thrust of the proposal is to see how using the Resource Utilization Groups III system in Nevada would affect Nevada staffing and reimbursement.

SENATOR MATHEWS MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST WHICH ADDRESSES RECOMMENDATION NO. 2. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

3. A proposal was made to compel the Division of Health Care Financing and Policy to increase, on a yearly basis, its health care facility provider reimbursement rates and to make its annual budget estimates in response to the health care component of the consumer price index. §§

(This issue pertains to rate setting for nursing home facilities that receive reimbursement from the Medicaid program.)

According to Mr. Cashdollar, the proposal, as originally submitted to the Legislative Committee on Health Care, only covered one aspect of the Nevada Medicaid long-term care rate setting process. As the process is currently calculated, it uses the *Consumer Price Index* as the measure

of inflation. He said the proposal as submitted suggests that the *Consumer Price Index* is not an appropriate measure of inflation in health care or long-term care.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE INCLUDE A STATEMENT IN THE FINAL REPORT WHICH ADDRESSES RECOMMENDATION NO. 3 AND THAT WOULD ENCOURAGE THE DIVISION OF HEALTH CARE FINANCING AND POLICY TO USE THE MEDICAL COMPONENT OF THE CONSUMER PRICE INDEX. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

4. A proposal was made to compel the Division of Health Care Financing and Policy to extend the allowable billing period for Medicaid providers to submit claims from 120 days to 365 days. Further, the proposal would require the division to establish a billing review system that prevents the division from immediately rejecting claims for minor or trivial omissions or errors made by long-term care providers in submittals of their federally required "3049 Authorization to Bill" forms. §§

(According to written comments submitted by Mr. Cashdollar, Nevada Medicaid time lines are shorter than the time lines imposed in other states for processing payment of long-term care facility bills. These shorter time lines are difficult to meet, create unnecessary obstacles for long-term care providers, and they create unnecessary extra effort for the state and providers. Further, unpaid bills result in millions of dollars of lost revenue for facilities, and facilities have been placed in situations where they have provided care for Medicaid-eligible clients that is uncompensated by the division.)

Mr. Cashdollar pointed out that the current reimbursement system is designed to enable most Medicaid long-term care providers to "break even." In Fiscal Year (FY) 1996-1997, when the division rejected claims that exceed the 120-day time period or because they had minor errors, it cost long-term care facilities more than \$3 million. He added that this figure does not include the number of dollars associated with claims that were not submitted to the division because the nursing facility knew they exceeded the 120-day period. He, therefore, recommends changing the timeline from 120 days to 365 days.

Chairman Rawson urged the committee to put a strong statement in its final report indicating that the agency should be directed to smooth its claim processing system, including allowing adequate time for statement submission and shortening the payment time. He also suggested that the Senate Committee on Human Resources and Facilities and the Assembly Committee on Health and Human Services write letters of intent that will follow the budget process.

Assemblyman Close suggested that the long-term care industry keep a record of the problems they have in this process so there is documentation of delay.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE INCLUDE A STATEMENT IN THE FINAL REPORT WHICH ADDRESSES THE CONCEPT OF RECOMMENDATION NO. 4. ADDITIONALLY, MEMBERS OF THE LONG-TERM CARE INDUSTRY ARE URGED TO DOCUMENT PROBLEMS CONCERNING THIS TOPIC. THE MOTION WAS SECONDED BY ASSEMBLYMAN CLOSE AND PASSED UNANIMOUSLY.

5. A proposal was made to compel the Division of Health Care Financing and Policy to develop a demonstration waiver of certain federal requirements (similar to the state of Minnesota). The waiver should seek to demonstrate a system that combines and integrates Medicare acute care benefits with Medicaid's long-term care coverage, and it should minimize the need for the frail elderly to impoverish themselves as a condition of eligibility for long-term care benefits. \$\$

(According to written comments submitted by Mr. Cashdollar, the current division of responsibility for acute health care and long-term care creates confusion for the nation's senior citizens. Further, placements may not be made that are based on a patient's needs. The state has the capacity to develop a "demonstration" project that integrates these programs. Finally, the burden of negotiating the various bureaucracies created by separate programs will be eased for the state's increasingly growing, and vulnerable senior population.)

Mr. Cashdollar mentioned that this recommendation has a lot in common with one cited earlier by the Home Health Care Association of Nevada. He noted Mr. Gerard's reference to the PACE program, which encompasses the same idea as this recommendation. According to Mr. Cashdollar, by legislative accident there are two health care systems for the acute care needs of the elderly: one is a federal program, which is Medicare; and the other is a long-term care program, which is Medicaid. Mr. Cashdollar remarked that many states are attempting to consolidate these programs and eliminate some of the "cracks" in the system. He stated further that a problem exists when the elderly are required to become impoverished to get long-term care.

Chairman Rawson suggested the committee ask the division to develop a waiver that they could report to the Legislative Committee on Health Care for approval and recommendation to the 2001 Legislature. He estimated that it may cost approximately \$200,000 to prepare that waiver.

Mr. Thompson stated that there are two separate items included in this one proposal. In his opinion, the first item, combining Medicare, acute care, and Medicaid long-term care benefits, may be appropriate. According to Mr. Thompson, the second item, minimizing the need for the frail elderly to impoverish themselves as a condition of eligibility for long-term care benefits, needs further scrutiny since it would dramatically change the eligibility thresholds under which the Medicaid program is run. He mentioned that budget constraints may render this proposal infeasible. He recommended that the committee develop approximate costs of these proposals.

Assemblywoman Buckley mentioned that if the committee was inclined to vote positively on Recommendation No. 29, which would recommend an interim study on alternatives to long-term care, this could perhaps be folded into that recommendation to consider how to make Medicaid and Medicare work better together.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST WHICH DIRECTS THE LEGISLATIVE COMMISSION TO CONDUCT AN INTERIM STUDY CONCERNING RECOMMENDATIONS NOS. 5 AND 29. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

6. A proposal was made to compel the Division of Health Care Financing and Policy to develop a "continuous quality improvement" (CQI) approach to measure the well-being of long-term care patients and to measure satisfaction with their care in nursing home facilities. This demonstration project would be conducted simultaneously with the current criteria that measure patients' satisfaction with their quality of care in these facilities. The results of this demonstration project should be reported to the Legislative Committee on Health Care by July 1, 2000, at which time the committee may review the findings and report its recommendation regarding this proposal to the Interim Finance Committee. \$\$*

(According to written statements submitted by Mr. Cashdollar, the Health Care Financing Administration (HCFA), United States Department of Health and Human Services, has indicated that a CQI must be demonstrated parallel to the current oversight system to provide for accurate comparisons of the advantages and disadvantages of the CQI versus the current measures of quality. Mr. Cashdollar asserts that Nevada will benefit from the CQI because this measure illustrates a more cooperative approach to assessing the quality of care provided by long-term care facilities. He further states that, in Nevada, the current measurement system has only served to demoralize care givers and long-term care facilities because of its penalizing approach. Finally, the system may not produce information that is useful to potential long-term care consumers.)

According to Mr. Cashdollar, the system for applying continuous quality improvement already exists; the quality indicators have been devised, the necessary software is available, and as of this summer (1998), every nursing facility is required to compile and transmit this information electronically. This data may be manipulated to implement this continuous quality improvement approach.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST, IN THE FORM OF A RESOLUTION, WHICH URGES THE DIVISION OF HEALTH CARE FINANCING AND POLICY, DHR, TO CARRY OUT THE STEPS OUTLINED IN RECOMMENDATION NO. 6. FURTHER, STAFF WILL PREPARE A LETTER TO THE DIVISION CONCERNING ITS ACTION ON THIS RECOMMENDATION AS WELL AS TO INCLUDE A STATEMENT CONCERNING THIS ITEM IN THE

FINAL REPORT OF THE COMMITTEE. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN BUCKLEY AND PASSED UNANIMOUSLY.

7. A proposal was made to compel the Bureau of Licensure and Certification, Health Division, DHR, to publish, at least annually, nursing facility survey results in a report that summarizes the results in a format that allows members of the general public to determine the quality of care that a facility provides its patients. §§*

(According to written comments submitted by Mr. Cashdollar, the current nursing home survey results are reported in a format that does not permit a layperson to determine whether the facility in question provides a quality level of care for its patients.)

Chairman Rawson noted this issue may be regulated by provisions in the Nevada Administrative Code. These surveys are conducted to ensure that certain facilities comply with regulatory requirements.

Mr. Cashdollar added under current federal law, the survey results for each nursing facility must be posted in the facility. He said he visits the facilities, reads the surveys, and, in his opinion, they are not in "plain English."

Richard J. Panelli, Chief, Bureau of Licensure and Certification, DHR, advised that his agency currently compiles a "report card" on all the facilities in the state of Nevada. It is published once a year and includes the survey findings in a condensed form. He stated the bureau uses two indicators to represent conditions in facilities: "satisfactory" or "needs improvement." In Mr. Panelli's opinion, the terminology is the source of the problem. He pointed out that in a survey process, the inspectors are looking for exceptions to regulations, and they do not have an opportunity to stress the "good" qualities of an institution.

Mrs. Freeman inquired whether the bureau provides outreach to groups of seniors, such as the American Association of Retired Persons, to inform them of the existence of the survey results.

Mr. Panelli responded the reports are available, but the bureau has not made an active effort to inform seniors of their existence.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST, IN THE FORM OF A RESOLUTION, WHICH ADDRESSES RECOMMENDATION NO. 7, INCLUDING A STATEMENT TO THE EFFECT THAT THE BUREAU OF LICENSURE AND CERTIFICATION, DHR, IMPLEMENT A POLICY TO MAKE SURVEY RESULTS AVAILABLE IN PLACES WHERE SENIOR CITIZENS MAY CONGREGATE ON A REGULAR BASIS. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN BUCKLEY AND PASSED UNANIMOUSLY.

Chairman Rawson directed staff to work with Mr. Panelli and Mr. Cashdollar to clarify the proposed language changes.

*8. A proposal was made to compel the Bureau of Licensure and Certification to give preference in hiring of nursing facility surveyors to those that have professional long-term care giver experience. The requirement for preference in hiring should be effective for all nursing facility surveyors hired after July 1, 1999.**

(According to written comments submitted by Mr. Cashdollar, individuals with long-term care giver experience will better understand the quality of care issues that should be taken into consideration when they assess facilities for compliance with federal and state laws.)

SENATOR MATHEWS MOVED THAT THE COMMITTEE INCLUDE A STATEMENT CONCERNING RECOMMENDATION NO. 8 IN THE FINAL REPORT OF THE COMMITTEE. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

*9. A proposal was made to amend Nevada Revised Statutes (NRS) 449.0105, and NRS 449.249 through NRS 449.2496 to delete the requirement that a home for individual residential care be permitted to register, and require that such a home must be licensed as a medical or other related facility pursuant to this chapter.**

(According to Mr. Cashdollar, it appears that some individuals operate registered homes purposely to avoid being licensed as a group home. For example, an individual may have two registered homes, which gives him care over four people. Mr. Cashdollar asserts that, in this situation, the owner of both homes should be licensed as a group home. When an individual bypasses the regulatory system in this manner, citizens who pay for care in these homes are at risk for being neglected or abused by their care givers.)

NOTE: Assembly Bill 118 of the 1997 Legislative Session sought to amend these statutes, however, this measure failed to be adopted.

Mr. Cashdollar explained that a person experienced in licensing oversight of the group home sector of long-term care suggested this recommendation because there are registered facilities that do not meet the more stringent licensing requirements. He asserts that this licensing requirement would increase accountability and oversight of these facilities.

Mr. Panelli advised that there are approximately 300 registered facilities. He said implementation of this proposal would significantly impact the number of surveyors that would be required, and in previous discussions, it was decided that fees would have to be charged for the licensure process.

Chairman Rawson inquired whether a lesser standard, such as registration and an inspection, would still screen out the individuals who were trying to avert the law.

According to Mr. Panelli, the registered facilities constitute a large number of complaints to his agency. He indicated that investigating these complaints strains the bureau's resources. He affirmed that Chairman Rawson was correct in assuming that public safety is being jeopardized by some of the registered facilities.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 9. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN BUCKLEY AND PASSED UNANIMOUSLY.

(Items 10 and 11 were proposed by Sky Heatherton, R.N., Westwood Assisted Living.)

10. A proposal was made to enact legislation that requires the Department of Business and Industry to adopt regulations governing an agency or an individual who makes referrals to others for assisted living facilities or group homes and who charge a fee for the referral service or otherwise receives compensation from owners of such facilities in payment for referrals. Such legislation should require disclosure of any financial interests held by the referral agency in facilities to which a referral is made. \$\$*

(Ms. Heatherton states that referral agencies are becoming increasingly common in Nevada; however, some referral agencies require assisted living facilities or nursing homes to pay a fee to the referral service for the privilege of having a client referred to a facility. Some referral agencies are operated by companies that also own long-term care facilities, and consumers are not made aware that the referral agent is referring to a long-term care facility that it may own. Ms. Heatherton also indicated that some companies pay fees to individuals that are payments for making referrals to their facility. Consumers may not be aware that the referral was made strictly for the financial benefit of the facility and the person who was paid to make the referral.)

Stating that the item needs additional discussion, the committee members agreed to place Recommendation No. 10 on a future meeting agenda.

11. A proposal was made to compel the Division of Health Care Financing and Policy to make any internal changes needed or apply for appropriate waivers to permit Medicaid-eligible individuals to choose between being maintained in an assisted living facility or in a nursing home. \$\$*

(According to Ms. Heatherton, current Nevada Medicaid rules require that clients who receive Medicaid assistance must be placed in a nursing home whether or not they require full-time, regular nursing assistance. Some clients do not require this level of care, and they may be cared for satisfactorily by an assisted living facility and at a lower cost than the cost of a nursing home.)

Stating that this item needs additional discussion, the committee members agreed to place Recommendation No. 11 on a future meeting agenda.

Hospice and Pain Management Issues

(Richard Fitzpatrick, President, Hospice Association of Nevada.)

12. Include a statement in the committee's final report that encourages:

- Health care provider training programs in Nevada to add pain management courses to their curricula;*
- Physicians to routinely record pain intensity levels on the vital sign charts of patients;*
- Physicians and other health care providers to make more frequent and earlier referrals to hospice care;*
- The Bureau of Licensure and Certification to eliminate impediments that inhibit the ability for organizations to deliver high quality hospice care in the home and in homelike settings; and*
- A society that views death as part of life by educating the public about end-of-life decisions and creating a stronger awareness that all Nevadans have certain rights provided by law.*

Bernard H. Feldman, MD, MPH, Vice Chair, Department of Pediatrics, University of Nevada School of Medicine, agreed with the intent of Recommendation No. 12, but pointed out that physicians may not be able to record pain intensity levels in all situations. For example, it would be difficult to measure pain levels for children, especially for infants.

Chairman Rawson noted the words "when feasible" should be added to the second bulleted item.

SENATOR MATHEWS MOVED THAT THE COMMITTEE AMEND THE SECOND BULLETED ITEM IN RECOMMENDATION NO. 12 TO READ AS FOLLOWS: PHYSICIANS TO ROUTINELY RECORD PAIN INTENSITY LEVELS ON THE VITAL SIGN CHARTS OF PATIENTS *WHEN FEASIBLE*; [NOTE: THE NEW LANGUAGE IS ITALICIZED.] THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

Physical Fitness Training Program for Senior Citizens

(This item was derived from committee testimony by Glen Martin, Local Coordinator, American Association of Retired Persons.)

13. A proposal was made to adopt a resolution informing certain entities to promote the benefits of a physical fitness training program for senior citizens. The following organizations should coordinate this awareness program through their licensees, members, and other interested persons or organizations with the assistance of the American Association of Retired Persons: (1) the Aging Services Division, DHR; (2) the Health Division, DHR; (3) the Board of Medical Examiners; (4) the State Board of Nursing; (5) the Great Basin Primary Care Association; (6) the Nevada Association of Health Plans; (7) the Nevada Association of Hospitals and Health Systems; (8) the Nevada Health Care Association; (9) the Nevada Nurses Association; (10) the Nevada Rural Hospital Project; (11) the Nevada State Medical Association; and (12) the public.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE AMEND RECOMMENDATION NO. 13 BY ADDING THE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF NEVADA AND THE STATE BOARD OF PHYSICAL THERAPY EXAMINERS TO THE LIST OF ENTITIES TO BE INFORMED ABOUT PROMOTING THE BENEFITS OF A PHYSICAL FITNESS AND TRAINING PROGRAM FOR SENIOR CITIZENS; AND INCLUDE A STATEMENT IN THE FINAL REPORT OF THE COMMITTEE CONCERNING RECOMMENDATION NO. 13. THE MOTION WAS SECONDED BY ASSEMBLYMAN CLOSE AND PASSED UNANIMOUSLY.

Individuals with Chronic or Life-Threatening Illnesses

(Items 14, 15, and 16 were submitted by Ronald S. Oseas, M.D., Chief, Pediatric and Adolescent Hematology and Oncology, Sunrise Children's Hospital.)

14. A proposal was made to compel indigent care programs administered by Nevada counties (pursuant to Chapter 428 of the NRS) to pay for prescription medications for individuals who have been diagnosed with chronic or life-threatening illnesses. By virtue of these medical conditions, such persons may eventually qualify for Medicaid. The proposal asks further that if such individuals are determined eligible for Medicaid, the Medicaid program should reimburse the counties for their expenses on behalf of these patients. §§

May S. Shelton, Director Washoe County Social Services, and Chairman, Nevada Welfare Directors Association, testified that she had concerns about this proposal, and she advised that the statutes require all counties to have guidelines and standards approved by the Board of County Commissioners for their programs.

Chairman Rawson pointed out that the committee made a strong statement regarding cancer drugs, because cancer patients may miss out on the important first benefits of those drugs due to the cost. Further, he expressed that drugs are an integral component in the treatment of diabetes, especially children's diabetes. He asked if it would accomplish the purpose of the recommendation to include a statement in the final report of the committee to the effect that it is good public policy to cover prescription medications, especially in life-threatening illnesses or long-term acute illnesses, through public programs.

Mr. Thompson advised that his concern would be the eligibility issue. He asserted that prescription drugs would be covered for anyone that is determined to be eligible for Medicaid. He said the real issue regarding indigent care programs for the county is that their primary responsibility is for hospitalization.

Susan Pacult, Program Administrator, Clark County Social Service, stated she had submitted a position paper to the committee (see Exhibit J). She explained there is a provision at the county level that guarantees certain prescriptions and medications through UMC for people who have applications pending for the Medicaid program. If they are eligible for Medicaid, the bills are forwarded to Medicaid for payment; if they are covered by the Clark County Social Service's program, it pays for them at that time. Further, Ms. Pacult remarked that if the prescription was written by a doctor other than a UMC physician, it could create an additional financial impact for the county because it would not be able to take advantage of the discount rate through UMC.

Based on these concerns, the committee did not take action on Recommendation No. 14.

15. A proposal was made to compel indigent care programs administered by Nevada counties (pursuant to Chapter 428 of the NRS) to pay current Medicaid reimbursement rates to health care providers that are reimbursable through Medicaid for care provided to individuals who have been diagnosed with chronic or life-threatening illnesses and who may potentially qualify for Medicaid. Further, if such individuals are determined eligible for Medicaid, the proposal seeks to compel the Medicaid program to reimburse the counties for these expenses. §§

Ms. Shelton advised that based on statute, counties are required to reimburse Medicaid rates for acute care. She said that for outpatient care, they use contracted providers which could be a problem if a person wanted to use his own physician.

Based on the concerns stated in regard to the previous recommendation, the committee did not take action on Recommendation No. 15.

16. A proposal was made to urge Nevada's Congressional Delegation to introduce and/or support federal legislation to expedite eligibility determinations for individuals who apply to federally-sponsored social welfare (Medicaid, Medicare, Supplemental

Security Income, Supplemental Security Disability Income) programs to alleviate the financial, medical, and mental health burden on individuals who are awaiting benefits from these programs.

Mr. Thompson suggested that "Medicaid" be removed from the list because the other items are situations where the Federal Government is making those determinations, as opposed to Medicaid where if the Federal Government makes the SSI determination sooner, recipients automatically become eligible for Medicaid.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE AMEND RECOMMENDATION NO. 16 BY DELETING "MEDICAID" FROM THE LIST OF SOCIAL WELFARE PROGRAMS; DIRECT STAFF TO PREPARE A LETTER TO MEMBERS OF NEVADA'S CONGRESSIONAL DELEGATION CONCERNING ITS ACTION ON THIS RECOMMENDATION; AND INCLUDE A STATEMENT CONCERNING THIS ITEM IN THE FINAL REPORT OF THE COMMITTEE. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

Licensure for Physical Therapists in Nevada

17. a. A proposal was made to amend NRS 640.120 to require the Board of Physical Therapy Examiners to issue temporary licenses to certain physical therapists in Nevada. Such licenses shall be issued to an applicant for licensure who has submitted an application to the board for permanent licensure in the state, who holds a license in good standing from another state and can verify such, and who has written confirmation that he will be employed in the state. For the period of his temporary licensure, an applicant granted such a license shall be supervised by a supervising physical therapist who holds a Nevada license in good standing, unless such supervision creates a hardship for the employer.

(Jeanette Belz, President and Chief Executive Officer, Nevada Association of Hospitals and Health Systems. See the Attachment for suggested language of the amendment, Exhibit K.)

OR

1. An alternative to this proposal would be to amend NRS 640.120 to permit the Board of Physical Therapy Examiners to enter into agreements with other states to recognize licenses granted in those states to physical therapists as meeting the licensing requirements in Nevada.

(This concept is commonly referred to as "reciprocal" licensure, and it was instituted for teacher licensing in Senate Bill 58 of the 1995 Legislative Session.)

Chairman Rawson mentioned that he received a letter opposing Recommendation No. 17 from the Board of Physical Therapy Examiners. He remarked if there was not a motion, the committee would not take action. The committee did not take action on Recommendation No. 17.

Steroid Warning Labeling

(Items 18 and 19 were proposed by Leslie Ortega, Steroid Warning Network.)

18. A proposal was made to urge Nevada's Congressional Delegation to adopt federal legislation that requires manufacturers of prescription drugs and pharmacists to label products, "STEROID," that contain steroid ingredients.

(In her testimony before the committee, Ms. Ortega indicated that consumers may be prescribed steroids unknowingly, in the form of eye drops, facial creams, injections, nasal sprays, or skin ointments. Further, she stated the following: (a) one prescription may contain a single, or a combination of several steroid ingredients; (b) many steroid-related side effects are life-threatening and may be permanent; (c) steroid-induced diseases include arthritis, coronary artery disease, hypertension, myopathy (muscle disease/weakness), open-angled glaucoma, osteoporosis, premature menopause, secondary diabetes mellitus, and skin atrophy ("wasting away"). Finally, Ms. Ortega identified frequent problems associated with administering and prescribing steroids such as: (a) the failure of physicians or pharmacists to inform patients of possible side effects; (b) failure to follow manufacturers' recommendations; and (c) inadequate manufacturer and Pharmacy labeling.)

ASSEMBLYWOMAN FREEMAN MOVED TO ADOPT RECOMMENDATION NO. 18; DIRECT THAT A LETTER BE SENT TO MEMBERS OF NEVADA'S CONGRESSIONAL DELEGATION; AND INCLUDE A STATEMENT IN THE FINAL REPORT OF THE COMMITTEE FOR THIS CONCEPT. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN BUCKLEY AND PASSED UNANIMOUSLY.

19. A supplemental proposal was made to adopt a resolution urging the Board of Medical Examiners and the State Board of Pharmacy to promote public awareness of the adverse effects of steroids in prescription medications. The proposal asks that this campaign emphasize that physicians and pharmacists adhere to manufacturer's recommendations for precautions and testing with regard to individual products.

ASSEMBLYWOMAN FREEMAN MOVED TO AMEND RECOMMENDATION NO. 19 BY DIRECTING STAFF TO SEND A LETTER TO THE BOARD OF MEDICAL EXAMINERS AND THE STATE BOARD OF PHARMACY URGING THESE BOARDS TO PROMOTE AWARENESS AMONG ITS LICENSEES OF THIS ISSUE. THE MOTION WAS SECONDED BY

ASSEMBLYWOMAN BUCKLEY AND PASSED UNANIMOUSLY.

Diabetes Issues

20. A proposal was made to compel the Division of Health Care Financing and Policy to extend the provisions of Assembly Bill 477 (Chapter 214, Statutes of Nevada 1997) to the Medicaid program. This bill required certain policies of health insurance to include coverage for the management and treatment of diabetes. §§

(Larry Matheis, Executive Director, Nevada State Medical Association.)

In response to Mrs. Freeman's inquiry, Ms. Buckley advised that A.B. 477, which "requires certain policies of health insurance to include coverage for management and treatment of diabetes," was sponsored by Assemblyman Dario Herrera and co-sponsored by Assemblyman Joseph E. Dini, Jr. to ensure that diabetes management, care, and treatment was a covered benefit in health insurance policies in Nevada. Ms. Buckley asked Mr. Thompson if this was already a covered benefit in the Medicaid program.

Mr. Thompson answered that children are covered, and he believes that adults are covered as well. He stated that he would report back to the committee if this is not the case.

Chairman Rawson directed staff to include a statement in support of Recommendation No. 21 in the final report of the committee.

21. A proposal was made to urge Nevada's Congressional Delegation to encourage HCFA to expedite the adoption of regulations related to Medicare and the coverage of diabetes.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE INCLUDE A STATEMENT CONCERNING RECOMMENDATION NO. 21 IN THE FINAL REPORT OF THE COMMITTEE. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

22. A proposal was made to appropriate funding to the University of Nevada School of Medicine to establish a multidisciplinary diabetes care program for children and adolescents in Nevada who have Type I and Type II diabetes. The program would be established in partnership with Sunrise Medical Center and the University Medical Center of Southern Nevada. The proposed program should include direct funding for two pediatric endocrinologists, two diabetologists, one nurse who is certified in diabetes education, a dietician, and a social worker. Funding for the program shall come from the State General Fund for the first two years after which time the program should be funded entirely from donations and grants. Finally, the program should be authorized to bill private insurance plans for care provided to patients that have health insurance. §§

(Dr. David Donaldson, Department of Pediatrics, University of Nevada School of Medicine, testified that he is a pediatric endocrinologist who cares for children with complex genetic problems as well as survivors of childhood cancer. He emphasized that Type II diabetes has increased in recent years, and statistics indicate that the current number of cases of pediatric diabetes is at epidemic proportions. He stated further that: (a) an important aspect of the care of Type II diabetes is to identify the populations at risk and to promote good public health practices within those groups; (b) local coalitions within a community may occasionally provide diabetes screening as a service, but for the most part there is no funding in Nevada for diabetes testing for high-risk family members of persons with diabetes; and (c) it is important that any form of managed care include a degree of oversight of the quality of care that is being delivered and not just a short-term focus on the financial aspects.

Dr. Donaldson suggested that Nevada mirror the concept as utilized by the Barbara Davis Diabetes Center in Denver, Colorado. This program uses community resources and state hospital foundations to provide multidisciplinary diabetes care for adolescents and children. Such care includes: (1) programs for primary prevention to identify children who are at a high risk of developing diabetes and providing them with prevention information; and (2) programs that prevent secondary complications from diabetes.

Dr. Donaldson indicated that presently, Columbia Sunrise Hospital and University Medical Center, both of Southern Nevada, have contributed significant resources to help develop a Pediatric Diabetes and Endocrinology Program for the area; however, there has been little or no financial assistance from foundations or the state for this type of program. He explained that if adolescent diabetics do not develop and practice good health care, the result is commonly young adults who: (a) require renal dialysis as a result of kidney failure; (b) suffer total blindness or have severely impaired vision; (c) may require amputation of limbs; and (d) face the potential to lose 30-plus years of productivity over a lifetime.)

ASSEMBLYWOMAN BUCKLEY MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST WHICH ADDRESSES RECOMMENDATION NO. 22. THE MOTION WAS SECONDED BY ASSEMBLYMAN CLOSE AND PASSED UNANIMOUSLY.

Nevada Medicaid Issues

(Items 23 through 29 were proposed by Jon Sasser, State Outreach Coordinator, Washoe Legal Services.)

23. a. A proposal was made to compel the Division of Health Care Financing and Policy to develop a single application to determine eligibility for the Medicaid and Nevada Check-Up programs. Such application should be in use by July 1, 1999.

OR

1. Mr. Sasser proposed an alternative to this proposal which is to compel the Division of Health Care Financing and Policy to develop an application form that permits an applicant to voluntarily determine whether his assets exceed the requirements of the Medicaid program. The application shall be stamped with a date that reflects the day the application was received by the division. This proposal should be implemented by July 1, 1999.* §§

Paul Gowins, Nevada Forum on Disability and the Nevada Healthcare Reform Project, testified that during its last meeting, the forum voted to support Recommendation Nos. 23 through 35. Mr. Sasser, in response to Mrs. Freeman's question as to the difference between "a" and "b," replied that it depends on the position on assets. He clarified "b" assumes there continues to be an assets test, but if that is eliminated, "a" would be more appropriate.

Complying with Chairman Rawson's request that he propose wording, Mr. Sasser combined Recommendation Nos. 23(a) and 24 to read as follows:

Legislation to be prepared to require that there be a single application developed for determination of eligibility for Nevada Check-Up and the Child Health Assurance Program (CHAP), and that the staffing be created in such a way that a single agency could act upon that application.

ASSEMBLYWOMAN BUCKLEY MOVED THAT THE COMMITTEE COMBINE RECOMMENDATION NOS. 23(a) AND 24 AND PREPARE A BILL DRAFT REQUEST WHICH REQUIRES THAT THERE BE A SINGLE APPLICATION DEVELOPED FOR DETERMINATION OF ELIGIBILITY FOR NEVADA CHECK-UP AND THE CHILD HEALTH ASSURANCE PROGRAM; AND THAT STAFFING BE CREATED IN A WAY THAT A SINGLE EMPLOYEE COULD ACT UPON THAT APPLICATION WITHIN THE AUTHORITY OF FEDERAL LAW. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

24. A proposal was made to compel the Division of Health Care Financing and Policy to permit a worker who makes determinations for Medicaid eligibility to be permitted to determine a person's eligibility for the Nevada Check-Up program. §§

See Recommendation No. 23.

25. A proposal was made to compel the Division of Health Care Financing and Policy to conduct an agency study of the advantages and disadvantages and cost and personnel needed to adopt the federal option in Title XIX of the Social Security Act to provide Medicaid coverage to individuals who are considered "medically needy" pursuant to the federal definition of this term. The proposal suggests that the results of the study be reported to the Legislative Committee on Health Care by June 1, 2000, at which time the committee will review the study and report its recommendation to the Interim Finance Committee.* §§

Ms. Buckley asked if it would be possible to look at an incremental approach to the medically needy program. She expounded if the Legislature is concerned with the price tag of adopting the option of the federal medically needy program in Medicaid, perhaps they could begin by covering the disabled during their two-year waiting period for Medicare.

Mr. Thompson asserted there is a potential problem with federal requirements in this incremental approach. He added if this approach were possible, it may need to be done through a waiver at the federal level. He suggested if the committee chooses to recommend a study, the sources of revenue within the state should also be considered.

ASSEMBLYWOMAN BUCKLEY MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST WHICH DIRECTS THE DIVISION OF HEALTH CARE FINANCING AND POLICY, DHR, TO CONSIDER AN INCREMENTAL APPROACH TO A "MEDICALLY NEEDY" PROGRAM; TO CONSIDER THE SOURCES OF REVENUE FOR SUCH A PLAN; TO FOCUS ITS STUDY ON PERSONS WHO ARE DISABLED, INCLUDING THOSE PERSONS WHO MUST WAIT TWO YEARS TO RECEIVE MEDICARE BENEFITS, AND OTHER GROUPS AS FEASIBLE; AND TO WORK WITH NEVADA'S COUNTIES TO ESTABLISH A "MEDICALLY NEEDY" PROGRAM AS WELL AS THE FEDERAL GOVERNMENT TO DETERMINE WHICH WAIVER, IF ANY, WOULD BE NECESSARY. THE MOTION WAS SECONDED BY ASSEMBLYMAN CLOSE AND PASSED UNANIMOUSLY.

26. A proposal was made to compel the Division of Health Care Financing and Policy to conduct an agency study of the advantages and disadvantages and cost and personnel needed to adopt the federal option in Title XIX of the Social Security Act of presumptive eligibility for pregnant women and children in Medicaid and Nevada Check-Up. The proposal suggests that the results of the study be reported to the Legislative Committee on Health Care by June 1, 2000, at which time the committee will review the study and report its recommendation to the Interim Finance Committee.* §§

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST ADDRESSING RECOMMENDATION NO. 26. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

27. A proposal was made to compel the Division of Health Care Financing and Policy to eliminate the assets test currently required by Nevada Medicaid rules for clients applying for eligibility under this program. §§

(At its May 29, 1998, meeting, the committee adopted a motion that directs the division to eliminate the assets test from the Child Health

Assurance Program as it pertains to pregnant women and children who are participants in the Medicaid program.)

SENATOR MATHEWS MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST ADDRESSING RECOMMENDATION NO. 27. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

28. A proposal was made to compel the Division of Health Care Financing and Policy to develop a budget that effectively expands its Medicaid waiver programs to eliminate current waiting lists. The proposal seeks to compel the division to increase the scope of services available by such waivers to the maximum extent allowable by federal law. * §§

Testimony indicated that this item is pending before the Subcommittee of the Legislative Committee on Health Care to Address Medicaid Managed Care Issues for Persons with Disabilities. Therefore, the committee did not take action on Recommendation No. 28.

29. A proposal was made to compel the Legislative Commission to conduct an interim study regarding alternatives to long-term care. The proposed study should, among other things: (a) identify the alternatives to long-term care for individuals needing such care; (b) analyze the cost of each type of care; (c) discuss the advantages and disadvantages to the quality of life for patients in each type of facility; (d) identify the personnel requirements in each type of facility; and (e) determine feasible methods to fund care for individuals in each type of facility.*

See Recommendation No. 5.

(Items 30 through 35 were submitted by Donny Loux.)

30. A proposal was made to compel the Legislative Commission to conduct an interim study to assess the impact of Nevada Medicaid's managed care policy upon participants in Nevada's programs for TANF. Such a study should assess, among other things: (a) the quality of health care provided to participants; (b) whether participants were able to access specialist providers and, if so, if patients were seen in a timely fashion; (c) whether participants were required to visit health care providers that were located in their immediate geographic areas; (d) whether participants were able to receive prescription medications in a timely fashion; (e) whether participant complaints were resolved and in what fashion they were resolved; and (f) any other criteria that will enable the Legislature to determine whether the managed care program is appropriately serving participants and is permitting the state to adequately control the Medicaid budget.

ASSEMBLYMAN CLOSE MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST ADDRESSING RECOMMENDATION NO. 30 AND INCLUDING RECOMMENDATION NO. 38(b). THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

31. A proposal was made to amend NRS 439B.220 to establish a statutory subcommittee of the Legislative Committee on Health Care to consider the health care and medical needs of people with chronic and disabling conditions, including the elderly. This permanent subcommittee would examine health issues and trends related to disability, including disability which is a result of the aging process. Among other things, the subcommittee should be authorized to study and make recommendations to the Legislative Committee on Health Care regarding such issues as long-term care, prevention of disability, disability in children caused by abuse and neglect, work incentives, health insurance, temporary disability benefits, and family preservation. Further, the subcommittee should be authorized to appoint members who are not legislators who will serve as uncompensated members of the committee. Finally, an initial duty of the subcommittee might be to study the feasibility of establishing a temporary disability state program.*

Chairman Rawson directed staff to include a statement concerning Recommendation No. 31 in the final report.

32. A proposal was made to compel the Department of Business and Industry to establish a managed care ombudsman program for participants in health insurance plans in Nevada. The ombudsman shall be independent of managed care organizations or insurers that are licensed in Nevada. The proposal includes the following items:

a. The commissioner should establish the office of the health care ombudsman by contract with any nonprofit organization. The office will be administered by the state health care ombudsman, who will be an individual with expertise and experience in the fields of health care and advocacy.

b. The health care ombudsman office will: (1) assist health insurance consumers with health insurance plan selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and services; (2) assist health insurance consumers to understand their rights and responsibilities under health insurance plans; (3) provide information to the public, agencies, legislators, and others regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns; (4) identify, investigate, and resolve complaints on behalf of individual health insurance consumers and assist those consumers with the filing and pursuit of complaints and appeals; (5) analyze and monitor the development and implementation of federal, state, and local laws, regulations and policies relating to health insurance consumers, and recommend changes it deems necessary; (6) facilitate public comment on laws, regulations, and policies, including policies and actions of health insurers; (7) promote the development of citizen and consumer organizations; (8) ensure that health insurance consumers have timely access to the services provided by the office; and (9) submit to the Legislature and to the Governor on or before January 1 of each year a report on the activities, performance, and fiscal accounts of the office during the preceding year.

c. The state health care ombudsman may: (1) hire or contract with persons to fulfill the purposes of this chapter; (2) review the health insurance records of a consumer who has provided written consent. Based on the written consent of the consumer, the consumer's guardian

or legal representative, a health insurer should be required to provide the state ombudsman access to records relating to that consumer; (3) pursue administrative, judicial, and other remedies on behalf of any individual health insurance consumer or group of consumers; (4) delegate to employees and contractors of the ombudsman any part of the state ombudsman's authority; (5) adopt policies and procedures necessary to carry out the provisions of this chapter; and (6) take any other actions necessary to fulfill the purposes of this chapter.

d. All state agencies should be required to comply with reasonable requests from the state ombudsman for information and assistance. The Division may adopt rules necessary to assure the cooperation of state agencies under this section.

e. In the absence of written consent by a complainant or an individual utilizing the services of the office, or his or her guardian or legal representative, or by court order, the state ombudsman, its employees and contractors will not disclose the identity of the complainant or individual.

f. The state ombudsman, its employees and contractors should not have any conflict of interest relating to the performance of their responsibilities under this chapter. For purposes of this section, a conflict of interest exists whenever the state ombudsman, its employees, contractors or a person affiliated with the state ombudsman, its employees and contractors: (1) have direct involvement in the licensing, certification, or accreditation of a health care facility, health insurer, or a health care provider; (2) have a direct ownership interest or investment interest in a health care facility, health insurer, or a health care provider; (3) are employed by, or participating in the management of a health care facility, health insurer, or a health care provider; or (4) receive or have the right to receive directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer, or health care provider.

g. The state ombudsman should be able to speak on behalf of the interests of health care and health insurance consumers, and to carry out all duties prescribed in this chapter without being subject to any disciplinary or retaliatory action. Nothing in this section shall limit the authority of the commissioner to enforce the terms of the contract.

Health care ombudsman implementation report. The administrator and the health care ombudsman should report to the Interim Finance Committee and Legislative Committee on Health Care on or before September 15, 1999, and periodically thereafter at the request of either committee. The report should provide the committee with an update on the status of implementation of the health care ombudsman program together with a description of the manner in which the health care ombudsman is, and will be in the future, coordinating his or her activities with existing ombudsman programs such as the Aging Services Division, DHR. §§*

(According to Ms. Loux, this proposed legislation regarding the "Office of Health Care Ombudsman" is modeled after legislation that was adopted in Vermont.)

ASSEMBLYWOMAN BUCKLEY MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST ADDRESSING RECOMMENDATION NO. 32. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

Chairman Rawson further directed staff to work with Ms. Loux concerning Recommendation No. 32.

*33. A proposal was made to include as a statement in the final report of the committee that a recommendation be made to the Division of Health Care Financing and Policy to implement the federal Maternal and Child Health Bureau's (MCHB) Quality Assurance Measures for Children with Special Health Care Needs in the division's Medicaid and Nevada Check-Up managed care programs.**

(A description of the MCHB measures is included as Exhibit L of these minutes and will be available in the Research Library.)

ASSEMBLYWOMAN FREEMAN MOVED TO ADOPT RECOMMENDATION NO. 33. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

34. A proposal was made to compel the Division of Health Care Financing and Policy to develop alternative program resources for children with chronic and disabling conditions, who are financially eligible for the program, and who have a need for program services that are beyond those offered in Nevada Check-Up. §§*

Ms. Loux observed that this recommendation would have no financial impact and clarified that her proposal is for coordination of all existing resources for children.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE AMEND RECOMMENDATION NO. 34 BY REPLACING "DEVELOP ALTERNATIVE" WITH "COORDINATE EXISTING"; AND INCLUDE A STATEMENT IN THE FINAL REPORT OF THE COMMITTEE IN SUPPORT OF THIS RECOMMENDATION. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

35. A proposal was made to compel the Division of Health Care Financing and Policy to conduct an agency study of the advantages and disadvantages and costs and personnel needed to develop a Medicaid "buy-in" program for people with disabilities who are returning to work. Among the items to be analyzed, the "buy-in" program should be a premium-based Medicaid insurance program for people with disabilities that permits participants to have a one-time spend-down provision that will: (a) allow adults eligible for Title XVI of the Social Security Act to return to the work force without fear of losing their health insurance; (b) prevent job loss for parents of children eligible for Title XVI program benefits; and (c) provide needed medical services that would not normally be covered by commercial health insurance plans. The proposal suggests that the results of the study be reported to the Legislative Committee on Health Care by June 1, 2000, at which

time the committee will review the study and report its recommendation to the Interim Finance Committee.* \$\$

Chairman Rawson suggested that Recommendation No. 35 be placed on a future meeting agenda and it would dovetail with issues being addressed by the Subcommittee of the Legislative Committee on Health Care to Address Medicaid Managed Care Issues for Persons with Disabilities. The committee agreed to place this recommendation on a future meeting agenda.

(The following items were derived from written testimony and submitted by Adair Dammann, Campaign Director, AFL-CIO.)

36. A proposal was made to prohibit the Division of Health Care Financing and Policy's practice of requiring a 12-month "lock-in" of enrollees in managed care programs administered by the division. It was further suggested that the division permit monthly "disenrollment" from a managed care plan by Medicaid enrollees.* \$\$

Chairman Rawson suggested the committee wait until it had further information on Recommendation No. 36 before taking action. Therefore, the committee did not take action on this recommendation.

37. A proposal was made to compel the Division of Health Care Financing and Policy to make any internal changes needed and to seek any necessary waivers to reimburse initial visits to health care providers and "essential community providers" by patients who are enrolled at a later date in Medicaid or Nevada Check-Up. \$\$

The Chairman directed staff to include a statement concerning Recommendation No. 37 in the final report of the committee.

38. a. A proposal was made to compel the Division of Health Care Financing and Policy to mitigate or otherwise prevent essential community providers from losing revenue in managed care programs administered by the division. It was suggested that such protection may include guaranteeing patient volume to such providers and requiring a certain percentage of referrals to essential community providers. The proposal seeks to compel the division to monitor, track, and enforce the designated referral pattern and to develop penalties for plans that violate the designated referral percentages. It was further suggested that the guarantee of adequate patient volume to essential community providers be based on a provider's current patient volume data. Finally, it was suggested that the committee endorse and adopt the definition of an "essential community provider" as: A provider of health care who provides services at no charge, or for a fee for services based upon a sliding scale that is determined based on the income of the patient, who does not restrict access or services because of the financial limitations of a patient, and who historically has served medically needy or medically indigent patients and has demonstrated a commitment to serve such patients by dedicating a significant portion of its business to such patients; or is the only provider of health care in its community and to the best of its ability has served the medically indigent patients in its community. \$\$

OR

2. An alternative proposal might be urge the Division of Health Care Financing and Policy to conduct timely analysis of its utilization data to determine whether essential community providers are being harmed by the shift to managed care. Further, it was suggested that the committee urge the division to take necessary corrective action within the limits of its authority under state and federal law to reverse any loss in patients and revenues to such providers. \$\$

Mr. Thompson remarked that in developing the managed care programs and the overall Medicaid program, the idea is to foster choice, availability of care, and ensure that appropriate care is provided in the most efficient means possible. Therefore, he believes a policy that purports to guarantee a certain number of patients is not beneficial for this program.

Chairman Rawson asked Dr. Yacenda if Recommendation No. 38(b), amended as follows, would meet the needs of the drafters: ". . . urged the Division of Health Care Financing and Policy to conduct a timely analysis of its utilization data to determine whether essential community providers are being harmed by the shift to managed care and further allow them to make some adjustments accordingly." Further, Chairman Rawson suggested that it be included in the study of Recommendation No. 30.

Dr. Yacenda expressed his opinion that the committee's intention that essential community providers not be harmed was already on record from a previous meeting. Further, it was Dr. Yacenda's understanding that there be a definition or actual description of essential community providers put into statute or into a formal document indicating that what constitutes "essential community providers" embraces the attributes included in Recommendation No. 38.

ASSEMBLYWOMAN FREEMAN MOVED TO AMEND THE MOTION OF THE COMMITTEE REGARDING RECOMMENDATION NO. 30 BY REQUESTING A BILL DRAFT REQUEST THAT DIRECTS THE DIVISION OF HEALTH CARE FINANCING AND POLICY, DHR, TO CONDUCT TIMELY ANALYSIS OF ITS UTILIZATION DATA TO DETERMINE WHETHER ESSENTIAL COMMUNITY PROVIDERS ARE BEING HARMED BY THE SHIFT TO MANAGED CARE; DIRECTS THE DIVISION TO TAKE NECESSARY CORRECTIVE ACTION WITHIN THE LIMITS OF ITS AUTHORITY UNDER STATE AND FEDERAL LAW TO REVERSE ANY LOSS IN PATIENTS AND REVENUES TO SUCH PROVIDERS AND ALLOWS THEM TO MAKE ADJUSTMENTS ACCORDINGLY. [NOTE: THE NEW LANGUAGE IS ITALICIZED]; AND INCLUDES A STATEMENT IN THE FINAL REPORT OF THE COMMITTEE IN SUPPORT OF RECOMMENDATIONS NOS. 30 AND 38(b). THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

39. A proposal was made to send a letter to the chairmen of the Senate Committee on Finance and Assembly Committee on Ways and

Means of the 1999 Legislature to urge support of the Division of Health Care Financing and Policy's efforts to have sufficient technical consultants (or agency staff) and computer hardware and software to perform an analysis of utilization data for its managed care programs in a timely fashion.

ASSEMBLYMAN CLOSE MOVED TO ADOPT RECOMMENDATION NO. 39 AND INCLUDE A STATEMENT IN THE FINAL REPORT OF THE COMMITTEE EXPRESSING SUPPORT OF THIS CONCEPT. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN BUCKLEY AND PASSED UNANIMOUSLY.

40. A proposal was made to compel the Division of Health Care Financing and Policy to adopt automatic assignment procedures for individuals who do not select a Medicaid managed care plan. It was suggested that this procedure take into account the providers that have traditionally served such individuals. \$\$*

Dr. Yacenda described Colorado's automatic assignment procedure for persons who do not select a specific managed care provider when they are signed up for the program. He stated that this program uses the managed care network of existing essential community providers. He believes that the automatic assignment system in the Medicaid managed care program should use a mechanism that defaults an enrollee to the providers that this person may normally seek for care.

ASSEMBLYWOMAN FREEMAN MOVED: THAT THE COMMITTEE SEND A LETTER TO THE DIVISION OF HEALTH CARE FINANCING AND POLICY URGING IT TO PURSUE THE CONCEPT CONTAINED IN RECOMMENDATION NO. 40; AND THAT A STATEMENT BE INCLUDED IN THE FINAL REPORT OF THE COMMITTEE CONCERNING THIS ITEM. THE MOTION WAS SECONDED BY ASSEMBLYMAN CLOSE AND PASSED UNANIMOUSLY.

Essential Community Providers

(The following items were derived from a survey by the committee regarding essential community providers.)

41. A proposal was made to compel the Division of Health Care Financing and Policy to cooperate with the Community Health Centers of Southern Nevada to develop and pursue an agreement that permits this clinic to provide primary care dental services for high-risk children suffering from advanced stages of dental disease. \$\$*

Responding to Mrs. Freeman's request for clarification, Dr. Yacenda remarked that Community Health Centers of Southern Nevada has developed a comprehensive, state-of-the-art dental suite in its facility, and it is building a larger dental facility that will be a public dental clinic. This facility is being developed with the support of the City of North Las Vegas, and the county commissioners. He suggested modifying Recommendation No. 41 to include a community health center which is opening a dental facility of its own in northern Nevada. Dr. Yacenda asserted that would also be a public dental clinic that provides services on a sliding fee scale.

The Chairman directed staff to include a statement in the final report of the committee to the effect that:

Community Health Centers of Southern Nevada, as well as appropriate northern Nevada facilities, be considered along with other essential community providers to provide primary care dental services for high-risk children suffering from advanced stages of dental disease.

42. A proposal was made to compel the Division of Health Care Financing and Policy to develop contracts for the Medicaid managed care program that include utilization and reimbursement of the Special Children's Clinic for diagnostic and intervention services for all eligible children from birth to age three. In addition, such contracts should include reimbursement of the specialty medical clinics for the birth to 21 years of age population. \$\$*

Mr. Thompson stated that the mission of the department is to provide services in an as efficient means as possible to all individuals that are receiving its care. He explained that the Medicaid managed care program has specific distinctions in that most children that would be receiving Special Children's Clinic services would not be included in the managed care program. He continued that this recommendation would require managed care organizations to include the Special Children's Clinic in their network.

Based on this discussion, the committee did not take action on this recommendation.

*43. A suggestion was made that the state should continue to maintain a viable rural health care system and that any development of urban health care systems should not be done at the expense of rural health. It was suggested that any policy that was developed at the expense of rural areas is counterproductive to the needs of Nevada's residents.**

Chairman Rawson directed staff to include a statement concerning Recommendation No. 43 in the final report of the committee.

*44. A proposal was made to urge Nevada's Congressional Delegation to adopt legislation in support of the continuation of the Medicaid disproportionate share funds to hospitals. It was reported that such funds are essential for hospitals to continue to provide care to uninsured and low-income patients.**

Chairman Rawson directed staff to send a letter to members of Nevada's Congressional Delegation urging them to adopt legislation in support of

the continuation of the Medicaid disproportionate share funds to hospitals. He further requested staff to include a statement concerning Recommendation No. 44 in the final report of the committee.

Minority Health Issues

(Item 45 was submitted by John Yacenda, MPH, Ph.D., Executive Director, Great Basin Primary Care Association.)

45. A proposal was made to enact legislation that establishes a Division of Minority Health within Nevada's Department of Human Resources.

The mission of the division should be to: (a) assume a leadership role in working or contracting with state and federal agencies, the state's university and community college system, private interest groups, local communities, private foundations, and other states' organizations of minority health to develop minority health initiatives, including bilingual communications; and (b) maximize the use of existing resources without duplicating existing efforts. The duties of the division should be to: (a) provide a central information and referral source and serve as the primary state resource in coordinating, planning, and advocating access to minority health care services in Nevada; (b) coordinate conferences and other training opportunities to increase skills among state agencies and government staff in management and in the appreciation of cultural diversity; (c) pursue and administer grant funds for innovative projects for communities, groups, and individuals; (d) provide recommendations and training in improving minority recruitment in state agencies; (e) publicize minority health issues through the use of the media; (f) network with existing minority organizations; (g) solicit, receive, and spend grants, gifts, and donations from public and private sources; and (h) contract with public and private entities in the performance of its responsibilities.

The division should be funded from "stimulus funds" of state agencies with which the organization has established relationships and unobligated and unexpended federal funds and state appropriations. "Stimulus funds" would be derived from 2 percent of the funding used by state agencies that provide health and social services to minorities. "Stimulus funds" may appear in one of four forms: (a) appropriated federal funds that are spent at the discretion of the division or are spent on specific activities within the scope of a project of the state agency receiving the federal dollars, which are passed through to the division (e.g., Centers for Disease Control funds for the prevention of Human Immunodeficiency Virus (HIV) would be targeted to the division's efforts to address HIV primary and secondary prevention in minorities); (b) state of the art equipment and supplies assigned from agencies' purchasing pools to the division, subject to the same provisions as item (a); (c) full-time equivalencies from respective agencies (in full or part); and (d) State General Fund dollars appropriated directly to the division, or moved to the division from another state agency receiving general funds.

After the first two years of operation, the appropriate minimum level of ongoing support from the State General Fund for the division will be determined, and patterns of revenue/grant dollar sharing between the division and other agencies will be established. Moreover, mechanisms to assume unobligated and unexpended federal funds and state appropriations from partner agencies will be firmly in place.

Further, the division should submit a biennial report, not later than March 1 of each odd-numbered year, to the Legislature regarding its activities, findings, and recommendations related to minority health issues.

Executive Director: Appointment; qualifications; classification; restrictions on other employment. The division should have an executive director, who will be appointed by the Governor. The qualified person will have successful experience in the administration and promotion of a program comparable to that provided by this proposal. The executive director of the division is in the unclassified service of the state. Except as otherwise provided in the NRS, the executive director of the division shall devote his entire time to the duties of his office and shall not follow any other gainful employment or occupation.

Executive Director: Duties. The executive director of the division should: (1) be jointly responsible to the Governor and the Legislature; (2) direct and supervise all the technical and administrative activities of the division; (3) attend all advisory committee meetings and act as secretary, keeping minutes of the proceedings; (4) report to the Governor and Legislature all matters concerning the administration of the office; and (5) request the advice of the advisory committee regarding matters of policy, but be responsible, unless otherwise provided by law, for the conduct of the administrative functions of the division; (6) compile, with the approval of the advisory committee for submission to the Governor and Legislature, a biennial report regarding the work of the division and such other matters as he may consider desirable; (7) serve as contracting officer to receive funds from the Federal Government or other sources for such studies, grant and funding initiatives, and community-based program activities as the division deems necessary; (8) attend all meetings of any special study committee appointed by the Governor or conceived by the Legislature pursuant to this act and act as secretary, keeping minutes of the proceedings; and (9) perform any lawful act which he considers necessary or desirable to carry out the purposes and provisions of this chapter.

Executive Director: Appointment of staff. The executive director of the division may appoint such professional, technical, clerical, and operational staff as the execution of his duties and the operation of the division may require. At minimum, the division should be comprised of a professional staff liaison, a budget analyst, and a management assistant. The "professional staff liaison" should be

responsible to maintain active communication between the division and members of the minority communities, state and local government programs serving these communities, and community-based nonprofit providers of services to minorities. The "budget analyst" should be able to interact with other state agency personnel to develop financial and program resources for the division, monitor grants and contracts with local agencies and organizations, and, as directed by the executive director, monitor and manage the fiscal matters of the division, including the managing and processing of service and travel reimbursements to members of the advisory committee. The "management assistant" should be the office manager of the division, and should conduct all business to maintain the efficient operation of the division's clerical and support duties, including the hiring of appropriate support staff to meet division needs, as well as the division's orderly interaction with the public, other state and local agencies, the Governor's office and the Legislature.

The oversight committee should be comprised of a minimum of 15 members to be appointed by the Governor to renewable two-year terms. The chairman of the committee should be elected by the members at its first meeting of each new year. Three members each of the committee shall be comprised of persons who are African American, Hispanic, Asian/Pacific Islander, and Native American. The members shall represent a geographic cross-section of these groups in Nevada. One member shall be appointed by the Nevada State Senate and the Nevada State Assembly, respectively. One member shall be appointed by the Governor. The duties of the committee should be to: (a) advise, generally, and assist the organization on achieving its mission; (b) promote health and the prevention of disease among members of minority groups; (c) review special initiative funding provided by the organization to community-based public and private programs serving the health and disease prevention needs of minorities; (d) consolidate policy development and public initiative activities; and (e) approve all public reports developed by the division for distribution to the Federal Government, the Governor, or the Legislature.

Salary and expenses of advisory committee members; payment of claims. Advisory committee members who are not in the regular employ of the state are entitled to receive a salary of not more than \$80, as fixed by the commission, for each day spent on the work of the advisory committee. Advisory committee members who are in the regular employ of the state shall serve without additional salary. While engaged in the business of the advisory committee, each member and employee of the division is entitled to receive the per diem allowance and travel expenses provided for state officers and employees generally. Claims for payment of all expenses incurred by the advisory committee, including the salaries and expenses of its members, must be made on vouchers and paid as other claims against the state are paid.

Powers of advisory committee. The advisory committee may develop subcommittees of the advisory committee and noncommittee members whenever necessary or appropriate to assist and advise the advisory committee in the performance of its duties and responsibilities under this act.

ASSEMBLYWOMAN BUCKLEY MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 45. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

Belen Gabato, Philippine Nurses Association, requested that the advisory board consider including a member of the Philippine Nurses Association and the Philippine Medical Association of Nevada, since their members are in the health care field and are qualified to address minority health issues in the Asian American community. She added that the Philippine-American community is the largest minority group within the Asian-American community.

Dr. Yacenda was asked to work with the Philippine Nurses Association and Philippine Medical Association of Nevada to select a representative to serve as a member of the oversight committee of the proposed Division of Minority Health within Nevada's Department of Human Resources.

Chairman Rawson directed that a statement be included in the final report of the committee regarding Ms. Gabato's comments.

Children's Health Insurance Plan

(Items 46 through 49 were derived from written testimony by Dr. John Yacenda.)

46. A proposal was made to compel the Division of Health Care Financing and Policy to include all existing programs and agencies identified in the State Plan for Nevada Check-Up who play a role in enrolling children in Medicaid (e.g., Women, Infants and Children (WIC) centers, FQHCs, Special Children's Clinics, Baby Your Baby Program, Family Resource Centers, Family-to-Family program centers, and public hospitals with out-stationed workers), to have contracts with the division to conduct specific "find, engage, advise, motivate, and assist" activities relative to Nevada Check-Up eligibility and enrollment. Such contracts shall include staff training guarantees, resources for targeted outreach and community-based media promotion, enrollment enhancements for outreach and eligibility productivity, personnel costs, out-stationed state eligibility workers, and so on.

(Dr. Yacenda states that such efforts would ensure that enrollment is conducted and verified entirely at the community level.)

Based on discussion and the fact that the Nevada Check-Up program must still work out details with HCFA, the committee members agreed to place this recommendation on a future meeting agenda.

47. A proposal was made to compel the Division of Health Care Financing and Policy to permit automatic enrollment in Nevada Check-Up, if the family applies to the program and pays the necessary fees, for all children who are eligible for the WIC program in Nevada Check-Up.

(Dr. Yacenda asserts that families with income at 185 percent of the federal poverty level qualify for WIC and, therefore already meet the designated income eligibility requirements for Nevada Check-Up.)

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE INCLUDE A STATEMENT CONCERNING RECOMMENDATION NO. 47 IN THE FINAL REPORT OF THE COMMITTEE. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

48. The committee received a proposal to compel the Division of Health Care Financing and Policy to access the maximum amount of funding available to the state through the federal TANF program to conduct its outreach efforts for Nevada Check-Up.

(Nevada Check-Up's administrative and outreach and enrollment funds are approximately \$4.7 million. The enhanced federal matching funds available to Nevada for administrative costs and outreach enrollment resulting from welfare reform are approximately \$3.2 million. Medicaid dollars for outreach and enrollment are matched at 50 percent by the Federal Government. All of these funding resources should be coordinated into a single "find, engage, advise, motivate, and assist" program that addresses the needs of families and children who are making the transition from welfare, families with children eligible for Medicaid, and families with children eligible for Nevada Check-Up. The "menu" of coverages, and access to such coverage, must be consistent for every outreach and eligibility worker, and every person contacted as a potential enrollee.)

SENATOR MATHEWS MOVED THAT THE COMMITTEE INCLUDE A STATEMENT CONCERNING RECOMMENDATION NO. 48 IN THE FINAL REPORT OF THE COMMITTEE. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

49. The committee received a proposal to compel the Division of Health Care Financing and Policy to facilitate the enrollment of Native American children in Nevada Check-Up by using tribal or other organizations that work collaboratively with Nevada tribes. Upon the qualification of eligible children, such children should be enrolled immediately, and Indian Health Service and tribal health clinics should be included in the provider networks that deliver services to these children. It is proposed further to amend Chapter 233A of the NRS to create a Nevada Check-Up Indian Advisory Council as a subcommittee of the Nevada Indian Commission. The subcommittee will make recommendations to the commission, which will require the commission's approval before the recommendations may be acted upon. Once the commission approves the recommendations, the commission shall advise the division of its concerns and offer solutions to resolve such issues related to Nevada Check-Up. The Advisory Council should consist of three members who are appointed by the commission. The appointed members need not be members of the commission. Members who serve on the Advisory Council serve without compensation, and the council should meet at least one time each year.

ASSEMBLYWOMAN FREEMAN MOVED THAT THE COMMITTEE PREPARE A BILL DRAFT REQUEST CONCERNING RECOMMENDATION NO. 49. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN BUCKLEY AND PASSED UNANIMOUSLY.

ADJOURNMENT

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

Respectfully submitted,

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Jo Greenslate

Research Secretary

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APPROVED:

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Senator Raymond D. Rawson, Chairman

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Date

LIST OF EXHIBITS

Exhibit A was provided by Cherie Jamason, CFRE, President and CEO, Food Bank of Northern Nevada, Sparks, Nevada. This exhibit contains the following items:

1. A pamphlet titled "Hunger — The Faces & Facts."
2. A newspaper article from *Reno Gazette-Journal* dated June 10, 1997, titled "New group feeding area's hungry kids."
3. A newspaper article from *Reno Gazette-Journal* dated May 4, 1998, titled "Casino and food bank aim to restart donation program."

Exhibit B was provided by John Busse, Executive Director, Home Health Care Association of Nevada (HHCAN). It is a letter addressed to Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care, from HHCAN, dated July 31, 1998, Re: "Recommendations of Home Health Care Issues for Consideration during the 1999 Nevada Legislative Session."

Exhibit C was provided by Rosetta Johnson, President, Alliance for the Mentally Ill of Nevada. This exhibit contains the following items:

1. Magazine articles from *The Nation's Voice on Mental Illness*, "News from your State, Open Your Mind."
2. An Interim Report to Congress by the National Advisory Mental Health Council dated April 1997, and titled "Parity in Coverage of Mental Health Services in an Era of Managed Care."
3. A special report from the *American Journal of Psychiatry* dated October 1993, and titled "Health Care Reform for Americans With Severe Mental Illnesses: Report of the National Advisory Mental Health Council."
4. A paper by William M. Mercer titled "Case Studies — A Guide to Implementing Parity for Mental Illness."
5. A magazine article from *The Nation's Voice on Mental Illness* titled "Schizophrenia in Monozygotic Twins."
6. A paper, dated January 1997, titled "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?" from the Research Center on Managed Care for Psychiatric Disorders, funded by the National Institute of Mental Health.
7. A booklet titled "NAMI's Campaign to End Discrimination — Science and Treatment Fact Book," from *The Nation's Voice on Mental Illness*.
8. A paper, dated December 23, 1997, titled "The Mental Health Parity Act of 1996, Summary of the Law."

Exhibit D is a proposal, dated August 3, 1998, presented by William R. Hale, Chief Executive Officer, University Medical Center, titled "Formation of a County Organized Health System — An Innovative Approach to the Healthcare Needs of Nevada's Uninsured."

Exhibit E is a memorandum, dated July 31, 1998, from Jack D. Close, Sr., P.T., Chairman, Subcommittee of the Legislative Committee on Health Care to Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care, subject: "Summary of results from the first meeting of the subcommittee created to address Medicaid Managed Care Issues for Persons with Disabilities."

Exhibit F is a hand-written draft submitted by Helen C. Gallardo, Nevadans Acting for Welfare Reform, of a sample application for both the Nevada Check-Up program and the Nevada Medicaid program.

Exhibit G is a letter and questions from Rick Cline, who did not attend the meeting, presented by Mary Jean Thomsen, Community Advocacy Coordinator, Northern Nevada Center for Independent Living.

Exhibit H is a Report to the Secretary, United States Department of Health and Human Services, dated July 29, 1996, titled "Hispanic Agenda for Action: Improving Services to Hispanic Americans." This exhibit was presented by Elena Lopez-Bowlan.

Exhibit I is a Memorandum from Winthrop Cashdollar to Senator Raymond Rawson, Chairman, Nevada Legislative Committee on Health Care, dated July 10, 1998, Subject: Bill Draft Requests. This exhibit is Attachment A of the Work Session Document.

Exhibit J is a document titled "Position Paper of Clark County Regarding Items Contained in Work Session Document, August 3, 1998." This exhibit was submitted by Susan Pacult, Program Administrator, Clark County Social Service.

Exhibit K is a document dated February 1998, titled "Nevada Association of Hospitals and Health Systems, Temporary Licensure of Physical Therapists, Proposed Bill Language." This exhibit was an attachment to the Work Session Document.

Exhibit L is a document titled "Quality Community Managed Care — A Guide for Quality Assurance Measures for Children with Special Health Care Needs — Includes Pertinent Measures from Medicaid HEDIS."

Exhibit M is the "Attendance Record" for this meeting.

Copies of the material 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 (702) 684-6827.