MINUTES OF THE MEETING

OF THE

LEGISLATIVE COMMITTEE ON HEALTH CARE

(*Nevada Revised Statutes* 439B.200)

May 29, 1998

Las Vegas, Nevada

The ninth meeting of the Nevada Legislature's Committee on Health Care for the 1997-1998 interim was held on Friday, May 29, 1998, at 9:30 a.m., in Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. This meeting was video conferenced to Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Pages 3 and 4 contain the "Meeting Notice and Agenda."

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Raymond D. Rawson, Chairman

Assemblywoman Vivian L. Freeman, Vice Chairman

Senator Bernice Mathews

Senator Maurice E. Washington

Assemblywoman Barbara E. Buckley

Assemblyman Jack D. Close

OTHER LEGISLATORS PRESENT IN LAS VEGAS:

Assemblywoman Jan Evans

OTHERS PRESENT IN LAS VEGAS:

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

Marc Bennett, Chief Operating Officer, HealthInsight

John Busse, Home Health Care Association of Nevada

Thelma Clark, Rulon Earl Resident Council, Inc.

Charlotte Crawford, Director, Department of Human Resources (DHR)

Dr. Bernard H. Feldman, University of Nevada School of Medicine (UNSOM)

Elizabeth Gilbertson, Southwestern Regional Director, HEREIU Fund

Fred Hillerby, Hillerby & Associates

James Kinard, D.D.S.

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

Elena Lopez-Bowlan

Larry Matheis, Executive Director, Nevada State Medical Association

Gary Milliken, Gem Consulting

Guy Perkins, Division of Insurance, Department of Business and Industry

(attending on behalf of Alice Molasky-Arman, Commissioner of Insurance)

Robert A. Ostrovsky, President, Ostrovsky & Associates

Jon L. Sasser, Washoe Legal Services

Carla Sloan, Administrator, Aging Services Division, DHR

Marie H. Soldo, Executive Vice President, Government Affairs, Sierra Health

Services, Inc.

Christopher Thompson, Administrator, Division of Health Care Financing and

Policy, DHR

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

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

Association

OTHERS PRESENT IN CARSON CITY:

Winthrop Cashdollar, Executive Director, Nevada Health Care Association

C. Edwin Fend, Coordinator, Capitol City Task Force, American Association of Retired Persons (AARP)

Donny L. Loux, Chief, Office of Community Based Services, Department of

Employment, Training and Rehabilitation

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

Roxanne Duer, Senior Research Secretary

REVISED AGENDA

MEETING NOTICE AND AGENDA

Name of Organization: Legislative Committee on Health Care

(Nevada Revised Statutes 439B.200)

Date and Time of Meeting: Friday, May 29, 1998

9:30 a.m.

Place of Meeting: Grant Sawyer State Office Building

Room 4412A, B, and C

555 East Washington Avenue

Las Vegas, 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:

Legislative Building

Room 4100

401 South Carson Street

Carson City, Nevada

A G E N D A

I. Opening Remarks

Senator Raymond D. Rawson

*II. Approval of Minutes for the Committee's Meetings on April 6, 1998, in Las Vegas, Nevada, and on May 4, 1998, in Carson City, Nevada

III. Discussion of Beneficial Aspects of Mandatory Medicaid Managed Care for the Program Administered by Nevada's Department of Human Resources

1. Background Information
2. Summary of Successes in Other States and in Nevada

*IV. Discussion and Possible Recommendations Concerning Elimination of the Assets Test Used to Determine Eligibility in the Nevada Medicaid and Nevada Check-Up Programs

*V. Discussion and Possible Recommendations for a Consultant to Study Managed Care for Medicaid Recipients Not Presently Eligible for Such Services and for a Medically Needy Program

*VI. Potential Discussion of Issues in Nevada Check-Up

VII. Information Concerning the State Board of Nursing and Regulations Previously Discussed by the Committee

VIII. Presentation of the Study Concerning Minority Health, Conducted by Creshelle Nash, M.D., Fellowship in Minority Health Policy, Commonwealth Fund/Harvard University

*IX. Discussion of Topics for Future Meetings

X. Public Testimony

*XI. Adjournment

*Denotes items on which the committee may take action.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call Roxanne Duer, at 684-6825, as soon as possible.

Notice of this meeting was posted in the

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

OPENING REMARKS

Chairman Rawson called the meeting to order and roll was taken by the secretary.

APPROVAL OF MINUTES FOR THE COMMITTEE'S MEETINGS

ON APRIL 6, 1998, IN LAS VEGAS, NEVADA, AND ON

ON MAY 4, 1998, IN CARSON CITY, NEVADA

ASSEMBLYWOMAN FREEMAN MOVED FOR APPROVAL OF THE MINUTES OF THE APRIL 6, 1998, MEETING OF THE LEGISLATIVE

COMMITTEE ON HEALTH CARE IN LAS VEGAS, NEVADA, AND THE MAY 4, 1998, MEETING IN CARSON CITY, NEVADA. ASSEMBLYMAN CLOSE SECONDED THE MOTION WHICH PASSED UNANIMOUSLY.

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DISCUSSION OF BENEFICIAL ASPECTS OF MANDATORY

MEDICAID MANAGED CARE FOR THE PROGRAM ADMINISTERED BY

NEVADA'S DEPARTMENT OF HUMAN RESOURCES

Chairman Rawson introduced Assemblywoman Jan Evans, who presented the committee with a historical overview regarding managed care for Medicaid clients (please refer to Exhibit A).

Assemblywoman Jan Evans

Mrs. Evans thanked Ms. Charlotte Crawford, Director, Department of Human Resources (DHR); Mr. Christopher Thompson, Administrator, Division of Health Care Financing and Policy; Mr. Vince Juaristi, Executive Assistant, Governor's Office, as well as the Health Care Committee members for their participation and diligent efforts in the creation of Nevada's Children's Health Insurance Program.

Additionally, Mrs. Evans stated that the availability of quality health care is a top priority, and that recently she has received numerous telephone calls concerning the scheduled start-up of mandated managed care for Medicaid clients, which has brought up the past issues of access, quality care, and possible impacts on traditional community providers.

Mrs. Evans explained that, among other things, Senate Bill 559 (Chapter 620, *Statutes of Nevada*) of the 1993 Legislative Session required the Legislative Committee on Health Care to conduct a study to evaluate and develop a mandatory coordinated care system for all Medicaid recipients. The issues encountered during the 1993-1994 interim are presently being debated.

Continuing, Mrs. Evans stated that because these concerns have not been resolved, there is a move to delay the October 1, 1998, start-up date of the mandated Medicaid managed care program. During the 1995 and 1997 Legislative Sessions, plans for mandated managed care for Medicaid clients, as well as budget and appropriation provisions, were made based on costs and time lines so that commencement of the transition from voluntary to mandated managed care would take effect on October 1, 1998.

In 1995, a full managed care program was to be implemented. A Medicaid managed care oversight committee was appointed consisting of Senator Bernice Mathews, Senator Raymond D. Rawson, Assemblywoman Jan Evans, and Assemblyman Lynn C. Hettrick. In the midst of the bidding process, the Legislature was notified that because of congressional changes in Title XIX of the Social Security Act, it would not be prudent to proceed until pending modifications were resolved. Due to the uncertainty, the oversight committee instituted a voluntary program that would transition into a fully capitated program. The Interim Finance Committee (IFC) viewed this as a workable alternative. A further delay of the October 1, 1998, deadline would violate legislative intent.

Mrs. Evans then referred to Senate Bill 427 (Chapter 550, *Statutes of Nevada 1997*), which creates the Division of Health Care Financing and Policy within DHR, and requires the Legislative Committee on Health Care to evaluate expanding access to health care in this state. She mentioned that the committee must observe the directives of the bill when offering advice and guidance in implementing the mandated program, as well as approving or disapproving program revisions. Mrs. Evans requested that the committee expeditiously identify revisions and work with the DHR in meeting the October 1, 1998, deadline.

Commenting further, Mrs. Evans stated that Assemblywoman Barbara E. Buckley introduced Assembly Bill 156 (Chapter 140, *Statutes of Nevada 1997*), which makes various changes concerning certain entities that provide health care services through managed care. Among other things, it establishes standards for the review of services by managed care organizations, utilization review, quality assurance, data collection, and monitoring of health care services. These standards place managed care under more stringent rules than those relating to the fee for service system.

Mrs. Evans then focused her comments on the subject of cost savings and the argument that managed care will not produce sufficient cost benefits to make the managed care program worthwhile. In 1993, the projected budget savings were in the 3 to 5 percent range; with additional studies, that figure was set at a possible 3 percent savings. In 1997, the Senate Committee on Finance and the Assembly Committee on Ways and Means established the Medicaid budget predicated on a 2 percent savings. Realistically, however, full managed care was viewed more in the light of cost control than in cost savings.

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In response to a question about protecting essential community providers (ECPs), Mrs. Evans stated that the contract for Medicaid includes the same language as the Nevada Check-Up Program, and that health maintenance organizations (HMOs) must demonstrate a good faith effort when negotiating with all interested providers.

Concluding her remarks, Mrs. Evans urged the DHR to proceed with the October 1, 1998, deadline for mandated Medicaid managed care coverage, and urged the HMOs and providers to work together to provide Nevada's Medicaid families with a managed care program that will improve their health status. Mrs. Evans also requested that the committee establish an ongoing evaluation of Medicaid managed care to be provided by an impartial evaluator. It was brought to the committee's attention that when the Medicaid managed care program is fully implemented, the next issue to be addressed will be that of managing Medicaid for the aged, blind, and disabled. While the aged, blind, and disabled constitute about one-half of the Medicaid enrollment, as consumers of Medicaid dollars, they account for nearly two-thirds of Medicaid expenditures.

Responding to a question by Assemblywoman Freeman, Mrs. Evans stated that the program should not be considered an "end point," but as a work in progress which will encourage more discussion and raise further questions. This is an ongoing process and the committee's responsibility is to continue to work toward improving the health care process.

Senator Washington asked Assemblywoman Evans what policies or issues need to be resolved in order to implement a mandatory Medicaid managed care program. In Senator Washington's experience, less than half of the participants who are eligible for the program are not enrolled and he questioned why they are not taking advantage of a managed care program.

Mrs. Evans stated that, in her opinion, there will continue to be legitimate questions regarding managed care, and closure has not been reached regarding many of these issues.

With regard to the terms of enrollment in managed care, and not specifically for Medicaid clients, a similar issue has been encountered with the new Nevada Check-Up Program. In order for these programs to work, there must be a great deal of public education and community outreach. People are not going to immediately understand or recognize the features

of a new program without outreach efforts. There is, however, evidence from other states that have preceded Nevada with children's health care programs where enrollment has lagged. These states have learned that it is an ongoing effort to educate and inform people about how the program works and what it will mean to individuals and their families.

Assemblywoman Buckley stated that the Health Care Committee has a statutory responsibility to review the proposed plan and to implement the concept approved by the Legislature. Speaking to the issue of ECPs, Ms. Buckley questioned how to protect those providers who contribute to the health care delivery system and will accept anyone regardless of their ability to pay, or the status of their insurance coverage. The main issue this committee has encountered over the past few months is that even though the contract states that there should be a "good faith effort" when negotiating with all providers, there remains a concern that in the private health insurance arena there are separate contracts which guarantee bed space to certain providers. Therefore, even if an ECP is on the list, that does not mean they are going to receive referrals.

In response to Senator Washington's concern regarding a lack of ECP participation, Mrs. Evans stated that this is part of the negotiating process. The DHR will submit a request for proposal (RFP) which describes a broad base of parameters and the managed care organizations, in turn, will negotiate toward an agreement with a variety of providers. The process is based on bargaining, discussions, and negotiations, with the main focus on the health status of the people enrolled in the program. Until the close of the RFP, it is not known if there are any interested providers. This is a public/private partnership, and if the private sector does not consider this as functionable for them, they will not participate.

Background Information

Marla L. McDade

Ms. McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, referenced the handout titled "Report Regarding the Beneficial Aspects of Mandatory Medicaid Managed Care Systems," provided by the Research Division, Legislative Counsel Bureau. (Please refer to Exhibit B for details.) Ms. McDade stated that some of the items contained in the report are reflective of Assemblywoman Evans' remarks.

Ms. McDade noted that:

- States chose managed care for Medicaid recipients in an effort to enhance access for beneficiaries, improve quality of care, and reduce program costs to state budgets;
- Although evidence on the success of this approach is mixed, interviews with state officials, provider organizations, and advocates indicate that these are still states' objectives;
- Forty-four states have mandatory programs for Medicaid managed care;
- Many studies indicate that low reimbursement rates and poor provider participation have made beneficiaries overly reliant on emergency departments and on clinics and physicians that see mostly Medicaid patients;
- Policymakers are often reluctant to increase fee for service payment rates and doubt that higher rates will increase the number of Medicaid providers;

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- State officials anticipate a greater likelihood of improved access if managed care plans are required to attract and retain an adequate number of providers. States prefer this approach rather than simply increasing provider reimbursement rates because the state's expenditure risk is limited; and
- Adequate access to providers can be monitored, although this is not always easy.

Continuing, Ms. McDade explained that the beneficial aspects of Medicaid managed care are:

- States have multiple goals in enacting managed care programs for Medicaid beneficiaries, and primary among these goals is increasing access to health care for low-income people;
- There is a positive public health benefit to providing health care to populations that previously did not participate in this system;
- Managed care efficiencies enable states to offer Medicaid recipients "medical homes"; and
- States may expand services and eligibility in their existing Medicaid programs to provide care to more people.

Ms. McDade indicated that an April 1998 study in the *American Journal of Preventive Medicine* showed that HMOs are more likely than preferred provider organizations (PPOs)/indemnity plans to offer health promotion programs and have formal relationships with community and public health providers. An article in *The Economist*, March 17, 1998, states that the HMO revolution has drastically curbed the pace of health inflation while maintaining and sometimes improving medical standards in the United States. Also, HMOs appear to reduce hospital stays by 30 percent, while pregnant women in managed care are two-thirds as likely to undergo a cesarean section as women in fee for service systems. In another study, it was noted that the likelihood of low birth weight babies was lower in the capitated payment group than in the fee for service payment group.

Summary of Successes in Other States and in Nevada

Discussion continued citing Medicaid managed care experiences in other states:

1. Wisconsin reports significant public health benefits from HMOs relative to health check screens for children under five years of age; the rate of measles, mumps, and rubella vaccinations; health care visits (preventive and nonpreventive) for 20-year-olds; and cesarean section rate for 12 to 49-year-olds. (Please refer to Exhibit B for a detailed comparison.)

2. For Fiscal Year (FY) 1992, Arizona saved 11.0 percent of the estimated cost of a traditional Medicaid program, and in FY 1993, the managed care program realized a savings of 11.3 percent compared to the cost of a traditional program.

3. In Oklahoma's urban areas, fully capitated HMOs provide services while in rural areas the state has instituted a primary care case management program. The managed care program covers the standard Medicaid population, and the state has plans for a similar program for the aged, blind, and disabled in 1999. In 1996, when individuals were assigned to HMOs, their rate of transferring between HMOs was about 4 percent.

4. New York City, New York indicates that Medicaid managed care enrollees reported better access to care and higher levels of satisfaction as compared to conventional Medicaid beneficiaries.

5. An evaluation of Rhode Island's "Rite Care" illustrates those designated outcome measures for access to and quality of prenatal care during the first year of operation of the program showed improvements on all such measures. The comparative analysis for pregnant women with private insurance plans did not show the same improvement.

6. Regarding Early and Periodic, Diagnostic, Screening and Treatment (EPSDT) for Medicaid children, the Office of Inspector General, U.S. Department of Health and Human Services, concluded that:

> A comparison of the EPSDT results in Michigan and Nevada to the others in our sample shows that there [are] very strong statistical differences in managed care plan performance. These states identify children currently due for EPSDT screens to their managed care plans and closely monitor EPSDT performance by managed care plans for these children.

Commenting further, Ms. McDade explained that the federal Balanced Budget Act of 1997 eliminated the waiver requirement for moving Medicaid recipients into managed care. Congress took this action because many states had already moved their clients into Medicaid managed care and the waiver process was no longer necessary. This also enabled states more flexibility in how they designed their programs.

In conclusion, Ms. McDade stated that:

- Significant public health benefits are realized when Medicaid recipients participate in managed care programs;
- Stable budgets allow states to increase eligibility levels and available services in their Medicaid programs;
- States have benefitted from the stability of costs; and
- Medicaid recipients are able to participate in health plans that are similar to those of commercial health insurance.

Assemblywoman Buckley asked if similar criteria for the voluntary managed care program is available for Nevada. For example, if recipients were using more preventative measures in an HMO program, that would be a favorable factor for the committee to consider in terms of adopting a Medicaid managed care plan in Nevada.

In response to Ms. Buckley, Mr. Thompson, identified on page 2, commented that at the conclusion of the Health Care Committee's meeting on May 4, 1998, there was an informal meeting to discuss the development of information for establishing criteria and which specific questions need to be addressed.

Assemblyman Close stated that he is concerned about the delay in receiving this critical information which the committee can use as a baseline document. He mentioned the importance of DHR making this a high priority.

DISCUSSION AND POSSIBLE RECOMMENDATIONS CONCERNING ELIMINATION OF THE ASSETS TEST USED TO DETERMINE ELIGIBILITY

IN THE NEVADA MEDICAID AND NEVADA CHECK-UP PROGRAMS

Christopher Thompson

Mr. Thompson, Administrator, Division of Health Care Financing and Policy (DHCFP), DHR, explained that the assets test requirement in Medicaid has historically been a part of the program for cash assistance in the State of Nevada. The Medicaid program was expanded through a federal mandate to include pregnant women and children that were at a somewhat higher income, essentially going up to 133 percent of poverty for pregnant women and children up to age 6, and up to 100 percent of poverty for those children born after October 1, 1983. However, the State of Nevada chose not to impose the assets test and in 1992, as a result of budget difficulties within the state, discussions ensued regarding cuts in various programs. At that time, the State determined that the Medicaid program would institute an assets test for the Child Health Assurance Program's (CHAP) low-income children and pregnant women. That policy was adopted in July 1992. Some of those policies that were initially adopted in 1992 were subsequently reversed during the 1993 Legislative Session. Other policies, including the inclusion of an assets test in Medicaid, were defacto ratified by the 1993 budget process and subsequent budgets in 1995 and 1997.

Mr. Thompson further stated that over the last three interims the division has discussed topics regarding the expansion of groups eligible for Medicaid. Such items included the assets test, adding groups that are considered "optional" under federal law, increasing the age to 18 for the coverage of low-income children, and moving beyond the 133 and 100 percent levels up to as high as 185 percent, which is an option allowed under federal law. Also under consideration is the medically needy program, presumptive eligibility, and, as a result of the Balanced Budget Act of 1997, continuous eligibility for persons who are on Medicaid for a period up to an additional 12 months. All of these issues are matters that will require full committee discussion as well as legislative authorization to enable the policies to move forward.

Mr. Thompson then expressed his concern regarding the potential budget impact of eliminating the assets test and indicated that other budget items may not be funded as a result of this decision. When developing Nevada Check-Up, the assets test was discussed extensively. It was determined that as the transition from a Medicaid entitlement program to the Nevada Check-Up program evolves, and with the elimination of the assets test and administering an income test, providing low-cost health care coverage to these individuals would be a significant commitment of resources by the state. The division is in favor of eliminating the assets test, from the standpoint of assuring that children have access, as well as reducing the administrative burden.

Senator Rawson stated that it appeared that the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services is concerned with the fact that there is an assets test requirement for Medicaid, while the children's program has taken a different approach.

Responding to Chairman Rawson's statement, Mr. Thompson stated that if HCFA will not allow the assets test, then the division will need to reconsider several options, one of which is the elimination of an assets test for the Medicaid program.

In reference to CHAP, Chairman Rawson indicated that regardless of the committee's decision pertaining to the assets test, the division must continue with implementation of the children's health insurance program and maintain an ongoing dialog with HCFA in reaching a decision. If the committee were to recommend elimination of the assets test, that decision will probably carry through into the 1998 Session of the Legislature and would be included in the budget documents.

Mr. Thompson then explained that the program was designed for administrative simplicity and with the intent of offsetting the $3 million in administrative fees. He stated that any administrative program changes will increase the cost of the program. If HCFA requires the division to determine whether a child is eligible for Medicaid before they are enrolled in the new program, then, in the short-term, the division will need to establish a much broader administrative process in determining check-up eligibility. Further development of these additional administrative procedures will delay the program. He believes that HCFA will make a determination on or about June 25, 1998 regarding whether the program will be approved or denied.

Assemblywoman Buckley stated that it seems clear from HCFA's letter that it is "deeply troubled," and that it would make sense for the committee to initiate the process of eliminating the assets test in the CHAP program, scheduling this item for the next IFC meeting, and determining the division's needs. With regard to the Aid to Families with Dependent Children (AFDC) population, the committee may need to recommend a BDR. These actions will send a message to HCFA that appropriate steps have been taken to eliminate the CHAP assets test, and that a BDR has been submitted to eliminate testing for the AFDC population.

Jon Sasser

Mr. Sasser, identified on page 2, presented the committee with two documents prepared by Washoe Legal Services titled "Proposal to Promote 'Seamlessness' Between the Children's Health Assurance Program (CHAP) and Nevada Check-Up" (please refer to Exhibit C), and "Barrier: The CHAP Assets Test" (please refer to Exhibit D). Mr. Sasser then referred to Exhibit C and the projected program cost increase of $4,358,707, which consists of federal and state dollars, and identified the following points:

- It was estimated that there were 568 CHAP applications denied because of excess assets, and 568 applications not submitted because of the assets test and potential denial;
- Of the 1,136 CHAP applicants who were denied, all will be eligible for the Nevada Check-Up Program because their incomes are well under 200 percent of poverty, and that there will not be a reduction in this figure to enroll them in the new Check-Up program; and
- The assets test can be eliminated and the Medicaid program will still be well under budget in the 1997-1998 interim. The budget figure for enrollment was set at 60,000 children, with the assumption that all those children would be enrolled in the program by July 1, 1998. At the present time, there are 4,000 to 6,000 inquiries, and of those inquiries it is not known which are eligible for Medicaid or Nevada Check-Up, or who will pay an enrollment fee.

Responding to Mr. Sasser's presentation, Chairman Rawson stated that during the 1999 Legislative Session, the Senate Committee on Finance and the Assembly Committee on Ways and Means may consider whether eliminating the assets test will allow individuals who cannot afford health care, access to free care.

In response to Senator Washington, Mr. Sasser explained that an individual will be able to participate in either program, and that it will be a question of whether their coverage will be under CHAP or the Nevada Check-Up Program. Mr. Sasser indicated that if the person has assets that could be used for medical care, they will be enrolled in the Nevada Check-Up Program, which does not consider assets as long as their income is under 200 percent of the federal poverty level.

Continuing, Mr. Sasser focused his comments on the issue of "seamlessness" with general discussion regarding the enrollment process. At the present time, an applicant may wait two to three months for enrollment in the Nevada Check-Up Program, and 45 days for approval from the Welfare Division of DHR for CHAP enrollment. Elimination of the assets test would alleviate the "cumbersome" process and enable streamlining of the administrative system. It was noted that the objective of the program is to assist families in enrolling their children into the most appropriate program as quickly as possible.

Responding to Chairman Rawson's question, Mr. Thompson explained that the assets test is only for the CHAP program. He pointed out that there are two classes of participants required to disclose assets to determine Medicaid eligibility: (1) children; and (2) pregnant women. For administrative simplicity, the same criteria should apply to both of these groups.

With regard to Senator Washington's concern regarding eliminating the assets test, Mr. Thompson suggested that the committee assist the division by making a motion indicating the need for approval of the Check-Up program, and include language which would support drafting a BDR for consideration by the 1999 Legislature.

In reference to Mr. Thompson's recommendation, Mr. Sasser stated that it is not necessary to draft legislation since none of the other eligibility criteria for the program was processed through legislation. An option would be for the committee to recommend a regulatory change for eliminating the assets test through the Welfare Division, which could be achieved through the administrative process.

In answer to Chairman Rawson, Mr. Sasser replied that there is not a federal asset threshold requirement in CHAP for either pregnant women or children under specific age levels. He noted that only eight other states have an assets test.

Chairman Rawson suggested that an appropriate motion could be that the committee recommend that the division eliminate the assets test for CHAP, which may be subject to IFC's approval. He emphasized that a clear-cut message be sent to HCFA regarding streamlining the application process for CHAP, and indicated that it is his recommendation that this process be expedited so that Nevada's children will continue to receive health care coverage.

In response to Assemblyman Close's question, Mr. Thompson clarified that the $6 million estimate is inclusive of the pregnant women as well as the children in CHAP.

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ASSEMBLYWOMAN FREEMAN MOVED FOR COMMITTEE RECOMMENDATION THAT THE DIVISION OF HEALTH CARE FINANCING AND POLICY, NEVADA'S DEPARTMENT OF HUMAN RESOURCES, ELIMINATE THE ASSETS TEST FROM THE CHILD HEALTH ASSURANCE PROGRAM AS IT PERTAINS TO PREGNANT WOMEN AND CHILDREN IN MEDICAID. ASSEMBLYWOMAN BUCKLEY SECONDED THE MOTION WHICH CARRIED WITH SENATOR WASHINGTON VOTING NAY.

Charlotte Crawford

Ms. Crawford, identified on page 2, commented that there are two options to consider which may make for a smoother transition for DHR and the division to execute the motion approved by the committee. There is a consensus that elimination of the assets test is needed, and that an explicit message in support of this action be sent to HCFA. Ms. Crawford suggested that the committee could direct DHR to draft a budget proposal which would include eliminating the CHAP assets test for the 1999 Legislative Session. A second option could be that the committee direct DHR to advise the IFC of the budget impacts for the remainder of this biennium and to determine whether IFC would recommend execution of that action pending full approval of the Legislature.

Chairman Rawson responded that the committee would consider the options, and that as soon as the budget implications for this year can be prepared, they should be reported to IFC for final approval.

ASSEMBLYWOMAN BUCKLEY MOVED FOR COMMITTEE SUPPORT TO PREPARE A LETTER TO THE HEALTH CARE FINANCING ADMINISTRATION OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, URGING ITS APPROVAL OF THE CHILDREN'S HEALTH INSURANCE PROGRAM BASED ON THE FACT THAT THE LEGISLATIVE COMMITTEE ON HEALTH CARE IS IN THE PROCESS OF STREAMLINING THE PROGRAM. ASSEMBLYMAN CLOSE SECONDED THE MOTION WHICH CARRIED UNANIMOUSLY.

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DISCUSSION AND POSSIBLE RECOMMENDATIONS FOR

A CONSULTANT TO STUDY MANAGED CARE FOR MEDICAID RECIPIENTS NOT PRESENTLY ELIGIBLE FOR SUCH SERVICES AND FOR A

MEDICALLY NEEDY PROGRAM

Ms. McDade, identified on page 8, referred to a document submitted by the Nevada Health Care Reform Project (NHCRP). (Please refer to a letter titled "Nevada Mandatory Medicaid Managed Care," Exhibit E, submitted by Ruth Mills, for detailed information.) The NHCRP requested that the committee delay any decisions regarding mandatory Medicaid managed care until the 1999 Legislative Session and suggested that a complete assessment be made regarding:

- Quality, access, and the cost of care to the Medicaid population;
- Care for the non-Medicaid indigent population;
- Essential community providers of care for the indigent; and
- The state budget.

Discussion ensued regarding the expansion of Medicaid coverage and utilizing state resources for the needy population.

Fred Hillerby

Mr. Hillerby, identified on page 2, stated that one of the charges of the committee is to review the expansion of Medicaid to include people who might not otherwise be eligible. Due to the complexity of the children's health insurance programs and other issues, it would be helpful to have assistance in evaluating what it would cost the state to expand the Medicaid program to include the needy community.

Chairman Rawson explained to the committee that recommendations need to be made for consideration during the 1999 Legislative Session. He further stated that action should be taken on this issue in order to proceed with the medically needy program. One approach is to start with a consultant, or to request a BDR which would provide for a more comprehensive study.

Donny Loux

Ms. Loux, identified on page 2, concurred with utilizing an independent consultant. According to Ms. Loux, Ms. Sarah Rosenbaum, with the George Washington University Center on Health Policy Research, has conducted a national study of Medicaid managed care contracts relative to the implementation of Medicaid managed care issues of marketing, enrollment, benefit services, quality assurances, and provider concerns, as well as expertise in the development of contracts for Medicaid managed care. Ms. Loux indicated that there possibly is funding for technical assistance through the Robert Wood Johnson Foundation which many states have taken advantage of for implementing Medicaid managed care for special populations. The organization to contact regarding special populations with the Robert Wood Johnson Foundation is the National Medicaid Working Group. Regarding consumer protection, quality assurance, and performance indicators, the contact person is Jane Perkins with the National Health Law Program.

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Elizabeth Gilbertson

Ms. Gilbertson, identified on page 2, commented that in order to make intelligent judgments regarding expansion of programs for new populations not currently contemplated, the Robert Wood Johnson Foundation has to have an understanding of the utilization of costs and the outcome of current programs in place. Although a lot of data has been collected regarding the existing mandatory program versus the voluntary managed care programs, obtaining information from data is a time-consuming process; however, if this is not done and addressed by this committee with the proper resources, it will not be of benefit.

Chairman Rawson indicated to the committee that the Legislative Committee on Health Care is budgeted for two more meetings and that there is approximately $60,000 to $80,000 allocated for consultant services. It was suggested that the best approach would be to agendize an action item

for the August 3, 1998, work session to determine those issues that will be directed toward the study. Senator Rawson encouraged anyone who has an interest in this agenda item to prepare and submit a list of issues to staff by July.

Winthrop Cashdollar

Mr. Cashdollar, identified on page 2, expressed his support to use an independent consultant and commented that of particular concern is the long-term care issue. He said there is considerable interest in the long-term care aspect of establishing a medically needy program.

Chairman Rawson responded that the committee may have one special hearing regarding long-term care issues before the 1999 Legislative Session. He encouraged interested persons to submit recommendations concerning long-term care to staff before the August 3, 1998, work session.

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POTENTIAL DISCUSSION OF ISSUES IN NEVADA CHECK-UP

Chairman Rawson commented that this item was agendized to address any concerns regarding the Nevada Check-Up Program, and referred to a position statement developed by the Nevada Health Care Reform Project (NHCRP) entitled "Children's Health Insurance Plan" (please see Exhibit F for detailed information). Senator Rawson then asked the committee if there was any objection to having a consultant address the issues outlined in the position paper in their study.

Assemblywoman Buckley stated that when the committee voted to approve the Nevada Check-Up Program that all ECPs be included in her motion. In conversations with the Governor's office, Ms. Buckley was reassured that there was an oversight, and that the application had already been prepared, but would be amended to reflect the motion and the vote of the committee.

In response to Ms. Buckley's question, Ms. Crawford stated that the full range of ECPs were not included, and DHR will review the list and report back to the committee.

Adair Dammann

Ms. Adair Dammann, Nevada Service Employees Union, representing Service Employees International Union (SEIU) Local 1107, American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), explained that the NHCRP is a statewide coalition with expertise in a number of constituency organizations that have comprehensively reviewed the Nevada Check-Up Program as well as the Medicaid managed care plan proposals. The mission statement of NHCRP is that of expansion of affordable quality care to all Nevadans. The issues that have been presented are complex, but NHCRP maintains that a study must be conducted based on the actual experience of the voluntary Medicaid managed care program. There should be a thorough understanding of the programs currently in place, the utilization that has occurred, and the impact on the system when patients transition into managed care.

John Canham-Clyne

Mr. Canham-Clyne, Research Analyst, Culinary Workers Union, and a participant with NHCRP, said his main concern is whether moving to mandatory Medicaid managed care will: (1) improve beneficiaries' ability to access doctors and other providers; and (2) shift utilization away from unnecessary hospitalization and toward preventive services.

Discussion continued focusing on the issues of access, health care inflation and HMO premium rate inflation, capitation rates, disenrollment rates, and fee for service provider rates.

In closing, Mr. Canham-Clyne noted that information about managed care experiences throughout the nation, as well as existing fee for service and voluntary programs provide an opportunity to review these issues and answer certain policy questions before moving forward with mandatory managed care.

Chairman Rawson explained to the committee that this agenda item was not noticed as an action item due to discussions with the Legislative Counsel Bureau's Legal Division, and the fact that the committee does not have the right to stop the Medicaid managed care program. Chairman Rawson cited the following legal opinion:

> It is the opinion of this office that the Legislative Committee on Health Care may not override the will of the entire Nevada Legislature by directing the Department of Human Resources not to go forward with the implementation of the Medicaid managed care program for certain populations by October 1, 1998.

Continuing, Chairman Rawson noted that no specific review periods exist for the mandatory program, and that every session of the Legislature is an automatic review period of items submitted by the committee.

Ms. Crawford commented that the DHR is sensitive to the important role that ECPs provide, and will continue to make every effort to ensure that the transition period preserves the ECPs. Ms. Crawford asked that an inaccuracy, which has been repeatedly stated, be corrected. She explained that in terms of the voluntary managed care program currently relevant to the population being referred to, 65 percent of that population has volunteered to participate in a managed care option, and 20 percent are in HMOs. Since the HMO voluntary option was added, it would appear that a number of individuals find that a preferable option to receive their service.

Continuing, Chairman Rawson indicated that correspondence to Ms. Crawford from the Senate Committee on Human Resources and Facilities stated the following:

> The Senate Committee on Human Resources and Facilities directed that a letter of intent be provided to you to convey, in the strongest possible terms, the commitment of this body to the inclusion of the Federally Qualified Health Centers (FQHCs), the University Medical Center (UMC), and the University of Nevada School of Medicine (UNSOM) within the process of establishing the managed care system. It is the fundamental intent of the Legislature that these entities continue to operate and be viable components of the Medicaid managed care network of health care delivery. It is also the intent of this legislation to increase the number of paying patients being served by the clinics; there is no intention to take patients away from the clinics. Any HMO wishing to participate in the state's Medicaid managed care program must demonstrate to your complete satisfaction that they have negotiated in good faith with these entities for the provision of services. While the term "in good faith" already has certain legal status, additionally, the burden of proof must be on the HMO to provide clear evidence: (1) that there was substantive interaction among the parties; (2) that sincere, concerted efforts were made by the HMO to include all three entities within its service system for this program; and (3) that actual offers were presented and discussed.

William R. Hale

Mr. Hale, Chief Executive Officer, University Medical Center (UMC), Las Vegas, stated that the committee has the endorsement of UMC, considering the fact that ECPs will be protected, to establish a Medicaid managed care program.

Assemblywoman Buckley stated that she was in agreement with the Legislative Counsel Bureau's legal opinion that an interim committee cannot overrule the will of the Legislature, however, the committee still has the obligation to vote on the matter and suggest amendments. Continuing, Ms. Buckley thanked the Governor's Office, the DHR, and the division for their commitment to work with ECPs so they will not be adversely affected during this transition period.

Ms. Gilbertson, identified on page 2, commented that the impact of ECPs should be included in the monitoring process. Therefore, when setting forth criteria that can be used for tracking purposes, there will be substantive information available when the Legislature convenes in 1999.

John Yacenda, MPH, Ph.D.

Dr. Yacenda, identified on page 2, asked the committee if an update could be provided regarding the Nevada Check-Up Program including the number of current applications received and how many of those are Spanish.

Answering Dr. Yacenda's questions, Mr. Thompson indicated that 4,153 children have applied, and of those the number of Spanish language applications is approximately 6 percent. Of those applicants, approximately 2,056 are Caucasian, 1,078 Hispanic, 395 African American, 246 Asian, 112 Native American, and 266 are of miscellaneous descents. He noted that African Americans may be under represented.

Discussion continued regarding proposed applicant information for choosing a particular HMO, specific information relative to families that meet the income eligibility levels of Medicaid, and the benefits of enrolling in Medicaid.

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INFORMATION CONCERNING THE STATE BOARD OF NURSING REGULATIONS PREVIOUSLY DISCUSSED BY THE COMMITTEE

Chairman Rawson informed the committee that the State Board of Nursing requested that an announcement be made regarding the current status of the essential eligibility requirement, and that the Legislative Commission, at its April 17, 1998, meeting, rejected the regulation stating that it did not meet legislative intent. Based on its decision, the board withdrew the regulation. The proposed delegation regulation, which had been referred back to the Nursing Practice Advisory Committee, was tabled by the committee. The Certified Nurse Assistant (CNA) requirement for 400 hours of employment as a condition for renewal, has been rescheduled to be heard on June 5, 1998, based on the technical notice error.

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PRESENTATION OF THE STUDY CONCERNING MINORITY HEALTH, CONDUCTED BY CRESHELLE NASH, M.C., FELLOWSHIP IN MINORITY HEALTH POLICY, COMMONWEALTH FUND/HARVARD UNIVERSITY

Dr. Yacenda, identified on page 2, presented a slide presentation (please see Exhibit G) regarding minority health. He addressed the following items:

- When planning government-funded health care programs, the need to recognize the importance of culture and identity in implementing these programs should be recognized;
- In 1990, the U.S. Congress passed the Disadvantaged Minority Health Improvement Act which formally established the Office of Minority Health (OMH) within the Office of the Assistant Secretary for Health. Offices of minority health have been established in five U.S. Department of Health and Human Services agencies: (1) Agency for Health Care Policy and Research; (2) Centers for Disease Control and Prevention; (3) Health Resources and Services Administration; (4) National Institutes of Health; and (5) the Substance Abuse and Mental Health Services Administration;
- In 1990, five states had established minority health entities: Indiana, Michigan, Missouri, Ohio, and South Carolina. Eight years later, there are now 34 states, and in the 1999 Nevada Legislature, this number will increase to 35;
- Funding for OMH comes from varied sources, with states carrying the bulk of the responsibility. Three offices are federally funded, nine are funded with a combination of federal and state dollars, and 17 are solely state funded; and
- The characteristics of successful state minority health entities are that they:

    1. Report directly or have a strong link to the state health organization;

    2. Are able to integrate their activities with those of the health department and other state agency programs; and

    3. Must not depend solely on federal funds or resources for its existence and there must also be a firm state commitment.

Continuing, Dr. Yacenda explained what an OMH could do for Nevada:

- Provide policy development leadership;
- Prepare reports, analyses, and talking papers on minority health issues;
- Conduct state and local surveys, studies, and advocacy on minority health issues;
- Create a resource library and serve as a data bank on minority health issues;
- Provide technical assistance to minority community-based organizations and other public and private organizations and agencies that serve minorities; and
- Secure federal, state, local, and private funding to enhance minority health programs.

In conclusion, Dr. Yacenda recommended that the:

1. Legislative Committee on Health Care discuss an OMH at its August 3, 1998, work session, and fully endorse a BDR to develop an OMH for Nevada.

2. BDR mentioned in Recommendation 1 include the formation of an OMH that has a statutory relationship with an advisory board of representatives from the recognized minorities in Nevada.

3. OMH be funded through a combination of state and other funding mechanisms at an appropriate match (i.e., for every federal dollar the state will match a dollar; for every two nonfederal dollars, the state will match a dollar).

Elena Lopez-Bowlan

Ms. Lopez-Bowlan, identified on page 2, spoke to the committee about the special health needs of minorities as well as the disparities of minorities in Nevada. Of major concern is that racial ethnic information in Nevada has "failed miserably," and that if an OMH was established in Nevada, the health needs and lack of racial ethnic information would be addressed.

Robert A. Ostrovsky

Mr. Ostrovsky, identified on page 2, informed the committee that as a member of the Governor’s Health Care Committee, there is a great deal of concern regarding the lack of coordinated health care within the State of Nevada. An upcoming report from the committee strongly recommends that a coordinated effort take place at the state level regarding health care issues, of which minority issues will be acknowledged.

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DISCUSSION OF TOPICS FOR FUTURE MEETINGS

Chairman Rawson reiterated to the committee that due to budgetary matters the work of the full committee needs to reach completion. It was requested that the advisory committee

participate in the August 3, 1998, work session so that the full committee can address all the data and study issues relative to previous meetings. Chairman Rawson expressed his appreciation to the advisory committee for the "tremendous" amount of work and effort involved on their part, and indicated that there may be a need in the future for the full committee to convene and that members will be kept apprised of future meetings.

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Tom Wood

Mr. Wood, representing Pharmaceutical Research Manufacturers of America (PHRMA), explained to the committee that PHRMA is the main source for virtually all the new drugs in the United States and produces over half of the new drugs in the world. Twenty-one percent of sales and exports go back into research which, for this year, translates to $20 billion. It is the contention of PHRMA that the 78 percent portion of health care which represents drugs is fully implemented and available, and increases favorable outcomes as well as lowers expenses in other areas of health care, such as hospitalization, emergency rooms, provider visits, and quality of life. Mr. Wood indicated that PHRMA supports the principles of managed care if it is patient-based. The concern is that if managed care is involved in budget cuts, the drug program with the greatest availability of quality drugs becomes a single target without due process to outcomes, and that situation would not be in the best interest of the patient. At the present time, the Nevada Check-Up drug delivery program does not have a state oversight provision for pharmaceutical availability. It was requested that this issue be addressed at a future committee meeting.

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PUBLIC TESTIMONY

Paul Gowins

Mr. Gowins, representing the Disability Forum, stated that there are several items that the disability community would like to include as study topics:

1. Conduct a thorough study with information and data collected regarding disability issues before a bill is drafted for the managed care program.

2. Appoint a subcommittee to address issues for people with disabilities.

3. Compare similar managed care systems in other states.

4. Expand Medicaid for medically needy individuals.

Chairman Rawson appointed Assemblyman Close as the chairman of the subcommittee to address disability issues, and appointed Ms. Donny Loux as a subcommittee member. It was noted that interested persons wishing to serve on the subcommittee should contact Mr. Close.

Continuing, Chairman Rawson stated that as the subcommittee reviews disability issues, and in light of potential cost savings ideas, that there remain adequate security for the disabled community and no loss of benefits. A prerequisite of the study will be to provide better health care to the disabled as well as care to more individuals.

There being no further committee business, the Chairman adjourned the meeting at 2:25 p.m.

Respectfully submitted,

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Roxanne Duer

Senior Research Secretary

APPROVED BY:

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Senator Raymond D. Rawson, Chairman

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Date: _____

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LIST OF EXHIBITS

Exhibit A is a copy of the testimony of Assemblywoman Jan Evans dated May 29, 1998.

Exhibit B is a report submitted by Marla McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, titled "Report Regarding the Beneficial Aspects of Mandatory Medicaid Managed Care Systems," dated May 29, 1998.

Exhibit C is a document submitted by Jon L. Sasser, Washoe Legal Services, titled "Proposals to Promote ‘Seamlessness’ Between the Children’s Health Assurance Program (CHAP) and Nevada Check-Up."

Exhibit D was submitted by Jon L. Sasser, Washoe Legal Services, and is a report titled "Barrier: The CHAP Assets Test."

Exhibit E submitted by Ruth Mills, Coordinator of the Nevada Health Care Reform Project, is a letter titled "Nevada Mandatory Medicaid Managed Care," dated May 29, 1998.

Exhibit F is a copy of a letter submitted by Ruth Mills, Coordinator of the Nevada Health Care Reform Project, titled "Children's Health Insurance Plan," dated May 29, 1998.

Exhibit G is a copy of the slide presentation titled "Office of Minority Health (OHM) . . .," submitted by John Yacenda, MPH, Ph.D., Executive Director, Great Basin Primary Care Association, dated May 29, 1998.

Exhibit H is the Attendance Record for this meeting.

Copies of the materials distributed in the meeting are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. You may contact the library at (702) 684-6827.