MINUTES OF THE MEETING

OF THE

LEGISLATIVE COMMITTEE ON HEALTH CARE

(*Nevada Revised Statutes* 439B.200)

May 4, 1998

Carson City, Nevada

The eighth meeting of the Nevada Legislature's Committee on Health Care for the 1997-1998 interim was held on Monday, May 4, 1998, at 9:48 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

Senator Maurice E. Washington

Assemblywoman Barbara E. Buckley

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblyman Jack D. Close

OTHERS PRESENT IN CARSON CITY:

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

Marc Bennett, Chief Operating Officer, HealthInsight

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)

Bernard H. Feldman, M.D., University of Nevada School of Medicine

C. Edwin Fend, Capital City Task Force Coordinator, State Legislative Committee,

American Association of Retired Persons (AARP)

Fred Hillerby, Hillerby & Associates

Larry Matheis, Executive Director, Nevada State Medical Association

Robert A. Ostrovsky, President, Ostrovsky & Associates

Jon L. Sasser, Washoe Legal Services

Carla Sloan, Administrator, Aging Services Division, DHR

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

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

Alice Molasky-Arman, Commissioner of Insurance, Division of Insurance, Nevada's Department of Business and Industry

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

OTHERS PRESENT IN LAS VEGAS:

Thelma Clark, Rulon Earl Resident Council, Inc.

Elizabeth Gilbertson, Southwestern Regional Director, HEREIU Fund

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

Ruth Mills, 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

Melissa Stafford Jones, Senior Research Analyst

Risa L. Lang, Principal Deputy Legislative Counsel

Leslie Hamner, Deputy Legislative Counsel

Ricka Benum, Senior Research Secretary

Jo Greenslate, Research Secretary

REVISED

MEETING NOTICE AND AGENDA

Name of Organization: Legislative Committee on Health Care

(Nevada Revised Statutes 439B.200)

Date and Time of Meeting: Monday, May 4, 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

Las Vegas, Nevada

A G E N D A

1. Opening Remarks by the Chairman

Senator Raymond D. Rawson

*II. Approval of Minutes from March 9, 1998, Meeting

III. Discussion Concerning Role of Essential Community Providers in Managed Care Programs Administered by Nevada's Department of Human Resources (DHR)

IV. Update Concerning Robert Wood Johnson Foundation Grant Application for "Covering Kids"

Charlotte Crawford, Director, DHR

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

Association

*V. Presentation, Discussion, and Recommendations Regarding *Nevada Administrative Code* (NAC) 632.192 and 632.193, as amended by Legislative Counsel Bureau File No. R139-97, "Adopted Regulation of the State Board of Nursing which Revises Provisions Governing Renewal of Certificate to Practice as Nursing Assistant"

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

VI. Status Report Regarding Study of Uninsured in Nevada

*VII. Discussion of Topics for Consideration at Future Meetings

*VIII. Directions to Staff

IX. Public Testimony

*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, 401 South Carson Street, 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.

APPROVAL OF MINUTES FROM

MARCH 9, 1998, MEETING

ASSEMBLYWOMAN FREEMAN MOVED FOR APPROVAL OF THE MINUTES OF THE MARCH 9, 1998, MEETING OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE IN CARSON CITY. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN BUCKLEY AND PASSED UNANIMOUSLY BY THOSE WHO WERE PRESENT. SENATOR MATHEWS WAS ABSENT FOR THE VOTE.

DISCUSSION CONCERNING ROLE OF ESSENTIAL COMMUNITY PROVIDERS IN MANAGED CARE PROGRAMS ADMINISTERED BY NEVADA'S DEPARTMENT OF HUMAN RESOURCES (DHR)

Marla L. McDade

Marla L. McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, referenced the packet of information previously mailed to committee members in April 1998 (see Exhibit A). She noted that after original responses to the questionnaire were mailed, additional responses were received and distributed at this meeting. Ms. McDade explained the green, bound packet contains a description of the questionnaire, and that the purpose of the document is to identify organizations throughout the state that are of the opinion they meet the definition of essential community providers.

Ms. McDade remarked that the questionnaire was not inclusive and that some respondents indicated that they did not have enough time to respond. She added that their responses are still being accepted, however, if they wish to submit additional information.

Looking more specifically at the issue, Ms. McDade found that states throughout the country are struggling with this issue as their Medicaid programs move into managed care. The United States Department of Health and Human Services is planning to conduct in-depth study on this issue to identify the impact on care for Medicaid recipients as well as the public health system.

Ms. McDade presented background information from item one of Exhibit A, titled "Report Concerning Essential Community Providers." She then mentioned there is not just one definition states are using of "essential community providers;" some states use the term interchangeably with "safety net providers" and "traditional providers" of health care. She noted in the information she is compiling, she is considering them all "essential community providers."

Continuing, Ms. McDade highlighted key points in Exhibit A. She mentioned the methods identified in information previously provided to the committee of how states might protect essential community providers and briefly reviewed the "Analysis of Responses" to the questionnaire which was transmitted via facsimile to the expanded membership and other interested parties.

Ms. McDade concluded her presentation by suggesting that additional criteria be developed with help from committee members.

Chairman Rawson read a letter into the record from William R. Hale, University Medical Center (UMC), dated April 22, 1998 (see Exhibit B). The letter recommends that the Legislative Committee on Health Care wait until commencement of the 1999 Legislature to make a decision regarding a mandatory Medicaid managed care program. The Chairman commented there were two concerns expressed by the Senate Committee on Finance and Assembly Committee on Ways and Means (also referred to as the "money committees" of the Legislature in these minutes) regarding mandatory managed care. They are:

> 1. Due to past actions by the DHR in the development of a mandatory Medicaid managed care program, members of the money committees were of the opinion that the DHR might not go ahead with the mandatory program. This action could impact some of the budgets and decisions that have already gone into the program. Senate Bill 427 (Chapter 550, *Statutes of Nevada 1997*), which "Creates division of health care financing and policy within department of human resources and requires legislative committee on health care to evaluate expanding access to health care in this state," includes language to ensure that the DHR did not delay the development of this program. Therefore, the Legislature wanted the interim committee on health care to have the authority to approve any substantive revisions in the mandatory program should the DHR determine that it was making changes that were not already approved by the Legislature.

2. The money committees were also concerned about the reorganization of the Division of Health Care Financing and Policy. They indicated that any significant restructuring should be brought to the Legislature through the approval of the interim committee on health care before proceeding.

According to Chairman Rawson, the Clark County commissioners are asking the health care committee to go beyond the scope of its authority. He stated permission has been given to establish a managed care program. However, if the parameters are changed or it is decided not to establish a managed care program, the health care committee needs to make a decision regarding those changes.

The Chairman recommended that the committee establish a time table for any hearings, requests for information, or proposals related to implementation of the managed care plan. He pointed out this issue is further complicated by the upcoming change of administration.

Charlotte Crawford

Charlotte Crawford (identified earlier on page 1) mentioned that three legislative sessions have directed the Department of Human Resources (DHR) toward a mandatory managed care program that is incorporated into the budget from the 1997 Legislature. The budget dictates that DHR move into a mandatory managed care program for the Temporary Assistance for Needy Families (TANF) and Child Health Assurance Program (CHAP) populations in October 1998. She mentioned that Christopher Thompson (identified on page 2) has had a number of hearings, and committee members have received draft contracts for both the managed care program and the Nevada Check-Up program for comment.

Responding to Chairman Rawson’s concern regarding opportunities for making changes and providing input, Mr. Thompson stated the contracts for both the Medicaid managed care and the Nevada Check-Up programs:

Are now in the final stages, however, there is still the opportunity for wording changes; and

- Would likely have changes in the contract language over time as a result of information the Division obtains, information from the managed care organizations, or input from the Federal Government and the Legislature.

Mr. Thompson added:

- Rates from the actuaries for the Medicaid managed care program are also in the final stages, and any changes in the contract resulting in impacts to the rates would be problematic at this point.

Mr. Thompson urged anyone with changes to submit them as soon as possible, but cautioned that if fundamental changes are made to the contracts that impact the determined rates, the changes will be difficult to incorporate.

Responding to Chairman Rawson's questions regarding the Medicaid managed care contract, Mr. Thompson iterated:

- Medicaid recipients that will be affected comprise between 55 and 60 percent of the total population.
- On a dollar volume basis, the number represents approximately 25 percent of total Medicaid payments.
- Any organization may bid for the contract providing it meets the terms of the contract, including compliance with the State of Nevada's licensure laws.
- There is no limit to the number of organizations that may bid on the contract.

William R. Hale

William R. Hale, Chief Executive Officer, UMC, referenced the first of several documents which he had distributed to the committee (see Exhibit C) titled "Fact Sheet." He read the second bulleted item on the first page which reads, "Public COTH member hospitals that treat Medicaid managed care patients are twice as likely to have negative operating margins as those without Medicaid managed care." He then read the second bulleted item under the heading "Implications" on the second page which states, "The presence of Medicaid managed care is associated with a greater likelihood of financial distress."

Mr. Hale testified that UMC has had a sordid past, suffering losses as a result of treating a great number of uninsured patients, and pointed out that it has been shown in many other states that a mandated Medicaid program creates numerous problems for a hospital such as UMC.

Other concerns regarding a mandated managed care program expressed by Mr. Hale are:

- People will have less access to care. Under the current, voluntary Medicaid health maintenance organization (HMO) program, there is also a fee-for-service component, consisting of traditional health care providers. A mandatory program will eliminate fee-for-service providers and reduce access to care.
- The State of Nevada is not exploring other ways to capture federal dollars. If the state proceeds with a mandated Medicaid managed care program, it will be difficult to go forward with a "medically needy" program in the future.

Mr. Hale claims there have been significant changes in the Medicaid population and circumstances regarding the population since health care legislation was passed by the Nevada Legislature in 1993, 1995, and 1997. He gave the following reasons to maintain the current health care system:

- Welfare caseloads are down.
- Quality of care will not necessarily be enhanced by a mandatory managed care program.
- A fee-for-service system allows freedom of choice.

- Patients whose financial status changes repeatedly would not have continuity of care under a Medicaid managed care program.

In conclusion, Mr. Hale again urged the committee to recommend further discussion before implementing a program that could possibly irreparably damage the safety net providers.

After hearing Mr. Hale's testimony, Assemblywoman Buckley readdressed the issue of the committee's authority to eliminate or significantly change the mandatory Medicaid managed care plan. She respectfully disagreed with the Chairman's earlier statement that the committee does not have jurisdiction to both consider whether to proceed with Medicaid mandatory managed care or to change or amend the plan, even if the contract has been drafted. In support of her position, she referenced Section 85, paragraph 2, of S.B. 427, which states, among other things, that the Legislative Committee on Health Care shall establish the manner: (1) of carrying out the purposes of the Medicaid managed care program; and (2) for determining the scope of services provided by the Medicaid managed care program. She said the bill also states that the Division shall not revise a managed care program until the Legislative Committee on Health Care has approved the revision.

Ms. Buckley reported that the money committees considered the issue of mandatory Medicaid managed care and projected an October 1, 1998, starting date, but they never reviewed a plan or program because it had not yet been drafted. In Ms. Buckley's opinion, if the assumptions are changing, it is mandatory under the terms of the statute for the committee to discuss and vote on those changes.

The Chairman emphasized that the entire Legislature has debated this issue, voted on it, and made its position known. He further clarified that to protect its interest in this issue, the Legislature requires approval by the Legislative Committee on Health Care for any variation in the legislation, such as deciding not to have a managed care program. In the Chairman's opinion, it is inappropriate for a committee of five members to overrule the Legislature. He does concur, however, that the issue should be studied and debated further, and perhaps be addressed again by the 1999 Legislature.

Ms. Crawford corrected an earlier statement by saying the DHR temporarily withdrew its contract and bid, not because of the projected 1 to 3 percentage savings of the mandatory managed care program, of which DHR was aware, but because the United States Congress was considering a block granting of Medicaid nationally. She continued that the level of block granting that would have been awarded to Nevada was lower than the projected DHR budget and would not have covered the cost of the mandatory managed care program.

Ms. Buckley concurred with the Chairman's remark that an interim committee cannot override the will of the entire Legislature. It was her understanding that the money committees expressed their will that the managed care program begin October 1, 1998, and the administration has asserted it will carry out the Legislature's will. However, the plan itself was never submitted to the money committees. She opined it would not be the money committees' intention nor the entire Legislature's intention to allow the administration to submit this plan without any legislative oversight. Therefore, in reviewing the plan, if the committee is of the opinion that there is reason to study it further before implementing a "drastic" step, the committee has the ability to do so.

Chairman Rawson pointed out that the budget is $8.2 billion per biennium, and it is the Executive Branch's option to implement the budget once it has been approved. He stated the committee's oversights are fairly simple and non directive. He expressed his willingness to work with the committee to discuss the plan. He reiterated his opinion it would be improper to "vote out" the Medicaid managed care plan altogether, because the decision to implement such a plan has been made.

Assemblyman Close recalled two legislative sessions in which the managed care plan was debated. As a member of the money committees, his opinion is that they were looking for a way to save the state a large volume of money that was being expended without having some control over it. He stated he still supports that concept, but his concern at this point is the small number of bidders for the project which will limit access of Medicaid patients to fewer types of services. Mr. Close maintained he would still like to see the program implemented, but not at the sacrifice of some of the providers who would like to participate, such as UMC.

Responding to Chairman Rawson's inquiry as to whether UMC is eliminated at this point from participating in the plan,

Mr. Thompson stated that:

- UMC has been working closely with the Division of Insurance, Nevada's Department of Business and Industry, to secure a vehicle that would enable them to operate as a managed care provider.
- The impact on UMC is that of approximately $55 million in Medicaid revenues it receives, about $14.5 million is disproportionate share revenue, with $40.5 million from service revenues.
- Only about $10.5 million would be affected by the proposed managed care plan.

Alice Molasky-Arman, Commissioner of Insurance, remarked the Division has been working with Mr. Hale on standards that would be required in the event that a plan were proposed for UMC to partner with an indemnity insurer. Conditions that must be met under such a plan are:

- The insurer must be licensed.
- The entire risk must be transferred to the insurer.
- The administrator for the program must be licensed and a resident of Nevada.

To Ms. Molasky-Arman's knowledge, such a plan has not yet been developed by UMC. She added the proposals the Division of Insurance has received have been in relation to the Children's Health Insurance Program, and not necessarily to Medicaid; however, that could be incorporated within the same type of plan.

Chairman Rawson pointed out that the projected savings are relatively modest at approximately $3 million per year, but noted that amount would pay for health insurance for 3,000 additional children. He emphasized that the will of the committee is that UMC and other essential providers not be taken out of the process or harmed financially.

Mr. Hale affirmed that UMC has been working diligently with the Division of Insurance regarding an indemnity program for the Nevada Check-Up program. However, he stated UMC has been unable to find an insurer willing to accept the risk and go forward with that program, and it does not appear viable at this point for UMC to proceed.

Additionally, Mr. Hale observed that Mr. Thompson's numbers were close to his own. Mr. Hale showed approximately $12 million out of the TANF population per year. He continued that historically other states have shown that as much as 50 percent of that population is moved from essential or safety net providers to other providers. His estimation is the impact would be as much as $6 million of lost revenues to UMC.

Responding to the Chairman's inquiry as to whether insurance regulations would allow the committee to take the position of steering patients to certain hospitals, Ms. Molasky-Arman opined that probably could not be done if any risks were being transferred. A possibility she did mention is the federal legislation with respect to Medicare and the establishment of provider service organizations (PSOs). She noted this program option has not yet been implemented, but suggested that it could be broadened by the state for this type of program. She added that it would require some type of legislation or regulation because currently the PSO concept applies only to the Medicare + Choice Program (Title XVIII of the Social Security Act).

C. Edwin Fend (identified on page 1) expressed his opinion that the focus of the discussion should be moved from delaying commencement of the program to implementing a quality program for Nevada residents, and then making necessary changes after discovering what problems arise.

Ms. Crawford reminded the committee of the October 1, 1998, budget implementation deadline. She stressed the fact the committee still had to work with money committees and advise them if the committee would be unable to meet its budget obligation, which is a strong possibility if discussion of the plan is deferred any further. Other concerns Ms. Crawford expressed in delaying an implementation decision are:

- Significant changes in direction will have a fiscal impact that will require further actuarial analysis.

- If action is not taken soon, a mandatory program may not be implemented.
- The focus on a 1 to 3 percent savings, which is significant, is still not the primary issue.
- The primary issue is the affected population consists of 75 percent children who need quality care.

Contrary to Mr. Hale's comments, Ms. Crawford is of the opinion that the ability to increase access and quality does exist. She maintains that good, contracted managed care that is well monitored is showing a payoff in access and in quality, whereas in a fee-for-service system:

- Access cannot be assured; and
- Quality and continuity cannot be addressed since there is no way to track them.

Elizabeth Gilbertson (identified on page 2) mentioned the value of having access to data collected from the voluntary managed care program in analyzing the requirements of the mandatory managed care program.

Senator Washington concurred with Ms. Gilbertson's comment regarding gaining valuable information by studying data from the voluntary program.

Chairman Rawson agreed to place discussion of available data from the voluntary program on the committee's next agenda.

Fred Hillerby (identified on page 1) reminded the committee that from a comparative standpoint, the data will only represent managed care as it was at one time and as it will be six months from now, because it can never be compared to the fee-for-service system since there is no data required for that system.

Marie H. Soldo, Sierra Health Services, Inc., maintained that the managed care system offers far more access to providers in the community than have ever been offered by the fee-for-service system. Additionally, she pointed out that the level of quality standards required by the mandatory managed care health program and the children's Check-Up program are higher than those existing in the fee-for-service system. She referenced Section VII of *Request for Contract — Health Maintenance Organization for Medicaid Managed Care — Contract No. RFC NM 98-001*, which pertains to specific requirements that the managed care organizations (MCOs) meet on an ongoing basis.

Dr. Yacenda said he envisions three principle tracts: (1) the Legislative/Executive Branches; (2) the providers; and (3) the beneficiaries. According to Dr. Yacenda, the committee should focus on the beneficiary tract. He said the questions the committee needs answered regarding beneficiaries are:

- How do these individuals access care? Is it through an emergency room, the hospital entrance, a private physician or a central community provider, which in Nevada is mainly federally-qualified health centers (FQHCs)?
- What is this population's longevity under Medicaid? How often do they stay enrolled in Medicaid and how often do they switch? If children are enrolled early and leave the managed care setting, causing follow up on early detection of diseases to be truncated due to leaving the protected environment and entering another environment, there may be some issues to address.
- What is the level of patient satisfaction with voluntary Medicaid managed care?
- What is the level of service the providers are giving? A provider who serves 2 percent Medicaid recipients of its total patient population probably has negligible impact from a change, whereas a facility such as UMC would have a significant impact, as would a community health center with a large Medicaid population.

Larry Matheis (identified on page 1) maintained the committee has not fully addressed how the State of Nevada should deal with the medical needs of low-income people. He stated there is information which needs to be assembled and presented to clearly show whether or not the "experiment" of managed care is working. He proposed asking the

following questions:

- If it is working, can it work better?
- If it is not working, can it be changed to work?
- If it is not working, does it have to be abandoned and another approach followed?

Mr. Matheis opined there is little tangible information regarding success of the program. He suggested when making a decision in terms of what to advise the 1999 Legislative Session, the committee invoke the authority to retain an independent consultant who could:

- Address the information and experience within Nevada;
- Review the experience with managed care in Medicaid in other states;
- Develop a new information data base; and
- Provide a full report of the intricacies of a managed care program in Nevada.

The committee could then decide where to proceed, according to Mr. Matheis.

Mr. Thompson made the following points regarding data on the savings of a managed care program versus the fee-for-service system:

- DHR provided information which showed a savings of approximately 3.75 percent.
- A subsequent actuarial review of the data indicated that the savings is just under 3 percent.
- This information is preliminary. When dealing with Medicaid data, there was a period of time when the number of people kept increasing, and it was difficult to tell whether there was a different, higher risk population in the voluntary program as opposed to the fee-for-service program.

Continuing Mr. Thompson pointed out the clear indication from the Legislature's Interim Finance Committee (IFC), starting in April with the voluntary program, was that the voluntary managed care program was a temporary step. In conclusion, he expressed his opinion that the managed care program should move forward.

Pastor Willie Davis of Las Vegas testified that he works with several groups in his community who are concerned about steps taken by the Legislature regarding health care. He remarked that he is confused by the rhetoric, and would like to see committees formed to gather information and statistics to aid the committee in making a better decision. He expressed his hope that UMC will be able to participate in the managed care program in terms of funding because UMC provides care to most members of Pastor Davis's community due to the high number of uninsured and unemployed persons in that community. He referenced a letter from The Las Vegas Interfaith Council for Worker Justice, dated May 1, 1998 (see Exhibit D), which he requested be made a part of the record.

The Chairman announced postponement of the work session scheduled for May 29, 1998, due to concerns raised at this meeting.

Dr. James Kinard

Dr. James Kinard, representing the Nevada Dental Association (Association), announced the Association had identified a licensed insurer, Delta Dental, that is willing to insure the Nevada Check-Up population. He said Delta Dental:

- Is experienced in administering dental benefits;
- Would charge a rate of under the $12.50 limit set by the contract;

- Already has commercial programs for approximately 65 percent of the licensed dentists in the State of Nevada; and

- Would accept all licensed dentists under the Nevada Check-Up program, giving eligible children the broadest possible access to care.

Dr. Kinard introduced his associates from Delta Dental: Tom Burton, Director of Operations, and Chuck LaMont, Associate General Counsel.

In response to the Chairman's questions regarding further details of the plan, Dr. Kinard remarked:

- He provided a fee schedule to Mr. Thompson that includes comprehensive dental care.

- The plan provides for two child dental cleanings per year.

- If there were reserves, there would probably be an expansion in coverage of dental benefits.

Responding to Dr. Yacenda's concern regarding the $1,000 cap per year, Mr. Burton concurred the program is showing an annual maximum benefit of $1,000 per child. In Mr. Burton's opinion, the effect of that cap should be negligible because it is anticipated the plan will primarily be used for preventative and simple restorative work, and it is unlikely that amount would be exceeded.

In response to Chairman Rawson's observation that there will be some children with problems such as cleft pallet, baby bottle syndrome, etcetera, that will exceed $1,000, Mr. Burton assured the Chairman he would work with the Association to set up a group to review those cases on a timely basis to ensure that procedures that are medically necessary are covered.

Regarding the concern raised by Dr. Yacenda that the basis of charge be determined up front in establishing the $1,000 cap, Mr. Burton explained the dentists with whom the Association has reached an agreement will be approached and solicited for an addendum to that agreement, and there would be a specific fee schedule for those procedures. All dentists in the state will have the opportunity to either accept or reject the addendum.

Dr. Barry Stull

Dr. Barry Stull of Las Vegas stated American Insurance Company of New York (American) has developed a specific program for the Nevada Check-Up plan. Some of the specifics of this plan are:

- The reimbursement schedules lean toward infection, pain, and prevention, with the caveat the plan could be designed any way the plan administrators liked, after seeing where the payments are being made.

- American is a licensed company in the State of Nevada.

- The plan would be fully insured.

- All financial responsibilities would belong to American.

Dr. Stull further commented that like Delta Dental, the American plan:

- Does not require dentists to join a panel; it is open to every licensed dentist in the State;

- Ensures accessibility; and

- Bases the reimbursement schedule on the $12.50 per month per child rate.

Dr. Stull added American Group Administrators is a licensed third-party administrator in Nevada that would administer

the program in a Las Vegas office. He emphasized the program can be altered in any way the State sees fit as far as reimbursements are concerned.

Chairman Rawson noted there have been two plans presented, both within the required parameters. He said the committee will ask the State to develop appropriate guidelines for competition between the two plans, and it will now become an Executive Branch decision.

UPDATE CONCERNING ROBERT WOOD JOHNSON FOUNDATION GRANT APPLICATION FOR "COVERING KIDS"

John Yacenda

John Yacenda, MPH, Ph.D., Executive Director, Great Basin Primary Care Association, referenced a handout titled "Nevada's 'Covering Our Kids' Application" (see Exhibit E), which contains abbreviated parts of the full grant application. The information contained in the handout will give the committee an idea of what is included in the application, as well as the project summary, objectives, and a statement of the project assessment.

Dr. Yacenda commented that many people have worked hard to draft this grant application which seeks funding to employ staff in the local communities, and at the county and state levels, to champion efforts in local areas and coordinate the activities involved in establishing a health care plan for the children of Nevada. He mentioned an eventual goal of building a coalition in rural Nevada so that it too can address the needs of the rural areas.

Concluding his remarks, Dr. Yacenda spoke of establishing an evaluation task force, to be chaired by the State Demographer, Dr. Dean Judson, and co-chaired by Dr. Mary Patterson of the University of Nevada School of Medicine in Las Vegas.

Ms. Crawford thanked Dr. Yacenda for his work in the application process. She also expressed the administration's commitment to insuring as many uninsured children in Nevada as possible.

PRESENTATION, DISCUSSION, AND RECOMMENDATIONS REGARDING *NEVADA ADMINISTRATIVE CODE* (NAC) 632.192 AND 632.193, AS AMENDED BY LEGISLATIVE COUNSEL BUREAU FILE NO. R139-97, "ADOPTED REGULATION OF THE STATE BOARD OF NURSING WHICH REVISES PROVISIONS GOVERNING RENEWAL OF CERTIFICATE TO PRACTICE AS NURSING ASSISTANT"

John Busse

John Busse, Executive Director, Home Health Care Association of Nevada, confirmed the Chairman's understanding that the subject regulations have already been filed and are in effect.

Chairman Rawson iterated that the committee did not have an opportunity to review the regulations and has been requested to evaluate them. He stated since the regulations are already in effect, the committee cannot stop that action, but could address the possibility of requesting a bill draft or making a recommendation to the 1999 Legislative Session.

Mr. Busse expressed his appreciation for any action the committee may take on behalf of his association. He recapped the letter he submitted to the Legislative Health Care Committee, dated April 23, 1998, "Re: Certified Nurse Assistant Regulations Requiring 400 hours of Work" (see item 1 of Exhibit F). Mr. Busse also read another letter dated May 4, 1998, addressed to Legislative Healthcare Committee, "Re: 400-Hour Documented Work Requirements for Renewal of CNA License" (see item 2 of Exhibit F).

Mr. Busse mentioned another item of interest, which was a notice he received regarding a State Board of Nursing hearing before the Legislative Commission. He said the notice provided an information sheet which stated the results of the public hearing, noting 14 persons were in attendance excluding the board, its staff and attorneys, and that no persons spoke in opposition to the regulatory change. Mr. Busse maintained that "definitely" was not correct.

Mr. Busse emphasized that there is a "major" problem in communication and cooperation with the State Board of Nursing (Board). In his opinion, when a person's request is denied, he should receive a rationale for rejection of that request. He said that was not provided. When Mr. Busse requested meeting minutes, he was directed to the Board's website, where there were no minutes. He stated he has also not received meeting notices, and when he requested such notices, was directed to the website, where there were no meeting notices.

Continuing, Mr. Busse stated he was unaware of a problem until he learned through the LCB that the Certified Nursing Assistant (CNA) regulations requiring 400 hours of work had already been filed, but he was hopeful that adoption of the CNA regulations could perhaps be reconsidered.

Expressing his concern, Mr. Close remarked that he had attended several hearings dealing with this subject at which it was vehemently opposed by people licensed by the Board. He said the lack of communication between the licensees, the industry the Board espouses to represent, is troubling. Mr. Close recommended the committee take action to reevaluate the regulations that were opposed by so many individuals.

Chairman Rawson suggested the committee submit a letter to the State Board of Nursing asking it to reconsider this issue because of the lack of communication and criticism of the CNA regulations. He added if the board declined, the committee could request a bill draft to address this topic before the 1999 Legislature.

Senator Mathews recommended that a representative of the State Board of Nursing be asked to appear before the committee and explain the alleged lack of communication the board has demonstrated with its licensees.

Mrs. Freeman mentioned this was not the first time she has received complaints about the State Board of Nursing. She requested that staff provide the committee with a list of board members, their terms of office, when they will be reappointed, and their affiliation.

Chairman Rawson called for a motion to submit a letter to the State Board of Nursing requesting improvement in its communication methods and a response to the committee.

> SENATOR MATHEWS MOVED TO SUBMIT A LETTER TO THE STATE BOARD OF NURSING REQUESTING THAT IT IMPROVE ITS COMMUNICATION METHODS WITH ITS LICENSEES AND PROVIDE A RESPONSE TO THE LEGISLATIVE COMMITTEE ON HEALTH CARE. ASSEMBLYWOMAN FREEMAN SECONDED THE MOTION, WHICH CARRIED UNANIMOUSLY.

PUBLIC TESTIMONY

Diana Streuber

Diana Streuber, a Licensed Practical Nurse, UMC, Las Vegas, read her testimony from a document titled, "Testimony of Diana Streuber" (see Exhibit G). Her position is in opposition to the State Board of Nursing's new "Essential Eligibility Requirements."

Jeanette K. Belz, President and Chief Executive Officer, Nevada Association of Hospitals and Health Systems, clarified that her association has always supported the role of the State Board of Nursing and its mission as a professional licensing board to protect the public and patients. However, she said neither the association as a collective unit, nor its members individually, have been involved in the recent activities relating to the board's discussions to incorporate provisions of the Americans with Disabilities Act of 1990 or the delegation of tasks in Nevada's regulatory language. She maintained their presence has only been to monitor the activities of the board as they may impact the operations of

their member facilities, since one of the organization's functions is to keep the members apprised of health care related events as they happen.

DISCUSSION OF TOPICS FOR CONSIDERATION AT FUTURE MEETINGS

AND

DIRECTIONS TO STAFF

Jon L. Sasser

Jon L. Sasser, Washoe Legal Services, requested clarification regarding future agenda topics. He referenced a letter to Ms. McDade regarding integration of Medicaid with the Nevada Check-Up program around the assets test and the types of things which could be done without legislation, and wondered when those issues would be addressed, as well.

Chairman Rawson stated that the agenda for the May 29, 1998, meeting will focus on managed care and mandatory managed care issues. He explained that those items need to be addressed quickly, so that the DHR may proceed. He added the DHR needs to be given notice to be prepared for further discussion and possible modification or amendment. Responding to Mr. Sasser, the Chairman stated that the issues Mr. Sasser has raised could be an action item on the May 29, 1998, agenda.

Ms. Buckley mentioned it was her understanding that the Federal Government had given the DHR some feedback regarding the application for the Nevada Check-Up program. She requested the Chairman to direct Mr. Thompson to distribute copies of that letter to members of the committee.

Mr. Thompson agreed to distribute the letter as soon as he receives the official copy from Washington, D.C.

ADJOURNMENT

There being no further committee business, the Chairman adjourned the meeting at 12:30 p.m.

Respectfully submitted,

Jo Greenslate

Research Secretary

APPROVED:

_____

Senator Raymond D. Rawson, Chairman

_____

Date

LIST OF EXHIBITS

Exhibit A, provided by Marla L. McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, contains the following items:

1. A presentation titled "Report Concerning Essential Community Providers for the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200)," which was provided by the Research Division, Legislative Counsel Bureau, and dated May 4, 1998.

2. A report titled "Essential Community Provider Participation, Risk-Based Contracting," which was prepared by the National Academy for State Health Policy, and dated January 1997.

3. A blue, bound packet containing the original responses to a questionnaire mailed on April 16, 1998.

4. A green, bound document titled "Summary of Questionnaire Responses."

Exhibit B is a letter from William R. Hale, Chief Executive Officer, University Medical Center (UMC), addressed to Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care, dated April 22, 1998.

Exhibit C, provided by Mr. Hale, contains the following items:

1. A Fact Sheet titled "Public COTH Member Hospitals are at Financial Risk," prepared by the Association of American Medical Colleges, Volume 2, Number 4, dated March 31, 1998.

2. A letter from William R. Hale, Chief Executive Officer, University Medical Center (UMC), addressed to Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care, dated April 22, 1998.

3. An article from *Hospitals & Health Networks* titled "Medicaid: States Serve up a Real Turkey," dated November 20, 1997.

Exhibit D is a letter from The Las Vegas Interfaith Council for Worker Justice, addressed to Interim Legislative Committee on Health Care Issues, presented by Pastor Willie Davis, and dated May 1, 1998. The letter includes an attachment which is an article from *Clark County Medical Society*, titled "Physicians Must Defend Healing Art of Nursing," by Mitch Keamy, M.D.

Exhibit E is a document titled "Nevada's 'Covering Our Kids' Application," presented by John Yacenda, MPH, Ph.D., Executive Director, Great Basin Primary Care Association, and consisting of the application's Table of Contents, a Project Summary, a chart showing Nevada's "Covering Our Kids" Coalitions, and a paper titled "Project Objectives, Strategies, and Expected Outcomes."

Exhibit F, provided by John Busse, Executive Director, Home Health Care Association of Nevada, contains the following items:

1. A cover memorandum from John D. Busse, Executive Director, to Marla McDade, Legislative Counsel Bureau, dated April 23, 1998, "Re: 400 Hours Work Documented Requirements for CNA's."

2. A letter to Senator Raymond D. Rawson, Chairman, and Members of the Legislative Health Care Committee, dated April 23, 1998, "Re: Certified Nurse Assistant Regulations Requiring 400 hours of Work."

3. A bulletin from the Nevada State Board of Nursing, titled "Important CNA Update," dated December 15, 1997.

4. A letter from Wanda F. Paisano, R.N., Director of Professional Services, Home Health Services of Nevada, addressed to Kathy Apple, R.N., M.S., Executive Director, Nevada State Board of Nursing, dated January 7, 1998, "Re: Employment Hours Requirement for CNA's."

5. A letter from Ruth Jagodzinski, R.N., President, Home Health Care Association of Nevada, addressed to Kathy

Apple, R.N., M.S., Executive Director, Nevada State Board of Nursing, dated September 26, 1997.

6. A letter from John Busse addressed to Mr. Chairman, Ladies and Gentlemen of the Committee, dated May 4, 1998, "Re: 400-Hour Documented Work Requirements for Renewal of CNA License."

Exhibit G is a presentation titled "Testimony of Diana Streuber Before the Legislative Committee on Health Care Issues, Grant Sawyer Building, 555 East Washington Avenue, Las Vegas, Nevada," dated Monday 4, 1998, and information supporting testimony by Diana Streuber, SEIU Local 1107.

Exhibit H is a presentation titled "Testimony: Legislative Committee on Health Care, Monday, May 4, 1998, Carson City, Nevada," which was prepared by Certified Nurse Aides (CNAs) and provided for the record but not presented at the meeting.

Exhibit I is a presentation titled "Testimony — Legislative Committee on Health Care," prepared by Home Health Services of Nevada. This item was provided for the record, but not presented at the meeting.

Exhibit J 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.