MINUTES OF THE MEETING

OF THE

LEGISLATIVE COMMITTEE ON HEALTH CARE

(*Nevada Revised Statutes* 439B.200)

April 6, 1998

Las Vegas, Nevada

The seventh meeting of the Nevada Legislature's Committee on Health Care for the 1997-1998 interim was held on Monday, April 6, 1998, at 8 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, 4, and 5 contain the "Meeting Notice and Agenda."

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Raymond D. Rawson, Chairman

Senator Maurice E. Washington

Assemblywoman Barbara E. Buckley

Assemblyman Jack D. Close

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Assemblywoman Vivian L. Freeman, Vice Chairman

Senator Bernice Mathews

OTHER LEGISLATORS PRESENT:

Senator Bill R. O'Donnell

Senator John (Jack) B. Regan

Assemblyman Joseph E. Dini, Jr.

Assemblyman Dario Herrera

OTHERS PRESENT:

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.

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

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

Elizabeth Gilbertson, Southwestern Regional Director, HEREIU Fund

Fred Hillerby, Hillerby & Associates

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

Ruth Mills, Nevada Health Care Reform Project

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

Jon L. Sasser, Washoe Legal Services

Robert A. Ostrovsky, President, Ostrovsky & Associates

Carla Sloan, Administrator, Aging Services Division, Department of Human Resources (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

Bill Welch, President, Nevada Rural Hospital Project

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

Association

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 Lang, Principal Deputy Legislative Counsel

Leslie Hamner, Deputy Legislative Counsel

Steve Abba, Senior Program Analyst

Ricka Benum, Senior Research Secretary

MEETING NOTICE AND AGENDA

Name of Organization: Legislative Committee on Health Care

(Nevada Revised Statutes 439B.200)

Date and Time of Meeting: Monday, April 6, 1998

8 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 from February 2, 1998, Meeting

III. Presentation Concerning Labeling for Prescription Drugs

Leslie Ortega, Steroid Warning Network, Las Vegas, Nevada

IV. Information Presented on Behalf of the State Diabetes Control Project

A. Presentation Regarding Burden of Diabetes in State of Nevada

Randall Todd, Ph.D., Chief, Bureau of Disease Control and Intervention Services, State Epidemiologist, Health Division, Nevada's Department of Human Resources (DHR)

B. Past Legislation and Outstanding Legislative Issues

Assemblyman Joseph E. Dini, Jr.

Assemblyman Dario Herrera

C. Report from the Nevada Diabetes Council

David Govaker, M.D., Chairman

D. Presentation from the African-American Diabetes Support Group

Dorothye Boswell, Organizer

1. Summary and Concluding Remarks

David Govaker, M.D.

*V. Presentation of Proposal for Establishment of Pediatric Endocrinologist Program in Nevada

David Donaldson, M.D., Department of Pediatrics, University of Nevada

School of Medicine

*VI. Presentation of Proposal for Dental Services in Managed Care Programs Administered by DHR

J. Gordon Kinard, D.D.S., Nevada Dental Association

*VII. Discussion of Temporary Licensure for Physical Therapists

*VIII. Presentation Concerning Mandatory Medicaid Managed Care Program

Charlotte Crawford, Director, DHR

Christopher Thompson, Administrator, Division of Health Care Financing and

Policy, DHR

A. Update Concerning Progress

B. Discussion of Request for Contract for Services of Health Maintenance Organizations and Managed Care Organizations

*IX. Update Regarding Nevada Check-Up

Christopher Thompson, Administrator, Division of Health Care Financing and

Policy, DHR

A. Discussion of Request for Contract for Services of Health Maintenance Organizations and Managed Care Organizations

B. Discussion of Outreach Efforts

*X. Presentation Concerning Eligibility Determinations for Certain State-Administered Health Programs

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

Myla C. Florence, Administrator, Welfare Division, DHR

*XI. Presentation Regarding Outreach Issues for Medicaid and Nevada Check-Up Program and Update Concerning Robert Wood Johnson Foundation Grant Application for "Covering Kids"

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

*XII. Discussion of Role of University Medical Center in a Managed Care Environment

William R. Hale, Chief Executive Officer

*XIII. Discussion of Requests for Proposal for Consultant Services

*XIV. Status Report Regarding Study of Uninsured in Nevada

*XV. Directions to Staff

*XVI. Discussion of Items for Future Meetings

XVII. Public Testimony

XVIII. Adjournment

*Denotes items on which the committee may take action.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, Capitol Complex, Carson City, Nevada 89701-4747, or call Ricka Benum, 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 Rawson called the meeting to order and roll was taken by the secretary.

The Chairman reminded the committee of the upcoming work session, scheduled for May 29, 1998. He requested that all recommendations be submitted by the May 4, 1998, meeting to allow for any necessary discussion and review.

APPROVAL OF MINUTES FROM FEBRUARY 2, 1998, MEETING

The first order of business was approval of the minutes from the committee's fifth meeting. Chairman Rawson requested a motion for approval.

ASSEMBLYMAN CLOSE MOVED FOR APPROVAL OF THE MINUTES OF THE FEBRUARY 2, 1998, MEETING OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE HELD IN LAS VEGAS, NEVADA. ASSEMBLYWOMAN BUCKLEY SECONDED THE MOTION WHICH PASSED UNANIMOUSLY.

PRESENTATION CONCERNING LABELING FOR PRESCRIPTION DRUGS

Leslie Ortega

Ms. Ortega, Steroid Warning Network, Las Vegas, spoke on steroid_related medical conditions which result from the use of prescription drugs containing steroids. The Steroid Warning Network is a nonprofit organization founded by Ms. Ortega, which provides emotional support and educational information for persons with medical problems related to steroid hypersensitivity. (Please see Exhibit A for the information provided by Ms. Ortega.) In addition, Ms. Ortega informed the committee that:

- Consumers may be prescribed steroids unknowingly, in the form of eye drops, facial creams, injections, nasal sprays, or skin ointments;
- One prescription may contain a single, or a combination of several steroid ingredients;

- Many steroid-related side effects are life-threatening and may be permanent;
- Examples of steroid-induced diseases include:

    1. Arthritis;
    2. Coronary Artery Disease;
    3. Hypertension;
    4. Myopathy (muscle disease/weakness);
    5. Open-angled Glaucoma;
    6. Osteoporosis;
    7. Premature Menopause;
    8. Secondary Diabetes Mellitus; and
    9. Skin Atrophy ("wasting away").

In addition, Ms.Ortega identified frequent problems associated with administering and prescribing steroids such as:

- Failure to inform patients of possible side effects;
- The failure of physicians to follow manufacturers' recommendations; and
- Inadequate manufacturers' and pharmacies' labeling.

Dana S. McReynolds

Mr. McReynolds, Las Vegas, relayed his near-fatal experience of steroid-induced diabetes after being administered a drug known as Prednisone. He received no warning of the potential side effects of Prednisone, which is a form of steroids, from the attending physician or the pharmacy. Mr. McReynolds indicated the only information provided with the prescription addressed "altered carbohydrate metabolism," to which he did not know the meaning. He testified he now recognizes this to mean diabetes.

Concluding, Ms. Ortega offered the following recommendations for consideration and requested that the committee:

- Encourage passage of Federal and State regulations to require manufacturers and pharmacies to specifically label products containing steroid ingredients;
- Promote pharmaceutical, physician, and public awareness of the adverse effects of prescription steroids; and
- Emphasize adherence to manufacturers' recommended precautions and testing of individual products.

Chairman Rawson indicated his intention for the committee to address the issue of labeling prescription medication during its work session. He directed staff to prepare any necessary documentation for the work session.

INFORMATION PRESENTED ON BEHALF

OF THE STATE DIABETES CONTROL PROJECT

David Govaker, M.D.

Dr. Govaker, Chairman, Nevada Diabetes Council, spoke on the recently formed organization and extended a desire to provide assistance and/or information to the committee to achieve an understanding of the effects of diabetes. He referred

to the handout prepared by the Nevada Diabetes Council (Exhibit B) and indicated the goal of the five-part presentation is to provide a factual briefing of the aspects and varying degrees of the disease.

PRESENTATION REGARDING BURDEN OF DIABETES IN STATE OF NEVADA

Randall Todd, Ph.D.

Dr. Todd, Chief, State Epidemiologist, Bureau of Disease Control and Intervention Services, Health Division, Nevada's Department of Human Resources (DHR), outlined the major classes of diabetes and offered an overview of the epidemiology and impact associated with this disease.

Diabetes was described as a group of conditions whereby there is a defect in the body's production of insulin, the inability to utilize insulin produced, or both. The result is high glucose, or sugar in the blood. There are four main types of diabetes:

1. Type 1 diabetes is also known as juvenile onset diabetes or insulin-dependent diabetes, and accounts for approximately 5 to 10 percent of cases in Nevada.

2. Type 2 diabetes is the most common category of the disease and is also known as adult or maturity onset diabetes. This type of diabetes is noninsulin dependent and accounts for 90 to 95 percent of instances of the illness.

3. The third category is gestational diabetes which develops in approximately 2 to 5 percent of pregnancies. The disease generally disappears when the pregnancy is over, although it commonly leaves a risk factor for later development of Type 2 diabetes in the mother.

4. The fourth type of diabetes, which accounts for 1 to 2 percent of cases, is termed secondary diabetes. A diabetic condition may be the consequence of factors such as certain drugs, infectious diseases, or surgery.

Dr. Todd focused his testimony on Type 2 diabetes. He stated that:

- Patients generally do not have control over the risk factors for diabetes. These factors include: (1) ethnic background; (2) family history or previous history of gestational diabetes; and (3) old age.
- Physical inactivity and obesity are factors that may contribute to the risk of diabetes that a person may control.
- African-Americans, certain Asian groups, Hispanics, and Native Americans are at an increased risk and have a higher rate of diabetes.
- Complications that result from the disease contribute to the high cost of diabetes-related illnesses. Other illnesses may include:

  1. Heart disease. The death rate is two to four times higher for diabetic patients, and they have two to four times higher risk of a stroke. Sixty to 65 percent of diabetics have high blood pressure which is an independent risk factor for heart disease and strokes;

  2. Blindness. Nationally, there are between 12,000 and 24,000 new occurrences of blindness due to diabetes;

  3. Kidney disease. Approximately 40 percent of new cases of "end-stage renal" disease are diabetic patients;

  4. Nerve damage and a decrease in sensations. Sixty to 70 percent of diabetics have some degree of nerve damage; the more serious instances resulting in amputation of the lower extremities. Fifty percent of lower extremity amputations involve diabetics; and

  5. Lower resistence to infectious diseases, such as influenza and pneumonia.

Dr. Todd told the committee that there have been problems in detailing the number of diabetics specific to Nevada. However, the estimates from the Center for Disease Control (CDC) indicated that:

- In 1994, Nevada had approximately 41,655 adults with diagnosed diabetes, and an additional 32,000 adults that had not been diagnosed (but were diabetic);

- At the same time, there were an additional 315,000 adults estimated with substantial risk factors for diabetes, 10 percent of which more than likely already had the disease and were in the undiagnosed category. The remaining number were at a high risk of developing the disease; and

- The cost estimates for 1994, provided by the CDC, included the combination of the amounts for direct medical care and indirect costs, such as lost productivity and premature mortality, totaled $567 million for Nevada.

Concluding, Dr. Todd outlined the strategy developed to reduce these associated costs in Nevada, which is to focus on the burden of diabetes by primarily addressing the complications caused by the disease. He indicated there is a need to establish complete, current, and Nevada-specific background of data to better understand the impact on the state's citizens. Also, this will allow for the monitoring of progress as changes are implemented in the care of diabetics.

Dr. Govaker emphasized that diabetes impacts more than 100,000 Nevada citizens. During the 1997 Legislative Session there was an attempt to address access to appropriate care for diabetes through Assembly Bill 477 (Chapter 214, *Statutes of Nevada*). The measure stipulates, along with other requirements, that any policy of health insurance for hospital, medical, or surgical expenses include coverage for the management and treatment of diabetes, including training for self-management of diabetes.

PAST LEGISLATION AND OUTSTANDING LEGISLATIVE ISSUES

Assemblyman Joseph E. Dini, Jr.

Mr. Dini, Assembly District No. 38, focused his comments on the active stance taken by the 1997 Nevada Legislature regarding the issue of diabetes. He provided the following information:

- In 1997, the CDC reported that the number of Americans with diabetes was at its highest level ever at 15.7 million estimated cases, or 6 percent of the population;

- The results of a study published in the journal *Diabetes Care*, February 1998, indicate that the costs of medical expenditures incurred by people with diabetes were estimated to be $77.7 billion in 1997;

- The study further indicated that, in 1997, diabetes cases expended a total of approximately $98 billion from the United States (U.S.), with direct medical costs reaching $44.1 billion; and

- Direct medical costs for inpatient care decreased from $37.2 billion to $27.5 billion, in keeping with the current trend to reduce hospital costs of all diseases. However, this reduction was offset by significant increases in nursing home and outpatient care.

Continuing, Mr. Dini commented that the elderly are most affected economically by the cost of diabetes, indicating that two-thirds of all medical expenditures are sustained by persons 65 years or older. He noted that:

- Persons with diabetes paid an average of $10,071 for health care insurance in 1997, while others paid an average of $2,699;

- Diabetes is the fourth leading cause of death by disease in the U.S. and is one of the more common diseases to affect Nevada's citizens, especially the state's aging population;

- The key points of A.B. 477 prohibit health insurance policies to be written in Nevada unless the policy includes coverage for the management, self-management, and treatment of diabetes. Providers are required to fully disclose this policy requirement to each policyholder and subscriber, and to provide the same deductible, copayment, coinsurance and other features offered to all other policyholders without exception; and

- With the technological advances in the treatment and management of many diseases occurring constantly, this legislation allows persons with diabetes the opportunity to use the information and training needed.

Mr. Dini concluded by stating that diabetes is a manageable disease that can allow the majority of those diagnosed to lead active, healthy, and normal lives. Please see Exhibit C for the complete text of Mr. Dini's comments.

Assemblyman Dario Herrera

Mr. Herrera, Assembly District No. 16, echoed the sentiments of Mr. Dini, and thanked those who recognized the importance of A.B. 477 during the 1997 Legislative Session and supported the measure.

Responding to an inquiry regarding additional coverage for uninsured senior diabetics, Mr. Herrera indicated that A.B. 477 served as the first step in resolving problems specific to persons with diabetes. During future legislative sessions it will be necessary to continue to identify appropriate solutions to address the concerns of senior citizens as well as all diabetics.

Bernard Feldman, M.D., MPH

Dr. Feldman, identified on page 2, emphasized the importance of testing children for diabetes, which was not included as a specific provision under A.B. 477. He pointed out that Type 1 diabetes begins during childhood and can also be detected during that time. Dr. Feldman stated that health insurance policies may not include coverage for diabetes testing, although insurance provisions must now cover treatment of the disease.

Larry Matheis

During the committee discussion that ensued, Mr. Matheis, identified on page 2, commented that A.B. 477 "filled a basic gap" for diabetics who are fortunate enough to have insurance by clearly defining the baseline of coverage. Further, the issues raised since the bill's passage illustrate the complexity of the system whereby multi levels of government are needed to address the problems of a single disease to coordinate action.

Additionally, Mr. Matheis stated that the passage of A.B. 477 makes it necessary for the Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services, Washington, D.C., to adopt regulations as to how the provisions will be implemented for Medicare beneficiaries. He indicated the cost implications to the Federal Government have created problems and the need to develop additional regulations. Further, he explained that the Carrier Advisory Committee, which sets policies for payment of all Medicare covered services, will also need to address the issue.

Mr. Matheis recommended that:

- Nevada's Congressional Delegation, which meets regularly with HCFA, be advised of the delayed time line of the provisions contained under A.B. 477; and

- Since provisions under A.B. 477 do not specifically address Medicaid policy, the committee ensure that Nevada Medicaid policies regarding coverage of diabetes conform to the provisions outlined under the bill.

Fred Hillerby

Mr. Hillerby, identified on page 2, clarified that the health maintenance organizations (HMOs) in Nevada do provide coverage for diabetes testing of children. He stated that it is his understanding that the Nevada Check-Up Program will also include provisions for coverage of pediatric diabetes testing.

REPORT FROM THE NEVADA DIABETES COUNCIL AND

SUMMARY AND CONCLUDING REMARKS

Dr. Govaker concluded the presentation with a description of the functions of the Nevada Diabetes Control Program, a CDC-funded program. The Diabetes Control Program established the Nevada Diabetes Council, which assists the State Health Division, DHR, to address issues related to diabetes in Nevada.

The goal of this newly formed organization is to identify methods to help diabetics in the state. To accomplish the task, four workgroups were established to address concerns and concentrate on issues particular to the assignments of each

specific group's description and focus. The individual sections include:

1. The Data Work Group, which assembles and maintains factual information related to diabetes in Nevada. The data includes estimates on the percentages relating to diabetes, statistics on migration of persons with the disease moving to Nevada, outcome on treatment methods, and continual refining of the information for accuracy.

2. The Public Education Work Group, which serves to identify specific areas and issues that the council and other related agencies should address to better educate the citizens in Nevada. These programs may include public awareness of the disease and symptoms related to diabetes.

3. A Professional Education Work Group. This subcommittee identifies areas which lack programs of ongoing education geared to persons working in medical-related fields such as nurses, nurse practitioners, physician assistants, and physicians. These ongoing educational programs ensure that the health care professionals treating persons with diabetes have the necessary facts and latest technology for proper treatment.

4. The Access To Care and Legislative Issues Work Group works with the other three sections to identify access to care issues, specific to diabetics. Also, the group assists the council in its interactions with the Legislative Committee on Health Care and addressing legislative issues pertaining to diabetes.

Robert Fischer

Mr. Fischer, President and Chief Executive Officer, Nevada Broadcasters Association, outlined his experience of being diagnosed with adult onset or Type I diabetes shortly before relocating from California to Nevada. According to Mr. Fischer, he was unsuccessful in obtaining health insurance coverage for 42 months after moving to the state and being a productive member of the Las Vegas community. He further relayed that after successfully applying for health insurance and seeking treatment from a local physician his coverage was terminated due to a preexisting condition of diabetes. The insurance company was notified by Mr. Fischer of the provisions contained under A.B. 477 and the termination of coverage was rescinded. He emphasized the effect this experience had on his life and the importance of insurance coverage for diabetics who are less fortunate.

John Yacenda, MPH, Ph.D.

Dr. Yacenda, identified on page 2, questioned whether the Nevada Diabetes Council includes representatives from the Hispanic and Native American populations. He noted that both groups have a disproportionately high rate of diabetes.

In response Dr. Govaker indicated that the council is in its formative stages and the bylaws have yet to be ratified. He noted that information regarding the specific makeup of the group will be available at a later date and indicated that there will be adequate representation.

Salli Vannucci

Ms. Vannucci, Program Manager, Diabetes Control Program, Carson City, clarified that both groups mentioned by Dr. Yacenda are represented on the Nevada Diabetes Council. She named the organizations either participating or that have been invited to participate as: (1) Hispanic Services; (2) the Indian Health Community, including four tribes from the Native American community; (3) the National Association for the Advancement of Colored People (NAACP); and (4) the National Association of Latino Americans.

Chairman Rawson suggested a letter to the U.S. Congress be prepared urging speed in implementing federal regulations. He indicated that a letter would serve the same purpose as a resolution during the 1999 Legislative Session.

PRESENTATION FROM THE AFRICAN-AMERICAN DIABETES SUPPORT GROUP

Ms. Boswell, Organizer, was unable to attend and the item was removed from the meeting schedule.

PRESENTATION OF PROPOSAL FOR ESTABLISHMENT

OF PEDIATRIC ENDOCRINOLOGIST PROGRAM IN NEVADA

David Donaldson, M.D.

Dr. Donaldson, Department of Pediatrics, University of Nevada School of Medicine (UNSOM), testified that in the capacity of a pediatric endocrinologist he cares for children with complex genetic problems as well as survivors of childhood cancer. He emphasized that Type 2 diabetes has increased in recent years and statistics indicate that the current number of cases of pediatric diabetics is at epidemic proportions.

Additional comments were provided by Dr. Donaldson. He stated that:

- An important aspect of the care of Type 2 diabetes is to identify the populations at risk and to promote good public health practices within those groups;
- Local coalitions within a community may occasionally provide diabetes screening as a service, but for the most part there is no funding in Nevada for diabetes testing for high-risk family members of persons with diabetes; and
- It is important that any form of managed care includes a degree of oversight of the quality of care that is being delivered and not just a short term focus on the financial aspects.

Dr. Donaldson suggested that Nevada mirror the concept as utilized by the Barbara Davis Diabetes Center, Denver, Colorado. (Please refer to Exhibit L.) The program involves the use of community resources and state hospital foundations which provide multidisciplinary diabetes care for adolescents and children, which includes:

1. Programs for primary prevention to identify children who are at a high risk of developing diabetes and providing them with prevention information; and

2. Secondary prevention of diabetes and associated complications.

Continuing, Dr. Donaldson stated that presently, Columbia Sunrise Hospital and University Medical Center, both of Southern Nevada, have contributed significant resources to help develop a Pediatric Diabetes and Endocrinology Program for the area. There has been little or no help from foundations or the state for this type of program. Dr. Donaldson proposed that:

- As a public health initiative, the State of Nevada provide additional resources needed for a comprehensive childhood diabetes and endocrinology program to be developed jointly at the two Southern Nevada facilities. The initiative would provide for the creation of a statewide pediatric diabetes outcome data base to promote the development of similar programs under the auspices of UNSOM and other state and community advisory boards; and
- Additional resources be allocated to fund: (1) a second pediatric endocrinologist; (2) a diabetic nurse-specialist, to coordinate preventive studies; and (3) a child psychologist or clinical social worker to teach adolescents to be responsible for their own diabetes care.

Dr. Donaldson explained that if adolescent diabetics do not develop and practice good health care, the result is commonly young adults who:

1. Require renal dialysis from kidney failure;

2 Suffer total blindness or severely impaired vision;

3. May require amputation of limbs; and

4. Lose 30-plus years of productivity over a lifetime.

In conclusion, Dr. Donaldson requested greater community, family, and state involvement to provide quality preventive diabetes care and support to adolescents and children with the disease.

Nancy Russell

Ms. Russell, Las Vegas, testified that she was diagnosed as a Type 1 diabetic at the age of 12. She supported the concept

outlined by Dr. Donaldson for preventive and, if necessary, early diabetic care. Ms. Russell attributes her good health, productivity, and high-quality life to early education and proper diabetic care.

Kent Deever

Mr. Deever, Las Vegas, outlined his family's experience since his four-year-old daughter's diabetes diagnosis. He emphasized the importance of parental knowledge regarding pediatric specialists to address the essential care that young diabetic patients require. Mr. Deever praised the "exceptional" education provided to parents of diabetic children by Dr. Donaldson, and asked the committee to carefully consider his requests for funding.

During the committee discussion, Chairman Rawson asked for clarification from Dr. Donaldson regarding several items. Dr. Donaldson explained that:

- One in 500 school-age children have been diagnosed with diabetes in Nevada;
- Approximately 400 to 500 adolescents and children under the age of 21 years of age are Type 1 diabetics in Southern Nevada;
- Northern Nevada has an estimated 100 to 200 adolescents and children diagnosed with Type 1 diabetes;
- Many of the state's younger population of diabetics are undertreated and not consulting with a pediatric endocrinologist; and
- The business of a pediatric endocrinologist is not an income-generating business. The specialized field requires an additional three years after pediatric residency training, and endocrinologists are paid less and work many more hours than other physicians.

Chairman Rawson requested the committee's support to direct a letter to the budget administrators of all Nevada counties with an appeal for the public health departments and community hospitals to take an active role in the application of funds to address the issue of pediatric care for diabetic children. He indicated his intention is to allow time for the issue to be considered for inclusion in the committee's final recommendations to the 1999 Legislature. The Chairman did not view the request as an unfunded mandate to the counties, but rather a mechanism of allowing time to draft a bill.

Mr. Close noted the need to implement an investigative process to compile accurate data related to diabetes to effectively address the issues in the 1999 Legislative Session.

Chairman Rawson stated that a letter would be directed to the county administrators asking that they support the concept to stabilize the program currently managed by Dr. Donaldson, until such time the committee takes action on the issue during its work session. The Chairman requested Dr. Donaldson to provide information on the essential elements for a similar program and to identify what necessary components will be required by the state to continue a successful pediatric endocrinology program.

Bernard H. Feldman, M.D.

Dr. Feldman, identified earlier, offered praise for the "outstanding" assistance provided by Dr. Donaldson. He created the program and set up the two endocrinology centers and without his efforts there would be no specialized care for children afflicted with diabetes. Dr. Feldman emphasized that a pediatric endocrinology program must be affiliated with the UNSOM since the community cannot support a physician in private practice. It is imperative that the medical school and the counties develop programs supported by the state to develop a diabetes program.

PRESENTATION OF PROPOSAL FOR DENTAL

SERVICES IN MANAGED CARE PROGRAMS ADMINISTERED BY DHR

J. Gordon Kinard, D.D.S.

Dr. Kinard, Past President of the Clark County Dental Society and the Nevada State Dental Association (NDA), provided the committee with an overview of the dental proposal to be included in the state's managed care program. (Please see

Exhibit D for the complete text of Dr. Kinard's remarks.) The committee was informed that:

- Eighty percent of dentists in the State of Nevada are members of the NDA;
- The NDA endorses available and easy access to dental care statewide and has implemented a program for increased access under the Nevada Check-Up Program by including care in all areas;
- There is support for equal access to dental care for all program participants with the objective of maximum oral health care for children; and
- The proposed program of the NDA will include a bonded and licensed third party administrator (TPA), patient and family education, and peer review and compliance.

In order to increase access in the rural areas, dental care should be administered from: (1) community health centers; (2) NDA member and nonmember dentists; and (3) a pediatric residency program. The suggested approach will include:

1. Priority and classification of oral conditions, identified as priority I through IV;
2. Initial oral examination;
3. Emergency dental care; and
4. Referral arrangements.

In conclusion, Dr. Kinard stated that the program offers simple access, as well as preventive and quality care that include elements of proper dental education.

During the discussion that followed there was clarification that:

- The state administrators set aside the $3 million figure for dental services under the proposed Nevada Check-Up Program. Also, that figure is consistent with the amounts allocated under the Medicaid Program in Nevada, and was agreeable with the Legislative Committee on Health Care;
- The outlined priority system was included to ensure that an established system is implemented whereby all dentists will address the oral health problems of participating children in a consistent manner. The system will also provide oversight for utilization and over or under treatment by the dentist; and
- The future use of dental hygienists may be possibly more accessible without the direct supervision of a dentist if the child has been examined by a dentist within a six-month period.

Dr. Kinard indicated that the goal is to have the cost of providing dentistry under the program decline and possibly raise the number of procedures that are covered. He added that the dental portion of the plan may, in the future, be successful enough to include orthodontia. Also, it was emphasized that the policy of the NDA is not to encourage higher reimbursement schedules for the participating dentists, but rather to provide more services and better oral health.

Further discussion revealed that:

- Most dentists are trained to provide some degree of treatment to disabled children;
- The UNSOM dental residency program will be hospital-based and equipped to handle any treatment situation for disabled and/or handicapped children, including general anesthesia and wheelchair accessible operating areas;
- The director of the residency program is a pedodontist and is scheduled to join UNSOM on July 5, 1998; and
- The proposal is essentially a dental managed care organization for children to be administered by the NDA and the scope of services outlined would be included under the coverage of the Nevada Check-Up Program.

Dr. Kinard indicated the proposal is in the conceptual stage and he was unclear on the specific requirements necessary for the NDA to include the plan under the Nevada Check-Up Program. He has reviewed a draft of the contractual language to be submitted to the state. However, Dr. Kinard was not clear whether the proposal would require the NDA to create a

separate entity or structure another corporate arrangement to satisfy the various state regulations. The NDA is open to either: (1) a contractual arrangement with the State of Nevada, or (2) a subcontract agreement with the MCOs associated with the Nevada Check-Up Program.

The obligation for oversight of standards of care, and compliance with the federal criteria for time frames will remain with the DHR. Negotiations are ongoing between the NDA and a TPA as to the responsibilities each is willing to assume.

Chairman Rawson asked if the committee was in agreement and would be comfortable directing that state administrators work with the NDA to go forward with the proposal to include the dental plan. He stated that the Legislative Committee on Health Care should be updated on the progress of discussions and the details of working through specific issues. The Chairman further noted it will be necessary for the NDA and the state administrators to include the MCOs in the contractual discussions.

DISCUSSION OF TEMPORARY LICENSURE FOR PHYSICAL THERAPISTS

Jeanette K. Belz

Ms. Belz, identified on page 2, submitted a letter on behalf of the Nevada Association of Hospitals and Health Systems, dated March 23, 1998, to Senator Raymond D. Rawson (Exhibit E).

Joseph D. Cracraft, M.D.

Dr. Cracraft, President of the Nevada Physical Therapy Association, reaffirmed the position of the State Board of Physical Therapy Examiners regarding the time frames involved to license applicants. During the March 9, 1998, meeting of the Legislative Committee on Health Care, several medical institutions and the Nevada Association of Hospitals expressed concerns pertaining to permanent and temporary licensure of therapists.

Three examples of temporary licensure were outlined in the letter submitted by Dr. Cracraft. (Please see Exhibit F.) He summarized that the decision of the board is consistent with the temporary licensing practices of other states, and reiterated previous testimony that in recent years there has been an increase of 100 percent in the number of states that have removed temporary licensure from their statutes. Further, the information provided reaffirmed the opinion of the Federation of the Board of Physical Therapy Examiners regarding the time frame involved to license applicants for physical therapy.

Chairman Rawson summarized that the board essentially views the instances in question as corrected and does not intend to modify its licensure procedures.

Assemblyman Close pointed out that during the previous committee meeting he requested written information from the board providing specific time frames involved to complete licensure requests of recent applicants. Indicating that he has not been provided the desired documentation to substantiate timely processing of applications and details of necessary efficiency improvements, Mr. Close requested no action be taken.

PRESENTATION CONCERNING

MANDATORY MEDICAID MANAGED CARE PROGRAM

UPDATE CONCERNING PROGRESS AND

DISCUSSION OF REQUEST FOR CONTRACT FOR SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS AND MANAGED CARE ORGANIZATIONS

Christopher Thompson

Mr. Thompson, identified on page 2, updated the committee on the current schedule for the implementation of mandatory managed care for the Medicaid Program. He referred to the draft copy of the *Request for Contract, Health Maintenance Organization* (please see Exhibit G), and noted that the final version is intended to be released by May 15, 1998, and will

include the rates for the program. It is anticipated that final bidders complete the formal agreement process by June 15, 1998, and after readiness reviews. The enrollment process will be finalized by mid-September 1998, with services to begin on October 1, 1998.

Responding to inquiries from the committee, Mr. Thompson clarified that:

- The mandatory program will include individuals receiving cash welfare assistance and low-income pregnant women and children currently receiving Medicaid benefits;
- Only the populations of Clark and Washoe Counties will be included in mandatory managed care at this time;
- The aged, disabled, and rural populations will be moved to mandatory managed care as soon as administratively possible; and
- For individuals already receiving Medicaid benefits, there will be a six-month graduated phase-in period to be included under the mandatory managed care program.

Jon Sasser

Mr. Sasser, identified on page 2, earlier, asked for procedural clarification regarding whether the committee's responsibility is to examine that the Medicaid managed care program meets certain criteria stated within the current statutes or, if under the language contained in Senate Bill 427, (Chapter 550, *Statutes of Nevada 1997*), the committee is to approve expanding the access to health care in the upcoming year. Senate Bill 427 creates the Division of Health Care Financing and Policy within the Department of Human Resources and requires the Legislative Committee on Health Care to evaluate expanding access to health care in this state. He noted that much of the criteria already outlined by statute is not reflected under the proposed contract submitted by DHR, such as expansion of eligibility and the statutory definition of "essential community providers."

Chairman Rawson indicated that it may be necessary to request an opinion from Nevada's Office of the Attorney General. However, the opinion from the Legislative Counsel is that the DHR may not proceed without the approval of the Legislative Committee on Health Care. The Chairman directed staff to review the contract to ensure that the legal requirements outlined in the legislation have been met. He requested that staff be prepared to review the requirements at the next meeting.

Responding to Assemblywoman Buckley, Mr. Thompson indicated the projected rates for mandatory managed care are still being reviewed by the actuaries and not yet available. Secondly, the projected savings with the implementation of mandatory managed care is approximately 1 to 3 percent. The program is designed to expand access and ensure that the state has sufficient primary care providers. The savings is a secondary issue.

In further response to Ms. Buckley, Mr. Thompson stated that the current per-person cost for Medicaid varies according to age groups. The estimated amounts listed below were provided by Mr. Thompson.

- The per-person cost for Medicaid for individuals from birth to 1 year of age is approximately $275 per month.
- The cost for the 1-year to 14-year-old population is between $45 and $65 per month.
- For the age group of 14 years to 18 years the cost is $80 for males and approximately $100 for females.

It was noted that the low savings projections are due to DHR maintaining aggressive utilization controls as well as an aggressive rate schedule. Mr. Thompson predicted that without managed care, continued access problems would result in an eventual increase in costs and rates.

Adair Dammann

Ms. Dammann, Political Coordinator, Nevada Service Employees Union, Service Employees International Union (SEIU) Local 1107, American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), spoke on the potential problems anticipated with the shift to mandatory managed care outlined under the draft *Request for Contract* provided by DHR. She requested that the Chairman hold comprehensive hearings specifically to investigate mandatory Medicaid

managed care for the state. According to Ms. Dammann:

- The impact on tax-financed programs will involve millions of dollars and may create a ripple effect on the health care industry statewide;
- Medical research indicates that HMOs may not be suitable to provide appropriate health care treatment to the poor population;
- Legislative history shows that problems originally associated with the cost increases that initiated the proposal were primarily focused on federally mandated enrollment and benefit expansion; and
- The provisions contained in the draft contract potentially could leave the state with 75 percent of the liability for hospital costs in excess of $50,000.

Ms. Dammann recommended careful review of several contract issues:

- Consumer protection for enrollees;
- Presumptive eligibility for both the Check-Up and Medicaid Programs; and
- Methods for preserving the role of safety net providers.

Emphasizing the impact Medicaid privatization will have on health care systems particularly in the diverse areas of the state, Ms. Dammann recommended:

- Retention of a fee-for-service system in rural areas that do not have the population necessary to support a managed care network;
- Reimbursement of the initial medical visits to health care providers for individuals that have applied for Medicaid and are later accepted; and
- Extending assistance and support to public hospitals and other essential community providers to eliminate legal obstacles hindering the formation of their own networks.

Continuing, Ms. Dammann urged the committee to examine the market characteristics specific to each region in Nevada and take appropriate measures to ensure that safety net providers remain as whole entities. Also, she encouraged the implementation of mechanisms to monitor changes brought by the new programs and require detailed data reporting from contractors to enable any necessary corrective action, should the essential community providers experience adverse effects from the programs. Please see Exhibit H for the complete text of Ms. Dammann's comments.

Katie Hughes-Appel

Ms. Hughes-Appel, Clark County employee, and Executive Board member SEIU, Local 1107, AFL-CIO, outlined her experience not only as an employee of University Medical Center (UMC) but also as the parent of a critically ill child. Ms. Hughes-Appel encouraged the committee to examine the impact of the proposal and hold additional public hearings before approving mandatory managed care for the Medicaid Program.

UPDATE REGARDING NEVADA CHECK-UP

Christopher Thompson

Mr. Thompson, identified earlier, referred to the draft contract for the Nevada Check-up Program (Exhibit I) and noted the similarities between the two contracts. He stated that the plan is considered a fully-capitated program and, therefore, simpler in terms of eligibility. Additionally, the following items contained in a draft proposal were outlined by Mr. Thompson:

- Services consist of a limited benefits package and the plan is a statewide managed care program;

Some of the federal coverage requirements, such as those regarding fair hearings, will not apply under the Nevada Check-Up Program;

- Primary coverage and health care services in the rural areas where fully capitated managed care providers are not available will be handled by essential community providers, such as rural health clinics; and

- The accelerated start-up date for the Nevada Check-Up Program is July 1, 1998, therefore, the finalization of contract terms will occur by mid-April 1998.

DISCUSSION OF OUTREACH EFFORTS

Continuing, Mr. Thompson discussed the efforts implemented to reach the eligible population for enrollment of the Nevada Check-Up Program.

- Applications have been received for enrollment of approximately 400 children with initial distribution through the county school systems;

- Hospital organizations have also been contacted by DHR staff for possible distribution of applications;

- In upcoming months DHR staff will issue public service announcements and concentrate on public interest programing to ensure that all eligible individuals will be aware of the program; and

- After July 1, 1998, DHR will investigate more targeted outreach efforts to contact eligible populations that have not yet applied.

Elena Lopez-Bowlan

Ms. Lopez-Bowlan, identified on page 2, asked whether specific outreach efforts were in place to target the Hispanic communities. Secondly, whether the DHR will implement a system of record-keeping for the minority populations enrolled in the Nevada Check-Up Program.

Mr. Thompson responded that the program application is printed in both English and Spanish. Efforts have been made to reach the Hispanic populations through the agency's community family resource centers, and that detailed information pertaining to demographics will be tracked by DHR. Also, attempts have been made to overcome any cultural and language barriers as there is concern that some amount of resistance may be encountered within the Hispanic communities for fear of discovery of undocumented aliens. Mr. Thompson added that it is important to make it known that eligibility is determined by the income of the family and citizenship status of the child.

Responding to questions from Mrs. Freeman, Mr. Thompson explained that:

- The total amount budgeted for the administrative costs of the Nevada Check-Up Program is $600,000, with more than 50 percent allocated for the combined areas of eligibility, enrollment and outreach efforts;

- The Division of Health Care Financing and Policy, DHR, has several staff members with limited multilingual skills. One newly-contracted staff person is fluent in Spanish and is assigned to direct inquiries that come through the toll-free line;

- The Health Insurance Portability and Accountability Act (HIPAA) permits individuals to continue to receive the benefit of coverage in another state providing there has been no break in coverage for more than 63 days;

- The concerns addressed pertaining to presumptive eligibility will be specific to the Medicaid Program and not the Nevada Check-Up Program; and

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) are encompassed under the benefits package of the Nevada Check-Up Program as well as all preventive care and well-baby clinics. Philosophically, the exception may be the treatment aspect since not all medical services are available, even though the benefit package is extensive.

PRESENTATION CONCERNING ELIGIBILITY

DETERMINATIONS FOR CERTAIN STATE-ADMINISTERED HEALTH PROGRAMS

Mr. Thompson continued his presentation and explained presumptive eligibility to be the process by which an individual is deemed eligible based on an initial screening by the health care provider at the time that individual requires service. Further, under the Medicaid Program he explained that:

- Individuals can be determined to be eligible for services received up to three months prior to the enrollment application. Presumptive eligibility grants protection for the health care providers and offers assurance they will receive payment for their services;
- Significant program costs and changes would be involved should Nevada's administrators decide to move to a presumptive eligibility system;
- Administrators have attempted to structure continuity of care in the Nevada Check-Up Program by continuous eligibility, but the concept is that presumptive eligibility would not serve to simplify the process; and
- For a number of years, presumptive eligibility has been available under Medicaid only for pregnant women. In 1997, the regulations were broadened to also include children covered by Medicaid.

Mr. Thompson directed the committee's attention to two memorandums provided to staff (Exhibit J) which respond to previously posed questions regarding mandatory Medicaid managed care and eligibility issues.

During the lengthy dialogue that ensued, Mr. Thompson and the committee discussed several different case scenarios of eligibility and treatment circumstances. Responding to questions from Assemblywoman Buckley, Mr. Thompson testified these charges for prenatal services will be paid to the provider as long as the individual completes the application for Medicaid within a 90-day period from the date of service.

Continuing, Mr. Thompson commented it is the function of insurance to determine any retroactive coverage. The function of the Nevada Check-Up Program is not to be a federal, or state entitlement, or a program to cover all needs regardless of status, but rather, a means of providing access to affordable insurance. The state has the obligation to use all possible means to inform parents of their ability to enroll in the children's health insurance program. However, parents who choose not to join the program and not to obtain health care insurance should realize some liability if their child becomes ill.

During the discussion pertaining to eligibility issues, concern was expressed that DHR policy should not preclude methods for eligibility disputes. Mr. Thompson reiterated that the agency will attempt in any way possible to work with applicants if eligibility is questioned. If there is a challenge as to whether the information provided by the applicants is factual, the DHR will work through its normal process and attempt to resolve any situation to confirm the accuracy of the application.

Charlotte Crawford

Ms. Crawford, identified on page 2, reiterated that the enrollment and monthly fees are mechanisms to emphasize an incentive for good health care practices for the participants. The payments involve the beneficiaries in the concept of obtaining insurance and making decisions in the process as opposed to the perception of an entitlement program.

Myla C. Florence

Ms. Florence, Administrator, Welfare Division, DHR, testified that the decision not to have the Welfare Division provide eligibility functions was due in part to: (1) the existing caseloads of the division's social workers; and (2) the possibility that anticipated changing roles of eligibility workers may have a negative impact on the already overburdened Welfare staff.

Applications will be available at Welfare Division offices, and staff will provide basic referral and resource information to individuals determined not to be eligible for the Medicaid program. However, all other functions and services will be provided through the DHR.

Bernard H. Feldman, M.D.

Dr. Feldman, identified on page 2, focused his comments on "Standards for Medical Records Keeping" contained in the *Request for Contract for Medicaid*, (please see Exhibit G, page 72) and the *Request for Contract for Nevada Check-Up*, (please see Exhibit I, page 82). Noting that the required standards are exactly the same under both proposals, Dr. Feldman

requested the following language be added:

> Every child's record must include a growth chart. Every child at the time of the visit must have weight and length taken, and charted in the child's record. For children less than 2 years of age, a head circumference must also be charted.

It was emphasized by Dr. Feldman that this information is one of the primary screening tools used by pediatricians to ensure a child is receiving adequate nutrition and does not have an underlying medical problem affecting growth.

Speaking to the contract section regarding elements of "Patient Visit Data," Dr. Feldman requested that the plan of treatment contain the addition of an assessment provided by a physician and signed by that physician.

Mr. Thompson expressed agreement and indicated that language would be added to the appropriate sections.

Donny Loux

Ms. Loux, identified on page 2, also referring to the *Request for Contract for Medicaid* (Exhibit G, page 65), requested the addition of language which would include "children with disabilities, chronic illnesses, and progressive diseases" under the section titled "Clinical Areas of Concern to be Monitored by the Provider." Ms. Loux indicated this language addition would ensure that the children that are in need are actually receiving the proper care.

DISCUSSION OF ROLE OF

UNIVERSITY MEDICAL CENTER IN A MANAGED CARE ENVIRONMENT

William R. Hale

Mr. Hale, Chief Executive Officer, UMC, commented briefly on the issue of mandatory Medicaid managed care and the potential for adverse effects on UMC.

According to Mr. Hale, it is imperative to guarantee the safety net providers in a managed care system and develop mechanisms to maintain their viability.

Assemblywoman Buckley stated that she had requested a fiscal briefing of mandatory managed care systems in other states, as well as an update of any fiscal effects from the previous interim study.

Steve Abba

Mr. Abba, Senior Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, provided information on safety net providers in mandatory managed care systems in other states. The information outlined by Mr. Abba was provided by Ms. Gretchen Endquist, currently a health care consultant.

Mr. Abba's comments focused on the following items. He indicated that:

- Since Nevada is pursuing a contract-type system, the options are limited and the state may need to include a mandatory-type requirement to protect the patient base of safety net providers;
- Any mandatory requirements will incur additional costs to the amount of services rendered under the contract; and
- There are three conceptual options for addressing the issue of safety net providers under mandatory managed care.

> 1. Under the first option, it is feasible to mandate the safety net provider role then, over time, transition the mandate out of the contract. This provides protection from the onset of the contract and through the transition period. Once this period expires, the goal is that the safety net providers have been "main-streamed" and functioning within the provider network.
>
> 2. The second option entails the establishment of monetary incentives for the provider networks, whereby the MCOs refer patients to the safety net providers. However, this option necessitates

developing a specific criterion that is closely monitored to ensure that referrals meet the requirements of the safety net providers and thereby meet the intent of the incentive. The cost of these incentives must be included in the overall capitated rate.

3. Under the third option, strong language urges negotiations with the safety net providers within the request for contract. Specific language stipulates that the contract will maintain an open referral process, which will allow the state to monitor the type and volume of referrals. Also, the request for contract would include language that will allow the state to intervene and adjust the mechanisms that offer protection to the safety net providers.

Concluding, Mr. Abba indicated that any variation of these options could be implemented.

PRESENTATION REGARDING OUTREACH ISSUES FOR MEDICAID

AND NEVADA CHECK-UP PROGRAM AND UPDATE CONCERNING ROBERT WOOD JOHNSON FOUNDATION GRANT APPLICATION FOR "COVERING KIDS"

John Yacenda, MPH, Ph.D.

Dr. Yacenda, identified on page 2, commented on the outreach strategies used initially for public awareness of the Nevada Check-Up Program. He summarized a sampling of the procedures required for applicants to enroll in the program and noted the areas that are in need of further review and possible revision. (Please see Exhibit J for the complete text of Dr. Yacenda's comments. According to Dr. Yacenda:

- The Nevada Check-Up Program may not have reached the population the plan was designed to target. It is essential that the program have a sound commitment to outreach and enrollment to effectively reach those individuals in need, educate them on available benefits, and assist them throughout the enrollment activities.
- The Nevada Check-Up applicants may be encountering barriers such as a cumbersome application process that is not client-friendly.
- The enrollment of the Nevada Check-Up Program must be geared to meet the needs of the people it is designed to serve. Therefore, it is essential that the application and enrollment process be made as easy as possible for the applicant, not for the administrators.
- The design of the outreach and maintenance of the program should be managed in a cultural and language-appropriate manner that serves to assist the participants, many of whom may never have had previous insurance.
- A coordinated outreach program needs to be designed to target non-custodial parents who are subject to medical child support court orders and do not have access to affordable employer-sponsored health insurance coverage.
- Low-income graduate and undergraduate college students with children should have equal access to the Nevada Check-Up Program.
- The program should target current low-income individuals, and tax returns from previous years should not be considered. As well, persons who are at the current eligible income should be the focus of outreach efforts.

In conclusion, Dr. Yacenda recommended:

1. Training for outreach and counter workers. Program workers should be site-based and mobile for access to community activities and settings. Involvement with the targeted population should be encouraged.

2. Implementation of: (1) culturally and language-appropriate education and informational materials; (2) radio and television advertisements; and (3) informational feeders, i.e., cash register receipts, grocery bags, grocery market bulletin boards/flyers, and milk cartons.

3. The Nevada Check-Up Program applications be pretested to uncover any barriers that applicants may encounter which may cause a reaction of resistence.

4. The enrollment processes be conducted and verified entirely at the community level. All agencies and existing programs involved in enrolling children in Medicaid should have contracts with the Division of Health Care Financing and Policy to conduct eligibility enrollment.

5. All children covered under the Women, Infants and Children USDA Special Supplemental Food Program (WIC) should automatically be enrolled in the Nevada Check-Up Program.

6. All funding resources should be coordinated into a single program that addresses the needs of the targeted low-income families and individuals.

7. Tribal-related agencies should facilitate the enrollment of Native American children. Upon qualified eligibility and an abridged-type enrollment process, Indian Health Services and tribal health clinics should be involved in the provider networks caring for these children.

Dr. Yacenda briefly commented on the Robert Wood Johnson Foundation grant program titled "Covering Kids." In Nevada, the initiative includes the combined efforts of the two most populous counties, 33 agencies and 40 individuals. The group's focus is to address the concerns and to benefit, on a statewide basis, low-income children.

During the brief discussion that ensued, it was noted that the outreach process must also involve the component of educating the targeted population.

The Chairman suggested the possibility of modeling some outreach efforts after commercial entities that successfully market a variety of products.

Charlotte Crawford

Ms. Crawford, identified previously, indicated that the application and outreach processes are portions of the program that will require several revisions to achieve appropriate and effective methods of implementation. Ms. Crawford invited input and involvement of other committee members, however, she stated that a formal design discussion of the details of the outreach portion of the Nevada Check-Up Program has not yet occurred. The Division of Health Care Financing and Policy prioritized the details of the program with the limited resources of the agency to ensure the timely start-up of the program. In the coming weeks, there will be extensive attention given to the outreach process.

A general discussion followed involving several committee members with various suggestions expressed to assist the administrators with mechanisms to extend the outreach efforts.

STATUS REPORT REGARDING STUDY OF UNINSURED IN NEVADA

Chairman Rawson announced that the questionnaires regarding the study of uninsured persons in Nevada have been mailed to two counties, and in the upcoming months the data will begin to accumulate. Although the process is behind schedule, he indicated that the study is underway.

DISCUSSION OF REQUESTS

FOR PROPOSAL FOR CONSULTANT SERVICES

The Chairman opened the meeting for discussion on the draft proposal for consultant services. Following brief comments, he indicated it is his intention not to contract for the services of an actuary. He stated that the other proposal was structured more broadly to accommodate any future review of the Nevada Check-Up Program.

PUBLIC TESTIMONY

The Chairman invited comments from members of the public attending in either Carson City or Las Vegas.

Theresa Morrow

Ms. Morrow, Las Vegas, discussed the implementation of mandatory managed care and its impact on the local funding base.

DISCUSSION OF ITEMS FOR FUTURE MEETINGS

There was earlier discussion on revising the established meeting dates of the committee. However, noting the number of conflicting schedules, Chairman Rawson stated the hearing set for May 29, 1998, in Las Vegas, would not be changed.

There being no further committee business, the Chairman adjourned the meeting at 3:10 p.m.

Respectfully submitted,

Ricka Benum

Senior Research Secretary

APPROVED BY:

_____

Senator Raymond D. Rawson, Chairman

Date: _____

LIST OF EXHIBITS

Exhibit A is material regarding the Steroid Warning Network, provided by Leslie W. Ortega.

Exhibit B is a copy of the comments of Assemblyman Joseph E. Dini, Jr., titled "Diabetes and Legislative Issues," dated April 6, 1998. The handout includes an article titled "Economic Study Highlight Enormous Burden of Diabetes," *Diabetes Forecast,* dated April 1998.

Exhibit C is an informational packet submitted by Dr. Govaker prepared by the Nevada Diabetes Council.

Exhibit D was submitted by Dr. J. Gordon Kinard and is the proposal sponsored by the Nevada Dental Association, which includes the Clark County Dental Society, Northern Nevada Dental Society, and the Northeastern Dental Society.

Exhibit E is a letter submitted by Jeanette K. Belz, President, Chief Executive Officer, Nevada Association of Hospitals and Health Systems, to Senator Raymond D. Rawson, dated March 23, 1998.

Exhibit F is a copy of a letter to Senator Raymond D. Rawson, Chair, Legislative Committee on Health Care, dated April 6, 1998, from Carolyn E. Sabo, Chair and Public Member, Nevada State Board of Physical Therapy Examiners, submitted by Dr. Joseph D. Cracraft.

Exhibit G is a document titled State of Nevada, Division of Health Care Financing and Policy, Medicaid Managed Care Program, *Request for Contract, Health Maintenance Organization*, RFC NM 98-001, Draft, dated March 18, 1998, submitted by Christopher Thompson, Administrator, Division of Health Care Financing and Policy, Department of Human Resources.

Exhibit H is a copy of the comments of Adair Dammann, Political Coordinator, Nevada Service Employees Union, Service Employees International Union (SEIU) Local 1107, American Federation of Labor-Congress of Industrial Organizations (AFL-CIO). During her testimony, Ms. Dammann cited statistics from an article contained in the *Journal of the American Medical Association*, October 2, 1996, titled "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems, Results From the Medical Outcomes Study," John E. Ware, Jr., Ph.D.; Martha S. Bayliss, MSc; William H. Rogers, Ph.D.; Mark Kosinski, MA; and Alvin R. Tarlov, M.D.

Exhibit I is a copy of the document titled State of Nevada, Division of Health Care Financing and Policy, Nevada Check-Up Program, Draft, *Request for Contract, Health Maintenance Organization and Managed Care Organization*, RFC NC 98-001, dated March 18, 1998, submitted by Christopher Thompson, Administrator, Division of Health Care Financing and Policy, Department of Human Resources.

Exhibit J is a Memorandum to Marla McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, from Chris Thompson, Administrator, Division of Health Care Financing and Policy Department, Department of Human Resources; and a second Memorandum to Marla McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, from Charlotte Crawford, Director, Department of Human Resources.

Exhibit K is a copy of the comments of John Yacenda, MPH, Ph.D., Executive Director, Great Basin Primary Care Association, dated April 6, 1998.

Exhibit L was material submitted by David Donaldson, M.D., titled "Information for Presentation of Proposal for Establishment of Pediatric Endocrinologist Program."

Exhibit M 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.