MINUTES OF THE MEETING

OF THE

LEGISLATIVE COMMITTEE ON HEALTH CARE

(*Nevada Revised Statutes* 439B.200)

February 2, 1998

Las Vegas, Nevada

The fifth meeting of the Nevada Legislature's Committee on Health Care for the 1997-1998 interim was held on Monday, February 2, 1998, at 10:10 a.m., in Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. This meeting was video conferenced to Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Pages 3 and 4 contain the "Meeting Notice and Agenda."

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Raymond D. Rawson, Chairman

Assemblywoman Vivian L. Freeman, Vice Chairman

Assemblywoman Barbara E. Buckley

Assemblyman Jack D. Close

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Bernice Mathews

COMMITTEE MEMBERS ABSENT:

Senator Maurice E. Washington

OTHER LEGISLATORS PRESENT:

Assemblyman David E. Goldwater

OTHERS PRESENT:

Marc Bennett, Chief Operating Officer, HealthInsight

John Busse, Home Health Care Association of Nevada

Winthrop Cashdollar, Executive Director, Nevada Health Care Association

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

Stacy Jennings, Nevada Association of Hospitals and Health Systems

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

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

Gary Mouden, Executive Director, Nevada Dental Association

Jon L. Sasser, Washoe Legal Services

Robert A. Ostrovsky, President, Ostrovsky & Associates

Carla Sloan, 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

Ricka Benum, Senior 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, February 2, 1998

10 a.m.

Place of Meeting: Grant Sawyer State Office Building

Room 4412A, B, and C

555 East Washington Avenue

Las Vegas, Nevada

NOTE: Revision to correct page number only.

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 by the Chairman

Senator Raymond D. Rawson

*II. Presentation Regarding Training of Pediatric Physicians in Nevada

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

*III. Dental Services for Nevada Check-Up

Gary Mouden, Executive Director, Nevada Dental Association

Dr. Dwight W. Meierhenry

Barry Stull, State Manager, American Group Administrators, Las Vegas

Lloyd Goldstein, President, American Group Administrators, Las Vegas

IV. Discussion of Children's Health Insurance Proposal for Nevada

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

Charlotte Crawford, Director, Department of Human Resources

*V. Items for Consideration in Nevada Check-Up

A. Assisting Children with Disabilities and Special Health Care Needs

B. Preventing Employers from Dropping Group Health Insurance Coverage or Reducing Benefits for Employees

C. Coordinating Nevada Check-Up with Medicaid

D. Identifying Issues Affecting Traditional Safety Net Providers

E. Identifying Impacts of Cost-Sharing on Nevada Check-Up Beneficiaries

F. Identifying Issues in the Enrollment Process

G. Identifying Provisions for Outreach and Marketing

H. Identifying Considerations for Quality Assurance

VI. Progress Report on Study of the 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, 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

The meeting was called to order by Chairman Rawson and he introduced the staff.

PRESENTATION REGARDING

TRAINING OF PEDIATRIC PHYSICIANS IN NEVADA

Dr. Bernard H. Feldman

Dr. Bernard H. Feldman, identified on page 2, provided background information that pertained to the training requirements of physicians specializing in pediatrics. During his presentation, Dr. Feldman highlighted key issues contained in the document titled, "The Education of Pediatricians in the United States." (Please refer to Exhibit A for details.) Referring to undergraduate education, he explained that:

- There are 126 American medical schools that vary in size from less than 100 students to 1,300 students.
- The University of Nevada School of Medicine has 52 students per class. Of these students, 48 must be Nevada residents.
- The first two years of study are comprised primarily of classroom and laboratory courses, such as anatomy and biology, et cetera.
- During the third year of medical school, students begin to manage patients under the supervision of faculty and senior resident students.
- The third year of medical school is also the beginning of "clerkships," or supervised clinical experiences, on both an inpatient and outpatient basis, which involve the major medical specialities including:

    1. Family medicine;
    2. Internal medicine;
    3. Obstetrics and gynecology;
    4. Pediatrics;
    5. Psychiatry; and
    6. Surgery.

- The fourth-year medical student is allowed to select "elective clinical experiences" either speciality or subspecialty in nature (i.e., anesthesiology or radiology), which provides firsthand education and information on specific areas of medicine.

Dr. Feldman provided additional information regarding graduate medical education. He explained that:

- The term "Residents" describes students in their first year out of medical school. Nationwide, there are over 20,000 first-year

resident positions, with 23 medical specialties, including family practice;

- The duration of the pediatric training program is three years. Approximately 10 percent of all medical school students choose the field of pediatrics, and there are currently 2,019 first-year pediatric positions in the country;
- The pediatric training program consists of 50 percent each, inpatient and outpatient care. Most pediatric care occurs in either a private or public clinic, or a physician's office, since only about 10 percent of pediatric patients are ever hospitalized; and
- Medical students are eligible for state licensure following state exams and after completion of the three-year program. A total amount of seven years of medical school is required for a student specializing in the field of pediatrics.

Continuing, Dr. Feldman summarized the fundamental points of postgraduate medical education for pediatric residency. He outlined the different requirements of an accreditation program and the complications associated with a residency.

- The Accreditation Council on Graduate Medical Education (ACGME), is a voluntary association which accredits postgraduates in Canada and the United States (U.S.). The council is composed of four representatives from the:

    1. American Board of Medical Specialties (ABMS);
    2. American Hospital Association (AHA);
    3. American Medical Association (AMA);
    4. Association of American Medical Colleges (AAMC); and
    5. Council of Medical Specialty Societies.

    Additional members include:

    6. One member from the Resident Physician Section of the AMA;
    7. Two members from the public sector;
    8. One non-voting member representing the Federal Government; and
    9. One non-voting member from the Residency Review Committee, Council Chair.

- The Residency Review Committee establishes the length of pediatric training and outlines the requirements. The committee includes members from the:

    1. American Board of Pediatrics (ABP);
    2. AMA Council on Medical Education; and
    3. American Academy of Pediatrics (AAP).

- The primary functions of the ABP are to track the residents in 227 accredited programs in Canada and the U.S. and to administer the certifying examinations.

Dr. Feldman described the history of the residency program since its provisional accreditation in October 1996. The first residents entered the program July 1, 1997. The current class has a total of eight pediatric residents, consisting of four first-year, two second-year, and two third-year positions. Starting July 1, 1998, the class will increase to six first-year positions, four second-year, and two third-year resident positions. The school's maximum number of resident students will be achieved with the class that begins July 1, 1999, which will have a total of 16 resident positions. He recruited two participating hospitals in southern Nevada.

Chairman Rawson questioned if Medicare regulations limit the number of students who can be accepted under the residency program.

In response, Dr. Feldman explained that:

- The salaries of all residents are paid using Medicare funds administered by the hospitals;
- Medicare developed a complex system to determine the amount each hospital is entitled for resident training;
- The hospitals administer all bookkeeping and payment of salaries; and

- Currently, the participating hospitals provide 50 percent of the total amount required for benefits and salaries of residents.

Recent regulations implemented by Medicare require that new programs reach their maximum position levels three years after inception. Therefore, by the year 2000, the UNSOM must have attained the maximum resident class level of 16 first-year positions. The number of resident pediatricians will remain the same until the Medicare regulations are changed.

Dr. Feldman commented that Medicare operates on the pretense that the country has an excess of physicians as well as an unequal distribution of medical practitioners nationwide. He said that:

- Medicare has implemented regulations that prevent growth of new medical school programs beyond the initial three-year period. Also, the regulations prevent expansion of all existing programs.

- The Federal administrators of Medicare need to be aware that Nevada is medically underserved and has the ability to train the needed number of physicians. Also, the UNSOM is able to pay its own faculty salaries by the treatment provided to patients.

Dr. Feldman addressed concerns pertaining to quality of care provided by physicians-in-training. He outlined the following topics:

- Physicians-in-training are required to be supervised by faculty members during each aspect of patient contact during their instruction.

- A long-accepted concept is that the best hospitals are also teaching facilities.

- Patients are attended to by a number of medical students each with an increased degree of training. Common examination procedures in a teaching hospital include:

    1. A visit by a medical student at which time he/she documents the patient's history and may provide an initial examination;

    2. A review of the patient's history by a "junior resident" who provides a second examination and offers an evaluation;

    3. An analysis of current treatment or therapy programs, suggestions for treatment, and changes in existing care are provided by a "senior resident"; and

    4. A review of each step completed by students, constant oversight and quality control by a faculty member who is considered to be the actual supervisor of a patient's care.

Concluding, Dr. Feldman commented that the goal of the resident program is to produce well-trained pediatricians who provide quality office care, are knowledgeable of critical illness, and recognize when hospitalization is necessary.

DISCUSSION OF CHILDREN'S HEALTH INSURANCE PROPOSAL FOR NEVADA

William R. Hale

Mr. Hale, Chief Executive Officer, University Medical Center (UMC), Las Vegas, introduced Mr. Alastuey to give his portion of the presentation.

Michael R. Alastuey

Michael R. Alastuey, Assistant County Manager, Clark County, Nevada, commended the work of the committee, the Governor's Office, and others involved in implementing the Nevada Check-Up Program and addressing the issue of the state's uninsured children. Mr. Alastuey commented on the key issues to be considered by the committee. He stated that:

- Management of a public hospital is a twofold community trust in which administrators must: (1) provide compassionate, high-quality care for all residents, regardless of their ability to pay; and (2) make responsible decisions for the best use of millions of taxpayer dollars invested to improve county facilities;

- The existing facilities of UMC and other public hospitals put them in an ideal position to provide a solid starting point for the Nevada Check-Up Program; and

- For years, public hospitals have served the needs of the uninsured population.

Mr. Alastuey offered the following recommendations for the proposed children's health insurance program:

- For purposes of continuity, patients should be considered eligible and enrolled at the time treatment is sought;
- Consider an existing provider's capacity and treatment patterns, then tailor the benefit options to local circumstances; and
- Establish enrollment fees on a level basis and as modestly as possible to promote an incentive for participation and allow for maximum capture of federal dollars.

According to Mr. Alastuey, UMC is evaluating the suggested concept that public providers become managed care organizations (MCOs). He offered the following additional comments:

- The complex and long-term project will require cooperation at several levels to eliminate specific legal obstacles in order for the county to accept the risks involved.
- To successfully adapt to the marketplace, it will be necessary for public providers to quickly evolve to become integrated delivery systems, managing comprehensive care for large numbers in a competitive environment.
- The shift of large numbers of Medicaid and Nevada Check-Up Program clients into MCOs may have an adverse impact on paying hospital patients. The alternative would be for the state to allow UMC and other public providers to develop preferred provider organization-style (PPOs) plans, rather than become fully capitated health maintenance organizations (HMOs).
- The MCO scenario is not a true level playing field for all participants. Many private MCOs that contract with UMC direct patients to other hospitals because of the commitments contained in preexisting contracts that guarantee certain numbers of patients will be directed to other hospitals. In order to stabilize the marketplace, consideration should be given to implementing adaptive mechanisms that would ease networks and public providers from their current market status through the changes being proposed.
- In order to compete, medical center-style networks will require initial access to a sufficient patient volume to achieve and maintain economies.
- To help achieve the goal of the Nevada Check-Up Program to provide health care benefits to the largest number of children, the long-term view of publicly-funded health care must involve decisions that will result in maximizing the returns of both preexisting and new investments, and include private, as well as public, networks.

Mr. Alastuey suggested that:

- The state give MCOs "bed-day-volume targets" as a transitional mechanism for safety-net hospital providers. Similar provisions are offered under private contracts and allow MCOs to manage their patient flow accordingly.
- Community clinics, MCOs, primary care and safety-net providers be included in all networks. Moving patients from fee-for-service Medicaid to MCOs restricts the patient's ability to choose providers, but the concept is the "heart" of managed care's cost-control strategy.

Concluding, Mr. Alastuey commented that the decisions made now will have a profound effect on future publicly-funded health care in Nevada. The state's decision to use MCO strategies may help maximize benefits and coverage in both the Nevada Check-Up and Medicaid programs. He added that private insurance programs can nurture and support community assets built and maintained by taxpayer investments.

Mr. Hale provided additional information, noting that:

- The majority of initial care of uninsured children is provided on an emergency room basis, and that many parents still do not seek preventive care for their children; and
- Once parents are advised of the available benefits of the Nevada Check-Up Program and educated on the advantage to methods of preventive health care, there will be an incentive to follow through with continuity of care in the primary system.

Chairman Rawson questioned the feasibility of public hospitals utilizing a classified employee to be responsible for eligibility certification under the Nevada Check-Up Program. He pointed out, however, that the goal is to move children away from emergency room and hospital visits for entry into the system, noting that it is the least cost-effective method of treatment. The ultimate goal of the program is to raise the level of care and consciousness in regard to treatment for an entire generation and it will be important to monitor any modifying behavior.

A general discussion ensued which focused on mechanisms or provisions to be included in the proposed program that would protect public hospitals in order to maintain the existing patient base. Mr. Hale suggested implementing a type of percentage system, based on the

current utilization rates from one facility to another, while taking into consideration the capacity or number of beds available at time of service.

Assemblywoman Buckley clarified the concern of Mr. Hale to be potential situations whereby a MCO with a network of several hospitals could contract with one facility for the purpose of directing a certain percentage of patients for treatment at that hospital. She emphasized a lack of support for the current trend of volume referrals, which ensures that a percentage of patients is directed to a hospital. Ms. Buckley suggested that:

- Taxpayer-funded insurance plans (i.e., Nevada Check-Up Program) not allow for use of volume-referral-type arrangements;
- The choice of hospital or treatment facility be specifically left to the patient and the attending physician; and
- The element of consumer choice be returned to the health care process.

Further, Mr. Hale told the committee that:

- All trauma cases in southern Nevada are handled at UMC, and patients considered to be "critical" are assigned to other facilities in accordance with a rotation system agreement to which all of the areas hospitals are associated;
- Physicians work well with MCOs that are involved in referral type arrangements;
- Doctors and health professionals do not separate patients according to category of insurance, rather the mind set is to care for the illness and the patient; and
- The UMC provides more than 50 percent of the uncompensated health care for the entire state, and this percentage substantiates the need to include a presumptive eligibility provision.

Mr. Hale agreed that hospital personnel could complete the initial eligibility status, with final verification to be done by the state.

Ms. Buckley expressed concern that a number of hospitals considered to be preferred providers cannot be accessed by certain patients, and she emphasized the need to bring an element of consumer choice back into the process.

Assemblyman Close inquired if UMC has received approval from the Division of Insurance, Nevada's Department of Business and Industry, to function as a PPO network and questioned if a legal opinion had been requested. Mr. Close indicated a desire for the committee to obtain a legal opinion before proceeding with further discussion.

Mr. Hale stated that UMC representatives have been meeting with both the Division of Insurance and DHR. Although the agencies have agreed to review the concept, neither has provided UMC with a determination. He stated that it is his understanding there are no legal obstacles to prevent UMC from establishing a PPO network and this was confirmed in the opinion issued by the Clark County District Attorney's Office. A concept paper is being developed and will be submitted to the Division of Insurance upon completion.

Chairman Rawson requested the Legal Division to provide the committee with an opinion to clarify whether Nevada law precludes a "not-for-profit" or public hospital from establishing, or being involved in, a PPO network in order to compete with other managed care providers.

During the committee's general discussion, certain topics were clarified by the Chairman. He summarized that:

- Implementing a program of primary case management will allow protection for UMC and other public hospitals to maintain the existing patient base.
- Federal guidelines require that determination for Medicaid eligibility be confirmed by a state employee.
- Under proposals of the Nevada Check-Up Program, the state will define the factors concerning: (1) how eligibility is to take place; and (2) who will make the determination.
- The DHR contends that in order to maintain control the state must be responsible for the eligibility function of both Medicaid and the Nevada Check-Up Program.
- There was a general consensus that the state program should: (1) implement a simplified structure in any proposed program; and (2) streamline the process of eligibility to provide more care whenever possible.
- Data from other states indicates that approximately one-quarter of persons eligible for health care programs take part through elective enrollment prior to requiring treatment. The remainder of the eligible population of uninsured people still enters the system under emergency conditions.

Bill Welch

Bill Welch, identified on page 3, outlined a few of the proposed components of the Nevada Check-Up Program he saw as potential areas of concern to rural health care providers. He primarily addressed the issue of presumptive eligibility. Mr. Welch stated that:

- In most instances, rural health care treatment is initiated prior to establishing program eligibility. Oftentimes, the health care providers assist in completing complicated forms and communicate with the appropriate entities for the patient;
- Not all MCOs are licensed to conduct business in rural areas of the state, in part because: (1) the MCOs may not currently have enrollees living in the rural areas; and (2) in the past, some MCOs have not demonstrated equitable contractual relationships with the rural providers;
- There is a possibility the state could select a MCO that does not currently have contracts with rural providers; and
- The MCOs frequently make contract changes for the purpose of including or deleting the services of a hospital or physician. Oftentimes, this requires patients to seek treatment from new providers and patients are directed to facilities out of their area.

Chairman Rawson indicated the items mentioned by Mr. Welch will be included for further discussion under Agenda Item V.

Robert A. Ostrovsky

Mr. Ostrovsky, identified on page 2, commented on the profile outlined to safeguard the UMC. He questioned whether the county would accept the risks involved for UMC to establish and operate in a capitated rate situation. He added that, his interpretation is the medical center is attempting to provide elements of managed care or preferred provider services, without becoming empowered under conditions of the law, as a HMO.

In response, Mr. Hale clarified the concept of the UMC proposal as a modified fee-for-service program, which would include premiums. He noted that the hospital, not the county, will be taking the risks, and emphasized that any type of capitated program implies an HMO and UMC is not applying for that status.

Elizabeth Gilbertson

Ms. Gilbertson, identified on page 2, favored presumptive eligibility and testified to the ongoing problems encountered in her association with participants during the enrollment process. She indicated that filling out forms as well as reading and understanding the complex material associated with health care programs seems to be a deterrent and discourages many individuals from enrolling.

PUBLIC TESTIMONY

Bobbie Gang

Ms. Gang, Incline Village, Nevada, introduced Louise Bayard-deVolo, and both ladies offered testimony on behalf of the Nevada Women's Lobby.

Louise Bayard-deVolo

Ms. Bayard-deVolo commended the expansion of services to be provided under the Nevada Check-Up Program and anticipated that allowable benefits will provide a full range of screening, diagnosis and treatment. She urged the committee to compare the range of services offered under the Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and the services recommended as basic care options suggested by the AAP, to those being considered by the committee.

Ms. Gang referred to two policy statements from the American Academy of Pediatrics entitled:

- "Guiding Principles for Managed Care Arrangements for the Health Care of Infants, Children, Adolescents, and Young Adults (RE9519)" (Please see Exhibit B); and
- "Scope of Health Care Benefits for the Health Care of Infants, Children, Adolescents and Young Adults Through Age 21." (Exhibit C contains the document in its entirety.)

Priority issues outlined by the AAP include access to appropriate primary health care providers, pediatric speciality services, treatment authorizations, quality assurance, and reimbursements or financing.

Ms. Gang requested the committee to review the essential services as outlined by the AAP (please refer to Exhibit C) that are currently not covered by the Title XXI Program and have not been discussed with regard to the Nevada Check-Up Program.

Additional items pertaining to the proposed program were addressed by Ms. Bayard-deVolo. She testified that the Nevada Women's Lobby is in favor of:

- A fee schedule that is flexible enough to allow for medical care to be delivered, even when families cannot pay the entire enrollment fee and premium amount; and
- Presumptive eligibility as a mechanism to remove barriers and promote access to medical services by the needy population and any additional costs to be built into the proposed program.

Chairman Rawson responded by assuring Ms. Gang these concerns would be addressed by the committee.

Alicia Smalley

Ms. Smalley, President Elect, Nevada Chapter, National Association of Social Workers, outlined three issues and requested they be considered and incorporated into the Nevada Check-Up Program. (Please see Exhibit D.) Ms. Smalley requested that:

- The committee recommend the continued use of social work case management services under the new state proposal. The services, as defined by Medicaid, are designed to assist with accessing needed educational, medical, social, and other services, and to provide families a connection to a variety of follow-up services and referrals;
- The provisions of the Nevada Check-Up Program not establish limits on the total amount to be covered per patient. It was noted that early intervention is used as an important mechanism in teaching children ways to address problems before they escalate. Programs that contain early intervention procedures have consistently proven to be well worth the cost; and
- The committee encourage early intervention practices be implemented by all providers.

Following a brief recess, the meeting was reconvened by the Chairman.

Assemblyman David E. Goldwater

Assemblyman Goldwater, representing Clark County Assembly District No. 10, thanked the Chairman for the opportunity to address the committee and noted his shared interest in health care concerns. He expressed disapproval of policy issues that have recently surfaced, which he perceives to be directed in one narrow and specific area—to develop the proposed children's health insurance program. His concern is that other options, such as expansion of the Medicaid Program will be set aside without consideration by the 1999 Legislature. According to Mr. Goldwater, the expansion of the existing system is a viable option and would be far easier to implement. He indicated that the additional funds were recently approved by the Federal Government for the purpose of expanding children's health insurance programs, not necessarily creating new ones.

Mr. Goldwater discussed the basis for his preference not to develop a new plan, and stated that:

- The administrative system of Medicaid is already in place and functioning smoothly;
- A comprehensive package of benefits currently exists under the Medicaid Program;
- The state will benefit from the enhanced purchasing power if the Medicaid Program is expanded; and
- Expanding the Medicaid Program will reduce the confusion that would be associated with any new program.

Concluding, Mr. Goldwater emphasized that the committee would not be precluded from considering a new health insurance program in addition to the expansion of the Medicaid Program.

Chairman Rawson pointed out that by addressing this issue during the interim, approximately 40,000 children will be receiving health care benefits almost a full year earlier than waiting until the 1999 Legislative Session. He also noted another option is to expand Medicaid and rename the entire plan, thereby creating one seamless program.

DENTAL SERVICES FOR NEVADA CHECK-UP

Gary Mouden

Mr. Mouden, identified on page 3, introduced a group of professionals that have been working to create a dental package that could be incorporated into the Nevada Check-Up Program. Please see Exhibit G for a copy of the informational material provided by Mr. Mouden.

Dr. Dwight W. Meierhenry

Dr. Meierhenry, Las Vegas, offered the following information and described the dental options to be encompassed by the proposal:

- The dental proposal for the Nevada Check-Up Program is more characteristic of a self-funded program;
- The proposed mission statement illustrates that since dental decay is a preventable disease there should be: (1) a reduction of dental infections; (2) a reduction of dental pain; and (3) the ability to make patients cosmetically attractive;
- The use of a third party administrator (TPA) ensures an accurate account of state funds which utilizes the maximum amount of dollars on treatment;
- The use of the first diagnostic clinic in the state incorporated into a triage section with an emphasis on prevention. Dentists will know in advance what needs to be done on a patient and the reimbursement for each procedure; and
- With an increased access to care, patients are provided a comprehensive program that increases oral health, prevents dental decay, and decreases dental-related infections and pain associated with those problems.

The diagnostic clinics will be situated in locations to accommodate easy access by the entire community. Dr. Meierhenry listed the potential Las Vegas sites:

- Epi-center on Maryland Parkway (Las Vegas);
- West Charleston Boulevard (Las Vegas); and
- North Las Vegas.

Additional proposed sites in Nevada include:

- Green Valley or Henderson;
- Reno; and
- Possibly a mobile clinic for use on a routine basis to serve rural areas. Also, diagnosis could be provided in local dental offices in which the diagnostic team would rent space.

Dr. Meierhenry emphasized that no dental services will be available at the diagnostic centers, only estimates of the care or treatment needed. Once the diagnosis is complete, service is provided by a dental provider in the area. All dentists licensed by the state will be encouraged to provide care to patients who have completed the diagnostic center's examination and education process.

ITEMS FOR CONSIDERATION IN NEVADA CHECK-UP

ASSISTING CHILDREN WITH DISABILITIES AND SPECIAL HEALTH CARE NEEDS

Chairman Rawson opened the discussion on Agenda Item V, B, the first item to be considered for action.

Marla McDade

Ms. McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, summarized the document prepared for the committee titled, "Children with Disabilities and Special Health Care Needs" (Exhibit F). She pointed out that according to The Maternal and Child Health Policy Research Center, a disability is defined in terms of social role limitations caused by chronic conditions. The characteristics of these children includes those with:

- Asthma, cancer, cerebral palsy, diabetes, mental illness or retardation, sickle cell anemia, and other conditions and diseases or combinations thereof, qualify as "disabled" or having "special health care needs."

Additionally, Ms. McDade used provisions from the Request for Contract (RFC) for the voluntary managed care program to provide the committee examples that may apply to the children's health insurance program. She noted that:

- Extremely emotionally disturbed children and disabled newborn children are specifically defined under the Request for Contract for voluntary managed care programs. Under provisions of the contract, the HMO is not obligated to provide care for the severely disabled child. Once a determination is made that the child is indeed severely disabled, treatment is handled under the conditions of

a fee-for-service system, until such time when they are covered under Supplemental Security Income (SSI);

- The HMO must accept the enrollment of any Medicaid eligible person who selects it, regardless of the participant's disability, handicap or health status; and

- The contract includes a "Stop Loss Provision" which provides that hospitalization that results in costs over $40,000 in a 12-month period allows for the HMO contractor to receive either 75 percent of the amount paid or 75 percent of the fee-for-service rates for additional costs per enrollee.

Referring to the comments of Ms. McDade, Assemblywoman Freeman inquired which services could be reimbursed by Medicaid under the certain conditions outlined in *Nevada Revised Statutes* (NRS) 422.303, "Reimbursement of registered nurse for certain services provided to person eligible for Medicaid." She also asked whether those provisions include services provided by hospice care givers, nurse practitioners, or registered nurses.

Ms. McDade explained the Medicaid statute provides that certain services are granted protection for reimbursement. She indicated she would provide a copy of the citation and further clarification to Ms. Freeman.

Assemblywoman Buckley expressed concerned with the lack of data that specifically focused on disabled children or those with chronic conditions who were mandatorily enrolled in managed care programs. She recounted her request to the Governor's Office to allow disabled children to be allowed a "fee-for-service option," or adopting additional case management and treatment for chronic conditions. Ms. Buckley explained funds were not available and the option could be discussed again during the 1999 Legislative Session. There was agreement for an additional provision to be included to allow for better access to ongoing treating physicians in certain speciality areas.

Additionally, there would be discussion with MCOs regarding the possibility of pilot programs to investigate rates. Ms. Buckley expressed a preference to include a fee-for-service Medicaid option available for seriously disabled children until such time that the completed data is available.

Chairman Rawson clarified that Ms. Buckley's concern narrowed down to disabled children from a slightly higher income of the low-income group. He noted many children from that specific group would already be eligible for public benefits. Further discussion disclosed that approximately 5 percent of disabled children come from families whose incomes are slightly above the categorical amounts allowed for eligibility for Aid to Dependent Children (ADC) or Medicaid. These children may be eligible for the Nevada Check-Up Program and in addition, are disabled or chronically ill. (Please note that ADC is now know as Temporary Assistance For Needy Families [TANF].)

It was suggested by the Chairman that contractors involved in Nevada Check-Up be required to accept all patients and include a provision for eliminating any predetermination for existing conditions. Ms. Buckley said her understanding of the Nevada Check-Up Program is that all children will be accepted regardless of any preexisting conditions. She restated the focus of her concern is with mandatory placement in managed care programs without the benefit of sufficient evidence that the health care needs of disabled children are being met.

Chairman Rawson suggested the program include a requirement for additional case management services, or that it include a mandate that adequate encounter statistics involving handicapped children be documented. The statistics would aid in determining whether or not the program is meeting the needs of disabled and chronically ill children.

Jon Sasser

Mr. Sasser, identified on page 2, requested a method be developed to ensure that the scope of services offered to special needs children will cover all their medical needs. He pointed out that certain treatments may be available under the Medicaid EPSDT program that may not be offered under Nevada Check-Up. He suggested that the services included under a proposed plan be clearly stated to address any "gaps" in the medical treatments.

Dr. Feldman restated the concern as whether or not a MCO will utilize appropriate pediatric subspecialists for children with chronic illnesses. He preferred the case management approach to ensure the committee's intention for better access and use of specialized pediatric medical treatment for disabled or chronically ill children.

Addressing the issue of statistics, Dr. Feldman pointed out that evaluating the health outcome of children with chronic conditions treated under MCOs will be a difficult and lengthy process. Data collected during the first year of the proposed program may illustrate access, health care utilization, and quality of care, but may not indicate health outcomes.

Marie Soldo

Ms. Soldo, identified on page 2, explained that a benefit under any plan can be defined to be as extensive or limited as necessary to address the special needs of disabled children. She indicated that an attempt could be made to keep records and statistics without violating confidentiality once children with special needs are identified based on their diagnosis. Ms. Soldo expressed a willingness to work with the committee and the state to define a benefit package within the designated budget.

Marc Bennett

Mr. Bennett, identified on page 1, commented that collecting data from the encounters with a MCO may not necessarily provide the full "picture" the committee is seeking. The purpose of managed care is that it suppresses usage. He predicted that by nature the MCO will attempt to manage and limit the treatment of disabled children who are high utilizers of care in a "capped" environment.

Chairman Rawson summarized the: (1) committee's discussion; (2) agreement that a requirement be included for data collection; and (3) committee's direction to the providers that there be adequate care and coverage for the chronically ill or disabled child.

Assemblywoman Freeman said the committee should be "very clear" in stating the expectations and requirements to be carried out. She viewed the option of additional services for case management as critical for these children.

In response to an inquiry from Chairman Rawson, Mr. Thompson explained that additional services for case management are not necessarily cost prohibitive. The emphasis should be placed on defining those children with special health care needs in developing the state's plan. Typically, MCOs already provide case management from the standpoint of use of primary physicians. Mr. Thompson said the state should be assured that case management for children with special health care needs includes individuals with expertise for children with particular disabilities.

> ASSEMBLYWOMAN FREEMAN MOVED FOR THE PROPOSED CHILDREN'S HEALTH INSURANCE PROGRAM TO MOVE FORWARD AS A PILOT PROGRAM AND TO SPECIFICALLY ASSIST CHILDREN WITH DISABILITIES AND SPECIAL HEALTH NEEDS BY PROVIDING ADEQUATE CASE MANAGEMENT. FURTHER, THE PROGRAM SHOULD PROVIDE FOR THE ACCUMULATION OF TREATMENT DATA WHICH WILL ENSURE BETTER ACCESS TO SPECIALITY PHYSICIANS FOR INDIVIDUALS WITH CHRONIC CONDITIONS. IT IS THE INTENT OF THE COMMITTEE TO REVISIT THE ISSUE AT A LATER DATE TO ASSESS THE DATA COLLECTED. ASSEMBLYMAN CLOSE SECONDED THE MOTION WHICH PASSED WITH ALL MEMBERS PRESENT VOTING YEA.

Charlotte Crawford

Ms. Crawford, identified on page 1, clarified that the position of the DHR administrators, regarding the case management component was not to offer special needs children a better level of care than all others, but to ensure that all children enrolled in the program, without restrictions for preexisting conditions receive the medical care within the covered benefits that are appropriate to their needs.

PREVENTING EMPLOYERS FROM DROPPING GROUP HEALTH INSURANCE COVERAGE OR REDUCING BENEFITS FOR EMPLOYEES

Dr. Donald S. Kwalick

Dr. Kwalick, identified on page 2, referred to the document titled, "Crowd Out" (Exhibit G), prepared by Ms. McDade, and noted the necessary distinction between public health care program and publicly funded health care program, which are oftentimes confused. He emphasized the importance of using the correct terminology so it is clear the discussion pertains to a publicly funded health care program.

Fred Hillerby

Mr. Hillerby, identified on page 2, addressed the issue of individuals canceling their private health insurance to become eligible for the proposed state plan. He requested initiating a waiting period if a person was previously covered and chose to cancel their coverage. This would prevent someone from risking being uninsured for the period of time required to become eligible.

During the discussion that followed, there was concern that a waiting period could possibly hurt families with children that the plan is designed to help should medical or emergency care be needed. It was noted that cost of insurance may be the reason people choose to "drop" their coverage, since some coverage may not be affordable.

It was suggested that a six-month waiting period be applied to persons who voluntarily cancel their health insurance coverage to enroll in the state's plan. The waiting period would not apply to persons who have been dropped from insurance coverage for reasons such as loss of employment, or other involuntary situations.

Assemblywoman Buckley requested the issue be placed on a future committee agenda noting that the issue of requiring a waiting period is a broad issue with many possible "gray" areas. Further discussion is warranted regarding availability, cost, penalties, and subsidization of employer premiums, in order to make fair proposals to the Legislature. She suggested a statement outlining the committee's purpose is to discourage crowd out and develop significant proposals after additional discussion.

Chairman Rawson pointed out that the proposed Nevada plan must include a "crowd out" strategy when submitted to the Federal Government. He noted that the Executive Branch of Nevada State Government indicated a policy to discourage "crowd out" that appears parallel to the sentiments expressed by the committee. The administration is encouraged to keep accurate records should the committee need such data in the future. Chairman Rawson told Mr. Thompson he would be asked to justify the policy that is adopted.

The Chairman requested the record reflect the committee's direction addressing the issue of group health insurance coverage or reducing benefits for employees, and the discouragement of what is known as "crowd out" in the insurance industry.

COORDINATING NEVADA CHECK-UP WITH MEDICAID

Jon Sasser

Mr. Sasser addressed the topic of eligibility criteria and pointed out the requirement of resource and assets tests applied under Medicaid, while there is no test for eligibility outlined in the proposed state plan. He requested clarification of the goal of incorporating two programs and a clear statement of policy that is being established.

Dr. John Yacenda

Dr. Yacenda also spoke to the different challenges of the Medicaid and Nevada Check-Up Programs, both striving for the same result to offer health care to low-income children. He supported a concept that would equalize programs by including presumptive eligibility in the Nevada Check-Up Program.

Mr. Thompson responded to an inquiry from Assemblywoman Buckley whether there will be one application for both programs. He stated that the Nevada Check-Up Program will use a simplified application form that does not provide the information necessary for a Medicaid determination. Further, it was not the intent for persons eligible for Nevada Check-Up to be required to submit a Medicaid application personally at the welfare offices. The administration's position calls for simplified eligibility for the proposed plan and an evaluation of changes surrounding Medicaid before the 1999 Legislative Session.

Continuing, Mr. Thompson said a determination will be made whether it would be preferable for the state to require a complete and full Medicaid application for the additional individuals, or whether only to require a simplified form without a resource test.

Assemblywoman Buckley asked for assurance that children are covered during the time a determination is being made, whether they will be eventually enrolled in Medicaid or the Nevada Check-Up Program. Mr. Thompson explained that if someone is determined eligible for Medicaid, he is required by regulation to enroll them in that program. If the full compliment of questions required by Medicaid are not asked of an applicant, then those requirements would not apply in determining eligibility for the state's program. He explained that should Medicaid eligibility be determined by his agency after review of a financial disclosure, the applicant is then furnished the necessary information to complete the Medicaid enrollment process.

Chairman Rawson polled the committee for agreement on a statement of policy. (He summarized the policy as it is to be achieved. "We want this is to be a seamless program...and want to take the least common denominator, to keep a sense of simplicity as we go through the process and make this a further legislative agenda item.")

Dr. Yacenda summarized a recent memorandum from the Health Care Financing Administration (HCFA) to state officials. The memorandum indicated that states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children. They also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.

Chairman Rawson stated it is assumed that these children are not left uninsured while a determination is made. If children are enrolled in the Nevada Check-Up Program and they are determined to be eligible for Medicaid, they are to be covered by the state's program until such time as the Medicaid benefits are in effect.

Mr. Ostrovsky asked if the consensus was for health care in the rural areas to meet or exceed existing standards.

Dr. Yacenda offered language that states: Assess the current level of health care available to our rural communities and in so doing assess the level of potential enrollment in those communities. From that point, match the nearest available speciality care provider that will be easily accessible in an urban community for the services that the rural clients may require.

Chairman Rawson said it should be stated that the committee's intent is not to disrupt existing care in rural areas by establishing this program, but rather to utilize existing care and supplement it if necessary. He cautioned that we do not want to aggravate the health care situation in the rural areas.

Assemblywoman Buckley cited language offered by the administration previously, which stated they would offer the same benefit package through MCOs in the rural areas and in the event they did not have an adequate network or were unable to complete this option, a fee-for-service plan would be considered.

Mr. Fend supported an option to permit rural health services to be administered by nurse practitioners.

Chairman Rawson said it should also be defined that the committee does not want to discourage any new technology or efficient methods to handle rural care, but does not want to dismantle existing systems.

Dr. Yacenda pointed out that certain rural border communities obtain health care in the neighboring state. Therefore, it will be necessary to have agreements and contracts with providers in other states when this plan is implemented.

Dr. Feldman asked how payment is rendered in communities with no MCOs.

Chairman Rawson said the managed care provider would be allowed to contract with existing providers on a fee-for-service basis in areas that have no licensed MCOs or if the area is out of a licensed service area, the standard fee-for-service programs applies.

> ASSEMBLYWOMAN BUCKLEY MOVED FOR THE COMMITTEE TO: (1) ENCOURAGE THE ADMINISTRATION TO EVALUATE AND TO DEVELOP A PREFERRED PROVIDER ORGANIZATION MODEL PROPOSAL WITH THE UNIVERSITY MEDICAL CENTER; (2) ENCOURAGE THAT THE PROPOSED PLAN INCLUDE A PROVISION TO INCLUDE ELIGIBILITY WORKERS AT THE PUBLIC HOSPITALS; (3) URGE THE ADMINISTRATION TO DEVELOP A SIMILAR ARRANGEMENT WITH THE UNIVERSITY OF NEVADA SCHOOL OF MEDICINE TO ENSURE THAT ITS CASE MANAGEMENT MODEL IS ALSO ENCOURAGED; (4) INCLUDE A PROVISION WHICH WILL PROHIBIT MCOs FROM "STEERING PATIENTS" OR OTHERWISE DIRECTING PATIENTS TO SPECIFIC HOSPITALS, AND PROHIBIT INCENTIVES THAT WOULD RESULT IN A GUARANTEED NUMBER OF PATIENTS TO ANY PROVIDER; (6) ENSURE EQUAL PARTICIPATION TO ALL PROVIDERS AND REQUIRE THAT THE MCOs OFFER THE SAME CONTRACTS TO "SAFETY NET" PROVIDERS AS REFERENCED IN SENATE BILL 427, (CHAPTER 550, *STATUTES OF NEVADA* 1997). [NOTE: S.B. 427 THE CREATES 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.]
>
> FURTHER, THE PROPOSED PLAN SHOULD INCLUDE LANGUAGE TO ADDRESS SITUATIONS WHEN PREFERRED PROVIDERS ARE NOT AVAILABLE TO SERVE THE RURAL AREAS. IN THESE SITUATIONS THE MCOs WILL BE REQUIRED TO PROVIDE FEE-FOR-SERVICE CONTRACTS TO PROVIDERS IN THOSE RURAL COMMUNITIES. ASSEMBLYMAN CLOSE SECONDED THE MOTION.
>
> ASSEMBLYWOMAN FREEMAN AMENDED THE MOTION TO INCLUDE SCHOOLS FOR NURSE PRACTITIONERS.

Mr. Welch voiced concern pertaining to the physicians who are not hospital-based in the rural areas, and stated that many may decide independently whether or not to participate in managed care contracting.

Dr. Yacenda clarified that Assemblywoman Buckley's motion included the out-of-state providers that are contracted for services or treatment to Nevada's rural residents.

Mr. Hillerby asked for clarification that the provision addressed in Ms. Buckley's motion regarding patient incentives applied only to the proposed children's health insurance program. He pointed out that instances do exist where some forms of incentives may contribute to the success of some plans. Ms. Buckley emphasized her motion applies only to the proposed children's health care program. Since it is a new program funded almost exclusively by taxpayer funds, the committee must guarantee it is structured in the best possible manner.

Dr. Yacenda asked for clarification if the intent of the motion is for the state to require a capitated amount to be placed on the PPO and primary case management issues referred to in the Ms. Buckley's motion.

In response, the Chairman said he perceives only a small number of participants will fall into the referenced category. He indicated that the intent is not to build additional risk into the program.

THE MOTION CARRIED. SENATOR MATHEWS WAS NOT PRESENT FOR THE VOTE.

Chairman Rawson outlined his intention to submit letters of intent to the Executive Branch and the Nevada Legislature's Interim Finance Committee (IFC) for the purpose of informing them of the direction the committee has taken. He opened the next item for discussion.

IDENTIFYING IMPACTS OF COST-SHARING ON NEVADA CHECK-UP BENEFICIARIES

Keith Beagle

Keith Beagle, President, Nevada Care, Las Vegas, a current licensed MCO, addressed the portion of the motion which called for the creation of a pilot program. He indicated that MCOs may be reluctant to participate in a project that involves an undetermined estimate of costs for a 12-month pilot program.

A brief discussion followed which focused on Mr. Thompson clarifying items, including Medicaid terminology.

IDENTIFYING PROVISIONS FOR OUTREACH AND MARKETING

Dr. Yacenda commented on the importance of implementing aggressive outreach methods that will be language and culturally sensitive. He referred to the document provided to the committee, titled "Outreach and Enrollment - Nevada Check-Up." (Please see Exhibit I for the document in its entirety.) He pointed out that the targeted groups often are the persons who mistrust government agencies.

Ms. Gilbertson pointed out that a critical aspect for consideration is in regard to the issue of the quality of care process, and she noted the importance of the Request for Proposal (RFP) to contain specifically outlined provisions of what is expected. The Chairman requested Ms. Gilbertson to work with staff to incorporate appropriate language into the RFP.

Mr. Bennett, identified earlier, commented that a primary goal for a quality assurance program is to improve and maintain the health status and quality of life of the members or participants. It is important to ensure the services offered under the Nevada Check-Up Program will provide the best quality of care that will improve the health status of the targeted children. Mr. Bennett recommended that:

- An effort be made to coordinate Medicaid functions with those proposed by the state to alleviate the obvious overlapping of applications; and
- The committee encourage and support improvement by addressing the number of quality functions such as recourse for grievances, inspection, and surveillance functions.

IDENTIFYING CONSIDERATIONS FOR QUALITY ASSURANCE

Chairman Rawson asked Mr. Thompson if the federal initiative sponsored by HCFA (known as the Quality Assurance Reform Initiative) has placed additional requirements on the states. In response, Mr. Thompson indicated the initiative is an attempt to evaluate and measure the quality of care provided by MCOs. He noted that the state's voluntary managed care program was developed in accordance with the provisions contained in the initiative.

PROGRESS REPORT ON STUDY OF THE UNINSURED IN NEVADA

Chairman Rawson informed the committee he had the opportunity to review the draft questionnaire and that it should be near completion. He indicated it may be ready for final examination by the committee's next meeting.

DISCUSSION OF TOPICS FOR CONSIDERATION AT FUTURE MEETINGS

and

DIRECTIONS TO STAFF

Chairman Rawson noted the upcoming meeting dates and directed staff to prepare the aforementioned letters of intent.

Larry Matheis

Mr. Matheis, identified on page 3, requested that the issue of pediatric oncology be scheduled as an upcoming agenda item. Secondly, he requested that a presentation from the newly formed Diabetes Council be scheduled.

Dr. Yacenda requested time be allotted on an upcoming agenda for information to be provided from the Inter-Tribal Council of Nevada to address issues and health concerns specific to the state's Indian children.

There being no further committee business, the Chairman adjourned the meeting at 3:30 p.m.

Respectfully submitted,

Ricka Benum

Senior Research Secretary

APPROVED BY:

_____

Senator Raymond D. Rawson, Chairman

Date: _____

LIST OF EXHIBITS

Exhibit A is a copy of the slide presentation of Dr. Bernard H. Feldman, University of Nevada School of Medicine, titled, "The Education of Pediatricians in the United States."

Exhibit B is a copy of the testimony of Bobbie Gang and Louise Bayard-de-Volo, Nevada Women's Lobby, dated February 2, 1998.

Exhibit C is material prepared by the American Academy of Pediatrics, titled "Guiding Principles for Managed Care Arrangements for the Health Care of Infants, Children, Adolescents, and Young Adults (RE9519), and submitted by Bobbie Gang, Nevada Women's Lobby.

Exhibit D is a copy of material from the American Academy of Pediatrics, titled "Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents and Young Adults Through Age 21 Years," submitted by Bobbie Gang, Nevada Women's Lobby.

Exhibit E is the testimony of Alicia Smalley, President-Elect, Nevada Chapter, National Association of Social Workers, dated February 2, 1998.

Exhibit F is a document prepared by Marla L. McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, titled "Children with Disabilities and Special Health Care Needs."

Exhibit G is the proposal outlining the dental services for the Nevada Check-Up Program submitted by Dr. Dwight W. Meierhenry, Las Vegas, Nevada. The handout included supporting documentation, titled "Title 21 Program," submitted by American Group Administrators, Inc.

Exhibit H is an informational document, titled "Crowd Out," prepared by Marla L. McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau.

Exhibit I is a document prepared by John Yacenda, MPH, Ph.D., Director, Great Basin Primary Care Association, titled "Outreach and Enrollment - Nevada Check-Up."

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.