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MEETING NOTICE AND AGENDA

Name of Organization: Legislative Committee on Health Care

(Nevada Revised Statutes 439B.200)

Date and Time of Meeting: Monday, August 3, 1998

9:30 a.m.

Place of Meeting: Legislative Building

Room 4100

401 South Carson Street

Carson City, Nevada

Note: Some members of the committee may be attending the meeting, and other persons may observe the meeting and provide testimony, through a simultaneous video conference conducted at the following location:

Grant Sawyer State Office Building

Room 4412A, B, and C

555 East Washington Avenue

Las Vegas, Nevada

A G E N D A

1. Opening Remarks by the Chairman

   Senator Raymond D. Rawson

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

III. Presentation Regarding Hunger and Its Effect in Nevada

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

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

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

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

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

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

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

VIII. Public Testimony

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

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

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

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

X. Adjournment

*Denotes items on which the committee may take action.

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

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

WORK SESSION DOCUMENT

August 3, 1998

Legislative Committee on Health Care

***Nevada Revised Statutes* 439B.200**

This Work Session Document was prepared by the staff of the Legislative Committee on Health Care. It contains a summary of major proposals that have been presented to the Committee in public hearings and correspondence through May 29, 1998. A citation concerning the source of each recommendation is noted, where available.

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

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

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

PROPOSALS FOR ACTION BY THE

LEGISLATIVE COMMITTEE ON HEALTH CARE

Long-term Care Issues

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

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

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

OR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(According to Ms. Heatherton, current Nevada Medicaid rules require that clients who receive Medicaid

assistance must be placed in a nursing home whether or not they require full-time, regular nursing assistance. Some clients do not require this level of care, and they may be cared for satisfactorily by an assisted living facility and at a lower cost than the cost of a nursing home.)

Hospice and Pain Management Issues

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

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

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

Physical Fitness Training Program for Senior Citizens

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

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

Individuals with Chronic or Life Threatening Illnesses

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

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

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

determined eligible for Medicaid, the proposal seeks to compel the Medicaid program to reimburse the counties for these expenses. **$$**

16. A proposal was made to urge Nevada's Congressional Delegation to introduce and/or support federal legislation to expedite eligibility determinations for individuals who apply to federally-sponsored social welfare (Medicaid, Medicare, Supplemental Security Income, Supplemental Security Disability Income) programs to alleviate the financial, medical, and mental health burden on individuals who are awaiting benefits from these programs.

Licensure for Physical Therapists in Nevada

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

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

OR

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

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

Steroid Warning Labeling

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

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

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

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

Diabetes Issues

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

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

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

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

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

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

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

Nevada Medicaid Issues

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

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

OR

b. Mr. Sasser propose an alternative to this proposal which is to compel the Division of Health Care Financing and Policy to develop an application form that permits an applicant to voluntarily

determine whether his assets exceed the requirements of the Medicaid program. The application shall be stamped with a date that reflects the day the application was received by the division. This proposal should be implemented by July 1, 1999.* **$$**

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

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

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

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

(At its May 29, 1998, meeting, the committee adopted a motion that directs the division to eliminate the assets test from the Child Health Assurance Program as it pertains to pregnant women and children who are participants in the Medicaid program.)

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

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

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

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

31. A proposal was made to amend NRS 439B.220 to establish a statutory subcommittee of the Legislative Committee on Health Care to consider the health care and medical needs of people with

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

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

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

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

(c) The state health care ombudsman may: (1) hire or contract with persons to fulfill the purposes of this chapter; (2) review the health insurance records of a consumer who has provided written consent. Based on the written consent of the consumer, the consumer's guardian or legal representative, a health insurer should be required to provide the state ombudsman access to records relating to that consumer; (3) pursue administrative, judicial, and other remedies on behalf of any individual health insurance consumer or group of consumers; (4) delegate to employees and contractors of the ombudsman any part of the state ombudsman's authority; (5) adopt policies and procedures necessary to carry out the provisions of this chapter; and (6) take any other actions necessary to fulfill the purposes of this chapter.

(d) All state agencies should be required to comply with reasonable requests from the state

ombudsman for information and assistance. The Division may adopt rules necessary to assure the cooperation of state agencies under this section.

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

(f) The state ombudsman, its employees and contractors should not have any conflict of interest relating

to the performance of their responsibilities under this chapter. For purposes of this section, a conflict of interest exists whenever the state ombudsman, its employees, contractors or a person affiliated with the state ombudsman, its employees and contractors: (1) have direct involvement in the licensing, certification, or accreditation of a health care facility, health insurer, or a health care provider; (2) have a direct ownership interest or investment interest in a health care facility, health insurer, or a health care provider; (3) are employed by, or participating in the management of a health care facility, health insurer, or a health care provider; or (4) receive or have the right to receive directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer, or health care provider.

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

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

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

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

(A description of the MCHB measures will be available at the August 3, 1998, meeting.)

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

35. A proposal was made to compel the Division of Health Care Financing and Policy to conduct an agency study of the advantages and disadvantages and costs and personnel needed to develop a Medicaid "buy-in" program for people with disabilities who are returning to work.

Among the items to be analyzed, the "buy-in" program should be a premium-based Medicaid insurance program for people with disabilities that permits participants to have a one-time spend-down provision that will (a) allow adults eligible for Title XVI of the Social Security Act to return to the workforce without fear of losing their health insurance; (b) prevent job loss for parents of children eligible for Title XVI program benefits; and (c) provide needed medical services that would not normally be covered by commercial insurance plans. The proposal suggests that the results of the study be reported to the Legislative Committee on Health Care by June 1, 2000, at which time the committee will review the study and report its recommendation to the Interim Finance Committee.* **$$**

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

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

Medicaid enrollees.* **$$**

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

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

OR

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

39. A proposal was made to send a letter to the chairmen of the Senate Committee on Finance and Assembly Committee on Ways and Means of the 1999 Legislature to urge support of the Division of Health Care Financing and Policy's efforts to have sufficient technical consultants (or agency staff) and computer hardware and software to perform an analysis of utilization data for its managed care programs in a timely fashion.

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

Essential Community Providers

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

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

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

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

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

Minority Health Issues

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

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

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

The division should be funded from "stimulus funds" of state agencies with which the organization has established relationships and unobligated and unexpended federal funds and state appropriations. "Stimulus funds" would be derived from two percent of the funding used by state agencies that provide health and social services to minorities. "Stimulus funds" may appear in one of four forms: (1) appropriated federal funds that are spent at the discretion of the division or are spent on specific activities within the scope of a project of the state agency receiving the federal dollars, which are passed through to the division (e.g., Centers for Disease Control funds for the prevention of Human Immunodeficienty Virus (HIV) would be targeted to the division's efforts to address HIV primary and secondary prevention in minorities); (2) state of the art equipment and supplies assigned from agencies' purchasing pools to the division, subject to the same provisions as item one; (3) full-time equivalencies from respective agencies (in full or part); and (4) State General Fund dollars appropriated directly to the division, or moved to the division from another state agency receiving general funds.

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

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

Executive Director: Appointment; qualifications; classification; restrictions on other employment. The division should have an executive director, who will be appointed by the governor. The qualified person will have successful experience in the administration and promotion of a program comparable to that provided by this proposal. The executive director of the division is in the unclassified service of the state.

Except as otherwise provided in the NRS, the executive director of the division shall devote his entire time to the duties of his office and shall not follow any other gainful employment or occupation.

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

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

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

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

Powers of advisory committee. The advisory committee may develop subcommittees of the advisory

committee and non-committee members whenever necessary or appropriate to assist and advise the advisory committee in the performance of its duties and responsibilities under this act.

Children's Health Insurance Plan

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

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

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

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

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

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

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

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