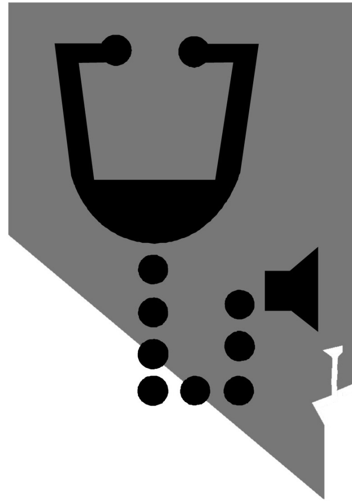

Nevada Strategic Health Care Plan

Recommendations and Strategies by Stakeholders and Legislators to Meet Growing Challenges Facing America's Most Dynamic State

Report of the Legislative Committee on Health Care

Nevada Revised Statute 439B.200

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A State Health Plan for Nevada

An effective health agenda to meet the growing challenges facing America's most dynamic state

IN RECOGNITION OF the existing and anticipated challenges associated with meeting Nevada's health care needs, Assembly Bill 342 (Chapter 418, Statutes of Nevada 2005) directed the Legislative Committee on Health Care (LCHC) to undertake a wide-ranging effort to develop a Nevada State Health Plan, to include, without limitation, a review of Nevada's health care needs as identified by State agencies, local governments, providers of health care, and the general public.

Environment at a Glance

Even a cursory review of health care indicators reveals that Nevada has serious issues facing its health care system. The health care system in Nevada faces the following challenges:

Shortage of Health Professionals. Nevada suffers from a severe shortage of health care professionals. Nevada ranks 48th among the states in the number of physicians per 100,000 population,[1] 49th in the number of nurses per 100,000 population,[2] 48th in the number of dentists,[3] and 48th in the number of social workers.[4] In its current condition, Nevada's education system cannot keep up with the need.

Uninsured Residents. A large percentage of Nevada's population is without health insurance. In a ranking of states by the uninsured rate, Nevada is tied for fourth highest with approximately 19%, or 426,000, of its citizens uninsured.[5]

Rapid Population Growth. Nevada's population growth rate is the nation's highest. By 2030 the state's population will more than double, to 4.3 million. Additionally, by 2030 the 65-plus age group (the group with the highest health care utilization and cost) will make up a larger share (19%, compared to 11% in 2000) of this much larger population.[6]

Low Medicaid Coverage. Compared to the rest of the nation, Nevada has a very low percentage of its population covered by Medicaid. Depending on the measure, Nevada Medicaid covers between 7% and 11% of the state's total population, which is just over half the average percentage covered by the rest of the states. In terms of Medicaid coverage of the state's population, Nevada ranks 47th among the states.[7] This situation contributes to the high level of the uninsured, lessens the volume of federal dollars returning to Nevada, shifts uninsured persons' health care risks and costs to the insured population, and results in the uninsured delaying medical treatment until a costly emergency room visit is the only care option.

Low Health Status. Nevada's overall health status ranked 37th in a survey performed by the United Health Foundation. Poor indicators are noted in child immunizations, prenatal care, and the size of the state's uninsured population.[8]

Behavioral Health Issues. Nevada ranks second among the states in the percentage of the population with poor mental health, first among the western states in the prevalence of the population with mental illness, and 37th in overall mental health care spending.[9]

Plan Development

In developing the Plan, the Legislative Committee on Health Care (LCHC) relied heavily on input from stakeholders involved in the State's health care system. This involvement included the receipt of testimony during the ten interim meetings of the Committee, the participation of approximately 100 individuals in six separate focus groups, and, finally, the convening of a Stakeholders' Health Summit that attracted 76 participants. The consensus recommendations adopted during the Summit form the basis of the Nevada State Health Plan.

Recommendations and Strategies

Seven major recommendation statements and 39 consensus strategies emerged from the process to form the Nevada State Health Plan. The seven major recommendation statements include:

- **Health Care Professional Education.** Improve and expand the State's capacity to provide a health care professional education continuum to increase the number of licensed health care professionals in the state.
- **Medicaid and SCHIP.** Expand program eligibility, enrollment and service coverage under the State's Medicaid and SCHIP programs.
- **Small Employer Health Insurance.** Develop mechanisms to provide coverage for the small employer market.

- **The Safety Net.** Improve access to services for both the insured and uninsured by supporting and expanding the safety net provider network.
- **Behavioral Health.** Increase access to and funding for an appropriately designed mental health and substance abuse program for Nevadans requiring these services.
- **Prevention and Wellness.** Expand and initiate programs that will improve the overall health status of Nevadans by focusing on prevention and wellness.
- **Health Care Planning.** Develop positive proactive plans for addressing the health care system challenges in Nevada with formalized planning bodies that coordinate and disseminate information on health care policy, quality, community needs, workforce issues, and health information technology and information exchange.

The 39 strategies adopted by the Stakeholders' Health Summit, arranged by the seven major recommendation statements, are presented below.

Health Care Professional Education

When compared to other states, Nevada ranks near the bottom in the number of health care professionals per 100,000 residents in nearly every category. Moreover, there is a significant disparity between Nevada's ratio and the national averages, as exemplified by the following:

- Nevada ranks 48th in the number of physicians per 100,000 with 196, compared to the national rate of 262.[10]
- Nevada ranked 43rd, in 2000, among 46 states with medical schools in the number of graduates, and graduated fewer new physicians per 100,000 population (2.8) than did the nation as a whole (6.4).[11]
- Nevada ranks 49th among the states with 604 nurses per 100,000 residents, compared to the national rate of 825. In this measure, Nevada is tied with California for last place.[12]
- Nevada has one of the lowest per capita rates of nurse practitioners in the nation at 15.2 per 100,000 residents [13] (well below the national rate of 33.7) and ranks near the bottom of the states in the ratios of certified nurse midwives and registered nurse anesthetists.[14]
- In per capita terms, Nevada ranks:[15]
  - 48th in the number of dentists,
  - 31st in the number of pharmacists,
  - 42nd in pharmacy techs,
  - 44th in psychologists, and
  - 48th in social workers.

Historically, Nevada has largely depended on attracting health care professionals from other states; consequently, efforts to develop the capacity for educating the health care workforce have not kept up with the state's explosive population growth. A current inventory of the health care professional education system reveals the following:

- the University of Nevada School of Medicine (UNSOM), with an entering class size of 52 students and 194 residents and fellows enrolled in 14 approved programs;
- Touro University College of Osteopathic Medicine, with an entering class size of 78 (and a capacity for 165) and 75 physician assistant students (with a potential enrollment capacity of 120);
- eight approved schools of nursing with aggregate enrollments of 1,570 registered professional nurse (RN) students;
- two community colleges offering licensed practical nurse (LPN) programs;
- masters degree in nursing programs at UNR and UNLV and a Ph.D. program at UNLV, with aggregate enrollments of 40;
- a masters degree in nursing program at Touro, with a class size of 17 (and a capacity for 90);
- a School of Dental Medicine at UNLV, with 300 doctoral students and 16 post-doctoral students;
- a School of Pharmacy at the University of Southern Nevada, with a 2005 entering class of 142 students;
- Schools of Public Health at both UNR and UNLV, with aggregate enrollments of 367 undergraduates and 172 graduate students;
- the UNLV School of Health and Human Sciences programs in physical therapy, health physics, kinesiology, nutrition sciences, clinical laboratory sciences and radiology, with aggregate enrollments of 1,152 undergraduate and 120 graduate students; and
- other social and behavioral science programs at UNLV and UNR, with aggregate enrollments of 150 undergraduates and 40 graduate students.

Strategies. In order to increase the number of licensed health care professionals in the state through an expansion of professional health care education, the Stakeholders' Health Summit adopted ten strategies for health care professional education:

1. Create, endorse and fund an integrated University of Nevada Health Science Center to do statewide research and training, including post-graduate education.
2. Expand UNSOM and the Graduate Medical Education (GME) program by:

- increasing the enrollment in the School of Medicine,
- increasing core faculty,
- expanding the GME program, and
- funding necessary capital expenditures to expand UNSOM.

3. Expand GME in Nevada, with steps to include adding faculty, funding capital expenditures, and seeking Congressional action to increase the existing Centers for Medicare and Medicaid cap on GME for Nevada.
4. Expand public nursing school programs by:
   - increasing faculty salaries,
   - doubling the enrollment at the public nursing schools,
   - increasing core faculty to support increased enrollment,
   - funding necessary capital expenditures, and
   - funding preceptor and clinical support.
5. Start a School of Pharmacy and Pharmaceutical Services.
6. Expand education for other health care professionals.
7. Expand clinical training capacity for graduate and post graduate psychologists.
8. Maximize Medicaid funding for GME and other postgraduate health professional training programs.
9. Expand loan repayment programs for students seeking graduate and undergraduate degrees in the health care professions.
10. Expand State funding for the Area Health Education Centers (AHECs) to support the education of health care professionals.

Medicaid and SCHIP

Nevada participates in both the Medicaid and State Children's Health Insurance Program (SCHIP, known in Nevada as "Nevada Check Up"). These programs are partnerships between the state and federal governments to provide health care coverage for low-income individuals. Medicaid covers low-income families and aged, blind and disabled individuals, and Nevada Check Up covers low-income uninsured children who are not eligible for Medicaid.

Nevada's strict eligibility rules have led to a lower percentage of its population being covered under Medicaid than in most other states. According to the Kaiser Family Foundation's State Health Facts, the income level to which Nevada Medicaid covers parents is substantially below the national average. While Nevada covers parents up to 26% of the Federal Poverty Level, the states on average provide coverage to the 43% level. The income for a family of three at 26% of the FPL is $4,316 per year. Nevada ranks 41st among the states in terms of parental eligibility for Medicaid.[16]

Also according to Kaiser, in federal fiscal year 2002, only about 10% of Nevada's population was enrolled in the Medicaid program, compared to a national average of 18%. In this measure, Nevada ranks 47th among the states. When viewed by the percentage of the population covered by Medicaid at different levels of income, Nevada also ranks low, being at just about half the coverage rate by income level as the average of the states:

Medicaid Enrollment: Nevada vs. U.S.[17]

Income Level	Nevada	U.S.
Up to 100% of FPL	27%	43%
Between 100% and 199% of FPL	14%	25%
Above 200% of FPL	2%	4%

Consistent with this low level of Medicaid coverage are statistics that indicate that Nevada is among the states with the highest levels of uninsured residents. Nevada has the same uninsurance rate (19%) as five other states, and there are only three states whose uninsurance rates are higher. However, the percentage of people with employer-sponsored insurance in Nevada (57%) is higher than the national average of 54%, and the percentage of people with individual policies and the percentage of people on Medicare are each only one percentage point below the national average.[18] This leaves the percentage of people covered by Medicaid in Nevada barely above half of the national average, suggesting that Nevada's higher uninsured rate is the result of Nevada's lower Medicaid coverage rate.

Long term care services nationally, as well as in Nevada, are a main driver of overall costs for the Medicaid program. The Nevada Division of Health Care Financing and Policy (DHCFP) reports that, in FY 2005, services to the elderly comprised 14.5% of the total Medicaid budget; this population represented only 5.8% of all Medicaid eligibles. Likewise, services to the blind and disabled comprised 43.8% of the total FY 2005 budget, but those eligibles represented only 14.7% of the population. Combined, 58% of the Medicaid budget was used for 20% of the population, a common occurrence for Medicaid programs across the country.

It is expected that the demand for long term care services among Medicaid recipients will grow as Nevada's population grows and ages (i.e., 11% of the state's population was 65-plus in 2000; by 2030, 18.6% of a much larger population will be in that age category).[19]

Strategies. In order to achieve improved coverage under Nevada's Medicaid and Check Up programs, the following

Medicaid and Nevada Check Up strategies were adopted by the Stakeholders' Health Summit:

1. Increase enrollment in Medicaid and Check Up through:
   - increasing and improving outreach to individuals who are potentially eligible but not enrolled in Medicaid and Nevada Check Up, and providing State funding for these outreach activities;
   - expediting eligibility for targeted Medicaid and Check Up eligible groups; and
   - adopting best practices for improving the eligibility process, which should involve development of partnerships with community organizations and providers.
2. Raise the income qualification level for parents to 100% of the federal poverty level (FPL) as soon as possible.
3. Expand and/or expedite the process by which individuals who qualify for Supplemental Security Income (SSI) are determined eligible for Medicaid.
4. Provide presumptive eligibility in the Medicaid program for pregnant women and for children.
5. Increase Medicaid and Check Up reimbursement to providers in eight separate service areas.
6. Enhance coverage under the Medicaid home and community based waivers by:
   - developing and implementing strategies to increase the number of case managers to serve persons enrolled in the Medicaid home and community based waiver programs, including the exploration of the merits of retaining an Administrative Services Organization;
   - adding services to the waivers for persons with traumatic brain injuries and to meet the needs of autistic children and adolescents; and
   - eliminating the waiting lists for all of the home and community based waivers.
7. Continue to explore advantages for Nevada under the Deficit Reduction Act of 2005 to enhance federal funding for the Medicaid program.
8. Through a working group with expansive representation, examine the strengths and weaknesses of the current long term care system and develop optional service delivery models that would lead to increased efficiencies, better out-comes, more individuals receiving services, and reducing individual participants' cost of care.

Small Employer Health Insurance

The majority of Americans receive health insurance through their employers. The size of the employer is a key factor in determining the cost of insurance, both to the employers and their employees. Large groups have lower premiums because they can divide the cost of claims for the group among a large number of people. In a small group, one employee with high medical claims can have a significant impact on the employer's cost of insurance. Small employers also incur higher administrative costs because they are small and because they typically work through a broker. Broker commissions, which range from 2% to 8%, are usually added to premiums. As such, cost is most often the largest barrier to small employers offering insurance to their employees.

Over the past five years, the cost of employer-sponsored coverage has increased by 59%. Between 2002 and 2003, health care premiums rose by 13.9%, and by 11.2% in 2004, while the rate of inflation increased by only 2.5%. Increases in premium rates are pricing a growing number of small businesses out of the insurance market. Firms do have the option of requiring employees to bear more of the cost of health care coverage, but in doing so they may make the cost of insurance beyond the reach of the employee.

In the early 1990s, Nevada tried to address the cost of small group insurance by allowing insurance companies and health plans to offer small employers a basic benefit plan. The premiums on this product were thought to be lower, largely because it was exempt from State-mandated benefits laws. Unfortunately, due to a very low take-up rate, the legislation was repealed shortly after it was enacted.

At least two factors have been cited for the very poor take-up rate. The law limited the broker commission to 2% on these policies and, as a result, brokers had little incentive to "push" the product. Also, the rollout of the product was not accompanied by any sort of marketing campaign.

Federal efforts to reform the small group market resulted in enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996. A key provision of HIPAA required states to adopt a series of insurance reforms designed to improve the availability and affordability of insurance products for small employers. HIPAA set a floor for rating restrictions, required guaranteed availability, and guaranteed renewal of policies in the small group market. As a result of HIPAA, small employers can access health insurance coverage.

Nevada responded to the enactment of HIPAA by enactment of A.B. 521 during the 1997 legislative session. The legislation created the Program of Reinsurance for Small Employers and Eligible Persons. This program was designed to address portability, availability and affordability

of health insurance in the individual and small employer market.

Under the Program, two levels of health benefit plans are offered: a basic and a standard plan. All insurance companies are required to offer the plans, and to lower costs, the plans are exempt from certain statutory required services and provider types. For policies written under the program, losses for any covered individual above a threshold are covered by a reinsurance pool at 90%. The reinsurance pool is funded through an assessment on the reinsuring carriers.

It has been reported that there is virtually no enrollment in the Program. It has been speculated that the lack of enrollment is because the carriers participating in the reinsurance fund are, in essence, reinsuring themselves.

In spite of the enactment of the Program of Reinsurance for Small Employers and Eligible Persons, cost of coverage remains a large barrier to small employers offering insurance.

In January 2005, the Legislative Committee on Health Care (LCHC) Subcommittee to Study Health Insurance Expansion Options issued a report identifying the Health Insurance Flexibility and Accountability (HIFA) waiver as a means to expand insurance to small employers. The original intent of this initiative was to target small employers (two to 50 employees) by offering a subsidy paid with State and federal funds. The subsidy would be available for the working uninsured with incomes below 200% of the federal poverty level (FPL).

Unfortunately, the recently enacted Deficit Reduction Act placed restrictions on the use of the federal funds Nevada was to use for the subsidy. The legislation prohibits the use of SCHIP funds for childless adults. This effectively negated the State's effort to target small employers with the use of leveraged federal funds.

The State has redirected its HIFA waiver to target the population of working uninsured that are parents and whose children are currently covered by Medicaid or Nevada Check Up (200% of the FPL).

As small employers are forced to drop or not offer insurance because of the cost, their employees join the ranks of the uninsured, of which there are approximately 426,000 in Nevada. Of this number, it is estimated that 83% are in households that have a full- or part-time worker.

Expanding the affordability of insurance for, and take-up of, insurance by small employers offers significant opportunities to ensure that Nevadans are able to receive health care services.

Strategies. In order to address issues pertaining to small employers, the Summit participants adopted the following strategies to explore and improve the affordability and availability of health insurance in the small group market.

1. Create a Task Force to look for long-term approaches to encourage small business owners to offer insurance and to evaluate why the existing small employer product that Nevada insurance companies are mandated to offer has such low take-up. Among the approaches that should be examined are:
   - various forms of standard benefit packages for the small group market;
   - providing subsidies for insurance, either to the population at large or to small employers; and
   - establishing a universal coverage program for Nevada.
2. Fully implement the concept of the HIFA waiver, but have the State assume the funding for the cost that the federal government will no longer provide.

The Safety Net

Safety net providers deliver health care services regardless of the patient's ability to pay. Because of the state's provider shortage, the safety net system fills gaps for both the insured and uninsured. In Nevada, the safety net system is largely comprised of:

- community health centers,
- University Medical Center and rural public hospitals, and
- County Indigent Fund programs.

The safety net strategies discussed during the planning process primarily focused on community health centers (CHCs). National studies have found that CHCs that provide primary care and prevention services save the Medicaid program at least 30% annually. This savings accrues from Medicaid beneficiaries who use health centers and then have reduced need for specialty care referrals and hospital admissions. It is also estimated that, if patients utilizing the emergency rooms for non-emergency services were redirected to a CHC, up to $8 billion could be saved nationally.[20]

Since 2001, there has been a federal focus on increasing the number of health centers and to expand funding for the overall program. Appropriations have increased by 53%, from $1.16 billion to $1.78 billion, over the past five years, and the FY 2007 President's budget request is at $2 billion.

There are two CHC systems in the state: Nevada Health Centers, Inc., and Health Access Washoe County (HAWC). These CHC systems provide services through 28 facilities across the state and offer a range of medical, behavioral health and dental services.

The CHCs provide services in every age, income and ethnic range. Their clients are both uninsured and insured, with the insured being covered by group, private and public

programs such as Medicare and Medicaid. In 2004, the CHCs served 55,588 Nevadans. By 2005, the CHCs served 67,904 Nevadans, an increase of 22%. These clients utilized 170,903 total visits of care, reflecting the increased pressure on the safety net system. Of the total visits, 53% were utilized by the uninsured, 23% were utilized by people enrolled in Medicaid, and the remaining 24% were utilized by people who had either Medicare coverage or private insurance. The total annual operating cost of the two systems is approximately $20.6 million.

Strategies. In order to expand and enhance safety net coverage in Nevada, the Summit participants adopted the following strategies.

1. Provide funding to Nevada's Federally Qualified Health Clinics (FQHCs) and FQHC look-alikes to improve access to health care services for both the uninsured and the insured. Funding should be for both capital and ongoing operations but be flexible enough to allow for unspent capital funds to be reallocated to ongoing operations.
2. Provide ongoing funding to support administration of local community networks that offer coordination of primary and specialty care services to the uninsured.
3. Increase funding for Senior Rx and Disability Rx programs.

Behavioral Health

There is a great need for behavioral health services in Nevada. Among western states, Nevada has one of the highest prevalence rates of mental illness, with 4% of the population living with a serious mental illness.[21] In terms of substance abuse, Nevada has one of the nation's highest percentages of population reporting past-month use of illicit drugs. Nevada's rankings with respect to substance abuse have improved markedly since 1999. In that year the state was ranked 1st in past-month use of illicit drugs (now 5th), 1st in illicit drug dependence (now 30th) and 8th in past-month binge alcohol use (now 47th).[22]

While improvements have occurred in substance abuse, other aspects of Nevada's service delivery system have not been able to meet the demand. Along with service infrastructure issues (e.g., lack of providers), behavioral health funding has historically been low in comparison to other states' programs.

For example, on a national comparison based on FY 2003 expenditures,[23] Nevada ranked:

- 37th in overall mental health spending and 36th in per capita expenditure ($63),
- 41st in state hospital spending and 42nd in per capita expenditure ($18),
- 33rd in community based program spending and 29th in per capita expenditure ($44), and
- 34th in the percentage of total mental health revenues from Medicaid (23%).[A]

Another example of the unmet need is contained in the Division of Mental Health and Developmental Services (DMHDS) 2004 prevalence study. The study estimated that there were 55,700 residents with either SMI or SED conditions in the Division's service area. The study reported that only 23,800 (43%) of those individuals received services from the Division.

The Clark County Mental Health Consortium reports similar figures for Clark County elementary school children in its 2004 report. Of the estimated 7,800 children with SED that need services, only 37% received services and, among them, 83% were underserved.

Recognizing the need to enhance Nevada's behavioral health delivery system, the State has recently provided significant resources to the system. Examples of recent funding initiatives include:

- Increasing funding for DMHDS mental health services. During the 2005 Legislative session, DMHDS received a 47% funding increase ($91.4 million) that provided for the following:
  - o *Southern Nevada Adult Mental Health Services:* medication clinic services, residential support, psychiatric ambulatory services, the opening of the new hospital, and the addition of beds to two other State facilities. Additionally, funding was provided for community residential placements, overflow beds, a Mental Health Court in Clark County, and support for a community triage center.
  - o *Northern Nevada Adult Mental Health Services:* medication clinic services, community residential services, and psychiatric ambulatory services. Additional funding was also provided to expand and support the Washoe and Carson City Mental Health Courts and a triage center for Washoe County.
  - o *Rural Clinics:* medication clinic services and an increase in outpatient services.
- Expanding the Wraparound in Nevada (WIN) program to provide case management and wraparound support to child welfare custody children with SED.
- Implementing the Behavioral Health Redesign by DHCFP to change the revenue flows and payment rules for behavioral health services. The redesign in-

[A] The national average was 39%, with the highest percentage found in the state of Washington at 87%.

creased the availability of community based services. Included in the redesign is the development of specialty clinics for the delivery of lower level services and the expansion of the number of providers available.

The significance of the recent funding increase for DMHDS's mental health services is depicted below. Also revealed is the dependency of the Division's mental health budget on general fund monies.

DMHDS Mental Health Agencies Budget Sources
Selected Years • Dollars in Millions

	FY 2005		FY 2006	
General Fund	$69.2	78%	$107.0	85%
Federal Funds	10.0	11%	10.9	9%
Fees	0.2	0%	0.9	1%
Other	9.2	10%	7.8	6%
Total	$88.7	100%	$126.5	100%

Strategies. In order to address issues pertaining to behavioral health, the Summit adopted the following strategies for enhancing behavioral health services:

1. Decrease the number of persons with behavioral health conditions who inappropriately utilize the emergency departments, by:
   - increasing the number of available psychiatric beds by paying for placement in private beds, and/or funding additional State-operated beds, and/or continuing to support and fund crisis beds such as those offered by WestCare, and/or incentivizing the private sector to add psychiatric beds to hospitals through the establishment of appropriate reimbursement rates;
   - expanding the crisis support system to include the enhancement of a mobile crisis team system to better meet the needs of children and families;
   - expanding ongoing community based behavioral health services; and
   - conducting a review of medical clearance requirements and making appropriate revisions to the rule.
2. Implement strategies to increase Medicaid funding for the State's behavioral health system.
3. Review the new Medicaid State Plan option available though the Deficit Reduction Act and waivers available under the 1915(c) waiver option and select the most appropriate approach to implement to enhance home and community based services for Medicaid eligible persons with SMI.
4. Review the new Medicaid demonstration grants established under the Deficit Reduction Act and waivers available under the 1915(c) waiver option and select the most appropriate approach to implement to enhance home and community based services for Medicaid eligible children and adolescents with SED.
5. Restructure and unify the behavioral health system as necessary in order to ensure delivery of effective and coordinated services.
6. Develop a comprehensive system for the delivery of behavioral health preventive services that is integrated across the community (e.g., schools, health care practitioners, private insurers).
7. Expand mental health/substance abuse parity requirements to incorporate a wider array of services and covered diagnosis.

Prevention and Wellness

Health indicators serve as a benchmark for assessing the health of a given population and provide a baseline for measuring improvement. The Fund for a Healthy Nevada reported statistics on the health status of Nevadans in September 2005.[24] These statistics showed the state as ranking low, when compared to other states, on a number of key health indicators:

- a high rate of mothers receiving late or no prenatal care,
- the fewest dentists per capita,
- the second highest rate of adults who smoke, and
- the highest rate of women smokers

While these statistics cause concern, there are some areas in which Nevada is showing improvement. The UnitedHealth Foundation report on state health rankings reveals that Nevada has been making positive strides since 1990. Specifically, the State has reduced infant mortality (from 9.4 per 1,000 live births in 1990, to 6.2 in 2005) and reduced the incidence of infectious disease (from 50 cases per 100,000 population in 1990, to 23 cases in 2005).[25]

In its 2005 report, the Foundation ranked Nevada as 37th among the states, citing as Nevada's primary concerns the low childhood immunization rate, a high violent crime rate, and a high uninsured rate.

Other studies also show Nevada with mixed results when compared to other states. For example, the Kaiser Family Foundation's StateHealthFacts.org website showed that Nevada is generally either average or slightly below average when compared to other states or national averages.[26]

Kaiser indicates that Nevada compares favorably on its rate of obesity among its population (Nevada 19%, U.S.

21%) and has a very low rate of death related to diabetes (Nevada 17.6 per 100,000, U.S. 25.4 per 100,000). The rankings indicate that Nevada is at or near the national average for these measures:

- cancer deaths per 100,000 (Nevada 203, U.S. 194)
- stroke deaths per 100,000 (Nevada 57, U.S. 56)
- heart disease deaths per 100,000 (Nevada 246, U.S. 241)
- percent of persons with a disability (Nevada 18%, U.S. 18%)

The Kaiser rankings also indicate that Nevada ranks worse than the national average for the following measures:

- number of deaths per 100,000 (Nevada 919, U.S. 845)
- motor vehicle deaths per 100 million miles driven (Nevada 2.0, U.S. 1.6)
- percentage of adults who are smokers (Nevada 23%, U.S. 21%)
- percentage of persons reporting poor mental health (Nevada 41%, U.S. 34%)
- percentage of persons with visits to a dentist or dental clinic in the past year (Nevada 65%, U.S. 70%)

Strategies. Implementing prevention and wellness strategies can improve the overall health status of Nevadans and help mitigate the rate of increase in health care expenditures. In order to improve the State's efforts relating to prevention and wellness, the Summit participants adopted the following strategies to improve the overall health of Nevadans.

1. Improve the immunization rate for all Nevadans through the addition of community based marketing, education and awareness campaigns targeted to both consumers and health care providers regarding the value of immunizations. In addition, the Nevada Department of Health and Human Services (DHHS) should review the current recommended vaccination schedule for possible changes.

2. Expand prenatal care services by "building out" the existing prenatal care network with continuity of care and perinatology services, consider the addition of case management services to the prenatal care program, and provide for presumptive eligibility under the Medicaid program for pregnant women.

3. Expand the Oral Health Care Program, including the addition of a State Dental Officer, adding resources for increasing access for oral health care for all age groups, and exploring the feasibility of requiring dental evaluations for children in kindergarten and second and sixth grades. Additionally, the Medicaid program should provide dental coverage to adults enrolled in the program.

4. Reduce exposure to second-hand smoke.

5. Invest in wellness programs to reduce chronic disease. Such programs should have concrete spending plans and be branded statewide.

Health Care Planning

All states have at least nominal health planning functions, and Nevada is no exception. However, the focus groups collectively expressed their perception that there is no centralized responsibility for health care planning in Nevada. There were recommendations and observations that Nevada needs a planning function that will have the attention of policy makers, perform analysis on the volumes of data that are collected, and promote policies to address the challenges facing the Nevada health care system.

The focus groups pointed to the stress that population growth is placing on the health care delivery system, the shortage of health care professionals, and the lack of access to primary and specialty care as evidence of inadequate planning in the state. Additionally, the focus groups commented that more could be done to encourage evidence-based practices, promote the evaluation of the system on the basis of outcomes and quality, and to address the disparity in access, coverage and outcomes among population groups. It was also observed that there was no regular, standardized assessment of community needs, no detailed analysis of the uninsured population, and inadequate or no planning for health care manpower needs.

It was also recognized that nearly all states have a shortage of some type of health care professional. According to a 2002 survey of the states, 90% of the states had a shortage of registered nurses, and a majority had shortages in five other professional categories.

There is concern that, with an aging population across the country, the supply of health care professionals will not adequately respond to increasing demand. This concern has spurred 44 states to create commissions charged with finding ways to encourage more people into these fields.

If most states have a workforce shortage problem, Nevada has one of the worst. In 2000, Nevada ranked among the bottom states in the number of health care professionals per 100,000 residents for almost all of the health care profession categories.[27] Nevada's population grew at a rate approximately three times the national average in 2005; without substantial growth in the health care workforce, these rankings very well may deteriorate.

Given the relatively scarce health care resources in Nevada, it is logical that existing resources should be used as efficiently and effectively as possible. Health Information Technology (HIT) and Health Information Exchange (HIE)

are strategies that promote efficiency in the delivery of health care.

HIT refers to the information technology used by providers in their offices, clinics, laboratories and hospitals. Examples include electronic prescribing, digital results delivery, and electronic medical records. HIE is the exchange of that information with other providers, with consumers, with health quality monitoring organizations, and with payers and researchers.

The Rand Corporation recently estimated that HIT would save the nation $77 billion annually if its adoption were widespread. Savings accrue primarily through:

- reductions of medical errors,
- increased efficiency,
- avoidance of duplicative health care procedures,
- improved coordination, and
- increased participation of consumers.

There is considerable momentum at the federal level, both in Congress and within the Administration, in moving toward comprehensive HIT and HIE. The Office of the National Coordinator for Health Information Technology (ONCHIT) was established to achieve 100% electronic health data exchange among payers, health care providers, consumers of health care, researchers and government agencies as appropriate.

The Centers for Medicare and Medicaid (CMS) also has a number of initiatives to support the adoption of health information technology. In Congress, 11 legislative initiatives have been proposed (with funding) to promote health information technology and exchange. A number of states, such as Arizona, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, New York, Oregon and Rhode Island, have taken steps to guide the development of HIT and HIE.

In 2005, eHealth Initiative conducted the "Second Annual Survey of State, Regional, and Community Based Organizations on Emerging Trends and Issues in Health Information Exchange" (supported by a cooperative agreement with the Health Resources and Services Administration, Department of Health and Human Services). eHealth Initiative is a national organization that monitors HIT and HIE initiatives across the states and provides assistance to states that want to move forward.

In April 2006, the eHealth Initiative released the rankings of states in the western region on their stage of progress toward HIE. Nevada ranked behind all of the other states in the West, including Arizona, California, Colorado, Utah and New Mexico.

The Summit participants saw an opportunity for a centralized health care systems planning function that could create a vision for the health care system, promote quality and technology, analyze data that is collected, define best practices, and inform consumers through the benchmarking health care indicators.

The ideal planning function would have a systematic process for collecting and disseminating quality and performance data, assessing and evaluating community and statewide health care system needs, compiling and analyzing data, and developing policy options.

Strategies. In order to enhance planning for the current and future health care needs of Nevadans, the following strategies were adopted at the Stakeholders' Health Summit.

1. Develop an adequately funded Office of Health Planning, with an Advisory Panel that will oversee health care planning and policy development within Nevada and that will:
   - integrate available data and collect additional data, perform analysis, plan for health system needs, and promote accurate information about health care costs to public and policy makers;
   - promote more informed decision making through the dissemination of information about both the quality and the cost of health care services; and
   - perform community needs assessments throughout Nevada that will serve as the basis for responding to gaps in services (needs), disparities among populations, and achieving better health outcomes (the assessments should identify the resources necessary to meet the community's needs and initiate a process to align needs and resources).
2. Within the Office of Health Planning, include an Office of Workforce Development that will oversee health care workforce planning and policy development within Nevada and that will:
   - collect, maintain and provide data analysis; issue reports; link with universities and colleges, relevant State departments, and other public/private entities; and commission studies and apply for grants;
   - review the operations of the health care professional licensing boards with respect to barriers to licensing;
   - review the scope of practice statutes and rules for licensed health care professionals;
   - develop and recommend strategies to attract and retain medical professionals (including nurses) in Nevada; and
   - provide additional funding for existing loan programs to attract and retain medical professionals.

3. Support the concept of a Nevada Academy of Health, which would be a public-private collaboration.
4. Promote development of HIT and coordinate the development of HIE by:
   - creating a time-limited statewide steering committee that will be convened and supported by the State for the purpose of developing a high level plan for e-Health;
   - creating a statewide governance committee that will be created and funded to implement the steering committee's high-level plan; and
   - enacting legislation to clarify and protect consumer privacy that follows and complements federal laws.

Moving the Plan Forward for Legislative Consideration

When considered strictly from the health care system perspective, the recommendations adopted by the Summit are reasonable, sound and measured. They are focused on addressing Nevada issues and meeting the foreseeable needs of current and future Nevadans. They are not an attempt to improve Nevada's rankings to the "top of the list" in any particular area.

However the package of recommendations and strategies that were presented to the Stakeholders' Health Summit would require, if enacted immediately, funding of at least $594 million in the next biennium. Therefore, not all of the recommendations are being presented for consideration during the upcoming Legislative session. However, a large number of the initiatives will be presented to the Legislature. Recommendations will be presented to the Legislature in one of three ways:

Universities. The Universities will present the Health Science Center concept that begins to address many of the health professional education issues. Their proposal will focus on health care professional education through the initial development of the University of Nevada Health Sciences Center (UNHSC). Two of the major elements are:

- implementation of the first steps of UNSOM Strategic Plan to double enrollment, expand Graduate Medical Education, add faculty and expand research; and
- UNHSC Multi-Professional Initiatives, an interdisciplinary approach to bringing together the health professional schools in a manner that creates greater focus on Nevada's population health issues, health improvement, and prevention.

The Legislative Request for the UNHSC will also include funding of capital facilities.

DHHS. The Nevada Department of Health and Human Services is reviewing many of the recommendations for inclusion in its budget request to the Governor. While there is no certainty at this point as to what may be included in the budget recommendations, some of the items that are being reviewed include recommendations that address:

- Medicaid reimbursement rates for services delivered by hospitals, physicians and other providers and in the rural areas;
- behavioral health services, particularly those related to the diversion of behavioral health clients from hospital emergency departments;
- the availability of home and community based long term care services; and
- adding efficiencies to the eligibility process.

LCHC. The Committee, through Bill Draft Requests (BDRs) and expressions of support, is addressing many recommendations related to planning, prevention, the safety net and nursing education. Included in these areas are such items as the following.

Doubling the State's capacity for nursing education. While the State recently doubled enrollment, projections indicate that another doubling will be required in the next 10 to 15 years. The nursing program expansion was not originally included in the Universities' HSC proposal; therefore, the Committee made a specific point of supporting this recommendation.

Creating planning functions in both DHHS and at the Universities. At DHHS, the Committee is supporting the creation of an Office of Health Planning, Analysis, and Policy Support with an Advisory Committee that, in addition to other duties, would collect, analyze and disseminate information regarding the health care system, cost and quality as well as performing community health care assessments; and performing special projects in the areas of the Deficit Reduction Act, long term care, the behavioral health system and HIT and HIE.

At the NSHE, the Committee's actions would support adding resources to support health care workforce development and provide incentives to attract or retain health care professionals.

Additionally, the LCHC is requesting resources to conduct a review of the operation of the health care licensing boards with respect to barriers to licensing the scopes of practice for licensed health care professions.

Expanding substance abuse services. Based on the recommendation of the LCHC Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse, the Committee is including such items as (a) funding a pilot program that provides long-term residential facility for substance abusers and (b) providing funding to the Department of Corrections for a comprehensive post-

incarceration treatment program to enable nonviolent offenders to transition back into society.

Supporting safety net providers that serve significant numbers of the uninsured. The recommendation package includes (a) creation of a grant program to support the expansion of, and services offered by, certain primary care clinics for treatment of uninsured patients, and (b) support for the development of networks extending from the primary care clinics to provide specialty services to the uninsured at discounted rates.

Funding wellness programs to prevent and control chronic diseases. Among the prevention and wellness programs for which the Committee expressed support were:

- an enhancement of the DHHS immunization registry,
- funding the State Dental Health Officer,
- expansion of the DHHS prenatal services program through outreach and educational initiatives, and
- providing a substantial increase in funds to support the expansion of wellness programs to prevent chronic disease through State funding for statewide initiatives.

This initiative would provide support for the Office of Minority Health; provide technical assistance and grants to community organizations, school districts, coalitions, taskforces and employers; assist communities in establishing prevention programs; conduct chronic disease screening and educational activities; and engage in outreach at public events to promote health awareness.

Supporting supplemental funding for the Senior Rx and Disability Rx programs. The purpose of this Committee action would be to reduce the number of individuals on waiting lists for the Disability Rx program. ◗

Process and Results

ASSEMBLY BILL 342 (Chapter 418, Statutes of Nevada 2005) directed the Legislative Committee on Health Care (LCHC) to undertake a wide-ranging effort to develop a Nevada State Health Plan, to include, without limitation, a review of Nevada's health care needs as identified by State agencies, local governments, providers of health care, and the general public.

LCHC started its mandated work in November 2005. The Committee's role throughout the planning process was to:

- provide overall guidance for the development of this Plan;
- receive testimony pertaining to Nevada's health care system;
- sponsor the planning process through the formation of stakeholder focus groups and the organization of a Stakeholders' Health Summit;
- supervise the activities of the consultants retained to facilitate the planning process; and
- coordinate with State agencies and monitor other planning activities that were occurring simultaneously with the Committee's activity.

These activities largely occurred simultaneously. The Committee held ten meetings to organize the planning process and receive testimony; at the same time six focus groups were meeting. Once the work of the focus groups was complete, the Committee organized and sponsored the Stakeholders' Health Summit. After the Summit, the Committee reviewed the Summit's recommendations and coordinated with the Nevada System of Higher Education (NSHE) and the Department of Health and Human Services (DHHS) in the adoption of potential recommendations for the upcoming Legislative session.

LCHC Activities

The Legislative Committee on Health Care (LCHC) maintained a heavy work schedule throughout the 2005-2006 interim. While its members were participating in the focus group and Summit activities, the Committee held 10 full Committee meetings to collect testimony concerning the status of the health care system in Nevada. The Committee finalized its interim activities in August 2006 at a work session to adopt recommendations for legislation and positions of support for various health care initiatives.

The Committee's first two meetings were largely concerned with organization for the planning process and collecting background information on existing strategic plans in Nevada. During these meetings, the Committee adopted its work plan and received updates on Nevada's existing strategic plans on:

- services provided to adults and children with disabilities,
- rural health issues,
- senior services, and
- the rates of payment for services provided by the DHHS.

The third meeting of the Committee accepted testimony on mental health services, health disparities and the uninsured population in Nevada. The fourth meeting focused on the state's health-oriented education institutions and health care professional licensing.

Meetings five and six focused on health care facilities, including hospitals, nursing homes, mental health facilities, community health centers and the health insurance market in Nevada.

The seventh meeting of the Committee was held in Elko and focused on issues of rural health care. Topics for which testimony was presented at this meeting included:

- rural health care,
- the certificate of need process for certain health facilities,
- access to behavioral health services,
- emergency medical transportation,
- telemedicine, and
- community health centers in rural Nevada.

In meeting eight, the Committee was briefed on various publicly supported health care systems, including Medicaid and Nevada Check Up, the public health system, chronic disease prevention and control, oral health programs, the Senior Rx and Disability Rx programs, and various safety net health care programs.

At its ninth meeting, in June, the full Committee was apprised of the recommendations adopted by the Stakeholders' Health Summit.

In its final meeting before its work session, the Committee received testimony regarding medical clearance for allegedly mentally ill persons, mental health and substance abuse services for children, expansion plans for nursing programs in the NSHE, potential structures for statewide

planning efforts for both the health care system and health care workforce issues, a rural emergency medical services fund, and a proposal for increasing access to health care services for certain uninsured persons in Nevada.

In August the Committee held its work session to discuss and take action on its recommendations and its work from the interim. In this meeting, the Committee adopted certain recommendations that emanated from the testimony it had received as well as from the Stakeholders' Health Summit. The Committee agendas and minutes and the Summary of Recommendations may be viewed online at http://leg.state.nv.us/73rd/Interim/StatCom/HealthCare.

Focus Groups

More than one hundred health care system stakeholders were invited to participate in the six focus groups that were held in February and March of 2006 *(see "Focus Group Participants" on page 17).* Each focus group addressed one of six general areas of Nevada's health care system:

- health care facilities,
- health care professionals,
- medical coverage,
- pharmaceutical coverage,
- health professional education, and
- the public health system.

The purpose of the focus groups was to identify issues related to the topic area and to formulate recommendations to address these issues. The results of all six focus groups were later combined, and background information was compiled. From that information, strategies were developed for consideration of the participants at the Stakeholders' Health Summit.

Each focus group engaged in a SWOT analysis. This involved an examination of:

- *Strengths*: Identification of elements that are already in place and working well in Nevada's health care system
- *Weaknesses*: Identification of elements that are missing or are not working well in Nevada's health care system
- *Opportunities*: Identification of factors from either inside or outside the system that can be used to make improvements in Nevada's health care system
- *Threats*: Identification of elements from either inside or outside the system that could provide set backs or impediments in making improvements to Nevada's health care system.

Upon completion of the SWOT analysis, participants were asked to brainstorm recommendations that would build on strengths, diminish weaknesses, take advantage of opportunities, and mitigate threats. These recommendations were then grouped into subtopic areas that targeted improvements in the overall topic area. The recommendations were then prioritized by the participants, who were each given five "dots" to place by the recommendations that they felt were their top priorities.

The recommendations receiving the most votes within each focus group were:

Health care facilities

- Change the current requirements related to mental health screening and medical clearance for mental health patients presenting at the emergency room in order to facilitate triage of these individuals to appropriate settings and services and to reduce unnecessary utilization of emergency rooms.
- Implement presumptive eligibility under Nevada's Medicaid program, including individuals applying for coverage under Supplemental Security Income.
- Expand eligibility and service coverage under Nevada's Medicaid program.
- Increase the number of instructors in health professional schools.
- Increase funding and access to appropriate placements and services for individuals with mental health conditions.
- Improve timeliness and appropriate utilization of emergency room services.

Health care professionals

- Adequately fund Medicaid (including mental health) to ensure "proper" provider compensation that will result in an adequate number of health care professionals who are willing to accept Medicaid clients.
- Tie funding for health care education to a systematically designed plan that is based on identified state health care workforce needs.
- Establish an independent task force to determine how to better utilize licensed health care professionals in order to address workforce needs.
- Examine the interaction of health care disciplines and their scopes of practice in order to develop strategies for improving utilization of health care professionals in the state.
- Develop primary care and prevention services in order to ease the burden on tertiary care facilities, especially in underserved areas, and to ensure a culturally sensitive, holistic approach to caring for patients.

Medical coverage

- Improve opportunities for small employers to offer employee health care coverage (e.g., greater product flexibility).
- Through a collaborative effort, increase outreach to Nevadans who are eligible for Medicaid/SCHIP but not enrolled, as well as improve the eligibility process itself.
- Develop a plan to leverage technology related to electronic transfer of information for both data base analysis and medical records.
- Develop a comprehensive and systematic process to identify community costs, access issues, service gaps, duplication of services/programs, impact of aging population, etc. (community needs assessment).
- Develop strategies to ensure access to coverage for the uninsurable.

Pharmaceutical coverage

- Create a third class of drugs that pharmacists can dispense without a physician prescription.
- Increase funding for the Senior Rx and Disability Rx programs.
- Expand the use of ancillary personnel (e.g., pharmacy technicians).
- Expand consumer education related to pharmacy programs and utilization.
- Fund programs targeted at increasing the use of e-prescribing.
- Develop strategies to increase the use of generics and over the counter drugs.

Health professional education

- Expand State funding for educational infrastructure, both operational and capital.
- Create, endorse and fund an integrated health sciences center for statewide research and training, including post-graduate education.
- Develop and enhance educational continuum to increase the number of all licensed professionals that are educated in-state. This includes increasing class sizes for student/residents, improving infrastructure needed to support the program (e.g., clinical sites, faculty, mentoring), and developing rural training tracks and post-graduate training.
- Create and fund an independent commission to study and develop a comprehensive plan that includes all the options (e.g., training, recruitment, retention, GME, use of retirees) for addressing health care professional workforce needs.
- Refocus Millennium scholarships on health care professionals and educators.

The public health system

- Improve funding for chronic disease prevention and control.
- Expand eligibility for Medicaid, and appropriately fund the expansion.
- Preserve county safety net programs.
- Create a new model for the delivery of health care services that includes the use of technology and independent practice models.
- Strengthen the Public Health Foundation and expand private-public partnerships.

The results of the focus group process were compiled, and six (later modified to seven) overarching recommendation statements were developed to guide the development of specific strategies to present to the Stakeholders' Health Summit. The seven major recommendation statements that were developed are:

- **Health Care Professional Education.** Improve and expand the State's capacity to provide a health care professional education continuum to increase the number of licensed health care professionals in the state.
- **Medicaid and SCHIP.** Expand program eligibility, enrollment and service coverage under the State's Medicaid and SCHIP programs.
- **Small Employer Health Insurance.** Develop mechanisms to provide coverage for the small employer market and for individuals who are uninsurable.
- **The Safety Net.** Improve access to services for both the insured and uninsured by supporting and expanding the safety net provider network.
- **Behavioral Health.** Increase access to and funding for an appropriately designed mental health and substance abuse program for Nevadans who require those services.
- **Prevention and Wellness.** Expand and initiate programs that will improve the overall health status of Nevadans by focusing on prevention and wellness.
- **Health Care Planning.** Develop positive proactive plans for addressing the health care system challenges in Nevada with formalized planning bodies that coordinate and disseminate information on health care policy, quality, community needs, workforce issues, and health information technology and information exchange.

These recommendation statements, as well as the 32 "high scoring" recommended strategies from the focus groups, served as the basis for developing six issue papers containing approximately 84 strategies and sub-strategies prepared for the Summit.

Stakeholders' Health Summit

On May 17, 2006, the Stakeholders' Health Summit was held at the Thomas and Mack Center on the campus of the University of Nevada, Las Vegas. Its purpose was to evaluate strategies and sub-strategies that were developed as a result of the focus group process and adopt recommendations that would represent the Nevada State Health Plan.

Invited to the event were 113 individuals who had participated in at least one of six focus groups held in February and March 2006. Seventy-six of the invitees attended the Summit.

Prior to the Summit, issue papers were developed in six areas and sent to Summit participants for review. Issue papers were prepared for the areas of Medicaid and SCHIP; Behavioral Health; Health Care Professional Education; Small Employer Health Insurance and the Safety Net; Planning; and Prevention and Wellness.

Each issue paper presented an overview of the topic area and strategies and sub-strategies that were developed for consideration by Summit participants. The proposed strategies were linked to the recommendations of the focus groups.

At the Summit, participants were divided into six break-out groups corresponding to the issue papers that had been distributed. Each participant was assigned to two groups, with assignments made to ensure balanced participation among representatives from providers, payers, advocates, State agencies and other stakeholders.

The Summit convened with an introduction to the day's events, followed by morning and afternoon break-out sessions. At the end of the morning break-outs, the entire group reconvened in a pre-lunch plenary session to review the decisions made. The process was repeated in the afternoon.

Each break-out group was assigned a moderator, recorder and reporter. The moderator outlined the strategies, facilitated discussion, and determined the level of consensus in support of or opposition to each strategy proposed. The recorder took notes of the discussion in the session and recorded any amendments to the previously identified strategies and to any new strategies that were introduced during the session. One member from the invitees was designated as the reporter, to speak for the group during the subsequent plenary session.

"Consensus" defined. Before dividing into the breakout groups, participants were advised that the goal of the day's process was to reach *consensus* on the strategies presented to the group. For the purposes of the Summit, "consensus" was defined as:

> …a decision most everyone agrees that they can at least live with as it relates to the proposal. Some people will be very supportive of the proposal; others may not be as supportive. While everyone may not be wildly enthusiastic about the proposal, if they do not oppose it, consensus will be declared. There will also be consensus if everyone agrees that the proposal should not be implemented.

Once in the break-out groups, participants discussed the strategies and were given the opportunity to suggest modifications, including deleting, amending or adding their own strategy. Each strategy was given an assessment as being:

- unanimously approved or disapproved,
- near-unanimously approved or disapproved, or
- a split decision.

Eighty-four strategies and sub-strategies were offered for consideration, and 12 strategies were added by participants.

The two plenary sessions provided a forum for the groups to report their decisions and respond to questions. The sessions also afforded the opportunity for participants to offer amendments or to propose new strategies.

Recommendations and Outcomes

The strategies and sub-strategies adopted at the Summit were consolidated for the purposes of presentation into 39 strategies. Other chapters of this report present and discuss each of the strategies in more detail. In addition, a high level description of each of the adopted strategies that comprise the Nevada Strategic Health Care Plan is contained in the Executive Summary.

Next Steps

The package of recommendations, if enacted immediately, has been estimated to require funding of at least $594 million in the next biennium. This is obviously not within the fiscal capacity of the State, particularly given the other priorities that the Legislature will be asked to fund in its upcoming session. Additionally, these recommendations are best considered by the Legislature in a variety of forums, including the Governor's budget recommendation, NSHE budget requests, bills introduced by the LCHC, and bills introduced by standing Committees.

At the time of this writing it is anticipated that a significant number of the recommendations will be presented to the Legislature in one of three ways: by the NSHE, through the Governor's budget and based on recommendations of the LCHC.

The NSHE. The NSHE is anticipated to present its Health Science Center concept that begins to address many of the health professional education issues through a legislative budget request. Their proposal will focus on health care

professional education through the initial development of the University of Nevada Health Sciences Center (UNHSC). Two of the major elements are:

- early Implementation of the UNSOM Strategic Plan to double enrollment, expand Graduate Medical Education, add faculty and expand research; and
- UNHSC Multi-Professional Initiatives, an interdisciplinary approach to bringing together the health professional schools in a manner that creates greater focus on Nevada's population health issues, health improvement, and prevention.

DHHS. The Nevada Department of Health and Human Services is reviewing many of the recommendations for inclusion in its budget request to the Governor. While there is no certainty at this point as to what may be included in the budget recommendations, some of the items that are being reviewed include recommendations that address:

- Medicaid reimbursement rates for services delivered by hospitals, physicians, other providers and in the rural areas;
- behavioral health services, particularly those related to the diversion of behavioral health clients from hospital emergency departments;
- the availability of home and community-based long-term care services; and
- adding efficiencies to the eligibility process.

LCHC. The Committee, through Bill Draft Requests (BDRs) and expressions of support, is addressing many recommendations related to planning, prevention, the safety net and nursing education. Included in these areas are such items as the following:

Doubling the State's capacity for nursing education. While the State recently doubled enrollment, projections indicate that another doubling will be required in the next 10 to 15 years. The nursing program expansion was not originally included in the Universities' HSC proposal; therefore, the Committee made a specific point of supporting this recommendation.

Creating planning functions in both DHHS and at the Universities. At DHHS, the Committee is supporting the creation of an Office of Health Planning, Analysis, and Policy Support with an Advisory Committee that, in addition to other duties, would collect, analyze and disseminate information regarding the health care system, cost, quality as well as performing community health care assessments; and performing special projects in the areas of the Deficit Reduction Act, long term care, the behavioral health system and HIT and HIE.

At the NSHE, the Committee's actions would support adding resources to support health care workforce development and provide incentives to attract or retain health care professionals.

Additionally, the LCHC is requesting resources to conduct a review of the operation of the health care licensing boards with respect to barriers to licensing the scopes of practice for licensed health care professions.

Expanding substance abuse services. Based on the recommendation of the LCHC Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse, the Committee is including such items as (a) funding a pilot program that provides long-term residential facility for substance abusers and (b) providing funding to the Department of Corrections for a comprehensive post-incarceration treatment program to enable nonviolent offenders to transition back into society.

Supporting safety net providers that serve significant numbers of the uninsured. The recommendation package includes (a) creation of a grant program to support the expansion of, and services offered by, certain primary care clinics for treatment of uninsured patients and (b) support for the development of networks extending from the primary care clinics to provide specialty services to the uninsured at discounted rates.

Funding wellness programs to prevent and control chronic diseases. Among the prevention and wellness programs for which the Committee expressed support were: enhancing the DHHS immunization registry, funding the State Dental Health Officer, expanding the DHHS prenatal services program through outreach and educational initiatives, and providing a substantial increase in funds to support the expansion of wellness programs to prevent chronic disease through State funding for statewide initiatives. This initiative would provide support for the Office of Minority Health, and provide technical assistance and grants to community organizations, school districts, coalitions, taskforces and employers; assist communities in establishing prevention programs; conduct chronic disease screening and educational activities and engage in outreach at public events to promote health awareness.

Supporting Supplemental Funding for the Senior Rx and Disability Rx Programs. The purpose of this Committee action would be to reduce the number of individuals on waiting lists for the Disability Rx program. ◗

Focus Group Participants

Name	Title / Organization	Health Facilities	Medical Coverage	Pharmaceutical Coverage	Public Health	Health Care Professionals	Professional Education
Ackerman, Gerald	Associate Director UNSOM Office of Rural Health						x
Anderson, Mary	District Health Officer Washoe County District Health Department				x		
Anspach, Jeanne	Nevada Health Division Bureau of Licensure and Certification	x					
Astley, Maury	Executive Director Nevada Dental Association					x	
Baepler, Don	Secretary/Treasurer Nevada State Board of Medical Examiners					x	
Bayona, Manuel	Director University of Nevada – Reno, School of Public Health				x		x
Begley, Doreen	Administrator Orvis Nursing Clinic, Reno				x		
Blumenthal, Alan	Medical Director PacifiCare of Nevada					x	
Boline, Steve	Regional CFO Nevada Rural Hospital Partners		x				
Bond, Bobbette	Government and Community Affairs Culinary Health Fund		x	x			
Bosse, Chris	Chairman, Data Finance Committee Nevada Hospital Association	x					x
Bridges, Nancy	Nurse Executive Nevada Hospital Association					x	
Brown, Frances	Dean, Health Science Community College of Southern Nevada						x
Burke, Brian	Rights Attorney Nevada Disability Advocacy & Law Center		x		x		
Canfield, Maria	Bureau Chief, Department of Health and Human Services Division of Health, Bureau of Alcohol and Drug Abuse				x		
Carro, Michelle	President Nevada State Psychological Association					x	
Cassano, Scott	Vice-President, Provider Services Sierra Health Services	x					
Cates, Patrick	ASO IV, Department of Health and Human Services Division of Health Care Financing & Policy						x
Chino, Michelle	Director, Center for Health Disparities Research UNLV School of Public Health				x		
Clark, Drennan (Tony)	Executive Director, Special Counsel Nevada State Board of Medical Examiners					x	
Cochran, Chris	Associate Professor UNLV, School of Public Health				x		
Cowling, Donna	Education Consultant Nevada State Board of Nursing						x
Crawford, Daryl	Executive Director InterTribal Council of Nevada				x		
Duarte, Chuck	Administrator, Dept. of Health and Human Services Division of Health Care Financing & Policy				x		

Name	Title / Organization	Health Facilities	Medical Coverage	Pharmaceutical Coverage	Public Health	Health Care Professionals	Professional Education
Dubroca, Darryl	CEO/Managing Director Spring Mountain Treatment Center	x					
Dugan, Christina	VP, Public Affairs Las Vegas Chamber of Commerce		x				
Durbin, Patricia	Executive Director Great Basin Primary Care Association				x		
Ebo, Emmanuel	Director of Pharmacy, SNAMHS State Director of Pharmacy, MHDS			x			
Elzy, Pat	Legislative Affairs Director Planned Parenthood of Mar Monte				x		
Everett, Kim	Actuary I Division of Insurance		x				
Foley, Helen	PacifiCare of Nevada		x				
Ford, Nancy	Administrator, Dept. of Health and Human Services Division of Welfare & Supportive Services				x		
Geinzer, Doug	President Recruiting Nevada					x	
Gilbertson, Elizabeth	Chairman Health Services Coalition	x					
Gold, Barry	Advocacy Director AARP		x				
Grimmer, Misty	Nevadans for Affordable Health Care	x	x				
Haartz, Alex	Administrator, Department of Health and Human Services Division of Health				x		
Haase, Susan	Nevadans for Affordable Health Care			x			
Hardesty, Cliff	Director of Pharmacy PacifiCare of Nevada			x			
Harter, Michael	Vice President for Administration Touro University - Nevada						x
Heard, Carl	Chief Medical Officer Nevada Health Centers, Inc.				x		
Heavey, Chris	Board Member Board of Psychological Examiners					x	
Heger, Jean	Corporate Director of Benefits Station Casinos, Inc.		x				
Hemmings, Mark	Program Manager Department of Health and Human Services, Division of Health					x	
Hillereby, Fred	Washoe Health System (now Renown Health)	x					
Huber, Deborah	Project Coordinator HealthInsight	x					
Hurst, Larry	Vice President, Government Affairs NevadaCare, Inc. (HMO)		x				
Jasmon, Joe	Executive Vice President/Chief Operating Officer Saint Mary's Regional Medical Center	x					

		Health Facilities	Medical Coverage	Pharmaceutical Coverage	Public Health	Health Care Professionals	Professional Education
Keith, Robin	President Nevada Rural Hospital Partners	x					
Kelly, Kathleen	Executive Director Board of Dental Examiners					x	
Kim, Jack	Nevada Association of Health Plans	x	x	x	x	x	x
Kimball, Cindy	Public Information Officer Nevada State Board of Nursing					x	
Kimbrough, Vicki	Truckee Meadows Community College						x
Kincaid, Robin	Training Director Nevada PEP		x				
Kiser Murphey, Cynthia	Sr. VP, Human Resources MGM Mirage		x				
Kwalick, Donald	Chief Health Officer Southern Nevada Health District				x		
LaPine, Joseph	VP, Compliance and Development RxAmerica			x			
Lau, Mary	President/CEO Retail Association of Nevada, Chain Drug Council			x			
Laxton, Ron	Administrator Washoe Medical Center (now Renown Health)					x	
Lay, Wendy	Deputy Director Great Basin Primary Care Association	x					
Lefkowitz, Todd	Vice President, Network Management & Development PacifiCare of Nevada	x					
Lenhart, James	Vice Dean, Residency Programs University of Nevada School of Medicine						x
Lynch, Ann	Vice President, Government Affairs Sunrise Hospital & Medical Center	x					x
MacMenamin, Elizabeth	Director of Government Affairs Retail Association of Nevada, Chain Drug Council			x			
Martin, Darryl	Assistant Clark County Manager Department of Family Services				x		
Matheis, Lawrence	Executive Director Nevada State Medical Association		x			x	x
McAllister, Rusty	President Professional Firefighters of Nevada	x					
McGee, Crystal	Nevada System of Higher Education						x
Miller, Jim	President/CEO Washoe Health System	x					
Montoya, Rosalie	Former Executive Director National Association of Social Workers, Nevada Chapter					x	
Musgrove, Dan	Executive Director, Intergovernmental Relations University Medical Center	x					
Pels-Jimenez, Karen	Nevada Service Employees International Union (SEIU) Local 1107					x	

		Health Facilities	Medical Coverage	Pharmaceutical Coverage	Public Health	Health Care Pro-fessionals	Professional Edu-cation
Perez, Karla	CEO/Managing Director Spring Valley Medical Center	x					
Perry, Charles	Executive Director - CEO Nevada Health Care Association	x				x	
Petersen, Christine	Vice President, Chief Medical Officer Sierra Health Services						x
Peterson, Colleen	Secretary/Treasurer Board of Examiners for Marriage and Family Therapists					x	
Pinson, Larry	Executive Secretary Nevada Board of Pharmacy			x			
Quilici, Susan	Health Information Manager Sanford Center of Aging, UNR						x
Retterath, Ken	Division Director Washoe County Dept of Social Services				x		
Robison, Randy	State Director Nevada NFIB		x				
Rosalin, Valerie	Director, Consumer Health Assistance Office of the Governor					x	x
Rosaschi, Rota	Executive Director Nevada Public Health Foundation				x		
Ruchala, Patsy	Director and Professor University of Nevada – Reno, Orvis School of Nursing						x
Salm, Chris	Nevada Service Employees International Union (SEIU) Local 1107					x	
Sasser, Jon	Statewide Advocacy Coordinator Washoe Legal Services		x		x		
Selleck Davis, Denise	Executive Director Nevada Osteopathic Medical Association		x			x	x
Shovlin, Jeff	Vice President of Benefits Harrah's Entertainment		x				
Singh, Tracy	Vice President Nevada Nurses Association					x	
Siversten, Darren	VP, COO Sierra Health Services, Managed Health Care Division			x			
Sloan, Carla	State Director AARP, Nevada	x		x			
Solde, Marie	Sierra Health Services		x				
Talley, Robert	Treasurer Nevada Dental Association					x	
Toney, Debra	Treasurer Southern Nevada Black Nurses Association				x		
Turner, Marcia	Director, Government Relations UNLV						x
Wadhams, Jim	Nevada Association of Health Underwriters		x				
Weiss, Pilar	Political Director Culinary Union Local 226	x					

Name	Title / Organization	Health Facilities	Medical Coverage	Pharmaceutical Coverage	Public Health	Health Care Professionals	Professional Education
Welch, Bill	President & CEO Nevada Hospital Association	x	x	x	x	x	x
Whipple, Ingrid	MHA Chief Executive Officer Montevista Hospital	x					
Willden, Michael	Director Department of Health and Human Services			x	x		
Winkelman, Darren	Carson City Environmental Health Department				x		
Works, Marina	Carson City Health Department				x		
Yedinak, Gail	Senior Management Analyst, Intergovernmental Relations University Medical Center of Southern Nevada				x	x	
Yost, Joseph	Manager Longs Pharmacy			x			
Yucha, Carolyn	Dean of School of Nursing University of Nevada - Las Vegas, School of Nursing						x

Health Care Professional Education

Compared to other states, Nevada ranks near the bottom in the number of health care professionals in nearly every category

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OVERVIEW

WHEN COMPARED TO other states, Nevada ranks near the bottom in the number of health care professionals per 100,000 residents in nearly every category. Moreover, there is a significant disparity between Nevada's ratio and the national averages, as exemplified by the following:

- Nevada ranks 48th in the number of physicians per 100,000, with 196, compared to the national rate of 262.[28]
- In 2000, among 46 states that have medical schools, Nevada ranked 43rd in the number of graduates, and graduated fewer new physicians per 100,000 population (2.8) than did the nation as a whole (6.4).[29]
- With 604 nurses per 100,000 population, compared to the national rate of 825, Nevada ranks 49th among the states. In this measure, Nevada is tied with California for last place.[30]
- Nevada has one of the lowest per capita rates of nurse practitioners in the nation at 15.2 per 100,000 population[31] (well below the national rate of 33.7) and ranks near the bottom of the states in the ratios of certified nurse midwives and registered nurse anesthetists.[32]
- In per capita terms, Nevada ranks:[33]
  - o 48th in the number of dentists,
  - o 31st in the number of pharmacists,
  - o 42nd in pharmacy techs,
  - o 44th in psychologists, and
  - o 48th in social workers.

Historically, Nevada has largely depended on attracting health care professionals from other states; consequently, efforts to develop the capacity for educating the health care workforce have not kept up with the state's explosive population growth. A current inventory of the health care professional education system reveals the following:

- the University of Nevada School of Medicine (UNSOM) with an entering class size of 52 students, and 194 residents and fellows enrolled in 14 approved programs;
- Touro University College of Osteopathic Medicine with an entering class size of 78 (and a capacity for 165) and 75 physician assistant students (with a potential enrollment capacity of 120);
- eight approved schools of nursing with aggregate enrollments of 1,570 registered professional nurse (RN) students;
- two community colleges offering licensed practical nurse (LPN) programs;
- masters degree in nursing programs at UNR and UNLV and a Ph.D. program at UNLV, with aggregate enrollments of 40;
- a masters degree in nursing program at Touro, with class size of 17 (and a capacity for 90);
- a School of Dental Medicine at UNLV with 300 doctoral students and 16 post-doctoral students;
- a School of Pharmacy at the University of Southern Nevada with a 2005 entering class of 142 students;
- Schools of Public Health at both UNR and UNLV, with aggregate enrollments of 367 undergraduates and 172 graduate students;
- the UNLV School of Health and Human Sciences programs in physical therapy, health physics, kinesiology, nutrition sciences, clinical laboratory sciences and radiology, with aggregate enrollments of 1,152 undergraduate and 120 graduate students; and
- other social and behavioral sciences programs at UNLV and UNR, with aggregate enrollments of 150 undergraduates and 40 graduate students.

FOCUS GROUP RECOMMENDATIONS

In three of the six focus groups convened for the development of the Nevada Strategic Health Plan, the participants developed recommendations that received broad support for actions involving health care professional education. These "high scoring" recommendations (listed with the originating focus groups) were to:

- Expand State funding for educational infrastructure, both operational and capital. *Health Professional Education*
- Create, endorse and fund an integrated health sciences center for statewide research and training, including post-graduate education. *Health Professional Education*
- Develop and enhance the educational continuum to increase the number of all licensed professionals that are educated in the state. This includes increasing class sizes for students/residents, improving infrastructure needed to support the program (e.g., clinical sites, faculty, mentoring), and developing rural training tracks and post-graduate training. *Health Professional Education*
- Tie funding for health care education to a systematically designed plan that is based on the identified state health care workforce needs. *Health Care Professionals*
- Increase the number of instructors in health professional schools. This includes (a) looking at criteria needed to teach and providing funding for health care instructors, (b) increasing recruitment of physicians and other health care professionals, and (c) ensuring high retention rates. *Facilities*

OTHER STAKEHOLDER GROUP RECOMMENDATIONS

On March 17, 2006, a Strategic Vision and Plan for the University of Nevada Health Sciences Center (UNHSC Plan) was presented for consideration to the Nevada Board of Regents.

The Strategic Vision and Plan defined the Health Sciences Center as "a University-based, integrated set of health professional education and biomedical research programs, aligned with supportive patient care programs." The overview of the UNHSC Plan called for the following actions:

- Build a more complete School of Medicine by increasing class size, increasing Graduate Medical Education (GME) program scope, strengthening community relationships and partnerships, and increasing faculty depth and breadth.
- Expand programs for nursing and other areas of the health professional workforce by increasing the class size and the scope of programs, establishing a School of Pharmacy, increasing faculty, and expanding community relationships.
- Improve state health outcomes and community health by enhancing community health education, research and service initiatives; focusing efforts across UNHSC on distinct education, research and service initiatives and the needs of Nevada; and collaborating with other agencies.
- Increase research and economic development by focusing research investments, increasing faculty depth and breadth, building community partnerships, and using UNHSC as an integrating vehicle.

Since the release of the initial Strategic Vision and Plan, the Board of Regents has prepared a Legislative budget request for funding for the Health Science Center, and the Chancellor's Office has released a plan to double the enrollment in public nursing programs by 2013. The Board of Regents is now engaged in an in-depth analysis to study other health sciences schools and programs analogous to that conducted for UNSOM.

Throughout 2006, the Governor's Commission on Healthcare Professional Education, Research and Training met to create short and long-term blueprints to enhance the level of healthcare professional education, research and training available in Nevada. In October 2006 the Commission released its recommendations. Among the recommendations related to healthcare professional education are to:

- create a University-based Health Science Center,
- expand Graduate Medical Education (GME) programs and "slots,"
- grow enrollment in the University of Nevada School of Medicine (UNSOM) and Touro University Nevada College of Medicine,
- grow nursing education programs,
- increase other healthcare professional education programs and enrollment,
- develop new non-profit public/private partnerships and support existing programs,
- collaborate with community physicians and other healthcare personnel in the expansion of healthcare professional training,
- expand the state's research capabilities to complement the development of healthcare professional education, and
- increase training for technical support personnel for biomedical endeavors.

OVERALL RECOMMENDATION STATEMENT

Based on the focus groups' deliberations, the following Recommendation Statement concerning health care professional education was developed:

Improve and expand the State's capacity to provide a health care professional education continuum to increase the number of licensed health care professionals in the state.

STAKEHOLDER HEALTH SUMMIT STRATEGIES

In order to increase the number of licensed health care professionals in the state through an expansion of professional health care education, strategies were developed from the recommendations identified by stakeholders in the focus group process. Supporting information was developed, and the strategies were presented to the participants in the Stakeholders' Health Summit. The Summit's adopted strategies for health care professional education were to:

1. Create, endorse and fund an integrated University of Nevada Health Science Center to do statewide research and training, including post-graduate education.
2. Expand UNSOM and the Graduate Medical Education (GME) program by:
   - increasing the enrollment in the School of Medicine,
   - increasing core faculty,
   - expanding the GME program, and
   - funding necessary capital expenditures to expand UNSOM.
3. Expand GME in Nevada, with steps to include adding faculty, funding capital expenditures, and seeking Congressional action to increase the existing Centers for Medicare and Medicaid cap on GME for Nevada.
4. Expand public nursing school programs by:
   - increasing faculty salaries,
   - doubling the enrollment at the public nursing schools,
   - increasing core faculty to support increased enrollment,
   - funding necessary capital expenditures, and
   - funding preceptor and clinical support.
5. Start a School of Pharmacy and Pharmaceutical Services.
6. Expand education for other health care professionals.
7. Expand clinical training capacity for graduate and post graduate psychologists.
8. Maximize Medicaid funding for GME and other post-graduate health professional training programs.
9. Expand loan repayment programs for students seeking graduate and undergraduate degrees in the health care professions
10. Expand state funding for the Area Health Education Centers (AHECs) to support the education of health care professionals

LCHC ACTIONS

In its August 10, 2006 Work Session, the Legislative Committee on Health Care (LCHC) took the following actions with respect to the strategies adopted by the Health Care Summit participants:

First, the LCHC adopted a policy statement to support an appropriation of $21.6 million, for the biennium, to the NSHE for the implementation of the 2006 Nursing Plan, to double the capacity of the NSHE's nursing programs from 1,570 in 2005 to 3,140 in 2013. The Plan request for the 2007-2009 biennium will support:

- increasing enrollment by 236 in 2007-2008 and by 265 in 2008-2009,
- adding approximately 43 faculty for 2007-2008 and 41 faculty for 2008-2009,
- approximately $13.8 million in Nursing Department salary and operating costs across the nine nursing programs,
- approximately $2.5 million in science-based nursing prerequisite courses, and
- approximately $5.2 million in space needs.

Also, the LCHC authorized a letter to be sent to Governor Guinn and the NSHE Board of Regents supporting the inclusion of the following items in the NSHE proposed budget to be presented to the 2007 Nevada Legislature:

- funding of $29 million for the biennium for the Early Implementation of the UNSOM Growth Plan including:
  - o increasing the incoming class size to 62 in 2007;
  - o increasing the number of GME "slots" by 37 in 2007 and by another 45 in 2008;
  - o adding 83 faculty positions through 2008, primarily to support the GME program growth;
  - o adding classified staff and funding other operating expenses to support the faculty growth;
  - o developing the Departments of Medical Genetics and Development and Molecular Medicine;

- funding of $13.1 million for the biennium for the Multi-Professional Initiatives at the new University of Nevada Health Science Center, to support interdisciplinary research, education and service programs directed at Nevada's core health problems;
- funding of $2.9 million over the biennium for initiating a School of Pharmacy in 2008 so that the first student class can enter in the Fall of 2009;
- funding of $1.6 million for the biennium for increasing the breadth and depth of dental education by adding advanced programs in endodontics, periodontics, oral and maxillofacial surgery and pediatric dentistry, and for supporting the establishment of a mobile dental office to serve rural and underserved communities and pediatric populations;
- funding of $5.1 million to support the infrastructure necessary to implement the University of Nevada Health Science Center;
- funding of $206 million to support major facilities for health professional education including:
    - UNHSC, Las Vegas Development ($98 million)
    - Shadow Lane Campus, Building B Completion ($28.2 million)
    - Health Education Building in Reno ($75 million)
    - planning funds for the UNHSC development ($5 million); and
- funding of $11.5 million in "one shot" equipment items.

BACKGROUND ON SUMMIT STRATEGIES

1. Create, endorse and fund an integrated University of Nevada Health Science Center to do statewide research and training, including post-graduate education.

This strategy is discussed in detail earlier in this chapter *(see "Other Stakeholder Group Recommendations").*

Since the adoption of the vision by the Board of Regents, additional planning and development of the Health Science Center has been progressing. Permanent staff is now on board to guide the development of the HSC, and Legislative funding requests have been assembled that address the HSC, UNSOM, and the nursing programs overseen by NSHE. By the spring of 2007, the Board of Regents will have completed its extended study of the health professional schools and programs within NSHE and make additional recommendations for consideration.

2. Expand the University of Nevada School of Medicine and the Graduate Medical Education program.

and

3. Expand GME in Nevada including adding faculty, funding capital expenditures, and seeking Congressional action to increase the existing Centers for Medicare and Medicaid cap on GME for Nevada.

Based on data from the Nevada Office of Rural Health, it is estimated that 1,358 additional patient care physicians will be needed by 2015 to maintain what the Office estimates to be Nevada's 172 physicians to 100,000 population.[34] To increase that ratio to the national average (estimated by the Office to be 222 per 100,000) by 2015, Nevada will need 2,917 additional patient care physicians.

Nevada's current educational system cannot produce this number of physicians. With a class size of 52, UNSOM has one of the smallest medical school class sizes in the nation, and the smallest compared with neighboring states of Arizona (107), Utah (104), and New Mexico (76, increasing to 101 in 2011).[35]

Additionally, the American Association of Medical Colleges places Nevada 46th in a national ranking of the number of residents trained in each of the 50 states. Nevada substantially lags behind its neighboring states in the number of residency and fellowship programs, total number of residents and fellows, and total number of faculty.[36]

Moreover, UNSOM is heavily dependent on community-based physicians who act as faculty. While this approach to providing faculty is appropriate for a small medical school and has served Nevada well, it will not support a significant expansion of either the School of Medicine or the GME programs.

The UNHSC Plan calls for substantial long-term growth at UNSOM in three dimensions: class size, GME and faculty. The table below illustrates the numbers of faculty, students and residents currently at UNSOM compared to the strategy contained in the initial UNHSC Plan.

UNSOM Faculty: Current and Projected

	Faculty	Students	Residents
Current UNSOM Situation	189	208	194
Initial UNHSC Plan	500	384	444
Change from Current to UNHSC	311	176	250

Increase Core Faculty. The UNHSC planning process examined the student-to-faculty and resident-to-faculty ratios of a number of UNSOM's geographic peer medical schools. Those metrics reveal that UNSOM's ratios of 1.1 students to faculty and 1.03 residents to faculty were signifi-

cantly higher than the ratios of peer institutions, which averaged 0.74-to-1 and 0.87-to-1, respectively.[37]

As the UNHSC presentation materials point out, the development of a more robust faculty should be the top priority of any expansion of the medical school. The proposed Summit strategy for core faculty expansion called for an initial expansion of 81 full-time UNSOM faculty for the 2007-2009 biennium; the Legislative budget request for the UNHSC mirrored this strategy, with the request for an additional 80 faculty for the biennium. Both strategies anticipate the addition of faculty in the biennia following 2007-2009 until both the enrollment and the GME programs reach their targeted level. The long-term goal for faculty levels at UNSOM is to meet the school's peer institutions faculty ratios.

Expand the GME Program. The UNHSC Plan calls for an expansion of the GME program as the "best way" to meet the state's workforce shortage. The importance of having a robust GME program is supported by a National Conference of State Legislatures study that shows that the majority of generalist physicians – and physicians in metropolitan areas – practice in the state in which they complete their most recent GME training.

The UNHSC Plan recommends expanding or adding 15 residencies and 20 fellowships over the next 12 years. The Nevada Hospital Association has proposed expanding or adding 15 GME programs for residents and fellows. Consensus will have to be achieved between UNSOM and the sponsoring hospitals on the specific GME programs to be expanded or added, as well as the timetable for implementation.

In formulating a recommendation for Summit consideration for expanding the GME program at UNSOM, the amount of support offered by the Nevada Hospital Association (NHA) was examined. NHA has indicated its willingness to fund an additional $22 million in GME costs through its participating hospitals. Using this funding level and a metric of $163,000 in annual hospital costs to support a resident in a hospital, the strategy presented for Summit consideration estimated that 135 residents could be added to the UNSOM program. The Legislative budget request for UNHSC performed a more refined estimate and is planning for the addition of 82 residents to the biennium, while maintaining its goal of adding 250 slots in the next 10 years.

The NHA support for GME is both welcomed and necessary. While the federal government is a large supporter of GME throughout the country (through the Centers for Medicare and Medicaid [CMS] and the Medicare program), the support it offers is capped by federal legislation. Although Nevada benefited from a recent redistribution of GME slots by CMS (picking up 26 new slots), the state's population growth will cause Nevada to continue to lag behind in the number of federally supported GME slots. Summit participants endorsed a strategy of the state's Congressional delegation introducing legislation to expand the number of federally supported GME slots in Nevada.

It has been pointed out that it can take anywhere from four to eight years to fully implement a GME expansion. One aspect that must be factored in is the length of time to receive accreditation from the Accreditation Council for Graduate Medical Education (ACGME), which requires site visits and extensive reviews. During this development time, it is anticipated that a more precise estimate of the need and capacity for residents will be developed.

Increase Enrollment at UNSOM. It is obvious that the existing class size at UNSOM will not produce the number of physicians needed in Nevada. While even doubling the class size would fall short of the need, it would ease the physician shortage. The Summit participants endorsed the doubling of enrollment concept contained in the UNHSC plan. It is anticipated that this doubling can be achieved by 2010, when expanded education facilities are targeted to be available.

Capital Requirements. The original UNHSC Strategic Plan called for a substantial increase in facility space to accommodate the planned growth in the UNSOM. At that time, the plan called for the addition of some 232,000 square feet. This addition includes classroom, research, clinical, administrative and support space. The Summit participants made a specific point to emphasize the need for facilities for both the UNSOM and the UNHSC. The NSHE Legislative budget request contains a facility request of some $206 million and $11.4 million in "one shot" equipment needs.

4. Expand public nursing school programs.

In 2003, the Legislature provided funding to double the enrollment in the Nevada public schools of nursing. By 2005, the schools had exceeded that goal, with enrollment increasing from 623 to 1,570 between 2001 and 2005.

While the doubling of enrollment may have helped Nevada climb from 51st to 49th in the state ranking in the ratio of RNs to population, additional steps must be taken for Nevada to have an adequate supply of nurses.

The UNHSC Plan contains estimates that show that the public schools of nursing will have to double again during the next 15 years to meet the nursing demand. The Nevada Hospital Association estimates that Nevada will need 662 additional nurses, each year, for the next five years.[38] In testimony to the Interim Legislative Committee, the Nevada Nurses Association stated that, for the 2005-06 academic

year, nursing schools were able to accept only 546 out of 1,442 qualified applicants.

According to the U.S. Bureau of Labor Statistics, among all occupations, registered nurses have the largest projected 10-year job growth. Across the country, the demand for nurses in the year 2012 is expected to be 2.9 million, up from 2.3 million in 2002. The total job openings, attributable to attrition and job creation, will be more than 1.1 million from 2002 to 2012. Although NSHE's nursing programs grew substantially in the past several years, there is still a shortfall in faculty, classrooms and facilities to accommodate all applicants and meet the state's workforce demand for qualified nurses. With adequate resources, the NSHE is committed to again doubling the capacity of its nursing programs.

At the LCHC's request, the NSHE developed the *2006 Nursing Plan: A Plan to Double the Capacity of NSHE's Nursing Programs by 2012-2013.* Under the plan, the NSHE will increase the capacity of its nursing programs to at least 3,140 students through academic year 2012-13, an increase of 1,570 students over the next three biennia. Substantial resources are required to accomplish this goal.

As outlined in the *2006 Nursing Plan,* there are three areas that will require funding: nursing department salary and operating costs; space needs; and science-based nursing prerequisite course and faculty needs. The funding requirements contained are outlined in the table below *(in millions of dollars).*

Nursing Plan: Funding Requirements

	2007-09	2009-11	2011-13
Department Salaries/Operations	$13.8	$12.5	$9.8
Space	5.2	6.6	7.1
Prerequisite Courses	2.5	1.9	1.5
Total	$21.6[B]	$21.0	$18.4

In addition to these requirements, the *2006 Nursing Plan* indicates that the Board of Regents will be requesting funding, through the Capital Improvement Project, of $49.25 million for the design and construction of a Nursing and Science Building at Nevada State College and $8 million for the relocation of UNLV's nursing program to the Shadow Lane campus.

Additionally, the Regents will be requesting funding for a new Nevada Nursing Scholarship. This will be a need-based scholarship program targeting students enrolled in a nursing program at a NSHE community college, state college or university.

Faculty Salaries. During the focus group process it was stated that there is substantial inequity in faculty salaries among the state's various nursing programs. The Chancellor responded to this concern by commissioning a study of nursing compensation throughout the NSHE. The study, *2006 Review of Nursing Faculty Salaries,* was released in November 2006. The report examined nursing faculty salaries in the system and compared those salaries to (a) regional salary data compiled by the American Association of Colleges of Nursing and (b) nursing salaries for universities offering baccalaureate and higher degree programs in nursing in the states of California, Arizona, Oregon and Washington. Additionally, the study examined the Nevada Hospital Association's *Regular Compensation Salary Survey.*

The conclusion of the report was that there was no evidence to support a system-wide nursing salary adjustment. The report found that NSHE salaries are competitive with regional area nursing programs and "often exceed average salaries paid in the region and select western states." Additionally, the report found that "salaries actually paid in clinical settings … do not indicate that clinical salaries sufficiently exceed NSHE salaries to attract NSHE faculty to such positions … except perhaps at the community colleges."

However, in spite of the report's findings, Nevada may want to take a broader view of nursing faculty salaries. Nursing programs must be taught by nurses and other professionals with at least a master's level of education. Currently, there is a national shortage of qualified faculty, attributable to the scarcity of nurses with a master's and higher, as well as competition from the private sector. If teaching positions are not highly competitive, the aggressive expansion of the public nursing training program in Nevada will continue to struggle to attract adequate faculty.

Compounding the difficulty of attracting faculty is the fact that 44 other states reportedly face nursing shortages. While there is a variety of options available to the states to alleviate these shortages, education and training are pre-eminent. Therefore, there is likely to be an increased demand throughout the country for nursing faculty.

5. Start a School of Pharmacy and Pharmaceutical Services.

Nevada has one private school of pharmacy, at the University of Southern Nevada (USN). With 1,500 applications a year (150 from Nevada residents) the program accepts 140 students per year, with 40 to 45 coming from Nevada. In addition, Nevada, through the Western Interstate Compact on Higher Education (WICHE), sends five students to attend out-of-state, publicly supported colleges.

[B] Some totals may appear not to add up, due to rounding

In 2000 and again in 2004, the Nevada Board of Regents approved plans to establish a School of Pharmacy to be shared by UNR and UNLV. When fully developed, the program would graduate 60 new pharmacists (Pharm.D.) each year. The plans for a pharmacy school were not funded by the Legislature.

The UNHSC Plan released in March 2006 and the subsequent Legislative budget request included a pharmacy school in the Health Science Center plan.

The pharmacy school plan anticipates that the school will be phased in over six years, with an ultimate class size of 220 professional students and 60 Pharm.D. graduates a year. It is anticipated that the first class will graduate in 2012. The early plans for the school include a six-year funding requirement. The annual amounts of State support required to establish and operate the school are presented below.

Pharmacy School: State Support Needed

Year 1:	$3.5 million
Year 2:	$3.6 million
Year 3:	$5.4 million
Year 4:	$5.6 million
Year 5:	$5.2 million
Year 6:	$5.3 million

6. **Expand education for other health care professionals.**

   and

7. **Expand clinical training capacity for graduate and post graduate psychologists.**

Nevada has a shortage of nearly all health professionals, including psychologists, medical technologists and dentists. While expanding the state's education programs will not, by itself, satisfy the shortages, the public healthcare professional training programs must play a role.

The Board of Regents has studied the needs and issues confronting the UNSOM and the various schools of nursing and is preparing to expand that study to other health sciences schools and programs. The studies will examine student enrollment, faculty composition, and future growth plans for the other health sciences programs.

The examination may include schools and programs in the following areas: Public Health, Dental Medicine, the UNLV School of Allied Health, applicable programs in the College of Health and Human Sciences at UNR, behavioral health programs, and key health programs at the State/Community Colleges.

8. **Maximize Medicaid funding for GME and other post-graduate training programs.**

Medicare has long been a primary funding source for Graduate Medical Education (GME). However, in 1996 Medicare instituted a cap on the number of residents that it would support and allocated the number of slots to the various states. The total number of available resident slots has essentially been frozen at the 1996 counts.

This is a serious problem for states that, like Nevada, are experiencing rapid growth. According to the Nevada Hospital Association, in 2004-05 there were 156 residents in non-VA hospitals in Nevada, while only 134 of those slots were Medicare approved. This means that the teaching hospitals in the state had to absorb the full cost of over 22 residents during that year.

While Medicare is the largest payer nationally for the expenses of GME, Medicaid is the second-largest. In fact, it has been reported that the average State Medicaid GME payments are eight to nine percent of total Medicaid inpatient hospital expenditures, while Medicare's GME payments represent only about seven percent of its total inpatient hospital expenditures. Nationally, Medicaid GME contributions range from less than 1% to a high of 32% of inpatient costs.

In FY 2004, Nevada's Medicaid program provided approximately $820,000 in targeted GME payments to the three teaching hospitals in the state: UMC, Washoe Medical Center (now Renown Health) and Sunrise.

There are three potential opportunities for Nevada Medicaid to expand its support for GME. Nevada Medicaid can:

- reconstitute the methodology it uses to pay hospital-based residency costs,
- potentially include nursing program educational costs in the GME payment formula, and
- explore expanding its support for Graduate Medical Education that is delivered outside of the hospital setting.

It should be noted that the increased GME funding contemplated for this option would not benefit UMC, which receives Upper Payment Level (UPL) payments. These payments implicitly include payment for the full share of Medicaid GME costs.

For basic GME payments to hospitals, Nevada uses a fixed amount of State funding and a modified Medicare methodology. If State funding were increased, the amount of Medicaid funding provided to teaching hospitals could be increased by as much as $680,000 through a methodology change that CMS has approved for a number of states. To

implement this change, DHHS would have to file and receive approval for a State Plan Amendment.

Another potential opportunity to increase GME payments concerns nursing program costs. In a review of Medicare cost reports for the three teaching hospitals, it was noted that none of the hospitals segregates the costs associated with the training of nursing graduates. If these costs were separately reported, it may be possible to receive approval from CMS for nursing GME payments. Such payments, as with the basic GME payments, are limited to Medicaid's share of the costs, most often derived by allocating costs based on the number of bed days in a facility that are paid for by Medicaid.

The third opportunity for increasing GME payments concerns non-hospital facilities or programs. Some states have reportedly been successful in getting approval from CMS for these types of GME payments. Non-hospital facilities or programs may include mental health programs and community health clinics. In order to seek CMS approval for such a strategy, Nevada would have to determine the appropriate method of isolating and identifying the GME costs and prepare an amendment to the State Plan for Medicaid.

9. Expand State funding for the Area Health Education Centers (AHECs) to support education of health care professionals.

Area Health Education Centers (AHECs) are academic-community partnerships that serve a number of functions, including:

- training health care providers in sites and programs that are responsive to state and local needs;
- providing health career education and recruitment programs targeted to K-12 students; and
- linking the resources of university health science centers with local planning, educational and clinical resources to provide multidisciplinary educational services to improve health care delivery in underserved areas.

Nevada has three AHECs: AHEC of Southern Nevada serving Clark, Esmeralda, Lincoln and Nye Counties; High Sierra AHEC serving Carson City, Douglas, Lyon, Storey and Washoe Counties; and Northeastern Nevada AHEC.

Southern Nevada and High Sierra each receives approximately $80,000 in federal funding. Northeastern Nevada is not a federally recognized AHEC and, therefore, operates under the auspices of the UNSOM Office of Rural Health. The State appropriates $300,000 to $400,000 annually that is used by the AHECs to leverage federal grant money.

Nevada AHECs participated in the effort to double nursing school enrollment by contributing funding for the nursing programs in the two rural colleges. The Northeastern Nevada AHEC also built the new medical and dental clinic in Elko that is used for medical and dental student rotations.

Initiatives that could be implemented by AHECs with expanded State funding include:

- expanding the high school health career awareness and recruitment program,
- enhancing salaries for preceptors and clinical supervisors,
- upgrading telemedicine equipment, and
- covering continuing education costs for faculty. ◗

Medicaid and SCHIP

Eligibility limitations have contributed to low public sector coverage and a high proportion of uninsured

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OVERVIEW

NEVADA PARTICIPATES IN both the Medicaid and State Children's Health Insurance Program (SCHIP, known in Nevada as "Nevada Check Up"). These programs are partnerships between the state and federal governments to provide health care coverage for low-income individuals. Medicaid covers low-income families and aged, blind and disabled individuals, and Nevada Check Up covers low-income uninsured children who are not eligible for Medicaid. In Nevada the Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) is responsible for administering the two programs.

Nevada's strict eligibility rules have led to a lower percentage of its population being covered under Medicaid than in most other states. According to the Kaiser Family Foundation's State Health Facts, the income level to which Nevada Medicaid covers parents is substantially below the national average. While Nevada covers parents up to 26% of the Federal Poverty Level, the states on average provide coverage to the 43% level. The income for a family of three at 26% of the FPL is $4,316 per year. Nevada ranks 41st among the states in terms of parental eligibility for Medicaid.[39]

Also according to Kaiser, in Federal Fiscal Year (FFY) 2002, only about 10% of Nevada's population was enrolled in the Medicaid program, compared to a national average of 18%. In this measure, Nevada ranks 47th among the states. When viewed by the percentage of the population covered by Medicaid at different levels of income, Nevada also ranks low, being at just about half the coverage rate by income level as the average of the states:

Medical Enrollment: Nevada vs. U.S.[40]

% of population with income	*Nevada*	*U.S.*
Up to 100% of FPL	27%	43%
Between 100% and 199% of FPL	14%	25%
Above 200% of FPL	2%	4%

Coincident with this low level of Medicaid coverage are statistics that indicate that Nevada is among the states with the highest levels of uninsured residents. Nevada has the same uninsurance rate as five other states (19%), and there are only three states whose uninsurance rates are higher. The percentage of people with employer-sponsored insurance in Nevada (57%) is higher than the national average of 54%. The percentage of people with individual policies and the percentage of people on Medicare are each one percentage point below the national average.[41] This leaves the percentage of people covered by Medicaid in Nevada barely above half of the national average, suggesting that Nevada's higher uninsurance rate is the result of Nevada's lower Medicaid coverage rate.

Long term care services nationally, as well as in Nevada, are a main driver of overall costs for the Medicaid program. The Nevada DHCFP reports that, in FY 2005, services to the elderly comprised 14.5% of the total Medicaid budget; this population represented only 5.8% of all Medicaid eligibles. Likewise, services to the blind and disabled comprised 43.8% of the total FY 2005 budget, but these eligibles represented 14.7% of the population. Combined, 58% of the Medicaid budget was used for 20% of the population, a common occurrence for Medicaid programs across the country.

It is expected that the demands for long term care services among Medicaid recipients will grow as Nevada's population grows and ages (i.e., 11% of the state's population was 65-plus in 2000; by 2030, 18.6% of a much larger population will be in that age category).

Expenditures in the Medicaid program more than doubled from State Fiscal Years (SFYs) 2000 to 2005, while average enrollment has increased by 77% to 176,418. Enrollment in Nevada Check Up averaged just over 25,000 children in SFY 2004, and the most recent enrollment in the program is 27,564.

Enrollment	Nevada Medicaid	Nevada Check Up
Average Enrollment FY05	176,418	26,750
Average Enrollment FY04	172,779	25,025
Percent Growth FY04-05	2.1%	6.9%
Average Enrollment FY00	99,411	8,079
Percent Growth FY00-05	77%	231%
Expenditures		
FY 2005 Total (millions)	$1,177.4	$38.4
FY 2004 Total (millions	$971.2	$30.2
Percent Growth FY04-05	21%	27%
FY 2000 Total (millions)	$489.4	$13.8
Percent Growth FY00-05	140%	179%
FY05 Per Member Per Month Costs	$556.16	$119.75

Eligibility for Nevada's Medicaid program is relatively restrictive compared to other states. Nevada has among the lowest qualifying income levels and only a limited number of optional eligibility categories. Check Up, which covers children up to 200% of the Federal Poverty Level (FPL), is also restrictive in that, to be eligible, children must not have had health insurance within the last six months.[C] Premiums are charged, though at nominal levels.

These limitations have contributed to low public sector coverage and a high proportion of uninsured. For example, 7.1% of Nevadans were covered by Medicaid in 2003-04, with Nevada being ranked 50th nationally (out of 51) in percent of population covered under Medicaid. Further, 19% of Nevadans were uninsured, with Nevada being ranked seventh highest among states in the percentage of the population uninsured.[42]

For both Medicaid and Check Up, the State delivers services through fee-for-service and managed care models. Services are delivered primarily on a fee-for-service basis for enrollees who are blind, aged or disabled and/or reside in a rural/frontier area. In Clark and Washoe counties, enrollment in one of the two managed care plans (Anthem Blue Cross and Blue Shield or Health Plan of Nevada) is mandatory for Temporary Assistance for Needy Families (TANF), Children Health Insurance Program (CHAP) and Check Up populations.

The managed care plans are required to provide medical and dental care, as well as limited behavioral health and short-term nursing home services. Other services for these recipients, such as long term care services and more intensive behavioral health services, are not the responsibility of the managed care plans and are provided on a fee-for-service basis.

[C] Nevada is one of 15 states with the longest allowable (six months) "going bare" period.

FOCUS GROUP RECOMMENDATIONS

In four of the six focus groups convened for the development of the Nevada Strategic Health Plan, the participants developed recommendations that received broad support for actions involving Medicaid and or Check Up. These "high scoring" recommendations (and the originating focus groups) were:

- Expand eligibility and service coverage under Nevada's Medicaid program. *Health Facilities, Public Health*
- Through a collaborative effort, increase outreach to Nevadans who are eligible for Medicaid or SCHIP but not enrolled, as well as improve the eligibility process itself. *Medical Coverage*
- Implement presumptive eligibility under Nevada's Medicaid program, including individuals applying for coverage under Supplemental Security Income. *Health Facilities*
- Adequately fund Medicaid (including mental health) to ensure that provider compensation will result in an adequate number of health care professionals who are willing to accept Medicaid. *Health Care Professionals*

OTHER STAKEHOLDER RECOMMENDATIONS

In addition to the focus groups strongly recommending enhancements to the current Nevada Medicaid and SCHIP programs, similar recommendations have been included in strategic plans developed by other Nevada stakeholder groups:

- Washoe County Access to Health Care Network: *Five-Year Strategic Plan (2003-2008)* included recommendations related to expanding eligibility criteria, improving reimbursement structures, and conducting outreach and a resource awareness campaign.
- State of Nevada Department of Human Resources: *Strategic Plan for Rural Health Care* included recommendations related to expanding Check Up to parents of eligible children, streamlining the Medicaid and Check Up eligibility criteria, establishing an on-line application, considering Medicaid reimbursement enhancements for rural providers, and providing payment for services delivered via telemedicine.
- State of Nevada Department of Human Resources: *Strategic Plan for People with Disabilities* included numerous recommendations related to Medicaid and delivery of services to people with disabilities (e.g., additional home and community based waiver services).
- State of Nevada Department of Human Resources: *Strategic Plan for Senior Services* included recommendations related to funding and implementing a single

point of entry system for information, referral, assistance, care planning and management.

OVERALL RECOMMENDATION STATEMENT

Based on the focus groups' deliberations, the following Recommendation Statement concerning Medicaid and Nevada Check Up was developed:

Expand program eligibility, enrollment and service coverage under the State's Medicaid and SCHIP programs

STAKEHOLDERS' HEALTH SUMMIT STRATEGIES

In order to achieve improved coverage under Nevada's Medicaid and Check Up programs, strategies were developed from the recommendations identified by stakeholders in the focus group process. Supporting information was developed, and the strategies were then presented to the participants in the Stakeholders' Health Summit. The following Medicaid and Nevada Check Up strategies were adopted at the Summit:

1. Increase enrollment in Medicaid and Check Up through:
    - increasing and improving outreach to individuals who are potentially eligible but not enrolled in Medicaid and Nevada Check Up and providing state funding for these outreach activities;
    - expediting eligibility for targeted Medicaid and Check Up eligible groups; and
    - adopting best practices for improving the eligibility process, which should involve development of partnerships with community organizations and providers.
2. Raise the income qualification level for parents to 100% of the federal poverty level (FPL) as soon as possible.
3. Expand and/or expedite the process by which individuals who qualify for Supplemental Security Income (SSI) are determined eligible for Medicaid.
4. Provide presumptive eligibility in the Medicaid program for pregnant women and for children.
5. Increase Medicaid and Check Up reimbursement to providers by:
    - adopting the Medicare 2007 fee schedule to pay professionals beginning in SFY 2008 and update annually thereafter; incorporating the use of modifiers instead of the current practice of across-the-board upward adjustments for a certain type of procedures or for a targeted population (e.g., pediatrics); basing payment rates on place of service (facility vs. non-facility settings) rather than the current either/or approach;
    - paying the same rate to all professional service providers delivering the same service, if such service is within their scope of practice;
    - increasing professional services payments for providers in rural settings by 20% above the rates set for urban providers;
    - increasing rates paid to home health providers and personal care assistants;
    - allowing for reimbursement of telehealth for a peer-to-peer process, specifically for consultation and radiology services;
    - increasing hospital inpatient rates to cover costs with annual adjustments based on CMS Health Care Indicators;
    - changing methodology to allow Critical Access Hospitals to receive full cost reimbursement for out-patient services; and
    - paying enhanced rates to free-standing in-state nursing facilities to care for behaviorally-challenged Medicaid recipients.
6. Enhance coverage under the Medicaid home and community based waivers by:
    - developing and implementing strategies to increase the number of case managers to serve persons enrolled in the Medicaid home and community based waiver programs, including the exploration of the merits of retaining an Administrative Services Organization;
    - adding services to the waivers for persons with traumatic brain injuries and to meet the needs of autistic children and adolescents; and
    - eliminating the waiting lists for all of the home and community based waivers.
7. Continue to explore advantages for Nevada under the Deficit Reduction Act of 2006 to enhance federal funding for the Medicaid program.
8. Through a working group with expansive representation, examine the strengths and weaknesses of the current long term care system and develop optional service delivery models that would lead to increased efficiencies, better out-comes, more individuals receiving services, and reducing individual participants' cost of care.

LCHC ACTIONS

In its August 10, 2006, Work Session, the Legislative Committee on Health Care (LCHC) took the following actions with respect to the strategies adopted by the Health Care Summit participants:

- Requested legislation to fund the DHCFP budget request to fund slightly more than $2 million from the State General Fund for services to clients with traumatic brain injuries under the Physically Disabled Waiver.
- Authorized a letter to be sent to Governor Guinn expressing the Committee's support for the inclusion of the following items in the DHHS proposed budget to be presented to the 2007 Nevada Legislature:
  - Increase and improve outreach to individuals who are potentially eligible but not enrolled in Medicaid and Nevada Check Up, and provide State funding for these outreach activities.
  - Expedite eligibility for pregnant women and children in Medicaid and Check Up.
  - Adopt best practices for improving the eligibility process, which should involve development of partnerships with community organizations and providers.
  - Expand and/or expedite the process by which individuals who qualify for Supplemental Security Income (SSI) are determined eligible for Medicaid.
  - Increase Medicaid and Check Up reimbursement to providers as recommended by the Summit.
- Recommended enhanced coverage under the Medicaid home and community based waivers by:
  - Developing and implementing strategies to increase the number of case managers to serve persons enrolled in the Medicaid home and community based waiver programs including the exploration of the merits of retaining an Administrative Services Organization.
  - Adding services to the waivers to meet the needs of autistic children and adolescents.
  - Eliminate the waiting lists for all home and community based waivers.

BACKGROUND ON SUMMIT STRATEGIES

1. Increase enrollment in Medicaid and Nevada Check Up

Health care researchers have estimated that a large percentage of the uninsured are, in fact, eligible for Medicaid and SCHIP but have not applied. For example, one national study found that, for uninsured children, 52% would be eligible for Medicaid and another 25% would be eligible for SCHIP.[43] Another study looking at adults estimated that 46% of low-income adults (parents and adults without children) could be covered by public coverage.[44] Given these findings, numerous states have employed strategies to decrease the number of uninsured by increasing enrollment in Medicaid. Those strategies generally involve simplifying Medicaid and SCHIP enrollment processes and increasing outreach efforts for those programs.

The situation appears to be similar for Nevada, especially with respect to children. Based on an analysis of CPS data from 2003 to 2005, there are 72,000 uninsured children in families with incomes up to 200% of the FPL. A substantial number of these children should be eligible for either Medicaid or Nevada Check Up.

For the past seven years, Nevada has had a Robert Wood Johnson "Covering Kids & Families" grant, totaling $1.6 million, to develop activities to increase enrollment and retention in Nevada's SCHIP and Medicaid programs. Monies from this grant were matched with federal Medicaid and SCHIP dollars. With the Great Basin Primary Care Association serving as the lead organization, the grant funds supported two local projects: Clark County Health District, covering the southern part of the state, and United Way of Northern Nevada, covering northern urban cities and surrounding areas as well as rural and frontier communities. As a result of these projects, a number of outreach strategies have been implemented, including:

- direct one-to-one outreach in the community,
- partnering with human service agencies that assist families in applying for Check Up and Medicaid,
- holding application assistance sessions at the local schools,
- conducting trainings on the eligibility application process,
- attending health fairs to distribute eligibility applications, and
- using Vista and AmeriCorps volunteers to assist families with application processes.

While this grant ends in August 2006, grant applications for additional outreach dollars have been submitted to various funding organizations, including the Trust Fund for Healthy Nevada. The DHHS Division of Welfare and Supportive Services is responsible for determining Medicaid eligibility, and DHCFP is responsible for determining Check Up eligibility.

While no specific data was available regarding the reasons for Medicaid denials, disenrollments, and churning in the system (i.e., individuals falling off and coming back on

the program), Check Up data shows that about 20% of initial denials were due to procedural reasons (e.g., lack of information, lack of cooperation) and that about 37% of the reasons for disenrollments were procedural (e.g., not responding to redetermination process, lack of information, loss of contact).

Nevada's current eligibility process includes a number of "best practices" that have been recommended by health care experts as effective means for streamlining eligibility and reducing procedural barriers:

- 12-month redetermination periods,
- no asset test for pregnant women and children,
- no face-to-face requirement for Check Up and Medicaid (if not also applying for TANF/Food Stamp), and
- On-line Check Up application (can be submitted electronically but one still needs to sign and submit with documentation).

Other recommended best practices that could be used to further enhanced Nevada's eligibility process include:

- 12-month continuous eligibility for Medicaid and Check Up, in which a person maintains eligibility regardless of certain changes in family income or circumstances;
- use of community agencies in taking and submitting applications;
- adoption of on-line interactive electronic applications, as used in California;
- joint Medicaid and Check Up application;
- reduction in Medicaid documentation requirements;
- simplification of Medicaid notices, including issuing notices in Spanish as well as English; and
- consolidation or alignment of the Medicaid and Check Up eligibility processes so that it is performed by the same government unit or has similar requirements.

Additionally, the Check Up program charges quarterly premiums for coverage under the program. (The quarterly premiums vary by income level and range from $15 to $70.) Researchers and experts generally agree that premiums – even nominal ones – discourage enrollment of low-income populations.

2. Raise the income qualification level for parents of Medicaid children

The focus groups recommended, and the Stakeholders' Health Summit supported, expanding eligibility for parents of Medicaid and Nevada Check Up children. The strategy adopted was to raise the income eligibility level to 100% of the FPL as soon as possible, and to de-link Medicaid and TANF eligibility.

Parents were selected for this expansion because, under federal Medicaid rules, parents can be added as a coverage group through a state plan amendment. With a state plan amendment, the State does not have to demonstrate budget neutrality, but it does have to offer the expansion statewide as an entitlement.

Because of the entitlement nature of such an expansion, the eligibility expansion was offered to the Stakeholders' Health Summit as either phased-in or all-at-once. The Summit supported the latter.

A reasonable estimate of the annual cost of medical benefits for the eligibility expansion to parents with incomes up to 100% of the FPL is $31.4 million annually ($14.5 million in State funds). Such an expansion is estimated to bring an additional 10,800 individuals into the State's Medicaid program.

3. Expand and/or expedite the process by which individuals who qualify for Supplemental Security Income (SSI) are determined eligible for Medicaid.

Low-income individuals who receive Supplemental Security Income (SSI) benefits because of age, disability or blindness are eligible for Nevada's Medicaid program under a federally mandated eligibility category. The Nevada Department of Employment, Training & Rehabilitation is responsible for determining whether individuals with permanent disabilities are eligible for SSI. Most initial SSI decisions are made within 90 days, but on average, with appeals, it takes an average of 10 months for a final decision.

Many special-needs individuals who would meet SSI disability criteria (and have not applied or are waiting for a decision) seek health services through emergency departments or State-only or safety net programs. For example, DHCFP indicates that, as of 2004, there were approximately 2,000 individuals who were seriously mentally ill and being treated with State-only dollars.

Summit stakeholders recommended that the State adopt mechanisms to expedite Medicaid eligibility for low-income disabled individuals in order to allow those individuals to qualify for Medicaid in a timelier manner. Several possible options for accomplishing the recommendation were identified in the materials prepared for the Summit, but the Summit participants did not recommend a specific approach. The possible options include the following:

- A new CMS rule. This rule, adopted by the Centers for Medicare and Medicaid Services (CMS), provides a quick disability determination process for those who are obviously disabled. It is reported that favorable decisions will be made in such cases within 20 days after the claim is received by the state disability determination agency. Although the new rule took effect in Au-

gust 2006, the federal government is phasing in its implementation. The new process will not be implemented in Nevada for at least a year.

- 210 Optional Medicaid Coverage Group. The "210 group"[D] eligibility category allows individuals to qualify for Medicaid if they would be eligible for, but are not receiving, cash assistance under SSI. DHCFP believes that disability determination under the 210 group could be made within two months, thus making the applicant eligible for Medicaid benefits before being finally determined eligible for SSI.
- State Assessment for Serious Mentally Ill. With a few exceptions, federal regulations require that the State use the same definition of disability as used under SSI. In order to further streamline the process, some states have sought approval by SSA for alternative but comparable disability assessments. In the case of Arizona, for example, SSA has agreed to accept the assessment for serious mental illness (SMI) conducted by the State's behavioral health division in lieu of a determination by the disability determination bureau. Nevada currently uses the LOCUS assessment tool to determine eligibility for individuals with SMI.
- Single Application for SSI and Medicaid. Most states, including Nevada, automatically enroll all SSI recipients in Medicaid. Nevada, however, is one of seven "SSI-Criteria" states that require SSI beneficiaries to file a separate Medicaid application with the State, which allows the State itself to determine eligibility for Medicaid. Thirty-three states rely on SSA to determine Medicaid eligibility for the SSI beneficiaries. The latter may afford a more streamlined process for both the applicant as well as the State.

Cost Estimate. The strategy that was recommended for consideration by the Summit was the 210 option. For the 210 option, the cost estimate involves two distinct pieces:

- administrative costs to reduce the eligibility determination wait time from ten months to two months, and
- the medical costs that will be incurred because the individuals will be eligible for an additional eight months.

The administrative costs are composed of systems modifications, an outside vendor to perform medical reviews, and additional State staff. With the assumption that FY 2008 is a "start up" year and FY 2009 will be the first full year of operations, the estimated State costs for administration are $700,000 in FY 2008 and $3.5 million in FY 2009.

The cost of medical services for the 210 population reflects the eight-month period that this population will be receiving medical services because of the accelerated eligibility determination. Using assumptions provided by DHCFP, it is estimated that the cost to the State of medical services provided to the 210 population will be:

FY 2008 *(start up year):*	$0
FY 2009:	$ 6.1 million
FY 2010:	$28.3 million

The estimates do not reflect potential savings from bringing these high-cost individuals onto Medicaid earlier. The savings may accrue because:

- they will be receiving health care for an additional eight months,
- their medical conditions may not be as severe as the population that is currently entering the program, and
- their care will be managed more closely from an earlier time period.

4. Provide presumptive eligibility in the Medicaid program for pregnant women and for children.

Under federal Medicaid law, states can elect to provide *presumptive eligibility* both to pregnant women and to children. Presumptive eligibility allows states to provide immediate coverage in circumstances where pregnant women and children appear to meet the income requirements of Medicaid or SCHIP, instead of requiring a full determination of eligibility before services can be delivered.

In order to maintain coverage, families determined eligible under presumptive eligibility must apply and be found eligible through the regular application process by the end of the month following the presumptive eligibility application. States receive federal matching funds for the costs of covering pregnant women and children found eligible under a presumptive eligibility program, even if the regular application process subsequently determines that they are not eligible.

States electing to take advantage of presumptive eligibility must involve and train certain health care providers and community-based organizations in the presumptive eligibility process. Community-based organizations include organizations that serve schools, certain government agencies, and low-income children. Many of these entities are already engaged in efforts to find and help eligible pregnant women and children enroll in Medicaid and SCHIP, and the presumptive eligibility process allows those entities to take the next step of serving presumptively eligible clients on an immediate, albeit temporary, basis.

The advantages of presumptive eligibility include:

[D] This eligibility category is known as the "210 group" because of the section of the Federal Register section authorizing (42 CFR 435.210).

- making health care services available more quickly than under the regular eligibility determination process,
- extending the enrollment process into the community by involving community organizations that are typically involved in outreach, and
- increasing enrollment in the Medicaid and SCHIP programs.

On the last point mentioned above, studies have shown that families are more likely to enroll if the enrollment process is simple and easy, they receive assurance that they are eligible, and they can enroll in a convenient location. The presumptive eligibility process provides opportunities to address each of these issues.

Despite the benefits of presumptive eligibility, there are concerns; in fact, with respect to programs for children, as of May 2002, only nine states have authorized presumptive eligibility for children in their Medicaid programs, and only five states have authorized it in their SCHIP programs.

States are hesitant to avail themselves of the presumptive eligibility process for two primary reasons: concerns about cost implications, and questions about whether presumptive eligibility is necessary when the state has simplified the application and enrollment process.

With respect to cost, presumptive eligibility carries both administrative costs (for example, training of qualified entities and the processing of applications) and programmatic costs (such as delivering health services during a presumptive eligibility period). In addition, some state officials have expressed concern that presumptive eligibility would put their state at risk of providing health care services to applicants that are not actually eligible for, or do not enroll in, the Medicaid or SCHIP program.

5. Increase Medicaid/SCHIP reimbursement rates

Nationally, adequacy of Medicaid reimbursement rates has been a longstanding concern among policymakers and providers. Low reimbursement is often cited as one of the causes of limited provider participation in Medicaid and SCHIP programs, leading ultimately to reduced client access to care. These same concerns have been expressed by Nevada stakeholders.

Recently, the State has taken a number of steps to increase provider reimbursement rates:

- As the result of 2001 legislation, the Provider Rates Task Force was established and assigned to review provider rates related to home and community based services provided to seniors and to persons with developmental disabilities, as well as for mental health services and therapies. The Task Force recommendations have been implemented in stages, with the full recommended provider rate increases implemented by FY 2005.
- In the summer of 2004, the DHCFP held public workshops regarding Medicaid and Check Up reimbursement rates, specifically focusing on rates for services that are billed by physicians and other health care practitioners.
- The DHHS Division of Health Care Finance and Policy (DHCFP) proposed ten provider rate enhancements, of which three – air ambulance, mental health rehabilitative treatment services, and home infusion therapy – were included in the Governor's recommended budget and subsequently funded by the Legislature.

In 2006, DHCFP began considering other areas for rate increases in the Medicaid program. Increasing the rates to providers will create incentives for providers to continue to participate in the Medicaid program.

In the area of professional fee schedules, DHCFP had been considering proposing revising their fee schedules by:

- adopting the Medicare 2007 fee schedule to pay professionals beginning in SFY08 and updated annually thereafter;
- paying the same rate to all providers delivering the same service, within their scope of practice and as defined by Medicare;
- increasing payments for providers in rural settings by 20% above the rates set for urban providers;
- providing a rate increase to home health agencies; and
- allowing for reimbursement of telehealth for a peer-to-peer process.

In the area of facility reimbursement, DHCFP identified the following potential revisions to the fee schedules:

- increasing hospital inpatient rates to cover costs and updated based on CMS Health Care Indicators;
- reimbursing critical-access hospitals for the full cost of outpatient hospital services, as is already done for inpatient hospital services (Medicare also pays the full cost for these services to critical access hospitals); and
- paying enhanced rates to free-standing in-state nursing facilities to care for behaviorally challenged Medicaid recipients to avoid out-of-state placement.

Cost Estimate. The cost estimates for the State share of the rate increases presented to the Stakeholders' Health Summit are $34.7 million in SFY08 and $38.6 million in SFY09, for a total State General Fund cost of $73.3 million in the biennium.

6. Enhance coverage under the home and community based waiver program

Stakeholders have consistently stressed the need for Nevada to enhance its long term care services provided in home and community based settings. This recommendation came from process participants and is reflected in the DHHS *Strategic Plan for People with Disabilities*. The overall goal of this recommendation is to develop systems of care that provide a flexible array of community services and supports to frail elderly or persons with developmental disabilities or physical disabilities who wish to remain in the community.

Historically, under Medicaid there have been three key avenues through which states provide home and community based services to persons at risk of institutionalization. Nevada's Medicaid program takes advantage of all three:

- Provision of home health services, a mandatory Medicaid service. In FY 2004, 891 clients received this service at a cost of $6.3 million.
- Provision of personal care services, an optional Medicaid service. In FY 2004, 3,642 clients received this service at a cost of $33.8 million.
- Provision of home and community based services through 1915(c) waivers. In the most recent waiver year,[E] a total of 3,045 clients were served through one of four waivers at a cost of $35.7 million.

The dollars expended on home and community based waiver services increased by 27%, to $45.4 million, from waiver year 2004 to waiver year 2005. It should be noted that clients in the waiver programs also receive non-waiver services (also referred to as "State plan services") that other Medicaid clients receive. The total cost of services (waiver and non-waiver) provided to clients enrolled in the waiver programs in waiver year 2005 was $91.7 million.

In waiver year 2005, the annual costs for waiver clients (including both waiver services and state plan services) were much below the anticipated costs for these clients if the waivers were not in existence. These differences, by waiver, are shown in the following table:

Waiver	Costs with Waiver	Estimated Costs without Waiver	% Lower with Waiver
WIN[F]	$31,861	$53,833	-41%
CHIP[G]	$14,245	$36,939	-61%
WEARC[H]	$19,832	$32,230	-38%
MRRC[I]	$32,858	$125,707	-74%

[E] Nevada's four 1915(c) waivers have different reporting periods. The "waiver year" represents the reporting year for each waiver.

[F] Persons with physical disabilities

[G] Frail elderly

[H] Elderly in adult residential care

In comparing Nevada's home and community based waiver programs to other states' programs in 2002, the Kaiser Commission on Medicaid and the Uninsured (2005) found that:

- Nevada had a low number of clients participating in its waivers (47th nationally);
- Nevada's total expenditures for the waiver programs were the lowest of all the states;
- Nevada's average expenditure per waiver participant (waiver services only) was below the national average:

Average Expenditures per Waiver Recipient

	Nevada	National
MR/DD	$23,132	$34,581
Aged	4,450	6,181
Physically Disabled	3,522	13,433

- Twenty-two states had separate home and community based waivers for persons with traumatic brain injury and spinal cord injury; 20 states had waivers for children with special needs; and 15 states had waivers for persons with HIV/AIDS (Nevada had none of these waivers).

While consideration should be given to undertaking a redesign of the overall long term system, the stakeholders adopted three short-term strategies related to expanding and enhancing coverage under the current home and community based waiver programs:

- expanding the number of case managers serving persons in the waivers,
- adding services to the waivers for persons with traumatic brain injuries and children and adolescents with autism, and
- providing sufficient funding to eliminate the waiting list for all of the home and community based waivers.

The number of case managers should be expanded because authorized waiver slots in the Community Home-Based Initiative Program (CHIP), Waiver for Independent Nevadans (WIN) and Waiver for Elderly and Adult Residence Care (WEARC) programs are not being filled due to a lack of State case managers. Case managers in these programs must be Nevada-licensed social workers for the CHIP and WEARC waivers, and licensed health professionals for WIN.

As one strategy to fill these waiver slots, DHHS needs to alleviate the shortage of case managers. To this end, DHHS could loosen the qualifications requirements for case managers or contract with an outside medical management firm

[I] Persons with mental retardation and related conditions

or an Administrative Services Organization to either provide case management services or to provide overall management of the waivers. The stakeholders at the Summit declined to make a specific recommendation as to obtaining more case managers but did recommend that strategies be adopted for increasing the number of case managers, with the retention of an Administrative Services Organization as being one option to be explored.

High-level cost estimates were presented for some of the strategies associated with the existing waivers, including $200,000 of State General Fund per year to support expanding the number of case managers, $1 million per year in State funds for services for traumatic brain injury services, and approximately $10 million per year in State funds to eliminate the waiting lists for the waivers that existed in February 2006. No estimate was prepared for the addition of autistic children and adolescents to the waivers.

7. Continue to explore advantages for Nevada under the Deficit Reduction Act of 2006 to enhance federal funding for the Medicaid program.

The federal Deficit Reduction Act (DRA), which became law on February 1, 2006, provides states with a number of new Medicaid program options related to the delivery of services to persons with disabilities and long term care needs. These provisions include the following:

- beginning January 1, 2007, allowing families with incomes up to 300% of the FPL to buy Medicaid coverage for their disabled children;
- continuing grants programs to the states to allow working individuals with a disability to buy into Medicaid and receive access to personal assistance and other health and employment services;
- beginning January 1, 2007, allowing states to offer home and community based services as a Medicaid State Plan option (as opposed to applying for a waiver);[J]
- establishing or continuing the following community based demonstration grants:
  - o "Money Follows the Person Rebalancing Demonstration," which is aimed at shoring up community based infrastructure so that individuals have a choice of where they live and receive services (will begin to award grants 1/1/07). This competitive two-year grant provides incentives for states to reallocate long term care services to community options by providing an enhanced match rate for one year for each person that the state transitions from an institution to the community. This enhanced federal matching funding is intended to free up state Medicaid match that could be used to pay for one-time transition expenses (e.g. rental security deposits).
  - o "Real Choice System Change Grants for Community Living," which is the continuation of a current grant program used to design and construct systems infrastructure that will result in improvements in community long-term support systems (e.g., improved access to support services, information technology, affordable housing).
  - o "Demonstration to Offer Home and Community based Alternatives to Psychiatric Residential Treatment Facilities for Children," which is aimed at testing the effectiveness of improving and maintaining the functional level of children with psychiatric disabilities as well as the cost-effectiveness of Medicaid-funded home and community based services as alternatives to residential psychiatric treatment centers.
- beginning January 1, 2007, allowing states to offer self-directed personal care services (cash and counseling), including self-directed personal care services provided by family members as a Medicaid State Plan option (as opposed to needing to apply for a waiver;[K] and
- allowing an individual who purchases a qualified private long term care policy, but who eventually uses all its benefits, to apply for Medicaid without having to spend most of his/her assets first.

DHHS has been evaluating the advantages and disadvantages of the various provisions of the DRA. The DRA contains opportunities that are consistent with several of the goals expressed by the focus groups and advocacy groups for long term care services. Additionally, the DRA also includes opportunities for cost avoidance and cost savings. A report evaluating the DRA and its opportunities for Nevada would be helpful to policymakers and the public in setting the course for the Nevada health care system in the future.

[J] Under this option, a state can establish the number of individuals to be covered, services are limited to persons with income up to 150% of the FPL, and individuals are not required to meet an institutional needs test in order to receive home and community based services.

[K] This provision allows states to restrict the geographic areas of the state where services are available and to limit the populations eligible to receive such services.

8. Through a working group with expansive representation, examine the strengths and weaknesses of the current long term care system and develop optional service delivery models that would lead to increased efficiencies, better out-comes, more individuals receiving services, and reducing individual participants' cost of care.

The recommended working group should be convened by the Department of Health and Human Services and view its charge to include long term care services available to both Medicaid and non-Medicaid populations and should be supported through additional funding as soon as practicable.

Long term care functions and operations are dispersed among multiple divisions and are delivered through separate systems of care. Developing a more effective and efficient system of care for the elderly and for people with disabilities will likely improve financial performance and definitely minimize access barriers and provide real choices to recipients.

To support the overall goal of more Nevada seniors getting the benefits, services and supports they need, Nevada's Task Force on Senior Services identified the need to design, fund and implement a single point of entry system for information, referral, assistance, care planning and care management. More recently, the Accountability Committee for the Nevada Strategic Plan for Senior Services added a recommendation that the Governor support consolidating the Medicaid waivers.

Medicaid programs in several states, including Colorado, Maine, New Hampshire, Arizona, Wisconsin and Kentucky, are analyzing or undergoing structural reforms of their long term care service delivery systems. These reform efforts include:

- single point of entry systems, which serve multiple populations, combine or coordinate financial and function eligibility determinations and coordinate multiple funding streams;
- global budgeting in which all of the components of long term care spending (e.g., nursing facility, home and community based, State-funded personal care programs) are consolidated into a single State agency budget such that funding can follow the person as they move between services;
- individual budget models (e.g., Independence Plus Medicaid initiative and consumer self-directed programs), in which beneficiaries are given a budget to purchase services and participate in the planning, hiring and managing of workers, and a fiscal intermediary is used to issue checks and perform tax withholding for workers; and
- contracting with administrative services organizations or managed care organizations to manage long term care services either on a performance basis or on a risk basis; responsibilities of these organizations range from the provision of enhanced care coordination to the provision of the full array of administrative related services including case management.

There is a task force in place to examine long term care services in Nevada. However, Summit participants did not believe that this group sufficiently represented the stakeholders and ought to be expanded. While participants supported the notion of having the State provide funding to underwrite this effort, the group believed that there is great urgency to begin the journey of redesigning the system and that the deliberations should begin immediately, with funding to follow during the Legislative session. ◗

Small Employers

Issues relating to the affordability of health insurance – and access to it – are critical

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OVERVIEW

THE VAST MAJORITY of Americans receive health insurance through their employers. The size of the employer is a key factor in determining the cost of insurance, both to the employers and their employees. Large groups have lower premiums because they can divide the cost of claims for the group among a large number of people. In a small group, one employee with high medical claims can have a significant impact on the employer's cost of insurance. Small employers also incur higher administrative costs because they are small and because they typically work through a broker. Broker commissions, which range from 2% to 8%, are usually added to premiums. As such, cost is most often the largest barrier to small employers offering insurance to their employees.

Over the past five years, the cost of employer-sponsored coverage has increased by 59%. Between 2002 and 2003, health care premiums rose by 13.9% and by 11.2% in 2004, while the rate of inflation increased by only 2.5%. Increases in premium rates are pricing a growing number of small businesses out of the insurance market. Firms do have the option of requiring employees to bear more of the cost of health care coverage, but in doing so they may make the cost of insurance beyond the reach of the employee.

In the early 1990s Nevada tried to address the cost of small group insurance by allowing insurance companies and health plans to offer small employers a basic benefit plan. The premiums on this product were thought to be lower, largely because it was exempt from State-mandated benefits laws. Unfortunately, due to a very low take-up rate, the legislation was repealed shortly after it was enacted. At least two factors have been cited for the very poor take-up rate. The law limited the broker commission to 2% on these policies and, as a result, brokers had little incentive to "push" the product. Also, the rollout of the product was not accompanied by any sort of marketing campaign.

Federal efforts to reform the small group market resulted in enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996. A key provisions of HIPAA required states to adopt a series of insurance reforms designed to improve the availability and affordability of insurance products for small employers. HIPAA set a floor for rating restrictions, required guaranteed availability, and guaranteed renewal of policies in the small group market. As a result of HIPAA, small employers can access health insurance coverage.

Nevada responded to the enactment of HIPAA by enactment of A.B. 521 during the 1997 legislative session. The legislation created the Program of Reinsurance for Small Employers and Eligible Persons. This program was designed to address portability, availability and affordability of health insurance in the individual and small employer market.

Under the program two levels of health benefit plans are offered: a basic and a standard plan. All insurance companies are required to offer the plans, and to lower costs, the plans are exempt from certain statutory required services and provider types. For policies written under the program, losses for any covered individual above a threshold are covered by a reinsurance pool at 90%. The reinsurance pool is funded through an assessment on the reinsuring carriers.

It has been reported that there is virtually no enrollment in the Program. It has been speculated that the lack of enrollment is because the carriers participating in the reinsurance fund are, in essence, reinsuring themselves.

In spite of the enactment of the Program of Reinsurance for Small Employers and Eligible Persons, cost of coverage remains a large barrier to small employers offering insurance.

In January 2005, the Legislative Committee on Health Care (LCHC), Subcommittee to Study Health Insurance Expansion Options, issued a report identifying the Health Insurance Flexibility and Accountability (HIFA) waiver as a means to expand insurance to small employers. The original intent of this initiative was to target small employers (two to 50 employees) by offering a subsidy paid with State and federal funds. The subsidy would be available for the work-

ing uninsured with incomes below 200% of the federal poverty level (FPL).

Unfortunately, the recently enacted Deficit Reduction Act placed restrictions on the use of the federal funds Nevada was to use for the subsidy. The legislation prohibits the use of SCHIP funds for childless adults. This effectively negated the State's effort to target small employers with the use of leveraged federal funds.

The State has redirected its HIFA waiver to target the population of working uninsured that are parents, and whose children are currently covered by Medicaid or Nevada Check Up (200% of the FPL).

As small employers are forced to drop or not offer insurance because of the cost, their employees join the ranks of the uninsured, of which there are approximately 426,000 in Nevada. Of this number, it is estimated that 83% are in households that have a full- or part-time worker.

Expanding the affordability of insurance for, and take-up of insurance by, small employers offers significant opportunities to ensure that Nevadans are able to receive health care services.

FOCUS GROUP RECOMMENDATIONS

Members of the Medical Coverage focus group developed a recommendation that received broad support for actions related to small employers. This "high scoring" recommendation was:

- Improve opportunities for small employers to offer employee health care coverage (e.g., greater product flexibility).

OVERALL RECOMMENDATION STATEMENT

Based on the focus groups' deliberations, the following Recommendation Statement concerning small employers was developed:

Develop mechanisms to provide coverage for the small employer market.

STAKEHOLDERS' HEALTH SUMMIT STRATEGIES

In order to address issues pertaining to small employers and individuals who cannot obtain insurance, strategies were developed from the recommendation identified by stakeholders in the focus group process. Supporting information was developed, and the strategies were then presented to the participants in the Stakeholders' Health Summit. The Summit adopted the following strategies to improve affordability and availability of health insurance in the small group market.

1. Create a Task Force to look for long-term approaches to encourage small business owners to offer insurance and to evaluate why the existing small employer product that Nevada insurance companies are mandated to offer has such low take-up. Among the approaches that should be examined are:
   - various forms of standard benefit packages for the small group market;
   - providing subsidies for insurance, either to the population at large or to small employers; and
   - establishing a universal coverage program for Nevada.
2. Fully implement the concept of the HIFA waiver but have the State assume the funding for the cost that the federal government will no longer provide.

BACKGROUND ON SUMMIT STRATEGIES

1. Create a Task Force to look for long-term approaches to encourage small business owners to offer insurance and to evaluate why the existing small employer product that Nevada insurance companies are mandated to offer has such low take-up.

While 96% of large firms in Nevada offer health insurance, only about 45% of firms with less than 50 employees offer coverage. Although this participation level of small employers in Nevada is higher than the national average of 43%, it still represents a large pool of employees that are without health insurance coverage.

The Summit participants rejected the adoption of any specific strategy to increase small employer participation in health insurance coverage. This position was taken because participants felt that not enough information was available to discern the reasons for the low rate of small employer insurance offering.

Instead of recommending a specific strategy to encourage small employer insurance take-up, the Summit recommended a task force to examine the issue. Among the options that the Summit felt the task force should examine are: standardizing the benefit for the small group market; providing subsidies for insurance, either to the population at large or to small employers; and, establishing a universal coverage program for Nevada.

Standardized Plans. With its Program of Reinsurance for Small Employers and Eligible Persons, Nevada has established a standardized health plan for small employers.

The theory of adopting a standardized plan is to ease the administrative burden on small employers in their shopping

for insurance. With a standardized plan, the employer's purchasing decision can be focused not on benefit design, but on price and delivery system (e.g., point of service, HMO or PPO).

The essential elements in the design of standardized plans are to adopt a benefit design that both offers the coverage small employers want and to price the product at an affordable price.

It is unknown whether either of these elements exist in the current Nevada HIPAA product, and is an area of investigation that should be pursued by the recommended Task Force.

Standardized Plan with Premium Cap. A variation of the simple standardized plan is a standardized plan with a premium cap. Under this approach, a standardized product is combined with a limit on the premiums that may be charged for that product.

Maryland, for example, has implemented this strategy, creating a guaranteed issue product that all carriers participating in the small group market must sell. The plan has a floor equal to the actuarial equivalent of the minimum benefits required to be offered by a federally qualified HMO, but the cost of the plan is not permitted to exceed 10% of Maryland's average annual wage. If the cost of the package exceeds this cap, the cost sharing that is permitted under the policy is adjusted.

Providing Subsidies for Insurance. In considering subsidies for insurance, there are two types of subsidies that could be offered: a direct premium subsidy; and a reinsurance device.

A direct premium subsidy reduces either (or both) the employer's or the employee's costs and is tied to the specific enrollment of a particular employee. For example, this may be a subsidy payment of $100 per month to an employee.

The other form of subsidy is a reinsurance device. This approach limits the dollar amount of claims that an insurance company will have to pay for any enrollee. Costs above this limit are paid (either in whole or in part) by the State. By limiting the amount of claims that an insurance company will have to pay for any enrollee, the insurance company has reduced risk and, in turn, reduced premiums. For example, the State may pay (in whole or in part) all of the claims above $50,000 in a year submitted to an insurance company for a particular individual that has coverage.

The following discussions present the key points of each of these two subsidy options.

Direct Premium Subsidies. In designing a direct subsidy program, there are a number of overall policy decisions that need to be considered:

- Benefit package. Is the benefit package standardized, or are different packages offered by different commercial carriers eligible for subsidy? Is the benefit package limited or comprehensive? What deductibles and copays are allowable?
- Target population. Is the target population small employers or the uninsured in general? Are adults with children and those who are childless equally eligible for the subsidy? Is the subsidy limited to those whose incomes are below a certain threshold? Are dependents of employees eligible for the subsidy? Are part-time workers eligible for the program?
- Contribution. If the subsidy is directed to small businesses, is there a minimum contribution required by the employer? What contribution is expected of employees? How much is the subsidy of the total premium? Does the amount of the subsidy vary based on the enrollee's income?
- Limited liability. Does the State limit its liability under the direct subsidy program to a fixed amount of appropriated dollars on a first come, first served basis? Or will the State provide a subsidy for everyone who wants to take advantage of the program, regardless of the cost to the State?
- Adverse selection. Will there be a "going bare" period required? This means that in order to be eligible for the product, the business could not have offered creditable insurance for a set period of time. Is there a minimum level of employee participation?

There are several variations of direct subsidy programs. One would be a standardized, subsidized product offered to a broad subset of the population (e.g., low-income). Another would be a standardized, subsidized product focused on small employers. A third would be to offer a subsidy for any health insurance package that a small business may want to buy, as long as it meets certain state requirements.

Standardized Product with Subsidy Offered to a Broad Population. An example of a standard benefit plan coupled with direct premium subsidy that is offered to a broad population is Pennsylvania's "adultBasic" product. The benefits include preventive care, physician services, inpatient hospitalization, outpatient services and emergency care. Coverage for prescription drugs is not available. The individual premium averages about $312 per month.

The target population for the product is working individuals, ages 19 to 64, with annual incomes up to 200% of the FPL. The individual contracts directly with a health plan authorized to offer the product. The employer does not participate in the process. This means that sole proprietors who meet the income eligibility requirement may participate.

Enrollees in adultBasic pay $32 per month to the health plan, and the state pays the difference. Due to limited funds,

the total enrollment in the program in the last few years has been approximately 40,000, with a waiting list of between 80,000 and 110,000. Individuals on the waiting list may pay the full premium amount and receive coverage. The total amount of the subsidy is approximately $110 million per year. The state uses a portion of its tobacco settlement money to fund the program.

Subsidies Targeted to Small Employers. Rather than offering a subsidized product to the broad population, many states are looking to target small businesses. There are at least three rationales for states to target subsidy programs to this group of uninsured.

- by reducing the costs to the employees, more employees will participate in the program; with more employees participating, the risk is spread across more people, and premium rates are lowered;
- when premiums are lowered, employers may be encouraged to offer insurance; and,
- perhaps most important, with multiple payers the costs for every payer is reduced. The HIFA waivers available from Medicaid are motivated by this notion and require that there be an employer-sponsored insurance component in any waiver request submitted. With state-funded programs and HIFA waivers, employers, employees, the state and, in the case of a HIFA waiver, the federal government, all share the cost of coverage.

This approach, often referred to as "3-share" (employer, employee and state), has been modestly successful in a number of states.

The first 3-share initiative began in Muskegon County, Michigan, in 1994 under a grant from the W.K. Kellogg Foundation. The cost of the program is divided among employers, employees and the state or a private foundation, although the shares may not be equal.

Parameters for employee participation differ among the 3-share programs but are generally consistent in requiring that the employee and the employee's dependents must be uninsured and not eligible for public programs. The programs are sometimes available to part-time (more than 15 hours and less than 40) as well as full-time workers. The specifics of the benefit plans vary. Some are standardized and some are not, but most include primary care, hospitalization, x-ray and labs, surgery, and prescription drugs. Discounted dental and vision services may also be available.

Small Employer Subsidies With Standard Plans. Both Maine's "Dirigo Choice" program and New Mexico's "State Coverage Initiative" are examples of standardized benefits coupled with a subsidy targeted to individuals working for small employers. Maine's Dirigo program negotiates directly with commercial carriers to underwrite two Dirigo Choice products for groups of one to 50 individuals. The products are identical except for deductibles. The subsidy, which is available to employees and individuals with incomes below 300% of the FPL, buys down both the deductible and the premium on a sliding-scale basis. Under Maine's plan, the employee pays the entire premium through a wage deduction. However, Dirigo provides qualified employees an electronic debit card with the subsidy amount so the result is that the employee is reimbursed immediately. The ongoing costs of Maine's plan are financed by an assessment on insurers not to exceed 4%.

The New Mexico plan also has a standardized benefit package that may be offered to small employers with one to 50 employees. A subsidy is available for employees with incomes below 200% of the FPL, and the amount of the subsidy is scaled to family income. The subsidy is not available for dependents. Employers must not otherwise offer health care coverage in order to participate. New Mexico's initiative is funded using SCHIP dollars to support both childless adults and parents. The State's waiver was granted prior to the Deficit Reduction Act (DRA) prohibition on the use of SCHIP funds for childless adults.

Small Employer Subsidies With Non-Standard Plans. Nevada's original HIFA waiver proposal in 2005 contained an employer-sponsored insurance component with a subsidy component. The original (and the current) HIFA waiver concept included a non-standardized benefit package. Insurers and health plans can offer small employers any benefit plan so long as that plan meets the minimum benefit plan allowed by the Department of Insurance. To participate in the program, small employers must not have offered insurance coverage within the last six months. Under the original plan, the State, with matching federal funds, would have provided subsidies for all employees below 200% of the FPL. With the subsidy being allowed for all employees, the marketing target for the program was small businesses.

Because of the prohibition in the DRA with respect to using SCHIP funds for childless adults, this has now been changed. The HIFA waiver is now proposed to offer a subsidy to employees who are parents of children enrolled in the Medicaid or Nevada Check Up. The subsidy reduces the cost of the premium to the employee, therefore making the purchase of offered insurance more affordable.

The Oregon Family Health Insurance Assistance Program (FHIAP) is a second example of a subsidy coupled with a non-standardized benefit package targeted to small employers. Under the program, employees and individuals with incomes below 185% of the FPL pay the entire premium and are reimbursed based on a sliding scale.

Reinsurance Devices. A few states have state-funded reinsurance programs for targeted populations enrolled in pri-

vate health insurance. New York has a reinsurance program built into its "Healthy NY" program, whereby private health insurers that offer Healthy NY are reinsured for individuals who have higher annual medical costs.

Healthy NY is targeted to low-wage workers, small employers and the self-employed. It is administered by New York's Department of Insurance, but the Department funnels all eligibility determinations and enrollment functions down to the private sector health plans.

There are two products offered under Healthy NY, one that includes a pharmacy benefit and one that excludes it. As such, the product is the same across all health plans, so individuals choosing to enroll in the program have only to make decisions on health plan preference and price.

Health plans are able to charge what they wish for the Healthy NY product under the state's "file and use" provision for rate regulation. The premiums charged for Healthy NY have been significantly lower than the regular commercial market, in part because of a slimmer benefit package but primarily due to the reinsurance component. For example, when the Insurance Department changed the reinsurance level in July 2003 from covering 90% of annual costs per person in the $30,000-$100,000 range to the lower range of $5,000-$75,000, all health plans lowered their Healthy NY premiums by 17%.

To be eligible to participate in Healthy NY, a small employer must have fewer than 50 employees, 30% of whom must earn less than $33,000 a year (adjusted for inflation). The employer must contribute half of the premium, and at least 30% of employees must participate in the program. Part-time workers and an employee's dependents are allowed to participate, but the employer does not have a mandatory contribution toward the premiums for these enrollees. Self-employed individuals and working individuals not eligible through an employer's plan may also participate in Healthy NY if their household income is below 250% of the FPL.

One important consideration associated with a reinsurance program is the notion of "adverse selection," that is, that only (or at least a disproportional number of) people with high medical needs will sign up for the program. If adverse selection occurs in a reinsurance program, the claims of these individuals would typically exceed the reinsurance threshold. If a reinsurance program is in place and has adverse selection, the cost to the state increases. With increasing costs, either more funding must be put into the program or a fewer number of individuals can participate.

New York may be one of the few states in the nation that can successfully "pull off" a reinsurance program because the state has community rating of the small market. With community rating (and an exclusion of pre-existing conditions in the Healthy NY program), New York has not seen a great deal of adverse selection in their program.

Nevada's HIPAA product, the Program of Reinsurance for Small Employers and Eligible Persons, is a reinsurance program for small employers, but the reinsurance is the obligation of the carriers writing policies under the program, not the State.

Universal Coverage. At the time of the Summit three states had passed universal coverage laws (Hawaii in the 1970s, Maine in 2003, and Massachusetts earlier in 2006). Those states differed in their approach to providing coverage.

Hawaii's law is an employer mandate; coverage must be offered to employees but not dependents. Hawaii is unique in that it is exempt from Employment Retirement Income Security Act (ERISA), so the state imposed mandate applies to firms covered by ERISA as well as well as those firms not covered by that federal law. The Census Bureau reports a current uninsured rate of 9.9% for Hawaii, but the rate of uninsurance has been as low as 2%.

Maine's program was implemented in 2003 and uses a basic structure of a state-operated health purchasing coalition for small employers, sole proprietors and individuals. Dirigo Choice offers subsidies to enrollees with family income below 300% of the FPL to meet their cost for premiums and the plan's deductible. The program has statutory authority to request an assessment on insurers not to exceed 4% of gross premiums per year to fund the program.

Massachusetts has built upon the concept of employer and personal responsibility with a "play or pay" approach. Employers not offering coverage are provided incentives to pay for employee coverage through the use of pre-tax dollars. Employers choosing not to offer coverage face penalties of $295 per full-time equivalent employee beginning in 2007. Individuals face penalties (eliminating the personal exemption on state taxes) if they fail to obtain coverage.

Massachusetts recognized that very small employers (fewer than ten workers) find it difficult to find affordable plans. Therefore, the state is allowing the merger of individual markets and small group markets. This merger will provide a larger risk pool and, hopefully, lower overall premiums for a significant number of employees. The conference report on the legislation estimates a 24% reduction in non-group premium costs. The bill was signed into law on April 12, and the provisions will become effective in July 2007.

Since the enactment of the Massachusetts plan, many more states have expressed interest in extending the principles of personal responsibility to their own jurisdictions.

Summit participants felt that exploring the concept of universal coverage should be incorporated into the charge

of the Task Force assembled to look for long-term approaches to encourage small business owners to offer insurance.

2. Fully implement the concept of the HIFA waiver but have the State assume the funding for the cost that the federal government will no longer provide.

As previously discussed, the original Nevada HIFA waiver proposal targeted small employers by offering a $100 subsidy for insurance premiums for employees. Under this concept, the subsidy would have been extended to all employees with incomes below 200% of the federal poverty level. Given this eligibility design, the target market for the product would have been small employers that had not previously offered health insurance.

Prior to receiving approval from the Centers for Medicare and Medicaid Services (CMS) for the Nevada HIFA waiver, the Congress enacted the Deficit Reduction Act of 2005 (DRA). The DRA prohibited the use of SCHIP funds for health care expenditures for childless adults. This prohibition directly impacted the design of Nevada's HIFA waiver in that employees of small employers were divided into two groups: those that could receive the subsidy under the DRA (employees that are parents); and, those that could not (employees that are not parents). As a result the Nevada HIFA waiver was redesigned to provide a premium subsidy only to employees that are parents that work for a small employer that offers insurance.

The Summit participants adopted a strategy to return to the original concept of the HIFA waiver to target small employers not now offering insurance. The Summit recommended that the State provide the funding for the subsidy that the DRA prohibited to be provided by SCHIP funds. ◗

Safety Net Coverage

Because of Nevada's provider shortage, the safety net system fills gaps for both the insured and the uninsured populations

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OVERVIEW

AS SMALL EMPLOYERS are forced to drop or not offer insurance because of the cost, their employees join the ranks of the uninsured, of which there are approximately 426,000 in Nevada. Of this number, it is estimated that 83% are in households that have a full- or part-time worker.[45] As this population grows, it is more and more likely to turn to the safety net system for access to health care services.

Safety net providers deliver health care services regardless of the patient's ability to pay. Because of the state's provider shortage, the safety net system fills gaps for both the insured and uninsured. In Nevada, the safety net system is largely comprised of:

- community health centers,
- University Medical Center and rural public hospitals, and
- County Indigent Fund programs.

The safety net strategies discussed in the planning process focused on the community health centers (CHCs). National studies have found that CHCs that serve as a key provider of primary care and prevention services save the Medicaid program at least 30% annually. This savings accrues from Medicaid beneficiaries that use health centers, and then have reduced need for specialty care referrals and hospital admissions. It is also estimated that if patients utilizing the emergency rooms for non-emergency services were redirected to a CHC, up to $8 billion could be saved nationally.[46]

Since 2001, there has been a federal focus to increase the number of health centers and to expand funding for the overall program. Appropriations have increased 53% from $1.16 billion to $1.78 billion over the past five years, and the FY 2007 President's budget request is at $2 billion.

There are two CHC systems in the state: Nevada Health Centers, Inc., and Health Access Washoe County (HAWC). These CHC systems provide services through 28 facilities across the state and offer a range of medical, behavioral health and dental services.

The CHCs provide services in every age, income, and ethnic demographic range. Their clients are both uninsured and insured, with the insured being covered by group, private and public programs such as Medicare and Medicaid. In 2004, the CHCs served 55,588 Nevadans. By 2005, the CHCs served 67,904 Nevadans, an increase of 22%. These clients utilized 170,903 total visits of care, reflecting the increased pressure on the safety net system. Of the total visits, 53% were utilized by the uninsured, 23% were utilized by people enrolled in Medicaid, and the remaining 24% were utilized by people who had either Medicare coverage or private insurance. The total annual operating cost of the two systems is approximately $20.6 million.

FOCUS GROUP RECOMMENDATIONS

In three of the six focus groups convened for the development of the Nevada Strategic Health Plan, the participants developed recommendations that received broad support for actions related to safety net coverage. These "high scoring" recommendations (and the originating focus groups) were:

- Preserve county safety net programs. *Public Health*
- Develop primary care and prevention services in order to ease the burden on tertiary care facilities, especially in underserved areas and to ensure a culturally sensitive, holistic approach to caring for patients. *Health Professionals*
- Increase funding for the Senior Rx and Disability Rx programs. *Pharmaceutical Coverage*

OVERALL RECOMMENDATION STATEMENT

Based on the focus groups' deliberations, the following Recommendation Statement concerning safety net coverage was developed:

Improve access to services for both the insured and uninsured by supporting and expanding the safety net provider network.

STAKEHOLDERS' HEALTH SUMMIT STRATEGIES

In order to address issues pertaining to safety net coverage, strategies were developed from the recommendations identified by stakeholders in the focus group process. Supporting information was developed, and the strategies were then presented to the participants in the Stakeholders' Health Summit. The Summit adopted the following strategies to increase access to health care services by enhancing the safety net.

1. Provide funding to Nevada's Federally Qualified Health Clinics (FQHCs) and FQHC look-alikes to improve access to health care services for the both the uninsured and the insured. Funding should be for both capital and ongoing operations, but be flexible enough to allow for unspent capital funds to be reallocated to ongoing operations.
2. Provide ongoing funding to support administration of local community networks that offer coordination of primary and specialty care services to the uninsured.
3. Increase funding for Senior Rx and Disability Rx programs.

LCHC ACTIONS

In its August 10, 2006, Work Session, the Legislative Committee on Health Care (LCHC) took the following actions with respect to the strategies adopted by the Stakeholders' Health Summit participants:

First, the Committee recommended appropriating $600,000 annually to DHHS for Senior Rx and Disability Rx programs. The priority for this additional funding is to reduce the number of individuals currently on waiting lists for the Disability Rx program.

Also, the Committee recommended expanding funding among safety net providers by:

- providing a biennial appropriation of $10 million from the State General Fund for the creation of a grant program to support the expansion of FQHCs (federally qualified health centers), FQHC lookalikes, and rural health care centers as defined by the federal government;[L]
- providing an annual $1 million appropriation from the State General Fund to the DHHS for the support of Nevada's Access to Health Care Share Responsibility pilot program, which:
  - o will operate a medical discount plan as defined by NRS 695H.050;
  - o establishes that participants in the program must be (1) employed but not offered insurance by their employer; (2) within 100 to 250 percent of the federal poverty level; and (3) not eligible for any other State or local health insurance program
  - o allows fees to be collected for participation in the program at $300 per year ($250 covered by the employer and $50 covered by the employee)
  - o provides that funds not expended at the end of the State fiscal year will be placed in a "member care fund" to be used to cover major health care costs for pilot program participants that have exhausted their resources;
  - o commences in Clark and Washoe counties as soon as practicable, and a portion of the administration fees must be utilized to develop a plan to expand the program to additional areas in Nevada with special emphasis an the rural areas;

BACKGROUND ON SUMMIT STRATEGIES

1. Provide funding to Nevada's Federally Qualified health Clinics (FQHCs) and FQHC look-alikes to improve access to health care services for both the uninsured and the insured.

With a shortage of providers for the insured and the size of the uninsured population, safety net providers in Nevada are seeing increased demand for their services. With State support for the enhancement and expansion of community health centers (CHCs), Nevada will increase access to health care for a broad spectrum of people and likely restrain the cost increases in the health care system.

A number of states provide direct funding to CHCs, with the most common sources of funding being general revenue, tobacco settlement or tobacco tax dollars, and provider taxes. Among Nevada's neighboring states, Arizona provides $10 million to CHCs, New Mexico $16.7 million, and Utah $700,000. Oregon and Idaho do not provide

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[L] The funding may be used to assist with capital or operational costs that enhance or expand the health centers ability to provide primary care services, including dental services.

direct support. In 2006, Nevada provided $817,000 in support to CHCs for oral health, specialty care for the uninsured, public health preparedness and other health services.

In the past five years, Nevada's CHCs (including tribal health clinics) saw their annual client visits climb from 50,000 to 170,000. Patient payment for those visits is based on a sliding scale, with low-income individuals paying nothing and higher-income individuals paying per-visit fees. Over half of the visits were provided to uninsured residents. The cost per medical visit averages approximately $90, with the cost per dental visit being higher.

With State support, existing centers can provide more or expanded services, and new centers can be developed.

The strategy presented for the Stakeholders' Health Summit contemplated $10 million per year in State support. For the first five years, the funds would be distributed in two ways:

- $5 million for support of new facilities or expansion of existing clinics, and
- $5 million for support of services provided to the uninsured on a per-visit basis.

Under the strategy adopted by the Summit, Nevada would provide funding to FQHCs and FQHC look-alikes and the funding stream would be flexible enough to allow for unspent capital funds to be reallocated to ongoing operations.

2. Provide ongoing funding to support administration of local community networks that offer coordination of primary and specialty care services to the uninsured.

In Nevada and throughout the country local communities have implemented initiatives designed to provide access to health services for the uninsured. These initiatives are based on local relationships within the health care delivery system. The State can foster these local initiatives by supporting the administrative costs of these initiatives.

One example of these initiatives is AccessHealth in southern Nevada, managed by Great Basin Primary Care Association. AccessHealth is designed to coordinate enrollment, assignment to a medical home, and referrals that make a range of discounted health services available to the uninsured. AccessHealth is not a health insurance program but instead provides access to a coordinated range of health services at discounted rates.

To be eligible for the program, individuals must be Nevada residents and have income above the Medicaid standard but below a designated threshold (for a family of four, annual income must be between $20,000 and $50,000). The individual or family must also not have coverage through Medicaid, Medicare or their employer. Once enrolled, each individual is assigned a primary care physician who coordinates referrals to specialists and hospitals.

There is no enrollment fee for AccessHealth. However, members are expected to pay for services at the time the service is rendered but at a negotiated discounted rate. The network of providers that has agreed to discounted rates includes CHCs, multi-specialty groups, sole practitioners, hospitals, radiology and lab services, outpatient surgery centers as well as other providers. To discourage utilization, the network does not include emergency rooms.

A similar program that arranges for primary and specialty care is the Pima County Access Program (PCAP), a membership-based, health care referral program in southern Arizona. Unlike AccessHealth, there is an enrollment fee in PCAP. Once enrolled in PCAP, an individual has access to deeply discounted primary and specialty care and hospital services. Primary care, provided through a CHC, is based on a sliding fee scale. Specialist consults are $25, hospitalization is $400/day; ICU is $600/day. Specialty care services are set at 30% of the Medicare rate. Prescriptions are offered through pharmacy discount programs. All fees are payable at the time of service. Emergency room services are not covered unless the member is admitted. If not admitted, the patient is responsible for 100% of the charges.

The PCAP program is open to individuals ineligible for public programs, and with income levels up to 250% of FPL. If an employer subsidizes any portion of an employee's health insurance costs, that individual is not eligible to participate. However, if the individual is in a probationary or waiting period, enrollment would be permitted. Employers who have never offered health insurance are permitted to pay the enrollment fee on behalf of the employee.

These types of community-based initiatives fill the gaps for the uninsured, but their development depends on funding for administrative support and local initiative and relationships.

If the State supported these activities, additional and expanded networks could grow and provide broader access to health care for the uninsured in Nevada.

3. Increase funding for Senior Rx and Disability Rx programs

Nevada has statutorily mandated that a portion of the tobacco settlement monies be used to support two state-sponsored drug assistance programs, Senior Rx and Disability Rx.

With the enactment of Medicare Part D, Senior Rx provides assistance with out-of-pocket expenses for seniors who are eligible for Medicare Part D and as well as cost-sharing for members who are not Part D eligible. Eligibility

for the Senior Rx is set for FY 2006 at annual income levels of $23,175 for a single individuals and $30,168 for couples. The program has no asset test, but eligibles must be 62 years of age or older and have continuously lived in Nevada for the preceding 12 months.

For SFY 2006 Senior Rx will receive approximately $8 million in funding and serve approximately 8,600 seniors. While there is a great deal of uncertainty surrounding the implementation of Part D, program administrators are reasonably confident that Senior Rx has sufficient funding to support the seniors that have applied for the program. There is no waiting list for services.

It may take another year before the impact of Part D on Senior Rx is fully understood, at which time the question of whether or not the program will require additional state support can be revisited.

In January of 2006 Nevada began the Disability Rx program. This program assists disabled individuals with the cost of prescription medicines. The income, asset and residency requirements of Senior Rx apply to the Disability Rx program, with the additional requirement of some proof of disability. For SFY 2006, approximately $470,000 is available for the program, which was originally estimated to support 147 individuals but has since been raised to 556 as of January 2007.

With the uncertainty of the impact of Part D, and the lack of experience in supporting the disabled community (no claims experience), Disability Rx has stopped admitting individuals into the program. There were approximately 76 individuals on the waiting list as of mid-January 2007.

The cost of funding the option for Disability Rx is approximately $600,000. The priority for this additional funding is to reduce the number of individuals currently on waiting lists for the Disability Rx program. ◗

Behavioral Health

Despite the need for behavioral health services, Nevada's service delivery system has not been able to meet the demand

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OVERVIEW

THERE IS A GREAT NEED for behavioral health services in Nevada. Among western states, Nevada has one of the highest prevalence rates of mental illness, with 4% of the population living with a serious mental illness.[47] In terms of substance abuse, Nevada has one of the nation's highest percentage of population reporting past-month use of illicit drugs. However, Nevada's rankings with respect to substance abuse have improved markedly since 1999. In that year the State was ranked 1st in past-month use of illicit drugs (now 5th), 1st in illicit drug dependence (now 30th) and 8th in past-month binge alcohol use (now 47th).[48]

While improvements have occurred in substance abuse, other areas of Nevada's service delivery system has not been able to meet the demand. Along with service infrastructure issues (e.g., lack of providers), behavioral health funding has historically been low in comparison to other states' programs.

For example, on a national comparison based on FY 2003 expenditures, Nevada ranked:[49]

- 37th in overall mental health spending and 36th in per capita expenditure ($63);
- 41st in state hospital spending and 42nd in per capita expenditure ($18);
- 33rd in community based program spending and 29th in per capita expenditure ($44); and
- 34th in the percentage of total mental health revenues from Medicaid (23%).[M]

Another example of the unmet need is contained in the DMHDS 2004 prevalence study. The study estimated that there were 55,700 residents with either SMI or SED conditions in the Division's service area. The study reported that only 23,800 (43%) of those individuals received services from the Division.

The Clark County Mental Health Consortium reports similar figures for Clark County elementary school children in its 2004 report. Of the estimated 7,800 children with SED that need services, only 37% received services and, among them, 83% were underserved.

Recognizing the need to enhance Nevada's behavioral health delivery system, the State has recently provided significant resources to the system. Examples of recent funding initiatives include:

- Increasing funding for DMHDS mental health services. During the 2005 Legislative session, DMHDS received a 47% funding increase ($91.4 million) that provided for the following:
  - o *Southern Nevada Adult Mental Health Services:* medication clinic services, residential support, psychiatric ambulatory services, the opening of the new hospital, and the addition of beds to two other State facilities. Additionally, funding was provided for community residential placements, overflow beds, a Mental Health Court in Clark County, and support for a community triage center.
  - o *Northern Nevada Adult Mental Health Services:* medication clinic services, community residential services, and psychiatric ambulatory services. Additional funding was also provided to expand and support the Washoe and Carson City Mental Health Courts and a triage center for Washoe County.
  - o *Rural Clinics:* medication clinic services and an increase in outpatient services.
- Expanding the Wraparound in Nevada (WIN) program to provide case management and wraparound support to child welfare custody children with SED.
- Implementing the Behavioral Health Redesign by DHCFP to change the revenue flows and payment

[M] The national average was 39%, with the highest percentage found in the state of Washington at 87%.

rules for behavioral health services. The redesign increased the availability of community based services. Included in the redesign is the development of specialty clinics for the delivery of lower level services and the expansion of the number of providers available.

The significance of the recent funding increase for DMHDS's mental health services is depicted below. Also revealed is the dependency of the Division's mental health budget on general fund monies.

DMHDS Mental Health Agencies Budget Sources
Selected Years • Dollars in Millions

	FY 2005		FY 2006	
General Fund	$69.2	78%	$107.0	85%
Federal Funds	10.0	11%	10.9	9%
Fees	0.2	0%	0.9	1%
Other	9.2	10%	7.8	6%
Total	$88.7	100%	$126.5	100%

Responsible Agencies

Responsibility for delivering publicly funded mental health and substance abuse (i.e., behavioral health) services is shared by various units within the Department of Health and Human Services (DHHS), including the following:

Division of Mental Health and Developmental Services (DMHDS). This Division is responsible for the overall administration of the behavioral health system in Nevada and has specific responsibility for the delivery of mental health services to adults (18 years of age and older) with serious mental illnesses (SMI). The Division also has specific responsibility to serve children and adolescents with serious emotional disturbances (SED) in the 15 rural counties. The Division oversees the operation of two inpatient psychiatric hospitals for adults as well as outpatient community based programs. It operates 21 community mental health centers, 17 of which are clinics in rural areas.

Division of Child and Family Services (DCFS). This Division is responsible for the delivery of all services to children and adolescents in the two urban counties and, in that capacity, provides community based outpatient behavioral health and residential treatment services to children and adolescents (under 18 years of age) with SED, most of who are in the child welfare and juvenile justice systems. DCFS operates one inpatient psychiatric facility, a residential treatment facility and two community based mental health programs for children and adolescents – one in the north and one in the south. The south program includes five neighborhood family service centers.

Division of Health Care Financing and Policy (DHCFP). This Division is responsible for overseeing the State's Medicaid and SCHIP programs, including the coverage and funding of behavioral health services for eligible recipients. In addition to funding Medicaid covered services provided by DMHDS and DCFS, the Division contracts with two managed care plans that are responsible for delivering some behavioral health services to plan enrollees.[N]

Division of Health Services, Bureau of Alcohol and Drug Abuse (BADA). This Division is responsible for the oversight and funding of community based prevention, treatment and recovery support related to alcohol and drug addiction. BADA provides no direct services; rather, it contracts with community providers.[O]

FOCUS GROUP RECOMMENDATIONS

In the Health Care Facilities focus group, participants developed the following "high scoring" recommendations that received broad support:

- Change current requirements related to mental health screening and medical clearance for mental health patients presenting at the emergency room in order to facilitate triage of these individuals to appropriate settings and services and to reduce unnecessary utilization of emergency rooms.
- Improve timeliness and appropriate utilization of emergency room services.
- Increase funding and access to appropriate placements and services for individuals with mental health conditions.

OVERALL RECOMMENDATION STATEMENT

Based on the focus groups' deliberations, the following Recommendation Statement concerning behavioral health was developed:

Increase access to, and funding for, an appropriately designed mental health and substance abuse program for Nevadans requiring these services.

STAKEHOLDER HEALTH SUMMIT STRATEGIES

Supporting strategies were developed from the recommendations identified by stakeholders in the focus group process. Supporting information was developed and the strategies were then presented to the participants in the Stake-

[N] Enrollees who are SED or SMI may choose to opt out of managed care and receive traditional fee-for-service benefits.

[O] This Bureau will be moving under the Division of Mental Health and Developmental Services effective July 1, 2007.

holder Health Summit. The adopted strategies from the Summit were as follows:

1. Decrease the number of persons with behavioral health conditions who inappropriately utilize the Emergency Departments by:
   - increasing the number of available psychiatric beds by paying for placement in private beds; and/or funding additional state operated beds; and/or continuing to support and fund crisis beds such as those offered by WestCare; and/or incentivizing the private sector to add psychiatric beds to hospitals through the establishment of appropriate reimbursement rates;
   - expanding the crisis support system, to include the enhancement of mobile crisis team system to better meet the needs of children and families;
   - expanding on-going community based behavioral health services; and
   - conducting a review of medical clearance requirements and making appropriate revisions to the rule.
2. Implement strategies to increase Medicaid funding for the State's behavioral health system.
3. Review the new Medicaid State Plan option available though the Deficit Reduction Act and waivers available under the 1915(c) waiver option and select the most appropriate approach to implement to enhance home and community based services for Medicaid eligible persons with SMI.
4. Review the new Medicaid demonstration grants established under the Deficit Reduction Act and waivers available under the 1915(c) waiver option and select the most appropriate approach to implement to enhance home and community based services for Medicaid eligible children and adolescents with SED.
5. Restructure and unify the behavioral health system as necessary in order to ensure delivery of effective and coordinated services.
6. Develop a comprehensive system for the delivery of behavioral health preventive services that is integrated across the community (e.g., schools, health care practitioners, private insurers).
7. Expand mental health/substance abuse parity requirements to incorporate a wider array of services and covered diagnosis.

LCHC ACTIONS

In its August 10, 2006, Work Session, the Legislative Committee on Health Care (LCHC) took certain actions, described below, with respect to behavioral health services. Some of the actions taken are directly related to the Stakeholders' Health Summit; others relate to the testimony LCHC received during the interim, and still others relate to activities of the Committee's subcommittees.

- Requested legislation to revise Nevada Revised Statutes to require medical screening to occur before an allegedly mentally ill person is admitted (current language reads "transported") to a mental health facility. The language will also alter the definition of a "mental health facility" such that it does not include a community triage center.
- Adopted a policy statement to support:
  - o an annual appropriation of $621,000 to fund a pilot program that provides a long-term residential treatment facility for substance abusers, with an emphasis on providing comprehensive prevention and treatment services and programs;
  - o an annual appropriation of $1,296,000 to the Department of Corrections to fund comprehensive post incarceration treatment programs to enable nonviolent offenders to successfully transition back into society; and
  - o an appropriation of $1,505,000 for FY 2008 and $1,608,845 for FY 2009 to the Division of Mental Health and Developmental Services to fund Nevada's two existing community triage centers.
- Recommended legislation that creates the Licensed Professional Counselors (or Licensed Mental Health Professional) credential in Nevada.[P]
- Authorized a letter to be sent to Governor Guinn expressing LCHC support for inclusion of the following items in the DHHS proposed budget to be presented to the 2007 Nevada Legislature:
  - o increase the number of available psychiatric beds available by (a) providing funding to pay for the use of private psychiatric beds and (b) considering incentives to the private sector to build more psychiatric beds;
  - o decrease the number of persons with behavioral health conditions that inappropriately utilize the hospital Emergency Departments by (a) expanding the crisis support system to include the enhancement of the mobile crisis team system to better meet the needs of children and families, (b) con-

[P] Nevada is one of only two states that do not recognize the LPC credential.

tinuing to fund the crisis beds such as those offered by WestCare, and (c) expanding community based behavioral health services; and

- o implement strategies to increase Medicaid funding for the State's behavioral health system.

- Requested legislation that would create the Office of Health Planning, Analysis and Policy Support in the DHHS. It is presumed that if this Office is created, two of the Office's activities may include:
  - o review of the Deficit Reduction Act and the 1915(c) waiver option to enhance home and community based services for Medicaid eligible persons with SMI and/or SED, and
  - o supporting efforts to review, restructure and unify the behavioral health system as necessary in order to ensure delivery of effective and coordinated services.

BACKGROUND ON SUMMIT STRATEGIES

1. Decrease the number of persons with behavioral health conditions who inappropriately utilize the Emergency Departments

Hospital emergency departments (EDs) across the country are facing increased pressure as the number of ED visits continues to grow. In the past decade, ED visits have increased by 26%. National health experts have attributed this growth to an increase in the unwillingness of physicians to provide on-call coverage, an increased number of patients using the ED as their source of primary care, and an increased number of patients with serious mental illness (SMI) going to EDs. While the privately insured are still the largest proportion of ED users, ED visits by Medicaid clients increased by 23%.

Overcrowded hospital EDs continue to be a serious health care challenge in Nevada, especially with the state's unprecedented population growth. Nevada hospital utilization data shows an increase in the average number of ED visits per day from 1,959 in calendar year 2004 to 2,259 in the first quarter of 2005.

In January 2006 in Clark County, there was an average of 67 acutely suicidal or homicidal psychiatric patients per day that were waiting on legal hold, either in the ED or in a hospital bed, before being transferred to an inpatient psychiatric bed. Those patients waited an average of 4.6 days.

Long waits are attributed to both a shortage of psychiatric inpatient beds (Nevada ranked 43rd nationally in number of state psychiatric beds per 100,000 in 2002[50]) and Nevada's medical clearance law. This law (NRS 433A.165) requires a person with mental health needs to be examined by a medical health care professional to determine, prior to transfer to a mental health facility, if the person has a medical problem.

To date, Nevada has taken the following steps to address this "crisis":

- relieving ambulance wait times in the EDs through the passage of SB 458 in 2005, which required hospitals to provide emergency services and care to persons not later than 30 minutes after arrival at the hospital ED;
- increasing the number of psychiatric inpatient beds with the opening in 2006 of a new inpatient psychiatric hospital, the funding of beds in the Old Hospital in Building 1300, and providing for 50 "overflow" psychiatric beds in Clark County;
- increasing the funding for crisis and emergency behavioral health services including psychiatric ambulatory services, which provide 24-hour emergency walk-in services and psychiatric observation units (the increased level of funding for the FY 2006-07 biennium should provide services to approximately 6,000 clients); and
- implementing a new service (mobile crisis) that, in Clark County, provides evaluation services ten hours a day, seven days a week to persons who are on legal holds;[Q]

Despite these efforts, the stakeholders continued to identify this as an ongoing issue that needed to be addressed. Stakeholders identified and supported several strategies or sub-strategies to continue the effort to decrease inappropriate use of EDs by persons with behavioral health problems. A brief discussion of those strategies follows.

Paying for placement in private psychiatric beds. There are two private psychiatric inpatient facilities in the Las Vegas Valley that the State could use for overflow placements. To date, the State has been hesitant to utilize these beds because of the cost differential associated with the private beds and State-operated beds. The difference in cost is significant. Based on conversations with facility management, it appears that the cost per day (with attending doctors) for a private facility would be approximately $615, compared to approximately $425 at State-owned facilities.

However, the use of the private psychiatric beds may provide an overflow outlet for the system to move persons with behavioral health problems who wait in the EDs for a psychiatric placement.

[Q] The teams evaluate between 300 and 400 clients a month, with 30-40% of those evaluated being diverted from inpatient care and provided community services and supports. In the rural counties, the service provides immediate mental health response to jails, hospitals and other settings 24 hours a day, seven days a week.

Funding additional State-operated beds. The new psychiatric hospital at SNAMHS has opened, and with the availability of the new beds there may be at least temporary relief for the "holding" of patients in EDs. For perspective, based on the capital and operating appropriations for the new psychiatric hospital, the costs of adding 100 State-operated beds are estimated to be:

Capital costs:	$29,000,000
Annual operating costs:	$15,512,500

Maintaining support for the crisis beds. During the 2005 Legislative session, funding was made available for 50 crisis beds in Clark County to partially divert from EDs persons with behavioral health problems. The DHHS deployed this funding through an RFP process that resulted in WestCare being awarded a contract to provide the 50 crisis beds. By most accounts, this program has been successful in diverting patients from the EDs. Unfortunately, the funding used for the program is "one time" in nature, and must be renewed in the next Legislative session in order for the program to continue.

Incentivizing the private sector to add psychiatric beds to hospitals through the establishment of appropriate reimbursement rates. As an alternative to the options above, it may be possible to provide incentives to hospitals to add psychiatric beds to both existing and, perhaps more important, future facilities. The major advantage of this option for providing additional psychiatric bed is found in the Medicaid rules. Under Medicaid, if Medicaid-eligible adults between the ages of 21 and 65 are placed in an institute for mental disease (IMD),[R] no Medicaid funding is available. However, Medicaid reimbursement is available for psychiatric beds in a general acute hospital, even for adults. Such a situation presents the opportunity for the State to increase its reimbursement rate to a level at which no more State funds are expended than at a State facility, but with federal funds the hospital could receive a reimbursement level that may prove attractive.

Expanding the Crisis Support System. Two crisis support services – Psychiatric Emergency Service and Mobile Crisis Teams – may relieve the EDs of patients that are potentially acutely suicidal or homicidal and awaiting placement.

Psychiatric Emergency Service provides (a) 24-hour emergency walk-in services for people in crisis, through the service's Psychiatric Ambulatory Unit (PAS), and (b) emergency treatment in a 72-hour observation unit for persons in need of short-term observation, stabilization and treatment in a secure environment through the Psychiatric Observation Unit (POU). Together, these components deflect approximately 45% of the persons receiving the services from inpatient admission.

The Mobile Crisis Team travels to Las Vegas-area EDs to evaluate psychiatric patients who await placement. If appropriate, the team can develop a discharge plan and, if approved by the attending physician, discharge the patient. It is uncertain how many waiting patients this service has discharged from EDs, but the service operates seven days a week from 7:00 AM to 10:00 PM.

*Expanding on-going community based services***.** Based on a review of the DMHDS Performance Indicators, three services have a positive record of reducing the time that SMI clients spend in an inpatient setting. These three services are Group Housing, the Program for Assertive Community Treatment (PACT), and Intensive Supported Living Arrangements (SLA).

The Performance Indicators reveal that:

- for Group Housing, the time that a client spends in an inpatient setting falls from approximately 10% to approximately 2% after initiating services (there are currently 382 clients in the program in the Las Vegas area);
- for PACT, the time that a client spends in an inpatient setting falls from approximately 15% to approximately 5% after initiating services (there are currently 132 clients in the program in the Las Vegas area); and
- for Intensive SLA, the time that a client spends in an inpatient setting falls from approximately 35% to approximately 5% after initiating services (there are currently 25 clients in the program in the Las Vegas area).

2. Implement strategies to increase Medicaid funding for the Behavioral Health system

Based on a nationwide comparison of states' revenue sources for behavioral health, the Nevada percentage of FY 2003 revenue from Medicaid is much lower than the national average (23% vs. 39%). According to that comparison, some of the highest percentages of revenues from Medicaid are found in several nearby western states (e.g., Washington at 87% and Arizona at 69%). These states also have higher mental health per capita expenditures ($91.01 and $126.33, respectively) than Nevada ($62.78).

In examining the budget by funding source for DMHDS for FYs 2005 and 2006, it is difficult to see how the percentage of Medicaid funding reported in the above cited national comparison can be achieved. The earlier presentation of the DMHDS budget indicated that the percentage of federal funds was 11% in FY 2005 and 9% in FY 2006.

If in fact the Medicaid reimbursement is low, the suspected cause would be a low Medicaid enrollment rate for

[R] An IMD is defined as a facility that provides only behavioral health services.

the SMI population. The insurance eligibility report for the Division indicates that only 23% of the SMI and SED caseload has Medicaid eligibility.

The advantage that Medicaid offers from a State fiscal standpoint is that the State receives federal match dollars for every dollar the State spends on covered services delivered to eligible individuals by registered providers. For FY 2006, the federal Medicaid match rate for Nevada is 54.76%.

To maximize federal Medicaid funds, the State should ensure that all persons who are potentially eligible for Medicaid apply and enroll. In addition to ensuring that the clients are Medicaid eligible, to claim Medicaid funds the State must ensure that all behavioral health providers are registered Medicaid providers, and the services provided are Medicaid covered services.

If 80% of the SMI caseload would be eligible for Medicaid (up from an assumed level of 23%), and 75% of the community service dollars are used for Medicaid eligible services by Medicaid registered providers, the Division could realize an approximate $8 million increase in Medicaid funds. Since these funds would be a repayment of previously expended State funds, these funds could in turn be used as Medicaid match. In the end, the Division could increase expenditures by approximately $17 million without any additional State appropriations.

3. Review the new Medicaid State Plan option available through the Deficit Reduction Act and waivers available under the 1915(c) waiver option and select the most appropriate approach to implement to enhance home and community based services for Medicaid eligible persons with SMI

In FY 2005, DMHDS provided mental health services to approximately 27,400 Nevadans, the majority of whom were clients with SMI. It did not provide services to an estimated 27,000 additional residents who have an SMI condition. In addition to expanding services to cover these individuals, increasing the use of home and community based services is a high priority for consumers and the Division.

The Division has implemented programs that support a model of community care, such as an assertive community treatment program, mobile crisis teams, medication clinics, supported employment programs and supported living arrangements.

As previously discussed, Nevada's Medicaid program can serve as an important funding source for clients enrolled in DMHDS programs.

Historically, many states (including Nevada) have been able to fund support services for Medicaid recipients through the Medicaid State Plan. In order to do this, a state needed to invoke the "rehabilitation service option." However, given recent pronouncements by the Centers for Medicare and Medicaid Services (CMS), there is a widespread concern among state Medicaid programs that coverage under the rehabilitation option will be limited in the future.

There are, however, two other options that Nevada could pursue that would allow it to enhance its community based program for adults with SMI. These options would allow the State to increase eligibility for adults with SMI and to expand the service array of home and community based services to provide respite, prevocational, supported employment, etc.

The first of these two options has very recently become available under the federal Deficit Reduction Act (DRA). The other option is to pursue a home and community based waiver for the SMI. A discussion of each of these options follows.

Home and community based State plan option. Under the DRA of 2005, states are allowed to offer home and community based services as a Medicaid State plan option as opposed to needing to apply for a waiver. Under this option:

- Services are limited to persons with incomes up to 150% of the FPL.
- Individuals are not required to meet an institutional needs test in order to receive home and community based services.
- The scope of services may include any services permitted under the 1915(c) waiver.
- A state can limit the number of individuals to be covered and the geographical area in which services are provided.
- There must be a needs-based criteria and an independent evaluation to determine an individual's eligibility for the services.

1915(c) home and community based waiver. Under a 1915(c) wavier option, states can provide home and community based services to targeted populations that are at risk of institutionalization and have incomes up to 300% of SSI (221.5% of the FPL). The program can also be limited to a specific geographic region, and the number of waiver participants can be limited.

Approval of a waiver is contingent on a state being able to document the waiver's cost-neutrality; that is, costs under the waiver cannot be higher than the cost of the person residing in an institutional setting. This requirement has created problems for many states.

The Medicaid statute specifically excludes coverage of individuals aged 21 to 64 in institutions for mental diseases (IMD), and thus only SMI individuals under age 21 and over 65 may receive waiver services. However, Colorado was successful in obtaining a 1915(c) waiver for adults with

a major mental illness. Their waiver uses the nursing facility level of care as the institutional standard. Through this waiver, they cover adult day care, alternative care facilities, electronic monitoring, home modifications, non-medical transportation, respite care, personal care and homemaker services.

Although pursuing a waiver is an option, it is unclear as to whether CMS would grant such a waiver, particularly since a state plan option has been introduced under the DRA.

The consensus at the Stakeholders' Health Summit was for the DHHS to evaluate both options and to implement the most appropriate approach to enhancing home and community based services for Medicaid eligible persons with SMI.

4. Review the new Medicaid demonstration grants established under the Deficit Reduction Act and waivers available under the 1915(c) waiver option and select the most appropriate approach to implement to enhance home and community based services for Medicaid eligible children and adolescents with SED

The provision of behavioral health services for children and adolescents with SED is a shared responsibility between the Division of Child and Family Services (DCFS), which cares for children in the northern and southern regions of the state, and DMHDS, which cares for children in the rural counties.

Nevada's Medicaid and SCHIP programs play a more significant role in the funding of behavioral health services for children than for adults. This is due to the fact that children are eligible for Medicaid at higher family income levels than adults, and foster care children are covered under Medicaid. Additionally, behavioral health service coverage for children and adolescents is broader, since there is no IMD exclusion as for adults, and children and adolescents have access to expanded services under Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

Through the Behavioral Health Redesign, the Division of Health Care Financing and Policy (DHCFP) has increased Medicaid's ability to fund support services needed by individuals with behavioral health conditions. Medicaid now covers the following behavioral health services for children and adolescents who are SED:

- inpatient mental health services and alcohol/substance abuse detoxification and treatment for adults under 21 years of age;
- targeted case management;
- mental health outpatient services, including assessments; neurocognitive, psychological and mental status testing; and mental health therapeutic interventions (e.g., partial hospitalization, intensive outpatient, medication management, and crisis intervention);
- mental health rehabilitation services, including basic skills training, day treatment program, family-to-family support services, peer-to-peer support services, psychosocial rehabilitation, and treatment home; and
- outpatient alcohol and substance abuse services, including therapies and evaluations.

The Legislature and DCFS have expanded the Wraparound in Nevada (WIN) program, which serves up to 500 children (and their families) in the child welfare foster care system. Based on a wraparound process model, WIN uses intensive case management, focuses on individual case planning that is family driven, and uses informal supports to reduce the need for out-of-home placement.

An initial analysis of WIN youth compared to children that are not in the waiver showed that costs were lower for WIN youth, more WIN youth moved to lower levels of care, and a greater percentage of WIN youth had improved functioning levels (decrease in mental health symptoms).

While there are approximately 500 children in WIN, many more children receive services through the rehabilitation option under the State plan. As noted in the previous strategy, there is a fear that the Centers for Medicare and Medicaid Service (CMS) may restrict coverage under the rehabilitation option. There are, however, two other options that Nevada could pursue that would allow it to enhance its community based program for children and adolescents with SED.

As in the previous strategy discussion for the SMI, the first of the two options for SED children and adolescents became available in 2006 under the federal Deficit Reduction Act. The other option, also paralleling the SMI strategy, is to pursue a home and community based waiver for the SED. A discussion of each of these options follows.

Medicaid grant to move children from residential treatment centers into the community. Under DRA, demonstration projects will be funded for up to 10 states to test the effectiveness of improving or maintaining a child's functional level and the cost-effectiveness of providing home and community based alternatives to psychiatric residential treatment services for children enrolled in Medicaid. This provision differs from regular 1915(c) waivers in that, under those waivers, the standard of institutional care that must be met is care in a hospital, nursing facility or ICF/MR.[5]

Other than the institutional level of care, demonstration projects apparently must follow the other requirements of

[5] Intermediate Care Facilities for the Mentally Retarded.

the 1915(c) waiver program, including a demonstration that the average costs of home and community based services do not exceed the average cost of residential child psychiatric treatment facilities. Participants in the demonstration program will be eligible to continue to receive Medicaid reimbursable home and community based services following the termination of the demonstration, but no new recipients can be enrolled. The demonstration will last for five years. States will be selected through a competitive bidding process, with $218 million available for the projects during FY 2007 - 2011.

1915(c) home and community based waiver. Under the 1915(c) waiver option, states can provide home and community based services to targeted populations that are at risk of institutionalization (e.g., inpatient psychiatric hospital) and that have incomes up to 300% of SSI (221.5% FPL). Under the waiver, a state may exempt parental income and look only at a child's income, which means that children who are not found in regular Medicaid and SCHIP could qualify.

The program can be limited to a specific geographic region, and the number of waiver participants can be limited. Approval of a waiver is contingent on a state being able to document the cost-neutrality of the waiver (that is, the cost of the waiver services cannot be higher than the cost of the child residing in an institutional setting). For purposes of this waiver, an institutional setting must be a hospital, ICF/MR, or nursing home. For a 1915(c) waiver, institutional care does not refer to a residential treatment center.

Four states – Indiana, Kansas, New York and Vermont – have been able to offer home and community based waiver services for children with SED by documenting the cost neutrality of the waiver compared to the state's hospital expenditures.

The consensus at the Stakeholders' Health Summit was for the DHHS to evaluate both of these options and to implement the most appropriate approach to enhancing home and community based services for Medicaid eligible children and adolescents with SED.

5. **Restructure and unify the behavioral health system as necessary, in order to ensure delivery of effective and coordinated services**

   and

6. **Develop a comprehensive system for the delivery of behavioral health preventive services that is integrated across the community (e.g. schools, health care practitioners, and private insurers)**

In 2002, President Bush's New Freedom Commission on Mental Health identified fragmented delivery of mental health services as a major obstacle and encouraged states to (a) facilitate new partnerships among governmental entities to better use existing resources for persons with mental illness and (b) develop comprehensive strategies to respond to needs and preferences of consumers or families.

Nevada's current behavioral health system is fragmented, with a quilt-work of services, funding and entry points and with multiple service delivery systems and multiple agencies responsible for delivering the care. For example, a Medicaid-eligible child in Clark County could receive behavioral health services through a Medicaid health plan, through a DCFS clinic or through BADA (Bureau of Alcohol and Drug Abuse) for substance abuse services. Once the child turns 18, a DMHDS clinic may provide services as opposed to DCFS.

This type of fragmentation has serious consequences for clients, their families and the funders of the system:

- lack of coordination and continuity of care,
- lack of access to needed care,
- financial inefficiencies in terms of inability to maximize federal Medicaid money, and
- inability to effectively monitor overall system performance and ensure accountability in terms of expenditures.

Additionally, recent studies have found that Nevada has a large numbers of individuals who have behavioral health conditions and are not being served in the system. Developing a more effective and efficient system of care for persons with behavioral health conditions would eliminate barriers to service and improve financial performance. These efficiencies could allow the State to serve more of the individuals who are not being served now.

In response to tighter resources, growing demand for services, and poorly performing program outcomes, numerous states (e.g., Pennsylvania, New Mexico and Arizona) have focused on system redesigns in order to unify the delivery of behavioral health services. For example, the unifying of Philadelphia's behavioral health system has produced significant savings that are being reinvested in a wide range of programs for homeless persons, children in schools and other supports services; increased access to treatment; better coordination of services across all jurisdictions and funding streams; and greater accountability to consumers and their families and more involvement in planning and monitoring services.

Similarly, in Nevada there has been a growing concern among behavioral health stakeholders with regard to the fragmentation and lack of integration of Nevada's behavioral health service delivery model. This is exemplified by the findings and recommendations set forth by two panels.

First, the Nevada Mental Health Plan Implementation Commission recommended development of a comprehensive state mental health plan to overcome the problems of fragmentation in the mental health delivery system. The Commission also recommended that the plan identify opportunities to leverage resources across multiple agencies that administer both State and federal funds. The Commission goes on to state that it envisions a single entity coordinating the plan.

Second, the Clark County Mental Health Consortium identified the need for an integrated infrastructure to support effective and accessible behavioral health service delivery. It recommended that this infrastructure include public engagement and outreach, system management, integrated access, collaborative service processes, utilization management, workforce development, integrated financing, and ongoing utilization focused evaluation.

The Stakeholders' Health Summit supported a strategy to restructure and unify the system to increase efficiencies, lead to better outcomes, allow more individuals to receive services, and reduce the cost of care. In pursuing this strategy, the background materials prepared for Summit participants suggested that consideration be given to developing a system in which:

- there is consolidated management responsible for overseeing the delivery of behavioral health services to all individuals with behavioral health conditions regardless of age, condition or geographical location;
- services are driven by consumer choice, utilizing disease management principles and evidence-based practice models with an emphasis on community care and the recovery focus of services; and
- funding streams are integrated and follow the client, not the agency.

7. Expand mental health/substance abuse parity requirements to incorporate a wider array of services and covered diagnoses

Mental health and substance abuse parity requirements prohibit insurers and health care service plans from discriminating in offering coverage for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. In essence, parity requires insurers to provide the same level of benefits for behavioral health afflictions as for other physical disorders and diseases. These benefits include visit limits, deductibles, co-payments, and lifetime and annual limits.

There is no federal law on mental health parity, and state laws that address parity vary substantially across the country. The National Mental Health Association classifies states into five categories of parity: "best," "good," "limited," "mandates, not parity" and "no parity or mandate laws." The Association classifies Nevada as having a limited parity law.

Nevada has a mandated benefit for serious mental illness that requires all coverage sold in the state to contain benefits for that affliction. However, State law limits coverage to six of the 13 recognized diagnoses listed in the *Diagnostic and Statistics Manual* of the American Psychiatric Association.

Nevada further limits its parity law by exempting small employers (less than 25 employees) and exempting the requirement from plans if the coverage would increase premiums by 2% or more. Further, the law does not require benefits for psychosocial rehabilitation for custodial inpatients. Finally, the law provides a limit on cost-sharing to be not more than 150% of the out-of-pocket expenses required for medical and surgical plans.

Summit participants adopted a recommendation that Nevada expand its parity law to cover a broader array of services and diagnoses without specifying the extent of the expansion. ◗

Prevention and Wellness

Compared to other states, Nevada ranks low on a number of key health indicators

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OVERVIEW

HEALTH INDICATORS *(see page 73)* serve as a benchmark for assessing the health of a given population and provide a baseline for measuring improvement. The Fund for a Healthy Nevada reported statistics on the health status of Nevadans in September 2005.[51] These statistics showed the state ranking low, when compared to other states, on a number of key health indicators:

- a high rate of mothers receiving late or no prenatal care,
- the fewest dentists per capita,
- the second-highest rate of adults who smoke, and
- the highest rate of women smokers.

While these statistics cause concern, there are some areas in which Nevada is showing improvement. The United-Health Foundation report on state health rankings reveals that Nevada has been making positive strides since 1990. Specifically, the State has reduced infant mortality (from 9.4 per 1,000 live births in 1990 to 6.2 per 1,000 in 2005) and reduced the incidence of infectious disease (from 50 cases per 100,000 population in 1990 to 23 cases per 100,000 in 2005).[52]

In its 2005 report, the Foundation ranked Nevada as 37th among the states, citing as Nevada's primary concerns the low childhood immunization rate, a high violent crime rate, and a high uninsurance rate.

Other studies also show Nevada with mixed results when compared to other states. For example, the Kaiser Family Foundation's StateHealthFacts.org website showed that Nevada is generally either average or slightly below average when compared to other states or national averages.

Kaiser indicates that Nevada compares favorably on its rate of obesity among its population (Nevada 19%, U.S. 21%) and has a very low rate of death related to diabetes (Nevada 17.6 per 100,000, U.S. 25.4 per 100,000). The rankings indicate that Nevada is at or near the national average for these measures:[53]

- cancer deaths per 100,000 (Nevada 203, U.S. 194)
- stroke deaths per 100,000 (Nevada 57, U.S. 56)
- Heart disease deaths per 100,000 (Nevada 246, U.S. 241)
- Percent of persons with a disability (Nevada 18%, U.S. 18%)

The Kaiser rankings also indicate that Nevada ranks worse than the national average for the following measures:

- number of deaths per 100,000 (Nevada 919, U.S. 845)
- motor vehicle deaths per 100 million miles driven (Nevada 2.0, U.S. 1.6)
- percentage of adults who are smokers (Nevada 23%, U.S. 21%)
- percentage of persons reporting poor mental health (Nevada 41%, U.S. 34%)
- percentage of persons with visits to a dentist or dental clinic in the past year (Nevada 65%, U.S. 70%)

The implementation of prevention and wellness strategies can improve the overall health status of Nevadans and help mitigate the rate of increase in health care expenditures.

FOCUS GROUP RECOMMENDATIONS

In three of the six focus groups convened for the development of the Nevada Strategic Health Plan, the participants developed recommendations that received broad support for actions related to prevention and wellness. These "high scoring" recommendations (and the originating focus groups) were:

- Improve funding for chronic disease prevention and control. *Public Health*
- Develop primary care and prevention services in order to ease the burden on tertiary care facilities, especially in underserved areas and to ensure a culturally sensi-

tive, holistic approach to caring for patients. *Health Professionals*

- Initiate a campaign focused on importance of early detection of health care issues and preventive services as a means to mitigate cost of expensive care later on. *Medical Coverage*
- Strengthen the Public Health Foundation and expand private-public partnerships. *Public Health*

OTHER STAKEHOLDER RECOMMENDATIONS

In addition to the focus groups recommending enhancements to the State's prevention and wellness programs, the Governor's Commission on Medical Education, Research and Training also took note of the need for public health programs by recommending that Nevada develop goals and set and maintain standards regarding the state's critical public health challenges:

- increasing access to preventive services, including health promotion and disease prevention, health behavior education, immunization practices, alcohol and drug addiction, unplanned pregnancies and mental health;
- supporting initiatives directed toward specific high-risk populations; and
- expanding public/community health improvement initiatives including public education and exposing healthcare trainees to the most pressing community health issues.

Further, in the November 2006 election, a considerably broader and more diverse group of stakeholders – Nevada voters – strongly approved Question 5, which amended NRS Title 15 to ban smoking in most non-gaming public places. By their votes, the citizens of Nevada expressed their support for a vital aspect of prevention and wellness.

OVERALL RECOMMENDATION STATEMENT

Based on the focus groups' deliberations, the following Recommendation Statement concerning prevention and wellness was developed:

Expand and initiate programs that will improve the overall health status of its citizens by focusing on prevention and wellness.

STAKEHOLDER HEALTH SUMMIT STRATEGIES

In order to address issues pertaining to prevention and wellness, strategies were developed from the recommendations identified by stakeholders in the focus group process. Supporting information was developed, and the strategies were then presented to the participants in the Stakeholder Health Summit. The Summit adopted the following strategies to improve the overall health of Nevadans.

1. Improve the immunization rate for all Nevadans through the addition of community based marketing, education and awareness campaigns targeted to both consumers and health care providers regarding the value of immunizations. In addition, the Nevada Department of Health and Human Services should review the current recommended vaccination schedule for possible changes.
2. Expand prenatal care services by "building out" the existing prenatal care network with continuity of care and perinatology services, consider the addition of case management services to the prenatal care program and provide for presumptive eligibility under the Medicaid program for pregnant women.
3. Expand the Oral Health Care Program including the addition of a State Dental Officer, adding resources for increasing access for oral health care for all age groups and exploring the feasibility of requiring dental evaluations for children in kindergarten, second and sixth grades. Additionally, the Medicaid program should provide dental coverage to adults enrolled in the program.
4. Reduce exposure to second-hand smoke.
5. Invest in wellness programs to reduce chronic disease. Such programs should have concrete spending plans and be branded statewide.

LCHC ACTIONS

In its August 10, 2006, Work Session, the Legislative Committee on Health Care (LCHC) took the following actions with respect to the strategies adopted by the Health Care Summit participants:

- Supported enhancement of the State immunization registry at DHHS through additional appropriations to offset federal funding reductions, provide additional staff and to create an outreach and follow-up program.
- Supported expansion of certain prenatal services at DHHS through new outreach and educational initiatives. With additional appropriations the program could expand its media and outreach campaign to target Hispanic and African American populations.

- Supported expanding the Oral Health Program at DHHS by providing funding for the State Dental Health Officer.
- Supported a significant expansion in the DHHS wellness programs to reduce chronic disease. The expansion should include funding for the Office of Minority Health as well as providing technical assistance and the distribution of funds to community organizations, school districts, coalitions, taskforces and employers to assist communities in establishing prevention programs, conduct chronic disease screening and educational activities and engage in outreach and awareness activities.

BACKGROUND ON SUMMIT STRATEGIES

1. Increase immunization.

A 2002 Institute of Medicine (IOM) report called immunization programs a "national treasure that is too often taken for granted." The report emphasized the importance of reminders and assessments as vital to successful immunization programs and noted that these functions are facilitated by the use of immunization registries. Overall, the IOM ranked immunization registries as one of the most useful instruments for assessing the effectiveness of targeted health and medical care programs.

An immunization registry is used to consolidate immunization records into a centralized repository. The benefits to having records located in one database and accessible via computer are numerous:

- For families, a registry means there is an official record of immunizations available to meet requirements for day care or school enrollment, a source to verify immunizations are up to date, and a check to prevent unnecessary duplication of vaccinations.
- For health care providers or health plans, a registry provides information on current recommendations or new vaccine requirements, consolidates immunization history from multiple providers into a single record, reduces paperwork, and can provide information about when a patient's immunizations are overdue.
- For public health officials, a registry provides information for targeting interventions, can be used to generate immunization reminders, and helps in the monitoring of adverse events.

The recent outbreak of mumps in the Midwest provides an example of a registry's usefulness. By reviewing records in the state's immunization registry, Indiana public health officials found almost 200 middle school and high school students in one county had not received the second required measles-mumps-rubella (MMR) inoculation.

Nevada has had efforts underway for several years to implement an immunization registry. The Robert Wood Johnson Foundation's All Kids Count project awarded a two-year grant to the State in 1998 to establish an online immunization information system. That project encountered a number of difficulties due to bankruptcy of the software vendor and contractor personnel issues. The goal of establishing a computerized-accessible registry was not immediately achieved. In 2003, the State revamped the system and went online in 2004. The registry is now operational and staffed by one IT person.

Nevada's rate of childhood immunizations is the lowest in the nation, with only 68% of children ages 19 to 36 months receiving recommended vaccinations. The national average for this age group is 81%.[54] A number of factors have been identified as contributing to the low Nevada rates including: the rapid growth in population, the loss of medical records when citizens move into Nevada, the shortage of health care providers to meet the demand for services, and the lack of utilization of the State's immunization registry.

The majority of Nevada's immunization program is federally funded. The State uses funds provided through the Vaccines for Children program, the federal Section 317 program, the Social Services Block Grant and the Nevada Check-Up program for both the purchase of vaccines and operational expenses. The State support for the program is limited to the State match required for the Nevada Check-Up program. The CDC has indicated it will be cutting funding for the 317 grants (which are the only source of funding for Nevada's immunization program operations) by 5% in calendar year 2006 and by another 5% in 2007.

Other states provide supplemental support for their immunization program and have enhanced the operation of their registries. For example, New Mexico, a state not too dissimilar to Nevada, has an immunization registry that is staffed with a program manager, help desk support, trainers, quality assurance, and IT personnel. The maintenance cost of New Mexico's program is $400,000 annually. And Wisconsin has made its registry accessible to individuals via the internet under a program called "Public Immunization Record Access." By allowing public access, the registry allows parents to determine whether or not their children's shots are up-to-date.

2. Expand prenatal care services.

The National Center for Health Statistics defines adequate prenatal care as a prenatal visit with a health professional within the first trimester of pregnancy, and additional visits according to a defined periodicity schedule. Nevada

ranks 41st in the nation for adequate prenatal care, and 49th in early entry into prenatal care.[55]

Research has shown a relationship between prenatal care and birth outcomes. It has also correlated prenatal care with improved birth weights. Similarly, lack of such care has been linked to increased risks of low-birth-weight births, premature births, neonatal mortality, infant mortality, and maternal mortality.

The reasons why women fail to obtain prenatal care are varied and are influenced by age, socioeconomic status and race or are related to the health care system. An Institute of Medicine report identified influences associated with low rates of prenatal care, including:

- socio-demographic factors: poverty, inner-city or rural residence, less than 18 years of age, unmarried, lack of a high school diploma;
- system-related factors: lack of insurance coverage, shortage of providers, language and cultural barriers, lack of information regarding availability of care;
- attitudinal factors: unplanned pregnancy; prenatal care not valued or understood; fear of doctors, hospitals or procedures; lifestyle (drug abuse, smoking, homelessness); and denial, apathy or concealment of pregnancy.

Other studies have identified race and ethnicity as factors in whether or not a woman receives proper prenatal care. This appears to be true in Nevada as well. The Nevada Vital Statistics Report indicates the percentage of Blacks and Hispanics receiving prenatal care in the first trimester lags behind that for Whites and Asians:

Percentage of Mothers Receiving Prenatal Care in the First Trimester[56]

White	89%
Asian	85%
Native American	76%
Black	71%
Hispanic	65%

What is particularly alarming about the low percentages of mothers receiving prenatal care among Blacks and Hispanics is that the Black infant mortality rate is over three times the rate for Nevada as a whole and the Hispanic population has the highest birth rate of any group in the state. Hispanics also tend to have children at a younger age than the state as a whole.

As indicated above, lack of information about the need for prenatal care and where that care can be accessed are significant factors in pregnant women failing to obtain proper prenatal care. The Maternal and Child Bureau operates an information and referral line called the "Maternal and Child HealthLine" and conducts a $100,000 media campaign to encourage mothers to access prenatal care.

The Nevada Maternal Child Health Advisory Board (MCHAB) has as its top priority improving access to comprehensive preconceptual, prenatal and postpartum services for all Nevada women of childbearing age. The MCHAB is also seeking ways to expand prenatal services.

3. Expand the Oral Health Care Program.

During his term as U.S. Surgeon General, Dr. C. Everett Koop noted, "You are not healthy without good oral health." In 2000, a Surgeon General report noted that research had pointed to connections between oral infections – primarily gum infections – and diabetes, heart disease, stroke, and preterm low-weight births. The report also noted that for children, tooth decay is the most common chronic childhood disease.

Oral health is a real concern for the children in Nevada. According to the report "The Burden of Oral Disease in Nevada 2005," over 60% of five-year-olds in Nevada's Head Start program have already developed one or more cavities. The report further indicated that tooth decay was experienced in 47% of the children by age three, 52% by age four, and, by the third grade, fully 67% of the children had experienced tooth decay. The Burden report also indicated that 37% of third graders had not received treatment for the decay.

Nevada established an Oral Health Initiative in 1999 with funding from the Maternal and Child Health (MCH) Block Grant. The State has developed an Oral Health Plan, implemented a broadly based Oral Health Program, and invested in the infrastructure required to address the needs of its citizens statewide. The program is supported through federal dollars, volunteer services, and donations from the private sector.

With these resources Nevada has developed the following state-wide activities:

- Oral Health Surveillance. Information is collected and evaluated through telephone surveys, oral health screenings, Medicaid data, and data collected from safety net providers throughout the state. Findings are published annually.
- Dental Sealants (Nevada Seal). Volunteer hygienists apply dental sealants to second graders in schools where 50% of the students are enrolled in the free or reduced lunch programs and in rural schools where access to dental care is limited.
- Healthy Smile Happy Child is an awareness and prevention effort targeted to parents to reduce incidence of "baby bottle" tooth decay.

- Oral Health Education is a consumer awareness program on the importance of oral health that utilizes radio and television advertising, brochures, and direct consumer education in community-based settings such as Family Resource Centers.

These programs are supplemented by community-based initiatives that utilize donations and safety net providers to operate the following services:

- Miles for Smiles is a program operated by Nevada Health Centers, Inc., consisting of three mobile dental clinics. Two units, sponsored in part by Anthem Blue Cross/Blue Shield Foundation, are open to all persons and operate in Las Vegas. The third unit was donated by the Ronald McDonald Charities and provides services to children under age 18 in and around Elko. The program also received a $50,000 grant from the Fund for a Healthy Nevada (FFHN).
- Health Access Washoe County's two dental clinics have four full-time dentists, eight full-time dental assistants, two full-time hygienists and a full-time project coordinator. In 2003, the clinics had over 15,944 visits. The activities of the clinic were partially funded by a $69,500 grant from FFHN to purchase dental equipment to provide direct services to children.

At least two other mobile dental programs are underway in the state:

- The Care-A-Van operated by Saint Mary's Medical Center is funded through donations and a grant from the FFHN. The unit visits schools and applies sealants to second graders. Uninsured patients, as well as Medicaid and Nevada Check Up clients, received treatment based on a sliding fee scale.
- The other program focuses on reducing the incidence of oral cancer. The Crackdown on Cancer program, operated by the UNLV Dental School, travels to public high schools throughout Nevada via a mobile RV health clinic to screen students for oral health problems resulting from tobacco use. Once identified, students are provided treatment, preventive education, and counseling.

4. Reduce exposure to secondhand smoke.

Nevada has the highest rate of women smokers in the country and second highest rate of adults who smoke.

The potential risks associated with long-term smoking are well documented, and current research on the effects of exposure to secondhand smoke finds that non-smokers are also at increased risk for lung cancer and heart disease. A 1992 EPA risk assessment found the link between secondary exposure to tobacco smoke for infants and children was increased respiratory tract infections and middle ear infections.

Public health officials have indicated that tobacco use and exposure to secondhand smoke as having the most significant impact on the overall health of Nevadans. These officials report that reducing the exposure to secondhand smoke and requiring smoke-free workplaces will have significant positive long-term health effects.

Restrictions on where smoking is allowed are also associated with decreased cigarette consumption and increased cessation rates among workers and the general public. In 2000, the *American Journal of Public Health* reported that "laws with comprehensive restrictions led to more worksites with smoking policies and increased the likelihood that workers would quit smoking." As this Plan was prepared, 12 states had enacted 100% smoke-free workplaces.[T]

Recent surveys have noted a reduction in heart attacks in cities with newly enacted no-smoking ordinances. In Pueblo, Colorado, health officials found that heart attack rates dropped 27% in the 18 months after a smoking ban went into effect. Similarly, Helena, Montana's heart attack-related hospital admissions dropped by half six months after its ordinance became effective.

Acknowledging the adverse impact on the public's health, the Nevada Comprehensive Tobacco Control Five-Year Strategic Goals and Objectives 2005-2010 has as its second objective eliminating non-smoker's exposure to secondhand smoke.[U] A similar objective is reiterated in the Nevada Cancer Plan.

In the November 2006 election, Nevada voters amended NRS Title 15 to ban smoking in most non-gaming public places, thus expressing their concern for non-smoker exposure.

5. Invest in wellness programs to prevent chronic disease.

Chronic diseases account for one-third of the years of potential life lost before age 65, and the treatment of chronic diseases accounts for approximately 75% of U.S. medical care costs. Most chronic diseases are preventable since they are primarily the result of longstanding risk factors which are completely modifiable.

A recent study in the *New England Journal of Medicine* reviewed the impact of chronic disease and predicted that "today's younger generation will have shorter and less

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[T] Colorado, Delaware, Florida, Massachusetts, Montana, New Jersey, New York, North Dakota, Rhode Island, South Dakota, Utah and Washington.

[U] The first priority is to prevent young people from starting the smoking habit.

healthy lives than their parents for the first time in modern history unless we intervene." Nevada can take action to avert the occurrence of this trend by implementing a statewide grant program to prevent and control chronic disease.

The U.S. National Center for Health Statistics defines "chronic disease" as a disease lasting three months or longer that generally cannot be prevented by vaccines or cured by medications. Examples of chronic disease include arthritis, asthma, diabetes and obesity.

According to the CDC, chronic diseases are among the most preventable health problems since many share the same known risk factors such as physical inactivity, poor nutrition, and tobacco use or exposure to tobacco.

Based on current population statistics, almost half of all Nevadans will develop at least one chronic disease, and one in five will have two or more. Investing in prevention programs, or those aimed at delaying the onset of chronic disease, would have a significant impact on the both the overall long-term health of Nevadans, and on health care expenditures.

The financial burden of chronic disease is significant. According to an article in Obesity Research, Nevada's annual medical expenses attributable to obesity were estimated at $337 million (2003), of which $56 million was paid for by Medicaid. Estimated costs to the Nevada Medicaid program for smoking was $90 million in 1998. The Nevada Cancer Plan notes that the direct impact for cancer on Nevada was $1.1 billion, or $585 per person, in 2002.

Prevention and education are among the best strategies for reducing the costs associated with chronic disease, and partnering with communities to support and develop prevention and wellness programs have proven to be an effective tactic in this regard.

In 2006, the National Governor's Association (NGA) embarked on a campaign to create healthier states. Understanding that the cost to states for treating chronic diseases is substantial, the NGA urged state leaders to initiate and support prevention and wellness programs, to partner with local communities and the private sector, and to improve the health status of their citizens. The foundation of the program is that wellness must be promoted where we work, learn, and live. NGA recommended that states partner with employers, local communities and the schools.

Schools in particular are an excellent place to initiate such wellness programs. In the past thirty years, childhood obesity rates have doubled for children ages 2-5, and more than tripled for those aged 6-11. Approximately 15% of school-age children are overweight or obese. Over 9 million children, or one in seven, are at increased risk of weight-related chronic disease. These statistics led to the U.S. Surgeon General's declaration, in 2004, that obesity among American children had reached an epidemic level.

Preventing childhood obesity, or other chronic diseases, begins with education. Schools are a natural setting to educate children about healthy diets, the importance of active play, and healthy behaviors. It is also a setting where children can see such concepts reinforced.

In this vein, the federal government has required all schools participating in the National School Lunch Program to have local wellness policies in place by July 2006. Though not dictating what those policies should be, the federal requirements specify that at a minimum the programs should include goals for:

- nutrition education,
- physical activity,
- a plan for measuring implementation of the local wellness policy,
- involving in policy development parents, students, representatives of the school food authority, and the public.

While schools are required to develop these programs, no new federal or state dollars are provided for implementation. A partnership among the State, county health district officials and the schools should be considered for the development of school-based and other wellness programs.

State support for public health programs at the local level has ranged from sporadic to non-existent. It has been reported that in the 1990s the State supported public health by providing a per capita amount of funding to support general public health activities. At that time, the funding amount was $1.00 per capita. During a time of fiscal stress for the State, it is understood that the funding was dropped to $0.50 per capita, and then further reduced to a total funding level of $1.00 (a technical move that was made to keep the budget line open).

Summit participants were presented a strategy for the State to invest in wellness programs. Grants issued pursuant to this strategy would promote development and implementation of programs to address specific health behaviors leading to chronic disease, such as physical inactivity, poor nutrition, tobacco use, and exposure to second hand-smoke. Similarly, grant funds would be allocated to improve the management of certain chronic conditions to prevent disability and improve quality of life, such as cardiovascular disease, diabetes, cancer and asthma. Funded projects would be evidence-based and linked to measurable health indicators and include well-designed evaluation plans. ◗

Health Care Planning

The widely held view among Nevada health care stakeholders is that the state has no centralized responsibility for health care planning

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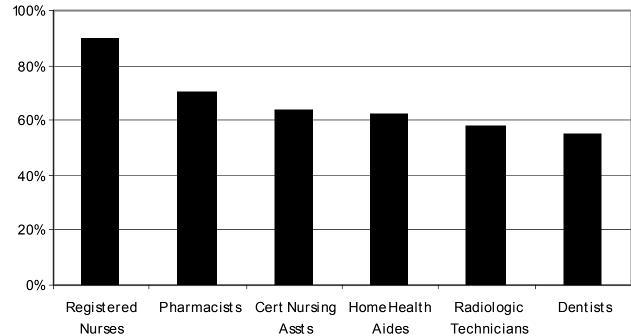
OVERVIEW

ALL STATES HAVE at least nominal health planning functions, and Nevada is no exception. However, the focus groups collectively expressed their perception that there is no centralized responsibility for health care planning in Nevada. There were recommendations and observations that Nevada needs a planning function that will have the attention of policy makers, perform analysis on the volumes of data that are collected, and promote policies to address the challenges facing the Nevada health care system.

The focus groups pointed to the stress that population growth is placing on the health care delivery system, the shortage of health care professionals, the lack of access to primary and specialty care – including mental health and long term care – as evidence of inadequate planning in the state. Additionally, the focus groups commented that more could be done to encourage evidence-based practices, promote the evaluation of the system on the basis of outcomes and quality, and to address the disparity in access, coverage and outcomes between population groups. It was also observed that there was no regular, standardized assessment of community needs, no detailed analysis of the uninsured population, and inadequate or no planning for health care manpower needs.

The focus groups also recognized that nearly all states have a shortage of some type of health care professional. According to a 2002 survey of the states, 90% of the states had a shortage of Registered Nurses, and a majority had shortages in five other professional categories.[57]

There is concern that, with an aging population across the country, the supply of health care professionals will not adequately respond to increasing demand. This concern has spurred 44 states to create commissions charged with finding ways to encourage more people into these fields. Examples of initiatives undertaken by states include:



Source: The Center for Health Workforce Studies, School of Public Health, University at Albany, SUNY. "State Responses to Health Worker Shortages: Results of 2002 Survey of States," November 2002.

- creating task forces related to workforce development,
- developing loan repayment programs for individuals entering health care professions,
- health career marketing,
- career ladder development,
- labor department or workforce investment boards, and
- collecting and tracking workforce data on health care professions.

If most states have a workforce shortage problem, Nevada has one of the worst. In 2000, Nevada ranked among the bottom states in the number of health care professionals per 100,000 residents for almost all of the health care profession categories.[58] Nevada's population grew at a rate approximately three times the national average in 2005;[59] without substantial growth in the health care workforce, these rankings very well may deteriorate.

Given the relatively scarce health care resources in Nevada, it is logical that existing resources should be used as efficiently and effectively as possible. Health Information Technology (HIT) and Health Information Exchange (HIE) are strategies that promote efficiency in the delivery of health care.

HIT refers to the information technology used by providers in their offices, clinics, laboratories and hospitals.

Examples include electronic prescribing, digital results delivery, and electronic medical records. HIE is the exchange of that information with other providers, with consumers, with health quality monitoring organizations, and with payers and researchers.

The Rand Corporation recently estimated that HIT would save the nation $77 billion annually if its adoption were widespread. Savings accrue primarily through:

- reductions of medical errors,
- increased efficiency,
- avoidance of duplicative health care procedures,
- improved coordination, and
- increased participation of consumers

There is considerable momentum at the federal level, both in Congress and within the Administration, in moving toward comprehensive HIT and HIE. The Office of the National Coordinator for Health Information Technology (ONCHIT) was established to achieve 100% electronic health data exchange among payers, health care providers, consumers of health care, researchers and government agencies as appropriate.

The Centers for Medicare and Medicaid (CMS) also has a number of initiatives to support the adoption of health information technology. In Congress, 11 legislative initiatives have been proposed (with funding) to promote health information technology and exchange. A number of states, such as Arizona, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, New York, Oregon and Rhode Island have taken steps to guide the development of HIT and HIE.

In 2005, eHealth Initiative conducted the *Second Annual Survey of State, Regional, and Community Based Organizations on Emerging Trends and Issues in Health Information Exchange* (supported by a Cooperative Agreement with the Health Resources and Services Administration, Department of Health and Human Services). eHealth Initiative is a national organization that monitors HIT and HIE initiatives across the states and provides assistance to states that want to move forward. In April 2006, the eHealth Initiative released the rankings of states in the western region on their stage of progress toward HIE:

- Stage 1 Awareness
- Stage 2 Regional Activity
- Stage 3 State Leadership
- Stage 4 Statewide Planning
- Stage 5 Statewide Plan
- Stage 6 Statewide Implementation

Nevada was ranked at Stage 1 behind all of the other states in the West, including Arizona (ranked at Stage 4) and California, Colorado, Utah and New Mexico (all ranked at Stage 2).

Collectively, the focus groups saw an opportunity for a centralized health care systems planning function that could create a vision for the health care system, promote quality and technology, analyze data that is collected, define best practices, and inform consumers through the benchmarking health care indicators.

The need for a centralized planning component charged with comprehensive health planning was identified in almost every focus group. The ideal planning function would have a systematic process for collecting and disseminating quality and performance data, assessing and evaluating community and statewide health care system needs, compiling and analyzing data, and developing policy options.

FOCUS GROUP RECOMMENDATIONS

In four of the six focus groups convened for the development of the Nevada Strategic Health Plan, the participants developed recommendations that received broad support for actions related to State health planning. These "high scoring" recommendations (and the originating focus groups) were:

- Develop a comprehensive and systematic process to identify community costs, access issues, service gaps, duplication of services/programs, impact of aging population, etc. (community needs assessment). *Medical Coverage*
- Create a new model for the delivery of health care services that includes use of technology and independent practice models. *Public Health*
- Establish an independent task force to determine how to better utilize licensed health care health professionals in order to address workforce needs. *Health Care Professionals*
- Create and fund independent commission to study and develop a comprehensive plan that includes all the options (e.g., training, recruitment, retention, Graduate Medical Education (GME), use of retirees) for addressing health care professional workforce needs. *Health Care Professionals*
- Examine the interaction of health care disciplines and their scopes of practice in order to develop strategies for improving utilization of health care professionals in the State. *Health Care Professionals*
- Expand use of ancillary personnel (e.g., pharmacy technicians). *Pharmaceutical Coverage*
- Develop a plan to leverage technology related to electronic transfer of information for both data base analysis and medical records. *Medical Coverage*

- Fund program(s) targeted at increasing use of e-prescribing. *Pharmaceutical Coverage*

OTHER STAKEHOLDER GROUP RECOMMENDATIONS

Throughout 2006, the Governor's Commission on Healthcare Professional Education, Research and Training met to create short and long-term blueprints to enhance the level of healthcare professional education, research and training available in Nevada. In October 2006 the Commission released its recommendations. Among the recommendations related to planning for healthcare in Nevada are to:

- support and expand initiatives that focus on collecting and analyzing accurate metrics like morbidity, mortality, incidence, national rankings and comparative analysis;
- ensure appropriate although streamlined licensure and certification oversight;
- create a Nevada Academy of Health to provide ongoing policy recommendations to the Governor and the Legislature regarding healthcare professional education, medical research and strategic planning for improved healthcare outcomes;
- join the Nursing Licensure Compact;
- streamline healthcare professional licensing, privileging and credentialing requirements without sacrificing quality;
- enact "eminent physician licensing" legislation;
- reduce practice restrictions including EMT/Paramedics in emergency rooms and the scope of practice for Certified Nursing Assistants; and
- develop statewide branding, marketing and reasonable housing to assist in recruitment efforts of healthcare professionals.

OVERALL RECOMMENDATION STATEMENT

Based on the focus groups' deliberations, the following Recommendation Statement concerning health care planning was developed:

Develop positive proactive plans for addressing its health care system challenges with formalized planning bodies that coordinate and disseminate information on health care policy, quality, community needs, workforce issues, and health information technology and information exchange.

STAKEHOLDER HEALTH SUMMIT STRATEGIES

In order to enhance planning for the current and future health care needs of Nevadans, and to improve effectiveness of the health care system, strategies were developed from the recommendations identified by stakeholders in the focus group process. Supporting information was developed and presented, and the following strategies were adopted at the Stakeholders' Health Summit.

1. Develop an adequately funded Office of Health Planning, with an Advisory Panel that will oversee health care planning and policy development within Nevada and that will:
    - integrate available data and collect additional data, perform analysis, plan for health system needs, promote accurate information about health care costs to the public and to policy makers;
    - promote more informed decision making through the dissemination of information about both the quality and the cost of health care services; and
    - perform community needs assessments throughout Nevada that will serve as the basis for responding to gaps in services (needs), disparities among populations, and achieving better health outcomes. The assessments should identify the resources necessary to meet the community's needs and initiate a process to align needs and resources.
2. Within the Office of Health Planning, include an Office of Workforce Development that will oversee health care workforce planning and policy development within Nevada and that will:
    - collect, maintain and provide data analysis, issue reports, link with universities and colleges, relevant state departments and other public/private entities, commission studies and apply for grants;
    - review the operations of the health care professional licensing boards with respect to barriers to licensing;
    - review the scope of practice statutes and rules for the various licensed health care professionals;
    - develop and recommend strategies to attract and retain medical professionals (including nurses) in Nevada; and
    - provide additional funding for existing loan programs to attract and retain medical professionals.

3. Support the concept of a Nevada Academy of Health, which would be a public-private collaboration.
4. Promote development of Health Information Technology (HIT) and coordinate the development of Health Information Exchange (HIE) by:
   - creating a time-limited statewide Steering Committee that will be convened and supported by the State for the purpose of developing a high level plan for e-Health;
   - creating a statewide governance committee that will be created and funded to implement the steering committee's high-level plan; and
   - enacting legislation to clarify and protect consumer privacy that follows and complements federal laws.

LCHC ACTIONS

In its August 10, 2006, Work Session, the Legislative Committee on Health Care (LCHC) adopted a recommendation to establish a coordinated statewide health care planning effort by:

- adding responsibilities and resources to the Department of Health and Human Services, in support of creating:
  - o the Office of Health Planning, Analysis, and Policy Support that, in addition to other duties, would collect and disseminate information regarding health care quality and perform community health care assessments; and
  - o an Advisory Committee to the Office of Health Planning, Analysis, and Policy Support
- providing funding for special projects within the new Office of Health Planning, Analysis, and Policy Support including:
  - o examining the Deficit Reduction Act for opportunities to improve or enhance long term care services, services to individuals with serious mental illness and children with serious emotional disturbances; and
  - o creating a Task Force on long term care system redesign;
  - o examining ways to improve the behavioral health system through system restructuring; and
  - o creating a steering committee to develop a high level plan for Health Information Technology (HIT) and Health Information Exchange (HIE)
- adding resources to the Nevada System of Higher Education (NSHE) to support:
  - o consolidation of certain functions related to health care professionals
  - o new responsibilities to enhance health care workforce development
  - o incentives to attract or retain health care professionals
- adding resources to the LCHC to conduct a review of the operation of the health care licensing boards with respect to barriers to licensing and statutes and rules related to scopes of practice for the licensed health care professions.

BACKGROUND ON SUMMIT STRATEGIES

The strategies outlined for consideration of the Summit participants were divided into three broad sections:

- establishing a State-sponsored planning function with separate divisions that address analysis and policy, quality, community assessment, and regulation;
- establishing an Office of Health Care Professional Workforce Development; and
- initiating the coordinated development of health information technology and health information exchange in Nevada.

1. Create an Office of Health Planning to oversee health care planning and policy development within Nevada.

A newly created Office of Health Planning would serve at least three functions: analysis and policy, quality, and community assessment.

In performing the analysis and policy function, the Office would integrate available data, collect additional data, perform analysis, plan for the health system needs, promote informed decision-making, and provide accurate information about cost of health care and health care-related issues to the public and Nevada's policymakers.

The analysis and policy function would be the major focal point for State health policy development. Through this function the Office would identify current health issues and emerging trends that affect the state. It would conduct policy analysis on issues relating to health care and the delivery of health care services. The Office would partner with health care experts and stakeholders from across Nevada to develop projects focused on improving the health status and access to health care services in the most efficient and effective manner. This function would include preparing and updating the biennial State Health Plan.

The quality function would promote more informed decision-making through the dissemination of information about the quality and cost of health care services provided

in Nevada. The public and health care providers will be the target audience of this activity.

In the short term, the quality activities of the Office would produce reports on current issues affecting the quality of health care. These activities may begin by focusing on the publicly reported health care quality information currently available. In the future, it is anticipated that the Office will produce risk-adjusted reports on health care facility and provider outcomes and provider pricing information to the public.

The community needs assessment function of the Office would produce assessments on communities throughout Nevada. A community health assessment is a tool used to assess the overall health status of a given population. Through extensive information gathering, the assessment identifies the availability of resources, such as the number of physicians or hospitals, as well as financial sources, such as State or federal funding or grants. It also provides a snapshot of the health status of the population, including factors that may have specific effects on health, such as smoking. The information from the assessment is then used to propose solutions and to make informed policy decisions on how best to meet the needs of the population.

The community assessment function would also have the responsibility to recommend benchmarks for the health care system so improvements to the system can be measured.

2. Create an Office of Healthcare Workforce Development to oversee professional workforce planning and policy development in Nevada.

Nevada needs to find effective and immediate ways to address its growing shortages of health care professionals. While the expansion of health care professional education is an important strategy, emphasis also needs to be placed on recruitment and retention in terms of both new graduates and already trained professionals who are licensed in other states.

The private sector has taken the lead in this endeavor with a variety of approaches, including providing both monetary (e.g., signing bonuses, compensation packages, financial assistance to set up practice) and non-monetary (e.g., redefined job specifications) incentives.

The State can play a significant role in shaping an attractive health care workforce environment. This can include:

- documenting, through data analysis and reporting, where shortages are most acute;
- tracking and monitoring strategies used throughout the State to attract health care professionals;
- monitoring the State's regulatory activities;
- developing and administering provider incentives; and
- providing attractive compensation for health professionals working for public programs.

Any efforts the State undertakes must carefully balance the need to address workforce shortages with the mandate to protect public health and safety.

Office of Healthcare Workforce Development. By establishing an Office of Healthcare Workforce Development (OHWD), Nevada would begin to centralize its response to shortages of health professionals. The Office would serve at least three functions: analysis and planning on workforce issues, perform special projects on regulatory affairs, and administer incentives for attracting and retaining health care professionals.

The Nevada OHWD could include a Health Workforce Advisory Council. The membership would represent government agencies, education institutions, the health care industry and other interested parties (e.g., consumers, advocates, unions). The Council could help guide data collection and analysis, shape recommendations regarding changes to regulatory processes and changes to scopes of practice, and identify strategies to recruit and retain health professionals.

The analysis and planning function of the Office would include overall responsibility for developing options to address Nevada's health care workforce needs.

In executing this mission, the Office would provide staff support to the Health Workforce Advisory Council; collect, maintain and provide an analysis of data; issue reports; link with universities and colleges, relevant State departments and other public and private entities; and commission studies. In addition, the Division would monitor developments in other states, research and apply for grant opportunities, and issue a biennial report on the status of, and issues confronting, the Nevada health care workforce.

To a limited degree, the planning and analysis functions could also operate as an information clearinghouse for out-of-state health care professionals considering relocating to Nevada.

Regulation and Licensing. The regulatory affairs function of the Office would be charged with a review of the State's regulation of health care professionals. It could fulfill this responsibility by undertaking two initial projects, and if, at the completion of these projects, it is determined that the function has been completed, the function will expire.

The two initial regulatory projects that the Office could undertake are:

- a review of the operation of the licensing boards with respect to barriers to licensing, and

- a review of the scopes of practice statutes for the various licensed professionals.

With respect to barriers to licensing, anecdotal evidence suggests that health care professional licensing can be a painfully protracted process for both health care professionals and the licensing boards.

During the focus group process there were reports of long waiting times, inefficiencies and a desire to be "regulatory friendly" to health care professionals seeking to locate in Nevada. To ensure that health care professional licenses are being granted in the most "regulatory friendly" fashion consistent with the protection of the public, the Office could undertake a project to evaluate:

- the amount of time it takes from application to granting of license for each board;
- the licensing/certification requirements in Nevada compared to the rest of the nation;
- the extension of endorsements and reciprocity to out-of-state health care professionals;
- the timing and accessibility for required tests, in terms of both administering and scoring; and
- the use of an online application and renewal process for licenses.

Scope of Practice. With respect to examining the scope of practice statutes and rules, the 1995 Pew Health Professions Commission Report suggests that states should base their practice acts on health care professionals being able to demonstrate competence based on knowledge, training, skills, and experience.

Since the release of the Pew Commission Report, most states have authorized the use of physician extenders (e.g., advanced practice nurses and physician assistants). Those professions are playing an increasingly important role in the delivery of effective health care services. The Council on Graduate Medical Education reports (2004) that many of these non-physician clinicians are now operating with a new degree of practice autonomy based on statutory and regulatory changes that have been made in many of the states.

Nevada should review existing scopes of practices to see if there are ways to allow health care professionals such as physicians' assistants, advanced practice nurses, pharmacists and pharmacy technicians, as well as dental hygienists to act as extenders beyond what they are currently permitted to do. Any change would likely have to be accompanied by a demonstration of the necessary skills to safely perform any expanded duties, or provide that they be performed under appropriate supervision.

Incentives. The administration of incentives function of the Office would be charged with administering any incentive programs that the State may adopt to attract or retain medical professionals in the state or in a particular area of the state.

Nevada needs to consider strategies to attract students who have completed their education to stay in Nevada as well as to recruit out of state professionals. The Office could administer existing or new incentive programs that would be targeted to fulfill this strategy. The particular incentive programs could be developed based on the best practices from other states. Some options for incentives that the Office may consider examining include the following.

Loan Repayment Programs. The Nevada Health Services Corp is the State's only health education loan repayment program. With just over $100,000 in State and federal matching funds, the NHSC is supporting 13 active participants, including M.D.s, dentists, clinical social workers and mental health workers. The NHSC is quite small in comparison with other states; for example, Indiana contributes approximately $1 million annually to three loan repayment programs for physician and nursing students, and Arizona contributes more than $500,000 to several loan repayment programs.

These programs allow loan forgiveness in exchange for providing a certain number of years (usually two to five) in a medically underserved area. Loan programs, which can be matched by HRSA grant funds, can be targeted to primary care physicians as well as a broad array of other health professionals. While there is some concern that these loan repayment programs do not provide long-term solutions, they can be an effective interim solution as other longer-range options are put into place.

Health Professionals Employed by Public Programs. There are several types of health care professionals working for public programs in the state. With State personnel rules and the necessity for Legislative appropriations, the State is often not as nimble as the private sector in responding to market forces. As a result, it is not unusual for health professionals working in the public sector to be compensated at below-market levels, with the result being position vacancies and difficulties in recruiting.

This is acutely true in the area of mental health services. With the large number of mental health facilities and services operated by the State, it is critical that the State address its own shortages of health care professionals. To address this need, the Office of Workforce Development may undertake salary surveys and review the needs for stipends and other payments to attract and retain health care professionals, particularly in rural and remote areas. A fund could be made available to the Interim Finance Committee that could be released during the biennium to address these requirements.

In addition to creating new incentive programs, the State should ensure that it is maximizing the incentive programs that are available on a national level and identify potential private funding sources to supplement those programs. A possible strategy for the State to consider would be to transfer the administration of existing federal programs to the new OHWD. The programs that could be transferred include The National Health Service Corps (NHSC) program and the J-1 Visa Waiver Program.

3. Support the concept of a Nevada Academy of Health, which would be a public-private collaboration.

The Governor's Commission on Medical Education, Research and Training recommended the creation of a Nevada Academy of Health, with the mission of providing policy recommendations to the Governor and the Legislature on the public and private healthcare professional education, medical research, and strategic planning for improved healthcare outcomes in Nevada. The Academy would focus its efforts on:

- healthcare professional education,
- establishing quality benchmarks for healthcare professional education,
- analysis of data related to health planning and healthcare workforce, providing forums and fostering collaboration between the public and the private sector, and
- advancing economic development through technology transfer and business partnerships that advance economic development.

Further, the Academy would provide objective and targeted recommendations to policymakers that are developed through a systematic process of evaluation that will examine individual proposals in the context of clinical, educational and scientific integrity; priorities; quality; correlation with Nevada's health care needs; and resource effectiveness.

It is anticipated that this recommendation of the Governor's Commission will be integrated with the Summit's recommendations regarding Health Planning and Healthcare Workforce.

4. Promote development of Health Information Technology (HIT) and coordinate the development of Health Information Exchange (HIE).

Implementation of Health Information Technology (HIT) and coordinating the development of Health Information Exchange (HIE) on a broad basis in Nevada would provide numerous benefits including:

- reducing medication errors that could lead to adverse consequences;
- making available a patient's conditions, treatments, allergies and medication history in response to an emergency;
- reducing unnecessary and duplicative tests and procedures, thanks to sharing of the results among providers;
- coordinating care across the health care delivery system through the sharing of information, with resulting improved health outcomes;
- allowing consumers to access their own health record and test results; and
- restraining the growth in health care costs, resulting in an improved business environment.

There are health information technology initiatives going on in Nevada, but there are few initiatives in health information exchange. For example:

- Sierra Health Services is aggressively moving to statewide electronic prescribing and has already adopted electronic health records.
- Washoe Medical Center (now Renown Health) had previously adopted an electronic medical record, but it is now implementing the integrated EPIC system that allows a unified record in facilities and ambulatory settings, e-prescribing, and a billing system.
- University Medical Center (UMC) is in the process of securing funding to replace their current system with a system that integrates systems, provides for an electronic medical record and allows for electronic physician ordering.
- The Center for Health Data and Research, housed within the Bureau of Health Planning and Statistics of the DHHS, is developing a data warehouse that will link 35 health and related databases.
- Spring Valley Hospital has installed components of an electronic medical record.

As evidenced by eHealth Initiative's ranking of Nevada, HIT in the state is developing in silos, with little activity in HIE.

The State can provide leadership in the development of HIT and HIE by sponsoring the planning process and by supporting Regional Health Information Organizations moving to Health Information Exchange.

The planning process would be supported by the State through the creation of a statewide Steering Committee for e-Health. The Committee would be charged to develop the direction and a high-level plan for statewide implementation of HIT and HIE within ten years.

The primary responsibilities of the Steering Committee would be to:

- create a vision for HIT and HIE in Nevada;

- begin an inventory of HIT and HIE initiatives;
- test the waters with Nevada leaders;
- identify and propose solutions to barriers to implementation; and
- develop a high-level plan that can guide implementation over a seven- to ten-year period.

The Steering Committee should include physicians, hospitals (including public, for profit, urban and rural), health plans, insurers, consumers, medical trade associations, pharmacies, employers, medical schools, unions, government agencies (including Medicaid and the Department of Information Technology), and researchers.

The resulting high level plan should:

- define the ongoing governance structure for HIT and HIE,
- identify achievable goals and the steps to get there,
- establish HIT and HIE priorities,
- begin to resolve financial barriers including how government can subsidize HIT and HIE,
- formulate a strategy to ensure that privacy and security is protected, and
- determine how to leverage current Nevada initiatives.

From the initial Steering Committee meeting, the plan should be completed in six to eight months. At the outset, it is critical that the plan provide for flexibility while at the same time defining (as best it can) what needs to occur, why and when it needs to occur, and who is responsible.

Once the Steering Committee plan is formulated, the governance structure recommended should be implemented and provided funds to operate and subsidize early implementation. The governing entity, whether governmental or a nonprofit corporation, will have responsibility for guiding implementation of the plan. The entity will:

- provide guidance and direction for HIT and HIE in Nevada;
- guide policy and legislative changes;
- collaborate with existing HIT efforts in Nevada;
- develop standards for the interface of HIT and HIE, building on the national efforts defining interoperability standards of ONCHIT and CMS;
- develop and support regional health information organizations (RHIOs) and promote health information exchange initiatives;
- develop the statewide technical infrastructure that is necessary for data access and sharing, including a web portal for shared information such as a patient health summary, results delivery service, immunization records and advance directives;
- develop a statewide patient health summary that is a first step toward statewide electronic medical records;
- receive and distribute funds; and
- create incentives, such as grants and subsidies, to promote HIT and HIE.

In order to fulfill these responsibilities, the governing body should be supported with a full-time staff, have a governing board comprised of key players, and have an extensive committee structure. The subcommittee structure of the planning process can be maintained so long as the responsibilities of each are clearly articulated in the plan and deliverables are defined.

Based on the work of the Steering Committee and the Governance Body, the State should enact legislation that allows for HIE initiatives that are in compliance with federal HIPAA standards. Nuances in Nevada law may have to be modified to facilitate HIE and encourage information sharing between providers. ◗

Health Care Status Indicators

To assist the Legislative Committee on Health Care and the stakeholders involved in developing the Nevada Strategic Health Plan, a series of health and demographic indicators were collected and compiled from publicly available sources. The indicators are helpful in placing the Nevada health care system in context, especially in relation to the rest of the states.

The specific indicators that were compiled and shared with the stakeholders included demographics, health status, health professional workforce, the Medicaid program, and health facilities.

The picture that emerged of the Nevada system is sobering. The indicators reveal the significant shortage of health care professionals in Nevada, the high number of uninsured residents, the extremely high rate of population growth that the state can expect in the next 25 years, the state's low level of Medicaid coverage, the high prevalence of behavioral health issues among the Nevada population, and the relatively low health status of the state's residents.

The following discussions present the most notable observations derived from the data that was shared with the stakeholders and from other work performed in support of the planning process.

Population Growth

According to the U.S. Census Bureau, Nevada in recent years has been and, for the next 25 years, will continue to be at or near the top of the list of rapidly growing states. Based on 2000 Census projections, the state's population is expected to more than double, growing by 114% to 4.3 million between 2000 and 2030. During the same period, the U.S. population is expected to grow by only 29%.

The U.S. population is aging, and so is Nevada's. In 2000, 11% or 219,000 of Nevada's population were over the age of 65; by 2030, Nevada's over-65 population will grow to 19% of the population, representing just over 797,000 seniors.

It is safe to predict that a quickly growing and aging population will challenge many aspects of Nevada's health care system. For example, without a corresponding increase in the number of health professionals, the current shortage in that area will become more severe. More people, and especially more seniors, mean that State health care expenditures will rise as more people need more health care services and as a greater percentage of the population becomes eligible for Medicaid benefits. As it stands now, Nevada's health care spending, as a percentage of the Gross State Product, is the lowest of any state.

Health Professionals

Nevada suffers from a severe shortage of health care professionals. Per 100,000 population, Nevada ranks 48th among the states in the number of physicians, 49th in the number of nurses, 48th in the number of dentists, and 48th in the number of social workers.

While most states face a shortage of health professionals, few are in Nevada's league. With 196 non-federal physicians per 100,000 population, Nevada is 25% below the U.S. median of 262. Similarly, in nursing, with 59 nurses per 10,000 population, Nevada is tied with California for last place among the states, also 25% below the 50-state average.

Nevada ranks last or close to last in a number of other categories of health care professionals: pharmacy aids and technicians (42nd); psychologists (44th); physical therapists (48th); occupational therapists (49th), speech and language pathologists and audiologists (50th); radiology technicians (49th); clinical laboratory technicians (49th); dieticians and nutritionists (44th); home health aides (49th); and nurse aides, orderlies and attendants (49th).

Many other states are facing, or will face, similar shortages as the baby boomers in the health care profession begin to retire. For example, the Center for Health Workforce Studies at the University at Albany reported in a November 2002 study that a majority of states had shortages in nurses and in five other professional categories.

The American Academy of Family Physicians reported in a September 2006 study that almost all states will have a shortage of primary care physicians by 2020. The report indicates that the U.S. will require 39% more primacy care physicians over the next 14 years to meet increased demand. The report also noted that, between 1997 and 2005, the number of medical school graduates who enter the primary care field decreased by more than half, as more graduates have entered specialties with higher pay and more control over work hours.

As other states begin to face these shortages in health care professionals, the pool of available professionals will be more highly recruited, compounding the challenges to Nevada to grow its health care professional workforce.

Further, as Nevada's population continues its explosive growth, the State's education system will not be able to keep up with the need. The University of Nevada School of

Medicine (UNSOM) has a current class size of 52. Even if the State substantially expands the education system, additional strategies will have to be developed to keep pace with population growth.

Insurance Coverage

In looking at the Nevada population as a whole, the percentage of people with employer-sponsored insurance in Nevada (at 57%) is higher than the national average of 54%. The percentages of people in Nevada with either individual policies or on Medicare are both within one percentage point of the national average.

With respect to employer-sponsored health insurance, employers in Nevada offer health insurance to their employees at a higher rate (89%) than both the national average (87%) and neighboring states. By firm size, 96% of the large firms in the state offer insurance.

However, from an eligibility perspective, a lower percentage of employees in Nevada are eligible for their employer's plan (75%) than the national average (79%) and all but one, Utah, of the neighboring states. Nevada has an average take-up rate by those employees that are eligible for these plans.

Regarding the cost of employer-sponsored insurance, Nevada has average premiums for single coverage of $3,578 annually, which are only slightly above the national average of $3,481. However, the average employee contributions of $474 are well below the national average of $606, indicating employers in Nevada pick up an above-average share of the total cost of their employee's health insurance. Both the total cost and the employee share are slightly higher for smaller firms (less than 50 employees) at $3,610 and $508, respectively.

Uninsured. Despite Nevada's relatively high rate of persons covered by employer-sponsored insurance, only three states have higher uninsured rates than Nevada's 19%. Approximately 426,000 residents are without insurance, over half of whom (214,000) are employed adults.

The category of health insurance coverage for which Nevada departs markedly from the nation as a whole is in Medicaid coverage. By one measure, the percentage of people covered by Medicaid in Nevada (at 7%) is barely above half of the national average of 13%, suggesting that Nevada's higher rate of uninsured is the result of Nevada's lower Medicaid coverage rate.

In examining the uninsured in Nevada, the data reveal the following:

- There are approximately 110,000 uninsured children and almost 314,000 uninsured adults younger than 65.
- Of the uninsured, about 72,000 children and an estimated 160,000 adults are in households with incomes below 200% of the Federal Poverty Level (FPL).
- Over 80% of the uninsured in Nevada are in families with at least one employed person, and 72% have at least one full-time worker in their family.

When the uninsured receive medical care, the costs are often shifted to the insured population. A recent study estimated that the 2005 costs for uninsured persons in Nevada totaled $397 million, of which $314 million was covered by higher premiums for those who have private insurance.

Medicaid

The income levels up to which Nevada Medicaid covers parents and children are lower than almost every other state. As a result, Nevada Medicaid covers the smallest percentage nationwide of its non-elderly residents in each of these three income ranges:

% of FPL	Nevada	U.S.
Up to 100%	27%	43%
100% to 199%	14%	25%
200% and up	2%	4%

Nevada's strict eligibility rules have led to a lower percentage of the overall population being covered under Medicaid than in most other states. Another source reported that, in federal fiscal year 2002, about 10% of Nevada's population was enrolled in the Medicaid program, compared to 18% nationally. Nevada's ranking in this category is 47th.

It would be reasonable to conclude that raising the percentage of Nevadans covered by Medicaid would offer at least three significant benefits:

- more federal dollars would be returned to the State;
- there would be a reduction in the necessity of health care providers shifting the cost of care for the uninsured to the insured population; and
- individuals who are added to Medicaid coverage would tend to seek treatment at an earlier and less expensive stage in their medical condition, rather than putting off medical care until a visit to the emergency room is their only viable treatment option.

Health Status

The United Health Foundation publishes an annual report that ranks each state based on overall health status. In its 2005 report on Nevada's health status, the Foundation ranks Nevada at 37, citing as the primary concerns Nevada's low childhood immunization rate, a high violent crime rate, and a high uninsured rate.

With respect to childhood immunization, Nevada ranks 51st in the country (the District of Columbia is included in the survey) in the percentage of children (at 68%) between 19 and 35 months who have been immunized.

Among the rest of the health status indicators, Nevada is generally either average or slightly below average. Nevada compares favorably in its obesity rate (19%, versus the 21% national average) and has a very low rate of diabetes-related deaths (17.6 per 100,000, versus 25.4 nationwide).

Nevada is at or near the national average for deaths caused by cancer (203 per 100,000 population, versus 194 for the U.S.), stroke (57 vs. 56), heart disease (246 vs. 241), and disability (18% vs. 18%).

Nevada compares unfavorably to the national average in:

- overall deaths (919 per 100,000 population, versus the U.S. average of 845),
- motor vehicle deaths (2 per 100 million miles driven, versus the U.S. average of 1.6),
- adults who smoke (23%, vs. 21% U.S.),
- persons reporting poor mental health (41%, vs. 34% U.S.),
- per capita State mental health agency expenditures ($57, vs. U.S. median spending of $74), and
- persons who visited a dentist or dental clinic in the past year (65%, vs. 70% U.S.).

Health Facilities

Nevada's hospital capacity has not kept up with population growth. The number of hospital beds per 1,000 people in Nevada (1.91) ranked 48th in 2003, down from 42nd in 2002.

It is probably this lack of hospital capacity that causes utilization of hospital-based services in Nevada to be lower than utilization of the same services in most other states. The per-thousand rate for hospital admissions (95, ranked 44th), inpatient days (496, ranked 43rd), ER visits (279, ranked 49th) and outpatient visits (1,019, ranked 51st) are among the nation's lowest.

Whether nursing home capacity is adequate for Nevada cannot be determined from the available statistics. Though the percentage of Nevada's elderly population in nursing homes (1.7%) is one of the lowest in the country, the occupancy rate at Nevada's nursing homes (84%) is under the national average (86%). ◗

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