HB

318

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
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Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

MEMORANDUM February 19, 1991

SUBJECT: Constitutional Issues - Advanced Nurse Practitioners (7LS-0778)

TO: Senator Virginia Collins

FROM: Terri Lauterbach
Legislative Counsel

You have asked whether it would be constitutional for the Alaska Medicaid program to cover directly only the services of pediatric and family nurse practitioners without covering directly the services of other advanced nurse practitioners.[1] You are concerned that there may be a violation of the equal protection clause of the state constitution.

In our opinion, offering direct reimbursement under Medicaid to only certain types of ANP's probably results in the kind of arbitrary classification prohibited under the state's equal protection clause. Since direct reimbursement of some types of ANP's is optional under federal law, however, the state Medicaid statutes would need to be amended to correct this constitutional deficiency.

The state's equal protection clause is found in art. I, sec. 1, Constitution of the State of Alaska, which provides that "...all persons are equal and entitled to equal rights, opportunities, and protection under the law...."

The Alaska Supreme Court has interpreted this clause to offer broader protection than the corresponding federal clause.[2] In so doing, our court has said that in order for a classification to be valid, it must be reasonable, not arbitrary, and must bear a fair and substantial relation to a legitimate governmental objective, and, depending on the importance of the individual's interest involved, a greater or lesser

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[1] You have told me that some of the other types of advanced nurse practitioners are women's health, adult, neo-natal, school nurse, geriatric, and psychiatric.

[2] This is why the classifications may be valid under the federal constitution but not valid under the state constitution. However, I am not aware of any case **upholding** different treatment of these ANP classifications on the federal level either; they may turn out to also violate the federal constitution.

legal services memorandum

burden will be placed on the state to show this fair and substantial relationship.[3] Our courts have also said that the guarantee of equality of treatment prohibits a classification that denies to one group of persons the enjoyment of certain rights that are afforded to another group when, considering the purpose of the state program, there is no reasonable basis for not treating both groups the same.[4]

In the situation you have described to me, the services of two types of ANP's will be covered directly under the Medicaid program, as required under federal law, but the services of all other ANP's will not be covered directly, even though federal law would allow them to be and even though they may provide exactly the same type of service.[5]

Since services of all ANP's are covered when the ANP is associated with a physician or a hospital and federal law would only allow coverage of services performed within the scope of an ANP's certification, there does not appear to me to be any basis for saying that the services of other ANP's would be of an unacceptable quality.

You have also told me that, regardless of a particular ANP's certification, many of the services performed by one ANP are the same as those performed by ANP's with other types of certifications.

I also note that the Medicaid program covers all physician services, regardless of the fact that some physicians have specialties and some do not. In other words, the Medicaid program covers a given service performed within the scope of a physician's licensure and does not distinguish among family physicians, general physicians, pediatricians, gynecologists, etc., when they perform services that all are authorized to perform.

Furthermore, it appears that most of the other ANP specialties you told me about would be especially useful to the Medicaid population, which is primarily pregnant women, women with children, and elderly persons. It would seem that special training in women's health, adult, neo-natal, school nurse, and geriatric areas would be as useful to Medicaid recipients as special training in family and pediatric care.

Finally, I note that the state does not allow this type of discrimination among licensed providers to be practiced by insurance companies. See AS 21.36.090, which specifically lists advanced nurse practitioners among those whose services must be

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[3] See, for instance, Wilson v. Municipality of Anchorage, 669 P.2d 569 (Alaska 1983).

[4] See, for instance, Leege v. Martin, 379 P.2d 447 (1963).

[5] "Direct" coverage means that the ANP does not have to be associated with a physician or other health care provider, like a hospital.

covered by insurance policies if the services are within the scope of their lawful authority. It would be rather inconsistent for the state to practice a type of discrimination that it prohibits private parties from practicing.

Given these facts, I am unable to conceive a constitutionally sound basis for the state to refuse to cover directly the services of all ANP's after it has started to cover directly the services of some ANP's. This seems to be exactly the kind of arbitrary classification prohibited under our state equal protection clause. It would deny to some ANP's the opportunity to be directly reimbursed for services that other ANP's are directly reimbursed for. It gives to some ANP's the opportunity to participate directly in the Medicaid program while denying that opportunity to other ANP's.

The insidiousness of this classification must be balanced against whatever legitimate governmental objective is served by the classification.

It is stated in AS 47.07.010 that the purpose of the Medicaid program is to provide "uniform and high quality medical care" to needy persons of the state. According to you, there is some evidence that ANP's provide the **only** medical care available in some rural communities and that many persons in these communities are eligible for Medicaid. The goal of providing Medicaid services to these people would not be served by a policy of covering only some types of ANP's when it may be another type of ANP that is in the community, providing the same basic services. Even when other health care providers are available, increased access to ANP's means increased access to health care delivery.

A second objective of the classification may be to save money by not covering services of some practitioners. While saving money is a legitimate goal, use of an arbitrary classification of providers is not well-tailored to that goal. There is already a statutory mechanism for dealing with shortfalls if the legislature fails to appropriate enough money for the Medicaid program. That mechanism is the priority listing of optional coverages in AS 47.07.035. The legislature has determined which **services** should be cut first when there is not enough money to cover everything. Therefore, there is no need to discriminate against **providers** of those services in order to save money.

In conclusion, there seems to me to be no legitimate basis for directly reimbursing some types of ANP's and not others, as long as they are delivering services that are within the scope of their practice.

However, because of the way the federal law is written, a change in Alaska's Medicaid law is required to achieve an equitable result. Under the federal law, direct reimbursement of some ANP's is **mandatory** and direct reimbursement of other

ANP's is **optional.** Under the Alaska statutory scheme, federally mandated provisions of Medicaid automatically become part of our program under AS 47.07.030(a). In order to add something that is optional under federal law, the state must amend AS 47.07.030(b).

Please let me know if you have questions about this memo or if I can be of other assistance.

TML:lmb/mai
91-054.lmb

Enclosure

April 18, 1991

Testimony in Regard to
Senate Bill No. 211

I am resident of the State of Alaska since August 1990 and currently serve as ANP/FNP (Advanced Nurse Practitioner/ Family Nurse Practitioner) to the Sunshine Community Health Center in Talkeetna Alaska.

I would like to submit the following statement in support of Bill No. 211. I believe that Bill No. 211 which provides for coverage of services to the people of the State of Alaska by Advanced Nurse Practitioners should become law because:

I. it would lessen existing discrimination limiting accessibility to health services by rural and remote Alaskans living in communities too small to financially support a physician.
   A. Physicians usually demand a larger income base (average annual income > $120,000) in selecting practice sites.
   B. Nurse practitioners annually earn from $27,000 to $40,000 (many including myself earn much less).

II. it would enable Advanced Nurse Practitioners to finance scheduled preventive health screening, treatment, and referral visits to small remote villages reducing Medicaid financed urgent air evacuations of villagers for preventable medical emergencies.

III. it would make health education more accessible. Health education is vital in reducing risk of illness and injury and improving lay persons capacity for self care and independence.
   A. National League of Nursing accreditation for graduate programs preparing Nurse Practitioners requires teaching and learning theory and method as a major component of the curriculum. Accredited nursing programs at all levels are required to include more preparation in health teaching skills than any other health care provider curriculum.
      1. Example: Light, Baker, Brockman (Lake Superior State University 1988-89) demonstrated that 60% of a group of 60 years and older adults could be taught to successfully reduce their total serum cholesterol through simple palatable diet changes. Carrots and broccoli are less expensive, more effective, and less toxic than cholesterol reducing medications.

   B. Transcultural communication skills are included in preparing Nurse Practitioners in most American Graduate Nursing Programs.
      1. The health care provider must be able to assess the

misc. back-up

meanings of the concepts of illness and health to members of other cultures in order to prepare effective health teaching which clients can accept.

IV. it would promote the coordination of services between the Alaska State Health Department nurses visiting a village and the resident nurse practitioner.
   A. quality of care should be improved at lower cost through teamwork provision of:
      1. prenatal services.
      2. health screening of children.
      3. immunizations to adults and children.

V. It would permit coordination of services between the Alaska Native Health Service and the area resident Nurse Practitioner for Medicaid eligible Natives reducing client travel and access to care.

VI. it would lay the ground work for a state research plan to evaluate and improve the quality, accessibility, and cost effectiveness of health care services.
   A. Research questions:
      1. What does a Medicaid dollar really provide Alaskans?
      2. Does the care provided meet reasonable standards of quality?
      3. Are there less expensive alternatives which might provide equivalent accessibility and quality?
   B. A central data bank would be necessary which meets standards for the protection of the clients' rights of confidentiality.
      1. My experience as a grantee of the W. K. Kellogg Foundation makes me feel that they would be interested in funding such research.

VII. it should provide a direct energy conservation measure because rural clients would reduce gasoline consumption traveling to distant physician services for care.

Respectfully submitted by:
Dixie L. Light PhD, FNP/ANP (Registered to vote in Willow Alaska.
Mile 61.5 Parks Highway
P.O. Box 382
Houston, Alaska 99694
Telephone (907) 892-8804 (home) or 733-2273 (work on Wednesdays and Thursdays)

POSITION STATEMENT ON THIRD PARTY REIMBURSEMENT FOR NURSE PRACTITIONERS

Prepared by P.E.E.R., the Organization of Alaskan Nurse Practitioners

August, 1987

P.E.E.R.'s Position

P.E.E.R. strongly supports the policy of issuing direct third party payment as reimbursement for professional services rendered by all licensed Nurse Practitioners (NPs) in Alaska. The services offered by NPs are legally recognized by the State of Alaska in specific Nurse Practice Acts, and are equivalent, and in some cases, more holistic in approach, than services provided by physicians in primary care. Reimbursement for NP services would benefit the public by:

1. enabling NPs to establish independent practices and clinics by providing a mechanism to finance their businesses. Currently, most NPs are employed by physicians or other entitities, in part because they CANNOT receive direct third party payment.

2. offering more freedom of choice to the public in their selection of competent health care providers.

3. potential reduction in health care costs through competition for provision of services.

4. potential expansion of health care services of NPs in the private sector in under-served areas.

The Significant Contribution of Nurse Practitioners in Alaska

Licensed NPs in Alaska are in sufficient numbers to deserve recognition as an important group of health care providers: as of July, 1987, 129 NPs were licensed and claimed residence in the state. Another 40 NPs are estimated to work in federal governmental agencies (such as Elmendorf Hospital or the Indian Health Service); they are not required to apply for state licences in order to practice. This section describes only the licensed NPs.

Family nurse practitioners outnumber the other eight types of nurse practitioners in Alaska (Table 1). Nurse practitioners impact health care services in Alaska in a variety of work settings (Table 2). Only eleven are in independent practice; of those, six practice in rural settings. Independent practice became an option in December, 1984, with the passing of the new regulations that included placement of NPs under the sole jurisdiction of the Alaska Board of Nursing. Five of the independent practitioners are nurse midwives, who may collect fees from third party payers as stipulated in Alaska Statutes, Sec. 47.07.030--others may not, or do so with difficulty.

The majority of Alaskan NPs hold a Bachelor's or Master's

degree in nursing (86) in addition to their specialized nurse practitioner training, and certification through national certifying bodies (Table 3). In contrast to R.N. degree status for entry into NP training programs in the 1960s, the current national trend is for that training to take place in conjunction with Master's degree preparation, illustrated by the Family Nurse Practitioner program at the University of Alaska's College of Nursing and Health Sciences.

No studies have been conducted in Alaska to assess the quality of care provided by nurse practitioners, nor how their care might differ from that of a physician. Numerous studies in the lower 48, however, have shown that . . ."within their areas of competence, nurse practitioners provide care whose quality is equivalent to that of care provided by physicians", and that patients are generally satisfied with their care (US Congress, Office of Technology Assessment, 1986, pages 5-6). The American Academy of Nurse Practitioners provides a summary of the recent studies documenting the quality of services provided by NPs (addendum 1; also cites the OTA study mentioned above).

Alaskan NPs have demonstrated their willingness to work in under-served rural areas in Alaska: 51 of the currently employed 126 state-licensed NPs work in settings other than in Anchorage, Fairbanks, or Juneau. Their jobs entail multiple responsibilities and require high levels of expertise (see addendum 2 for an example of a rural practice).

The National Trends

Congress continues to consider a variety of proposals to mandate third party reimbursement for NPs. So far, federally mandated payments are limited to a few State Medicaid programs, Champus, and some programs in the Federal Employees Health Benefit Program (refer to Appendix B, US Congress, Office of Technology Assessment, 1986). At least 13 states currently permit direct payment for NP services, including Oregon, a state that also supports the independent practice of NPs.

Conclusion and Our Recommendations

We contend that without direct reimbursement to NPs in the State of Alaska, the practice settings of NPs are limited, which in turn, effectively limits competition among providers, patient choices of providers, and ultimately, adversely impacts upon health care costs. We therefore recommend that:

1. third party insurers voluntarily offer to provide direct reimbursement for NP services, and/or that

2. the state legislature amend the statutes to mandate such reimbursement to <u>all</u> licensed NPs, not just to nurse midwives as is now the case.

Thanks is extended to Gail McGuill, Executive Director, Alaska Board of Nursing, for her assistance in obtaining the NP data.

ALASKA STATE LEGISLATURE

Office of Majority Whip

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VICE CHAIR
HEALTH, EDUCATION
& SOCIAL SERVICES

COMMUNITY AND
REGIONAL AFFAIRS

INTERNATIONAL TRADE
AND TOURISM

CHAIR
CHILDREN'S CAUCUS

REPRESENTATIVE BETTYE DAVIS

DISTRICT 14 SEAT B · EAST ANCHORAGE · MULDOON

M E M O R A N D U M

TO: REPRESENTATIVE GEORGIANNA LINCOLN, CO-CHAIR
REPRESENTATIVE PAT CARNEY, CO-CHAIR
HOUSE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE

FROM: REPRESENTATIVE BETTYE DAVIS BD

DATE: MAY 10, 1991

RE: HB 318 - "An Act providing for coverage of advanced nurse practitioner services under the Medicaid program"

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I respectively request that HB 318, "medicaid payments to nurse practitioners," be scheduled for hearing before the House Health, Education & Social Services Committee, at your earliest convenience. HB 318 is the companion legislation to SB 211, sponsored by Senator Virginia Collins.

Currently, Alaska only allows independent nurse mid-wives to enroll as medicaid providers. In the fall of 1991, independent family or pediatric advanced nurse practitioners will be able to enroll.

Independent advanced nurse practitioners with a different designation of title, e.g., geriatric nurse practitioner or women's health care nurse practitioner, are unable to enroll as medicaid providers under current state law.

This bill would allow <u>all</u> advanced nurse practitioners, in independent practice, to enroll. Regardless of speciality title, these nurse practitioners may be performing identical services for a patient. Yet, only those who are in the nurse mid-wife, family, or pediatric advanced practitioner categories will be allowed to enroll as a medicaid provider.

Sponsor statement.

A memorandum to Senator Virginia Collins (attached), from the Division of Legal Services, questions the constitutionality under our state equal protection clause.

Should funding become inadequate, there is a statutory mechanism for dealing with shortfalls. This mechanism appears in this bill, and the field of advanced nurse practitioners has been added to the list.

In Alaska, where nursing shortages are ever-present, this bill would encourage nursing professionals rather than discriminate against certain speciality groups within the general category.

At least 13 states currently permit direct payment for nurse practitioner services; and this bill is fully supported by the Organization of Alaskan Nurse Practitioners.

It is my hope to be granted a hearing next week; at which time, SB 211 should have passed the Senate and been referred to House HESS. We will then be prepared to waive it on to House Finance.

Your prompt response is appreciated. If you have any questions, please feel free to contact me, or Caren Robinson of my staff, at X3875.

POSITION PAPER/Department of Health & Social Services

House Bill 318

"An Act providing for coverage of advanced nurse practitioner services under the Medicaid program; and reordering the priorities granted to optional services offered under the Medicaid program."

This bill would amend AS 47.07.030 to allow Advanced Nurse Practitioners ("ANPs") to enroll as Medicaid providers, provide Medicaid-eligible recipients with those services which Medicaid covers and which are within the scope of their licensure, and directly receive Medicaid reimbursement. This bill also amends AS 47.07.035 to place this new provider group 17th in the list of optional services to be deleted in the event of a funding shortfall.

Currently, many Advanced Nurse Practitioners do receive Medicaid reimbursement, but only indirectly. For any ANP who is employed by a hospital, nursing home, physician's clinic, mental health or rural health clinic, or a physician, the enrolled provider for whom they work receives Medicaid reimbursement for their services.

However, ANPs except nurse midwives who practice independently cannot currently enroll as Medicaid providers.

This situation will change in the Fall of 1991, when Alaska will implement a provision of the Omnibus Reconciliation Act of 1989 which requires all states to grant Medicaid provider status to independently-practicing ANPs who specialize in family or pediatric medicine.

Industry sources indicate that, of 141 ANPs licensed to practice in Alaska, just 37 are either in full or part-time independent practice and are likely to choose to enroll. Of these 37, 24 are family specialists and one is a pediatric specialist. Whether or not HB 318 were to pass, these 25 will shortly be allowed to enroll in Medicaid if they choose to do so. (The department expects virtually all will enroll.)

We therefore believe that HB 318 would initially affect only the following ANPs:

(a) 4 Mental Health specialists (all part-time practitioners)
(b) 5 Women's Health Care specialists (all full-time)
(c) 1 School Nurse Practitioner specialist (part-time)
(d) 2 Geriatric specialists (one full-time, one part-time)

DHSS POSITION PAPER

Often, the opportunity to directly receive reimbursement from a major third-party payor can affect patterns of practice. The potential to directly receive Medicaid reimbursement might, over time, induce more ANPs to enter independent practice. This is a pattern that has occurred with other provider groups elsewhere. From conversations with many ANPs over the last two years, we have concluded that this is unlikely to occur in Alaska. The financial disadvantages, the loss of personal freedom, and the very strong traditional practice patterns of ANPs, argue against any significant growth in independent practice as a direct effect of Medicaid reimbursement.

However, those ANPs who currently practice independently do seem to serve a higher percentage of low-income patients than is true of many other provider types. We suspect that ANPs who do enroll in Medicaid will serve a higher percentage of Medicaid recipients than do most physicians, for example.

For many years, the department has had ANPs as employees (both in administrative roles and in direct public health services positions), and has had extensive dealings with ANPs as part of the Medicaid program and as eligibles in health care. In our judgement ANPs have extremely rigorous licensure requirements, a strong tradition of service, and unquestionably high professional standards.

We would respectfully suggest that HB 318 be amended to adjust the 17th-position placement of ANPs within the "prioritization list" of AS 47.07.035. In terms of the numbers of providers, affected recipients, dollars, and relative degree of patient need, we feel that placement of this optional service first in services listed is more appropriate. (Please note that those services listed first are intended to be deleted first in a funding shortfall.)

Kimberly B. Busch

Kimberly B. Busch, Acting Director
Division of Medical Assistance

Theodore A. Mala

Theodore A. Mala, MD, MPH
Commissioner
Dept. of Health & Social Services

POSITION PAPER/Department of Health & Social Services

1991

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DHSS Position - SB 211

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For: Kimberly B. Busch, Acting Director
Division of Medical Assistance

Theodore A. Mala, MD, MPH
Commissioner
Dept. of Health & Social Services

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. HB 318

Revision Date: _____ Department Affected: Health & Social Services

Title: An Act Providing for Coverage of Advanced Nurse Practitiioners... BRU: Medicaid

Component: Non-Facility

Sponsor: Senator Collins

Requestor: _____ COMPONENT SERIAL NO. 0 2 3 0

Expenditures/Revenues: Thousands of Dollars

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	17.4	14.1	16.7	19.9	23.5	28.0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS CLAIMS	40.4	99.7	123.0	151.8	187.3	231.1
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	57.8	113.8	139.7	171.7	210.8	259.1
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	27.7	54.0	66.5	81.9	100.6	123.9
FEDERAL FUNDS	30.1	59.8	73.2	89.8	110.2	135.2
OTHER	0	0	0	0	0	0
TOTAL	57.8	113.8	139.7	171.7	210.8	259.1

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)
See attached analysis

Prepared By: Kimberly A. Boyd Phone: 465-3355

Division: Division of Medical Assistance Date: 4-18-91

Approved by Commissioner: _____

Agency: Health and Social Services Date: 5/15/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impact Agency(ies).

Fiscal Note Analysis

HB 318

(1) We assume: full-time ANP works 40 hrs/week, 48 weeks/year, charges $90/hour, and is likely to have a patient mix that is approximately 30% Medicaid-eligible. Medicaid pays ANPs 80% of the charges normally billed to the general public. Therefore, a full-time ANP is likely to bill Medicaid for $41,472 per year (1920 hours x $90/hr = $172,800 x 30% x .80 = $41,472)

(2) Part-time ANPs work, on average, 30% of full-time ANPs. $41,472 x 30% = $12,442 per year

(3) 6 full-time and 6 part-time ANPs will enroll in Medicaid.

6 x $41,472 = $248,832
6 x 12,442 = 74,652

$323,484

(4) Of this theoretical maximum billing, we assume 75% will be for services which Medicaid recipients would have received from an array of other types of enrolled providers. Many of those providers would have billed Medicaid more for their services, so it is reasonable to posit some program savings will occur. However, we have no way to estimate how many recipients will leave each existing provider type (and payment level), so we cannot estimate the savings involved.

(5) The remaining 25% will be new services, of two types: services which eligible persons now receive from ANPs (and for which ANPs probably receive little or no compensation) and services which eligibles now either defer or do without. From the latter category, the increased access to services patients would experience by adding ANPs as providers may result in services which are more timely or even preventive, thus producing a savings of later, more expensive Medicaid costs. However, again, those savings cannot be quantified.

FY92

(a) A start date of January 1, 1992 is assumed, since time would be required to modify the Medicaid payment system and recruit, enroll, and train new providers. Benefits costs for FY92 would therefore be 40.4 (323.5 x .25 x .5) Benefits are 50% federal (20.2), 50% state funds.

(b) A one-time FY92 cost is involved in modifying the payment system to accept this provider type. (A major portion of the cost of these changes are already budgeted for adding some ANPs under the OBRA '89 federal mandate.) Only 6 system edits will be required, at a cost of $1080 per edit = $6.5. (3.3 fed, 3.2 state)

(c) The systems contractor will travel to on-site-train new providers and provide them with service-specific manuals and materials, at a one time FY92 cost of 5.0 (2.5 fed, 2.5 state.)

(d) These providers are expected to generate 950 claims in FY92, (half-year) at a contracted processing cost of $6.23 per claim. 950 x $6.23 = 5.9. This cost is 70% federal (4.1), 30% state (1.8).

FY93 and following

(a) FY92 service costs are doubled for a full year of service, and this adjusted FY92 cost is increased by 23.4% (4.6% for price increases, 7.0% for increases in the number of eligible recipients, and 11.8% for utilization increases).

(b) Claims processing contractual costs are adjusted for a full FY92 year (1900 claims), then increased by 18.8% (7.0% for eligibles, 11.8% for utilization increases). The contract price per claim remains at $6.23.

HOUSE COMMITTEE REPORT

(7)

Date Referred: May 8, 1991 FURTHER REFERRALS: Finance

Date of Committee Action: 5-16-91

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 318

HOUSE BILL NO. 318 MEDICAID PAYMENTS TO NURSE PRACTITIONERS

"An Act providing for coverage of advanced nurse practitioner services under the Medicaid program; and reordering the priorities granted to optional services offered under the Medicaid program."

RECOMMENDATIONS: [ ] the same title
be replaced with _____ [ ] a new title

[ ] have attached amendments(s)
[✓] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[✓] fiscal impact DHSS [ ] fiscal note(s) _____

[ ] zero fiscal note _____ [ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Doris Davis	✓				
[illegible]	✓	(CARNEY)			
[illegible]	✓	(LINCOLN)			
J. E. Gonzales	✓	(GONZALES)			
Bettye Davis	✓				

[illegible] - CHAIRMAN'S SIGNATURE LINCOLN