STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
**DIVISION OF HEALTH CARE FINANCING AND POLICY**
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**Division of Health Care Financing and Policy**
**Notice of meeting to solicit public comments and intent to act**
**Upon Amendments to the Medicaid Services Manual (MSM)**

**Public Hearing February 12, 2015**
**Minutes**

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| Date and Time of Meeting: | February 12, 2015 at 9:15 am or at the conclusion of the State Plan Public Hearing |
| Name of Organization: | State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) |
| Place of Meeting: | State of Nevada Health Division<br>4150 Technology Way, Room 303<br>Carson City, Nevada 89701 |
| Place of Video Conference: | The Division of Health Care Financing and Policy (DHCFP)<br>1210 S Valley View Blvd. Suite 104<br>Las Vegas, Nevada 89102 |

**Attendees**

**<u>In Carson City, NV</u>**

Jenni Bonk, DHCFP
Sheri Eggleston, DHCFP
Alexis Tucey, DHCFP
Betsy Aiello, DHCFP
Scott Mayne, Washoe County/Clark County
Renee Necas, DHCFP
Kathy Stoner, DHCFP
Darrell Faircloth, Senior DAG
Greg Gittus, Alkermes
Joanna Jacob, Ferrari Public Affairs
Charles Duarte, Community Health Alliance
Lori Mariluch, Renown Health
Dwight Hansen, Nevada Hospital Association
Marti Coté, DHCFP
Brandy Johnson, DPBH
Tammy Moffitt, DHCFP

**<u>In Las Vegas, NV</u>**

Michael Howie, MMH
Jason Schwartz, MMH
Chris Lazarte, Serenity
Barry Wickland, Life Quest

**Introduction:**

Ms. Tammy Moffitt, Chief of Program Integrity, Division of Health Care Financing and Policy (DHCFP), opened the Public Hearing introducing herself, Ms. Betsy Aiello, Deputy Administrator of the DHCFP and Mr. Darrell Faircloth, Senior Deputy Attorney General (DAG).

Ms. Moffitt – The notice for this public hearing was published on January 9, 2015 in accordance with the Nevada Revised Statute 422.2369.

Ms. Moffitt – Items one, two, and three will not be heard today and have been removed from the agenda.

**1. For Proposed Action: Discussion and proposed adoption of changes to MSM Chapter 200 – Hospital Services**

Ms. Renee Necas:

Revisions to MSM Chapter 200 are being proposed to clarify policy regarding: authorization and reimbursement of elective cesarean delivery and early induction of labor prior to 39 weeks gestation; authorization requirements related to newborn admissions and deliveries prior to a hospital admission; concurrent review submission timeframes; and sterilization consent forms. The administrative days, hospitals with swing beds, and observation policies have been clarified and relocated from the body of Chapter 200, to Chapter 200 Attachment A. Policy was added regarding: authorization requirements and reimbursement of ancillary services in addition to the swing bed per diem rate and the observation hourly rate; reimbursement of ancillary services subsequent to the observation 48 hour policy limit; and covered/non-covered observation services. Required documentation related to administrative days, hospitals with swing beds, and observation services was added. In addition, Quality Improvement Organization (QIO)-like vendor processes, billing language, and language already in other MSM Chapters were removed.

The effective date is March 1, 2015.

At the conclusion of Ms. Necas' presentation, Ms. Moffitt asked Ms. Aiello, Deputy Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

Ms. Aiello's Comments:

- Emphasized removal from the new language additions both for Policies #2-04 and #2-05 under prior authorization sections, the chapter examples that were listed. They were meant for clarification, but have been found to be confusing and thought to be the only chapters applicable and MSM is applicable across the whole range.

Mr. Faircloth's Comments:

- Recommended removal of a redundant set of words (MSM Chapter) at the top of Policy #02-05 page 12. In addition, in the new provisions that are within attachment A, Policies #02-03, #02-04 and #02-05 recommended addition of alpha/numeric characters to outline this particular set of provisions to enable reference to the chapter easily and describe it particularly in written materials.

Public Comments:

- Ms. Lori Mariluch asked if reimbursement beyond 48 hours for ancillary services would be reinstated for observation services.

- Ms. Necas responded Section 203.4.A.3.c.8 in the current policy states that ancillary services rendered during observation hours that exceed the 48 hour limit is not reimbursed was specifically removed. New policy allowing reimbursement for those services as an outpatient hospital service was added. The Provider Type 12 billing guide does direct providers that they should not submit claims for observation hours and/or ancillary services provided during observation hours that exceed the 48 hour policy limit. This means they would bill up to the 48 hours of observation and only ancillary services should be demonstrated on the claims.

- Mr. Dwight Hansen stated he does not object and recognizes this is merely to clarify and reorganize various policies. Because it applies to Administrative Days, I would like to comment mainly because our members are having a difficult time in discharging Medicaid patients to the proper level of care, whether it is Skilled Nursing, Long-term Acute Care (LTAC), Rehab, etc. This is especially true with the Medicaid Managed Care Organization (MCO) patients, as well as with all Medicaid patients. Hospitals have held patients in Administrative day categories for 20-30 and more days because they are unable to find a proper facility to discharge them to. This is especially true with the expansion of Medicaid and most of those patients are going into an MCO. We are hopeful the DHCFP will look at this to make sure there is adequate network adequacy with the expansion of Medicaid to allow for the proper discharge of patients. Not only is it a financial difficulty for hospitals, but it serves to get the patients into the proper setting for their care.

- Mr. Faircloth asked if ancillary services should not be billed separately if observation days during the period of observation (the 48 hours) are reached.

- Ms. Necas responded during the period of the 48 hour period of observation they can bill the ancillary services, subsequent to the 48 hour policy limit. The only thing that should be billed for is for ancillary services that occur. There are cases where a recipient could remain after the 48 hours for such things as additional testing. The facility cannot bill for more than the 48 hours of observation, but for those additional ancillary services that are required, such as lab tests or a diagnostic, they can bill for those services.

- Ms. Moffitt – Recommended the Deputy Administrator approve with the addition of the appropriate alpha and/or numeric outline of all bolded titles in the attachments, with the corrections discussed and any applicable spelling or grammar corrections as appropriate.

- Ms. Aiello – Approved the changes with the addition of the alpha and/or numeric characters, removal of the sections, information discussed and grammar corrections.

- Ms. Moffitt – Closed the Public Hearing for the MSM Chapter 200 Hospital Services.

**2. For Possible Action: Discussion and proposed adoption of changes to MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services**

Ms. Alexis Tucey:

Revisions to MSM Chapter 400 are being proposed to ensure Nevada Medicaid is following federal guidelines for coverage of institutionalized individuals who are ages 22-64 that are in an Institution for

Mental Disease (IMD). The revisions comply with the Center for Medicare and Medicaid Services (CMS) State Medicaid Manual, Chapter 4, 42 CFR 1009 (2) and 42 CFR 435.1010.

Policy revisions include an IMD description and coverage and limitations in Attachment D, adding verbiage to inform and guide providers to ensure continuity of care and clarification of provider responsibilities.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity.

Effective Date: March 1, 2015.

At the conclusion of Ms. Tucey's presentation, Ms. Moffitt asked Ms. Aiello, Deputy Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

<u>Ms. Aiello's Comments:</u>

- No Comments

<u>Mr. Faircloth's Comments:</u>

- Suggested with regards to Attachment D urged to add alpha/numeric outline as discussed.

<u>Mr. Charles Duarte:</u>

- Commented Attachment D, Section 2, subsection e states that coverage of services for ages 21 through 22 years, and asked if it should be up to 22 years. Throughout the attachment it reads services are to continue between ages 21 and 22 and not through 22.

<u>Ms. Tucey</u>

- Stated it would be an appropriate revision to make with that intention of that section of the policy to revise the word through and change it to up to.

Ms. Moffitt – Recommended the Deputy Administrator approve with the addition of the appropriate alpha and/or numeric outline of all bolded titles in the attachment with the corrections discussed and any applicable spelling or grammar corrections as appropriate.

Ms. Aiello – Approved the changes with the addition of the Alpha and/or Numeric characters, with the deletion and revisions read into the record as well as the change to attachment D, Section 2 subsection e to read 21 up to 22 years.

Ms. Moffitt – Closed the Public Hearing for the MSM Chapter 400 Mental Health and Alcohol/Substance Abuse Services.

**3. For Possible Action: Discussion and Proposed Adoption of the Institution for Mental Disease (IMD) Survey Form**

Ms. Alexis Tucey:

The purpose of the survey form is to determine if a facility meets the federal guidelines and definition of an IMD. The definition of an IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases are determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

The effective Date is March 1, 2015.

At the conclusion of Ms. Tucey's presentation, Ms. Moffitt asked Ms. Aiello, Deputy Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

Ms. Aiello's Comments:

- No comment

Mr. Faircloth's Comments:

- Under age of population, number one on the form, states does your facility provide services for recipients under the age of 21 should that read age 22.

Ms. Tucey:

- Responded it should be age 21 as defined in MSM Chapter 400, receiving services up to age 21 and prior to turning age 21, therefore clarification under the age of 21 is needed.

Public Comments:

- Mr. Scott Mayne stated he is supportive of the survey form and the questions asked. How the information is utilized and the results of that have been inconsistently applied it seems like across the nation. For example, Kid's Cottage with Washoe County Social Services does emergency shelter care for abused and neglected kids in Washoe County and that is the intent of the facility. They provide services because kids come in with severe issues, being separated or taken away from their parents. They do get therapy services provided on campus and it is one campus. It is understanding how some of this will be applied and I understand there are some caveats and ability for the division to make a decision on whether its intent is a Institution for Mental Disease (IMD). It is making sure we do not roll in facilities like that just because there are over 16 beds and they provide mental health services. Many of the kids have issues that get Psychosocial Rehabilitation (PSR) type services, assessment services, therapy services and could bump up against that 50 percent of the facility getting some kind of treatment either on or off campus. I wanted to express that concern, supportive of the survey and getting the information. It is just how it will be used and implemented.

- Ms. Tucey replied in response to referencing kids, I do want to re-emphasize the institutions for mental disease is applicable to ages 22-64. When hearing the terminology kids, I am presuming they are under the age of 21 for these recipients. Policy is very specific to that age range of 22-

64. In regards to the concerns on how the information will be utilized, this information is based on the Centers for Medicare/Medicaid Services (CMS) Manual, State Manual, Chapter 4; this form went through CMS staff themselves reviewing the form ensuring the form is in compliance with their policies and guidelines. CMS went through a couple of the initial surveys the DHCFP utilized this for, validated it, what the outcomes became with those surveys that were initially utilized this particular form in process with. Also, CMS extended the opportunity for the DHCFP if there is something that is questionable, extenuating circumstances that do not seem clear-cut to the DHCFP staff reviewing and to take the results to CMS for additional clarification.

- Mr. Mayne asked Ms. Tucey to verify that this is not applicable to kids 21 and under. My understanding is that the state of Utah and Colorado applied this to a program called Rite of Passage (ROP) that receives many kids from the child welfare juvenile justice environment that impacted their ability to provide services within their programs.

- Ms. Tucey replied specifically within the requirements and limits applicable to specific services based off the CMS State Manual, Chapter 4, Section 4390 specific institutions for mental disease, it indicates the public law 92-603 to include inpatient psychiatric services for individuals under age 21 or in certain circumstances under age 22. This is all outlined within CMS State Manual, Chapter 4.

- Ms. Aiello stated that the DHCFP may have to take your question back. There may be other regulations applying. This may not be specific with the form DHCFP is building and deterring whether it is an adult institution, there may be other licensures and services. The DHCFP does not have the ability to answer your question specifically other than the Institutions for Mental Disease (IMD) rule here today.

- Mr. Duarte stated there is a potential conflict and this supports Mr. Mayne's comment where designation of a facility as an IMD, which then moves it into a licensing realm which requires them to be licensed as an IMD i.e., a psychiatric hospital or a hospital and I would not like to see those confusions or conflict occur with this rule and believe that would further limit the number of providers out there in the community. Even though they are serving children for such as if they are designated as IMD, I believe this is a risk that they will be put under a different licensure category.

- Ms. Aiello responded the DHCFP may have to clarify that it is IMD in regards to Medicaid reimbursement, but possibly not for full licensure. At this point we need to use this form to determine whether we are able to reimburse Medicaid funding, it may be a term that is specific to Medicaid verses the state licensure or requirement in state regulation.

Ms. Moffitt – Recommended the Deputy Administrator approve with the corrections discussed.

Ms. Aiello – Approved the IMD Survey Form with directions to staff, to both clarify in the chapter and form directions that this form only indicates guidelines and does not impact any state licensing definitions or requirements.

**4. For Possible Action: Discussion and proposed adoption of changes to MSM Chapter 600 – Physician Services**

Ms. Jenni Bonk:

The Affordable Care Act (ACA) has increased the eligible population covered by Medicaid and placed emphasis on parity for medical and mental health services. After recent guidance from Centers for Medicare & Medicaid Services (CMS), Nevada Medicaid is planning to expand services provided at Federally Qualified Health Clinics (FQHCs). New policy is being proposed to allow providers to be reimbursed for ancillary services (i.e. group therapy for behavioral health issues) which are billed outside the encounter rate at an FQHC. The providers providing non-Health Resources and Services Administration (HRSA) approved ancillary services at FQHCs must be enrolled under the specific provider types for the services they are billing. Billing guidelines will be updated to reflect how to bill for ancillary services. Clarification regarding billing for dental and denture services under an encounter is provided which does not follow the policy for these services outlined in MSM Chapter 1000, Dental.

The existing and proposed FQHC policy would move from the body of Medicaid Services Manual (MSM) Chapter 600 to an Attachment to MSM Chapter 600. The covered and non-covered services provided in an FQHC encounter are further elaborated.

Changing Federally Qualified Health Clinics to Federally Qualified Health Centers.

The effective Date is March 1, 2015.

At the conclusion of Ms. Bonk's presentation, Ms. Moffitt asked Ms. Aiello, Deputy Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

Ms. Aiello:

- Asked for clarification, under the encounter rate it reads as Optician (including dispensing of eyeglasses) but under non-covered services it lists eyeglasses. This may be confusing to others.

Ms. Bonk:

- Replied I will clarify if that is referring to dispensing of the eyeglass versus the actual eyeglasses.

Public Comments:

- Mr. Duarte, on behalf of National Alliance on Mental Illness, Nevada (NAMI) as a board member, we appreciate the effort to allow FQHCs to bill for services not typically covered by an encounter particularly group therapy. NAMI national has a part of its policy platform providing integrated care, including primary medical and behavioral health services settings like FQHCs. We are making every effort at Community Health Alliance (CHA) to do that and stay consistent with the goals of NAMI, to have the ability to provide group therapy which is the most efficient way of providing mental health treatment where appropriate. Thank you for allowing us to bill that outside the encounter rate.

  I appreciate the addition of encounter rates for radiology and lab services. These will go a long way to help us support those services in our health center and elsewhere throughout the state.

I do not have an answer on Optician services, except I would agree that the eyeglasses themselves probably are not included in the encounter, but the Optician services should be so the actual service by the health professional should be part of the encounter and the eyeglasses should not.

Last comment is under Health Services, Section B, Non-covered services under a FQHC encounter, I believe the exclusion from the encounter of preventive dental disease services would have a deleterious effect on dental hygiene programs for children. In Washoe County we were estimating a reduction of about 30 percent of our ability to serve the kids in Washoe County school district. We provide hygiene services to all second graders throughout the school district. We visit 22 schools each year and it will impact that as well as preventive dental services in our Wells Medical/Dental center. We are currently the largest provider of primary dental care and this is an important component. Those programs lose thousands of dollars every month and we need to be supported by grant and charitable donations. There is loss of potential revenue here for preventive dental services throughout our organization. This could further reduce our ability to serve the community. We ask that the DHCFP keep that in place. In a previous discussion with Ms. Aiello prior to the hearing there was a suggestion of adding language so that non-covered would include only for adults and that it would be limited. I think one thing that should be considered is that Medicaid supported a policy previously of allowing dental hygiene services for pregnant women over the age of 21. There was a lot of research to support that as a means of preventing pre term birth, which is very costly. If there are going to be any limits for adults that you exclude pregnant women from those limitations.

- Ms. Aiello recommended removing number four under Policy #06-17 B (Preventive Dental Services) because we cover preventive services as we cover Medicaid and do not cover them for over adult. I believe it will not be allowed to be billable outside the encounter rate because it is not covered for adults and the intention of these non-covered services was to identify clearly what could be billed outside the encounter rate.

  Also, under Optician, including dispensing of eyeglasses should be removed and leave eyeglasses if they truly are excluded, but if the policy is truly FQHC under the encounter rates and supposed to include the eyeglasses Ms. Aiello asked Ms. Bonk and Ms. Coté to clarify before finalizing the chapter.

- Ms. Bonk responded my understanding is that Optician services are allowed and eyeglasses are outside the encounter.

- Mr. Faircloth asked are you saying the eyeglasses are covered under a separate policy and somebody else will bill for them.

- Ms. Bonk responded the Optician would be able to bill outside of FQHCs and would have to use that provider type, not the 17, but the FQHC provider type. They could bill for the eyeglasses under their Optician provider type.

- Ms. Aiello stated we do not need the language including dispensing of eyeglasses as this falls into the Opticians scope of practice.

- Ms. Bonk replied the key word there would be dispensing and by removing that there is no confusion.

- I thank you for making those revisions and clarifications. The way that we bill for those services are as you described. Even if we are billing for an encounter, we only bill an encounter where the recipient is eligible for those services. For example, if it is an adult male or a non-pregnant person we do not bill for preventive or restorative services because it is not a covered benefit under other sections of the MSM. We have to use both our own regulations but also understand covered and non-covered in sections of the MSM under non-covered services for a FQHC encounter. If we enroll as the correct Behavioral Health provider type, then we will be able to bill for Fee-for-Service for group therapy.

- Ms. Bonk responded that is correct and stated Ms. Coté confirmed eyeglasses do belong in the non-covered services under FQHC encounter.

Ms. Moffitt – Recommended the Deputy Administrator approve with the corrections discussed.

Ms. Aiello – I approve Chapter 600 with the changes submitted, rewording clinics to centers, adding alpha/numeric characters for the headings as well as character in front of each section listed under authority that would fall appropriately, changing the bullet points to the appropriate numbers, in Section A.1.m removing the parenthesis and words within after the word Optician, removing number four and renumber as appropriate in Section B.

Ms. Moffitt – Closed the Public Hearing for the MSM Chapter 600 Physician Services.

**5. For Possible Action: Discussion and proposed adoption of changes to MSM Chapter 2500 Case Management**

Ms. Alexis Tucey

Revisions to MSM Chapter 2500 are being proposed to clarify that qualified providers who are employees or contractors of the state may provide Targeted Case Management (TCM) services to the Seriously Mentally Ill (SMI) population. This will be done in accordance with State Plan section 1915(g).

The effective date is March 1, 2015.

At the conclusion of Ms. Tucey's presentation, Ms. Moffitt asked Ms. Aiello, Deputy Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

Ms. Aiello’s Comments:

- No comment

Mr. Faircloth’s Comments:

- No comment

Public Comments:

- Mr. Jason Schwartz stated TCM through Mohave is billed through Nevada System of Higher Education (NSHE) and not directly through University of Nevada School of Medicine (UNSOM). With a development of another school in Las Vegas and some discussion of expansion of TCM through that school I was wondering if it might not be NSHE expedient to add language to say in addition to University Nevada School of Medicine or NSHE entities such that we are not withheld from expanding these services. Additionally we do not want the state to be in a crisis situation similar to 1992, such that if the current school of medicine decides to withdraw direct service support and maintain only physician provided psychiatric services we would want an alternative to continue to provide behavioral health services to the thousands of people that are currently receiving them through Mohave. My suggestion is to add a phrase, NSHE entity, or provider as opposed to limitation to the Nevada University School of Medicine given that the new school of Medicine will have a different name etc. If an entity is providing targeting case management as a contractor of the state of Nevada what will be the reimbursement rate, will it be based on cost based reimbursement, what is the calculation of cost based for that reimbursement, and if it is cost based reimbursement will it include both the State Medicaid and federal match or would it be limited to the federal match if it was to a state contractor.

- Ms. Tucey responded unfortunately, I am not able to discuss the reimbursement as that is something that is handled through our Rates unit, I would not be able to give you the methodology in which that is determined. The DHCFP can take it back and follow up with the rates unit for that type of determination in regards to how that rate methodology is determined.

- Ms. Aiello commented regarding your first comment expanding to NSHE, the DHCFP will take that back because we can review it in the next month or two and evaluate further the implications of how that would be worked out.

- Ms. Brandy Johnson stated the specifics related to the reimbursement methodology or the process will be contained in that contractual language. There is a contract requirement and/or employee situation so in the employee situation it will be billed through the state entity and in the event of a contract the specifics related to the reimbursement methodology will be contained in that contract and are actually more so the property of the Division of Public and Behavioral Health (DPBH) versus Medicaid. This is a path pass through type of service therefore the rates are set or outlined in coordination with that contract language. The specific provider agreement that has been approved through Department of Education (DOE) Board of Examiners that allows for the addition in a contractual relationship with the TCM provider and has the language specific where the rates can be found and what the agreement and process responsibilities are of that contracted entity and/or person.

- Mr. Faircloth stated it is my understanding that the attempt here was simply to clarify that the coverage is to include those employees and contractors that are affiliated with that particular agency. In terms of other changes within the University of School of Medicine, UNSOM or NSHE, it is unclear at this point whether that falls within the definition of an organization affiliated with UNSOM as it currently reads. It is also unclear as to whether this will change in any way the rate structure that is in place. To my knowledge, your intent today was not to make any changes with regards to the rates that are in place, so unfortunately I cannot say whether we should make any further changes at this point and not fully appreciating the reorganization that might be occurring at UNLV or within NSHE perhaps those are things we should take back and take a further look at. I do not see that it makes any impact upon your addition of the language to propose to add today. My suggestion is to pass this today, but take back the good suggestions and concerns that were brought up in Las Vegas and take a look at that rate structure and take a look at in light of changes potentially occurring within NSHE.

- Mr. Michael Howie commented I believe it would give Medicaid a lot more similar options regarding these services if the University Nevada School of Medicine as an affiliate was replaced simply with NSHE and that would allow a lot more diversity and flexibility going forward.

- Ms. Tucey thanked Mr. Howie for his recommendation and stated the DHCFP will take that back and take a look at it. That would also require evaluation of the State Plan Amendment (SPA) to make an additional change with our State Plan as well as Medicaid Services Manual (MSM) to clarify that language.

- Mr. Mayne replied if you take a look at the language in the State Plan the request I would make is to take a look at the same language being attached to other sub groups of case management to allow for contractors for example DCFS or Washoe County Social Services, which is the child welfare program for example Nevada Parents Encouraging Parents (PEP) or the Children's Cabinet in doing case management services for those cases that do not necessarily rise to limited staffing ability of DCFS or Washoe County, abuse and neglect kids, but need this case management activities to keep from escalating in the system and I would also suggest that we expand that State Plan language to allow for the senior population as you look at Washoe County senior services who pays for the county match program and the ability to case manage those individuals before getting to that level through the senior program and potentially using county or other funding as a state match to ensure we keep as many people out of escalating up to either child welfare system or the long-term care system to keep them in the community through case management support without impacting the divisions general fund part of the budget. I do believe that would require some modification to the state plan. I suggest that it is consistent with language already being added and the existing language and recommending today to change the regulations as well.

Ms. Moffitt – Recommended the Deputy Administrator approve Chapter 2500 with the items discussed.

Ms. Aiello – Approved the changes as submitted and stated the DHCFP will follow through and evaluate all the suggestions provided here today.

Ms. Moffitt – Closed the Public Hearing for the Chapter 2500 Case Management.

## 6. General Public Comments

- No Comments

## 7. Adjournment

There were no further comments and Ms. Moffitt adjourned the public hearing at 11:05 A.M.

***An Audio (CD) version of this meeting is available through the DHCFP Administration office. For more detailed information on any of the handouts, submittals, testimony and or comments please contact Rita Mackie at rmackie@dhcfp.nv.gov or you may call (775) 684-3681.***