MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON WAYS AND MEANS
AND THE
SENATE COMMITTEE ON FINANCE
JOINT SUBCOMMITTEE ON K-12/HUMAN RESOURCES

Seventy-Second Session
March 1, 2005

The Assembly Committee on Ways and Means and the Senate Committee on Finance, Joint Subcommittee on K-12/Human Resources, was called to order at 8:05 a.m., on Tuesday, March 1, 2005. Chairman Sheila Leslie presided in Room 3137 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

ASSEMBLY COMMITTEE MEMBERS PRESENT:

Ms. Sheila Leslie, Chairwoman
Mr. Mo Denis
Mrs. Heidi S. Gansert
Ms. Chris Giunchigliani
Mrs. Debbie Smith
Ms. Valerie Weber

SENATE COMMITTEE MEMBERS PRESENT:

Senator Barbara Cegavske, Chairwoman
Senator Bernice Mathews
Senator William J. Raggio
Senator Dina Titus

COMMITTEE MEMBERS ABSENT:

None

STAFF MEMBERS PRESENT:

Steve Abba, Principal Deputy Fiscal Analyst
Gary Ghiggeri, Senate Fiscal Analyst
Lila Clark, Recording Committee Secretary
Connie Davis, Committee Secretary

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY- BUDGET ACCOUNT 101-3158 - BUDGET PAGE HCF&P-1

Charles Duarte, Administrator, Division of Health Care Financing and Policy (HCF&P), Department of Human Resources, identified himself for the record and introduced Mary Wherry, Deputy Administrator, Division of Health Care Financing and Policy, and Patrick Cates, Administrative Services Office IV, Division of Health Care Financing and Policy.

Mr. Duarte began his presentation with an overview of Exhibit B, "Budget Presentation to Senate Finance/Assembly Ways and Means Joint Subcommittee on Human Resources."

Mr. Duarte stated that he wanted to proceed with his presentation by discussing each of the budget accounts listed on the Agenda, but focus primarily on Administration, the Medicaid budget, and the Nevada Check Up budget. Mr. Duarte stated that as a component of the Administrative budget he would be discussing staffing and mandatory programs. There would be many issues regarding Budget Account 3243, the Medicaid budget, according to Mr. Duarte.

With respect to Nevada Check Up, Mr. Duarte said he wanted to cover not only Budget Account 3178, but also the Health Insurance Flexibility and Accountability (HIFA), Budget Account 3155. Mr. Duarte indicated he would also be presenting information regarding the Medicaid management information system, an update on Information Technology (IT), national Medicaid reform, and home and community based waiver services.

Mr. Duarte noted that page 1 of Exhibit B provided a general outline of the organization and the specific units that operated within the Division, including accounting and budget, rates and cost containment, business lines for managed care, Medicaid services, continuum of care, home and community based services, services for children, and program services which dealt with an array of Medicaid program services including pharmacy and behavioral health.

Mr. Duarte explained that page 3 of Exhibit B contained a chart which displayed the breakdown of General Funds by Division.

Page 4 of Exhibit B displayed the administrative component of Budget Account 3243, the Medicaid budget. Mr. Duarte pointed out that Administration costs accounted for only 6 percent of the overall budget.

Page 5 of Exhibit B contained a chart which showed the Division's expenditures in 2004 by provider type. Mr. Duarte said items of interest outlined in the chart were the expenditures in the area of pharmacy, hospital, long-term care, Health Maintenance Organizations (HMO) managed care services, and home and community based services.

Mr. Duarte indicated that the chart on page 6 of Exhibit B illustrated some important points. The chart illustrated the Temporary Aid for Needy Families (TANF) program, and the Children's Health Assurance Program (CHAP). While those two programs made up 69 percent of the overall caseload, they consumed only 30 percent of the budget. According to Mr. Duarte, the Aged, Blind, and Disabled Programs made up about 28 percent of the caseload but represented over 68 percent of the expenditures.

Page 7 of Exhibit B contained a chart divided by provider type for the Nevada Check Up Program. Mr. Duarte explained that the chart was distinctly different from the prior Medicaid chart because the majority of expenditures on that chart were for managed care. The majority of the children in the Nevada Check Up Program received their care through managed care organizations. Mr. Duarte noted that there were managed care organizations operating in both Washoe County and Clark County.

Mr. Duarte referred to page 8 of Exhibit B, which showed the percentage of administrative costs associated with Nevada Check Up, approximately 6 percent of total expenditures.

Page 9 of Exhibit B provided a summary of the Division's budget accounts as well as the Division's requests for the upcoming biennium. The Division was requesting $836 million in General Funds for FY2005-07, which represented an approximate increase of $184 million, or 28 percent, over the 2003 session.

Mr. Duarte stated additional staff were also being requested. Most of the staff requests were associated with caseload growth in the Division's district offices and dealt with case management and the waiver program. The net change for the biennium was an increase of 38 positions.

Mr. Duarte explained that Budget Account 3158, the Administration budget account, included administration accounting, budget, rate development, personnel, cost containment, policy compliance, surveillance utilization review, privacy and recipient rights, provider enrollment, and information technology. Mr. Duarte stated that the Division was requesting 12 additional Full-Time Equivalent (FTE) positions. Some of the positions related to caseload growth, some related to new mandatory programs, and some were at the Division's request.

Mr. Duarte directed the Committee members to page 17 of the Budget Presentation which outlined the positions the Division was requesting. In Budget Account 3158 there were five requested positions associated with caseload growth, and four positions associated with the federal mandate called the Payment Error Rate Measurement (PERM) Program.

Mr. Duarte explained that in Budget Account 3243, the Division was requesting a number of positions. Most of the positions were associated with caseload growth and actually related to the home and community based waiver programs. Two of the positions were being requested for the Nevada Check Up Program.

Chairwoman Leslie asked why the Division needed two management analysts in Decision Unit M-200 of Budget Account 3158, and also asked if the Division prioritized the positions in the event they were not all funded.

Mr. Duarte said he would provide a priority list. He also explained that Exhibit B, pages 18 through 27, contained a narrative associated with each of the positions and the justification for each position. He further explained that some of the positions were federal mandates. Mr. Duarte said there were positions associated with new regulatory processes, such as PERM.

Chairwoman Leslie asked about the Management Analyst IV position requested in Budget Account 3158, and requested an explanation as to why the Division needed another supervisor at that level.

Mr. Duarte stated that the Rates and Costs Containment Unit had a growing level of responsibility and complexity because of the methodologies that they had to implement in order to set appropriate rates. The Division wanted to expand the Unit's ability to manage professional rates associated with physicians and other types of professional service providers. The methodologies associated with those types of rates were fairly complex, and they were getting more complex. For example, according to Mr. Duarte, Medicare had recently

enacted quality improvement initiatives that were part of physician reimbursement. Mr. Duarte stated it was essential that the Division addressed expertise and professional supervision in the Rates and Cost Containment Unit.

Assemblyman Denis noted that currently the workload for computer technicians was approximately 130 computers per technician and the Division had requested the ratio be reduced to 60 computers per technician. He wondered if that was correct.

Mr. Duarte referred to Exhibit B, page 96, and informed the Subcommittee that the chart explained the DHCFP information technology network.

Mr. Denis asked where the two new requested positions would be located.

Mr. Duarte stated those two positions would be located in the Division's central office at 1100 East William Street, Carson City.

Mr. Denis asked how the Division determined where IT staff was deployed.

Mr. Duarte responded that the Division's primary IT staffing was located in the central office. Most of their servers were either within the facility or housed at the Department of Information Technology (DoIT) server farm. The Division had district offices in Reno, Fallon, Carson City, Elko, and Las Vegas, and employees commuted to those sites to do maintenance and repair work when necessary.

Mr. Denis asked if the Division had IT employees stationed in Las Vegas and Mr. Duarte answered that they did not. Mr. Denis then asked how many PCs the Division had in Las Vegas, and Mr. Duarte answered 45.

Mr. Denis expressed his concern for the cost to fly a technician to Las Vegas to effect a repair. Mr. Duarte explained that most of the Division's work was actually done remotely and most of the work orders that were submitted to the IT office could be handled on-site from a remote location. There were situations where installation and repair were physically required, but more frequently problems could be handled from a remote location.

Mr. Denis suggested that when the Division had enough PCs in one location they should consider placing an IT technician at that location.

Chairwoman Leslie asked why the Division needed the positions requested in Decision Unit M-502 for the implementation of the Medicare and Medicaid Information Services (MMIS). She wondered if the workload had increased and asked why they needed to monitor the fiscal agent more carefully.

Mr. Duarte explained that what the Division had done with their Management Information System was to develop a finer level of detail with respect to their accounting transactions and had begun to monitor those transactions more closely. He deferred to Patrick Cates to explain why the Division believed those positions were important.

Chairwoman Leslie asked if a cost savings would be realized by funding the two positions.

Patrick Cates, ASO, Division of Health Care Financing and Policy, replied that the two positions the Division had requested were a federal mandate for the Medicare and Medicaid Information Services (MMIS). The positions were to

provide reconciliation of the MMIS system, as well as oversight. The Division had found with the implementation of the MMIS that they had more opportunities and it was prudent to have more responsibility for the oversight of the fiscal agent and the claims payment system. When Anthem Blue Cross/Blue Shield had been the Division's fiscal agent the oversight they provided was at a very high level. In the course of the transition to the MMIS system, the Division discovered many areas that had not been examined that ensured the system paid claims correctly and interfaced with the State's Integrated Financial System (IFS) correctly.

Mr. Cates explained that the Division had a direct interface with the IFS system. The account code structure in the MMIS was much more complex, with a very high level of detail in the system that supplied information that had never been available in the old system. Mr. Cates said that in order to ensure appropriate fiscal control over that system, additional staff was needed. The Division used existing staff to provide much of the oversight but there were many areas that remained unaddressed. Additional staff would provide that oversight.

Chairwoman Leslie asked if there was a cost benefit savings and Mr. Cates replied it would be difficult to quantify a cost benefit savings. He said he was confident with the kind of oversight the Division was working toward, they could detect and prevent errors which should save money, ensure people were paid on time, allow the MMIS to run more efficiently, and reduce complaints dramatically.

Chairwoman Leslie asked if the Division had performed a pilot program with regard to Decision Unit M-503 and, if so, what had been learned.

Mr. Duarte replied that the Division had just employed a staff auditor for the PERM pilot which had begun in October 2004, the beginning of the federal fiscal year. The grant funds associated with the PERM pilot became available in the beginning of calendar year 2005. The Division had used the position to build some of the methodologies needed to do the payment error review that was required under the mandatory program.

Mr. Duarte continued with the presentation and referred the Subcommittee to page 28 of Exhibit B. The PERM program had been implemented for all states and included Medicaid and the State Children's Health Insurance Programs. The program was a requirement of two federal laws, the Improper Payment Information Act of 2002, and the Government Performance Results Act (GPRA). PERM attempted to detect overpayments, underpayments, or incorrect payments. The Division did this through a variety of mechanisms, all of which were labor intensive.

Step one was the review of claims processing. For instance, were the claims paid adjudicated in their information system appropriately, per policy.

Mr. Duarte said step two addressed the medical documentation provided by physicians and other practitioners. Step two involved reviewing medical records to ensure that medical necessity criteria had been met.

Step three addressed the accuracy of the eligibility of the claimant, according to Mr. Duarte. The Welfare Division conducted the eligibility reviews, but the Division had a significant responsibility to ensure that the payments were adjudicated properly in the system, that payments were validated, and that medical reviews were performed.

Mr. Duarte stated the Division would need four FTEs for the process. The four FTEs were two Health Care Coordinators, who conducted the medical reviews, an Administrative Assistant, and an Auditor. The Auditor was primarily responsible for review of claims adjudication; the two Health Care Coordinators were responsible for the review of medical records; and the Administrative Assistant supported the first three by collecting the files, medical records, and other data necessary to perform the reviews. Additionally, a physician, contracted for $50,000, would work with the Division to review medical records and assist in the evaluation of claims.

Mr. Duarte stated the program was quite extensive. The Division received and examined over 2,000 claims per year. The process was lengthy for each claim, as it involved acquiring medical records from the provider. Mr. Duarte said the Division had determined that four positions were justified, but were still concerned that those positions were not enough to do the job mandated and meet the goals established by the PERM. Mr. Duarte noted that sanctions could be received from the federal government if the Division had not appropriately identified payment errors.

Assemblywoman Gansert asked if what the Division did was to ensure billing was accurate and also that the health care was appropriate. Mr. Duarte replied in the affirmative.

Mrs. Gansert asked if there were penalties imposed if the Division discovered payment errors.

Mr. Duarte explained when they found a payment error the provider received training. If it was a billing problem the claim would be denied and funds would be retrieved from the provider. If it appeared to be a pattern, a utilization review was performed. The Division had staff who performed utilization reviews and determined whether or not it was a billing problem, education requirement for the provider, or whether it entailed fraud and abuse and had to be referred to the Medicaid Fraud Control Unit in the Attorney General's Office.

When asked if this was a duplication of effort, Mr. Duarte replied that the Division did believe the federally mandated program duplicated, to some degree, the surveillance utilization review system that was currently in place. However, it was federal law and the Division was required to supply the resources necessary to perform the work.

Chairwoman Leslie inquired about the contract for 20 hours per week of consultant time requested in Decision Unit E-409 and asked if the Division had provided justification for that request. Mr. Duarte stated he would be addressing that decision unit when he explained the HIFA waiver.

Again referring to Budget Account 3158, Chairwoman Leslie inquired about the salary recommendations with regard to the Bureau Chief. She noted that the position was actually listed as a Social Services Chief, but wondered if that was equivalent to a Bureau Chief.

Mr. Duarte responded that Bureau Chief was a term used by the Health Division and was usually a Grade 42. In the HCF&P Division, the position was a Grade 41. He further explained that the justification for the change from the classified service to the unclassified service was a determination made by the Department of Personnel during their review of the unclassified pay structure.

Chairwoman Leslie stated the Subcommittee had found an inconsistency in the Nevada Check Up budget. The Social Services Chief position that was recommended to be placed in the unclassified service was currently the Bureau Chief for Compliance/Surveillance and Utilization Review Subsystem (SURS). Additionally, E-901 proposes the transfer of the Bureau Chief for Nevada Check Up and Medicaid Services, a classified Social Services Chief position, from the Check Up budget to the Administration budget. In the Check Up budget, The Executive Budget recommended placing this position in the unclassified service; however, in Decision Unit E-901 the position remained classified.

Mr. Duarte explained there were two separate transactions involved. The first was to transfer the Unit Chief responsible for Nevada Check Up, as well as the Division's district offices and the Health Insurance for Work Advancement (HIWA) program, to Administration. Mr. Duarte said much of that Unit Chief's time was allocated to separate programs, such as Medicaid, Nevada Check Up, and other administrative activities. The Division believed it would be more efficient to have that position in Budget Account 3158. Chairwoman Leslie asked if both positions would become unclassified and Mr. Duarte replied that they were the same position as it was a transfer. Chairwoman Leslie asked if it was the intent of the Division to make the Unit Chief position unclassified and Mr. Duarte replied that it was.

DEPARTMENT OF HUMAN RESOURCES
HEALTH CARE FINANCING AND POLICY – MEDICAID - TITLE XIX
BUDGET ACCOUNT 101-3243- BUDGET PAGE HCF&P-14

Mr. Duarte continued his presentation with Budget Account 3243, the Medicaid budget. He directed the Subcommittee to page 30 in Exhibit B, regarding Caseload and Cost Per Eligible (CPE). There were two significant decision units in Budget Account 3243 that affected the Medicaid budget and that program, according to Mr. Duarte. The first was Decision Unit M-101, the request for rate increases for inflation, and the second was Decision Unit M-200, the demographic and caseload changes for the upcoming biennium. Both of the accounts were affected by the Medicaid payment projection methodology.

Decision Unit M-101 contained a projected impact of mandatory provider rate increases. Mr. Duarte said the Medicaid program was responsible under federal rule to provide certain levels of increases for certain provider types, specifically, hospice, pharmacy, federally qualified health centers, and other kinds of providers. The Division had a contract for non-emergency transportation which was a managed care contract. The Division was required under federal rule to ensure that the reimbursement rates for those programs were actuarially sound and actuarially certified. Mr. Duarte stated those adjustments took place in Decision Unit M-101. Additionally, if the Division made any rate increases in the current biennium those rate increases were annualized in Decision Unit M 101. Mr. Duarte noted there were substantial General Fund requirements in FY2006-07 associated with Decision Unit M-101; $26 million in FY2006 and $44 million in FY2007.

Chairwoman Leslie asked why the personal care aide (PCA) provider category, which was 8th on the agency's priority list of 10, had been singled out for a rate increase that was not included in The Executive Budget. She stated that it appeared that the Governor had chosen to fund the first three discretionary providers on the priority list and she asked what those first three were.

Mr. Duarte referred to page 43 of Exhibit B which listed discretionary rate increases for providers. The first three providers had received rate increases.

Chairwoman Leslie questioned the fact that the Division had funded the eighth provider, personal care aides, on the priority list and had skipped several providers listed ahead of that category. Mr. Duarte explained there had been a recommendation to increase the personal care aide rates for State plan services and waiver services consistent with the rates that were being provided by the Office of Disability Services and the Division of Aging Services.

Chairwoman Leslie asked whether the rate increase was a consistency matter and if the Office of Disability Services and the Division of Aging Services had not raised their rates, the Division of Health Care, Financing and Policy would not have skipped from fourth to eighth priority and raised the rates for personal care aides. Mr. Duarte concurred with Chairwoman Leslie's assessment.

Chairwoman Leslie noted the Division raised the proposed rate by $1.50 per hour, from $17 to $18.50, and asked how that particular amount had been determined.

Mr. Duarte answered the Division had conducted an analysis of rates for personal care aide services in 2002 through the Strategic Health Plan Rates Task Force. The Rates Task Force discussion considered what was paid for personal care aide services and at that time the rate was $17 per hour. Mr. Duarte said that after discussion and analysis there had been a recommendation to raise the rate.

Chairman Leslie added that during the last biennium the rate had been increased from $14.94 an hour to $17 per hour.

Chairwoman Leslie asked what providers had been skipped over in priorities four, five, six, and seven, to arrive at the eighth priority.

Mr. Duarte directed the Subcommittee to page 48 of Exhibit B. The discretionary rate increases that had been proposed in the Division's budget were listed. Mr. Duarte said those provider types were removed from the priority list because of funding considerations. The dollar amounts provided on page 48 were reflected in total dollars which included federal and state funds. State General Funds were approximately $61 million over the biennium. The largest components were physician services and in-patient hospital services. For physician services, the Division considered 2005 Medicare rates in an attempt to stay consistent with changes in the Medicare program reimbursements in order to maintain access to physician services, particularly specialty services. Mr. Duarte said that for in-patient hospital services the Division considered rebasing rates to 2004 costs and implementing a new methodology in FY2007 to pay hospitals in a manner similar to the way Medicare paid.

Mr. Duarte noted that other components of the rate increase, including PCA services, were shown. Those PCA costs were revised and that information was provided to the Department as part of their request for standardization of PCA rates.

Chairwoman Leslie requested that Mr. Duarte discuss the President's budget, the plan to limit Medicaid reimbursement for pharmaceuticals, and what impact that plan might have on the State budget.

Mr. Duarte explained that the President had proposed, as part of the federal 2006 budget, to change the method in which states purchased pharmaceuticals. Currently most states paid for the ingredients associated with the dispensing of a drug, and for the administration, or fill fee. A majority of the states, in terms of paying for ingredient costs, used something called the average wholesale price (AWP). Mr. Duarte said it was a somewhat deceptive number, because the AWP was not known. It was also not known whether the pharmaceutical manufacturers were providing the best pricing for the Medicaid program. However, in addition to paying the average wholesale price, a rebate was received from the manufacturers. The federal rebates were supposed to help arrive at "net best price" for that drug, according to Mr. Duarte. Essentially, the Division paid the pharmacy the AWP, and deducted a percentage believed to be appropriate, approximately 15 percent. The discount had increased from 10 percent to 15 percent in 2002. Mr. Duarte said most states used a variation of that methodology and paid somewhere between AWP minus 10 percent to AWP minus 17 percent, placing Nevada in alignment with most other states. Other states used wholesale acquisition costs, but essentially it was an average wholesale price.

The federal government had proposed to use something called the average sales price, according to Mr. Duarte. The Division had not seen a lot of detail regarding the proposal, but Mr. Duarte said, as he understood the plan, it entailed a periodic review of the cost of drugs to major retail purchasers. A national survey of those drugs was conducted, particularly those called single source or brand name drugs, to determine what price the large drug purchasers paid in order to use that price as the so-called best price to pay the pharmacies.

Mr. Duarte indicated that the Division had used the plan for many generic products. The program had been called the Maximum Allowable Cost Program, and the Division had surveyed, nationally, the price of specific generic products and set payments based on that cost. Mr. Duarte commented that it had been a big cost saver. Essentially what the President proposed was an expansion of that Maximum Allowable Cost Program. Mr. Duarte said the federal government had conducted a national review of drug pricing and applied it to brand name drugs, single-source brands or multi-source brands. Mr. Duarte said he did not know how the White House had reached their budget savings numbers because the Division had not received much detail.

Chairwoman Leslie asked if Mr. Duarte knew when the plan would be implemented, and Mr. Duarte answered in the President's 2006 federal budget.

Chairwoman Leslie asked what the impact would be for Nevada.

Mr. Duarte answered that potentially costs could be slightly reduced. The Division was performing initiatives that were similar to those the President proposed; Mr. Duarte could not project what cost savings might be accrued from the proposal. He said California had recently implemented the plan and authorities in California had related that the plan had reduced their payments to retail pharmacies and large chains, but the fill fee had to be significantly increased. California had realized a net savings, but had not realized a pure savings from changing to average sales price.

Mr. Duarte said that another concern was that when Medicare entered the pharmacy business there would be a lot of revenue pressure on retail pharmacies because the prices the prescription drug plans paid would probably be much lower than those the Division paid. In return, the retail pharmacies would put pressure on the state to maintain the revenues from the Medicaid program.

Mr. Duarte directed the Subcommittee to Exhibit B, page 30, and discussed Decision Unit M-200, the Division's caseload growth. Mr. Duarte said Decision Unit M-200 was essentially the multiplication of each of the caseloads managed, each of the aide categories, times the cost per eligible associated with that. Both Decision Unit M-101 and Decision Unit M-200 were presented in The Executive Budget, based upon costs and caseloads included in the agency budge request t. That agency request budget was developed in June 2004. Another Medicaid payment projection was performed in December of 2004, and that projection showed a dramatic increase in the costs associated with those two decision units. Mr. Duarte stated that when the Division analyzed the reason for the increase there had been some errors in data that had contributed to dramatic swings in costs per eligible for certain aide categories. That had been compensated for by adjusting those costs per eligible but the result was that both of those decision units in the December analysis had been considerably more expensive.

Mr. Duarte referred the Committee to Exhibit B, page 31, which demonstrated a comparison of the Division's June 2004 changes to Decision Unit M-101 and Decision Unit M-200 versus the changes associated with the December report. There was a $73 million difference in those two decision units associated with the two payment runs. Mr. Duarte explained there would be one more payment run in April, which would be part of the routine practice that the Division performed. The Division usually did one more projection before there was a closure of the budgets, and it was hoped that the costs would come out closer to the agency requests than the December analysis.

Mr. Duarte pointed out that there was the possibility of a significant cost swing from the June request, which was used to build The Executive Budget, and the April run that the Division would do for the Medicaid payment projection. He explained the Division chose the most prudent cost per eligible (CPE) for the December run, but those costs came out significantly different. Mr. Duarte said there had been sufficient concern about the reliability of the data for the December run, and that the Division stayed with the June 2004 Medicaid payment projection. Mr. Duarte explained that he wanted to point out to the Subcommittee that the two projections were significantly different and the Division was hoping to receive a more accurate reading in April.

Chairwoman Leslie commented that it appeared Mr. Duarte was anticipating a significant shortfall. Mr. Duarte replied that the Division was concerned there might be increased costs associated with Decision Unit M-101 and Decision Unit M-200. He said the Division planned to work closely with the fiscal staff at the Legislative Counsel Bureau.

Chairwoman Leslie commented that the Division traditionally used the April projections for closing the budget. Mr. Duarte commented that the April projections usually provided moderate adjustments in CPE and caseload, but there was such a significant difference in the projections it was difficult for the Division to predict what would happen.

Mr. Duarte said it should be pointed out with the June projection, that the caseloads on both fiscal years were higher than the December projection, therefore, the caseloads were higher and the costs were lower, per person, for the June projection. The Division wanted to retain that small buffer of increased caseload, in case there was a problem with caseload projections in the April projection. Mr. Duarte wanted to point out that the caseloads used in The Executive Budget, from the June projections, were higher than the current projections for caseload.

Chairwoman Leslie encouraged Mr. Duarte to work closely with the Fiscal Division staff and he agreed.

Chairwoman Leslie requested that Mr. Duarte review the Waiver for Independent Nevadans Quality Assurance Program (WIN), which had been previously called the Physically Disabled Waiver.

Mr. Duarte directed the Committee to Exhibit B, page 64.

Chairwoman Leslie asked for clarification of whether the Division had requested 20 new positions.

Mr. Duarte said the WIN program was a home and community based waiver for individuals with physical disabilities. He explained, for members new to the Subcommittee, that the Medicaid program, as a part of its core program, provided rehabilitative services. Those were services that restored function, primarily acute medical services. However, in a separate part of the Division's program, long-term care services were provided. Mr. Duarte stated that in the major part of the Medicaid program rehabilitative services were provided. To provide some of the support services for long-term care for individuals that needed such care, the Division was required to have a waiver from the Secretary of Health and Human Services. That waiver allowed the Division to provide the types of home and community based services that people needed to stay out of institutions.

Mr. Duarte continued and said those programs required that a client be at a nursing facility level of care, which was a fairly significant level of disability. Whether those individuals were mentally retarded, developmentally disabled, physically disabled, or aged, the waiver required that the individual must be at a nursing facility level of care. It was a fairly significant level of functional impairment, according to Mr. Duarte. The waiver was specific to individuals with physical disabilities, and the goal of the Division was to keep clients out of costly institutional care. The Division was seeking 97 additional waiver slots for the WIN Program and 16 of those waiver slots were associated with Decision Unit E-455. In the 2001 session, S.B. 174 had passed which required that the Division look at individuals who did not have the ability to perform certain activities of daily living, such as bathing, feeding, and toileting. Mr. Duarte reiterated that those were individuals who had a fairly high level of impairment and priority was given to request slots for those individuals. The Division estimated that approximately 16 slots were needed to meet the needs of those individuals in the waiver. Mr. Duarte said that, additionally, the Division had requested slots associated with meeting the wait list and had estimated that 81 slots would be needed over the biennium. Those were the additional slots requested in Decision Unit E-456.

Mr. Duarte stated there were three FTEs requested between the two decision units. There were also a number of other positions in the district offices associated with case management for those new slots.

Chairwoman Leslie said it appeared as if a total of 241 physically disabled slots were being requested between the two decision units, and Mr. Duarte responded that there were only 97 slots.

Chairwoman Leslie realized the other positions were caseload, and stated that during the last session the caseload had been funded at 37 to 1, and it appeared as if the Division had reduced that ratio to 30 or 33 to 1. Mr. Duarte responded that the case manager to client ratio was 37 to 1.

Chairwoman Leslie commented that in the agency request it stated the ratio at 30 or 33 to 1, which was why she was confused.

Mary Wherry, Deputy Administrator, HCFP, Department of Human Resources, asked if the Chairwoman had a specific citation because the Division had worked under the ratio of 37 to 1 for many years. Chairwoman Leslie said staff would recheck those numbers.

Chairwoman Leslie asked if the new positions were added would there be a savings realized in long-term care.

Mr. Duarte responded in the affirmative and directed the Subcommittee to page 66 of Exhibit B. He said the chart illustrated that despite the increase in the senior population in Nevada, and the increase in the aging caseload in the Medicaid program, the Division had experienced flat caseload numbers in nursing facilities. Between three State agencies that administered the waivers, the Aging Services Division, the Division of Mental Health and Developmental Services, and the Division's waiver staff, flat levels of institution caseloads had been maintained for clients. The other service that had a direct impact on keeping people out of institutions, as well as out of the waivers, was the Personal Care Aide program. Mr. Duarte said both approaches contributed to keeping people out of institutions and maintained the flat caseload numbers in nursing facilities.

Chairwoman Leslie said that was really good news and in a growing state, the fact that the Division was able to keep the caseload numbers flat, demonstrated that the waiver program was working.

Mr. Duarte directed the Subcommittee to page 68 of Exhibit B, which contained a chart entitled "WIN Waiver and Nursing Cost Comparison by Waiver Year." The information presented compared the WIN waiver costs with comparable nursing facility care and demonstrated that waiver costs were dramatically less expensive. He said 2002 had probably been the most accurate, and 2003 had some payment catch-up issues. Mr. Duarte said that the information showed how different the costs were for home and community based care.

Mr. Duarte explained that there were individuals who were referred to as part of the "woodwork effect" and only came into the program because a waiver was offered. That situation was monitored and routinely reported to the Legislative Counsel Bureau Fiscal Analysis Division. Mr. Duarte noted that was but a small component of the overall caseload in the waiver programs. It had always been a question of whether or not those people would end up in nursing facilities anyway if they did not receive some community support through Medicaid.

Chairwoman Leslie commented that she believed the Division was on the right track and she was glad the program had been implemented and would be expanded.

Chairwoman Leslie asked Mr. Duarte to speak about the Medicare Modernization Act (MMA). She said the Subcommittee had projected savings through the "clawback" provision and wanted to be sure the Division was comfortable with that projection. She said the Division had projected $17.8 million and asked if that projection was correct.

Mr. Duarte stated that page 39 of Exhibit B addressed the MMA program. He explained that the Medicare Modernization Act was passed in 2002 by Congress and required that Medicare beneficiaries received a new benefit called Part D. Mr. Duarte said Medicare paid for other services; Part A was hospital insurance; Part B was professional services such as physician services; Part C was managed care; and Part D was the new prescription drug benefit. The federal government had developed a revenue stream and Congress had developed a payment methodology for covering some of the costs that had previously been borne by Medicaid. Mr. Duarte said there were a large number of recipients, approximately 16,091, in the program that received both Medicare coverage and full Medicaid benefits. Those individuals no longer received pharmacy coverage through Medicaid. Mr. Duarte noted that, for the most part, those individuals were either severely disabled or frail elderly, were part of the program, and were heavy users of pharmacy benefits, as well as other services.

Under the MMA program, those individuals received their pharmacy coverage through Medicare. As a part of the payment methodology for the federal bill, states were required to pay some of the savings associated with Medicare taking over the coverage of those individuals. The states would be required to make a "phase down" contribution to the cost of pharmacy care and the Division euphemistically called that contribution the "clawback." In Nevada, the "clawback" contribution affected the 16,000 individuals who were dual-eligible. The "clawback" would begin in January 2006, and Decision Unit M-502 attempted to calculate that amount. Decision Unit M-502 had been developed at a time when the Division had very little information, and Mr. Duarte said he was not very confident about its accuracy. The Division had revised the calculation twice and the Division would provide that information to the Subcommittee, as well as to the Budget Division. He advised the Subcommittee that as soon as the Division knew more about the potential costs, they would provide more information.

Mr. Duarte said the Medicare Modernization Act (MMA) had an impact and the Division estimated that there would be a moderate cost savings and the MMA was budget neutral. Mr. Duarte said he hoped the MMA would not become a cost to the state.

Chairwoman Leslie questioned the fact the Division went from a $17.8 million savings in General Fund to cost neutral, and Mr. Duarte answered that the program could potentially reach the point where it was cost neutral. He said the current estimate was $1 million to $1.5 million less than what had been presented. The Division would not know the full impact until they received more information from the Part D plans in October 2005. In October the Division expected the federal government to provide them with the per-capita expense associated with each of those dual-eligibles. Mr. Duarte explained that the Division was in the process of working with their partners at CMS to

determine who was listed as dual-eligible with each organization in order to reconcile those numbers.

Chairwoman Leslie requested that before Mr. Duarte went on with other aspects of his presentation, he understood that the Committee had to close the budget with the most accurate figures available. She asked that he do what was needed to get the information from Washington in order to close the budget. Chairwoman Leslie said she knew that as details changed adjustments would have to be made.

Mr. Duarte replied he did not want to promise that the program was going to end up with a savings to the state but he would give the Committee the best number he could.

Mr. Duarte continued with his presentation and stated the Division was very concerned about the continuity of care for the beneficiaries they were serving. He explained that a large number of their recipients were heavy utilizers of pharmacy services. Many of them were mentally ill and received many of their prescriptions through Medicaid. Medicaid had a very broad offering of pharmaceuticals and open formulary. While Medicaid had a preferred drug list and prior authorization requirements, it also had an open formulary, and if people needed drugs they got them.

Mr. Duarte referred the Subcommittee to pages 40 and 41 of Exhibit B which outlined options being considered by the Division to ensure that clients would continue to get the kinds of pharmacy benefits that they needed. He urged the Subcommittee to keep in mind that the Medicare program was going to be structured like a commercial health plan and for a large number of Medicare beneficiaries that would be sufficient. Mr. Duarte said that for dual-eligibles, who were heavy utilizers of pharmacy benefits, the plan might not be sufficient. The Division was very concerned that the dual-eligibles continued to get the drugs they needed because Nevada would bear the costs in terms of long-term care and other types of support if clients did not receive needed pharmaceuticals.

Mr. Duarte said the Division had provided the Subcommittee with four options outlined in Exhibit B, and there was also a fifth option that he would address.

Option A showed what the costs would be if non-Part D drugs were covered. There were two categories of drugs that the Medicare program would not cover that Nevada covered. One category was mental health drugs, which included benzodiazepines and barbiturates, needed for some individuals with anxiety issues or with alcohol addiction. The second category was over-the-counter drugs, such as cold and cough preparations, as well as vitamins and minerals. Page 40 of Exhibit B showed the cost of providing coverage for those non-Part D drugs. Mr. Duarte said that taking into consideration the fact that the State would get federal match as well as federal rebates, the estimated cost to provide wraparound coverage for full-benefit dual-eligibles would be $2.2 million.

Mr. Duarte commented that Option B went a little further and showed what Nevada would pay for non-Part D drugs, over-the-counter, barbiturates, benzodiazepines, and co-pays. Those were the out-of-pocket expenses that beneficiaries of the program were currently not paying, but would have to pay under this program. Mr. Duarte said the cost to Nevada of Option B would be approximately $3.5 million.

Option C illustrated what the State, or Medicaid, paid for coverage of non Part D drugs, co-pays, and the cost of the drugs the Part D Medicare plans did not cover. Mr. Duarte explained that the way the Division performed the analysis was by examining commercial formularies and determined that the Part D plans would probably arrive at a cost close to a commercial drug formulary. Mr. Duarte said there were essentially two drugs in each class and Medicaid covered much more than that. Unfortunately, the cost was $14.7 million for Option C, and most of that was General Fund dollars.

Mr. Duarte said the final option would be coordinating through the Senior Rx Program, or having Senior Rx cover all of the wraparound benefits, as well as co-payments. Under this option there would be savings of approximately $6 million. Mr. Duarte noted that the estimates were very rough and there were no guarantees. The way the savings in the plan would occur was that the Senior Rx Program received rebates on some of those non-covered drugs not otherwise received by the state, and some of that rebate revenue could help offset the cost of covering the dual-eligibles.

Mr. Duarte said he wanted to speak about an important plan in terms of the overall care of those beneficiaries who had to deal with multiple health care systems, such as Medicare, Medicaid, and Senior Rx. Those were the Part C programs, managed care programs, associated with Medicare. Mr. Duarte said that while many people had concerns about managed care, for many of the State's beneficiaries, especially those who were dual-eligible and who had very complex health care needs, managed care was better than unmanaged care. If the managed care program could provide comprehensive pharmacy benefits as well as attend to the beneficiaries' overall health care needs, the Division believed that was an appropriate vehicle for seniors to have as an option.

The plan would be cost-effective to the State because the State would not pay for any Part D wraparound, the Medicare program would. The State would contract however, with those Medicare-managed care organizations if they needed to provide home and community based services. Mr. Duarte said there were special types of programs that Medicare offered under the Medicare Modernization Act, called special needs projects. Those entities were specific types of HMOs designed for dual-eligibles. Mr. Duarte commented that the Division understood there were a number of companies that had applied to provide that service in Nevada and the Division would appreciate the opportunity to work with those programs and have those offers available to seniors.

Mr. Duarte said he believed that the benefits associated with those types of options were significant enough that serious consideration should be given during the interim to deal with some of the complexities of budgets, unraveling some of those dollars, and providing the care that was needed through those comprehensive managed care plans. Mr. Duarte again explained that was the fifth option, although it was not listed in the presentation.

Chairwoman Leslie expressed concern regarding the complexities of the different options and the potential costs to the beneficiaries and the State. She wondered how senior Nevadans would determine what option was best for them when the Subcommittee members were confused with the plans.

Mr. Duarte said he understood the concerns and hoped the Division could provide information to the beneficiaries regarding the various options. He noted, however, that there was not much time as enrollment was in November for January, and the Division was very concerned about the quick time line.

Chairwoman Leslie commented that seniors might become revolutionaries once they discovered how difficult it was going to be to procure the drugs they were now receiving and maintain their health care.

Mr. Duarte responded that the Division tried to see the "silver lining." He said the special needs program had the possibility to provide comprehensive care. Currently seniors were having a hard time finding physicians, particularly specialty physicians for both Medicare and Medicaid. Managed care programs had an obligation, by contract, to ensure that those types of services were available. Mr. Duarte said the Division would do their best to explain that to beneficiaries.

Chairwoman Leslie stated that it was difficult to close this budget with any confidence because there were so many unknown factors.

Mr. Duarte agreed and stated that in two specific areas associated with the Medicare Modernization Act, the wraparound services and the "clawback," the Federal Financial Information Services (FFIS) said that states did not have the information they needed to budget. All states had the same problem, Nevada included. The exact costs were not known and probably would not be known until the formularies were released in the fall. The fact that the Nevada Legislature only met once every two years was a big problem as well, according to Mr. Duarte.

Mr. Duarte continued and directed the Subcommittee to page 52 of Exhibit B, the Behavioral Health Redesign. He explained that the redesign had been incorporated in Decision Unit E-402 and it included work that had been accomplished during the last two years with the community, strategic health plan groups, providers, and sister state agencies. Mr. Duarte pointed out that a large amount of work had gone into developing a program initiative that expanded mental health services through the Medicaid program. He said the General Fund impact would be $1 million in FY2006 and $3.2 million in FY2007.

Mr. Duarte said the goals of the overall plan were to increase the number of providers that provided mental health services in the community, increase the availability of wraparound services in the community, develop comprehensive coordination services to keep people in the community, and develop appropriate utilization management processes to ensure that people were receiving the right types of care in the right amount.

Mr. Duarte said goal number one was to increase the number of providers by developing specialty clinics. The Division had expanded qualifications for providers to include marriage and family therapists and licensed clinical social workers, who would be employed or would be consultants to those specialty clinics for behavioral health. The current system only allowed for marriage and family therapists and licensed clinical social workers to provide services under a public agency. Mr. Duarte said specialty clinics would open up the opportunity for private entities with those types of practitioners to provide care in the community. The Division would be able to build a larger provider network.

Mr. Duarte said the second goal was to expand service availability by increasing wraparound services. He said the goal added family support and peer support services to the mix of services available through Medicaid. The Division had considered better coordination of care, not just for children who were seriously emotionally disturbed or individuals who were seriously mentally ill, but also for individuals who had mental illness at a lower level of intensity. The mechanism used to accomplish that would be by contracting with those specialty clinics to provide case management for clients who did not meet the Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) level of care needs.

Goal three was to make sure children who were seriously emotionally disturbed or adults who were seriously mentally ill received targeted case management. Targeted case management was an intensive type of case management that the Division believed was necessary for those individuals with very high levels of need. Targeted case management would be provided by the state agencies, including the Mojave Mental Health Services. Mr. Duarte said the Division was working on a commercial rate for Mojave Mental Health Services with whom they had contact in January 2005. That rate was a significant reduction from the current rate that they received, and the Division would pay them under this methodology. Mojave Mental Health Services had the acumen and experience to provide high-quality services to this population, according to Mr. Duarte. The Division believed it would be a mistake to not allow Mojave Mental Health Services to continue, and to transition some of the targeted case management to other providers at a later date.

Mr. Duarte explained the fourth goal of the Division's initiative was to increase utilization management. He said they had worked with the Division's sister agencies and developed assessment tools so that individuals who had similar levels of need received the appropriate care at the correct level. Mr. Duarte said those types of criteria were established and sister agencies were using them. A level of service grid would be developed for each of those recipients and at each level of care there was a set of services that was appropriate, as well as the frequency and duration of those services. There would also be a prior authorization process and a claims review process in place.

Mr. Duarte directed the Subcommittee to page 54 of Exhibit B where the definition of a behavioral specialty clinic was available. He went on to explain that a behavioral specialty clinic was a public or private entity that contracted with Medicaid and Nevada Check Up to provide a host of outpatient behavioral health services, 24-hour-per-day emergency care services, and screening for recipients considered for admission to inpatient facilities. Mr. Duarte said the Division believed very strongly that those clinics needed to be the gatekeeper for those individuals to prevent unnecessary institutionalization, whether it was in the hospital emergency room or in an acute psychiatric facility.

Senator Cegavske asked Mr. Duarte if the behavioral health specialty clinic would assist with the current hospital emergency room situation in Las Vegas.

Ms. Wherry responded that she did not believe the behavioral specialty clinics would speak to that problem unless the requirement for medical screening was changed. A specialty clinic would not be able to do medical screening for someone with a serious mental illness before they were committed to an institution, as that was a separate issue. Ms. Wherry said she believed that the behavioral specialty clinics had been considered more for children, or people who were not seriously mentally ill and did not need to be committed to an institution. A specialty clinic might be able to perform an intervention in a

crisis situation to stabilize the immediate problem and schedule an appointment for normal office hours. Ms. Wherry commented that the clinics would be geared toward children.

Mr. Duarte stated that the Division had determined that more community based services were badly needed and the behavioral health specialty clinic concept would provide a complete range of community based services, as well as expanded capacity. He said that people who had been in an acute psychiatric facility or situation, and had been released, would have a larger array of providers in the community to maintain their stability. Those people would not have to rely on hospital emergency rooms as their point of access to care.

Assemblywoman Smith asked why all mental health services were not under one budget. She said it appeared very piecemeal to her, and wondered why mental health services were not more centralized.

Mr. Duarte replied that other State agencies had other missions. The Division of Health Care Financing and Policy operated the Medicaid Program and one of their missions was to provide mental health services. The Division also supported other State agencies by providing federal funds to help support the care those agencies provided to some Medicare recipients.

Mr. Duarte noted that most of the care provided by other State agencies, particularly in the mental health and developmental services, was to individuals who were not Medicaid eligible.

Mrs. Smith asked if Mr. Duarte was certain the system was the most cost-effective and efficient. Mr. Duarte said he understood Assemblywoman Smith's concerns, but the Division had an obligation to provide services to Medicaid recipients and that was what they were attempting to do. There was a dearth of providers statewide to serve the needs of the clients that the Division was responsible for, as well as the clients that the Mental Health and Developmental Services (MHDS) and the Division of Child and Family Services (DCFS) served. Mr. Duarte stated that the Division was helping to enhance the community's capacity to care for children and adults. If the Division could provide a revenue stream to help support the development of specialty clinics, perhaps those clinics would be able to help clients who were not Medicaid eligible.

Mrs. Smith commented that she was not challenging the system, or the Division of Health Care Financing and Policy; she was attempting to make some sense of a complex system.

Chairwoman Leslie commented that she believed the program was absolutely the correct way to proceed, both from a cost perspective and the Division's establishment of goals.

Chairwoman Leslie commented that it appeared as if a 20 percent "woodwork" effect had been built into the budget. She said she was convinced that there were people who were not currently being served, and wondered what the Division was basing the 20 percent figure upon.

Ms. Wherry responded that the Division had worked with their sister agencies to examine their projections because they were responsible for the mental health delivery systems. Those sister agency projections were of uncovered services, mainly based on waiting list situations. The DCFS had performed a survey, for

instance, with the school districts, teachers, and other school employees, to investigate how many students had mental health issues, considered how many were receiving care, and what the difference was. The Division had also worked with some of the information that had been used by the local consortia.

Ms. Wherry said there were many clients who could go from being a State employee covered by the Public Employees' Benefits Program (PEBP), for example, and then be unemployed and go to Nevada Check Up, and then to Medicaid. The Division wanted to become just one more funding stream, as any other commercial payer would be, so that when clients transitioned from one type of insurance company to another or from one type of payer source to another, they could still access the same provider or type of provider.

Chairwoman Leslie stated that ideally it would be the same provider.

Ms. Wherry said another way the Division had estimated how many people were not served was by investigating the number of recipients currently being served by psychologists.

Chairwoman Leslie inquired about services and said that area was confusing to her. Chairwoman Leslie referred to page 56 of Exhibit B under the heading of "Funding for Specialty Clinic Model," and said it appeared as if the Division had budgeted for two services per year in the first year, knowing that the start date was January 2006 and four services in the next year of the biennium. Chairwoman Leslie requested a definition of what "service" meant.

Ms. Wherry responded and referred to page 60 of Exhibit B, which outlined the level of care used by the Division. The page was entitled "Medicaid Behavioral Health Level of Service (LOS) System for Children and Adolescence." Ms. Wherry said by using the screening tool the identified recipient was designated as having a level of care need. If the recipient was at a level one, they would need basic services, such as 1 annual assessment and a total of 10 sessions per year for individual or family therapy.

Chairwoman Leslie asked if therapy sessions would be considered a service and Ms. Wherry replied that was correct.

Ms. Wherry continued and explained that the program would also allow 6 sessions of medication management, 4 care coordination services, and 4 family support services, which was the new service proposed under the mental health rehabilitation option. Ms. Wherry noted that the service was built into the program so the Division would not have to perform utilization management, which was a very expensive process and would be an absolute cap. If a recipient needed to have more than 10 sessions of therapy, for example, they could move to level two which would automatically provide a higher level of service.

Chairwoman Leslie commented that the movement within the levels was logical and made sense.

Chairwoman Leslie noted that two new services under the Mental Health Rehabilitation option were peer support and family support. The budget included 5,000 hours for each service at $22.50 per hour. Chairwoman Leslie wondered how that calculation had been arrived at.

Ms. Wherry responded that during the first year or so the Division believed there would be a slow growth in awareness of how people could actually use those services. There had been recent interest in opportunities for family support. Ms. Wherry said the Division was looking at FY2007 as a trial year for deciding how those services might ultimately be utilized. The Division would require that in order for someone to provide peer support or family support and bill Medicaid, they would have to go through a therapist to be certified that they were healthy enough to engage a peer or family member in the recovery process.

Chairwoman Leslie commended the Division for their progressive stance regarding mental health care.

Ms. Wherry noted that in some national conferences she had attended there were some peer wraparound services for recipients in other states. She believed Nevada was close to the "cutting edge" in that area.

Chairwoman Leslie commented that she believed the Division was pursuing the correct path and complimented them on good planning.

Assemblyman Denis asked if family support was a concept other states were pursuing.

Ms. Wherry replied that other states offered family support but often it was only for alcohol treatment where it was used in a recovery model. Family support was usually limited to states that received Substance Abuse and Mental Health Services Administration (SAMHSA) grants from the federal government. Ms. Wherry said that over the past eight years SAMHSA had given a number of grants to states to develop the wraparound system of care models for children and adolescents, and it was primarily those states that had begun to embrace the peer and family support services.

Mr. Denis asked if family support was limited to families with children and adolescents.

Ms. Wherry replied that what the Division envisioned was that if someone was seriously mentally ill and had been diagnosed in their late adolescence or early adulthood, and that family was struggling with their role in dealing with someone seriously mentally ill, it would be a less expensive and healthier intervention to offer a recovered family the opportunity to work with that family on dealing with their now-diagnosed person. Often families listened to other families more than they listened to a professional therapist.

Mr. Denis said he believed it was a wonderful program because often it cost more for care because families just gave up. It was very difficult to deal with a mentally ill family member. He said whatever could be done to encourage peer and family support would not only provide better care, but cost less in the long run.

Mr. Duarte referred to page 70 of Exhibit B, which outlined basic information on what was and was not provided for Traumatic Brain Injury (TBI). Mr. Duarte said the Division primarily provided rehabilitative services for TBI through the Comprehensive Outpatient Rehabilitation Program. What was lacking were specific services to support individuals who had TBI and needed long-term care, according to Mr. Duarte. The Division had requested an additional 45 waiver slots for the physical disabilities waiver to deal with TBI clients and to provide a set number of services such as, residential habilitation, behavioral adult day

care, and waiver case management for the slots. Those were services that were long-term in nature and currently not provided through the regular Medicaid Program. Mr. Duarte said that type of service was offered through the Office of Disability Services, however, they provided rehabilitative services just like the regular Medicaid Program and not long-term care services. Additionally, the office only served non-Medicaid clients. Mr. Duarte stated that in order to provide those types of services they had to be procured through a waiver.

Chairwoman Leslie asked for clarification if the requested items on page 70 of Exhibit B were included in the budget, and Mr. Duarte responded that they were not.

Mr. Duarte explained that individuals who were physically disabled but were TBI as well were being served through physical disabilities waivers, but the Division was attempting specifically to add those services to that waiver. Those services would be additional to the physical disabilities waiver.

Chairwoman Leslie asked what the budget impact would be. Mr. Duarte stated that page 71 of Exhibit B explained the cost.

Mr. Duarte commented that there had been a lot of discussion about children and adolescents with autism, and what was being provided by public programs. Medicaid provided services to individuals with autism and those services were explained on page 71 of Exhibit B. Mr. Duarte said, additionally, the Mental Retardation and Related Conditions (MRRC) waiver provided an array of services.

Mr. Duarte said what was lacking from those programs were specific autism services. Some of those services were provided through the early intervention programs, but not in Medicaid. In 2002, the Centers for Medicare and Medicaid Services (CMS) instituted guidelines that required states that wanted to provide those types of behavioral therapies to include them in a home and community based waiver. At that time they had been deemed habilitative or long-term in nature.

Chairwoman Leslie asked what the cost would be of adding those services. Mr. Duarte said the Division had not provided those costs, but had requested that when Mental Health and Developmental Services (MHDS) made their presentation for Developmental Services, that they speak to that issue.

Senator Titus said she had been at a meeting recently in Douglas County where the subject of autistic children had been raised. Some of the mothers of autistic children at the meeting had been willing to bring their children to a legislative hearing because it was believed that few people had a clear idea of what it was really like to raise an autistic child.

Chairwoman Leslie commented that last session a woman had come before the Legislature with a small child with autism and had testified how important it was to receive those services in the first three years of life because, if those children did not receive those services early, the opportunity for improvement was lost. Chairwoman Leslie noted that the Subcommittee had refused funding because of lack of funds.

Mr. Duarte addressed the Medicaid Management Information System (MMIS) and the Information Technology (IT) system and noted that the Division's findings, which were currently being corroborated by independent review, were

that there were many problems in the first three months of the program. The Division had worked to resolve most of those issues, but there were still problems with some claims payments. Page 91 of Exhibit B illustrated the increasing claims dollars being paid.

Mr. Duarte said that while there were still issues, he believed the Division had tackled the majority of the major claims problems. There were some challenges ahead, such as changes on the federal level, which would affect Medicaid in the next biennium. There was a recent requirement that all providers switch to national provider identification, which would result in significant changes to the provider's information systems. Mr. Duarte said there was another federal initiative to consolidate "crossover claims." Those were claims paid first by Medicare and secondly by Medicaid. Those types of claims had been significantly problematic for the Division, which paid second to the provider. There was an initiative at the federal level to consolidate those crossover claims payments into one national program.

Chairwoman Leslie commented that she believed the Subcommittee appreciated the difficulties the Division had and the hard work that was required to resolve those difficulties.

Chairwoman Leslie inquired as to whether the Division was still on schedule for the system certification from the federal government due in April 2005. Mr. Duarte said the Division was hoping for a certification visit from CMS to review the system, and the goal was to have the certification complete by the end of June 2005.

Robert Desruisseaux, representing the Northern Nevada Center for Independent Living (NNCIL), and the chairman of the Strategic Planning Accountability Committee (SPAC) for People with Disabilities, introduced himself for the record. Mr. Desruisseaux stated that through his association with SPAC, they had identified traumatic brain injury services, both long-term and community based, as a priority to address the needs of the Traumatic Brain Injury (TBI) community.

Mr. Desruisseaux said he would not spend much time on that because he wanted the Subcommittee to hear the stories from individuals and families who were both providing services and in need of those services.

Mr. Desruisseaux noted that he was before the Subcommittee in a third capacity, which was to fulfill a promise to his friend, Boyd, who could not appear today, but several of Boyd's friends were present. Mr. Desruisseaux said he had met Boyd approximately seven years before, while working at the NNCIL. A small musical group, or class, had been started and Boyd had been one of the initial members of that group. That musical group had moved on and become their own nonprofit group and they performed throughout the community. Boyd had been injured in 1989 and had significant physical disabilities in the beginning, but his rehabilitation had carried him through that part of his recovery. Mr. Desruisseaux said that by the time he had met Boyd he seemed like a very highly functional individual and if Boyd had not told him he was a survivor of TBI, he never would have known.

Mr. Desruisseaux said that information was significant because it led to the issues and problems that Boyd was having today. Most people who met Boyd had the same impression and did not see the difficulties he had on a daily basis. Nothing about Boyd would lead one to believe that he had TBI. Over the years

that Mr. Desruisseaux had known Boyd, he had seen him in the musical group and Boyd had appeared to be a mentor to others in the group. Boyd had no immediate family in the area and therefore no family support in the area. Boyd did have a brother who lived in the Midwest.

Approximately six months ago, Mr. Desruisseaux had been contacted by Boyd and a few of his friends to see if he could assist with a problem Boyd was having with his home. Boyd had lived in his home for approximately six or seven years and his bills were paid by his brother in the Midwest. While he was basically on his own, the finances were being taken care of by his brother. Boyd continued to have severe difficulty in decision making, deciding what was important and what was not, and taking action.

Mr. Desruisseaux said Boyd also had difficulty in dealing with repairs to his home. Because of the perception that Boyd "had it together" he was reluctant to ask for help. He wanted to be perceived as someone who did not need help. Mr. Desruisseaux said Boyd's home had come to the point where it was no longer safe because of water damage, rodent damage, and mold. Approximately six months ago, Boyd had to move out of his home and into the home of friends until he could save enough money to rent his own apartment. Mr. Desruisseaux said all of Boyd's friends were asking themselves what was next, how long would it be before Boyd lost this home.

Mr. Desruisseaux said that as an advocate at the Center for Independent Living, there was only so much that could be done to help Boyd, as the CIL was not a long-term, case management agency. Mr. Desruisseaux said the CIL had provided training to Boyd and met with him on a weekly basis, but at some point the responsibility would have to return to Boyd. Mr. Desruisseaux said the reason he was before the Subcommittee was to try to ensure that there would be some long-term services to meet the needs of the TBI community.

Chairwoman Leslie stated that she believed Boyd's story illustrated the needs of individuals with TBI very well. She asked if Boyd would have been eligible for one of the 45 slots that had been requested by the Division of Health Care Financing and Policy.

Mr. Desruisseaux replied that Boyd would probably not have been eligible because he would not have met the level of care because he only needed a small amount of help in order to succeed.

Chairwoman Leslie commented that it was unfortunate that more could not be done for those who only needed a small amount of help to live a productive life.

Assemblywoman Giunchigliani noted that in 1991 the Legislature had passed a law that had created the Office of Ombudsman for Aging Persons, exactly for the purpose of aiding seniors still in their homes who needed a little help with chores, such as getting to the grocery store, or understanding a new billing process. The Aging Services Division had done a wonderful job of expanding the program statewide, according to Ms. Giunchigliani. She wondered if something of that nature would work for people with TBI and other disabilities to help them remain in their homes.

Chairwoman Leslie agreed and stated she would like to explore that possibility as well. She said she believed it could be very cost-effective and would really help people like Boyd.

Vince Piersanti, private citizen, identified himself for the record and briefly testified regarding the need for a program to aid people like him who needed minimal help in their homes in order to remain as independent as possible.

Chairwoman Leslie thanked Mr. Piersanti for his courageous testimony and said it would be remembered.

Jennifer Pira, private citizen, identified herself, and read the following testimony into the record:

> My name is Jennifer Pira. I am here today on behalf of my brother, Tim Lane, who is a 50-year-old man who sustained a closed head injury in 1983 in Florida in an automobile accident and was comatose for 10 days. After regaining consciousness, he had the chance to be rehabilitated, which took several months.
>
> Some six months after, Tim was diagnosed with seizure disorder and had a slight speech impediment and severe short memory loss, but was able to reenter the workforce. For the next 20 years took anti-seizure medication and had maybe a total of nine seizure episodes in that time frame. Tim was a bachelor living on his own and around 12 years ago he came to northern Nevada to live and work. After seven years he was unable to function due to disabilities caused by cumulative behavior and depression and moved in and lived with me and my family.
>
> In August of 2003, Tim had a grand mal seizure. I found him in his room and he was rushed to Washoe Medical Center in Reno where he remained for 30 days. From there he was sent by Medicaid to a skilled nursing home in Provo, Utah, as there were no beds available in Nevada, his home state. After 7 falls, 2 sets of stitches in his head, and emergency brain surgery from falling from his bed, I was able to get him moved to another nursing home in Salt Lake City where Tim continued to be administered 19 psychotropic drugs due to his behavioral problems. With much effort we were lucky to get him accepted into the Nevada Community Enrichment Program (N.C.E.P.) in Las Vegas on September 29, 2004, where he now resides with high hopes that he can reenter the community after rehabilitation.
>
> This has been very hard on our family with Tim being out of state, but the saddest thing is that if Tim had had the community programs available to him through these many years of struggle and depression, he more than likely would not be where he is today.
>
> All of the Traumatic Brain Injury (TBI) patients, their families, and advocates that are here to speak today are in need of having community help in daily living so that they can remain active in the community and continue to flourish each at their own individual level as TBI has such a broad range of afflictions, challenges, and issues with not absolute definitive diagnosis.
>
> We ask the Subcommittee to help in assisting these people to remain on their own through funded assistance providing them with helpful life skills through the community so there will be less

> chance of them becoming overwhelmed or experiencing depression and regression, ending up like my brother, Tim, back to square one in a skilled nursing home or group home, lost in the system, where striving for a quality of life is a daily challenge.

Fred Inman, private citizen, identified himself and testified regarding his son, Craig, a victim of TBI.

Chairwoman Leslie stated that she understood how difficult the situation was and thanked Mr. Inman for testifying before the Subcommittee on behalf of his son. She said she believed the Subcommittee would do everything possible to provide extra help for those in need.

Mr. Desruisseaux said he wanted to be sure the Subcommittee was aware of the Nevada Community Enrichment Program (N.C.E.P.), which conducted a post-acute rehabilitative program in Las Vegas. That program was separate from the Medicaid Program.

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY- HIFA MEDICAL - BUDGET ACCOUNT - 101-3247 - BUDGET PAGE HCF&P-31

Chairwoman Leslie commented that the Health Insurance Flexibility and Accountability (HIFA) waiver would expand coverage to pregnant women, provide a subsidy to employees of small employers, and offer catastrophic event coverage.

Chairwoman Leslie noted that it had been mentioned during the budget overview that The Executive Budget included a cap on the enrollment in Nevada Check Up, and since then there had been talk of a budget amendment to lift that cap. She asked Mr. Duarte to address that issue.

Mr. Duarte responded that the HIFA waiver included three budget accounts, Budget Account 3158, Budget Account 3155, and Budget Account 3247. While there were no General Funds in Budget Account 3158, Decision Unit E-409, and Budget Account 3247, Decision Unit E-409, funds would flow into those budget accounts from a holding account, Budget Account 3155, which provided state matching funds for the entire HIFA program.

Mr. Duarte said page 74 of Exhibit B provided highlights of the five-year projection associated with expenditures associated with the HIFA waiver.

Mr. Duarte addressed Chairwoman Leslie's question regarding the cap on enrollment in Nevada Check Up and said the Governor's recommendation included the HIFA waiver as it was proposed by the Legislative Committee on Health. Subsequent to that recommendation, the Division had been asked to reduce General Fund expenditures. Mr. Duarte said separate and apart from HIFA the Division had identified some areas where potentially General Fund expenditures could be reduced; one of those areas was capping enrollment in the Nevada Check Up Program. The Division had proposed capping enrollment at 30,000 children. Mr. Duarte said enrollment projections were that by July 2007 that cap would have been reached. The savings associated with that cap were approximately $1.5 million in the General Fund.

Mr. Duarte referred to page 76 of Exhibit B where it was outlined what would happen if the cap were lifted. The projection would include an additional 1,817 children above the 30,000 level. Mr. Duarte said there were two ways of approaching the issue. HIFA was an expansion program that utilized the State Children's Health Insurance Program (SCHIP) federal funds. However, the primary goal of the SCHIP was to expand coverage for children. That mission conflicted with the expansion goals of HIFA. In order to get HIFA approved, the cap would have to be removed, so the Division was working with the Director's Office on a number of other opportunities to live within the General Fund appropriations requested for both the HIFA waiver and Nevada Check Up. One option was to delay implementation of coverage of pregnant women in the HIFA waiver. Mr. Duarte said that by delaying that coverage from three to four months, enough General Fund money could be saved to live within the General Fund appropriations for the biennium. Mr. Duarte emphasized that the decision was not a policy decision but a funding decision made in order to cap the Nevada Check Up Program.

Chairwoman Leslie said she understood about the conflict, but wondered when the budget amendment would be presented to the Subcommittee.

Mr. Duarte responded that there were two options. One was to live within the appropriations requested for both HIFA and Nevada Check Up and the other was to work within those appropriations to implement both programs and not have to cap Nevada Check Up.

Chairwoman Leslie commented that the Division was considering reversing the policy and not cap Check Up, but work out the money so that there would be no budget amendment for more funding.

Mr. Duarte responded that the plan could involve delaying some implementation of some coverage groups in HIFA.

Chairwoman Leslie commented that the Subcommittee would like to see the plan as soon as it was available.

Chairwoman Leslie asked if Mr. Duarte knew if there would be enough Title XXI funds to attend to the vaccines and HIFA waiver and any other projects covered by those funds.

Mr. Duarte responded that he was fairly comfortable with that funding, but it was difficult to determine what might happen with Congress with respect to reallocation of SCHIP funds. Last month Congress had reallocated approximately $16.8 million of Nevada's federal allotment for SCHIP. Mr. Duarte said if progression remained along the same lines, he believed the necessary funds would be available. According to Mr. Duarte, the way that HIFA was structured provided opportunity to live within the federal appropriation and still continue the program, because there was flexibility in funding.

Chairwoman Leslie asked how the program was actually going to function. She said she knew the Welfare Division would be receiving four new positions to perform eligibility for pregnant women, but it was not clear who would be administering the Employer Insurance Program (EIP) and the Catastrophic Event Coverage.

Mr. Duarte responded that the Catastrophic Event Coverage would cover individuals for single incidents that would result in the need for acute care, such as an accident. The coverage was aimed at those individuals presently covered through the Accident Indigent Fund. Mr. Duarte said that coverage would require an accumulation of medical expenses for an individual by an agency, and then approving those bills for payment to the hospital.

Mr. Duarte said that function would probably be best handled by the Nevada Association of Counties (NACO) because they currently administered the Accident Indigent Fund. NACO could contract that function if so desired, but should have some oversight of those dollars. The specific contract being discussed with NACO had to do with the administration of a specific part of the program. Two positions had been recommended for NACO so that claims could be tracked and when the appropriate eligibility level was attained, NACO could authorize payment to a hospital.

Chairwoman Leslie asked if anything was in writing in terms of how the administration was going to work for the Catastrophic Event Coverage and the EIP. Mr. Duarte responded that there was more backup information available and the Division was planning to contract the EIP coverage to a private firm.

Chairwoman Leslie observed that it appeared as if that administration would cost approximately $1.9 million by 2010 when 8,000 people were covered. Mr. Duarte acknowledged that was correct. Chairwoman Leslie commented that 22 percent administrative cost seemed high. Mr. Duarte said the activities associated with administering the EIP were significant. The Division had examined the possibility of reducing the frequency of validation of an individual's eligibility for the subsidy, but it was a very complex administrative process.

Chairwoman Leslie asked how the EIP premium subsidy would work; would the subsidy go to the employer, the employee, or the insurance company. Mr. Duarte replied that the premium subsidy would go to the employee.

Chairwoman Leslie asked if the administrator of the program would have to ascertain that the employee actually paid the insurance with the funds. Mr. Duarte responded that was correct, and, in addition, the administrator would have to validate that the employer was actually offering credible coverage that met the criteria.

Mrs. Smith asked if the federal poverty levels were the basis for the EIP and what those levels were. Mr. Duarte responded that it was 200 percent of the federal poverty level (FPL).

Chairwoman Leslie stated that she understood that the Division did not have all the answers but if the program was going to be approved the Subcommittee would need a more detailed plan, especially regarding the cap on enrollment in Nevada Check Up and where the numbers would be if that happened.

Mr. Duarte said the Division had a projection of what the cost savings could be by delaying enrollment of pregnant women and offered to provide those figures to staff.

Chairwoman Leslie said the other lingering question in her mind was the Catastrophic Event Coverage, which could be the most problematic part of the waiver to receive approval. Chairwoman Leslie asked if the Division had

received any indication from the federal government that they would be approving that part.

Mr. Duarte responded that while the Division had not received definitive support from the federal government, they had not received any questions from CMS that would indicate the program would be impossible. Mr. Duarte said he did not foresee any insurmountable barriers to approval.

Chairwoman Leslie commented that she believed the program was a progressive way to increase insurance coverage in Nevada as Nevada was still the fourth worst state in the nation in that respect.

Mr. Duarte informed the Subcommittee that the dollar level for a family of four that equaled 200 percent of the federal poverty limit was $37,700, and for an individual the figure was $18,620 annually.

DEPARTMENT OF HUMAN RESOURCES
INCREASED QUALITY OF NURSING CARE - BUDGET ACCOUNT - 101-3160 - BUDGET PAGE HCF&P-33

Chairwoman Leslie said the Subcommittee was interested in hearing about the possible limitations on the provider tax. She said she understood the President's proposal was to reduce the ceiling from 6 percent to 3 percent and asked what effect that would have on Nevada's program.

Mr. Duarte directed the Subcommittee to page 13 of Exhibit B, which provided information regarding Budget Account 3160, established after the 2003 session when A.B. 395 was passed. That bill had authorized the Division to establish a tax on freestanding, long-term care facilities of not more than 6 percent of their total annual gross revenue. Those tax revenues were used as matching funds to enhance the rates that were paid to nursing facilities.

Mr. Duarte noted that a chart on page 14 of Exhibit B showed the statewide average per diem that was the base rate for nursing facility care in Nevada. That rate was $121.66 per day. With the revenue stream, which could be used for matching funds for federal revenue, the rate increased to $157.00 per day.

Mr. Duarte said the President's 2006 proposal considered reducing the use of those types of allowable taxes. However, the reduction would be from 6 percent of revenue to 3 percent of revenue. Mr. Duarte stated that essentially that proposed reduction would cut the net enhancement in half for those providers.

Mr. Duarte said it was very difficult to take money away after it had been given, and the Division was concerned that there could be pressure for the State to maintain the rate.

Chairwoman Leslie commented that everyone had agreed that should the federal government reduce those funds, the State would not make up the difference.

Chairwoman Leslie asked if "behaviorally challenged" referred to Alzheimer's patients. Mr. Duarte replied there were a number of individuals who fell into that description such as Alzheimer's patients, people with general dementia, individuals who needed long-term care but were mentally ill, and individuals with Traumatic Brain Injury. Mr. Duarte stated there were currently approximately 82 recipients in out-of-state placement. The Division contracted with a number of institutions in Utah, Idaho, and California to care for those individuals.

Chairwoman Leslie commented that need had to be addressed somehow in the State.

Mr. Duarte said the Division had continued to work with the nursing facility industry on developing a behavioral health long-term care rate. Mr. Duarte said there had not been much interest in Nevada, but there had been interest from out-of-state facilities. The biggest hurdle, currently, had been locating an appropriate facility at a reasonable cost for programs to be developed in Nevada.

Chairwoman Leslie asked Mr. Duarte if the Division had submitted a bill draft request (BDR) to make Nevada's long-term care provider tax program conform to federal law. Mr. Duarte replied that was correct. Chairwoman Leslie asked if the industry supported that BDR. Mr. Duarte replied that the industry was in support of amending the statutes associated with A.B. 395.

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY- NEVADA CHECK UP PROGRAM - BUDGET ACCOUNT - 101-3178 - BUDGET PAGE HCF&P-31

Chairwoman Leslie said the questions concerning Budget Account 3178 related to the proposed rate increases for pharmaceuticals in the HMO capitation and caseload growth. Chairwoman Leslie asked if the Division's actuary developed the proposed rate increases for HMO providers for the upcoming biennium and if any other entity had tested whether or not those increases were reasonable.

Mr. Duarte replied that the Division worked with a national actuary firm, Milliman USA, because that firm could accomplish work far beyond what the Division was capable of doing in-house.

Chairwoman Leslie noted that the increases were significant. Mr. Duarte said if the increases were compared over time, Nevada Check Up had seen a rate decrease of approximately 4 percent per year since 2001. Medicaid had seen an increase of approximately 5 percent per year. If those increases were compared with the average growth of expenditures for other populations in the program, it was a fairly cost-effective way of doing business, according to Mr. Duarte.

Chairwoman Leslie commented that the Division had requested the addition of three new Family Service Specialists, which were eligibility positions, and she wondered how the average caseload would change with those additions.

Mr. Duarte stated that in terms of caseload growth the Division counted on their partners who were a part of the Covering Kids and Families coalitions to perform outreach for the Division by spreading the word about the availability of services through Nevada Check Up and Nevada Medicaid for Children. In the past two months the Division had seen significant growth in caseload, which was attributed to mass mailings occurring in Clark County. Caseload growth in Budget Account 3178 had been capped and the Division was projecting that it would reach 30,000 by July 2005.

Chairwoman Leslie asked how many cases each eligibility employee maintained, because a legislative ration had not been approved. Mr. Duarte said he did not have those figures readily available but could provide them.

Chairwoman Leslie said last session there had been controversy regarding people being disenrolled when they failed to pay their premium. She wondered if that problem had been solved. Mr. Duarte said that issue had diminished and large numbers of families had been referred to Medicaid when their cases had been reviewed. In the past few months the program had gone from 25,000 enrollees to over 28,000 enrollees.

Chairwoman Leslie asked if the Division had a number of how many people failed to pay their premiums and were disenrolled. Mr. Duarte referred to page 81 of Exhibit B which contained a chart outlining the number of and reasons for disenrollment.

Chairwoman Leslie asked if there was a standard for redeterminations and was that standard being met. Mr. Duarte stated the Division was performing annual redeterminations and that activity was current.

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY- INTERGOVERNMENTAL TRANSFER PROGRAM - BUDGET ACCOUNT - 101-3157 - BUDGET PAGE HCF&P-46

Chairwoman Leslie requested comment from Mr. Duarte regarding the President's budget and the potential impact to the Upper Limit Payment (UPL) Program.

Mr. Duarte responded that Budget Account 3157 was an account that collected monies from the counties to aid in providing state matching funds necessary to provide subsidies to hospitals that served large numbers of indigent and Medicaid clients, as well as provide subsidies to public, non-state hospitals. He said there were two programs administered out of Budget Account 3157, the Disproportionate Share Hospital (DSH) Program and the UPL Program. With respect to the President's proposal for the federal budget in 2006, there were initiatives underway to curtail the use of Intergovernmental Transfers. Mr. Duarte said, essentially, the President and Mike Leavitt, Secretary of Health and Human Services, United States Department of Health and Human Services, had termed the use of Intergovernmental Transfers as a way of "cheating the federal taxpayer."

Mr. Duarte said the Division had attempted to assure the Department of Health and Human Resources that there was a patient on the other end of those dollars, and there were health care facilities that would otherwise struggle without those funds. In addition, the Division was very careful to maintain compliance with federal regulations.

Mr. Duarte commented that the Division was concerned about the possibility of the federal government curtailing Intergovernmental Transfers, because the net State benefit was approximately $22 million per year from the DSH Program and the UPL Program. If that money was not received it would create a $22 million hole in the General Fund.

With regard to the UPL Program, Mr. Duarte stated the Division had performed some recalculations of the payments to hospitals. The Division was using more reliable data to perform the analysis and that analysis had resulted in a decrease projection for FY2006-07 of approximately $2.4 million per fiscal year of General Fund.

Chairwoman Leslie stated the Subcommittee was concerned as well because Nevada was 50th in the nation for money received back from the federal government for the state's taxpayers.

Exhibit C, "Physician Experience with Medicaid Claims Processing Issues Associated with Medicaid Management Information System Transition," was presented to the Subcommittee members.

Chairwoman Leslie opened the hearing to public testimony.

Jon Sasser, Statewide Advocacy Coordinator, Washoe Legal Services, representing Nevada Covering Kids and Families Statewide Coalition, introduced himself for the record. Mr. Sasser presented Exhibit D, "Covering Kids and Families, Nevada Statewide Coalition," to the Subcommittee members.

Mr. Sasser stated that Covering Kids and Families (CKF) was a program that had been in existence for approximately five years. The program had originally been funded by a Robert Wood Johnson Foundation grant and the purpose of the program was to ensure that every Nevada child had access to health insurance. Mr. Sasser said the program worked with the State to attempt to change policies and procedures that would simplify enrolling in the program.

Mr. Sasser stated the CKF program had three concerns regarding the Nevada Check Up budget. The first concern was the 30,000 enrollment cap and Mr. Sasser said he was relieved to hear that the cap might be lifted.

The second concern was that the funding from the Robert Wood Johnson Foundation would expire in August 2006, with approximately 10 months left in the present biennium. Mr. Sasser stated that CKF was doing everything possible to secure private funding to replace the Robert Wood Johnson Foundation grant because those funds were the State match and no General Funds were used. Mr. Sasser said he believed that CKF was doing the State's job by using Robert Wood Johnson Foundation money to cover the State's General Fund. That match secured 65 cents on the dollar in federal money to perform enrollment and outreach activities. There had been a budget enhancement unit submitted for $140,000 to cover the State match for the last 10 months of the biennium if private fund-raising was unsuccessful.

Mr. Sasser said the third concern was staffing for Nevada Check Up.

Exhibit E, a packet of materials entitled "Covering Kids," was submitted to the Subcommittee.

Mary L. Coon, Program Coordinator, Clark County Health District, introduced herself and read the following testimony into the record:

> When Covering Kids first started in the whole state of Nevada, there were 68 percent of all applications for Nevada Check Up returned for lack of information. We have since gone out to the public, explained what the program is, and taught them how to complete the applications in both English and Spanish. That percentage is now down to 9 percent. In southern Nevada we evaluate every single thing we do, we are very cost conscious with the money that we have. We give out things to the general public that will stay in their homes and be a continuous reminder that there is low-cost, or free health insurance available through

Medicaid and Nevada Check Up. Also, we translate all of our materials into Spanish.

This program has been instrumental in increasing the numbers of enrolled children. There are many, many more eligible uninsured children living in our state. We estimate, in Clark County alone, there are approximately 32,000 eligible, uninsured children. We are currently working with the Clark County School District to get those children enrolled.

In addition, we visit libraries, laundromats, domestic violence programs, Welfare to Work programs, early Headstart, and Clark County school nurses. Twice a year I do an in-service for all 180 school nurses. They are true supporters, they are out there, they see those sick kids. The program needs to continue. The Robert Wood Johnson Foundation was very generous to the point of $10.8 million in the last 7 years. This program needs to go on so that we can say that no child who needs to see a doctor will not get that care.

Chairwoman Leslie asked if the $140,000 was in the budget or not. Mr. Sasser responded that the $140,000 had been an enhancement unit and was not in the budget.

Chairwoman Leslie adjourned the meeting at 10:52 a.m.

RESPECTFULLY SUBMITTED:

_____
Anne Bowen, Transcribing
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sheila Leslie, Chairwoman

DATE:_____

_____
Senator Barbara Cegavske, Chairwoman

DATE:_____

EXHIBITS

Committee Name: Joint Subcommittee on K-12/Human Resources

Date: March 1, 2005 Time of Meeting: 8:05 a.m.

Bill #	Exhibit ID	Witness	Dept.	Description
	A			Agenda
	B	Charles Duarte	Division of Health Care Financing and Policy	Budget Presentation FY2005-07
	C	Nevada State Medical Association		Physician Experience with Medicaid Claims, Processing Issues Associated with Medicaid Management Information System Transition
	D	Jon Sasser		Covering Kids and Families, Nevada Statewide Coalition
	E	Mary Coon		Covering Kids brochures